5-12-98

STATE MEDICAL BOARD OF OHIO

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

REQUEST FOR APPLICATION FORMS

MEDICAL OR OSTEOPATHIC

PLEASE TYPE OR PRINT CLEARLY

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

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

PERSONAL INFORMATION

NAME:	LAST (Surname)	FIRST	MIDDLE	SUFFIX (Jr., II)
	YAKLIC	JEROME	LUMETTA	

ADDRESS:	NUMBER & STREET			
	5980 FOX TRACE COURT			
	CITY	STATE	ZIP CODE	COUNTRY
	HUBER HGTS	OH	45424	USA

TELEPHONE: BUSINESS: AREA CODE & NUMBER (937)257-1941 HOME: AREA CODE & NUMBER (937) 236-3598

BIRTH DATE:	MO/DAY/YR	BIRTH PLACE:	CITY	STATE	COUNTRY
	12/12/65		GROSSE POINTE	MI	USA

MEDICAL OR OSTEOPATHIC EDUCATION

MEDICAL OR OSTEOPATHIC SCHOOL OF GRADUATION:	SCHOOL NAME		
	WAYNE STATE UNIVERSITY SCHOOL OF MEDICINE		
	STREET ADDRESS		
	CITY	STATE	COUNTRY
	DETROIT	MI	USA

DATES ATTENDED: FROM: MO/YR 8/88 TO: MO/YR 6/92

DEGREE RECEIVED: MD DATE RECEIVED: MO/DAY/YR 6/2/92

OVER ⇨

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

SCHOOL NAME		
NONE		
STREET ADDRESS		
CITY	STATE	COUNTRY

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

REASON DEGREE NOT RECEIVED AT THIS SCHOOL

SCHOOL NAME		
NONE		
STREET ADDRESS		
CITY	STATE	COUNTRY

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

REASON DEGREE NOT RECEIVED AT THIS SCHOOL

FIFTH PATHWAY PROGRAM

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

AFFILIATED WITH:

HOSPITAL OR INSTITUTION	
NONE	
NAME OF MEDICAL SCHOOL	
CITY	STATE

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

QUALIFYING EXAM TAKEN: DATE TAKEN: MO/YR /

CONTINUED ⇨

GRADUATE MEDICAL EDUCATION

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

month/year	Hospital, University or Other	Complete Street Address (Street & Number / City, State/Country, Zip)	Position & Department	Level of Training (check one only)
7 / 92 TO 6 / 96	WAYNE STATE UNIVERSITY / DETROIT MEDICAL CENTER			☑ 1st year ☑ 2nd year ☑ 3rd year or above
TO	NONE			☐ 1st year ☐ 2nd year ☐ 3rd year or above
TO	NONE			☐ 1st year ☐ 2nd year ☐ 3rd year or above
TO -	NONE			☐ 1st year ☐ 2nd year ☐ 3rd year or above

OVER ⇨

WRITTEN EXAMINATIONS TAKEN

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

STATE/PROVINCE	DATE TAKEN	TYPE OF EXAM	SECTIONS TAKEN	FINAL RESULTS
MICHIGAN	(MO/YR) 6/90	(✓ ONE ONLY) ☐FLEX (PRE-1985) ☐FLEX (1985-1994) ☒National Boards ☐USMLE ☐State Board ☐LMCC	(✓ ONE ONLY) ☐Partial ☐Full Component ☐I ☐II Part ☒1 ☐2 ☐3 Step ☐1 ☐2 ☐3 ☐Partial ☐Full ☐Partial ☐Full	(✓ ONE ONLY) ☒PASS ☐FAIL
MICHIGAN	(MO/YR) 9/91	(✓ ONE ONLY) ☐FLEX (PRE-1985) ☐FLEX (1985-1994) ☒National Boards ☐USMLE ☐State Board ☐LMCC	(✓ ONE ONLY) ☐Partial ☐Full Component ☐I ☐II Part ☐1 ☒2 ☐3 Step ☐1 ☐2 ☐3 ☐Partial ☐Full ☐Partial ☐Full	(✓ ONE ONLY) ☒PASS ☐FAIL
MICHIGAN	(MO/YR) 3/3/93	(✓ ONE ONLY) ☐FLEX (PRE-1985) ☐FLEX (1985-1994) ☒National Boards ☐USMLE ☐State Board ☐LMCC	(✓ ONE ONLY) ☐Partial ☐Full Component ☐I ☐II Part ☐1 ☐2 ☒3 Step ☐1 ☐2 ☐3 ☐Partial ☐Full ☐Partial ☐Full	(✓ ONE ONLY) ☒PASS ☐FAIL
	(MO/YR)	(✓ ONE ONLY) ☐FLEX (PRE-1985) ☐FLEX (1985-1994) ☐National Boards ☐USMLE ☐State Board ☐LMCC	(✓ ONE ONLY) ☐Partial ☐Full Component ☐I ☐II Part ☐1 ☐2 ☐3 Step ☐1 ☐2 ☐3 ☐Partial ☐Full ☐Partial ☐Full	(✓ ONE ONLY) ☐PASS ☐FAIL
	(MO/YR)	(✓ ONE ONLY) ☐FLEX (PRE-1985) ☐FLEX (1985-1994) ☐National Boards ☐USMLE ☐State Board ☐LMCC	(✓ ONE ONLY) ☐Partial ☐Full Component ☐I ☐II Part ☐1 ☐2 ☐3 Step ☐1 ☐2 ☐3 ☐Partial ☐Full ☐Partial ☐Full	(✓ ONE ONLY) ☐PASS ☐FAIL
-	(MO/YR)	(✓ ONE ONLY) ☐FLEX (PRE-1985) ☐FLEX (1985-1994) ☐National Boards ☐USMLE ☐State Board ☐LMCC	(✓ ONE ONLY) ☐Partial ☐Full Component ☐I ☐II Part ☐1 ☐2 ☐3 Step ☐1 ☐2 ☐3 ☐Partial ☐Full ☐Partial ☐Full	(✓ ONE ONLY) ☐PASS ☐FAIL

CONTINUED ⇨

LICENSES IN THE UNITED STATES & CANADA

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

STATE/PROVINCE	ISSUE DATE	LICENSE #	BASIS OF LICENSE	LICENSE CURRENT
MICHIGAN	(MO/YR)	4301059625	(✓ ONE ONLY) ☒National Boards ☐FLEX ☐State Board exam ☐USMLE ☐LMCC ☐Other: ______	(✓ ONE ONLY) ☒YES ☐NO Expiration Date: 01/31/2001
	(MO/YR)		(✓ ONE ONLY) ☐National Boards ☐FLEX ☐State Board exam ☐USMLE ☐LMCC ☐Other: ______	(✓ ONE ONLY) ☐YES ☐NO Expiration Date: ______
	(MO/YR)		(✓ ONE ONLY) ☐National Boards ☐FLEX ☐State Board exam ☐USMLE ☐LMCC ☐Other: ______	(✓ ONE ONLY) ☐YES ☐NO Expiration Date: ______
	(MO/YR)		(✓ ONE ONLY) ☐National Boards ☐FLEX ☐State Board exam ☐USMLE ☐LMCC ☐Other: ______	(✓ ONE ONLY) ☐YES ☐NO Expiration Date: ______
	(MO/YR)		(✓ ONE ONLY) ☐National Boards ☐FLEX ☐State Board exam ☐USMLE ☐LMCC ☐Other: ______	(✓ ONE ONLY) ☐YES ☐NO Expiration Date: ______
	(MO/YR)		(✓ ONE ONLY) ☐National Boards ☐FLEX ☐State Board exam ☐USMLE ☐LMCC ☐Other: ______	(✓ ONE ONLY) ☐YES ☐NO Expiration Date: ______
	(MO/YR)		(✓ ONE ONLY) ☐National Boards ☐FLEX ☐State Board exam ☐USMLE ☐LMCC ☐Other: ______	(✓ ONE ONLY) ☐YES ☐NO Expiration Date: ______
	(MO/YR)		(✓ ONE ONLY) ☐National Boards ☐FLEX ☐State Board exam ☐USMLE ☐LMCC ☐Other: ______	(✓ ONE ONLY) ☐YES ☐NO Expiration Date: ______
	(MO/YR)		(✓ ONE ONLY) ☐National Boards ☐FLEX ☐State Board exam ☐USMLE ☐LMCC ☐Other: ______	(✓ ONE ONLY) ☐YES ☐NO Expiration Date: ______

OVER ⇨

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

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

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

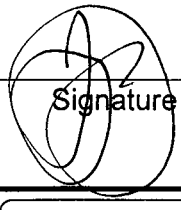
FEDERATION CREDENTIALS VERIFICATION SERVICE

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

If yes, date forwarded: 6 APR 98

CERTIFICATION

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



Signature of Applicant

6 APR 98
Date

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

18-1048

MEDICINE OR OSTEOPATHIC MEDICINE - PRELIMINARY EDUCATION FORM

TO BE COMPLETED BY ALL APPLICANTS

	LAST (Surname)	FIRST	MIDDLE	SUFFIX (Jr., II)
NAME:	YAKLIC	JEROME	LUMETTA	

HIGH SCHOOL OR EQUIVALENT:

SCHOOL NAME		
CHIPPEWA VALLEY HIGH SCHOOL		
CITY	STATE	COUNTRY
CLINTON TWP	MI	USA

DATES ATTENDED: FROM: MO/YR 9/80 TO: MO/YR 6/84

UNDERGRADUATE COLLEGE OR EQUIVALENT:

SCHOOL NAME		
ALBION COLLEGE		
CITY	STATE	COUNTRY
ALBION	MI	USA

DATES ATTENDED: FROM: MO/YR 8/84 TO: MO/YR 6/88 DEGREE RECEIVED: BA - CHEMISTRY

RJBolte

SCHOOL NAME		
CITY	STATE	COUNTRY

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

MEDICAL OR OSTEOPATHIC SCHOOL OF GRADUATION:

SCHOOL NAME		
WAYNE STATE UNIV. SCHOOL OF MEDICINE		
CITY	STATE	COUNTRY
DETROIT	MI	USA

DATES ATTENDED: FROM: MO/YR 8/88 TO: MO/YR 6/92 DEGREE RECEIVED: MD

FOR BOARD USE ONLY

CERTIFICATE OF PRELIMINARY EDUCATION

NO: 94682 DATE ISSUED: JUL 08 1998

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

Ray K Baumgartner
Entrance Examiner

Anand G. Gregan
Secretary

Revised 05/20/97

CONTINUED ⇨

STATE MEDICAL BOARD OF OHIO

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

FOR BOARD USE ONLY
☐ 34 ☒ 35
BK: 18 PG: 10 LN: 48
DATE: 6-13-98 FEE: $335.00 PMT: ✓

APPLICATION FOR CERTIFICATE - MEDICINE OR OSTEOPATHIC MEDICINE

5025

PLEASE TYPE OR PRINT CLEARLY

1. Social Security Number: Redacted

2. Full Name (Use no initials): LAST (Surname) YAKLIC | FIRST JEROME | MIDDLE LUMETTA | SUFFIX (Jr., II)

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

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

5. Current Address: STREET & NUMBER 5980 FOX TRACE COURT
CITY HUBER HGTS | STATE OHIO | ZIP CODE 45424 | COUNTRY USA

6. Physical Description:

HEIGHT	WEIGHT	HAIR COLOR	EYE COLOR	IDENTIFYING MARKS
6'2"	205	BROWN	GREEN	NONE

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

8. City In Ohio Where You Plan To Practice: CITY DAYTON OR COUNTY

PLANS OF PRACTICE: OBSTETRICS AND GYNECOLOGY

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

Name of Specialty Board	Board Certified Yes	Board Certified No	Year Certified	Country
AMERICAN BOARD OF OBSTETRICS AND GYNECOLOGY	☐	☐	WRITTEN BOARDS PASSED ORAL EXAM PENDING 11/98	
	☐	☐		
	☐	☐		

STATE MEDICAL BOARD OF OHIO
JUN 13 PM 2:59

RESUME - MEDICINE OR OSTEOPATHIC MEDICINE

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

6-92 graduation to: Yakic

A

month/year	Hospital, University or Other:	Position & Department	% Clinical
7 96	WRIGHT-PATTERSON USAF MEDICAL CENTER 74TH MDG /SGOG.	DEPT OF OB/GYN STAFF PHYSICIAN CHIEF OUTPATIENT SERVICES	75
TO	Complete Street Address: 4881 SUGAR MAPLE DRIVE Number & Street		% Admin. 25
PRESENT	WRIGHT-PATTERSON AFB, OH 45433 City State/Country Zip Code		

