app rec'd 1-22-14
lic no 11269
date 3-25-14

State Medical Board of Ohio

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

(614) 466-3934

med.ohio.gov

Ohio Expedited Physician Licensure Application

254818 **Record of receipt Order Number (required)**

1. ***Indicate License Type*** ○ M.D. ◉ D.O.

2. ***Name: Indicate your full legal name. Please list any maiden names or other names used.***

Last	First	Middle	Suffix
Lefkowitz	Janet	B	

Maiden Name:

All other names used:

3. ***Contact Information:*** *Please complete all sections*

Indicate which address you wish to use for mailings from the Medical Board. ○ Practice Address ◉ Home Address

Practice Address

Street 1: Phone Number:

Street 2: Fax Number:

City: State: Zip Code: email:

Home Address

Street 1: 1240 Heards Ferry Road Phone Number: +1 (860) 922-5110

Street 2: Fax Number:

City: Atlanta State: GA Zip Code: 30328 email: janet@drlefkowitz.com

4. ***Identification***

Date of birth	Birth City	State	Country
Apr 17, 1965	Brooklyn	NY	USA

SSN: Redacted

Gender: ○ Male ◉ Female

Your social security number is required to facilitate reporting to the federal Healthcare Integrity & Protection Data Bank (42 U.S.C. §1320a-7e(b), 5 U.S.C. §552a, and 45 C.F.R. pt. 61) and for accurate identification under the federal and state child support enforcement law (42 U.S.C. §666 and §3123.50, O.R.C.). It may also be used for reporting to the National Practitioner Data Bank (42 U.S.C. §11101 and 45 C.F.R. pt. 60) and for other investigative/enforcement purposes in compliance with Chapters 4730., 4731., 4760., 4762., or 4778. O.R.C. or as otherwise required by state or federal law.

5. Medical School: *List all medical schools you have attended, including those from which you did not graduate in chronological order. Attach and additional sheet if necessary.*

1. School Name: University of New England College of Osteopathic Medicine
Address: 11 Hills Beach Road
City: Biddeford State: ME Zip Code: 04005
Country: USA
Date From: August 1997
Date To: June 2001
Graduation Date: June 2001
Degree: DO

2. School Name:
Address:
City: State: Zip Code:
Country:
Date From:
Date To:
Graduation Date:
Degree:

6. Postgraduate Training: *List all postgraduate programs you have attended, including those you did not complete. Copy and attach additional pages if necessary.*

1. Hospital Name: Delaware County Memorial Hospital/Crozer Keystone
Address: 501 N. Lansdowne Avenue
City: Drexel Hill State: PA Zip Code: 19026
Country: USA
Department/Specialty: Rotating Internship
Date From: July 2001
Date To: June 2002
Successfully Completed? (•) Yes ( ) No
PGY (•) 1 ( ) 2 ( ) 3 ( ) 4 ( ) 5 ( ) other
PGT (•) Internship ( ) Residency ( ) Fellowship ( ) Research ( ) other

2. Hospital Name: St. Francis Hospital and Medical Center
Address: 114 Woodlawn Avenue
City: Hartford State: CT Zip Code: 06105
Country: USA
Department/Specialty: OB/GYN
Date From: July 2002
Date To: June 2006
Successfully Completed? (•) Yes ( ) No
PGY ( ) 1 ( ) 2 ( ) 3 ( ) 4 (•) 5 ( ) other
PGT ( ) Internship (•) Residency ( ) Fellowship ( ) Research ( ) other

3. Hospital Name:
Address:
City: State: Zip Code:
Country:
Department/Specialty:
Date From:
Date To:
Successfully Completed? ( ) Yes ( ) No
PGY ( ) 1 ( ) 2 ( ) 3 ( ) 4 ( ) 5 ( ) other
PGT ( ) Internship ( ) Residency ( ) Fellowship ( ) Research ( ) other

4. Hospital Name
Address
City State Zip Code
Country
Department/Specialty:

Date From
Date To

Successfully Completed?
○ Yes ○ No

PGY ○ 1 ○ 2 ○ 3 ○ 4 ○ 5 ○ other
PGT ○ Internship ○ Residency ○ Fellowship ○ Research ○ other

5. Hospital Name
Address
City State Zip Code
Country
Department/Specialty:

Date From
Date To

Successfully Completed?
○ Yes ○ No

PGY ○ 1 ○ 2 ○ 3 ○ 4 ○ 5 ○ other
PGT ○ Internship ○ Residency ○ Fellowship ○ Research ○ other

7. Examination History: *List each licensure examination you have taken (USMLE, NBME, NBOME, LMCC, Etc.). If additional space is necessary, copy and attach an additional sheet.*

Examination	Date Taken (mm,yyyy)	Pass / Fail	No. of Attempts
USMLE Step 1		● Pass ○ Fail	
USMLE Step 2 CK		● Pass ○ Fail	
USMLE Step 2 CS		○ Pass ○ Fail	
USMLE Step 3		○ Pass ○ Fail	
COMLEX Level 1	06/1999	● Pass ○ Fail	1
COMLEX Level 2 CE	03/2001	● Pass ○ Fail	1
COMLEX Level 2 PE	03/2001	● Pass ○ Fail	1
COMLEX Level 3	12/2003	● Pass ○ Fail	3
NBME Part I		● Pass ○ Fail	
NBME Part II		○ Pass ○ Fail	
NBME Part III		○ Pass ○ Fail	
NBOME Part I		● Pass ○ Fail	
NBOME Part II		● Pass ○ Fail	
NBOME Part III		● Pass ○ Fail	
LMCC Part I		○ Pass ○ Fail	
LMCC Part II		○ Pass ○ Fail	
FLEX Componet 1		○ Pass ○ Fail	
FLEX Componet 2		○ Pass ○ Fail	
FLEX Pre-1985		○ Pass ○ Fail	

