STATE MEDICAL BOARD OF OHIO

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

SECTION 1: Identification Information- Answer All Questions

1. Present Legal Name: HORN (last) JOYCE (first) LEE (middle) ____ (maiden if applicable)

2. Address: 7606 Constitution Drive (street & number)

Cincinnati, Ohio (city) 45215 (state) Hamilton (zip code) (country)

Intended place of practice: Cincinnati (city) Ohio (state) Hamilton (country)

Telephone: Business 513 872-4796 (area code) Home: 513 761-8443 (area code)

3. Place of Birth: Greenville, Ohio (city) Darke (state) ____ (country) Date of Birth: 11-09-58 (mo. day year)

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

5. Physical description:

Color of Hair Auburn Color of Eyes brown Height 5ft. 3 inches

Build petite Marks none Weight 120 lbs

6. Immigration or citizenship status:

Indicate which of the following documents you currently possess.

X U.S. Birth Certificate

____ Certificate of Naturalization
Number____ Date Issued____ City/State____

____ Declaration of Intention (issued by the U.S. District Court)
Number____ Date Issued____ City/State____

____ Alien Registration Receipt Card (issued by Dept. of Immigration & Naturalization)
Number____ Date Issued____ City/State____

____ Approved Petition for Immigrant Visa (issued by Dept. of Immigration & Naturalization)
Number____ Date Issued____ City/State____

____ Other, specify____

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

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

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

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

SECTION 2: Educational Background

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

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

name	address	From: mo/day/yr	To: mo/day/yr	degree
University of Michigan	Catherine St. Ann Arbor, Michigan	09/01/77	06/07/83	M.D.

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

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

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

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

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

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

Number_____ Date_____

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

SECTION 3: Postgraduate Training

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

Date mo/yr-mo/yr	Hospital	Complete Address	Position & Department	% Clin.	% Admin.
07/83 to present	Univ. of Cincinnati University Hosp.	234 Goodman St. Cincinnati, Ohio 45267	PGY I Obstetrics & Gynecology	100	

Total Number of Months in Approved* Training: 10
*Approved by LCME, AOA, or in Canada.

SECTION 4: Licensure Information- Answer All Questions

1. a) Are you a diplomate of the National Board of Medical Examiners?
Yes (X) No ( ) If so, specify year 1984
Are you a diplomate of the National Board of Examiners for Osteopathic Physicians and Surgeons?
Yes ( ) No ( ) If so, specify year _____
Are you a licentiate of the Medical Council of Canada?
Yes ( ) No ( ) If so, specify year _____

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

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

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

STATE	DATE (Mo/Yr.)				
None					
		FULL ( )	PARTIAL ( )	PASS ( )	FAIL ( )
		FULL ( )	PARTIAL ( )	PASS ( )	FAIL ( )
		FULL ( )	PARTIAL ( )	PASS ( )	FAIL ( )

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

State	Date of Issuance	License Number	Current
None			YES ( ) NO ( )
			YES ( ) NO ( )
			YES ( ) NO ( )
			YES ( ) NO ( )
			YES ( ) NO ( )

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

Country	Date Conferred	Is Right Currently Held? (Yes or No)
None		Yes ( ) No ( )
		Yes ( ) No ( )

4. Field of Specialization

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

Field	Board Certified	Year Certified	Country
Obstetrics & Gynecology	YES ( ) NO (IN TRAINING		
	YES ( ) NO ( )		

SECTION 5: General Information- Answer All Questions

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

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

STATE_____ DATE_____ CHARGE_____

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

If so, specify:_____
State or country Reason Date

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

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

If so, specify:_____
State or country Court Offense

_____
Date Disposition

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

If so, specify: _____
Reason Date

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

If so, specify: _____
School, Hospital or Institution

_____
City/State Country

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

If so, specify _____
Hospital or Institution

_____
City/State Country

SECTION 6: Resume

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

Horn

DATES mo/yr-mo/yr	HOSPITAL OR UNIVERSITY	COMPLETE ADDRESS (INCLUDING STREET, APARTMENT, (IF APPLICABLE), CITY, STATE ZIP CODE, AND COUNTRY (IF NOT IN THE U.S.)	POSITION & DEPARTMENT	% CLIN.	% ADMIN.
07/83 to present	University Hosp., Univ. of Cincinnati	Hospital address: 234 Goodman St. Cincinnati, Ohio 45267 Home address: 7606 Constitution Drive Cincinnati, Ohio 45215	PGY I resident Obstetrics/ Gynecology	100	

FORM 3

CERTIFICATE OF RECOMMENDATION

MUST BE COMPLETED FOR ALL APPLICANTS

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

I, Clarence R. McClain, M.D., a licensed and practicing physician in the state of
Recommending Physician
Ohio, affirm that Joyce Horn has been known to me personally and professionally for 2 years and that he/she is of good moral and ethical character. I offer the following in support of his/her application for full licensure:

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

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

I hereby recommend Joyce Horn, M.D. for full licensure to practice Medicine
Applicant
in Ohio.

University of North Carolina School of Medicine
Medical School of Graduation of Recommending Physician

Clarence R. McClain M.D.
Signature of Recommending Physician

Ohio
State of Licensure of Recommending Physician

Clarence R. McClain M.D.
Name of Recommending Physician (Please print)

28987
License No. of Recommending Physician

University of Cincinnati College of Medicine
231 Bethesda Ave, Cincinnati, Ohio 45267
513-872-7337
Address of Recommending Physician
Telephone Number (Include area code)

Subscribed and sworn to this 29 day of June, 1984.

(SEAL)

Mary K. Oldeng (McCarthy)
Notary Public

Date Commission Expires

UPON COMPLETION, RETURN TO:

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

MARY K. McCARTHY
Notary Public, State of Ohio
My Commission Expires Sept. 23, 1988

FORM 3

CERTIFICATE OF RECOMMENDATION

MUST BE COMPLETED FOR ALL APPLICANTS

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

I, Allen R Shade, a licensed and practicing physician in the state of
Recommending Physician
Ohio, affirm that Joyce Horn has been known
to me personally and professionally for 2 years and that ~~he/~~she is of good moral and ethical character. I offer the following in support of his/her application for full licensure:

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

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

I hereby recommend Joyce Horn for full licensure to practice Medicine
Applicant
in Ohio.

Ohio State University
Medical School of Graduation of Recommending Physician

Allen R Shade MD
Signature of Recommending Physician

Ohio
State of Licensure of Recommending Physician

ALLEN R SHADE
Name of Recommending Physician (Please print)

025107
License No. of Recommending Physician

6535 Apache Circle Cincinnati 45243
Address of Recommending Physician

513 561-9466
513-871-1818
Telephone Number (Include area code)

Subscribed and sworn to this 29 day of June, 19 84.

