

Submission Date and Time: 9/9/2018 5:38 PM

New License 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

No Response

First Name

Robyn

Middle Name

No Response

Last Name

Schickler

Maiden Name

No Response

Social Security Number

Redacted

Date of Birth

8/20/1987

Email Address

rschickler94@gmail.com

Phone Number

2396911445

Other Phone Number

2396911445

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?

F

What is your ethnicity?

White

In which country were you born?

United States

In which state were you born (if United States)?

Florida

In which city were you born?

Fort Myers

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.

801 E Walnut Street Apt 1419
Pasadena
CA
91101
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.

801 E Walnut StreetApt 1419
Pasadena
CA
91101
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:

Education History

List all undergraduate, graduate, and Medical Schools you have attended, including those from which you did not graduate. As you type, the name of your school should auto-populate. Once it does, click on it to select. If your school does not auto-populate, type and select Other. You will then enter your school's name and address in the fields that appear.

Educational Institution - University of South Florida College of Medicine

Degree Type - Other

Degree - Doctor of Medicine

Graduation date - 5/10/2013

Educational Institution - University of Central Florida

Degree Type - Bachelor's

Degree - Bachelor's of Science

Enrollment date - 8/20/2005

Graduation date - 6/1/2009

Employment History

List your employment history for the past five years including medical, non-medical, and post-graduate training. For any non-working time, you must indicate exactly what your activities were, such as vacation or seeking employment as well as your permanent address. If you worked for a physician staffing group or did locum tenens, you must list all facilities where you worked and include complete dates and addresses. Be sure to indicate the percentage of working time spent in clinical or other duties.

Employer / Non-Working Activity - University of Southern California

Job Title - Physician Fellow

Start Date - 7/1/2017

Average Hours/Week- 60

Street Address - 2020 Zonal Ave

Employment City - Los Angeles

Employment State - California

Employment Zipcode - 90033

Employment Country - United States

Employer / Non-Working Activity - University of South Florida

Job Title - OB/GYN Resident

Start Date - 7/1/2013

End Date - 6/30/2017

Average Hours/Week- 80

Street Address - 1 Tampa General Circle
Employment City - Tampa
Employment State - Florida
Employment Zipcode - 33606
Employment Country - United States

License Verification

You must complete the License Verification component if you hold or have ever held a professional license or certification in a state or Canadian Province. You must request verification of all your applicable licenses and certifications from the issuing state or Canadian province to be sent to the State Medical Board of Ohio. Please include both active and inactive professional licenses or certifications.

A-147911
Full
null
Active
null
California

Examination Tracking

List each licensure examination you have taken (USMLE, NBME, COMLEX USA, NBOME, LMCC, PMLEXIS, etc.)

Examination - USMLE Step 3
Status - null
Exam date - 11/18/2013
Number of Attempts - 1

Examination - USMLE Step 2 CS
Status - null
Exam date - 10/12/2012
Number of Attempts - 1

Examination - USMLE Step 2 CK
Status - null
Exam date - 7/31/2012
Number of Attempts - 1

Examination - USMLE Step 1

Status - null
Exam date - 5/13/2011
Number of Attempts - 1

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.

Residency Component

List all post-graduate training programs you have attended, including those you did not complete. As you type, the name of your Hospital/Institution should auto-populate. Once it does, click on it to select. If your Hospital/Institution does not auto-populate, type and select Other. You will then enter your Hospital/Institution name in the fields that appear.

Residency Number - RES14868
Hospital Name - University of South Florida Morsani Program
Address - null
City - Tampa
State - FL
ZipCode - null
Country - United States
PG Type - Residency
Department/Specialty - null
Start Date - 7/1/2013
End Date - 6/30/2017
Successfully Completed? - true
Other Hospital - University of South Florida Morsani Program

Residency Number - RES14869
Hospital Name - University of Southern California
Address - null
City - Los Angeles
State - FL
ZipCode - null
Country - United States
PG Type - Fellowship
Department/Specialty - null
Start Date - 7/1/2017
End Date - 6/30/2019
Successfully Completed? - false
Other Hospital - University of Southern California

Questions

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

Question - Have you ever been denied staff membership at any hospital, nursing home, clinic, health maintenance organization, or similar institution?

Answer - No

Question - Have you ever been warned, censured, disciplined, had admissions monitored, had privileges limited, had privileges suspended or terminated, been put on probation, or been requested to withdraw from or resign privileges at any hospital, nursing home, clinic, health maintenance organization, or other similar institution in which you have trained, been a staff member, or held privileges, for reasons other than failure to maintain records on a timely basis, or failure to attend staff or section meetings?

Answer - No

Question - Have you ever resigned from, withdrawn from, or terminated, or have you ever been requested to resign from, withdraw from, or otherwise been terminated from, a position with a medical partnership, professional association, corporation, health maintenance organization, or other medical practice organization, either private or public?

Answer - No

Question - Have you ever resigned from, withdrawn from, or have you ever been warned by, censured by, disciplined by, been put on probation by, been requested to withdraw from, dismissed from, been refused renewal of a contract by, or expelled from, a medical or podiatry school, clinical clerkship, externship, preceptorship, residency, postdoctoral training program, or graduate medical education program?

Answer - No

Question - Have you ever transferred from one graduate medical education program or postdoctoral training program to another?

Answer - No

Question - Have you ever, for any reason, lost specialty board certification in the U.S. or elsewhere, or been denied such certification, or denied examination for such certification?

Answer - No

Question - Has any board, bureau, department, agency or other body, including those in Ohio, in any way limited, restricted, suspended, or revoked any professional license, certificate or registration granted to you; placed you on probation; or imposed a fine, censure or reprimand against you?

Answer - No

Question - Have you ever voluntarily surrendered, resigned, or otherwise forfeited any professional license, certificate or registration issued to you by any board, bureau, department, agency, or other body; or have you ever withdrawn any application for licensure, relicensure, or examination, in any state (including Ohio), territory, province, or country?

Answer - No

Question - Have you ever, for any reason, been denied licensure or relicensure, application for licensure or relicensure, or the privilege of taking an examination, in any state (including Ohio), territory, province, or country?

Answer - No

Question - Have you ever been requested to appear before any board; bureau, department, agency, or other body, including those in Ohio, concerning allegations against you?

Answer - No

Question - Have you ever entered into an agreement of any kind, whether oral or written, with respect to a professional license, in lieu of or in order to avoid formal disciplinary action, with any board, bureau, department, agency, or other body, including those in Ohio?

Answer - No

Question - Have you ever been notified of any investigation concerning you by any board, bureau, department, agency, or other body, including those in Ohio, with respect to a professional license?

Answer - No

Question - Have you ever been notified of any charges, allegations, or complaints filed against you with any board, bureau, department, agency, or other body, including those in Ohio, with respect to a professional license?

Answer - No

Question - Have you ever been denied or have you ever surrendered a state or federal controlled substance or drug registration; had it revoked, terminated, or restricted in any way; or been warned, reprimanded, or fined by, or been requested to appear before, the responsible agency?

Answer - No

Question - Have you ever pled guilty to, been found guilty of a violation of any law, or been granted intervention or treatment in lieu of conviction regardless of the legal jurisdiction in which the act was committed, other than a minor traffic violation? If yes, submit copies of all relevant documentation, such as police reports, certified court records and any institutional correspondence and orders.

Answer - No

Question - Have you ever been arrested, forfeited collateral, bail, or bond for breach or violation of any law, police regulation, or ordinance other than for a minor traffic violation; been summoned into court as a defendant or had any lawsuit filed against you (other than a malpractice suit)? If yes, submit copies of all relevant documentation, such as police reports, certified court records and any institutional correspondence and orders.

Answer - No

Question - Have you been a defendant in a legal action involving professional liability (malpractice), or had a

professional liability claim paid on your behalf, or paid such a claim yourself? In addition, ask your malpractice insurance carrier(s) to provide a complete claims history report for the last 10 years to the State Medical Board of Ohio. If your current carrier has provided coverage for less than 10 years, ask your previous carrier to submit a claims history report to the Board.

Answer - No

Question - Have you ever been denied professional liability insurance or coverage, or had such insurance or coverage canceled, limited, or restricted in any way?

Answer - No

Question - Have you ever been denied or relinquished participation in any third party reimbursement program, whether governmental or private, including Medicaid and Medicare; or had such participation limited, restricted, suspended, or revoked; or been warned, reprimanded, requested to appear before, or fined by the responsible body?

Answer - No

Question - Have you ever been denied privileges, or had privileges revoked, suspended, restricted, reduced, or terminated by the Department of Defense, the Veteran's Administration, or any of their respective components?

Answer - No

Question - Have you ever been diagnosed as having, or have you been treated for, pedophilia, exhibitionism, or voyeurism?

Answer - No

Question - In the past five years, have you been diagnosed as having, or been hospitalized for a medical condition which in any way impairs or limits your ability to practice medicine with reasonable skill and safety? You may answer "NO" to this question if you hold a current training certificate to pursue training in Ohio and the only such medical condition is chemical dependency or substance abuse, and you have successfully completed or are currently receiving treatment at a program approved by this board and have adhered to all statutory requirements as contained in Section 4731.224 and 4731.25, O.R.C., and related provisions. Any questions concerning approval can be directed to the board offices.

Answer - No

Question - Do you use chemical substance(s) which in any way impair or limit your ability to practice medicine with reasonable skill and safety?