State Board Exam	Date Taken	State taken for	No. of Attempts	Pass / Fail
				○ Pass ○ Fail

8. *ECFMG and Fifth Pathway*

Certificate Number | Issue Date

School Name | Date From
Address | Date To
City | State | Zip Code | Graduation Date
Country | Degree

9. *State or Professional Licensure:* *List all state and Canadian provinces where you currently hold or have ever held any type of medical/osteopathic license. You must complete the attached "Licensure Verification" form (Form #1) and forward it to all states in which you have held any healthcare license or certification. The verifying entity must forward all documentation directly to the Board. Some state boards charge a fee for this information. Contact the state board where you hold or held a license to determine their requirements. (Attach additional pages if necessary).*

	State / Province	License Type	License Number	License Status		Issue Date
1	Georgia	Physician	70197	(•) Active	( ) Inactive	Jun 7, 2013
2	Rhode Island	Physician	DO00607	(•) Active	( ) Inactive	Jun 25, 2006
3	Massachussetts	Physician	251954	(•) Active	( ) Inactive	Jun 20, 2012
4				( ) Active	( ) Inactive	
5				( ) Active	( ) Inactive	
6				( ) Active	( ) Inactive	
7				( ) Active	( ) Inactive	
8				( ) Active	( ) Inactive	
9				( ) Active	( ) Inactive	
10				( ) Active	( ) Inactive	
11				( ) Active	( ) Inactive	
12				( ) Active	( ) Inactive	
13				( ) Active	( ) Inactive	
14				( ) Active	( ) Inactive	
15				( ) Active	( ) Inactive	

10. *Specialty Board Certification:* *Are you ABMS and / or AOA certified?* (•) Yes ( ) No

*If **Yes** complete information below*

Name of Board	American Board of Obstetrics and Gyn	Certificate Number	9012244	Issue Date	1/13/2013
Name of Board		Certificate Number		Issue Date	
Name of Board		Certificate Number		Issue Date	

*If **No** then you must request the following information to be sent to the Board:*

1. *An FCVS packet or:*
2. *a transcript of your licensing examination scores and an AMA or AOA profile.*
   (To obtain these documents, see page 1 of the instructions)

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

Dates: From/To | Activity *(medical, non-medical and post graduate training)*

FROM: Month: July; Year: 2001

TO: Month: June; Year: 2002; ○ In Progress

Activity Name *(Practice/Employment/Non-Working*)*: Rotating Internship

Activity Address: 501 N. Lansdowne Avenue

City: Drexel Hill State: PA Zip Code: 19026

Position / Department: Osteopathic Rotating Internship

Percent Clinical: 100% Percent Administrative: 0%

◉ Employment ○ Staff Privileges ○ Administrative ○ Other, Please describe below

Intern

Dates: From/To | Activity *(medical, non-medical and post graduate training)*

FROM: Month: July; Year: 2002

TO: Month: June; Year: 2006; ○ In Progress

Activity Name *(Practice/Employment/Non-Working*)*: Residency

Activity Address: 114 Woodland Avenue

City: Hartford State: CT Zip Code: 06105

Position / Department: OB/GYN Resident

Percent Clinical: 90% Percent Administrative: 10%

◉ Employment ○ Staff Privileges ○ Administrative ○ Other, Please describe below

OB/GYN Resident

Dates: From/To | Activity *(medical, non-medical and post graduate training)*

FROM: Month: July; Year: 2006

TO: Month: August; Year: 2006; ○ In Progress

Activity Name *(Practice/Employment/Non-Working*)*: Vacation

Activity Address: 32 Lawton Road

City: North Kingstown State: RI Zip Code: 02852

Position / Department:

Percent Clinical: Percent Administrative:

○ Employment ○ Staff Privileges ○ Administrative ◉ Other, Please describe below

1 month vacation/relocation from Connecticut to Rhode Island following residency training

Dates: From/To | Activity *(medical, non-medical and post graduate training)*

FROM: Month: August; Year: 2006

TO: Month: October; Year: 2013; ☐ In Progress

Activity Name *(Practice/Employment/Non-Working*)*: Caring for Women

Activity Address: 166 Tollgate Road

City: Warwick State: RI Zip Code: 02886

Position / Department: Attending physician

Percent Clinical: 90% Percent Administrative: 10%

◉ Employment ○ Staff Privileges ○ Administrative ○ Other, Please describe below

Attending OB/GYN physician in private practice affiliated with Kent Hospital, Warwick, RI and Wome

Dates: From/To | Activity *(medical, non-medical and post graduate training)*

FROM: Month: October; Year: 2013

TO: Month: ; Year: ; ◉ In Progress

Activity Name *(Practice/Employment/Non-Working*)*: Seeking Employment

Activity Address: 1240 Heards Ferry Road

City: Atlanta State: GA Zip Code: 30328

Position / Department:

Percent Clinical: Percent Administrative:

○ Employment ○ Staff Privileges ○ Administrative ◉ Other, Please describe below

Relocation due to husband's work. Seeking employment.