(SEAL)

Mary K. Olding (McCarthy)
Notary Public

Date Commission Expires

RECEIVED
OHIO MEDICAL BOARD
PM 2:04

MARY K. McCARTHY
Notary Public, State of Ohio
My Commission Expires Sept. 23, 1988

UPON COMPLETION, RETURN TO:

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

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

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

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

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

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

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

SECTION 9: Release of Applicant

STATE OF OHIO

COUNTY OF Hamilton SS: 379-64-2278

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

Joyce Horn, MD
(Signature of Affiant)

Subscribed and sworn to this 29 day of June, 1984

Mary K. Olding (McCarthy)
(Signature of Official Administering Oath)

(SEAL)

(Date Commission Expires) MARY K. McCARTHY
Notary Public, State of Ohio
My Commission Expires Sept. 23, 1988

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

SECTION 10: Affidavit of Applicant

STATE OF OHIO

SS: 379-64-2278

COUNTY OF Hamilton

Before me, personally appeared Joyce Horn
(Affiant)

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

JUL 3 PM 04

Joyce Horn, MD
(Signature of Affiant)

Subscribed and sworn to this 29 day of June, 19 84.

(SEAL)

Mary K. Olding (McCarthy)
(Signature of Official Administering Oath)

MARY K. McCARTHY
Notary Public, State of Ohio
My Commission Expires Sept. 23, 1988

(Date Commission Expires)

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

STATE MEDICAL BOARD OF OHIO
REQUEST FOR APPLICATION FORMS

PLEASE TYPE OR PRINT CLEARLY

OK # 50927 x88

I hereby submit the following information in order to receive an application for licensure:

NAME: HORN (LAST (Surname)) JOYCE (FIRST) LEE (MIDDLE) (SUFFIX (Jr.,II))

ADDRESS: 201 Harris Circle (STREET & NUMBER) Newark (CITY) DE (STATE) 19711 (ZIP) U.S. (COUNTRY)

TELEPHONE: BUSINESS: (302) 651-9700 (AREA CODE & NUMBER) HOME: (302) 239-7931 (AREA CODE & NUMBER)

BIRTH DATE: 11/09/58 (MO/DAY/YR) BIRTH PLACE: Greenville (CITY) OH (STATE) U.S. (COUNTRY)

MEDICAL EDUCATION

MEDICAL SCHOOL OF GRADUATION: University of Michigan (SCHOOL NAME) 1500 East Medical Center Drive (STREET ADDRESS) Ann Arbor (CITY) MI (STATE) 48109 U.S. (COUNTRY)

06/01/79 (FROM: MO/DAY/YR) 05/27/83 (TO: MO/DAY/YR) M.D. (DEGREE RECEIVED) 05/27/83 (DATE RECEIVED: MO/DAY/YR)

OTHER MEDICAL SCHOOLS ATTENDED: (IF "NONE ENTER "NONE")

NONE (SCHOOL NAME) (STREET ADDRESS) (CITY) (STATE) (COUNTRY)

/ / (FROM: MO/DAY/YR) / / (TO: MO/DAY/YR) (REASON EDUCATION NOT COMPLETED AT THIS SCHOOL)

(SCHOOL NAME) (STREET ADDRESS) (CITY) (STATE) (COUNTRY)

/ / (FROM: MO/DAY/YR) / / (TO: MO/DAY/YR) (REASON EDUCATION NOT COMPLETED AT THIS SCHOOL)

E.C.F.M.G. CERTIFICATE: YES ____ NO ✓ NUMBER ____ DATE ISSUED / /

FIFTH PATHWAY

FIFTH PATHWAY PROGRAM AT: ____ (HOSPITAL OR INSTITUTION) AFFILIATED WITH: ____ (NAME OF MEDICAL SCHOOL)
(IF "NONE", ENTER "NONE")

ADDRESS: ____ (STREET & NUMBER) (CITY) (STATE) (ZIP) DATE: / / (FROM) / / (TO)

QUALIFYING EXAM TAKEN: ____ DATE: / /

POSTGRADUATE TRAINING

LIST ALL POSTGRADUATE TRAINING (INTERNSHIP, RESIDENCY OR CLINICAL FELLOWSHIP), UNDERTAKEN IN THE U.S. OR CANADA. IF ADDITIONAL SPACE IS NEEDED, PLEASE ATTACH AN EXTRA SHEET.

HOSPITAL: University of Cincinnati (NAME) 234 Goodman Street (STREET ADDRESS) Cincinnati (CITY) OH (STATE) 45267
POSITION: internship/residency DEPARTMENT: OB-GYN DATE: 07/01/83 (FROM: MO/YR) 06/31/87 (TO: MO/YR)

HOSPITAL: ____ (NAME) (STREET ADDRESS) (CITY) (STATE)
POSITION: ____ DEPARTMENT: ____ DATE: / / (FROM: MO/YR) / / (TO: MO/YR)

HOSPITAL: ____ (NAME) (STREET ADDRESS) (CITY) (STATE)
POSITION: ____ DEPARTMENT: ____ DATE: / / (FROM: MO/YR) / / (TO: MO/YR)

HOSPITAL: ____ (NAME) (STREET ADDRESS) (CITY) (STATE)
POSITION: ____ DEPARTMENT: ____ DATE: / / (FROM: MO/YR) / / (TO: MO/YR)

LICENSES IN OTHER COUNTRIES

LIST ALL FOREIGN COUNTRIES IN WHICH YOU HOLD OR HAVE HELD A FULL RIGHT TO PRACTICE MEDICINE AND SURGERY. IF ADDITIONAL SPACE IS NEEDED, PLEASE ATTACH AN EXTRA SHEET.

COUNTRY: NONE ISSUE DATE: / / LICENSE # _____ CURRENT: YES__ NO__

COUNTRY _____ ISSUE DATE: / / LICENSE # _____ CURRENT: YES__ NO__

LICENSES IN THE UNITED STATES

LIST ALL STATES IN WHICH YOU ARE OR HAVE BEEN LICENSED TO PRACTICE MEDICINE AND SURGERY OR OSTEOPATHIC MEDICINE AND SURGERY. INDICATE THE LICENSE NUMBER, DATE OF ISSUANCE, WHETHER OR NOT THE LICENSE IS CURRENT, AND THE BASIS OF LICENSURE (E.G., FLEX EXAM, ENDORSEMENT OF OTHER STATE LICENSE, ENDORSEMENT OF DIPLOMATE STATUS, ETC.) IF ADDITIONAL SPACE IS NEEDED, PLEASE ATTACH AN EXTRA SHEET.