B

month/year	Hospital, University or Other:	Position & Department	% Clinical
6 92	Detroit Medical Center / Wayne State University / Dept OB/GYN	Resident Physician in OB/GYN	100
TO	Complete Street Address: 4707 St. Antoine Number & Street		% Admin. —
6 96	Detroit MI 48201 City State/Country Zip Code		

C

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

D

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

OVER

RESUME - MEDICINE OR OSTEOPATHIC MEDICINE

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

Ugaklic

i.e. 92 graduation to:

A

month/year	Hospital, University or Other:	Position & Department	% Clinical
7 96	WRIGHT-PATTERSON USAF MEDICAL CENTER 74TH MDG / SGOG.	DEPT OF OB/GYN	75
TO	Complete Street Address: 4881 SUGAR MAPLE DRIVE	STAFF PHYSICIAN CHIEF OUTPATIENT SERVICES	% Admin. 25
PRESENT	Number & Street		
month/year	WRIGHT-PATTERSON AFB, OH 45433		
	City State/Country Zip Code		

B

month/year	Hospital, University or Other:	Position & Department	% Clinical
6 92	Detroit Medical Center / Wayne State University / Dept OB/GYN	Resident Physician in OB/GYN	100
TO	Complete Street Address: 4707 St. Antoine		% Admin. —
6 96	Number & Street		
month/year	Detroit MI 48201		
	City State/Country Zip Code		

C

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

D

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

STATE MEDICAL BD OF OHIO
98 JUN 11 PM 12:

OVER

To: State Medical Board of Ohio

From: Jerome L. Yaklic, MD

RE: Application for state licensure

Attached please find my clinical resume with the addition of the time period from 6/92 to 6/96. I was a resident in obstetrics and gynecology during this time period. If you require any further information or confirmation please contact me at:

Jerome L. Yaklic, MD
5980 Fox Trace Court
Huber Heights, Ohio 45424-5457

937-236-3598

RESUME - MEDICINE OR OSTEOPATHIC MEDICINE

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

Ugaklic

A

7 96 month/year TO PRESENT month/year

Hospital, University or Other: WRIGHT-PATTERSON USAF MEDICAL CENTER 74TH MDG /SGOG.

Complete Street Address: 4881 SUGAR MAPLE DRIVE (Number & Street)

WRIGHT-PATTERSON AFB, OH 45433 (City / State/Country / Zip Code)

Position & Department: DEPT OF OB/GYN; STAFF PHYSICIAN; CHIEF OUTPATIENT SERVICES

% Clinical: 75

% Admin.: 25

B

month/year TO month/year

Hospital, University or Other:

Complete Street Address: (Number & Street)

City / State/Country / Zip Code

Position & Department

% Clinical

% Admin.

C

month/year TO month/year

Hospital, University or Other:

Complete Street Address: (Number & Street)

City / State/Country / Zip Code

Position & Department

% Clinical

% Admin.

D

month/year TO month/year

Hospital, University or Other:

Complete Street Address: (Number & Street)

City / State/Country / Zip Code

Position & Department

% Clinical

% Admin.

98 JUN 11 PM 2:59 OHIO STATE MEDICAL BOARD

OVER ⇨

RESUME - MEDICINE OR OSTEOPATHIC MEDICINE
PAGE TWO

E

month/year TO month/year

Hospital, University or Other:

Complete Street Address:

Number & Street

City State/Country Zip Code

Position & Department

% Clinical

% Admin.

F

month/year TO month/year

Hospital, University or Other:

Complete Street Address:

Number & Street

City State/Country Zip Code

Position & Department

% Clinical

% Admin.

G

month/year TO month/year

Hospital, University or Other:

Complete Street Address:

Number & Street

City State/Country Zip Code

Position & Department

% Clinical

% Admin.

H

month/year TO month/year

Hospital, University or Other:

Complete Street Address:

Number & Street

City State/Country Zip Code

Position & Department

% Clinical

% Admin.

CONTINUED ⇨

STATE MEDICAL BOARD OF OHIO

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

MEDICINE OR OSTEOPATHIC MEDICINE

FORM 1 - CERTIFICATE OF RECOMMENDATION

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

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

BLACK & WHITE PHOTOS ARE NOT ACCEPTABLE

I, Mark C Bidwell (recommending physician), a licensed and practicing physician in the state of Ohio (state of residence), affirm that JEROME YAKLIC (applicant) has been known to me personally for 2 years and that he/she is of good moral character.

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

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

*His/her relationship with patients is: excellent

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

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

*Additional comments: I recommend Dr. Yaklic without hesitation

I hereby recommend him/her to practice medicine or osteopathic medicine in the State of Ohio.

OVER ⇨

FORM 1 - CERTIFICATE OF RECOMMENDATION
MEDICINE OR OSTEOPATHIC MEDICINE

Mark C. Bidwell MD
Signature of Recommending Physician
(name stamps not acceptable)

Mark C. Bidwell, MD
Name of Recommending Physician
(please type or print clearly)

(937) 257-1941
Telephone Number
(include area code)

USAF Medical Center/SGHO
4881 Sugar Maple Dr.
WPAFB, Ohio 45433
Address of Recommending Physician
(include city, state and zip code)

Ohio 526666
State of Licensure & License Number of Recommending Physician
(please type or print clearly)

Subscribed and sworn to before me this 11th day of June, 1998.

Agnes M. Stannard
Notary Public Signature

AGNES M. STANNARD
Notary Public, State of Ohio
My Commission Expires 10-4-98
Date Commission Expires

(NOTARY SEAL)

Signature of Applicant

Date Photo Taken: 6/98
Mo/Yr

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

Revised 09/05/96

STATE MEDICAL BOARD OF OHIO
77 South High Street, 17th Floor • Columbus, Ohio 43266-0315 • (614)466-3934

MEDICINE OR OSTEOPATHIC MEDICINE

FORM 1 - CERTIFICATE OF RECOMMENDATION

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

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

BLACK & WHITE PHOTOS ARE NOT ACCEPTABLE

I, Marwan Almyahi, a licensed and practicing physician in the state of
(recommending physician)

Ohio, affirm that JEROME YAKLIC
(state of residence) (applicant)

has been known to me personally for 2 years and that he/she is of good moral character.

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

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

*His/her relationship with patients is: Excellent

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

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

*Additional comments: Good Sayen Physician,

I hereby recommend him/her to practice medicine or osteopathic medicine in the State of Ohio.

OVER ⇨

FORM 1 - CERTIFICATE OF RECOMMENDATION
MEDICINE OR OSTEOPATHIC MEDICINE

Marvin D Almquist
Signature of Recommending Physician
(name stamps not acceptable)

Marvin Almquist
Name of Recommending Physician
(please type or print clearly)

(513) 755 1014
Telephone Number
(include area code)

8999 Hiakeah Dr.
Address of Recommending Physician
(include city, state and zip code)
West Chester, Oh. 45069

Ohio 35068719-A
State of Licensure & License Number of Recommending Physician
(please type or print clearly)

Subscribed and sworn to before me this 15th day of June, 1998.

Agnes M. Stannard
Notary Public Signature

(NOTARY SEAL)

Date Commission Expires

AGNES M. STANNARD
Notary Public, State of Ohio
My Commission Expires 10-4-98

Signature of Applicant

Date Photo Taken: 6/98
Mo/Yr

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

Revised 09/05/96

State of Michigan
John Engler, Governor

Department of Consumer & Industry Services
Kathleen M. Wilbur, Director

Office of Health Services
Thomas C. Lindsay II, Director

Ottawa Building
P.O. Box 30670
Lansing, Michigan 48909-8170
Telephone: 517-335-0918
TDD: 517-373-7489

MICHIGAN BOARD OF MEDICINE
VERIFICATION OF LICENSURE AS OF 09/15/98

MEDICAL BOARD
77 S HIGH ST 17TH FL
COLUMBUS OH 43266-0315

Board: 43 Profession 01 ID Number: 059625 Type: R Format: Y

Name: JEROME LUMETTA YAKLIC MD SSN: Redacted
Address: 40370 SKENDER DRIVE Birth Date: 12/12/65
CLINTON TOWNSHIP MI 48038

Type: MEDICAL DOCTOR Original Date: 08/03/94
License Number: 4301059625 Status: LICENSED Expiration Date: 01/31/01
Qualified By: EXAMINATION

Fee Received: 09/08/98

Disciplinary Action: NONE
Open Formal Complaints: NONE

Tracey Peck

PERMANENT ADDRESS (ADDRESS ON MICHIGAN MEDICAL LICENSE)
40370 SKENDER DRIVE
CLINTON TWP, MICHIGAN 48038

STATE MEDICAL BOARD OF OHIO

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

MEDICINE OR OSTEOPATHIC MEDICINE

FORM 2 - VERIFICATION OF LICENSE

I am applying for a license to practice medicine or osteopathic medicine and surgery in the State of Ohio. The State Medical Board of Ohio requires that this form be completed by each state or Canadian Province in which I hold or have held licenses, whether now current or not. Please complete the form and return it directly to the State Medical Board of Ohio at the above address.

TO BE COMPLETED BY APPLICANT

Name: YAKLIC JEROME LUMETTA
last first middle suffix

Current Address: 5980 FOX TRACE CT License Number: 4301059625
Street Address

HUBER HGTS. OH 45424 Date of Birth: 12/12/65
City State Zip month/day/year

Medical/Osteopathic
School of Graduation: WAYNE STATE UNIV. SCHOOL OF MEDICINE

I hereby authorize the licensing agency of the State of MICHIGAN to furnish the information below to the State Medical Board of Ohio.

Signature of Applicant 8 JUNE 1998
Date

TO BE COMPLETED BY STATE BOARD OR CANADIAN PROVINCE

State: _____

Name of Licensee: _____
last first middle suffix

License Number: _____ Issue Date: _____
month/day/year

FORM 2 - VERIFICATION OF LICENSE
MEDICINE OR OSTEOPATHIC MEDICINE-
PAGE TWO

Is the applicant currently the subject of a pending investigation by a licensing or disciplinary authority in your state?

☐ Yes ☐ No ☐ Cannot answer under current state law

If yes, please attach complete details.

Have formal disciplinary proceedings been initiated against applicant's license by a disciplinary authority in your state?

☐ Yes ☐ No ☐ Cannot answer under current state law

If yes, please attach complete details.

Has the applicant ever been warned, censured or in any other manner disciplines or has applicant's license been revoked, suspended, or in any other manner limited by a licensing or disciplinary authority in your state?

☐ Yes ☐ No ☐ Cannot answer under current state law

If yes, please attach complete details.

_____
Signature

_____
Title

AFFIX BOARD SEAL
NOT VALID WITHOUT SEAL.

_____
Date

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

ADDITIONAL INFORMATION - MEDICINE OR OSTEOPATHIC MEDICINE

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

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

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

OVER ⇨

ADDITIONAL INFORMATION - MEDICINE OR OSTEOPATHIC MEDICINE
PAGE TWO

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

CONTINUED ⇨

ADDITIONAL INFORMATION - MEDICINE OR OSTEOPATHIC MEDICINE
PAGE THREE

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

State Medical Board of Ohio

77 S. High Street, 17th Floor • Columbus, Ohio 43266-0315 • 614/ 466-3934 • Website: www.state.oh.us/med/
Direct Dial 614-728-3055
Fax 614-466-4670 OR 614-728-5946

WPAFB

June 30, 1998

Dear Doctor:

Dr. Jerome Lumetta Yaklic who is/was Staff Physician OB/GYN 7/96 - present 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 application. ***This form MUST be completed and mailed or faxed to our office within two (2) weeks to ensure processing of the doctor's application.*** Your immediate attention to this matter will be greatly appreciated by the applicant as well as by us. Information provided is considered confidential under Section 149.42(A)(2)(a), Ohio Revised Code. Thank you for your time and assistance.

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

(2) What is/was your supervisory capacity? I am medical director of the department.

(3) At what hospital? WRIGHT PATTERSON USAF MEDICAL CENTER

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

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

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

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

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

(9) Would you recommend him/her for licensure? yes, without hesitation

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

Please return this form to the Ohio State Medical Board at the above address, or fax response to above number.