12. *Malpractice:* *List of all claims or suits for medical malpractice made against you. A claim is any formal or informal demand for payment to any person or organization. If you do not have any such claims or suits, this section will be blank. Please provide a detailed written description of the background and medical issues involved in each case. Attach additional sheets if necessary.*

Name of patient involved: State action took place

Name of Court Case Number (if applicable:

Current status of claim: ○ Open (pending) ○ Closed (settled or Judgment) ○ Dismissed (no money paid out)

Amount of judgment or settlement: Amount paid on your behalf

Month and Year of incident Month and Year of lawsuit

Insurance carrier at the time

What is / was your status: ○ Primary Defendant ○ Co-defendant ○ Other

Name of patient involved: State action took place

Name of Court Case Number (if applicable:

Current status of claim: ○ Open (pending) ○ Closed (settled or Judgment) ○ Dismissed (no money paid out)

Amount of judgment or settlement: Amount paid on your behalf

Month and Year of incident Month and Year of lawsuit

Insurance carrier at the time

What is / was your status: ○ Primary Defendant ○ Co-defendant ○ Other

Ohio Addendum to Application
ADDITIONAL INFORMATION QUESTIONS

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.

○ Yes	◉ No	1. Have you ever been denied staff membership at any hospital, nursing home, clinic, health maintenance organization, or similar institution?
○ Yes	◉ No	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?
○ Yes	◉ No	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?
○ Yes	◉ No	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?
○ Yes	◉ No	5. Have you ever transferred from one graduate medical education program to another?
○ Yes	◉ No	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?
○ Yes	◉ No	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?
○ 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?
○ Yes	◉ No	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?
○ 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?

○ Yes	◉ No	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?
○ Yes	◉ No	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?
○ Yes	◉ No	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?
○ Yes	◉ No	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?
○ Yes	◉ No	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? If yes, submit copies of all relevant documentation, such as police reports, certified court records and any institutional correspondence and orders. Photocopies will not be accepted.
○ Yes	◉ No	16. Have you ever been arrested, forfeited collateral, bail, or bond for breach or violation of any law, police regulation, or ordinance other than for a minor traffic violation; been summoned into court as a defendant or had any lawsuit filed against you (other than a malpractice suit)? If yes, submit copies of all relevant documentation, such as police reports, certified court records and any institutional correspondence and orders. Photocopies will not be accepted.
○ Yes	◉ No	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? 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.
○ Yes	◉ No	18. Have you ever been denied professional liability insurance or coverage, or had such insurance or coverage canceled, limited, or restricted in any way?
○ Yes	◉ No	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?
○ Yes	◉ No	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?
○ Yes	◉ No	21. Have you ever been diagnosed as having, or have you been treated for, pedophilia, exhibitionism, or voyeurism?

○ Yes ◉ No 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?

○ Yes ◉ No 22. 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 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? **You may answer "NO" to this question if** you hold a current training certificate to pursue training in Ohio and the only such medical condition is chemical dependency or substance abuse, and you have successfully completed or are currently receiving treatment at a program approved by this board and have adhered to all statutory requirements as contained in Sections 4731.224 and 4731.25, O.R.C., and related provisions. Any questions concerning approval can be directed to the board offices.

○ Yes ◉ No a) Are the limitations or impairment caused by your medical condition reduced or ameliorated because you receive ongoing treatment or received treatment in the past (with or without medication) or participate in a monitoring program?

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

○ Yes ◉ No 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?

"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?

○ Yes ◉ No 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.

○ Yes ◉ No 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?

○ Yes ○ No 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.

This form must be completed if you have responded yes to Additional Information Question #I5 and/or #16.
Make additional copies of this form as needed.

Name of applicant

Date of incident

Location of Incident (City / State)

Were you arrested:

◯ Yes ◯ No

If the incident was alcohol-related, did you submit to a breath, blood, urine or other test to determine the amount of alcohol in your body?

If Yes, type if test and result

What offense(s) were you charged with?

Were the charges amended?:

◯ Yes ◯ No

If Yes, what were the final charges

Disposition:

◯ Pending ◯ Charges Dismissed ◯ Charges Dropped ◯ Conviction

◯ Plea

◯ Other

You must provide a detailed written explanation of the event including a description of the event, what led up to the event and what was learned. This must be described in your own words. Do not reference attached documentation. If additional space is needed, attach a separate sheet. Submit copies of the police report/arrest record, a copy of the charges or ticket, a copy of the final court disposition and any other relevant documentation

To E-Mail you application:

You cannot save data typed into this form. Please print 1 copy of your completed form for your records. The e-mail option does not work on all systems. If you are having a problem e-mailing you application please use the mail option below.