STATE: OHIO ISSUE DATE: 8 16 84 LICENSE #: 50927 CURRENT: YES__ NO✓

BASIS OF LICENSURE: endorsement of diplomate status (Expires 6/30/91)

STATE: DELAWARE ISSUE DATE: 6 / 87 LICENSE #: C1-0002951 CURRENT: YES✓ NO__

BASIS OF LICENSURE: endorsement of diplomate status

STATE: _____ ISSUE DATE: / / LICENSE #: _____ CURRENT: YES__ NO__

BASIS OF LICENSURE: _____

STATE BOARD OR FLEX EXAMINATIONS TAKEN

LIST EACH AND EVERY STATE BOARD OR FLEX EXAM WHICH YOU HAVE TAKEN WHETHER IN OHIO OR ANY OTHER STATE, TERRITORY OR PROVINCE. IF ADDITIONAL SPACE IS NEEDED, PLEASE ATTACH AN EXTRA SHEET.

STATE: N/A DATE TAKEN: _____ PASS: ____ FAIL: ____ FULL ( ) PARTIAL ( )

STATE: _____ DATE TAKEN: _____ PASS: ____ FAIL: ____ FULL ( ) PARTIAL ( )

STATE: _____ DATE TAKEN: _____ PASS: ____ FAIL: ____ FULL ( ) PARTIAL ( )

ADDITIONAL ELIGIBILITY INFORMATION - ANSWER ALL QUESTIONS

DIPLOMATE OF THE NATIONAL BOARD OF MEDICAL EXAMINERS? PENDING ___ YES ✓ NO ___ DATE 7/84

DIPLOMATE OF THE NATL BOARD OF OSTEO MEDICAL EXAMINERS? PENDING ___ YES___ NO ✓ DATE /

ARE YOU APPLYING TO SIT FOR THE FLEX EXAM IN OHIO? YES ___ NO ✓

A LICENTIATE OF THE MEDICAL COUNSEL OF CANADA? YES ___ NO ✓ DATE / /

A U.S. CITIZEN? YES ✓ NO ___ BASIS OF CITIZENSHIP _____ DATE: / /

A GRADUATE OF A MEXICAN MEDICAL SCHOOL? YES ___ NO ✓ DATE / /

DEGREE OBTAINED (CHECK ONLY ONE): ACTA_____ TITULO_____ MEDICO CIRUJANO_____

HAVE YOU ACHIEVED A SCORE OF AT LEAST TWO HUNDRED THIRTY (230) ON THE TEST OF SPOKEN ENGLISH OF THE EDUCATIONAL TESTING SERVICE AS REQUIRED UNDER SECTION 4731.09, O.R.C.? (THE TOEFL, ECFMG EXAM, etc., ARE NOT EQUIVALENT AND CANNOT BE SUBSTITUTED FOR THE TSE) YES___ NO___

OHIO RESIDENT AT THE TIME OF ADMISSION TO MEDICAL SCHOOL? YES ___ NO ✓

IF YES, GIVE FULL ADDRESS AT THAT TIME:

_____

STREET ADDRESS CITY STATE ZIP

CERTIFICATION

I, JOYCE HORN, HEREBY CERTIFY THAT I AM THE PERSON REFERRED TO IN THE FOREGOING REQUEST FOR APPLICATION FORM; THAT THE STATEMENTS THEREIN ARE STRICTLY TRUE IN EVERY RESPECT AND THAT I HAVE READ AND UNDERSTAND THIS CERTIFICATION.

Joyce Horn 1-17-90

SIGNATURE DATE

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

PRELIMINARY EDUCATION FORM

My name IN FULL is HORN (LAST) JOYCE (FIRST) LEE (MIDDLE)

High School or Equivalent: Coldwater High School (SCHOOL NAME) Coldwater (CITY) MI (STATE) US (COUNTRY)

09 / 73 (FROM: MO/YR) 06 / 77 (TO: MO/YR) H.S. (DEGREE)

Undergraduate College or Equivalent: University of Michigan (SCHOOL NAME) Ann Arbor (CITY) MI (STATE) U.S. (COUNTRY)

09 / 77 (FROM: MO/YR) 06 / 83 (TO: MO/YR) B.S. (DEGREE)

(SCHOOL NAME) (CITY) (STATE) (COUNTRY)

/ (FROM: MO/YR) / (TO: MO/YR) (DEGREE)

Medical School of Graduation: University of Michigan (SCHOOL NAME) Ann Arbor (CITY) MI (STATE) U.S. (COUNTRY)

06/79 (FROM: MO/YR) 06/ 83 (TO: MO/YR) M.D. (DEGREE)

↳ Integrated Premed-Med. Program (6 yrs. total)

FOR BOARD USE ONLY

CERTIFICATE OF
PRELIMINARY EDUCATION

NO: _____

DATE ISSUED: _____

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

STATE MEDICAL BOARD OF OHIO
'06 JAN 25 PM 12:40

_____
Entrance Examiner

_____
Secretary

LOG OF CONTINUING MEDICAL EDUCATION
FOR THE PERIOD OF JANUARY 1, 1987 - DECEMBER 31, 1988

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

SIGNATURE Joyce Horn DATE 2-5-90

NAME JOYCE HORN

ADDRESS 201 Harris Circle
Newark, DE 19711

OHIO CERT # Ohio license #50927

CATEGORY I

YOU DO NOT HAVE TO ATTACH DOCUMENTATION

100 CREDIT REQUIREMENT
At least 40 credits must be earned in Category I. Please list Category II credits on the reverse side (maximum 60).

Name of Sponsor	Location	Description	Date	Credits
Columbia Univ.	NYC, NY	Symposium: Benign Vag & Reconstructive Vag Surgery	9-30-88	15
~~Danbury Hosp~~	~~NYC, NY~~	~~Advanced~~	~~4-28-89~~	~~15~~
ACOG	Boston, MA	Genetics postgrad course	4-30-88	12
ACOG	Worcester, MA	Lasers in GYN	11-9-88	23
				50

STATE MEDICAL BOARD
90 MAR 14 PM 4:40
RECEIVED

CATEGORY II 60 credits may be earned in this Category.

Name of Activity	Description	Date	Credits
Hospital sponsored conferences	Guest lectures, Tumor conferences, Path conferences	July 1987 thru Dec 1988	Total (37)
CREOG in training examination	Resident in training exam Univ of Cincinnati Senior resident	~ February 1987	20
		Total	57

Renewed 3-16-90

LOG OF CONTINUING MEDICAL EDUCATION
FOR THE PERIOD OF JANUARY 1, 1987 - DECEMBER 31, 1988

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

SIGNATURE Joyce Horn DATE 2-5-90

NAME JOYCE HORN

ADDRESS 201 Harris Circle
Newark, DE 19711

OHIO CERT # Ohio license #50927

CATEGORY I

YOU DO NOT HAVE TO ATTACH DOCUMENTATION

100 CREDIT REQUIREMENT
At least 40 credits must be earned in Category I. Please list Category II credits on the reverse side (maximum 60).