Sincerely,

Annette Jones

Annette Jones
Licensure Assistant

MD
Signature of Physician

KATHLEEN M. McCAULEY
Name of Physician (please type or print clearly)

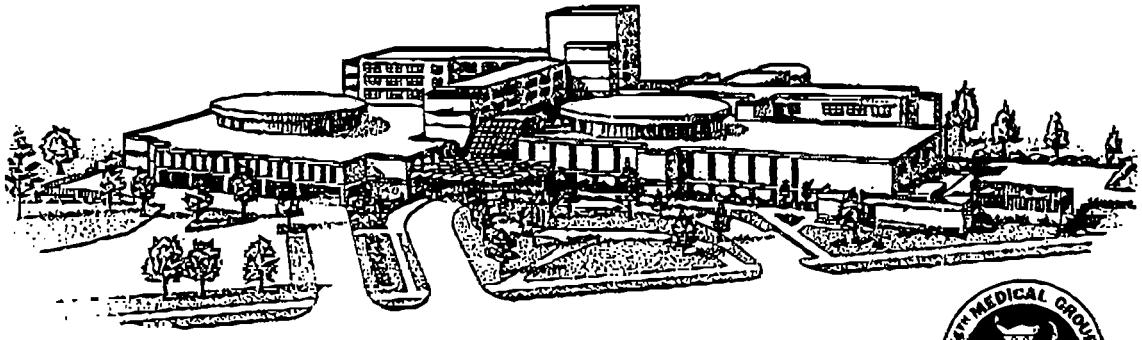
MEDICAL DIRECTOR, OB/GYN
Position

937-257-1941
Telephone number (include area code)

WRIGHT-PATTERSON MEDICAL CENTER
74th MEDICAL GROUP
4881 SUGAR MAPLE DR. WRIGHT-PATTERSON AFB OH 45433-5529

OBSTETRICS & GYNECOLOGY

OFFICE: DSN 787-1941 **COMMERCIAL** (937) 257-1941
FAX: DSN 787-3012 **COMMERCIAL** (937) 257-3012



TO: STATE MEDICAL BOARD OF OHIO

OFFICE NUMBER: 614 - 728 - 3055

FAX NUMBER: 614 - 466 - 4670

FROM SGOG/ K. McCAULEY, COL.

OFFICE NUMBER: 937- 257- 1941

NUMBER OF PAGES: 2 (including cover)

COMMENTS:

TRANSMITTAL DATE: 7 July 98 **TIME:** 1730

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

Physician Information Profile

This report is compiled exclusively for:

Name: **Jerome Lumetta Yaklic**
SSN: Redacted
DOB: **12/12/1965**
Recipient: **State Medical Board of Ohio**

NOTICE:

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

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

Table of Contents

Section I:

FCVS / FSMB Reports

FEDERATION CREDENTIALS VERIFICATION SERVICE

Physician Information Report

Identity:

Name:	**Jerome Lumetta Yaklic**	
Other Name Used:	**N/A**	
Gender:	**Male**	
Date of Birth:	**12/12/1965**	
Place of Birth:	**Grosse Point, MI**	
SSN:	Redacted	
Current Address:	**5980 Fox Trace Court** **Huber Heights, OH 45424-5457**	
Permanent Address:	**Same**	
Telephone Numbers:	Bus.:	**(937) 257-1941**
	Fax:	**N/A**
	Home:	**(937) 236-3598**
	Other:	**N/A**
Physical Description:	Height:	**6' 2"**
	Weight:	**205 lbs**
	Eye Color:	**Green**
	Hair Color:	**Brown**
Physical Marks:	Location:	**N/A**
	Description:	**N/A**

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

Institution:	**Albion College** **Albion, MI 49224**
Dates of Attendance:	**08/00/1984 - 06/00/1988**
Degree Awarded:	**Bachelor of Arts**

Medical Education:

Medical School:	**Wayne State University School of Medicine** **540 East Canfield Street Room 1272** **Detroit, MI 48201**
Dates of Attendance:	**08/22/1988 - 05/31/1992**
Graduation Date:	**06/02/1992**
Degree Awarded:	**Doctor of Medicine**
Unusual Circumstance:	**None**

Post Graduate Medical Education:

Institution:	**Wayne State University Hutzel Hospital** **Department of Obstetrics and Gynecology** **4704 St. Antoine** **Detroit, MI 48201**
Post Graduate Year:	**1**
Program Type:	**Internship**
Department:	**Obstetrics/Gynecology**
Dates of Attendance:	**07/01/1992 - 06/30/1993**
Completion:	**Yes**
Accreditation:	**ACGME**
Post Graduate Year:	**2-4**
Program Type:	**Residency**
Department:	**Obstetrics/Gynecology**
Dates of Attendance:	**07/01/1993 - 06/30/1996**
Completion:	**Yes**
Accreditation:	**ACGME**
Unusual Circumstance:	**None**

Examination History:

Transcripts Enclosed For:	**NBME Part I** **NBME Part II** **NBME Part III**

Board Action:

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

End of Report for:	**Jerome Yaklic, MD** **Packet ID #7310**

FEDERATION CREDENTIALS VERIFICATION SERVICE

Credentials Discrepancy* Report

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

Section of Profile in Question	FCVS Interpretation of Discrepancy	Solution to Discrepancy
Premedical Education	The applicant did not report complete dates of attendance for Albion College (month and year only).	Left to Board discretion.
Verification of Medical Education Wayne State University School of Medicine	This institution responded to the premedical education requirement by noting ''N/A;'' however, it did report an institution name and the courses taken.	Left to Board discretion.
Verification of Postgraduate Medical Education Wayne State University Hutzel Hospital	The applicant reports Program Type for PGY 1 is Residency. The institution reports Program Type for PGY 1 is Internship.	Left to Board discretion.

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

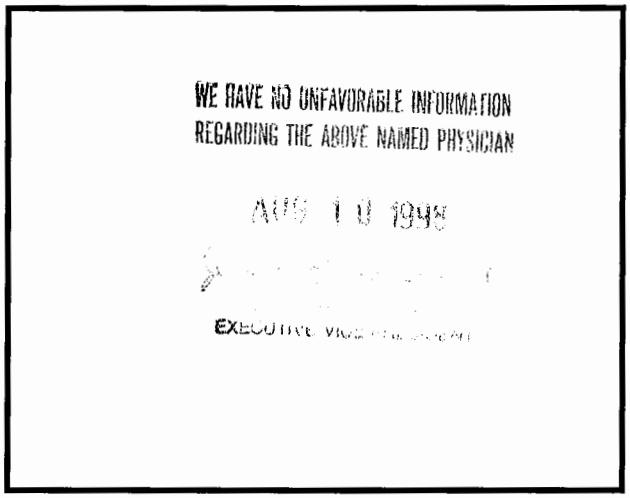
FCVS PACKET ID: 0007310

FEDERATION CREDENTIALS VERIFICATION SERVICE

Board Action Databank Search

State Queried For:	**Ohio**
Physician's Name:	**Yaklic, Jerome Lumetta**
Generational Suffix:	**N/A**
Degree:	**MD**
Date of Birth:	**12/12/1965**
Medical School:	**Wayne State University School of Medicine Detroit, MI**
Year of Graduation:	**1992**
Social Security Number:	Redacted
ECFMG Number:	**N/A**

Results:



Section II:

Identity

AFFIDAVIT AND RELEASE FROM APPLICANT

I, JEROME L YAKLIC,
(type/print your complete name)

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

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

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

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

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

YAKLIC
Applicant's **Printed** Last Name

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

12 MAY 1998
Date of Signature (must correspond to date of notarization)

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

State of KENTUCKY, County of HARDIN,
I certify that on the date set forth below the individual named above did appear personally before me and that I did identify this applicant by: (a) comparing his/her physical appearance with the photograph on the identifying document presented by the applicant and with the photograph affixed hereto, and (b) comparing the applicant's signature made in my presence on this form with the signature on his/her identifying document. The statements on this document are subscribed and sworn to before me by the applicant on this 12 day of MAY, 19 98.

Notary Public signature: Steven J. Mentz

My commission expires: 11/25/2001

PACKET ID: 0007310

By the signature and seal affixed hereto, the Federation Credentials Verification Service certifies that this page was copied directly from the original document.

Name: Donny Young Date: 5/20/97

Title: Credentials Verification Analyst

The Secretary of State
of the United States of America
hereby requests all whom it may concern to permit the citizen/
national of the United States named herein to pass
without delay or hindrance and in case of need to
give all lawful aid and protection.

Le Secrétaire d'Etat
des Etats-Unis d'Amérique
prie par les présentes toutes autorités compétentes de laisser passer
le citoyen ou ressortissant des Etats-Unis titulaire du présent passeport,
sans délai ni difficulté et, en cas de besoin, de lui accorder
toute aide et protection légitimes.

Jerome L Yaklic

SIGNATURE OF BEARER/SIGNATURE DU TITULAIRE

UNITED STATES OF AMERICA

PASSPORT
PASSEPORT

Type/Catégorie: P

Code of issuing State / code du pays émetteur: USA

PASSPORT NO./NO. DU PASSEPORT: 022293639

Surname / Nom: YAKLIC

Given names / Prénoms: JEROME LUMETTA

Nationality / Nationalité: UNITED STATES OF AMERICA

Date of birth / Date de naissance: 12 DEC/DEC 65

Sex / Sexe: M

Place of birth / Lieu de naissance: MICHIGAN, U.S.A.

Date of issue / Date de délivrance: 11 MAY/MAI 87

Date of expiration / Date d'expiration: 10 MAY/MAI 97

Authority / Autorité: PASSPORT AGENCY
CHICAGO

Amendments/ Modifications
SEE PAGE
24

P<USAYAKLIC<<JEROME<LUMETTA<<<<<<<<<<<<<<<<<<

0222936392USA6512127M9705102<<<<<<<<<<<<<<<<0

Section III:

Medical Education

FEDERATION CREDENTIALS VERIFICATION SERVICE (FCVS)

VERIFICATION OF MEDICAL EDUCATION

(This form must be completed by the medical school)

INSTRUCTIONS TO THE DEAN

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

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

VERIFICATION OF MEDICAL EDUCATION

Name of Institution: Wayne State University School Of Medicine

Complete Address:

Records & Registration
Wayne State University
School of Medicine
540 E. Canfield
Detroit, Mich. 48201

Street Address

Street Address

City State Zip Code(Postal Code)

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

Enrollment and Participation: Our records indicate that JEROME LUMETTA YAKLIC
(type/print individual's name: Last, First, Middle, Suffix)
attended our medical school for total of 4yrs [redacted] of continuous on-campus education on the following dates (mm/dd/yy):

From	To
8 / 22 / 88	5 / 26 / 89
8 / 22 / 89	5 / 21 / 90
7 / 09 / 90	6 / 21 / 91
7 / 01 / 91	5 / 31 / 92
/ /	/ /

This individual (check one):

✓ was awarded the degree of Doctor of Medicine on 06 / 02 / 92 (mm/dd/yy)

_____ was NOT awarded a degree (please attach an explanation)

VERIFICATION OF MEDICAL EDUCATION (continued)

Unusual Circumstances: The following questions apply to unusual circumstances that occurred during any part of the individual's medical education. Please circle the appropriate response. **"Yes" responses to any of these questions requires a written explanation.**

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

Premedical Education: Does your school have a premedical education requirement? Yes N/A No

If yes, include where your records indicate the individual completed his/her premedical education and the basic science courses taken (attach additional pages if necessary):

Premedical Institution(s): Albion College

Check Courses Taken: ✓ Physics _____ Biology/Zoology

✓ Organic Chemistry _____ Inorganic Chemistry

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

AFFIX INSTITUTIONAL SEAL HERE

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

Signature: Sandra J. Driscoll

MS. SANDRA J. Driscoll

Title: RECORDER

Date of Signature: 7/14/98

Telephone: (313) 577-1470

RECEIVED
JUN 29 1998
RECORDS & REGISTRATION OFFICE
WAYNE STATE UNIVERSITY SCHOOL OF MEDICINE

Wayne State University
School of Medicine
Detroit, Michigan 48201

Academic Record of :
YAKLIC, JEROME LUMETTA
40370 SKENDER DR
MT CLEMENS, MI 48044

Social Security Number :
Redacted
Date Admitted :
08/22/88

Place of Birth :	Date of Birth :	Legal Guardian :
GROSSE PTE FRMS, MI	12/12/65	JOSEPH R. YAKLIC

College(s) Attended :	Dates Attended :	Degree(s)	Earned :
ALBION COLLEGE	1984-1988	BA	06/88

Year I : 1988-1989

BIOCHEMISTRY	S
GENETICS	H
GROSS ANATOMY	S
HISTOLOGY/EMBRYOLOGY	S
NEUROSCIENCES	S
PHYSIOLOGY	S

Comprehensive Evaluation S

Year II : 1989-1990

BIOSTATS/EPIDEMIOLOGY	S
HEALTH CARE ISSUES	S
IMMUNOLOGY/MICROBIOLOGY	S
PATHOLOGY	S
PATHOPHYSIOLOGY	S
PHARMACOLOGY	S
PHYSICAL DIAGNOSIS	S
PSYCHIATRY	S