Answer - No

Question - Are you currently engaged in the illegal use of controlled substances?

Answer - No

Question - Are you an International Medical School Graduate?

Answer - No

Question - Are you or will you be in an accredited training program in Ohio?

Answer - No

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.

Title - AMA (MD) Physician Profile

Description - I attest to have a physician profile from the American Medical Association (AMA) (<https://profiles.ama-assn.org/amaprofiles/>) sent to the Board.

Attested - Attestation complete

Title - License Verification

Description - I attest that I will request License Verification(s) from any state(s), jurisdiction(s) or Canadian province(s) where I currently hold or previously held a full license. VERIDOC, electronic or standardized letters are acceptable for license verification.

Attested - Attestation complete

Title - FBI Report

Description - I acknowledge as an applicant I am required to complete an FBI criminal records check and the results should be sent directly to the State Medical Board of Ohio.

Attested - Attestation complete

Title - BCI Report

Description - I acknowledge as an applicant I am required to complete an Ohio BCI criminal records check and the results should be sent directly to the State Medical Board of Ohio.

Attested - Attestation complete

Review + Submit

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

Application Review - Completed

Attestation

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

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

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

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

I will immediately notify the board in writing of any changes to the answers to any of the questions contained in this application if such a change occurs at any time prior to the credential for which I have applied being granted to me by the board.

I understand my failure to answer questions contained in this application truthfully and completely may lead to denial, revocation, or other disciplinary sanction of the credential for which I have applied.

Consent to Electronic Signature - **Consented**

Date/Time Stamp - 9/9/2018 5:38 PM

Type your First Name and Last Name as they appear on the application to sign electronically.

Robyn Schickler

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.

FCVS

FEDERATION
CREDENTIALS
VERIFICATION
SERVICE

Medical Professional Information Profile

This report provides credentialing information for:

Name: **Schickler, Robyn Lynn**

Social Security Number: **Redacted**

Date of Birth: **August 20, 1987**

FID#: **217451475**

Recipient: **OH - State Medical Board of Ohio**

Delivery Date: **08/24/2018**

ABOUT THIS PROFILE

The Federation Credentials Verification Service (FCVS) was retained by the above referenced medical professional to verify his/her medical credentials for submission to your agency/organization. Unless noted otherwise, all documents contained in this report were received directly from the issuing institution per written request made by FCVS.

NOTICE: All documents bearing an original Official FCVS seal are certified to be an exact reproduction of the original. Where required, original documents are provided according to the agreements with the Institution issuing such document. FCVS maintains all original documents (excluding third-party examination transcripts) in the physician's source file.

This FCVS Medical Professional Information Profile ("Profile") is compiled and provided by the Federation of State Medical Boards of the United States, Inc. (Federation) as a reference source for, and only for, its member boards and other entities authorized by the Federation. The Profile embodies and contains confidential business information because the information, and the format and presentation of that information, comprise trade secrets of the Federation and because the Profile's disclosure would harm the Federation by providing others with an unfair business advantage in competing with the Federation's FCVS services. Further, the form of the Profile and the contents of this Profile, including the compilation of information in this Profile, are the Federation's copyrighted works and proprietary, confidential information and are subject to the protections of United States laws governing copyright, trademark and trade secrets, as well as various state laws protecting the Federation's trade secrets and other intellectual property rights. This Profile and its contents may not be (1) copied, reformatted, modified, published or displayed publicly or (2) used, disclosed, distributed, shared or sold, in whole or part, for any purpose, including use to establish any database or files as a compendium or otherwise, all of which is strictly prohibited without the express written consent of the Federation's CEO.

FCVSFEDERATION CREDENTIALS
VERIFICATION SERVICE**Affidavit and Release**Federation of
**STATE
MEDICAL
BOARDS**

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

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

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

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

Notary:
Your seal (or stamp)
must be partly upon
the photo and partly
upon the signature of
the applicant.



Robyn L. Schickler
Applicant's Signature (must be signed in the presence of a notary)

Schickler
Applicant's Printed Last Name

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

8/1/2018
Date of Signature (must correspond to date of notarization)

State of California, County of Los Angeles

I certify that on the date set forth below the individual named above did appear personally before me and that I did identify this applicant by: (a) comparing his/her physical appearance with the photograph on the identifying document presented by the applicant and with the photograph affixed hereto, and (b) comparing the applicant's signature made in my presence on this form with the signature on his/her identifying document. The statements on this document are subscribed and sworn to before me by the applicant on this 1 day of August, 2018.

Notary Public Signature: _____

My Notary Commission Expires: _____

please see attached for

notary

Please complete and mail this original document to the Federation of State Medical Boards at:

400 FULLER WISER ROAD | EULESS, TX 76039 | TEL (817) 868-5000

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FCVS ID Number

FCVS

FID Number

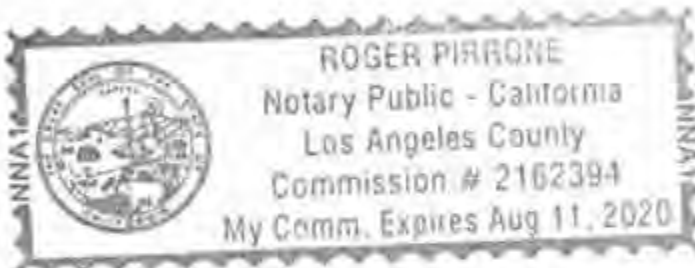
217451475

217 451 475

California Jurat

A notary public or other officer completing this certificate verifies only the identity of the individual who signed the document to which this certificate is attached, and not the truthfulness, accuracy, or validity of that document.

State of California
County of Los Angeles



Place Notary Seal Above

Subscribed and sworn to (or affirmed) before me

on this 1 day of August, 2018,
by

Robyn L. Schickler

proved to me on the basis of satisfactory evidence
to be the person(s) who appeared before me.

Signature Rogan R.
Signature of Notary Public

OPTIONAL INFORMATION

Although the information in this section is not required by law, it could prevent fraudulent removal and reattachment of this jurat to an unauthorized document and may prove useful to persons on the attached document.

Description of Attached Document

Title or Type of Document Affidavit & Release Document Date 8/1/18

Number of Pages: 1

217 451 475

Biographic Information

Medical professional Name(s): **Schickler, Robyn Lynn**

Date of Birth: August 20, 1987

Place of Birth: Fort Myers, FL, UNITED STATES

Contact Information

Home Address: 801 E Walnut Street
Apt 1419
Pasadena, CA 91101
UNITED STATES

Mobile Phone: (239) 691-1445

Email: rschickler94@gmail.com

Credentials Analysis Information for Identity

There is no Omission/Discrepancy/Miscellaneous information identified.

CERTIFICATION OF IDENTIFICATION

Certification by Notary Public Is Required

Applicant Full Legal Name: Schickler Robyn Lynn
Last First Middle

FCVS ID Number: 217451475



Notary – Please complete the section below:

State of California County of Los Angeles

I certify that on the date set forth below, the individual named above, did appear personally before me and presented one of the following forms of identification as proof of his/her identity (Birth Certificate or Passport). I further certify that I did identify this applicant by comparing his/her physical appearance with the photograph on a Government issued photo identification presented by the applicant.

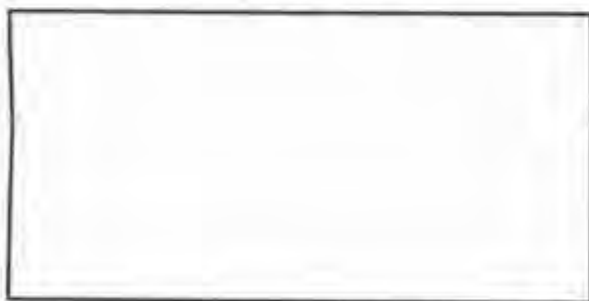
The statements on this document are subscribed and sworn to before me by the applicant on this
(Day) 8, of (Month) August, (Year) 2018.

Notary Public Signature: _____

Commission Expiration Date* (Month) _____ / (Day) _____ / (Year) _____

*** The notary's commission expiration date must be current and legible. If no expiration date, such as 'lifetime', an explanation must be provided.**

Notary Stamp Here



PLEASE SEE
NOTARY SEAL ON
ATTACHED PAGE

8-8-18

Please complete and mail this original document and a photocopy of the birth certificate or passport presented to the Notary to:

Federation of State Medical Boards

ATTN: FCVS

400 Fuller Wiser Rd., Suite 300

Eules, TX 76039-3856

pp

217 451 475

California All-Purpose Certificate of Acknowledgment

A notary public or other officer completing this certificate verifies only the identity of the individual who signed the document to which this certificate is attached, and not the truthfulness, accuracy, or validity of that document.

State of California

County of Los Angeles

S.S.

On 8-8-18 before me, JONATHAN A. URQUIDI, Notary Public

Name of Notary Public, Title

personally appeared ROBYN LYNN SCHICKLER

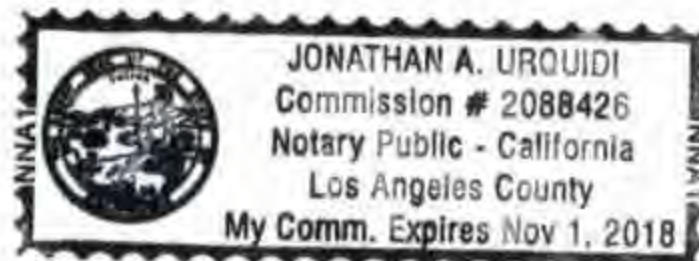
Name of Signer (1)

Name of Signer (2)

who proved to me on the basis of satisfactory evidence to be the person(s) whose name(s) is/are subscribed to the within instrument and acknowledged to me that he/she/they executed the same in his/her/their authorized capacity(ies), and that by his/her/their signature(s) on the instrument the person(s), or the entity upon behalf of which the person(s) acted, executed the instrument.