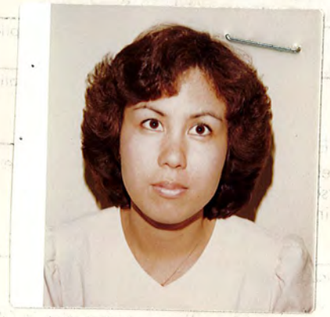
Horn, Joyce

Name of Sponsor	Location	Description	Date	Credits
Columbia Univ.	NYC, NY	symposium: Benign Vag & Reconstructive Vag Surgery	9-30-88	~~15~~ 15
~~Danbury Hosp~~	~~NYC, NY~~	~~Advanced~~	~~4-28-89~~	~~15~~
ACOG	Boston, MA	Genetics postgrad course	4-30-88	12
ACOG	Worcester, MA	Lasers in GYN	11-9-88	23
				50

STATE MEDICAL BOARD
90 FEB 16 AM 11:53

CATEGORY II — 60 credits may be earned in this Category.

Name of Activity	Description	Date	Credits



Universitatis Reipublicae Michiganensium

3 P12:04

PROCURATORES OMNIBUS HAS LITERAS PERLECTURIS

Salutem

Scitatis **Joyce Lee Horn** ingenuis moribus notis a Collegii Medicinae et Chirurgiae Professoribus commendatam, ut quae in studio et disciplina scientiaque Medicinae et Chirurgiae Artium bene probata sit, gradu

Doctoris in Arte Medica

nos renuntiasse, cujus in rei testimonium has literas Praesidis et Secretarii et Professorum nomina manusque gerentes, sigilloque Universitatis signatas, in manus ejusdem dedimus.

Datum ex aedibus Universitatis die vicesimo septimo Maii anno salutis millesimo nongentesimo octogesimo tertio Annoque Universitatis Reipublicae Michiganensium centesimo sexagesimo sexto

R. L. Kennedy Secretarius

Harold T. Shapiro Praeses

Professores

Decanus
Chem. Biol. Prof.
Chirurg. Prof.
Dermat. Prof.
Art. Med. Prof.
Anesthesiol. Prof.
Otorhinolaryngol. Prof.
Phy. Med. et Rehab. Prof.
Neurol. Prof.
Art. Family Pract. Prof.
Ophthalmol. Prof.

Physiol. Prof.
Art. Obst. et Gynaecol. Prof.
Path. Prof.
Art. Paediatr. et Mort. Cont. Prof.
Pharmacol. Prof.
Postgrad. Med. et Health. Pro. Educ. Prof.
Radiatic. Therapia. Art. Prof.
Hum. Gen. Prof.
Microbiol. et Immunitatis. Prof.
Radiol. Prof.
Anat. et Cell Biol. Assoc. Prof.
Psychiatr. Prof.

CATEGORY I

YOU DO NOT HAVE TO ATTACH DOCUMENTATION

100 CREDIT REQUIREMENT
At least 40 credits must be earned in Category I. Please list Category II credits on the reverse side (maximum 60).

Horn, Joyce

Name of Sponsor	Location	Description	Date	Credits
Columbia Univ.	NYC, NY	Symposium: Benign Vag & Reconstructive Vag Surgery	9-30-88	~~15~~ 15
~~Danbury Hosp~~	~~NYC, NY~~	~~Advanced~~	~~4-28-89~~	~~15~~
ACOG	Boston, MA	Genetics postgrad course	4-30-88	12
ACOG	Worcester, MA	Lasers in GYN	11-9-88	23
				50

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

7/6/84

Federation of State Medical Boards of the United States

JUL 12 1984

PREV. CORRES_____
ANS._____ FILE_____
CHECK_____
BY_____

Mrs. Fisher
Federation of State Medical Boards
of the United States, Inc.
2630 West Freeway
Suite 138
Fort Worth, Texas 76102

Dear Mrs. Fisher:

The following physician has applied for endorsement licensure in Ohio:

Joyce Lee Horn, M.D.

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

Sincerely,

Angela Albert

Angela Albert
Chief, Licensure

'84 JUL 17 A9:00

Derogatory Information:

WE HAVE NO UNFAVORABLE INFORMATION REGARDING THE ABOVE NAMED PHYSICIAN

JUL 13 1984

Bryant L. Galusha, M.D.

BRYANT L. GALUSHA, M.D.
EXECUTIVE VICE-PRESIDENT

EH

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

DATE July 6, 1984

Dear Doctor,

Dr. Joyce Horn, MD who is/was Resident OB/GYN 7/83-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 papers for licensure. Your immediate attention to this matter will be greatly appreciated by the doctor as well as by us. Information provided is considered confidential under Section 149.43(A)(2)(a), Ohio Revised Code. Thank you for your time and assistance.

(1) How long have you known the doctor? 1½ yr.

(2) What was/is your supervisory capacity? teacher.

(3) At what hospital? University of Cincinnati Medical Center.

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

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

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

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

(8) How is his/her command of the English language? (If applicable) NA.

(9) Would you recommend this doctor for licensure? yes.

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,
Sincerely,

Angela Albert
Angela Albert
Chief, Licensure

T. P. Barden
Signature of Doctor, please type or print name legibly beneath

TOM P. BARDEN MD.

Professor and Chairman.
Position

DATE

Telephone No. (513) 872 4796 (Include Area Code)

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

ENDORSEMENT OF CERTIFICATION

NATIONAL BOARD OF MEDICAL EXAMINERS
OF THE
UNITED STATES OF AMERICA

Joyce L. Horn, M.D.

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

Attest C. WILLIAM DAESCHNER, JR., M.D.
Chairman of the Board

SEAL

EDITHE J. LEVIT, M.D.
President of the Board

Philadelphia, Pa.