Comprehensive Evaluation S

Year III Clerkships: 1990-91

FAMILY MEDICINE	S
MEDICINE	H
OBSTETRICS/GYNECOLOGY	S
OPHTHALMOLOGY	S
OTOLARYNGOLOGY	S
PEDIATRICS	S
PSYCHIATRY	S
SURGERY	S

Comprehensive Evaluation S

Year IV Electives: 1991-92

ANESTHESIA	S
CLINICAL CARDIOLOGY	S
DIAGNOSTIC RADIOLOGY	S
EMERGENCY MEDICINE	S
GEN INTERNAL MEDICINE	S
NEUROLOGY	S
OB/GYN	S
REPRODUCTIVE GENETICS	S

Remarks : Doctor of Medicine Degree Granted : 6/02/92

JUL 14 1998

Sandra J. Driscoll MA

Official transcripts bear the seal and signature of the Registrar

Wayne State University

Upon the recommendation of

School of Medicine

the Board of Governors hereby confers upon

Jerome Lumetta Yaklic

the degree

Doctor of Medicine

in recognition of the achievements
specified for this degree

June 2, 1992
Detroit, Michigan

(TRUE COPY OF AN ORIGINAL DOCUMENT)

WAYNE STATE UNIVERSITY · 1868 ·

Sandra J. Driscoll

Ms. Sandra J.. Driscoll/Recorder
7/14/98

David Adamany
President of the University

Clemetene McClain
Secretary, Board of Governors

Section IV:

Postgraduate Medical Education

RECEIVED JUL 2 0 1998

FEDERATION CREDENTIALS VERIFICATION SERVICE (FCVS)

VERIFICATION OF POSTGRADUATE MEDICAL EDUCATION

(This form must be completed by the Program Director)

INSTRUCTIONS TO THE PROGRAM DIRECTOR

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

POSTGRADUATE MEDICAL EDUCATION HISTORY

Name of Institution: Wayne State Universtiy Hutzel Hospital

Complete Address: 4707 St. Antoine
Street Address
OB/GYN Residency office
Street Address
Detroit MI 48201
City State Zip Code(Postal Code)

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

Name and complete address of affiliated university/college: Wayne State University
Institution
OB/GYN Residency office
Street Address
4707 St. Antoine
Street Address
Detroit MI 48201
City State Zip Code(Postal Code)

Enrollment and Participation: Our records indicate that Jerome Yaklic, M.D.
(type/print individual's name: Last, First, Middle, Suffix)

participated in the following:

Program Type (Internship,Residency, Fellowship)	PGY (1,2,3,4)	Department (Pathology, Internal Medicine, etc.)	Dates Attended (month/day/year) From	To	Completed (Yes/No)	Accredited By (ACGME, RSC, AOA or Not Accredited)
Internship	1	OB/GYN	7/1/92	6/30/93	Yes	ACGME
Residency	2-4	OB/GYN	7/1/93	6/30/96	Yes	ACGME
			/ /	/ /		
			/ /	/ /		
			/ /	/ /		

VERIFICATION OF POSTGRADUATE MEDICAL EDUCATION (continued)

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

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

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

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

AFFIX INSTITUTIONAL SEAL HERE

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

Signature: Carole Kyros

Title: ASSOCIATE RESIDENCY PROGRAM DIRECTOR

Date of Signature: 7/14/98

Telephone: (313) 745-7292

Section V:

Examination History/ Score Transcripts

NATIONAL BOARD OF MEDICAL EXAMINERS®

Record of Scores and Endorsement of Certification

This document was prepared by
National Board of Medical Examiners (NBME)
3750 Market Street, Philadelphia, PA 19104-3190 - Telephone (215) 590-9592

Recipient: State Medical Board Ohio
77 S High Street
17th Floor
Columbus, OH 43266-0315

Date: 06/24/1998

Examinee: Jerome Lumetta Yaklic

Examinee ID: 3-410-493-5
Date of Birth: 12/12/1965

NBME Certification Date: 07/01/1993

Certificate#: 410493

This record shows only NBME passing scores for each NBME examination reported on this document unless a complete NBME examination history has been requested by the examinee. If applicable, also results for USMLE Steps taken by this examinee (and for which scores have been reported to date) are shown.

This examinee has successfully completed the examination, education and training requirements for NBME certification.

NBME PART I

Test Date	Pass/Fail	Score Scale	Total Score	(Min.Pass)	Individual Subject Scores						
					Anat	Phys	Bioc	Path	Micr	Phar	Beh Sci
06/1990	**Pass**	**Three-Digit**	415	(380)	445	510	400	325	335	425	585
		Two-Digit	77	(75)	78	82	75	70	71	77	87

NBME PART II

Test Date	Pass/Fail	Score Scale	Total Score	(Min.Pass)
09/1991	**Pass**	**Three-Digit**	194	(167)
		Two-Digit	80	(75)

NBME PART III

Test Date	Pass/Fail	Score Scale	Total Score	(Min.Pass)
03/1993	**Pass**	**Three-Digit**	495	(315)
		Two-Digit	81	(75)

*** * * END OF DOCUMENT * * ***

See reverse side for explanation of information reported above.

AFFIDAVIT AND RELEASE OF APPLICANT

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

ss STATE OF: OHIO
COUNTY OF: GREENE

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

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

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

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

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

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

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

Signature of Applicant

Subscribed and sworn to before me this 10th day of June 1998.

(NOTARY SEAL)

Signature of Notary Public AGNES M. STANNARD
Notary Public, State of Ohio
My Commission Expires 10-4-98

Date Commission Expires

Revised 10/21/96

STATE MEDICAL BOARD OF OHIO
98 JUN 11 PM 12:59

DETACH HERE AND REMIT THIS PORTION WITH FEE

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

CERTIFICATION

I CERTIFY, UNDER PENALTY OF LOSS OF MY RIGHT TO PRACTICE IN THE STATE OF OHIO, THAT I HAVE COMPLETED OR WILL HAVE COMPLETED DURING THE 1998-1999 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 4/15/99
(SIGNATURE OF APPLICANT) (DATE)

IDENTIFICATION NUMBER	AMOUNT DUE	DATE DUE
35-07-5267-Y	$305.00	07/01/99

JEROME LUMETTA YAKLIC,M.D.
5980 FOX TRACE COURT
HUBER HEIGHTS OH 45424

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: 0935075267" "0000030500"

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

Street

Street

City *State* *Zip Code*

County

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

YES *NO*

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

YES *NO*

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

YES *NO*

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

YES *NO*

☐ ☒ *4.) Had malpractice insurance cancelled or limited for other than failure to pay premiums?*

YES *NO*

☐ ☒ *5.)Except for actions taken by this board, been notified of any investigation concerning you by, or, been notified of, any charges, allegations, or complaints filed against you, any board, bureau, department, agency, or other body, including those in Ohio, with respect to a professional license? This includes denial, limitation, restriction, suspension, revocation, censure, reprimand or fine.*

YES *NO*

☐ ☒ *6.) Surrendered, or consented to limitation in any jurisdiction: a) A license to practice medicine;OR b) State or federal privileges to prescribe controlled substances?*

YES *NO*

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

SOCIAL SECURITY NUMBER
(Optional for purposes of identification)

Date Posted: 8/29/2011 2:04:12 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	Wright State Physicians Women's Health Care Berry Women's Health Pavilion One Wyoming Street, Suite 4130 Dayton, OH 45409 Montgomery County United States of America 937-208-6810 jlyaklic@mvh.org
CREDENTIAL MAIL ADDRESS	1032 Whispering Pine Lane Centerville, OH 45458 Montgomery County United States of America (937) 350-5083 jlyaklic@mvh.org
MAIN	1032 Whispering Pine Lane Centerville, OH 45458 Montgomery County United States of America (937) 350-5083 jyaklic@usa.net

License Information

License Number	35.075267
License Name	Jerome Yaklic

Fees

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

. 0

Medical Board Correspondence Email

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

. . . . . YES

Specialty Codes

1. Please select one specialty from the field below

. . . . . OBSTETRICS & GYNECOLOGY

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

. . . . . *{not Answered}*

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

. . . . . *{not Answered}*

CME-Physicians

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

. . . . . YES

Discipline

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

. . . . . NO

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

. . . . . NO

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

. . . . . NO

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

. . . . . NO

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

. . . . . NO

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

. . . . . NO

Social Security Number

1.

. . . . . Redacted

Nurse Collaboration Info

1. Are you currently in a collaboration agreement with any Clinical Nurse

Specialists, Certified Nurse-Midwives or Certified Nurse Practitioners?

. . . . . YES

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

. . . . . Karhryn Lowry-Collins, CNS, NP, Laura Russell NMW, Donna Gau-Jata NMW, Anne Erickson NMW, Mary Gorniak NMW, NP

Ohio Employment

1. Do you practice in Ohio?

. . . . . YES

Ohio Workforce Questions

1. "Clinical" - direct patient care

. 20-24

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.)

. 15-19

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

. 25-29

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

. 0

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

Clinical - Practice setting

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

. 10-14

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

. 10-14

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

. 1-4

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

. 0

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

. 0

Workforce Counties

1. Enter the first zip code:

. 45409

2. Enter the first county:

. . . . . Montgomery

3. Enter the second zip code:

. . . . . *{not Answered}*

4. Enter the second county:

. . . . . *{not Answered}*

5. Enter the third zip code:

. . . . . *{not Answered}*

6. Enter the third county:

. . . . . *{not Answered}*

Practice Arrangement (size)

1. Solo practitioner

. . . . . NO

2. Single-specialty Group

. . . . . N/A

3. Multi-specialty Group

. . . . . 10+

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

. . . . . YES

Workforce Language Question

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

. . . . . NO

ABMS Certified

1. Are you certified by an ABMS Board?

. . . . . YES

ABMS Specialty

1. Choose specialty from the dropdown list.

. . . . . Obstetrics and Gynecology

2. Choose specialty from the dropdown list.

. . . . . *{not Answered}*

3. Choose specialty from the dropdown list.

. . . . . *{not Answered}*

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

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

Date Posted: 4/16/2013 2:20:16 PM

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

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

Address Information

BUSINESS ADDRESS	Wright State Physicians Women's Health Care One Wyoming Street, Suite 4130 Dayton, OH 45409 Montgomery County United States of America 937-208-6810 jerome.yaklic@wright.edu
CREDENTIAL MAIL ADDRESS	1032 Whispering Pine Lane Centerville, OH 45458 Montgomery County United States of America (937) 350-5083 jerome.yaklic@wright.edu
MAIN	1032 Whispering Pine Lane Centerville, OH 45458 Montgomery County United States of America (937) 350-5083 jerome.yaklic@wright.edu

License Information

License Number	35.075267
License Name	Jerome Yaklic

Fees

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

Medical Board Correspondence Email

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

. . . . . YES

Specialty Codes

1. Please select one specialty from the field below

. . . . . OBSTETRICS & GYNECOLOGY

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

. . . . . *{not Answered}*

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

. . . . . *{not Answered}*

CME-Physicians

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

. . . . . YES

Discipline

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

. . . . . NO

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

. . . . . NO

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

. . . . . NO

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

. . . . . NO

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

. . . . . NO

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

. . . . . NO

Social Security Number

1.

. . . . . Redacted

Nurse Collaboration Info

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

. . . . . YES

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

. . . . . Anne Erickson CNM

Ohio Employment

1. Do you practice in Ohio?

. . . . . YES

Ohio Workforce Questions

1. "Clinical" - direct patient care

. 20-24

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.)

. 15-19

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

. 25-29

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

. 1-4

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

. 1-4

Clinical - Practice setting

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

. 10-14

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

. 10-14

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

. 1-4

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

. 1-4

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

. 1-4

Workforce Counties

1. Enter the first zip code:

. 45409

2. Enter the first county:

. . . . . Montgomery

3. Enter the second zip code:

. 45435

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?

. . . . . YES

Workforce Practice Address

1. Please list all practice locations. Include street address, city, state and zip. Example "123 E Main St, Suite 2, Anywhere, OH 55555;" Separate multiply addresses with a semicolon.