To Mail you application:

You cannot save data typed into this form. Please print 2 copies of your completed form. Keep one copy for your records and mail the other copy to:

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

Print Form

Submit by E-mail

State Medical Board of Ohio

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

Ohio Addendum to Application
Certificate of Recommendation for Medicine or Osteopathic Medicine

I MARK F. SCOTT, M. D., currently hold an active license to practice as a physician in the state of
(Recommending physician, print name legibly)
RHODE ISLAND /license number 7482, attest that all information I am providing is in conformance with the "Instructions for Completion of Recommendation Form," the photograph affixed hereto is a genuine likeness of the applicant, and provide this recommendation form related to the request for professional licensure by Janet Lefkowitz.
(Applicant print name legibly)

1. How do you know this applicant? As a colleague for over 10 years at Kent Hospital, Warwick, Rhode Island
2. How would you describe the applicant's medical knowledge? Commensurate with 10 years experience in general OB-GYN and consistent with an ABOG Board Certified OB-GYN
3. How would you describe the applicant's clinical technique? Commensurate with her years of experience in all clinical areas observed including surgeries and labor and delivery
4. How would you characterize the applicant's relationship with patients? Excellent with many of her patients having transferred to me after departure, lamenting her loss to them and the area
5. How would you describe the applicant's ability to work with peers and clinical staff? Excellent, with no areas of conflict or difficulty experienced in my time period of acquaintance with the applicant.
6. Have you personally known the applicant at least six months? ☑ Yes ☐ No
7. Does the applicant possess good moral character? (If no, explain) ☑ Yes ☐ No
8. Do you recommend this applicant for the professional license being sought? (If no, explain) ☑ Yes ☐ No
9. Are you aware of any other information (favorable or unfavorable) that could potentially impact this applicant's suitability for professional licensure or the Board's consideration of his/her application? (If yes, explain) ☐ Yes ☑ No
10. Have you attached additional correspondence or information to this form? ☐ Yes ☑ No

Signature of Applicant
Date Photo Taken: 12 / 13.
Month Year

Signature of Recommending Physician (Name stamps not accepted)

20 LENINHAN LA. E. GREENWICH RI 02818
Address (include house number and street, city, state and zip code)

Subscribed and sworn to before me this 16th day of January, 2014

NOTARY SEAL

Elizabeth Russo
Notary Public Signature

06-23-2014
Date Commission Expires

JAN 22 2014

State Medical Board of Ohio

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

Ohio Addendum to Application
EMPLOYER RECOMMENDATION FORM

Dr. Janet Lefkowitz, DO
(PLEASE PRINT APPLICANTS FIRST NAME AND LAST NAME)

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 their application for licensure. To ensure processing of the physicians application, please complete and return this form to the State Medical Board of Ohio at the above address within two (2) weeks. The form may also be faxed to the Board at (614) 644-1464. Your immediate attention to this matter will be greatly appreciated by the applicant as well as by us. Thank you for your time and assistance.

Position(s) held: Physician

Dates of Employment: 2006 to Oct 2013

1. How long have you known the applicant? 5 years
2. What is/was your supervisory capacity? Practice Manager
3. At what hospital/clinic? Caring For Women
4. How would you rate their medical knowledge and techniques? Highest Rating
5. In your opinion is the applicant of good moral and ethical character? Very much so
6. Does the applicant work well with peers and medical staff? Excellent
7. Does the applicant relate well to patients? Excellent
8. How is the applicant's command of the English language (if applicable)? Yes
9. Would you recommend the applicant for licensure? Yes

Additional comments (An additional sheet may be added if needed):

Sandra Smith
Signature of Physician

Sandra Smith
Name of Physician (Please type or print clearly)

Position

401-739-2000
Telephone number (include area code)

Caringlfw@gmail.com
E-Mail

401-732-7842
Fax number (include area code)

CompHealth.

RELEASE AND AUTHORIZATION INFORMATION

I: Lefkowitz (LAST NAME) Janet (FIRST NAME) (MIDDLE NAME) (PLEASE INCLUDE JR., SR., II, III, Etc.)

hereby affirm that the information I have provided on this application and attachments is true and correct and that it can be relied upon by CHG Companies, Inc. and its affiliates (collectively "CompHealth") for evaluating my potential as a locum tenens physician.

By applying for membership to, or when evaluating retention with CompHealth, I hereby authorize CompHealth, its affiliates and successors, to obtain any information that may be relevant to an evaluation of my professional qualifications, including but not limited to information about disciplinary actions or other confidential or privileged information, and other credentials.

I agree to provide and authorize the release by CompHealth to CompHealth clients of the followings a) vaccination records; b) reasonable documentation evidencing that I am in good health and free of communicable diseases; c) the result of and/or a copy of my criminal background check, if any; and d) the result of and/or a copy of my drug screen, if any.

I authorize CompHealth to disclose to and receive from current, prior, or potential employers and CompHealth clients making a reasonable inquiry, information relating to my qualifications, ability, and character to practice medicine, including information from the following sources: all medical schools, colleges, universities, transcript offices, medical institutions, or organizations, hospitals, employers, personal references, physicians, attorneys, companies or agencies who may furnish my criminal background history, companies that perform drug screens, medical malpractice carriers or organizations, business and professional associates, all government agencies and instrumentalities, the National Practitioner Data Bank, the Federation of State Medical Boards, the American Medical Association, American Osteopathic Association, American Board of Medical Specialties, DEA, state licensing boards, specialty boards, and any other pertinent source. This is a continuing authorization until such time as I have specifically revoked the same in writing which shall apply to all information received at any time by CompHealth relating to my qualifications, ability, and character to practice medicine.