07/02/84

Certificate # 278508

JUL 17

It is certified that the above is a facsimile of the Diplomate Certificate which has been or will be* awarded to the physician named above, who graduated from U MICHIGAN MEDICAL SCHOOL in MAY 1983 and whose birth date is 11/09/1958. This physician has successfully completed all examinations required for certification by the National Board of Medical Examiners. The scores obtained by this physician upon which his/her certification is based are as follows:

	Standard Score	Scale Score
PART I passed 06/82		
Anatomy, incl. histology and embryology	370	72
Physiology	420	75
Biochemistry	525	82
Pathology	540	83
Microbiology, incl. immunology	435	76
Pharmacology and Materia Medica	540	83
Behavioral Sciences	460	78
TOTAL TEST (Minimum Passing Score 380/75)	465	78
Part II passed 09/82		
Internal medicine and the medical specialties	570	86
Surgery and the surgical specialties	365	75
Obstetrics and Gynecology	530	84
Public Health and Preventive Medicine	315	73
Pediatrics	440	79
Psychiatry	355	75
TOTAL TEST (Minimum Passing Score 290/75)	410	78
PART III passed 03/84		
A General Test of Clinical Competence		
TOTAL TEST (Minimum Passing Score 290/75)	430	79.6
GENERAL AVERAGE (Parts, I, II, and III Scale Score)		78.5

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

Ann K. Heverling
Secretary for Certification

SEAL

07/10/84
Date

The University of Michigan
Medical School

Office of the Dean

DIPLOMA TRANSLATION

FOR: JOYCE L. HORN, M.D.

CLASS OF: 1983

The University of Michigan Medical School diploma, as translated into the English language, reads as follows:

From the Regents to anyone reading this letter: Greetings!

Be advised that we have awarded the degree of Doctor of Medicine to JOYCE L. HORN, M.D. recommended to us in the usual manner by the professors of the College of Medicine and Surgery (Medical School) as a person well-qualified in the study, discipline and sciences of Medicine and Surgery.

In proof of this we have given to (him/her) this letter, bearing the signatures of the President, the Secretary, and the professors.

Done on the premises of the University on the 27th day of May 1983.

Sincerely,

Wayne K. Davis

Wayne K. Davis, Ph.D.
Professor and Assistant Dean
for Curricular Affairs

(SEAL)

WKD/amp

M7300 Medical Science Building I • Ann Arbor, Michigan 48109-0010 • (313) 763-9600

STATE MEDICAL BOARD OF OHIO

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

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

Joyce Horn 10-15-86

(SIGNATURE OF APPLICANT) (DATE)

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

IDENTIFICATION NUMBER
35-05-0927

1
JOYCE LEE HORN
2647 BELLEVUE
APT 2
CINCINNATI OH 45219

MD & DO SPECIALTY CODES

ENTER ALL → SPECIALTY CODES 39 | | |

(SEE LIST ON ENCLOSED CARD) (LIMIT OF 3)

AMOUNT DUE $100.00

DATE DUE 11/15/86

EDM-14946

INSTRUCTIONS

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

TREASURER, STATE OF OHIO
BOX 2438 COLUMBUS, OHIO 43216

REPORT ANY CHANGE OF ADDRESS OF RECORD

(PLEASE PRINT)

LAST NAME FIRST NAME INITIAL

STREET ADDRESS

CITY STATE ZIP CODE

COUNTY

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

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

PRINCIPAL PRACTICE ADDRESS – IF DIFFERENT FROM THAT SHOWN ON FRONT

(PLEASE PRINT)

LAST NAME FIRST NAME INITIAL

STREET ADDRESS

CITY STATE ZIP CODE

COUNTY

SOCIAL SECURITY NUMBER REDACTED

EDM-14946-B

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

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

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

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

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

STATE MEDICAL BOARD OF OHIO

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

X Joyce Horn 2-5-90
(SIGNATURE OF APPLICANT) (DATE)

OT-00223-OF

#33208
3-19-90

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

IDENTIFICATION NUMBER 35-05-0927

Joyce Lee Horn, M.D.
201 Harris Circle
Newark, DE 19711

$100 current
25 penalty

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

AMOUNT DUE $125.00 DATE DUE 11/01/88

pr 782

INSTRUCTIONS

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

REPORT ANY CHANGE OF ADDRESS OF RECORD

(PLEASE PRINT)

2-4

LAST NAME | FIRST NAME | INITIAL

6-19-71

STREET ADDRESS

2-16-90

CITY | STATE | ZIP CODE

COUNTY

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

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

PRINCIPAL PRACTICE ADDRESS—IF DIFFERENT FROM THAT SHOWN ON FRONT

(PLEASE PRINT) (only till JUNE 1990)

HORN JOYCE L

LAST NAME FIRST NAME INITIAL

2323 PENNSYLVANIA AVE.

STREET ADDRESS

WILMINGTON, DE 19806

CITY STATE ZIP CODE

NEW CASTLE

COUNTY

SOCIAL SECURITY NUMBER [redacted]

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

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

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

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

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

QT-00224-OB

DETACH HERE AND REMIT THIS PORTION WITH FEE

STATE MEDICAL BOARD OF OHIO

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

CERTIFICATION

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

X Joyce Horn 11-13-90

(SIGNATURE OF APPLICANT) (DATE)

IDENTIFICATION NUMBER:	AMOUNT DUE	DATE DUE
35050927	$160.00	11/01/90

JOYCE LEE HORN, M.D.
8611 CALUMET WAY
CINCINNATI OH 452492430

MD & DO SPECIALTY CODES CURRENTLY ON RECORD

39 OBSTETRICS & GYNECOLOGY

☐ SPECIALTY CODE(S) CORRECT AS LISTED

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

CHANGE OF ADDRESS

STREET

STREET

CITY STATE ZIP CODE

COUNTY

:969696962: 0935050927 "00000

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

11475 Reading Rd
Street

Street

Cincinnati OH 45249
City *State* *Zip Code*

HAMILTON
County

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

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

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

YES	NO	
☐	☑	*1.) Been addicted to or dependent upon alcohol or any chemical substance? You may answer "no" to this question if you have successfully completed treatment at a program approved by this board and have subsequently adhered to all statutory requirements as contained in section 4731.224, O.R.C., and related provisions, or you are currently enrolled in a board approved program. Any questions concerning approval can be directed to the board offices.*
☐	☑	*2.) Had any disciplinary action taken or initiated against you by any state licensing board?*
☐	☑	*3.) Surrendered, or consented to limitation upon: a) A license to practice medicine; OR b) State or federal privileges to prescribe controlled substances?*
☐	☑	*4.) Had any clinical privileges suspended or revoked for reasons other than failure to maintain records or attend staff meetings?*

SOCIAL SECURITY NUMBER
(Optional for purposes of identification)

...ORATION WITH FEE

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

CERTIFICATION

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

X Joyce Horn 6-8-92
(SIGNATURE OF APPLICANT) (DATE)

IDENTIFICATION NUMBER	AMOUNT DUE	DATE DUE
35-05-0927	$160.00	07/01/92

JOYCE LEE HORN,M.D.
8611 CALUMET WAY
CINCINNATI OH 45249-2430

MD & DO SPECIALTY CODES CURRENTLY ON RECORD

39 OBSTETRICS & GYNECOLOGY

PROCESS ☑ SPECIALTY CODE(S) CORRECT AS LISTED. S

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

CHANGE OF ADDRESS

STREET
STREET
CITY STATE ZIP CODE
COUNTY

:96969696 2: 0935050927 :00000 16000:

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

10475 Reading Rd. #307
Street

Street

CINCINNATI OH 45241
City State Zip Code

County

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

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

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

YES	NO	
☐	☑	1.) Been addicted to or dependent upon alcohol or any chemical substance; or been treated for, or been diagnosed as suffering from, drug or alcohol dependency or abuse? You may answer "no" to this question if you have successfully completed treatment at a program approved by this board and have subsequently adhered to all statutory requirements as contained in section 4731.224, O.R.C., and related provisions, or you are currently enrolled in a board approved program. Any questions concerning approval can be directed to the board offices.
☐	☑	2.) Had a license denied by or had any disciplinary action taken or initiated against you by any state licensing board other than the State Medical Board of Ohio?
☐	☑	3.) Surrendered, or consented to limitation upon: a) A license to practice medicine; OR b) State or federal privileges to prescribe controlled substances?
☐	☑	4.) Had any clinical privileges suspended, limited or revoked for reasons other than failure to maintain records or attend staff meetings?

[redacted] REDACTED

SOCIAL SECURITY NUMBER

(Optional for purposes of identification)

DETACH HERE AND REMIT THIS PORTION WITH FEE

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

CERTIFICATION

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

X Joyce Horn (SIGNATURE OF APPLICANT) 3-27-94 (DATE)

IDENTIFICATION NUMBER	AMOUNT DUE	DATE DUE
35-05-0927	$250.00	05/01/94

JOYCE LEE HORN,M.D.
8611 CALUMET WAY
CINCINNATI OH 45249-2430

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: 0935050927 :00000 25000:

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

10475 Reading Rd #307
Street

Street

CINCINNATI OH 45241
City State Zip Code

HAMILTON
County

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

YES NO

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

YES NO

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

YES NO

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

YES NO

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

YES NO

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

YES NO

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

YES NO

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

YES NO

8.) After January 14, 1993, referred a patient, or participated in an arrangement or scheme for referral of a patient, for clinical laboratory services to a person or facility in which either you or a member of your immediate family has an ownership or investment interest, or any compensation arrangement?

SOCIAL SECURITY NUMBER
(Optional for purposes of identification)

DETACH HERE AND REMIT THIS PORTION WITH FEE

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

CERTIFICATION

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

X Joyce Horn 3-12-96
(SIGNATURE OF APPLICANT) (DATE)

IDENTIFICATION NUMBER	AMOUNT DUE	DATE DUE
35-05-0927	$250.00	05/01/96

JOYCE LEE HORN,M.D.
8611 CALUMET WAY
CINCINNATI OH 45249-2430

MD & DO SPECIALTY CODES CURRENTLY ON RECORD

OBG OBSTETRICS & GYNECOLOGY

PLEASE MAKE ANY CORRECTIONS

☒ SPECIALTY CODE(S) CORRECT AS LISTED

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

REPORT ANY CHANGE OF ADDRESS

3219 CLIFTON Ave # 125
STREET
STREET
CINCINNATI OH 45220
CITY STATE ZIP CODE
HAMILTON
COUNTY

:96969696 2: 0935050927" "00000 25000"

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

Street: 3218 CLIFTON AVE #125

Street:

City: CINCINNATI State: OH Zip Code: 45220

County: HAMILTON

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

YES NO

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

YES NO

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

YES NO

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

YES NO

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

YES NO

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

YES NO

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

YES NO

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

YES NO

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

[redacted] REDACTED

SOCIAL SECURITY NUMBER
(Optional for purposes of identification)

DETACH HERE AND REMIT THIS PORTION WITH FEE

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

CERTIFICATION

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

X Joyce Horn, MD 3/4/98
(SIGNATURE OF APPLICANT) (DATE)

IDENTIFICATION NUMBER	AMOUNT DUE	DATE DUE
35-05-0927-H	$275.00	05/01/98

JOYCE LEE HORN,M.D.
3219 CLIFTON AVE #125
CINCINNATI OH 45220

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: 0935050927 ⑈00000 27500⑈

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

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 a felony or misdemeanor.*

YES NO

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

YES NO

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

YES NO

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

YES NO

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

YES NO

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

YES NO

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

YES NO

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

SOCIAL SECURITY NUMBER
(Optional for purposes of identification)

DETACH HERE AND REMIT THIS PORTION WITH FEE

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

CERTIFICATION

I CERTIFY, UNDER PENALTY OF LOSS OF MY RIGHT TO PRACTICE IN THE STATE OF OHIO, THAT I HAVE COMPLETED OR WILL HAVE COMPLETED DURING THE 1998-2000 REGISTRATION PERIOD THE REQUISITE HOURS OF CONTINUING MEDICAL EDUCATION CERTIFIED BY THE OHIO STATE MEDICAL ASSOCIATION AND APPROVED BY THE STATE MEDICAL BOARD, AND THAT THE INFORMATION PROVIDED ON THIS APPLICATION FOR RENEWAL IS TRUE AND CORRECT IN EVERY RESPECT.

X Joyce Horn, MD 4-15-00
(SIGNATURE OF APPLICANT) (DATE)

IDENTIFICATION NUMBER	AMOUNT DUE	DATE DUE
35-05-0927-H	$305.00	07/01/2000

JOYCE LEE HORN,M.D.
3219 CLIFTON AVE #125
CINCINNATI OH 45220

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

RESIDENCE ADDRESS-THIS MUST BE ENTERED AT EACH RENEWAL.

STREET
STREET
CITY STATE ZIP CODE
COUNTY

:96969696 21: 0935050927" "0000030500"

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

10475 READING RD
Street

STE 307
Street

CINCINNATI | OH | 45241
City | State | Zip Code

HAMILTON
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.) Been notified by any board, bureau, department, agency, or other body including those in Ohio, other than this board, of any investigation concerning you, or any charges, allegations or complaints filed against you?

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?

REQUIRED:

[redacted] REDACTED

SOCIAL SECURITY NUMBER

DETACH HERE AND REMIT THIS PORTION WITH FEE

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

CERTIFICATION

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

X Joyce Horn, MD 62702
(SIGNATURE OF APPLICANT) (DATE)

IDENTIFICATION NUMBER	AMOUNT DUE	DATE DUE	$50 Late Fee Due After
35-05-0927-H	$305.00	07/01/02	10/01/02

JOYCE LEE HORN,M.D.
3219 CLIFTON AVE #125
CINCINNATI OH 45220

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

RESIDENCE ADDRESS-THIS MUST BE ENTERED AT EACH RENEWAL.