. . . . . One Wyoming Street, Suite 4130, Dayton, Ohio 45409; 725 University Blvd, Dayton, Ohio 45435

Practice Arrangement (size)

1. Solo practitioner

. . . . . NO

2. Single-specialty Group

. . . . . N/A

3. Multi-specialty Group

. . . . . 10+

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

. . . . . NO

Workforce Language Question

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

. . . . . NO

ABMS Certified

1. Are you certified by an ABMS Board?

. . . . . YES

ABMS Specialty

1. Choose specialty from the dropdown list.

. . . . . 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

. 1235164476

DEA number

1. Please enter your DEA number

. . . . . BY4640947

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: 9/17/2015 2:53:58 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

Wright State Physicians
Obstetrics and Gynecology
One Wyoming Street, Suite 4130
Dayton, OH 45409
Montgomery County
United States of America
937-208-6810
jerome.yaklic@wright.edu

License Information

License Number	35.075267
License Name	Jerome Yaklic

Fees

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

Medical Board Correspondence Email

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

. . . . . YES

Specialty Codes

1. Please select one specialty from the field below

. . . . . OBSTETRICS & GYNECOLOGY

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

. . . . . OTHER (specialty other than those listed)

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

. . . . . *{not Answered}*

CME-Physicians

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

. . . . . YES

Discipline

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

. . . . . NO

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

. . . . . NO

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

. . . . . NO

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

. . . . . NO

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

. . . . . NO

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

. . . . . NO

Social Security Number

1.

. . . . . Redacted

Nurse Collaboration Info

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

. . . . . NO

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

. . . . . *{not Answered}*

Ohio Employment

1. Do you practice in Ohio?

. . . . . YES

Ohio Workforce Questions

1. "Clinical" - direct patient care

. 20-24

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.)

. 10-14

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

. 20-24

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

. 5-9

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).

. 10-14

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

. 10-14

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:

. 45409

2. Enter the first county:

. . . . . Montgomery

3. Enter the second zip code:

. 45324

4. Enter the second county:

. . . . . Greene

5. Enter the third zip code:

. . . . . *{not Answered}*

6. Enter the third county:

. . . . . *{not Answered}*

7. Do you have more than one practice location?

. . . . . YES

Workforce Practice Address

1. Please list all practice locations. Include street address, city, state and zip. Example "123 E Main St, Suite 2, Anywhere, OH 55555;" Separate multiply addresses with a semicolon.

. . . . . 1 wyoming St Suite 4130, Dayton, Ohio 45409; 725 University Blvd, Fairborn, Ohio 45324; 1 Childrens PLaza, Dayton Ohio 45404

Practice Arrangement (size)

1. Solo practitioner

. . . . . NO

2. Single-specialty Group

. . . . . N/A

3. Multi-specialty Group

. . . . . 10+

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

. . . . . NO

Workforce Language Question

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

. . . . . NO

ABMS Certified

1. Are you certified by an ABMS Board?

. . . . . YES

ABMS Specialty

1. Choose specialty from the dropdown list.

. . . . . 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

. 1235164476

DEA number

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

. . . . . BY4640947

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.

Date Posted: 5/10/2017 11:14:49 AM

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

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

Address Information

CREDENTIAL MAIL ADDRESS	1032 Whispering Pine Lane Washington Twp, OH 45458 Montgomery County United States jerome.yaklic@wright.edu
MAIN	1032 Whispering Pine Lane Washington Twp, OH 45458 Montgomery County United States (937) 350-5083 jerome.yaklic@wright.edu

License Information

License Number	35.075267
License Name	Jerome Yaklic

Fees

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

Medical Board Correspondence Email

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

. . . . . YES

Specialty Codes

1. Please select one specialty from the field below

. . . . . OBSTETRICS & GYNECOLOGY

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

. . . . . OTHER (specialty other than those listed)

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 thanOhio?

. . . . . NO

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

. . . . . NO

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

. . . . . NO

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

. . . . . NO

Social Security Number

1.

. . . . . Redacted

Nurse Collaboration Info

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

. . . . . YES

2. List the name/names and type of licensure for each nurse with whom you are

collaborating. **For example: Jane Doe, CNP; Mary Smith, CNS.**

. . . . . Misty Uhl CNP

Ohio Employment

1. Do you practice in Ohio?

. . . . . YES

Ohio Workforce Questions

1. "Clinical" - direct patient care

. 20-24

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.)

. 20-24

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

. 20-24

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

. 0

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

. 0

Clinical - Practice setting

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

. 15-19

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

. 25-29

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:

. 45409

2. Enter the first county:

. . . . . Montgomery

3. Enter the second zip code:

. 45431

4. Enter the second county:

. . . . . Montgomery

5. Enter the third zip code:

. . . . . *{not Answered}*

6. Enter the third county:

. . . . . *{not Answered}*

7. Do you have more than one practice location?

. . . . . YES

Workforce Practice Address

1. Please list all practice locations. Include street address, city, state and zip. Example "123 E Main St, Suite 2, Anywhere, OH 55555;" Separate multiply addresses with a semicolon.

. . . . . Wright State Physicians Ob/Gyn 1Wyoming Suite 4130 Dayton OH 45409, Wright State Physicians Health Center 725 University Blvd Beavercreek OH 45324, Dayton Childrens Hospital 1 Childrens Plz Dayton OH 45404

Practice Arrangement (size)

1. Solo practitioner

. . . . . NO

2. Single-specialty Group

. . . . . N/A

3. Multi-specialty Group

. . . . . 10+

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

. . . . . NO

Workforce Language Question

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

. . . . . NO

ABMS Certified

1. Are you certified by an ABMS Board?

. . . . . YES

ABMS Specialty

1. Choose specialty from the dropdown list.

. . . . . 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

. 1235164476

DEA number

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

. . . . . BY4640947

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: 8/28/2019 3:56 PM

License Renewal Application

License Type - Doctor of Medicine (MD)

Personal Information

Provide the necessary personal information in the fields to the right. All fields with (*) are required and must be completed to continue the application process. Demographic and workforce data collected for some licensed healthcare professions is used to enhance the state's capacity for healthcare workforce forecasting, policy development, and research. This data is used to analyze the supply and demand of the healthcare workforce serving Ohio. If you do not have an Individual Provider Identifier (NPI) number please enter nine zeroes.

Title
Dr.
First Name
Jerome
Middle Name
Lumetta
Last Name
Yaklic
Maiden Name
No Response
Social Security Number
Redacted
Date of Birth
12/12/1965
Email Address
jyaklic@usa.net
Phone Number
(937) 350-5083
Other Phone Number
(937) 208-2850
What is your U.S. Residency status related to your employment?
United States Citizen
Do you consider yourself Hispanic, Latino/a or of Spanish origin?
No
What do you consider your race?
White
List languages you personally use to communicate with patients excluding an interpreter or software
English
Other Language
No Response
Individual National Provider Identifier - if N/A enter all zeroes
1235164476
Enter home US zip-code. Enter NA if unavailable
45458

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?
None
What is your gender?
Male
In which country were you born?
United States
In which state were you born (if United States)?
Michigan
In which city were you born?
GROSSE POINTE

Employment Status

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

What is your primary employment status
Actively working in a position(s) that requires this license
Which of the following best describes your five-year employment plan?
Maintain practice hours as is

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.

1032 Whispering Pine Ln
Dayton
OH
45458-6060
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.

128 E Apple St Ste 3800
Dayton
OH
45409-2902
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?
Yes
If you answered "Yes", are you currently serving in the military?
No
Has your spouse served in the military?
No
If you answered "Yes", are they currently serving in the military?
No Response
I declined to answer these questions

Secondary Email Recipient

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

Secondary Email Address:

Specialty Tracking Component

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

Medical Speciality Certification - American Board of Medical Specialties (ABMS)
Medical Speciality - Obstetrics and Gynecology (ABMS)
Medical SubSpeciality - null

Medical Speciality Certification - American Board of Medical Specialties (ABMS)
Medical Speciality - Obstetrics and Gynecology (ABMS)
Medical SubSpeciality - Female Pelvic Medicine and Reconstructive Surgery

Current Employment Location(s)

Please provide the following information for all practice sites where you use this license, beginning with the locations in which you spend most of your time. If you are not actively working or volunteering in a position that requires this license (e.g. student or recent graduate) employment location information is optional. Employment location information helps improve the accuracy and efficiency of Health Professional Shortage Area Designations and enables Ohio to identify healthcare workforce distribution.

Name of Practice Site - Wright State Physicians Obstetrics and Gynecology
Practice Settings - Medical School
Street Address - 400 Sugar Camp Circle
City - Oakwood
State - OH
Zip Code - 45409
Major Area of Focus or Specialty - Obstetrics and Gynecology (ABMS)
Total Hours Worked at this practice site, per Week - 24

Percent of time spent per week in each of the following at this practice site:
Direct Patient Care - 30
Teaching/Academic - 20
Research - 10
Professional Services - 0
Administrative Activities - 40
Other - 0
Total Hours- 100

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

Name of Practice Site - Wright State Phgysicians Obstetrics and Gynecology
Practice Settings - Medical School
Street Address - 725 University Blvd.
City - Fairborn
State - OH
Zip Code - 45324
Major Area of Focus or Specialty - Obstetrics and Gynecology (ABMS)
Total Hours Worked at this practice site, per Week - 4

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

Administrative Activities - 0
Other - 0
Total Hours- 100

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

Name of Practice Site - Five Rivers Health Center
Practice Settings - Medical School
Street Address - 1 Wyoming Street
City - Dayton
State - OH
Zip Code - 45409
Major Area of Focus or Specialty - Obstetrics and Gynecology (ABMS)
Total Hours Worked at this practice site, per Week - 8

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

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

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 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 submission of your last application for renewal have you been addicted to or

dependent upon alcohol or any chemical substance; or been treated for, or been diagnosed as suffering from, drug or alcohol dependency or abuse? You may answer NO to this question if you have successfully completed treatment at, or are currently enrolled in, a program approved by this Board and have adhered to all statutory requirements during and subsequent to treatment. You must answer YES if you have ever relapsed.
Answer - No

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

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

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

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

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

Question - Do you prescribe controlled substances?
Answer - Yes

Question - Primary DEA Number
Answer - BY4640947

Attachments

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

Review + Submit

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

Application Review - Completed

Attestation
I understand that submitting a false, fraudulent, or forged statement or document or omitting a material fact in obtaining licensure may be grounds for disciplinary action against my license. Under penalty of law, I hereby swear or affirm that the information I have provided in the application is complete and correct, and that I have complied with all criteria for applying.

Consent to Electronic Signature - **Consented**
Date/Time Stamp - 8/28/2019 3:56 PM
Type your First Name and Last Name as they appear on the application to sign electronically.
Jerome Yaklic
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.

84083

State Medical Board of Ohio
Application for License Restoration - Medicine or Osteopathic Medicine
Page 1

FOR BOARD USE ONLY		
BK:_____	PG:_____	LN:_____
DATE:_____	FEE: $405.00	PMT:_____

APPLICATION FOR LICENSE RESTORATION
MEDICINE OR OSTEOPATHIC MEDICINE

PLEASE TYPE OR PRINT CLEARLY

IDENTIFICATION

Social Security Number:	[redacted] Your Social Security number is required to facilitate reporting to the Federal Healthcare Integrity & Protection Data Bank (42 U.S.C. § 1320a-7e(b), 5 U.S.C. § 552a, and 45 C.F.R. pt 61); and accurate identification under the federal and state child support enforcement law (42 U.S.C. §666 and §3123.50, O.R.C.). It also may be used for reporting to the National Practitioner Data Bank (42 U.S.C. §11101 and 45 C.F.R. pt 60) 4731., 4760. or 4762 O.R.C. or as otherwise required by state or federal law.			
Full Name (Use no initials)	Last (Surname): YAKLIC	First: JEROME	Middle: LUMETTA	Suffix (Jr., II):
Maiden Name or Other Names Used (If none, enter "NONE"):	Last (Surname): NONE	First:	Middle:	Suffix (Jr., II):
Current Home Address **IMPORTANT** Notify the Board office immediately in writing of any change in address	Number and Street: 329 S. OUTER DRIVE		Apt.:	
	City: BAD AXE	State: MI	Zip Code: 48413	Country: USA
Telephone Number	Business: area code & number (989) 269-3923		Home: area code & number (989) 269-7666	
Birth Date	month/day/year 12/12/1965	Birth Place: City GROSSE POINTE	State: MI	Country: USA
Physical Description	Height: 6' 2"	Weight: 215	Hair Color: BROWN	Eye Color: GREEN	Identifying marks: NONE
Gender	☒ Male	☐ Female	For statistics only (optional)	
E-mail Address	jyaklic@usa.net			

Plans of practice in Ohio
Considering position with Wright State University Miami Valley Hospital.