I hereby forever waive and release CompHealth, its officers, employees, agents and third parties which provide or receive information regarding my credentials, including but not limited to the Federation of State Medical Boards and those entities listed above, from any claims, causes of action, damages and expenses, including reasonable attorney's fees arising from or relating to the provision, collection, verification, and dissemination of information about me.

Further, I agree to hold CompHealth harmless from any and all claims, causes of action, damages, judgments and expenses, including reasonable attorney's fees, arising from or related to the collection, verification and dissemination of credentialing information provided by me. I understand that this does contemplate a duty to hold CompHealth harmless from claims, causes of action and damages which may arise as a result of information provided about me from sources other than myself.

I understand that I have the burden of providing accurate and adequate information to CompHealth, its affiliates or successors, to demonstrate my qualifications. I understand that any misstatement in this form may constitute grounds for denial of referral to practice opportunities, grounds for civil damages, grounds for reporting the same to the NPDB or state licensing boards or cancellation of contract. If any material changes occur affecting my professional status, it is my obligation to notify CompHealth or the appropriate affiliate or successor as soon as possible. I attest that the information contained in this application is correct and complete.

I understand that the decision to refer me to practice opportunities by CompHealth is solely at the discretion of CompHealth.

I understand that any information received from references by CompHealth, including but not limited to quality evaluations, is confidential and may not be released to me without the consent of the reference.

A copy or facsimile of this document shall have the same effect as the original.

This document shall be interpreted according to the laws of the State of Utah.

Signature * DocuSigned by: Janet Lefkowitz 8E0C76E1245540A... Date * 12/30/2013

Social Security Number * Redacted

* Required Information

State Medical Board of Ohio

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

Ohio Addendum to Application
EMPLOYER RECOMMENDATION FORM

Dr. Janet Lefkowitz, DO
(PLEASE PRINT APPLICANTS FIRST NAME AND LAST NAME)

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 their application for licensure. To ensure processing of the physicians application, please complete and return this form to the State Medical Board of Ohio at the above address within two (2) weeks. **The form may also be faxed to the Board at (614) 644-1464.** Your immediate attention to this matter will be greatly appreciated by the applicant as well as by us. Thank you for your time and assistance.

Position(s) held: ~~7/18/06-9/1/13~~ attending physician on the Medical Staff OB-GYN

Dates of ~~Employment~~ Appointment: 7/18/06 - 9/1/13 (13)

1. How long have you known the applicant? 2006
2. What is/was your supervisory capacity? ASST. CMO
3. At what hospital/clinic? KENT HOSPITAL
4. How would you rate their medical knowledge and techniques? EXCELLENT
5. In your opinion is the applicant of good moral and ethical character? YES
6. Does the applicant work well with peers and medical staff? YES
7. Does the applicant relate well to patients? YES
8. How is the applicant's command of the English language (if applicable)? EXCELLENT
9. Would you recommend the applicant for licensure? YES - HIGHLY

Additional comments (An additional sheet may be added if needed): EXCELLENT PHYSICIAN!

PAUL F. McKENNEY MD FACP
Signature of Physician

PAUL F. McKENNEY MD
Name of Physician (Please type or print clearly)

ASST. CHIEF MEDICAL OFFICER
Position

401-737-7010 ext. 31503
Telephone number (include area code)

pmckenney@kenter.org
E-Mail

401-736-1099
Fax number (include area code)

CompHealth

P.O. Box 713100
Salt Lake City, UT 84171-3100
(800) 453-3030

FAX

FROM:

TO:

Attention: Medical Staff Office

From: Jenna Dunn

To: Kent Hospital

Pages: 3

Phone number: 401-737-7000

Date: 1/21/14

Fax number: 401-736-1099

Phone number: 801-930-3548

Comments:

Please complete the enclosed verification letter for Dr. Janet Lefkowitz. Please fax it directly to the Ohio Medical Board at ATTN: Kay Rieve / 614-644-1464. Please feel free to contact me if you have any questions.

Thank you! ☺

State Medical Board of Ohio

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

Ohio Addendum to Application
EMPLOYER RECOMMENDATION FORM

Dr. Janet Lofkowitz, DO
(PLEASE PRINT APPLICANTS FIRST NAME AND LAST NAME)

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 their application for licensure. To ensure processing of the physicians application, please complete and return this form to the State Medical Board of Ohio at the above address within two (2) weeks. **The form may also be faxed to the Board at (614) 644-1464.** Your immediate attention to this matter will be greatly appreciated by the applicant as well as by us. Thank you for your time and assistance.

Position(s) held: Staff member. Obstetrics + Gynecology

Dates of Employment: _____

1. How long have you known the applicant? 5 years
2. What is/was your supervisory capacity? Chief of Ob-Gyn at Women + Infants Hospital.
3. At what hospital/clinic? Women + Infants Hospital of RI
4. How would you rate their medical knowledge and techniques? Good
5. In your opinion is the applicant of good moral and ethical character? Yes
6. Does the applicant work well with peers and medical staff? Yes
7. Does the applicant relate well to patients? Yes
8. How is the applicant's command of the English language (if applicable)? Good
9. Would you recommend the applicant for licensure? Yes

Additional comments (An additional sheet may be added if needed): Highly competent + skilled physician

Maureen Phipps
Signature of Physician

MAUREEN PHIPPS
Name of Physician (Please type or print clearly)

CHIEF OF OB/GYN
Position

(401) 274-1122 x4-1575
Telephone number (include area code)

mphipps@wihri.org
E-Mail

401-453-7696
Fax number (include area code)

Women&Infants
New England's premier hospital for women and newborns

MEDICAL STAFF OFFICE
101 DUDLEY STREET
PROVIDENCE, RI 02905
(401) 274-1122 ext. 42300

January 21, 2014

TO WHOM IT MAY CONCERN:

Due to the increase in requests for information regarding Women & Infants Hospital's Medical Staff Appointees past and present, we regret we are unable to complete the form you sent us. We hope the information provided below will meet your needs.