I certify under PENALTY OF PERJURY under the laws of the State of California that the foregoing paragraph is true and correct.

WITNESS my hand and official seal.



[Signature]
Signature of Notary Public

Seal

OPTIONAL INFORMATION

Although the information in this section is not required by law, it could prevent fraudulent removal and reattachment of this acknowledgment to an unauthorized document and may prove useful to persons relying on the attached document.

Description of Attached Document

The preceding Certificate of Acknowledgment is attached to a document titled/for the purpose of CERT of I.D.

containing _____ pages, and dated _____.

The signer(s) capacity or authority is/are as:

- ☐ Individual(s)
☐ Attorney-in-fact
☐ Corporate Officer(s) _____

Title(s)

- ☐ Guardian/Conservator
☐ Partner - Limited/General
☐ Trustee(s)
☐ Other: Notarized Signing of doc

representing: only

Name(s) of Person(s) Employed; Signer If Representing

Additional Information

Method of Signer Identification

Proved to me on the basis of satisfactory evidence:

☒ form(s) of identification ☐ credible witness(es)

Notarial event is detailed in notary journal on:

Page # _____ Entry # _____

Notary contact: _____

Other

☐ Additional Signer ☐ Signer(s) Thumbprints(s)

☐ _____

*Of the United States,
in Order to form a more perfect Union,
establish Justice, insure domestic Tranquillity,
provide for the common defense,
promote the general Welfare, and secure
the Blessings of Liberty to ourselves and
our Posterity, do ordain and establish this
Constitution for the United States of America.*



SIGNATURE OF BEARER / SIGNATURE DU TITULAIRE / FIRMA DEL TITULAR

PASSPORT
PASSEPORT
PASAPORTE



SCHICKLER

ROBYN LYNN

Nationality / Nationalité / Nacionalidad

UNITED STATES OF AMERICA

Date of birth / Date de naissance / Fecha de nacimiento

20 Aug 1987

Place of birth / Lieu de naissance / Lugar de nacimiento

FLORIDA, U.S.A.

Date of issue / Date de délivrance / Fecha de expedición

08-Aug-2017

Date of expiration / Date d'expiration / Fecha de caducidad

07 Aug 2027

Endorsements / Mentions Spéciales / Annotaciones

SEE PAGE 27

UNITED STATES OF AMERICA

Type / Type / Tipo	Conte / Conte / Conting	Passaport No / No du Passaport / No de Passaport
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100	100	100

FC217R2E3

Name / Nom / Apellidos

SCHICKLER

Given Names / Prénoms / Nombres

ROBYN LYNN

Nationality / Nationalité / Nacionalidad

UNITED STATES OF AMERICA

Date of birth / Date de naissance / Fecha de nacimiento

20 Aug 1987

Place of birth / Lieu de naissance / Lugar de nacimiento

FLORIDA, U.S.A.

Date of issue / Date de délivrance / Fecha de expedición

08-Aug-2017

Date of expiration / Date d'expiration / Fecha de caducidad

07 Aug 2027

Endorsements / Mentions Spéciales / Anstaltsbesonderheiten

SEE PAGE 27

P<USASCHICKLER<<ROBYN<LYNN<<<<<<<<<<<<<<<<<
6631763539USA8708209F2708078284330086<195678

217 451 475

The Chronology of Activities is a comprehensive report of a medical professional's activities as reported to FCVS in the medical professional application.

Start Date	End Date	Activity Type	Location
08/15/2009	05/10/2013	Medical Education	University of South Florida College of Medicine Tampa Florida UNITED STATES
07/01/2013	06/30/2017	Postgraduate Training	University of South Florida Morsani Program Tampa Florida UNITED STATES
07/01/2017	06/30/2019	Postgraduate Training	University of Southern California Los Angeles California UNITED STATES

End of Chronology of Activities report for: Schickler, Robyn Lynn

Medical Education

Medical School: University of South Florida College of Medicine

Location: Tampa, FL

UNITED STATES

Credentials Analysis Information for Medical Education

There is no Omission/Discrepancy/Miscellaneous information identified.

Instructions to the Dean

Please complete both pages of this form, sign, date and seal on the front page then return to:
Federation Credentials Verification Service
Suite 300
400 Fuller Wiser Road
Euleless, TX 76039
or e-mail to:
fcvsmmed@fsmb.org

The individual identified on the attached **Authorization for Release of Information, Documents and Records** form has authorized your medical school to provide to the Federation Credentials Verification Service (FCVS) any and all information pertaining to their education at your institution.

Please note: If your institution processes transcript requests through another office, FCVS has likely made such a request under separate cover.

If your office also processes transcript requests, please attach the individual's official transcript (which indicates courses taken, dates and hours of attendance, and scores, grades, or evaluation).

Institution Name: University of South Florida Morsani College of Medicine

Address Line 1: 12901 Bruce B Downs Blvd, MDC 32

Address Line 2: _____

City: Tampa State/Province: FL ZIP Code (postal code): 33612

Country: United States of America

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

Premedical Education:

Years of education required for admission to your medical school: Four

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

Enrollment and Participation: Our records indicate that Schickler, Robyn attended our
(type/print individual's name: Last, First, Middle, Suffix)

medical school for a total of 166 weeks of medical education on the following dates: From 08 / 10 / 09 To 05 / 03 / 13
Month Date Year Month Date Year

This individual:

Was awarded the degree of Doctor of Medicine on 05 / 10 / 13
Month Date Year

Was NOT awarded a degree because: (please explain — attach additional pages if necessary)



Watermark
For FCVS internal use only.

**ELECTRONIC
SEAL
VERIFIED**

Print Name: Marrissa Cook

Signature: Marrissa Cook

Title: Registrar

Date: 10 / 17 / 13

Tel: 813-974-0828 Fax: 813-974-4619 E-mail: mcook@health.usf.edu

Unusual Circumstances

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

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

Personal/Family	From (Mo /Yr)___/___	To (Mo /Yr)___/___	<input type="checkbox"/> Approved	<input type="checkbox"/> Unapproved
Academic remediation	From (Mo /Yr)___/___	To (Mo /Yr)___/___	<input type="checkbox"/> Approved	<input type="checkbox"/> Unapproved
Health	From (Mo /Yr)___/___	To (Mo /Yr)___/___	<input type="checkbox"/> Approved	<input type="checkbox"/> Unapproved
Financial	From (Mo /Yr)___/___	To (Mo /Yr)___/___	<input type="checkbox"/> Approved	<input type="checkbox"/> Unapproved
Participation in joint degree Program (e.g., MD/PhD)	From (Mo /Yr)___/___	To (Mo /Yr)___/___	<input type="checkbox"/> Approved	<input type="checkbox"/> Unapproved
Participation in non-research special study (e.g., fellowship, international experience)	From (Mo /Yr)___/___	To (Mo /Yr)___/___	<input type="checkbox"/> Approved	<input type="checkbox"/> Unapproved
Participation in non-degree research	From (Mo /Yr)___/___	To (Mo /Yr)___/___	<input type="checkbox"/> Approved	<input type="checkbox"/> Unapproved
Other	From (Mo /Yr)___/___	To (Mo /Yr)___/___	<input type="checkbox"/> Approved	<input type="checkbox"/> Unapproved
Other	From (Mo /Yr)___/___	To (Mo /Yr)___/___	<input type="checkbox"/> Approved	<input type="checkbox"/> Unapproved

Please Specify:

2. Do this individual's official records reflect that he/she was ever placed on academic or disciplinary probation during his/her medical education?

YES ☐ NO ☒

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

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

Please specify reason:

3. Do this individual's official records reflect that he/she was ever disciplined for unprofessional conduct/behavioral reasons by the medical school or parent university?

YES ☐ NO ☒

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

4. Do this individual's official records reflect that he/she was ever the subject of negative reports for behavioral reasons or an investigation by the medical school or parent university?

YES ☐ NO ☒

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

5. Do this individual's official records reflect that there were any limitations or special requirements imposed on the individual because of questions of academic incompetence, disciplinary problems, or any other reason?

YES ☐ NO ☒

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

Medical School

Medical Professional Name: Schickler, Robyn

University of South Florida College of Medicine

Unusual Circumstances

Did you have any interruption(s) or extension(s) in your medical education? No

Were you ever placed on probation? No

Were you ever disciplined or placed under investigation? No

Were any negative reports for behavioral reasons ever filed by instructors? No

Were any limitations or special requirements imposed on you because of academic performance, incompetence, disciplinary problems or for any other reason? No

End of Applicant Reported Unusual Circumstances report for: Schickler, Robyn



Morsani College of Medicine - Office of Student Affairs – 12901 Bruce B Downs Blvd, MDC Box 4 - Tampa, FL 33612

Medical Student Performance Evaluation for

Robyn Schickler

October 1, 2012

Identifying Information

Ms. Schickler is a fourth-year student at the University of South Florida Morsani College of Medicine in Tampa, Florida.