MEDICAL BOARD
AUG 31 2009

CONTINUED ⇨

LICENSES IN THE UNITED STATES AND CANADA

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

STATE/PROVINCE	ISSUE DATE (MO/YR)	LICENSE NO.	LICENSE CURRENT YES	LICENSE CURRENT NO	EXPIRE(S)
MICHIGAN		4301059625	☒	☐	1/31/2010
			☐	☐	
			☐	☐	
			☐	☐	
			☐	☐	
			☐	☐	
			☐	☐	
			☐	☐	

SPECIALTY BOARDS

NAME OF SPECIALTY BOARD (If none, enter "N/A")	YEAR CERTIFIED	COUNTRY
AMERICAN BOARD OF OBSTETRICS AND GYNECOLOGY	1998	USA

SPECIALTIES

Below you will find a list of specialties for M.D.'s and D.O.'s. Each corresponding specialty is represented by a code. Please fill in the specialty code number corresponding to your correct specialty/specialties below. The specialty you indicate below will be printed in the Roster of Registered Physicians and Podiatrists.

EXAMPLES: **Code: AN - Anesthesiology** **Code: PD - Pediatrics**

SPECIALITIES (please fill in): | OBG | | GYN | | OBS |

SPECIALTY CODES

CODE	DESCRIPTION
AS	Abdominal Surgery
ADM	Addiction Medicine
ADP	Addiction Psychiatry
AMI	Adolescent Medicine (Internal Medicine)
ADL	Adolescent Medicine (Pediatrics)
OAR	Adult Reconstructive Orthopedics
AM	Aerospace Medicine
A	Allergy
AI	Allergy & Immunology
ALI	Clinical Laboratory Immunology (All & Imm)
PTH	Anatomic/Clinical Pathology
ATP	Anatomic Pathology
AN	Anesthesiology
BBK	Blood Banking/Transfusion Medicine
ICE	Clinical Cardiac Electrophysiology
CTS	Cardiothoracic Surgery
CD	Cardiovascular Diseases
CDS	Cardiovascular Surgery
PCH	Chemical Pathology
CHP	Child and Adolescent Psychiatry
CHN	Child Neurology
CBG	Clinical Biochemical Genetics
CCG	Clinical Cytogenetics
CG	Clinical Genetics
DDL	Clinical & Lab. Dermatological Immunology
ILI	Clinical & Lab. Immunology (Int. Med.)
PLI	Clinical & Lab. Immunology (Pediatrics)
CMG	Clinical Molecular Genetics
CN	Clinical Neurophysiology
CLP	Clinical Pathology
PA	Clinical Pharmacology
CRS	Colon & Rectal Surgery
CCA	Critical Care Medicine (Anesthesiology)
CCM	Critical Care Medicine (Internal Medicine)
NCC	Critical Care Medicine (Neurological Surg.)
OCC	Critical Care Medicine(OB-GYN)
PCP	Cytopathology
CODE	**DESCRIPTION**
D	Dermatology
DMP	Dermatopathology (Pathology)
DMD	Dermatopathology (Dermatology)
DS	Dermatologic Surgery
DIA	Diabetes
DR	Diagnostic Radiology
EM	Emergency Medicine
END	Endocrinology, Diabetes & Metabolism
EP	Epidemiology
FPS	Facial Plastic Surgery
FP	Family Practice
FOP	Forensic Pathology
PFP	Forensic Psychiatry
GE	Gastroenterology
GP	General Practice
GPM	General Preventive Medicine
GS	General Surgery
FPG	Geriatric Medicine (Family Practice)
IMG	Geriatric Medicine (Internal Medicine)
PYG	Geriatric Psychiatry
GYN	Gynecology
GO	Gynecological Oncology
HS	Hand Surgery (Orthopedic Surgery)
HNS	Head & Neck Surgery
HEM	Hematology (Internal Medicine)
HMP	Hematology (Pathology)
HO	Hematology/Oncology
HEP	Hepatology
IG	Immunology
PIP	Immunopathology
ID	Infectious Diseases
IM	Internal Medicine
MPD	Internal Medicine/Pediatrics
LM	Legal Medicine
MFM	Maternal & Fetal Medicine
MXR	Maxillofacial Radiology
MG	Medical Genetics
CODE	**DESCRIPTION**
MDM	Medical Management
MM	Medical Microbiology
ON	Medical Oncology
ETX	Medical Toxicology (Emer. Med)

PDT	Medical Toxicology (Pediatrics)
PTX	Medical Toxicology (Prevent. Med.)
OMO	Musculoskeletal Oncology
NPM	Neonatal-Perinatal Medicine
NEP	Nephrology
N	Neurology
NRN	Neurology/Diag. Radiology/Neuroradiology
NS	Neurological Surgery
NP	Neuropathology
RNR	Neuroradiology
NM	Nuclear Medicine
NR	Nuclear Radiology
NTR	Nutrition
OBS	Obstetrics
OBG	Obstetrics & Gynecology
OM	Occupational Medicine
OPH	Ophthalmology
ORS	Orthopedic Surgery
OSS	Orthopedic Surgery of the Spine
OTR	Orthopedic Trauma
OFA	Foot & Ankle, Orthopedics
OMM	Osteopathic Manipulative Medicine
OTO	Otolaryngology
OT	Otology/Neurotology
APM	Pain Management (Anesthesiology)
PDM	Pain Medicine
PLM	Palliative Medicine
PDA	Pediatric Allergy
PDC	Pediatric Cardiology
CCP	Pediatric Critical Care Medicine
PE	Pediatric Emergency Medicine (Emer. Med)
PEM	Pediatric Emergency Medicine (Pediatrics)
PDE	Pediatric Endocrinology
PG	Pediatric Gastroenterology
PHO	Pediatric Hematology/Oncology
PDI	Pediatric Infectious Disease
PN	Pediatric Nephrology
PO	Pediatric Ophthalmology
OP	Pediatric Orthopedics

CODE	DESCRIPTION
PDO	Pediatric Otolaryngology
PP	Pediatric Pathology
PDP	Pediatric Pulmonology
PDR	Pediatric Radiology
PPR	Pediatric Rheumatology
NSP	Pediatric Surgery (Neurology)
PDS	Pediatric Surgery (Surgery)
UP	Pediatric Urology
PD	Pediatrics
PM	Physical Medicine & Rehabilitation
PS	Plastic Surgery
PRO	Proctology
P	Psychiatry
PYA	Psychoanalysis
MPH	Public Health & General Preventive Med.
PCC	Pulmonary Critical Care Medicine
PUD	Pulmonary Disease
RO	Radiation Oncology
RP	Radiological Physics
R	Radiology
RIP	Radioisotopic Pathology
REN	Reproductive Endocrinology
RHU	Rheumatology
SP	Selective Pathology
SM	Sleep Medicine
SCI	Spinal Cord Injury
ESM	Sports Medicine (Emergency Medicine)
FSM	Sports Medicine (Family Practice)
ISM	Sports Medicine (Internal Medicine)
OSM	Sports Medicine (Orthopedic Surgery)
PSM	Sports Medicine (Pediatrics)
HSP	Hand Surgery (Plastic Surgery)
HSS	Surgery of the Hand (Surgery)
CCS	Surgical Critical Care (Surgery)
SO	Surgical Oncology
TS	Thoracic Surgery
TRS	Trauma Surgery
TTS	Transplant Surgery
UM	Undersea Medicine
U	Urology
VIR	Vascular & Interventional Radiology
VS	Vascular Surgery
OS	Other (i.e., specialty other than those listed)
US	Unspecified

RESUME - LICENSE RESTORATION - MEDICINE OR OSTEOPATHIC MEDICINE

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

	month/year TO month/year	Hospital, University or Other: / Complete Street Address: / City / State/Country / Zip Code	Position & Department	% Clinical / % Admin.
A	6 2000 TO PRESENT	HURON MEDICAL CENTER 1100 SOUTH VAN DYKE BAD AXE MI 48413	ACTIVE MEDICAL STAFF OB/GYN CURRENTLY CHIEF OF STAFF	90 10
B	12 2001 TO PRESENT	DECKERVILLE COMMUNITY HOSPITAL 3559 PINE STREET DECKERVILLE MI 48427	Consulting medical staff OB/GYN	100 -
C	10 2004 TO PRESENT	Scheurer Hospital 170 N. CASEVILLE RD PIGEON MI 48755	Courtesy medical staff OB/GYN	100 -
D	10 2004 TO Present	HILLS AND DALES COMMUNITY HOSPITAL 4675 HILL STREET CASS CITY, MI 48726	Courtesy medical staff OB/GYN	100 -

OVER ⇨

RESUME - LICENSE RESTORATION - MEDICINE OR OSTEOPATHIC MEDICINE
PAGE TWO

E	9 2005 month/year TO PRESENT month/year	Hospital, University or Other: HARBOR BEACH COMMUNITY HOSPITAL Complete Street Address: 210 S. FIRST STREET (Number & Street) HARBOR BEACH, MI 48441 (City / State/Country / Zip Code)	Position & Department: Consulting medical Staff OB/GYN	% Clinical: 100 % Admin.: —
F	month/year TO month/year	Hospital, University or Other: Complete Street Address: Number & Street City / State/Country / Zip Code	Position & Department	% Clinical % Admin.
G	month/year TO month/year	Hospital, University or Other: Complete Street Address: Number & Street City / State/Country / Zip Code	Position & Department	% Clinical % Admin.
H	month/year TO month/year	Hospital, University or Other: Complete Street Address: Number & Street City / State/Country / Zip Code	Position & Department	% Clinical % Admin.

ADDITIONAL LICENSE RESTORATION INFORMATION
MEDICINE OR OSTEOPATHIC MEDICINE

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

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

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

OVER ⇨

		YES	NO
10.	Have you ever been requested to appear before any board, bureau, department, agency, or other body, including those in Ohio, concerning allegations against you?	☐	☒
11.	Have you ever entered into an agreement of any kind, whether oral or written, with respect to a professional license, in lieu of or in order to avoid formal disciplinary action, with any board, bureau, department, agency, or other body, including those in Ohio?	☐	☒
12.	Have you ever been notified of any investigation concerning you by any board, bureau, department, agency, or other body, including those in Ohio, with respect to a professional license?	☐	☒
13.	Have you ever been notified of any charges, allegations, or complaints filed against you with any board, bureau, department, agency, or other body, including those in Ohio, with respect to a professional license?	☐	☒
14.	Have you ever been denied or have you ever surrendered a state or federal controlled substance or drug registration; had it revoked, terminated, or restricted in any way; or been warned, reprimanded, or fined by, or been requested to appear before, the responsible agency?	☐	☒
15.	Have you ever pled guilty to, been found guilty of a violation of any law, or been granted intervention or treatment in lieu of conviction regardless of the legal jurisdiction in which the act was committed, other than a minor traffic violation?	☐	☒
16	Have you ever forfeited collateral, bail, or bond for breach or violation of any law, police regulation, or ordinance other than for a minor traffic violation; been summoned into court as a defendant or had any lawsuit filed against you (other than a malpractice suit)?	☐	☒
17.	Have you been a defendant in a legal action involving professional liability (malpractice), or had a professional liability claim paid on your behalf, or paid such a claim yourself? If yes, include the case name, case number, court and address, date filed, and a summary of the underlying events. Indicate current status, including amount of settlement or judgment, if any. In addition, ask your malpractice insurance carrier(s) to provide a complete claims history report for the last 10 years to the State Medical Board of Ohio. If your current carrier has provided coverage for less than 10 years, ask your previous carrier to submit a claims history report to the Board.	☐	☒
18.	Have you ever been denied professional liability insurance or coverage, or had such insurance or coverage canceled, limited, or restricted in any way?	☐	☒
19.	Have you ever been denied or relinquished participation in any third party reimbursement program, whether governmental or private, including Medicaid and Medicare; or had such participation limited, restricted, suspended, or revoked; or been warned, reprimanded, requested to appear before, or fined by the responsible body?	☐	☒
20.	Have you ever been denied privileges, or had privileges revoked, suspended, restricted, reduced, or terminated by the Department of Defense, the Veteran's Administration, or any of their respective components? I WORKED AS AN AIR FORCE MEDICAL OFFICER FROM JULY 1996 - JULY 2000, I SEPARATED FROM AIRFORCE IN 2000	☐	☒

CONTINUED ⇨

		YES	NO
21.	Have you ever been diagnosed as having, or have you been treated for, pedophilia, exhibitionism, or voyeurism? If yes, please explain	☐	☒
22. a)	Within the last ten years, have you been diagnosed with or have you been treated for, bipolar disorder, schizophrenia, paranoia, or any other psychotic disorder?	☐	☒
b)	Have you, since attaining the age of eighteen or within the last ten years, whichever period is shorter, been admitted to a hospital or other facility for the treatment of bipolar disorder, schizophrenia, paranoia, or any other psychotic disorder?	☐	☒

If you answered "YES" to any part of this question, please provide details on a separate sheet, including date(s) of diagnosis or treatment, and a description of your present condition. Include the name, current mailing address, and telephone number of each person who treated you, as well as each facility where you received treatment, and the reason for treatment. Have each treating physician submit a letter detailing the dates of treatment, diagnosis and prognosis.