STREET

STREET

CITY STATE ZIP CODE

COUNTY

0935050927 30500

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

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

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

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

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

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

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

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

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

Street

Street

City *State* *Zip Code*

County

REQUIRED: [redacted] REDACTED

SOCIAL SECURITY NUMBER

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

CERTIFICATION

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

X Joyce Horn 5-4-04
(SIGNATURE OF APPLICANT) (DATE)

IDENTIFICATION NUMBER	AMOUNT DUE	DATE DUE	$50 Late Fee Due After
35 . 050927	305.00	7/1/2004	10/1/2004

Dr. JOYCE LEE HORN
3219 CLIFTON AVE #125
CINCINNATI OH 45220

MD & DO SPECIALTY CODES CURRENTLY ON RECORD

OBG

☑ **SPECIALTY CODE(S) CORRECT AS LISTED**

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

RESIDENCE ADDRESS-THIS MUST BE ENTERED AT EACH RENEWAL.

8611 CALUMET WAY
STREET

STREET

CINCINNATI OH 45249
CITY STATE ZIP CODE

HAMILTON
COUNTY

SELECT ONE ADDRESS FOR MAILINGS FROM THE BOARD.
— RESIDENCE X PRINICIPAL PRACTICE ADDRESS

0003665688 30500 35ZZ 050927 5.25

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

YES NO ☐ ☑ *1.) Have you been fou guilty of, or pled guilty or contest to, or receiv treatment or intervention lieu of conviction of, a felo or misdemeanor?*

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

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

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

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

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

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

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

Street

Street

City *State* *Zip Code*

County

REQUIRED:

[redacted] REQUIRED

SOCIAL SECURITY NUMBER

OHIO STATE MEDICAL BOARD
JUN 2 2004

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

CERTIFICATION

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

X Joyce Horn 5-4-04
(SIGNATURE OF APPLICANT) (DATE)

IDENTIFICATION NUMBER	AMOUNT DUE	DATE DUE	$50 Late Fee Due After
35 . 050927	305.00	7/1/2004	10/1/2004

Dr. JOYCE LEE HORN
3219 CLIFTON AVE #125
CINCINNATI OH 45220

MD & DO SPECIALTY CODES CURRENTLY ON RECORD

OBG

☑ SPECIALTY CODE(S) CORRECT AS LISTED

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

RESIDENCE ADDRESS-THIS MUST BE ENTERED AT EACH RENEWAL.

8611 CALUMET WAY
STREET

STREET

CINCINNATI OH 45249
CITY STATE ZIP CODE

HAMILTON
COUNTY

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

0003665688 30500 35ZZ 050927

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

YES NO

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

YES NO

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

YES NO

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

YES NO

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

YES NO

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

YES NO

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

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

☐ Check this Box if you have NO principal Practice address.

10475 READING RD
Street
SUITE 307
Street
CINCINNATI OH 45241
City State Zip Code
HAMILTON
County

REQUIRED:
REDACTED
SOCIAL SECURITY NUMBER

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

Joyce Horn
Signature of Applicant

06/01/04
Date

Date Posted: 4/4/2006 9:50:52 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	10475 Reading Rd Suite 307 Cincinnati, OH 45241 Hamilton County United States of America (513) 563 2030
MAIN	8200 Remington Rd. Cincinnati, OH 45242 Hamilton County United States of America (513) 563 2030

License Information

License Number	35.050927
License Name	JOYCE HORN
Email Address	

Fees

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

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 or revoked for reasons **other than failure to maintain records on a timely basis or to attend staff meetings?**

. . . . . NO

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

. . . . . NO

Social Security Number

1.

. . . . . REDACTED

Nurse Collaboration Info

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

. . . . . NO

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

. . . . . *{not Answered}*

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

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

Date Posted: 4/18/2008 9:09:54 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.

License Information

License Number	35.050927
License Name	JOYCE HORN
Email Address	FrWmnWebb@hotmail.com

Fees

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

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 or revoked for reasons **other than failure to maintain records on a timely basis or to attend staff meetings?**

. . . . . NO

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

. . . . . NO

Social Security Number

1.

. . . . . REDACTED

Nurse Collaboration Info

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

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

. . . . . *{not Answered}*

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

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

Date Posted: 4/29/2010 4:49:47 PM

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

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

License Information

License Number 35.050927

License Name JOYCE HORN

Fees

Relicensure Fee $305.00

========

Total Fees **$305.00**

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?

. . . . . NO

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

. . . . . *{not Answered}*

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

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

Date Posted: 4/6/2012 1:58:36 PM

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

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

License Information

License Number 35.050927

License Name JOYCE HORN

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?

. . . . . NO

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

. . . . . *{not Answered}*

Ohio Employment

1. Do you practice in Ohio?

. . . . . YES

Ohio Workforce Questions

1. "Clinical" - direct patient care

. 35-39

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

. 0

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

. 1-4

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

. 1-4

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

. 0

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

. 0

Clinical - Practice setting

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

. 30-34

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

. 20-24

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:

. 45241

2. Enter the first county:

. . . . . Hamilton

3. Enter the second zip code:

. 45220

4. Enter the second county:

. . . . . Hamilton

5. Enter the third zip code:

. . . . . *{not Answered}*

6. Enter the third county:

. . . . . *{not Answered}*

7. Do you have more than one practice location?

. . . . . 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.

. . . . . 10475 Reading Rd., Suite 307 Cincinnati, OH 45220; 3219 Clifton Ave., Suite 125 Cincinnati, OH 45220

Practice Arrangement (size)

1. Solo practitioner

. . . . . NO

2. Single-specialty Group

. 5-10

3. Multi-specialty Group

. . . . . N/A

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

. . . . . 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}*

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: 4/14/2014 2:23:53 PM

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

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

Address Information

CREDENTIAL MAIL ADDRESS

10475 Reading Rd
Suite 307
Cincinnati, OH 45241
Hamilton County
United States of America
(513) 563 2030
jhartmann@forwomeninc.net

License Information

License Number 35.050927
License Name JOYCE HORN

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?

. . . . . NO

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

. . . . . *{not Answered}*

Ohio Employment

1. Do you practice in Ohio?

. . . . . YES

Ohio Workforce Questions

1. "Clinical" - direct patient care

. 25-29

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

. 0

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

. 5-9

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

. 0

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

. 0

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

. 0

Clinical - Practice setting

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

. 0

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:

. 45241

2. Enter the first county:

. . . . . Hamilton

3. Enter the second zip code:

. 45220

4. Enter the second county:

. . . . . Hamilton

5. Enter the third zip code:

. . . . . *{not Answered}*

6. Enter the third county:

. . . . . *{not Answered}*

7. Do you have more than one practice location?

. . . . . 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.