Unique Characteristics

Ms. Schickler received her B.S. degree in Molecular Biology and Microbiology, cum laude, from the University of Central Florida in May 2009 and matriculated to the University of South Florida Morsani College of Medicine (MCOM) in August of the same year. Ms. Schickler is a member of the Scholarly Concentration Program, which is an elective program focusing on areas of interest beyond the medical school core curriculum. It fosters scholarly inquiry, creativity, intellectual curiosity, research and service. Ms. Schickler distinguished herself as an active participant in the Public Health Scholarly Concentration. Ms. Schickler was Vice President of the USF chapter of the American Medical Student Association and Secretary of the Infectious Diseases Interest Group. She is the current President of RESULTS USF, a community service organization related to global health and development; was the Health Fair Coordinator for the BRIDGE Clinic, a student-run clinic for the medically indigent in the university community area; Vice President of the International Health Service Corps (IHSC), and Class Representative for Shriners Children's Hospital. Additionally, she has gone on two medical mission trips to Panama with the IHSC. Ms. Schickler is a student member of the American Congress of Obstetricians and Gynecologists, Florida Medical Association, and Hillsborough County Medical Association. Ms. Schickler is working as co-investigator along with faculty in the MCOM Department of Obstetrics & Gynecology on a research project that involves determining the expression of the CK-19 gene in the peripheral blood of women undergoing IVF. Ms. Schickler enjoys running, yoga, leisure reading, and singing.

Academic History

- Date of Expected Graduation from Medical School: May 10, 2013
- Date of Initial Matriculation in Medical School: August 10, 2009
- Extensions, leave(s) of absence, gap(s), or break(s) in the student's educational program: ☒ Not applicable
- Transfer students: ☒ Not applicable

Date of Initial Matriculation in Prior Medical School:

Date of Transfer from Prior Medical School:

- Dual/joint/combined degree students: ☒ Not applicable
Date of Initial Matriculation in Other Degree Program:
Date of Expected Graduation from Other Degree Program:
Type of Other Degree Program:
- Was this student required to repeat or otherwise remediate any coursework during his/her medical education: ☒ No
☐ Yes
- Was this student the recipient of any adverse actions by the medical school or its parent institution? ☒ No
☐ Yes

Academic Progress

Preclinical/Basic Science Curriculum:

From first matriculation Ms. Schickler made very good academic progress through the College of Medicine curriculum. Evaluations from the basic science faculty indicate that she had an excellent fund of basic medical knowledge. Ms. Schickler was described as a highly motivated self-learner. Her maturity of judgment and analytical problem solving abilities were outstanding. She was considerate and tactful in her interactions with others. Her overall attitude and attention to responsibilities were excellent.

Core Clinical Clerkships:

INTEGRATED INPATIENT MEDICINE-PEDIATRICS: Ms. Schickler had a very good fund of knowledge that was above her peers. She did an excellent job of presenting on rounds. She was well organized in her thought processes and proceeded in a logical manner. She asked for feedback and acted upon it quickly. She was a team player with a great bedside manner. She was intelligent and professional and she will excel in whatever field she chooses.

PRIMARY CARE AND SPECIAL POPULATIONS: Ms. Schickler did a great job on the service. She was interested in learning, pleasant to work with, and eager to learn. She worked well as part of the medical team and easily established a rapport with the ancillary staff. She solicited feedback and was clinically well-rounded. She gave efficient and accurate H&Ps with timely notes. She was a reliable student with a solid fund of knowledge.

EMERGENT AND URGENT CARE: Ms. Schickler was well above the normal in all categories. She was motivated and exceeded the expectations of this clerkship. She had excellent interpersonal skills and had a good fund of knowledge and H&P skills. She demonstrated respect for her colleagues and staff, patients and their families. Ms. Schickler had an excellent overall performance.

NEWBORN MATERNAL HEALTH: Ms. Schickler received an Honors grade based upon meeting all the requirements of the clerkship. She had a very solid performance demonstrating her fund of knowledge on the written and oral exams. Her evaluations demonstrated strong history taking and physical examination skills, and strong diagnostic skills and selection of

treatment options. She displayed the ability to convey her fund of knowledge to the medical team. She was very mature and professional. There are no concerns in regard to any of her clinical abilities on this rotation.

NEUROPSYCHIATRY: Ms. Schickler received an Honors grade based on her excellent clinical performance. Her clinical skills were above average, and her notes were complete and thorough. She was consistently observed reading up on her patients and taking the time to look up answers before requesting assistance. She was punctual, respectful, and responded well to feedback. Ms. Schickler will do well in her chosen field of medicine.

SURGICAL CARE: Ms. Schickler received a positive evaluation in the clerkship based on her good clinical performance, passing grades on the shelf and departmental exams, and excellent professionalism. She had a good fund of knowledge based on her performance on the exams and comments of the clinical faculty and residents. She had strong clinical skills, and communicated well with the team. Her notes were organized and detailed. She was always prepared for the OR and showed interest in the cases. Ms. Schickler will make a fine house officer.

Core Year 4 Clinical Clerkship:

Ms. Schickler was prepared for her residency in Obstetrics/Gynecology via our novel, program-director approved, career track required of all year 4 students. For Obstetrics/Gynecology, Ms. Schickler was required to take an acting internship in Obstetrics/Gynecology, Critical Care, a specialty selective designed to train the student in common medical problems seen in Obstetrics/Gynecology, and other relevant electives of her choice. To date she has successfully completed the Critical Care, receiving an Honors grade. Ms. Schickler also taught junior students communication and clinical skills for over 90 hours during the year as part of a unique elective in teaching, learning both theory and practice of education.

Summary

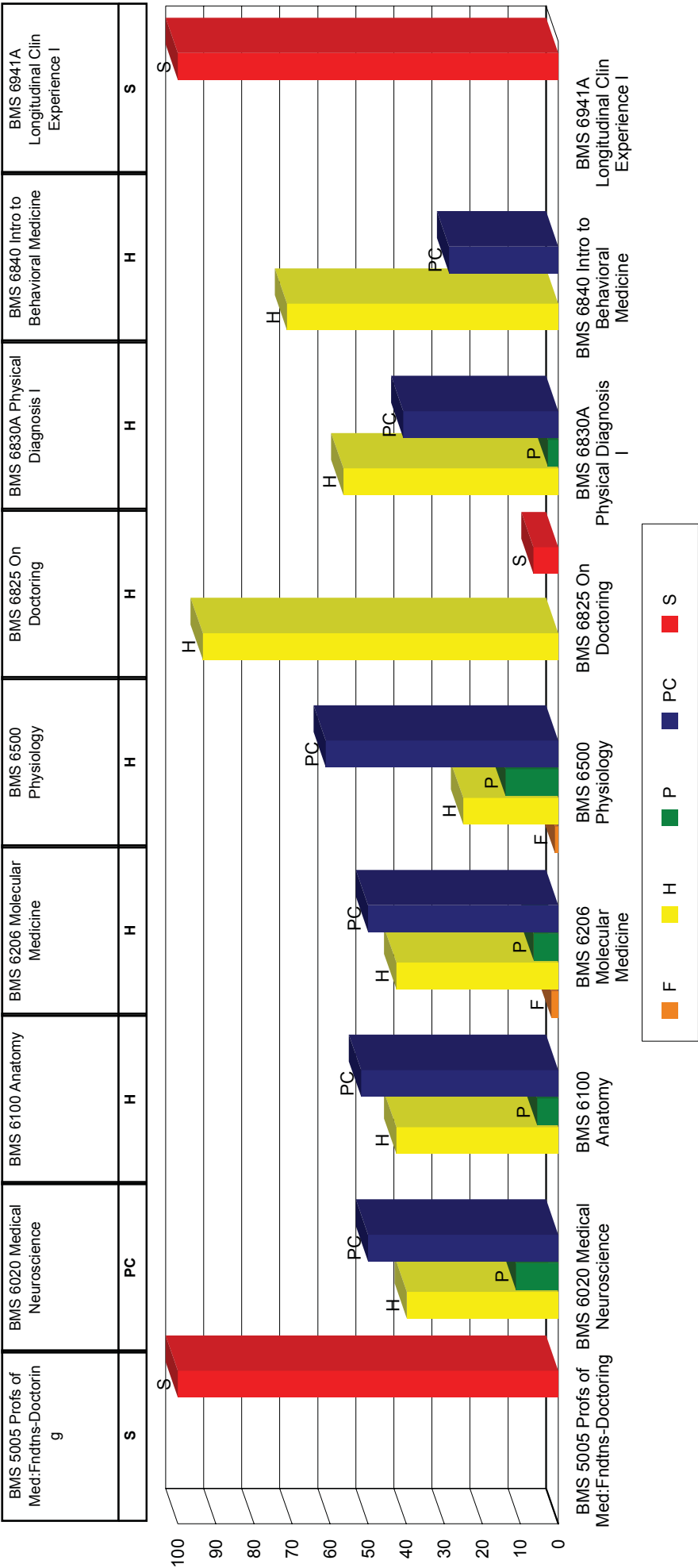
Ms. Schickler is an excellent student with excellent clinical skills, based on third year evaluations. She is a highly motivated learner, yet maintains a very compassionate and caring nature. She exhibits the highest of humanistic attributes and professional standards of behavior. She has demonstrated an excellence for her academic career as evidenced by winning the most outstanding Med III Student poster award at the USF Health Research Day in February 2012. At the end of the third year of the four-year curriculum Ms. Schickler ranks in the top half of a class with an original enrollment of 120 students. Based on the following factors: her aptitude for learning, involvement in multiple extracurricular activities and maintenance of a high standard of excellence, I recommend her as an excellent candidate for your residency program.