PRACTITIONER NAME:	Janet B. Lefkowitz, D.O.
APPOINTMENT:	FROM: 09/26/2006 TO: 09/30/2013
DEPARTMENT/SECTION:	Ob/Gyn
SPECIALTY:	OBSTETRICS & GYNECOLOGY
STAFF CATEGORY:	Active **Current Status**: Voluntary Resignation
CLINICAL PERFORMANCE:	Practitioner has been credentialed in accordance with JC Standards and meets or exceeds all clinical performance standards for privileging at Women & Infants Hospital
DISCIPLINARY ACTION:	Practitioner has no evidence of disciplinary action at Women & Infants Hospital
LIABILITY CLAIMS:	Please contact the practitioner's malpractice carrier for liability information.

Sincerely,

Sandra L. Drywa, Credentials Coordinator
Medical Staff Office
Women & Infants Hospital
P: (401) 274-1122 ext. 42339
F: (401) 276-7865
sdrywa@wihri.org

COMPREHENSIVE OSTEOPATHIC MEDICAL LICENSING EXAMINATION-USA

Official Transcript

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

Examinee: Lefkowitz, Janet B.

NBOME ID: 580241 **Date of Birth:** 4/17/1965

EXAMINATION	DATE COMPLETED	PASS / FAIL	3 - DIGIT STANDARD SCORE	3 - DIGIT MINIMUM PASSING	2 - DIGIT STANDARD SCORE	2 - DIGIT MINIMUM PASSING	NOTE
Level 1							
	1-Jun-1999	Pass	415	400	75	75	
Level 2 Cognitive Evaluation (CE)							
	6-Mar-2001	Pass	478	400	78	75	
Level 3							
	4-Dec-2001	Fail	312	350	73	75	
	11-Jun-2002	Fail	293	350	73	75	
	9-Dec-2003	Pass	426	350	77	75	

The National Board of Osteopathic Medical Examiners, Inc., does hereby certify the above to be a true report of the examinee.

Date Prepared: January 07, 2014

1105673710707970

-- please see reverse for information and description of notes -- v2.0

National Board of Osteopathic Medical Examiners, Inc.
8765 West Higgins Road Suite 200 Chicago IL 60631-4174
Phone: 773/714-0622 Fax: 773/714-0631

State Medical Board of Ohio

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

Affidavit and Authorization for Release of Information: You must attach a recent (less than 6 months old) passport quality, color photograph of yourself to this form. Take the form to a notary public and sign the form in the presence of the notary public. The notarized form then must be sent directly to this Board.

Affidavit and Authorization For Release of Information

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

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

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

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

I will immediately notify the board in writing of any changes to the answers to any of the questions contained in this application if such a change occurs at any time prior to a license to practice medicine being granted to me by the board

I understand my failure to answer questions contained in this application truthfully and completely may lead to denial, revocation, or other disciplinary sanction of my licensure or permit to practice medicine.

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

LEFKOWITZ

Applicant's Printed Last Name

JANET B.

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

1/10/14

Date of Signature

NOTARY

Dated 01/10/2014 Signed George L Smith

State of GEORGIA County of FULTON

SUBSCRIBED AND SWORN TO before me this 10 day of, January 2014

My Commission expires: 09/13/2015 NOTARY PUBLIC SIGNATURE & SEAL

GEORGE L. SMITH NOTARY PUBLIC GEORGIA My Commission Expires September 13, 2015 FULTON COUNTY

MEDICAL BOARD

JAN 13 2014

State Medical Board of Ohio

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

Ohio Addendum to Application
Certificate of Recommendation for Medicine or Osteopathic Medicine

I MAURO A COLAVITA, MD, currently hold an active license to practice as a physician in the state of
(Recommending physician, print name legibly)
RI /license number 08160, attest that all information I am providing is in conformance with the "Instructions for Completion of Recommendation Form," the photograph affixed hereto is a genuine likeness of the applicant, and provide this recommendation form related to the request for professional licensure by JANET LEFKOWITZ.
(Applicant, print name legibly)

1. How do you know this applicant? COLLEAGUE IN PRACTICE FOR 5 YEARS
2. How would you describe the applicant's medical knowledge? UP TO DATE
3. How would you describe the applicant's clinical technique? ABOVE AVERAGE
4. How would you characterize the applicant's relationship with patients? COLLABORATIVE
5. How would you describe the applicant's ability to work with peers and clinical staff? EXCELLENT