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

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

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

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

		YES	NO
23.	Do you have, or have you been diagnosed as having, a medical condition which in any way impairs or limits your ability to practice medicine with reasonable skill and safety? If yes, please explain.	☐	☒
a)	Are the limitations or impairment caused by your medical condition reduced or ameliorated because you receive ongoing treatment or received treatment in the past (with or without medication) or participate in a monitoring program? If yes, please explain.	☐	☒
b)	Are the limitation or impairments caused by your medical condition reduced or ameliorated because of the field of practice, the setting, or the manner in which you have chosen to practice? If yes, please explain.	☐	☒

If you receive such ongoing treatment or participate in such monitoring program the board will make an individualized assessment of the nature, severity, and duration of the risk associated with an ongoing medical condition so as to determine whether an unrestricted license should be issued, whether conditions should be imposed, or whether you are not eligible for licensure. Have each treating physician submit a letter detailing the dates of treatment, diagnosis and prognosis.

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

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

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

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

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

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

State Medical Board of Ohio

30 E. Broad Street, 3rd Floor, Columbus, OH 43215-6127

Richard A. Whitehouse, Esq.
Executive Director

(614) 466-3934
med.ohio.gov

MEDICAL BOARD
SEP - 4 2009

LICENSE RESTORATION - MEDICINE OR OSTEOPATHIC MEDICINE
FORM 1 - CERTIFICATE OF RECOMMENDATION

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

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

I, WILLIAM A. CORSINI, M.D (recommending physician, print name), a licensed and practicing physician in the state of Michigan (state of residence),

affirm that JEROME L. YAKLIS (applicant, print name) has been known to me personally for 10 years and that he/she is of good moral character. Further, the photograph affixed hereto is a genuine likeness of the applicant. I offer the following in support of his/her application for licensure:

- I rate his/her medical knowledge and technique as: excellent
- His/her relationship with patients is: excellent
- I rate his/her ability to work well with peers and medical staff as: excellent
- His/her command of the English language is: excellent
- Additional comments: no reservations

I hereby recommend him/her for restoration of his/her license to practice medicine or osteopathic medicine in the State of Ohio.

Address of Recommending Physician	Number & Street: 1060 S. Vandyke City: Bad Axe State: MI Zip Code: 48413	Telephone Number (include area code)	989-269-8701
Signature of Recommending Physician (name stamps not acceptable)	William A Corsini, MD	State of Licensure & License Number	MI 39677

APP
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Signature of Applicant

Date Photo Taken: 8 / 2009 (Mo/Yr)

Subscribed and sworn to before me this 31st day of August, 2009.

Charlene M. Marks
Notary Public Signature

10-1-13
Date Commission Expires

CHARLENE M. MARKS
Notary Public, State of Michigan
County of Huron
My Commission Expires Oct. 1 20
Acting in the County of Huron

NOTARY SEAL

RETURN COMPLETED FORM TO THE STATE MEDICAL BOARD OF OHIO AT THE ABOVE ADDRESS

To protect and enhance the health and safety of the public through effective medical regulation

State Medical Board of Ohio

30 E. Broad Street, 3rd Floor, Columbus, OH 43215-6127

(614) 466-3934
med.ohio.gov

Richard A. Whitehouse, Esq.
Executive Director

SEP 18 2009

LICENSE RESTORATION - MEDICINE OR OSTEOPATHIC MEDICINE
FORM 1 - CERTIFICATE OF RECOMMENDATION

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

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

I, Craig McManaman (recommending physician, print name), a licensed and practicing physician in the state of MICHIGAN (state of residence), affirm that JEROME L. YAKLIC (applicant, print name) has been known to me personally for 9 years and that he/she is of good moral character. Further, the photograph affixed hereto is a genuine likeness of the applicant. I offer the following in support of his/her application for licensure:

- I rate his/her medical knowledge and technique as: EXCELLENT
- His/her relationship with patients is: GOOD
- I rate his/her ability to work well with peers and medical staff as: GOOD
- His/her command of the English language is: GOOD
- Additional comments: None

I hereby recommend him/her for restoration of his/her license to practice medicine or osteopathic medicine in the State of Ohio.

Address of Recommending Physician	Number & Street: 1011 S. VANDYKE City: BAD AXE State: MI Zip Code: 48413	Telephone Number (include area code)	989 269-5015
Signature of Recommending Physician (name stamps not acceptable)		State of Licensure & License Number	MICHIGAN

API... pass... you... take... ...ent ...of ...ten ...ths

Signature of Applicant

Date Photo Taken: 8/2009 (Mo/Yr)

Subscribed and sworn to before me this 15th day of September, 2009.

Charlene M. Marks
Notary Public Signature

10-1-13
Date Commission Expires

CHARLENE M. MARKS
Notary Public, State of Michigan
County of Huron
My Commission Expires Oct. 1 2013
Acting in the County of Huron

NOTARY SEAL

RETURN COMPLETED FORM TO THE STATE MEDICAL BOARD OF OHIO AT THE ABOVE ADDRESS

To protect and enhance the health and safety of the public through effective medical regulation

LICENSE RESTORATION - MEDICINE OR OSTEOPATHIC MEDICINE
AFFIDAVIT AND RELEASE OF APPLICANT

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

ss STATE OF: Michigan

COUNTY OF: Huron

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

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

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

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

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

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

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

Signature of Applicant

Subscribed and sworn to before me this 27th day of August 2009.

Charlene M. Marks

Signature of Notary Public

(NOTARY SEAL)

10-1-13

Date Commission Expires

MEDICAL BOARD

AUG 31 2009

CHARLENE M. MARKS
Notary Public, State of Michigan
County of Huron
My Commission Expires Oct. 1 2013
Acting in the County of Huron

CERTIFICATION OF CONTINUING MEDICAL EDUCATION FOR THE PERIOD OF JULY 2, 2007 – JULY 1, 2009 (T-Z)

100 CREDITS REQUIREMENT:	AT LEAST 40 CREDITS MUST BE EARNED IN CATEGORY 1.

I certify the following to be true and correct. This form must be completed, signed and returned.

SIGNATURE	DATE (MO/DAY/YR)	OHIO CERTIFICATE NUMBER
[signature]	8/26/2009	75267

NAME LAST	FIRST	MIDDLE	SUFFIX (Jr., II)
YAKLIC	JEROME	LUMETTA	

ADDRESS NUMBER & STREET	CITY	STATE	ZIP CODE
329 S. OUTER DRIVE	BAD AXE	MI	48413

CATEGORY 1
(YOU MUST ATTACH DOCUMENTATION

NAME OF SPONSOR	LOCATION (CITY & STATE)	DESCRIPTION	DATE(S)	CREDITS
EXAMPLE: **Christ Hospital**	**Cincinnati, Ohio**	**Surgery Residency**	**08/01/07 thru 08/01/08**	**50**
AMERICAN COLLEGE OF OB/GYN	WASHINGTON DC	ACOG COGNATE PROGRAM	8/8/07-4/30/09	183

MEDICAL BOARD
AUG

Revised 07/24/2009

PLEASE LIST CATEGORY 2 ON REVERSE SIDE →

CATEGORY 2

A MAXIMUM OF *60 CREDITS* MAY BE EARNED IN THIS CATEGORY

NAME OF SPONSOR	LOCATION (CITY & STATE)	DESCRIPTION	DATE(S)	CREDITS
Examples: Self Instruction		**Pediatric Journal**	**10/07 thru 06/08**	**60+**

Return to My ACOG :

The American College of Obstetricians and Gynecologists

PROGRAM FOR CONTINUING PROFESSIONAL DEVELOPMENT

ACOG COGNATE PROGRAM

TRANSCRIPT

409 12th Street, SW
PO Box 96920
Washington, DC 20090-6920
(800) 673-8444 - (202) 863-2543
fax: (202) 484-1586
e-mail: cognates@acog.org

ACOG ID Number: F 000406799I

Jerome L. Yaklic MD
1005 S Van Dyke
Bad Axe, MI 48413

Cognates Posted August 14, 2009

Activity Date	Code	ACOG/ACCME Approved Category 1 Activity	COGNATE Credits	Cumulative Total by Cycle
02/04/2007	4023	CU-V6I1-CHEST PAIN	5.00	5.00
05/09/2007	4024	CU-V6I2-PREVENTIVE CARE	5.00	10.00
08/08/2007	4025	CU-V6I3-DERMATOSES	5.00	15.00
11/19/2007	4026	CU-V6I4-THROMBOSIS, THROMBOPHILIA & THROMBOEMBOLIS	5.00	20.00
12/31/2007	07	ACOG UPDATE TAPES	21.00	41.00
12/31/2007	04	ABOG RE-CERTIFICATION EXAM	35.00	76.00
03/11/2008	4028	CU-V7I1-EATING DISORDERS	5.00	81.00
03/12/2008	4027	CU-V6I5-DIABETES	5.00	86.00
12/31/2008	07	ACOG UPDATE TAPES	57.00	143.00
12/31/2008	04	ABOG RE-CERTIFICATION EXAM	35.00	178.00
04/30/2009	4031	CU-V7I4-LOWER URINARY TRACT DISORDERS	5.00	183.00
04/30/2009	4030	CU-V7I3-VISION	5.00	188.00
04/30/2009	4029	CU-V7I2-COSMETIC SURGERY	5.00	193.00

Summary of Category 1 COGNATE Credits for Primary Cycle

AWARD ELIGIBLE 01/01/2010

Reporting Years	Total COGNATE Credits
2007	76.00
2008	102.00

Summary of Category 1 COGNATE Credits for Secondary Cycle

Reporting Years	Total COGNATE Credits
2010	0.00
2011	0.00

2009	15.00		2012	0.00	
Total COGNATE Credits This Cycle		**193.00**	**Total COGNATE Credits This Cycle**		**0.00**

The Federation of State Medical Boards
of the United States, Inc
PO Box 619850
Dallas, Texas 75261-9850
Telephone: (817)868-4000
FAX (817)868-4099

BOARD ACTION CLEARANCE REPORT

September 23, 2009

Attn: Richard A. Whitehouse, Esq,
State Medical Board of Ohio
30 E. Broad St., 3rd FL
Columbus, OH 43215

Re: Board Action Query Dated: September 23, 2009
Your Reference Number:
FSMB Batch Number: BQ1673011

The following is a report of the search results from the Board Action Data Bank as of September 23, 2009 for practitioners submitted as part of the above-referenced batch for which NO board actions were identified.

Practitioners Cleared with No Actions as of September 23, 2009

Item	Name	DOB	School	Yr/Grad	Request ID
1	yaklic, jerome	12/12/1965	023040	1992	21393700

LICENSE HISTORY
State Board
MICHIGAN
OHIO

PLEASE NOTE: The licensure history information contained in these reports is not considered licensure verification but rather an indicator of known states of historical licensure for these individuals. Use of this information should be limited to cross-reference purposes.