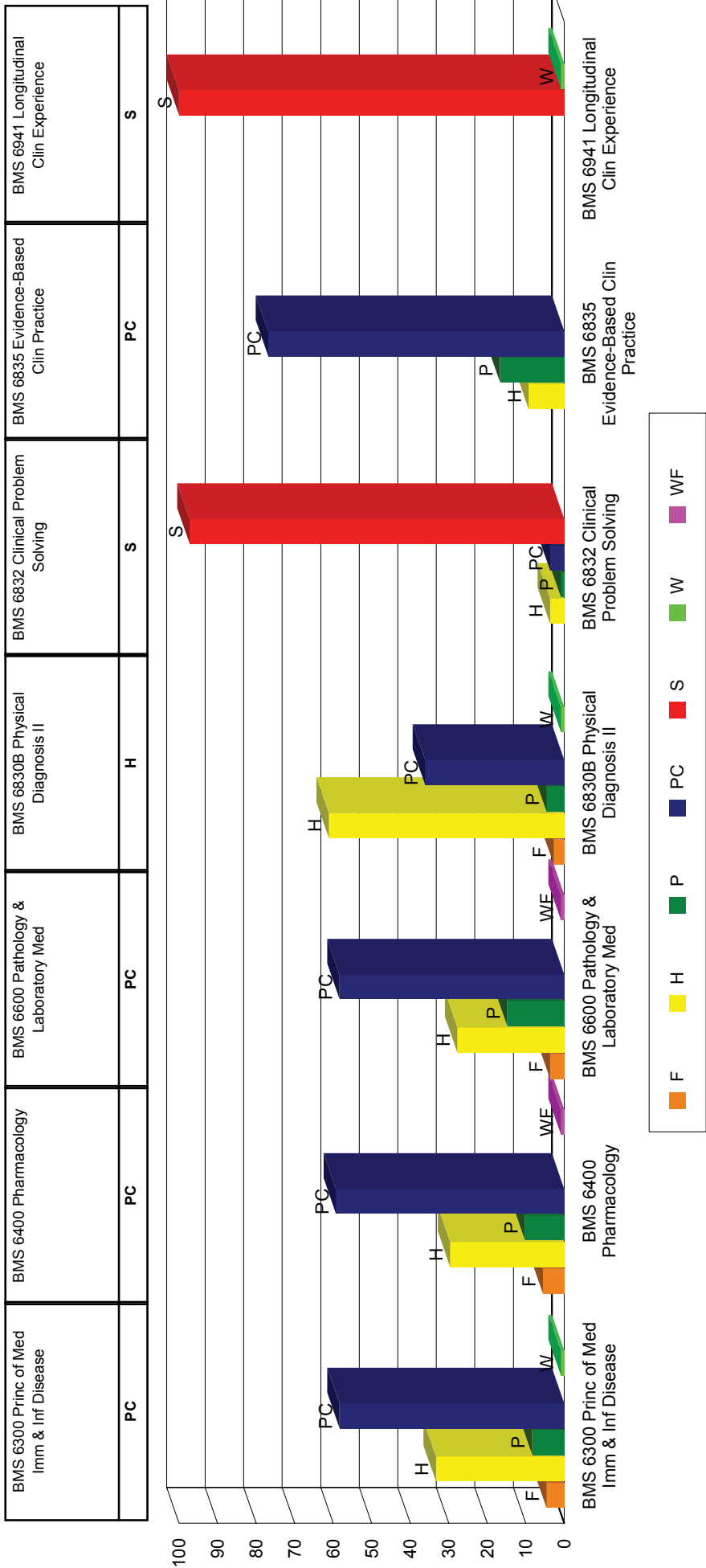
Troy Howell, MD
Department of Psychiatry
MD Career Advisor
Troy.howell@va.gov

g:mspe13/schickler

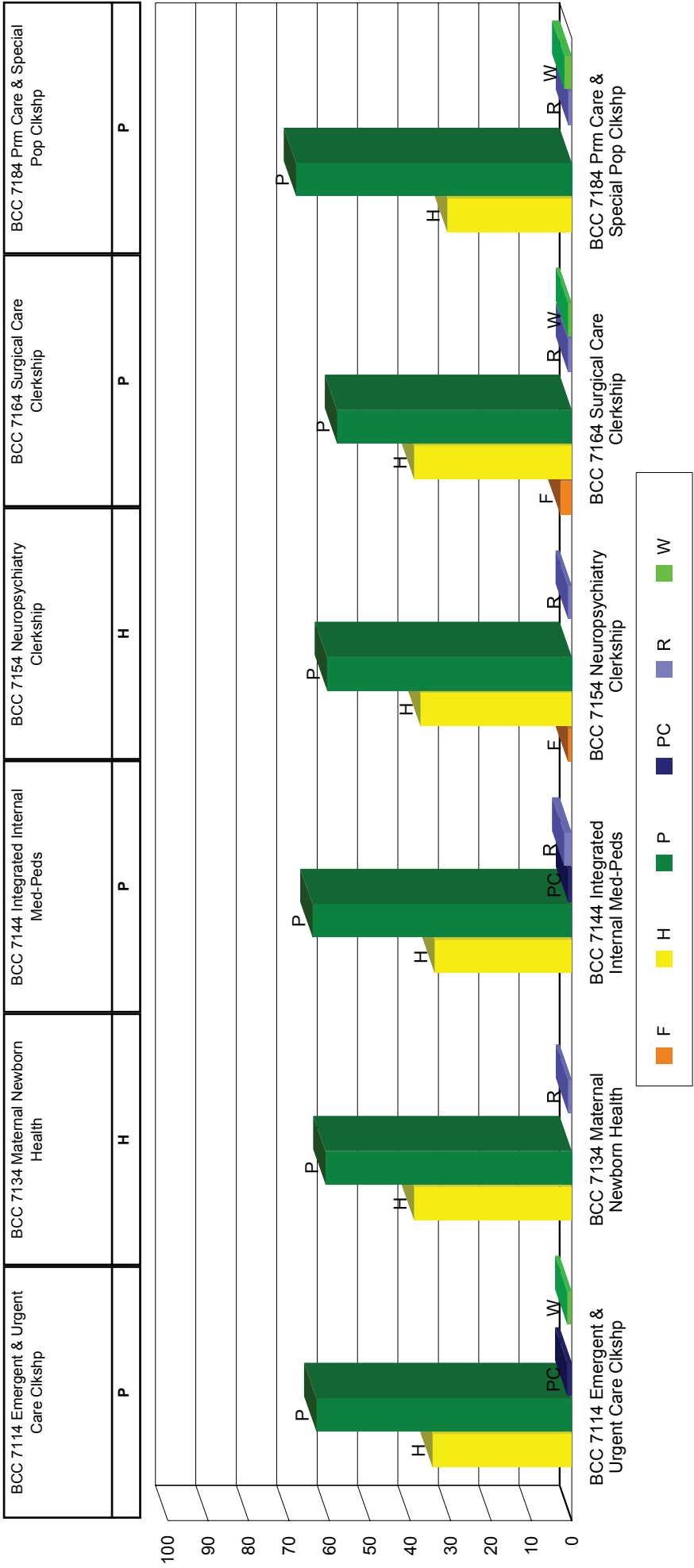
Comparative Performance in Preclinical / Basic Science Coursework (Year 1 - 2009/10)



Comparative Performance in Preclinical / Basic Science Coursework (Year 2 - 2010/11)



Comparative Performance in Preclinical / Basic Science Coursework (Year 3 - 2011/12)