6. Have you personally known the applicant at least six months?	☒ Yes	☐ No
7. Does the applicant possess good moral character? (If no, explain)	☒ Yes	☐ No
8. Do you recommend this applicant for the professional license being sought? (If no, explain)	☒ Yes	☐ No
9. Are you aware of any other information (favorable or unfavorable) that could potentially impact this applicant's suitability for professional licensure or the Board's consideration of his/her application? (If yes, explain)	☐ Yes	☒ No
10. Have you attached additional correspondence or information to this form?	☐ Yes	☒ No

Signature of Applicant
Date Photo Taken: 12/13.
Month Year

Mauro A. Colavita
Signature of Recommending Physician (Name stamps not accepted)

166 TOLLGATE RD., WARWICK, RI 02886
Address (include house number and street, city, state and zip code)

Subscribed and sworn to before me this 6 day of March, 2014

Notary Public Signature
NOTARY SEAL

9/12/17
Date Commission Expires

MEDICAL BOARD
MAR 10 2014

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

March 17, 2014

Attn: Aaron E. Haslam
State Medical Board of Ohio
30 E. Broad St., 3rd FL
Columbus, OH 43215-6127

Re: Board Action Query Dated: March 17, 2014
Your Reference Number:
FSMB Batch Number: BQ2413613

The following is a final report of the search results from the Board Action Data Bank as of March 17, 2014 for practitioners submitted as part of the above-referenced batch for which NO board actions were identified.

Practitioners Cleared with No Actions as of March 17, 2014

Item	Name	DOB	School	Yr/Grad	Request ID
10	Lefkowitz, Janet	04/17/1965	020010	2001	27220069

LICENSE HISTORY
State Board
MASSACHUSETTS
RHODE ISLAND

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.

Commonwealth of Massachusetts Board of Registration in Medicine

Janet B. Lefkowitz, D.O.

Physician Information

Except for the License information, this information has been reported by Dr. Lefkowitz.

License Number	251954	Accepting New Patients	No
License Status	Active	Accepts Medicaid	No
License Issue Date	6/20/2012	Translation Services Available	None Reported
License Renewal Date	4/17/2015	Insurance Plans Accepted	None Reported
Primary Work Setting	None Reported	Hospital Affiliations	None Reported
Business Address	166 Toll Gate Road Warwick, RI 02886 United States of America	NPI Number	1235149865
Business Telephone	(401) 738-6031		

Both The Joint Commission and the National Committee on Quality Assurance consider the Massachusetts Board of Registration to be a primary source provider for license status information.

Education & Training

The Education and Training information was verified as of the License Issue Date above.

Medical School	U. of New England College of Osteopathic Medicine
Graduation Date	6/2/2001
Post Graduate Training	Delaware County Memorial Hospital, Crozer-Keystone Health System, Intern:Osteopathic (6/25/2001 - 6/23/2002) St Francis Hospital and Medical Center, Intern:Obstetrics and Gynecology (7/1/2002 - 6/30/2003) St Francis Hospital and Medical Center, Resident:Obstetrics and Gynecology (7/1/2003 - 6/30/2006)

Specialty

This information has been reported by Dr. Lefkowitz.

Area of Specialty	Obstetrics and Gynecology

Board Certifications

This information has been reported by Dr. Lefkowitz.

American Board of Medical Specialties (ABMS)

Board Name	General Certification	Subspecialty
Obstetrics & Gynecology	Obstetrics and Gynecology	

Honors and Awards

Dr. Lefkowitz has reported no awards.

Professional Publications

Dr. Lefkowitz has reported no publications.

Malpractice Information

Dr. Lefkowitz has not made a payment on a malpractice claim in Massachusetts.

Disciplinary and/or Massachusetts Criminal Actions

Massachusetts Criminal Convictions, Pleas and Admissions

The Board has no record of felony or serious misdemeanor convictions regarding Dr. Lefkowitz.

Health Care Facility Discipline

The Board has no record of health care facility discipline regarding Dr. Lefkowitz.

Massachusetts Board Discipline

Dr. Lefkowitz has not been disciplined by the Board.

Out of State Board Discipline

The Board has no record of out of state discipline regarding Dr. Lefkowitz.

Instructions for obtaining public information about a physician are available at our public information page. Questions about a physician's Profile may be submitted to ma.profiles@state.ma.us. You may also contact the Massachusetts Board of Registration in Medicine, 200 Harvard Mill Square, Suite 330, Wakefield, MA 01880. Phone 781-876-8200 for public information about a physician or questions about a physician's Profile.

JANET BETH LEFKOWITZ

License No:	DO00607	**Profession:**	Physician	**License Type:**	Osteopathic Physician (DO)
License Status:	Active	**Issue Date:**	4/25/2006	**Expiration Date:**	6/30/2014
Secondary License Type:					

Education Information

School Name: University of New England Coll. of Osteopathic Med **Graduated:** 6/2/2001

Specialty Information

OBSTETRICS + GYNECOLOGY

Disciplinary Action

Disclaimer: The individual license information on the Licensee Lookup displays only the current license status (e.g., Active, Active Probation, Suspended, Revoked). For the disciplinary history of any individual licensee, please click on the link for the specific profession and then on the Disciplinary Actions link available on each professional board's webpage.

See Board Disciplinary Listings at http://www.health.ri.gov/lists/disciplinaryactions

CLOSE THIS WINDOW TO RETURN TO THE SEARCH RESULTS.