Source: Legal > / . . . / > **The Official American Board of Medical Specialties**
Terms: **yaklic jerome** (Edit Search)

Select for FOCUS™ or Delivery

The Official ABMS Directory of Board Certified Medical Specialists

The Official ABMS Directory of Board Certified Medical Specialists, 2008

JEROME LUMETTA **YAKLIC,** MD

PRACTICE TYPE: FT-Priv Prac Grp/Prtnrshp

PRIMARY CERTIFICATIONS:
Specialty Board 1: Obstetrics & Gynecology
Board Certified : Active
Certfication Date: November, 1998
Expiration Date: December, 2008
Board Certified 1: Active
Recertification Date 1: December, 2007
Recertification Expiration Date 1: December, 2009

EDUCATION TRAINING:
MD - Wayne State U, 1992

Res: Wayne State U/Detroit MC/Hutzel Hosp, Detroit, MI, 1992-1996, Obstetrics & Gynecology
StaffPhys: Huron Meml Hosp, Bad Axe, MI, 2000
Chief: Wright Patterson USAF Med Ctr, OH, 1996-2000, Gynecology
Staff Phys: Miami Vly Hosp, Dayton, OH, 1998-2000
Staff Phys: Deckerville Comm Hosp
Assoc Prof: Wright State U Sch Med, Dayton, OH, 1996-2000

BORN: December 12, 1965, Grosse Pointe, MI

Source: Legal > / . . . / > **The Official American Board of Medical Specialties**
Terms: **yaklic jerome** (Edit Search)
View: Full
Date/Time: Wednesday, September 23, 2009 - 11:27 AM EDT

JENNIFER M. GRANHOLM
Governor

STATE OF MICHIGAN
DEPARTMENT OF COMMUNITY HEALTH
LANSING

JANET OLSZEWSKI
Director

VERIFICATION OF LICENSURE
MICHIGAN BOARD OF MEDICINE
VERIFICATION OF LICENSURE AS OF 09/21/2009

NAME: Jerome Lumetta Yaklic

BIRTHDATE: 12/12/1965

ADDRESS: Lake Huron OB/GYN PLLC
1005 South Van Dyke
Bad Axe MI 484130000

TYPE: Medical Doctor

ORIGINAL DATE: 08/03/1994

LICENSE NUMBER: 4301059625 **STATUS:** Active

EXPIRATION DATE: 01/31/2010

OBTAINED BY: Examination

DISCIPLINARY ACTION NONE

OPEN FORMAL COMPLAINTS NONE

This license information was last updated on: 09/21/2009

State Medical Board of Ohio

30 E. Broad Street, 3rd Floor, Columbus, OH 43215-6127

Richard A. Whitehouse, Esq.
Executive Director

(614) 466-3934
med.ohio.gov

THIS FORM MUST BE COMPLETED BY A SUPERVISOR OR THE CHIEF OF STAFF

Huron Medical Center
Medical Staff Office

PLEASE COMPLETE AND FAX TO (614) 644-1464 THEN MAIL ORIGINAL.

September 21, 2009

Jerome L. Yaklic, M.D., who is/was Chief of Staff, is applying to restore his/her Ohio license, which expired in 2001. We would appreciate your assistance in filling out the following evaluation, so that we can process his/her documents for restoration. Dr. Yaklic stated on his/her restoration application that he/she was affiliated with your organization from 06/00 to present.

(1) How long have you known the doctor? 1 Year

(2) What is your capacity at the facility? President & CEO

(3) At what facility? Huron Medical Center

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

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

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

(7) Does this doctor relate well to patients? Yes

(8) Would you recommend this doctor's license be restored? Yes

Please indicate any information of a derogatory nature: _____

THIS FORM MUST BE COMPLETED BY A SUPERVISING PHYSICIAN

Janet C. Sternberg
Signature of Person Completing Form

Janet C. Sternberg
Name of Person Completing Form
(please print or type)

President & CEO
Position

989-269-1570
Telephone number (include area code)

Please return this form to the Ohio State Medical Board at the above address, Attn: Peri Vest

Sincerely,

Peri E. Vest

Peri E. Vest
Licensure/CME Renewal Assistant
State Medical Board of Ohio

LICENSE RESTORATION - MEDICINE OR OSTEOPATHIC MEDICINE
AFFIDAVIT AND RELEASE OF APPLICANT

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

ss STATE OF: Michigan

COUNTY OF: Huron

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

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

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

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

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

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

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

Signature of Applicant

Subscribed and sworn to before me this 27th day of August 2009.

Charlene M. Marks

Signature of Notary Public

(NOTARY SEAL)

10-1-13

Date Commission Expires

MEDICAL BOARD

AUG 31 2009

CHARLENE M. MARKS
Notary Public, State of Michigan
County of Huron
My Commission Expires Oct. 1 2013
Acting in the County of Huron

State Medical Board of Ohio

30 E. Broad Street, 3rd Floor, Columbus, OH 43215-6127

Richard A. Whitehouse, Esq.
Executive Director

(614) 466-3934
med.ohio.gov

THIS FORM MUST BE COMPLETED BY A SUPERVISOR OR THE CHIEF OF STAFF

Huron Medical Center
Medical Staff Office

PLEASE COMPLETE AND FAX TO (614) 644-1464 THEN MAIL ORIGINAL.

September 21, 2009

Jerome L. Yaklic, M.D., who is/was Chief of Staff, is applying to restore his/her Ohio license, which expired in 2001. We would appreciate your assistance in filling out the following evaluation, so that we can process his/her documents for restoration. Dr. Yaklic stated on his/her restoration application that he/she was affiliated with your organization from 06/00 to present.

(1) How long have you known the doctor? Since 2000

(2) What is your capacity at the facility? Past Chief of Staff, + Colleague

(3) At what facility? Huron Medical Center, Bad Axe MI

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

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

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

(7) Does this doctor relate well to patients? Yes

(8) Would you recommend this doctor's license be restored? Yes

Please indicate any information of a derogatory nature: _____

THIS FORM MUST BE COMPLETED BY A SUPERVISING PHYSICIAN

Rashid Ibrahim 9/30/09
Signature of Person Completing Form

Name of Person Completing Form
(please print or type)
RASHID IBRAHIM MD

Position
Immediate Past Chief of Staff

989-269-9265
Telephone number (include area code)

Please return this form to the Ohio State Medical Board at the above address, Attn: Peri Vest

Sincerely,

Peri E. Vest

Peri E. Vest
Licensure/CME Renewal Assistant
State Medical Board of Ohio

State Medical Board of Ohio

30 E. Broad Street, 3rd Floor, Columbus, OH 43215-6127

Richard A. Whitehouse, Esq.
Executive Director

(614) 466-3934
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Huron Medical Center
Medical Staff Office

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September 21, 2009

Jerome L. Yaklic, M.D., who is/was Chief of Staff, is applying to restore his/her Ohio license, which expired in 2001. We would appreciate your assistance in filling out the following evaluation, so that we can process his/her documents for restoration. Dr. Yaklic stated on his/her restoration application that he/she was affiliated with your organization from 06/00 to present.

(1) How long have you known the doctor? Since 2000

(2) What is your capacity at the facility? Past Chief of Staff, + Colleague

(3) At what facility? Huron Medical Center Bad Axe MI

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

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

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

(7) Does this doctor relate well to patients? Yes

(8) Would you recommend this doctor's license be restored? Yes

Please indicate any information of a derogatory nature: _____

THIS FORM MUST BE COMPLETED BY A SUPERVISING PHYSICIAN

Rashid Ibbad 9/30/09
Signature of Person Completing Form

Name of Person Completing Form
(please print or type)
RASHID IBBAD MD

Position
Immediate Past Chief of Staff

989-269-9265
Telephone number (include area code)

Please return this form to the Ohio State Medical Board at the above address, Attn: Peri Vest

Sincerely,

Peri E. Vest
Licensure/CME Renewal Assistant
State Medical Board of Ohio

LICENSE RESTORATION - MEDICINE OR OSTEOPATHIC MEDICINE
AFFIDAVIT AND RELEASE OF APPLICANT

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

ss STATE OF: Michigan
COUNTY OF: Huron

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

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

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

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

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

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

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

Signature of Applicant

Subscribed and sworn to before me this 27th day of August 2009.

Charlene M. Marks
Signature of Notary Public

(NOTARY SEAL)

10-1-13
Date Commission Expires

MEDICAL BOARD
AUG 31 2009

CHARLENE M. MARKS
Notary Public, State of Michigan
County of Huron
My Commission Expires Oct. 1 2013
Acting in the County of Huron

hp LaserJet *3030*

HP LASERJET FAX

Sep-30-2009 12:12PM

Fax Call Report

Job	Date	Time	Type	Identification	Duration	Pages	Result
685	9/30/2009	12:11:03PM	Send	716146441464	0:53	1	OK

FEB-21-1996 21:19 P.03/03

State Medical Board of Ohio
30 E. Broad Street, 3rd Floor, Columbus, OH 43215-6127

Richard A. Whitehouse, Esq.
Executive Director

(614) 466-3934
med.ohio.gov

THIS FORM MUST BE COMPLETED BY A SUPERVISOR OR THE CHIEF OF STAFF

Huron Medical Center
Medical Staff Office

PLEASE COMPLETE AND FAX TO (614) 644-1464 THEN MAIL ORIGINAL.

September 21, 2009

Jerome L. Yaldic, M.D., who is/was Chief of Staff, is applying to restore his/her Ohio license, which expired in 2001. We would appreciate your assistance in filling out the following evaluation, so that we can process his/her documents for restoration. Dr. Yaldic stated on his/her restoration application that he/she was affiliated with your organization from 06/00 to present.

(1) How long have you known the doctor? Since 2000

(2) What is your capacity at the facility? Past chief of Staff, + Colleague

(3) At what facility? Huron Medical Center Board Acs MI

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

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

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

(7) Does this doctor relate well to patients? Yes

(8) Would you recommend this doctor's license be restored? Yes

Please indicate any information of a derogatory nature: _____

THIS FORM MUST BE COMPLETED BY A SUPERVISING PHYSICIAN

Signature of Person Completing Form — 9/30/09

Name of Person Completing Form (please print or type)
RASHID ABDUL MD

Position
Immediate Past Chief of Staff

989-269-9265
Telephone number (include area code)

Please return this form to the Ohio State Medical Board at the above address. Attn: Peri Vest

Sincerely,
Peri E. Vest
Licensure/CME Renewal Assistant
State Medical Board of Ohio

To protect and enhance the health and safety of the public through effective medical regulation

TOTAL P.03

State Medical Board of Ohio

30 E. Broad Street, 3rd Floor, Columbus, OH 43215-6127

Richard A. Whitehouse, Esq.
Executive Director

(614) 466-3934
med.ohio.gov

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Huron Medical Center
Medical Staff Office

PLEASE COMPLETE AND FAX TO (614) 644-1464 THEN MAIL ORIGINAL.

September 21, 2009

Jerome L. Yaklic, M.D., who is/was Chief of Staff, is applying to restore his/her Ohio license, which expired in 2001. We would appreciate your assistance in filling out the following evaluation, so that we can process his/her documents for restoration. Dr. Yaklic stated on his/her restoration application that he/she was affiliated with your organization from 06/00 to present.

(1) How long have you known the doctor? 1 year

(2) What is your capacity at the facility? President & CEO

(3) At what facility? Huron Medical Center

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

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

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

(7) Does this doctor relate well to patients? Yes

(8) Would you recommend this doctor's license be restored? Yes

Please indicate any information of a derogatory nature: _____

THIS FORM MUST BE COMPLETED BY A SUPERVISING PHYSICIAN

Janet C. Sternberg
Signature of Person Completing Form

Name of Person Completing Form
(please print or type)
Janet C. Sternberg

Position
President & CEO

989-269-1570
Telephone number (include area code)

Please return this form to the Ohio State Medical Board at the above address, Attn: Peri Vest

Sincerely,

Peri E. Vest

Peri E. Vest
Licensure/CME Renewal Assistant
State Medical Board of Ohio

OCT – 8 2009

State Medical Board of Ohio

30 E. Broad Street, 3rd Floor, Columbus, OH 43215-6127

Richard A. Whitehouse, Esq.
Executive Director

(614) 466-3934
med.ohio.gov

October 13, 2009

Jerome Yaklic, M.D.
329 S. Outer Dr.
Bad Axe, MI 48413

Dear Dr. Yaklic:

Please be advised that your Ohio medical license #75267 has been restored as of October 13, 2009. Enclosed please find your wallet identification card bearing the expiration date of Oct. 1, 2011.

Should you have any questions, you may contact me at (614) 466-9255 or e-mail me at Peri.Vest@med.state.oh.us.

Sincerely,

Peri E. Vest

Peri E. Vest
License/CME Renewal Assistant

Please notify the board in writing, of any change in your address.

Please refer to your license number on all correspondence with the board.

Ohio law requires that every physician's wall certificate be displayed in the physician's office where a major portion of such physician's practice is conducted.

Please read the reverse side of this card carefully and sign it in the signature portion to indicate you have read it.

Dr. Jerome Lumetta Yaklic
329 S. Outer Dr.
Bad Axe MI 48413

If you answered affirmatively to the questions on your renewal application, issuance of this wallet ID card does not operate as a waiver of the Board's authority to impose discipline based on the information reported.

STATE MEDICAL BOARD OF OHIO

30 E. Broad St., 3rd Floor, Columbus, Ohio 43215-6127
www.med.ohio.gov

EXPIRES : **10/01/2011** ***LICENSE NUMBER*** **35 . 075267**

Dr. Jerome Lumetta Yaklic

Doctor of Medicine

is duly registered and entitled to practice in The State of Ohio until the expiration date. ***AUDIT # :*** **29547**