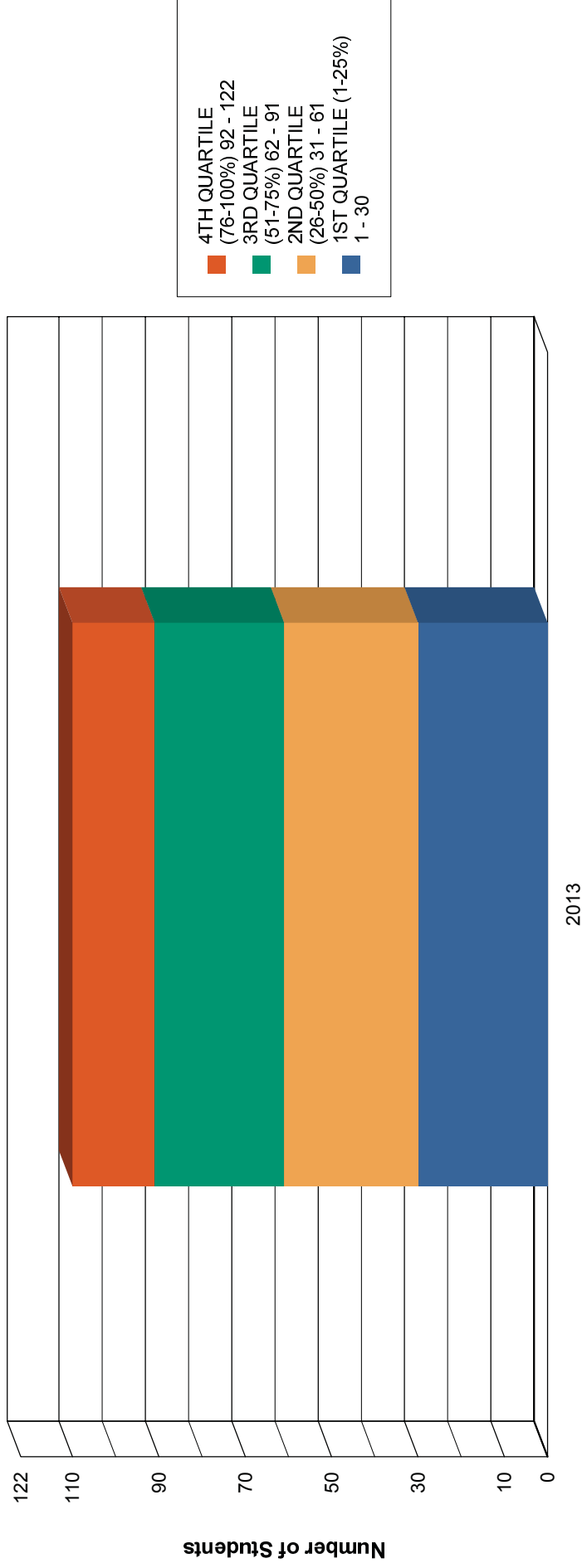


Schickler, Robyn

Graphic Representation of Overall Comparative Performance in Medical School

CLASS RANK

2ND QUARTILE (26-50%) 31 - 61



Special programmatic emphases, strengths, mission/goal(s) of the medical school: A strong foundation in basic science and extensive hands-on training in the clerkships are emphasized with the goal of preparing students for any area of medicine they wish to pursue. The curriculum is focused on student centered instruction and promoting life-long learning principles. Strengths include integrated year 1-2 courses, early clinical exposure, interdepartmental year 3 clerkships, and innovative year 4 disciplinary tracks that prepare students for their residencies. In addition to these requirements, many students also elect to complete a Scholarly Concentration (180 hours of time over 4 years) including a year 4 capstone project in one of 10 disciplines (e.g. Research, Education, Public Health, Engineering). This is credited in the MSPE if completed.

Unique structure of Year 3 Clerkships: Year 3 consists of six unique interdisciplinary clerkships (Primary Care & Special Populations-12 weeks in ambulatory settings, Neuropsychiatry-8 weeks, Integrated Inpatient Medicine & Pediatrics-12 weeks, Surgical Care-8 weeks, Emergent & Urgent Care-4 weeks [optional, may be taken in year 4 and replaced by an elective], Newborn Maternal Health-4 weeks). Therefore, the content of the traditional year 3 departmental clerkships is divided among novel interdisciplinary clerkships, and traditional content is distributed as follows:

- a. Internal Medicine is taught in both the inpatient Med-Peds clerkship (8 weeks) and in Primary Care (outpatient, 2 weeks), for a total of 10 weeks of time. Students must pass the Internal Medicine shelf exam to pass the inpatient Med-Peds clerkship.
- b. Surgery as part of Surgical Care (6 weeks). Students must pass the Surgery shelf exam to pass the clerkship.
- c. Pediatrics is taught in both inpatient Med-Peds (4 weeks), Primary Care (outpatient, 2 weeks), and Maternal-Newborn (newborn nursery, 1 week), for a total of 7 weeks of time. Students must pass the Pediatrics shelf exam to pass inpatient Med-Peds.
- d. Ob-Gyn is taught in Maternal-Newborn Health (3 weeks of ante partum, labor and delivery, and post partum care), Surgical Care (2 weeks of gynecologic surgery), and Primary Care (1-2 weeks of ambulatory gynecology), for 6-7 weeks of total time.
- e. Family Medicine is taught in the Primary Care Clerkship (outpatient, 4-6 weeks)
- f. Psychiatry is taught in Neuropsychiatry, with 6 weeks of combined inpatient-outpatient time. Students must pass the Psychiatry shelf exam to pass Neuropsychiatry.
- g. Neurology is taught in the Neuropsychiatry Clerkship (2 weeks of combined inpatient-outpatient work).

Year 4 academic program – Students are well prepared for the residency specialty of their choice via our novel program-director approved career tracks required of all year 4 students. The student is required to take an appropriate acting internship, two months of specialty courses designed to train the student in the specialty, and other elective courses of their choosing (total of 9 4th year rotations).

Average length of enrollment (initial matriculation to graduation) at the medical school: 4 years

AAMC “Guidelines for Medical Schools Regarding Academic Transcripts.” This medical school is: In full compliance with Guidelines’ recommendations.

Description of the evaluation system used at the medical school: Evaluation uses both performance driven grades as well as written formative evaluation of the student for each course addressing eight major competency areas. For the class of 2013 grades in years 1-2 were Honors (H = 90-100), Pass with Commendation (PC = 80-90), Pass (P = 70-79), Fail (F = < 70), Satisfactory (S), and U (Unsatisfactory). Grades in years 3-4 were H/P/F. In addition, clinical knowledge, skills and professional values are assessed via an OSCE (Year 2), a Comprehensive Clinical Performance Examination (end Year 3) and a digitally recorded history and physical examination that is reviewed with a clinician (Year 4). Students are reviewed by the Academic Performance Review Committee on an ongoing basis for overall academic performance and professionalism throughout their four years at the college.

Medical school requirements for successful completion of the USMLE Step 1 and Step 2: Students must take USMLE Step 1 prior to beginning Year 3 and must pass the exam before continuation in the curriculum. Passing USMLE Step 2 CS and CK is required for graduation.

Objective/Observed Structured Clinical Evaluation (OSCE) Requirements. OSCEs are used for:

- o Completion of course (Physical Diagnosis-Year 2)
- o Completion of third year clerkships (Clinical Performance Examinations in, Integrated Inpatient Medicine & Pediatrics, Newborn Maternal Health, and Surgical Care)
- o Graduation (end of year 3 Comprehensive Clinical Performance Examination)

Use of the course, clerkship, or elective director’s narrative comments in composite of the MSPE: Narrative comments submitted on course Summative Evaluations are edited for length or grammar, but not for content when transferred to the MSPE.

Description of the process by which the MSPE is composed at the medical school: The Office of Student Affairs and faculty career advisors compose the MSPE for all students. The Admin. Specialist collates student records and drafts the clinical evaluation section of the MSPE from narrative faculty comments. This is reviewed and edited by the Director of Student Affairs who also writes the unique characteristics, academic history, and pre-clinical paragraphs. Faculty career advisors write the summary paragraph and edit the document, followed by final editing by the Assoc. Dean for Student Affairs or the Assoc. Dean for Undergrad. Med. Education. The completed draft is then reviewed with the student for accuracy and concurrence. Graphic information is then added and is available to the student for review.

Students are permitted to review the MSPE prior to its transmission: Yes

University of South Florida, Morsani College of Medicine

Tampa, Florida

Name: Schickler, Robyn
ID Number: U66463446
Issued To: FCVS

Degree Awarded: MD 05/10/2013
Matriculation Date: 08/10/2009

Academic Year 2009-2010

Course #	Course Name	Contact Hours	Grade	Course #	Course Name	Contact Hours	Grade
----------	-------------	---------------	-------	----------	-------------	---------------	-------

BMS 5005 Profs of Med: Fndtns-Doctoring 64.5 S
BMS 6020 Medical Neuroscience 59.0 PC
BMS 6100 Anatomy 161.5 H
BMS 6206 Molecular Medicine 185.5 H
BMS 6500 Physiology 88.5 H
BMS 6825 On Doctoring 45.0 H
BMS 6830A Physical Diagnosis I 53.5 H
BMS 6840 Intro to Behavioral Medicine 50.5 H
BMS 6941A Longitudinal Clin Experience I 84.0 S

Y3 grading scale does not include a PC grade

Academic Year 2010-2011

Course #	Course Name	Contact Hours	Grade	Course #	Course Name	Contact Hours	Grade
----------	-------------	---------------	-------	----------	-------------	---------------	-------

BMS 6300 Princ of Med Imm & Inf Disease 129.0 PC
BMS 6400 Pharmacology 104.8 PC
BMS 6600 Pathology & Laboratory Med 229.5 PC
BMS 6830B Physical Diagnosis II 83.3 H
BMS 6832 Clinical Problem Solving 36.0 S
BMS 6835 Evidence-Based Clin Practice 104.0 PC
BMS 6941 Longitudinal Clin Experience 113.0 S
BMS 6992P Schol Conc 2-Public Health 10.0 S

--End of Transcript--

Academic Year 2011-2012

Course #	Course Name	Contact Hours	Grade	Course #	Course Name	Contact Hours	Grade
----------	-------------	---------------	-------	----------	-------------	---------------	-------

BCC 6173 Introduction to Clerkships 20.0 S
BCC 7114 Emergent & Urgent Care Clkshp 200.0 P
BCC 7134 Maternal Newborn Health 200.0 H
BCC 7144 Integrated Internal Med-Peds 600.0 P
BCC 7154 Neuropsychiatry Clerkship 400.0 H
BCC 7164 Surgical Care Clerkship 400.0 P

--Continued on Next Column--

CPX: Clinical Performance Examination
CCEE: Comprehensive Clinical Evaluation Encounter

Prior to the 2000-2001 academic year, contact hours were maintained in a legacy system and were not transferred to the currently used system.