. . . . . 10475 Reading Road Suite 307 Cincinnati, Ohio 45241; 3219 Clifton Avenue Suite 125 Cincinnati, Ohio 45220

Practice Arrangement (size)

1. Solo practitioner

. . . . . NO

2. Single-specialty Group

. 5-10

3. Multi-specialty Group

. . . . . N/A

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

. . . . . NO

Workforce Language Question

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

. . . . . NO

ABMS Certified

1. Are you certified by an ABMS Board?

. . . . . NO

NPI number

1. Please enter your current NPI number

. 1558340224

DEA number

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

. . . . . BH1076125

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: 4/12/2016 9:35:07 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.

License Information

License Number	35.050927
License Name	JOYCE HORN

Fees

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

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. . . . . *{not Answered}*

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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** haveyou 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}*

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1. Do you practice in Ohio?

. . . . . YES

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. 25-29

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. 5-9

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

. 0

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

. 0

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

. 1-4

Clinical - Practice setting

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

. 0

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

. 45-49

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:

. 45220

2. Enter the first county:

. . . . . Hamilton

3. Enter the second zip code:

. 45241

4. Enter the second county:

. . . . . Hamilton

5. Enter the third zip code:

. . . . . *{not Answered}*

6. Enter the third county:

. . . . . *{not Answered}*

7. Do you have more than one practice location?

. . . . . 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.

. . . . . 10475 Reading Road Suite 307, Cincinnati, Ohio 45241; 3219 Clifton Avenue, Sutie 125 Cincinnati, Ohio 45220

Practice Arrangement (size)

1. Solo practitioner

. . . . . NO

2. Single-specialty Group

. 5-10

3. Multi-specialty Group

. . . . . N/A

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

. . . . . NO

Workforce Language Question

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

. . . . . NO

ABMS Certified

1. Are you certified by an ABMS Board?

. . . . . NO

NPI number

1. Please enter your current NPI number

. 1558340224

DEA number

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

. . . . . BH1076125

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.

Submission Date and Time: 5/23/2018 2:20 PM

License Renewal Application

License Type - Doctor of Medicine (MD)

Personal Information

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

Title
Dr.
First Name
JOYCE
Middle Name
LEE
Last Name
HORN
Maiden Name
No Response
Social Security Number
REDACTE
Date of Birth
11/9/1958
Email Address
jhorn@forwomeninc.net
Phone Number
5135632030
Other Phone Number
No Response

Additional Information

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

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

GREENVILLE

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.

10475 Reading Rd Suite 307
Cincinnati
OH
45241
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.

10475 Reading Rd Suite 307
Cincinnati
OH
45241
United States

Military Service

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

Have you served in the military?
No
Has your spouse served in the military?
No
I declined to answer these questions

Secondary Email Recipient

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

Secondary Email Address:

Specialty Tracking Component

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

Questions

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

Question - At any time since signing your last application for renewal of your certificate have you ever been denied a license to prescribe, dispense, administer, supply, or sell a controlled substance by the drug enforcement administration or appropriate issuing body of any state or jurisdiction, based, in whole or in part, on inappropriate prescribing, dispensing, administering, supplying or selling a controlled substance or other dangerous drug?
Answer -
Question - At any time since signing your last application for renewal of your certificate have you ever had a restriction of a license issued by the drug enforcement administration or a state licensing administration in any jurisdiction, under which you could prescribe, dispense, administer, supply or sell a controlled substance, that was restricted, based, in whole or in part, on inappropriate prescribing, dispensing, administering, supplying, or selling a controlled substance or other dangerous drug?
Answer -
Question - At any time since signing your last application for renewal of your certificate have you ever been subject to disciplinary action by any licensing entity that was based, in whole or in part, on inappropriate prescribing, dispensing, diverting, administering, supplying or selling a controlled substance or other dangerous drug?
Answer -
Question - Have you completed at least two hours of continuing medical education, annually for the past two years, that were certified by the Ohio State Medical Association or the Ohio Osteopathic Association, that assist physicians in diagnosing qualifying medical conditions and treating these conditions with medical marijuana including the characteristics of medical marijuana and possible drug interaction.
Answer -
Question - At any time since signing your last application for renewal of your certificate do you have an ownership or investment interest in or compensation agreement with any medical marijuana entity or applicant?
Answer -
Question - At any time since signing your last application for renewal of your certificate have you been found guilty of, or pled guilty or no contest to, or received treatment or intervention in lieu of conviction of, a misdemeanor or felony?
Answer - No

Question - At any time since signing your last application for renewal of your certificate have you surrendered, consented to limitation of, or to suspension, reprimand or probation concerning, a license to practice any healthcare profession or state or federal privileges to prescribe controlled substances in any jurisdiction other than Ohio?
Answer - No

Question - At any time since signing your last application for renewal of your certificate has any board, bureau, department, agency, or any other body, including those in Ohio other than this board, filed any charges, allegations or complaints against you?
Answer - No

Question - At any time since signing your last application for renewal of your certificate have you been addicted to or dependent upon alcohol or any chemical substance; or been treated for, or been diagnosed as suffering from, drug or alcohol dependency or abuse?
Answer - No

Question - At any time since signing your last application for renewal of your certificate have you had any clinical privileges or other similar institutional authority suspended, restricted, revoked or placed on probation for reasons other than failure to maintain records on a timely basis or to attend staff meetings?
Answer - No

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

Question - Are you currently in a collaboration agreement with any Clinical Nurse Specialists, Certified Nurse-Midwives or Certified Nurse Practitioners?
Answer - No

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

Question - Primary NPI Number
Answer - 1558340224

Question - Primary DEA Number
Answer - BH1076125

Question - What is your current employment status?
Answer - Actively working in a position that requires the license I am renewing

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

Answer - No

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

Question - How many locations are you currently working in that require the license you are renewing?
Answer - 2

Question - Please provide the following information for up to 3 locations in which you use the license you are renewing, beginning with the locations you spend the most time: Facility Name, Address, City, State, Zip Code, Health Care Facility Type
Answer - For Women, 10475 Reading Road, Cincinnati, Ohio, 45241 OBGYN; For Women, 3219 Clifton Avenue, Cincinnati, Ohio 45220

Question - Do you have hospital privileges?
Answer - Yes

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

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

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

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

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

Attachments

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

Review + Submit

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

Application Review - Completed

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

Consent to Electronic Signature - **Consented**
Date/Time Stamp - 5/23/2018 2:20 PM
Type your First Name and Last Name as they appear on the application to sign electronically.
JOYCE HORN
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.