Rhode Island

georgia.gov

Georgia Composite Medical Board

Search Results

NOTE: Licenses renewed online within the past three business days may not be reflected here. Physician Profiles are available for physicians only.

Public Board Orders Disclaimer: Public Board order means that there is a public document concerning the License. The existence of a Board order does not necessarily mean the License was sanctioned by the Medical Board or that the License, if sanctioned, is currently under any type of disciplinary action.

Though other versions may work, this site is designed for Adobe Acrobat Reader 11.0.4 and above, and utilizes the Adobe PDF plug-in for the browser. If you experience any problems please make sure you are using one of these versions. You may select the following link to Adobe's site to download the latest version of Acrobat Reader (http://get.adobe.com/reader/)

1 Result found for "lefkowitz, Physician".

License Status	Name Address Issue / Expiration Dates	Specialty	Public Board Orders	Physician Profile
070197 Active	LEFKOWITZ, JANET BETH, DO 32 LAWTON AVE | NORTH KINGSTOW, RI 02852 Issue Date: 06/07/2013 Expiration Date: 04/30/2015	Obstetrics Gynecology	None	None

1 Result found for "lefkowitz, Physician".

Back to Top

NEW SEARCH

State Medical Board of Ohio

30 E. Broad St., 3rd Floor • Columbus, OH 43215-6127 • (614) 466-3934 • Website: http://med.ohio.gov/

3/25/2014

Janet Beth Lefkowitz
1240 Heards Ferry Road
Atlanta GA 30328

This is to notify you that you are now licensed to practice medicine or osteopathic medicine and surgery in the State of Ohio. The Board approved your request and your license number **011269** was issued on **03/25/2014** and will expire on **07/01/2016**.

Enclosed is your wallet card and wall certificate. The wall certificate, by law, must be displayed in your office or the place where a major portion of your practice is conducted.

Please be advised that verification of your Ohio license must be obtained directly from the Board's website at http://med.ohio.gov in the "Licensee Profile and Status section. The website is updated immediately to reflect newly issued licenses.

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

SECTION 4731.281, OHIO REVISED CODE REQUIRES WRITTEN NOTICE TO THE BOARD OF ANY CHANGE OF PRINCIPAL PRACTICE ADDRESS OR RESIDENCE ADDRESS WITHIN THIRTY DAYS OF THE CHANGE. *A CHANGE OF ADDRESS FORM IS AVAILABLE ON THE BOARD'S WEBSITE.*

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

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

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

Sincerely,

Nicole Weaver
Nicole Weaver
Chief, Licensure

Date Posted: 4/4/2016 12:38:31 PM

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

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

License Information

License Number 34.011269

License Name Janet Lefkowitz

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. **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?

. . . . . NO

NPI number

1. Please enter your current NPI number.

. 1235149865

DEA number

1. Please enter your DEA number

. . . . . BL9718567

OARRS Registration

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

. . . . . NO

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

. . . . . NO

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

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

Ohio
med.ohio.gov
State Medical Board of Ohio
30 East Broad Street, 3rd Floor, Columbus, Ohio 43215-6127 | (614) 466-3934

VERIFICATION OF LICENSURE/LETTER OF GOOD STANDING

This letter is to verify that the records of the State Medical Board of Ohio contain the following information for the indicated licensee as of 9/2/2016:

Identification Information

Full Name:	Janet Beth Lefkowitz
Date of Birth:	04/17/1965

License Information

Type of License:	Doctor of Osteopathic Medicine
License Number:	34. 011269
Original Licensure Date:	03/25/2014
Expiration Date:	07/01/2018
Status:	ACTIVE
Formal Action(s)*:	No

Sincerely,

A.J. Groeber
Executive Director

If there is a formal board action against this licensee and you need additional information or to receive certified copies of a public record, please send a written request to Med-PublicRecordRequests@med.ohio.gov detailing the nature of your subsequent inquiry. The online system makes certain scanned documents related to board actions taken on all Ohio licensees available to the public via the website at www.med.ohio.gov .

For general license verification questions, send an email to med.renewal@med.ohio.gov. All communications to the Board must include the name of the licensee and license number with each request.

Ohio
med.ohio.gov
State Medical Board of Ohio
30 East Broad Street, 3rd Floor, Columbus, Ohio 43215-6127 | (614) 466-3934

VERIFICATION OF LICENSURE/LETTER OF GOOD STANDING

This letter is to verify that the records of the State Medical Board of Ohio contain the following information for the indicated licensee as of 7/05/2016:

Identification Information

Full Name:	Janet Beth Lefkowitz
Date of Birth:	04/17/1965

License Information

Type of License:	Doctor of Osteopathic Medicine
License Number:	34. 011269
Original Licensure Date:	03/25/2014
Expiration Date:	07/01/2018
Status:	ACTIVE
Formal Action(s)*:	No

Sincerely,

A.J. Groeber
Executive Director

If there is a formal board action against this licensee and you need additional information or to receive certified copies of a public record, please send a written request to Med-PublicRecordRequests@med.ohio.gov detailing the nature of your subsequent inquiry. The online system makes certain scanned documents related to board actions taken on all Ohio licensees available to the public via the website at www.med.ohio.gov .

For general license verification questions, send an email to med.renewal@med.ohio.gov. All communications to the Board must include the name of the licensee and license number with each request.