The highest grade a student remedying a course is eligible to receive is a P.

**ELECTRONIC
SEAL
VERIFIED**

This is not official, unless it bears an official signature and the embossed Seal of the Morsani College of Medicine

18 February 2014

Date Issued

ce B. Downs Blvd., Tampa, FL 33612-4799

ce with the Family Educational Rights and Privacy Act of 1974, information from this transcript may not be a third party without written consent of the student.

University of South Florida Morsani College of Medicine and College of Pharmacy

Office of the Registrar - 12901 Bruce B. Downs Blvd., MDC 32, Tampa, Florida 33612

College of Medicine PH: (813) 974-0828 • FAX: (813) 974-4619

College of Pharmacy PH: (813) 974-5699

Morsani College of Medicine

HISTORY

The Morsani College of Medicine, one of four colleges comprising USF Health, was created by the Florida legislature in 1965. The charter class of medical students was admitted in September 1971. A School of Physical Therapy within the College of Medicine was created by the Florida legislature in 1987. A program of study leading to the Doctor of Physical Therapy degree began in 2005, and the charter class was admitted in August of that year. The transitional Doctor of Physical Therapy degree (DPT) was offered beginning in January 2011 and follows the same grading rubric as the DPT program.

ACCREDITATION

The University of South Florida College of Medicine MD program is fully accredited by the Liaison Committee on Medical Education which is composed of representatives of the Association of American Medical Colleges and the American Medical Association. The Doctor of Physical Therapy program is fully accredited by the Commission on Accreditation in Physical Therapy Education (CAPTE) having received initial accreditation in 2001 and reaccreditation in 2008.

EDUCATIONAL PROGRAMS AND GRADING SYSTEM (MD and DPT Programs)

1971 to 1983 3-Year MD Program

Year I - Pre-Clinical Coursework
Year II - Clinical Clerkships
Year III - Senior Electives

1984 to present* 4-Year MD Program

Years I & II - Pre-Clinical Coursework
Year III - Clinical Clerkships
Year IV - Senior Electives

1971 to 1983 MD Program

H, P, F, R (Course Repeated)

1984 to 2010 MD Program

H, PC, P, F

2011 to 2012 MD Program

Year I - S, U

Year II - H, PC, P, F

Year III - H, P, F, R (Remediation Required)

Year IV - H, PC, P, F

TRANSCRIPT LEGEND

2012 to present MD Program

Year I - S, U

Year II - S, U

Year III - H, P, F, R (Remediation Required)

Year IV - H, P, F

2005 to present 3-Year DPT Program

Year I - Foundations

Year II - Clinical Sciences

Year III - Integration & Clinical Education

2006 to present DPT Program

S, U, H, PC, P, F

GRADING KEY FOR ALL PROGRAMS

H Honors

PC Pass with Commendations

P Pass

F Fail

A Excellent

B Good

C Average

S Satisfactory

U Unsatisfactory

FRB Failure, Remediated to a B

FRC Failure, Remediated to a C

Other Grades and Symbols (not all are currently in use):

I Incomplete

W Withdrawal without Penalty

WF Withdrawal Failing

TC Transfer Credit

WP Withdrawal Passing

* Repeated Course

** Graduation Requirement/Independent Study Completed

*Beginning with the class of 1999 the College of Medicine

instituted a policy that MD students pass USMLE Step 1

and 2 as a graduation requirement

OFFICIAL TRANSCRIPTS BEAR THE OFFICIAL

SIGNATURE AND EMBOSSED SEAL OF THE

OFFICE OF THE REGISTRAR OF THE

UNIVERSITY OF SOUTH FLORIDA MORSANI

COLLEGE OF MEDICINE AND COLLEGE OF

PHARMACY.

College of Pharmacy

HISTORY

In the year 2007, the University of South Florida accepted the opportunity to champion, coordinate, and implement the creation of the USF Doctor of Pharmacy program. The College of Pharmacy, one of four colleges comprising USF Health, was created by the Florida legislature in 2010. The charter class of students for the doctor of pharmacy degree was admitted in August 2011.

ACCREDITATION

The Doctor of Pharmacy program at the University of South Florida College of Pharmacy was awarded Precandidate accreditation status during the June 22-26, 2011, meeting of the ACPE Board of Directors. Approval was based upon due consideration of the on-site Evaluation Team Report, the College's application materials, other communications received from the institution, and discussions with the Dean during the Board of Directors meeting. Please visit the USF College of Pharmacy website for detailed information about the accreditation process and status of the program.

EDUCATIONAL PROGRAMS AND GRADING SYSTEM (Pharmacy)

2010 to present 4-Year PharmD Program

Years I, II, & III - Pre-Clinical Coursework

Year IV - Clinical Coursework

2010 to present PharmD Program

A, B, C, F

FRB

FRC

TO TEST FOR AUTHENTICITY: Translucent globe icons **MUST** be visible from both sides when held toward a light source. The face of this transcript is printed on green SCRIP-SAFE® paper with the name of the institution appearing in white type over the face of the entire document.

UNIVERSITY OF SOUTH FLORIDA MORSANI COLLEGE OF MEDICINE • UNIVERSITY OF SOUTH FLORIDA COLLEGE OF PHARMACY • UNIVERSITY OF SOUTH FLORIDA MORSANI COLLEGE OF MEDICINE • UNIVERSITY OF SOUTH FLORIDA COLLEGE OF PHARMACY

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

12130512 SCRIP-SAFE® Securely Products, Inc. Cincinnati, OH

University of South Florida

has conferred on

Robyn Schickler

the degree of

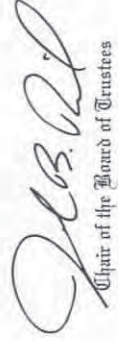
Doctor of Medicine

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

Morsani College of Medicine

In Witness Whereof the undersigned have affixed their names and the seal of the University
at Tampa, Florida, this tenth day of May, 2013.


Governor of the State of Florida


Chair of the Board of Trustees




President of the University


Dean of the College

ELECTRONIC
SEAL
VERIFIED

Postgraduate Training

Accreditation ID: 2201121075**Institution:** University of South Florida Morsani ProgramLocation: Tampa, FL
UNITED STATES**Accreditation ID:** None**Institution:** University of Southern CaliforniaLocation: Los Angeles, CA
UNITED STATES

Credentials Analysis Information for Postgraduate Training

Issue:

The Verification of Post Graduate Training Form from University of Southern California dated 07/01/2017 to 06/30/2019 reported in the Chronology of Activities is not included in the Profile.

Solution(s):

FCVS does not obtain verification of non-accredited training programs.

Verification of Postgraduate Medical Education

Institution: University of South Florida Morsani Program
Specialty: Obstetrics & Gynecology
Address: Tampa, FL

Attention: **Program Director**

Affiliated
University: _____

Verification For:

Name: Robyn Schickler

DOB: 08/20/1987

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

Program

Participation:
Important:

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

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

Report Internships, Residencies and Fellowships separately.

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

PGY: 1-4

Specialty/Subspecialty: Obstetrics & Gynecology

- ☐ Internship
☒ Residency
☐ Chief Residency
☐ Fellowship
☐ Research

From: 7/1/2013

To: 6/30/2017

Successfully Completed?: ☒ Yes ☐ No ☐ In Progress

Accredited by: ☒ ACGME ☐ AOA ☐ LCGME ☐ RSC ☐ CFPC
☐ RCPSC ☐ APPAP ☐ None of these

PGY: _____

Specialty/Subspecialty: _____

- ☐ Internship
☐ Residency
☐ Chief Residency
☐ Fellowship
☐ Research

From: _____

To: _____

Successfully Completed?: ☐ Yes ☐ No ☐ In Progress

Accredited by: ☐ ACGME ☐ AOA ☐ LCGME ☐ RSC ☐ CFPC
☐ RCPSC ☐ APPAP ☐ None of these

PGY: _____

Specialty/Subspecialty: _____

- ☐ Internship
☐ Residency
☐ Chief Residency
☐ Fellowship
☐ Research

From: _____

To: _____

Successfully Completed?: ☐ Yes ☐ No ☐ In Progress

Accredited by: ☐ ACGME ☐ AOA ☐ LCGME ☐ RSC ☐ CFPC
☐ RCPSC ☐ APPAP ☐ None of these

Unusual

Circumstances:

Check the correct response. Omitted responses require written explanation.

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

**ELECTRONIC
SEAL
VERIFIED**

1. Did this individual ever take a leave of absence or break from his/her training? ☐ Yes ☒ No
2. Was this individual ever placed on probation? ☐ Yes ☒ No
3. Was this individual ever disciplined or placed under investigation? ☐ Yes ☒ No
4. Were any negative reports for behavioral reasons ever filed by instructors? ☐ Yes ☒ No
5. Were any limitations or special requirements placed upon this individual because of questions of academic incompetence, disciplinary problems or any other reason? ☐ Yes ☒ No


Please explain any "Yes" response from above:

Certification:

Affix your institutional seal in this space. If no seal is available, you must have this form notarized

Completion of the following is certification that the information above is an accurate account of this individual's records and is true and correct. The signature line must contain the original signature, or the electronic typed signature, of the program director (M.D./D.O. only).

Name: Stephanie Ros, MD

Signature: 

Title: Residency Program Director

Date of Signature: 8/24/2018

Tel: 813-259-8876

Fax: 813-250-2560

E-Mail: sros@health.usf.edu

Graduate Medical Education

Medical Professional Name: Schickler, Robyn

Accreditation ID: 2201121075

Institution: University of South Florida Morsani Program

Specialty: Obstetrics & Gynecology

Unusual Circumstances

Training Period: 7/1/2013 - 6/30/2017 **Residency**

Did you have any interruption(s) or extension(s) in your medical education?	No
Were you ever placed on probation?	No
Were you ever disciplined or placed under investigation?	No
Were any negative reports for behavioral reasons ever filed by instructors?	No
Were any limitations or special requirements imposed on you because of academic performance, incompetence, disciplinary problems or for any other reason?	No

End of Applicant Reported Unusual Circumstances report for: Schickler, Robyn



University of South Florida
Morsani College of Medicine
Affiliated Hospitals

This is to certify that

ROBYN LYNN SCHICKLER, MD

*has served honorably and with proficiency as
Resident in Obstetrics & Gynecology*

from July 1, 2013 to June 30, 2017

James M. Palmer, DDS
James M. Palmer, DDS, MEd
Dean, Morsani College of Medicine



Charles Pailor, MD, MBA
Charles Pailor, MD, MBA
Program Director

James M. Palmer, DDS
James M. Palmer, DDS, MEd
Dean, Morsani College of Medicine

Licensure / Examinations

Exam: USMLE

Credential Analysis Information for Licensure / Examinations

There is no Omission/Discrepancy/Miscellaneous information identified.



United States Medical Licensing Examination® (USMLE®)

Certified Transcript of Scores

This document was prepared by
Federation of State Medical Boards of the United States, Inc. (FSMB)
400 Fuller Wiser Road, Euless, TX 76039-3856 - Telephone (817) 868-4000

Date: 08/24/2018

Federation Credentials Verification Service
ATTN: FCVS

FCVSIID: 406068

Examinee: Schickler, Robyn Lynn

Examinee ID: 5-259-347-2

Alt Name(s):

Date of Birth: 08/20/1987

Results for Steps taken by this examinee (and for which results have been reported to date) are shown below. For Steps that span more than one day, the test date reflects the day on which the examination began. Pass/fail outcomes are based upon the minimum passing level in place at the time of test administration and are not altered by subsequent revisions to the minimum passing level. Effective April 1, 2013, test results are reported on a three-digit scale only; two-digit scores reported for prior administrations will no longer be reported. Test results reported as passing represent an exam score of 75 or higher on a two-digit scoring scale.

USMLE STEP 1

Test Date	Pass/Fail	Score	Minimum Pass	Comments
05/13/2011	Pass	219	(188)	

USMLE STEP 2

Clinical Knowledge (CK)

Test Date	Pass/Fail	Score	Minimum Pass	Comments
07/31/2012	Pass	257	(196)	

Clinical Skills (CS)

Test Date	Pass/Fail	Comments
10/12/2012	Pass	

USMLE STEP 3

Test Date	Pass/Fail	Score	Minimum Pass	Comments
11/18/2013	Pass	213	(190)	

End of Exam History

NOTE: A search of the Physician Data Center of the Federation of State Medical Boards (FSMB) reveals no reported information on this examinee.



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400 Fuller Wiser Road, Euless, TX 76039-3856 - Telephone (817) 868-4000

Examinee: Schickler, Robyn Lynn

Examinee ID: 5-259-347-2

Date of Birth: 08/20/1987

INTERPRETATION OF RESULTS

USMLE transcripts include a complete examination history. On those Step examinations for which numeric scores are reported, a three-digit scale is used. Most scores fall between 140 and 260 on this scale. The recommended minimum passing score is shown on the front of the transcript next to the examinee's score for each administration along with a pass/fail outcome. Test results reported as passing represent an exam score of 75 or higher on a two-digit scoring scale. The level of proficiency required to meet the recommended minimum passing level for each USMLE Step is reviewed periodically and is subject to change. Such changes do not alter pass/fail outcomes from prior test administrations.

For examinations with reported scores, the Standard Error of Measurement (SEM) provides an index of the variation that would be expected to occur if an examinee were tested repeatedly using different sets of items covering similar content. The SEM is usually in the range of 4 to 8 points.

STEP 2 CLINICAL SKILLS (CS)

Step 2 CS results are reported as pass or fail, with no numeric score. Had the two-digit reporting scale been used, examinees would have had to achieve a score of 75 or higher in order to pass.

ANNOTATIONS APPEARING UNDER "COMMENTS"

Circumstances in connection with an administration shown on this transcript may result in one or more annotations listed next to the score. A description of each Comment is provided below:

Indeterminate - Results are at or above the passing level but cannot be certified as representing a valid measure of the examinee's knowledge or competence as sampled by the examination. No score is reported. Information regarding the nature of the indeterminate score is available. If such information is not enclosed with this transcript, it may be obtained by contacting the organization from which you received the transcript or the USMLE Secretariat, 3750 Market Street, Philadelphia, PA 19104, telephone (215) 590-9700.

Incomplete - The examinee sat for some, but not all, of the scheduled examination. No score is reported.

Irregular Behavior - The Committee for Individualized Review determined that the examinee engaged in irregular behavior. Examples of irregular behavior are described in the current edition of the USMLE Bulletin of Information. Information regarding the nature of the irregular behavior and the determination of the Committee is available. If such information is not enclosed with this transcript, it may be obtained by contacting the organization from which you received the transcript or the USMLE Secretariat, 3750 Market Street, Philadelphia, PA 19104, telephone (215) 590-9700.

Score Not Available - The score is not available. Further review and/or analysis may be pending, or it may have been determined that the score cannot be reported.

ANNOTATIONS APPEARING AS "NOTE"

Circumstances not in connection with an administration shown on this transcript may result in one or more annotations and an explanation or instructions to contact the appropriate individual or organization. The Note will appear at the end of the document.

PHYSICIAN DATA CENTER INFORMATION APPEARING AS "NOTE"

The Physician Data Center of the Federation of State Medical Boards (FSMB) contains actions reported to the FSMB by U.S. licensing and disciplinary boards, the U.S. Department of Health and Human Services, government regulatory entities and international licensing authorities. To be included in the Physician Data Center, an action must be a matter of public record or be legally releasable to state medical boards or other entities with recognized authority to review physician credentials. Certain actions reported to and released by the Physician Data Center are not disciplinary or otherwise prejudicial in nature. Such actions are reported to ensure that records are complete and to assist in preventing misrepresentation or the use of lost or stolen credentials by unauthorized persons. Once reported to the FSMB, an action becomes part of the permanent record of the individual physician, and the existence of such an action may be indicated on the USMLE transcript by a Note.

03/2015

This document was printed from a secure website and accurately reflects score information maintained by the FSMB.



MEDICAL BOARD OF CALIFORNIA



Licensing Program
2005 Evergreen Street, Suite 1200
Sacramento, CA 95815
(916) 263-2382 FAX (916) 263-2944
www.mbc.ca.gov

August 10, 2018

Ohio, State Medical Board of
77 S High St, 17th Fl
Columbus, OH 43215

To Whom It May Concern:

This is to certify that as of August 9, 2018, the records of the Medical Board of California (Board) indicate the following information:

Physician:	ROBYN LYNN SCHICKLER
License Number:	A147911
Issued Date:	March 7, 2017
Exam Type:	A Written Examination
Expiration Date:	August 31, 2020
License Status:	CURRENT
Board Discipline and/or Administrative Action:	No

If Board Discipline and/or Administrative Action is indicated, public records may be available at <http://www.mbc.ca.gov>; or you may contact the Board's Enforcement Program, Central File Room by email at central.fileroom@mbc.ca.gov, by fax at (916) 263-2420 or by mail at 2005 Evergreen Street, Suite 1200, Sacramento, CA 95815, to obtain information concerning the action.

Kimberly Kirchmeyer
Executive Director



State Medical Board of
Ohio

30 E. Broad St., 3rd Floor
Columbus, Ohio 43215
(614) 466-3934
www.med.ohio.gov

10/1/2018

Dear Robyn Schickler:

This is to notify you that you are now licensed to practice in the State of Ohio. The Board approved your request and your license number **35.134996** was issued on 10/01/2018 and will expire on 01/01/2020.

Below is a printable wallet card for your convenience. A wall certificate will be mailed to you within the next five business days. The wall certificate, by law, must be displayed in your office or the place where a major portion of your practice is conducted.

Please be advised that verification of your Ohio license must be obtained directly from the Board's website at <http://med.ohio.gov> or by going to <https://elicense.ohio.gov>. These websites are updated immediately to reflect license status.

Questions concerning licensure or renewal can be sent to med.license@med.ohio.gov or med.renewal@med.ohio.gov.

Sincerely,

State Medical Board of Ohio
Licensure & Renewal Department



State Medical Board of

Ohio

30 East Broad Street, 3rd Floor
Columbus, OH 43215-6127
614-466-3934
www.med.ohio.gov

THE RECORDS OF THE STATE MEDICAL BOARD OF OHIO INDICATE
THAT YOU HOLD THE FOLLOWING ACTIVE LICENSE:

35.134996
Robyn Schickler

Effective Date: 10/01/2018
Expiration Date: 01/01/2020