Application

Application Detail

License Type:	**Medical Doctor**
Profession Number:	**1501 - Medical Doctor**
File Number:	**139896**
Application:	**Medical Doctor by Exam Application**
Application Date:	**09/06/2018**

Suitability Question(s)

Have you passed all parts of a United States national examination (NBME, FLEX, or USMLE)? OR Are you licensed on the basis of a state board examination and currently hold a license in at least one other jurisdiction of the United States or Canada, have practiced pursuant to such licensure for a period of at least 10 years, and have received a passing score on the Special Purpose Examination of the Federation of State Medical Boards of the United States (SPEX)? OR Were you licensed prior to 1974 on the basis of a state board examination, are currently licensed in at least three other jurisdictions of the United States or Canada, and have practiced pursuant to such licensure for a period of at least 20 years	**Yes**

Application Questions

Military Veteran Fee Waiver - I have been honorably discharged from a branch of the United States Armed Forces within the previous 60 months.	**No**
I am selecting NICA Non-Participating - (I understand that a $250.00 fee will be included if I select this option.)	**Yes**

I will qualify for "In Training" status at the approval of my licensure application.	**No**
I plan to dispense medicinal drugs in the State of Florida for a fee or other remuneration and hereby register as required by Section 465.0276,F.S. I understand that the fee for the Dispensing Practitioner is $100.00 over and above the required initial license fee and will submit it along with the license fee.	**No**
I completed a board approved post-graduate training program within the last two years or have practiced medicine in another jurisdiction for two of the last four years.	**Yes**
Military Veteran Spouse Fee Waiver - I am the spouse of a military veteran who has been honorably discharged from a branch of the United States Armed Forces within the previous 60 months.	**No**

Personal Detail

Title:	**Dr**
First Name:	**Sara**
Middle/Second Name:	**M**
Last Name/Surname:	**Shunkwiler**
Birthdate:	**06/03/1979**
Gender:	**Female**
Race:	**White**
Social Security Number:	[redacted]

Addresses

Mailing Address

Address:	**3848 NW 62nd Ln** **ALACHUA** **GAINESVILLE, FL** **32653** **US**
Phone Number:	
Extension:	

E-mail Address: **sshunkwi@gmail.com**

Place of Practice

Address: **3848 NW 62nd Ln**

ALACHUA

GAINESVILLE, FL

32653

US

Phone Number:

Extension:

Federal Credentials Verification Services (FCVS)

Are you using the FCVS to verify your core credentials? **No**

Education History

School Name: **UNIVERSITY OF IOWA**

Street Address Line 1: **375 Newton Rd**

Street Address Line 2: **N/A**

City: **Iowa City**

State: **IOWA**

Postal/Zip: **52242**

Country: **UNITED STATES OF AMERICA**

Date of Graduation (mm/dd/yyyy): **05/12/2006**

Attended From (mm/dd/yyyy): **08/15/2001**

Attended To (mm/dd/yyyy): **05/12/2006**

Additional Education Questions

Are you currently in default on any health education loan or scholarship obligation? **No**

Have you completed the equivalent of 2 academic years of preprofessional, postsecondary education including, courses in anatomy, biology, and chemistry prior to entering medical school? **Yes**

Description: **Undergraduate degree at the University of Iowa. Graduated 5/2001**

Fifth Pathway

Did you attend an international medical school and do not possess a valid ECFMG Certificate?	**No**
Did you receive a bachelor's degree from an accredited United States college or University?	**Yes**
Did you study at a medical school which is recognized by the World Health Organization?	**Yes**
Did you complete all of the formal requirement of the International medical school, except the internship or social service requirements, and pass part I of the National board of Medical examination or the Education Commission for Foreign Medical Graduates Examination equivalent?	**No**
Did you complete an academic year of supervised clinical training in a hospital affiliated with a medical school approved by the Council on Medical Education of the American Medical Association and upon completion passed part II of the National Board of Medical Examiners examination or the Education Commission for Foreign Medical Graduates examination Equivalent?	**Yes**

Postgraduate Training 1

Program Name:	**UIHC Blood Banking and Transfusion Medicine Fellowship**
Mailing Address:	**200 Hawkins Drive C684 General Hospital Iowa City, IA 52242**
Program City:	**Iowa City**
Program State or Country:	**IOWA**
Program Type:	**FELLOWSHIP**
Specialty Area:	**PTH - BLOOD BANKING/TRANSFUSION MEDICINE**
Attended From (mm/dd/yyyy):	**07/01/2011**
Attended To (mm/dd/yyyy):	**08/28/2012**
Did you receive credit?	**Yes**

Postgraduate Training 2

Program Name:	**UIHC Cytopathology Fellowship**
Mailing Address:	**200 Hawkins Drive C684 General Hospital Iowa City, IA 52242**
Program City:	**Iowa City**
Program State or Country:	**IOWA**

Program Type:	**FELLOWSHIP**
Specialty Area:	**PTH - CYTOPATHOLOGY**
Attended From (mm/dd/yyyy):	**07/01/2010**
Attended To (mm/dd/yyyy):	**06/30/2011**
Did you receive credit?	**Yes**

Postgraduate Training 3

Program Name:	**University of Florida/SHANDS Anatomic and Clinical Pathology**
Mailing Address:	**PO BOX 100275 GAINESVILLE, FL, 32610-0275**
Program City:	**Gainesville**
Program State or Country:	**FLORIDA**
Program Type:	**RESIDENCY**
Specialty Area:	**PTH - PATHOLOGY-ANATOMIC AND CLINICAL**
Attended From (mm/dd/yyyy):	**07/01/2006**
Attended To (mm/dd/yyyy):	**06/30/2010**
Did you receive credit?	**Yes**

Exam History

Examination:	**USMLE/US/CANADA**
Date Passed (mm/dd/yyyy):	**06/21/2006**

United States Military and/or Public Health

Have you ever been in the United States Military and/or Public Health Service?	**No**
Have you ever been disciplined by any branch of the United States Armed Services or Public Health Service?	**No**

Other State License 1

Do you now hold or have you ever held a license to practice medicine or any other profession in any US State or territory?	**Yes**

Request verification of licensure status directly from the licensing entity or www.veridoc.org. Request international license verification(s) if you have practiced outside of the U.S. for at least two of the previous four years.

License Number:	**38726**
Type:	**MD**
Jurisdiction - Country:	**UNITED STATES**

Jurisdiction - State: **Iowa**

Other State License 2

Do you now hold or have you ever held a license to practice medicine or any other profession in any US State or territory? **Yes**

Request verification of licensure status directly from the licensing entity or www.veridoc.org. Request international license verification(s) if you have practiced outside of the U.S. for at least two of the previous four years.

License Number: **27647**

Type: **MD**

Jurisdiction - Country: **UNITED STATES**

Jurisdiction - State: **Nebraska**

Additional Employment Questions

Have you practiced medicine in another jurisdiction for two of the last four years or completed a board approved post-graduate training program within the last two years? **Yes**

Graduate Education

Do you currently, or have you had, responsibility for graduate medical education within the last 10 years? **Yes**

Initial Graduate Medical Education Responsibility and Faculty Appointments 1

List all institutions where you have had responsibility for graduate medical education or faculty appointment(s) at any medical school.

Name of Institution: **UNIVERSITY OF NEBRASKA COLLEGE OF MEDICI**

Initial Graduate Medical Education Responsibility and Faculty Appointments 2

List all institutions where you have had responsibility for graduate medical education or faculty appointment(s) at any medical school.

Name of Institution: **DES MOINES UNIVERSITY COLLEGE OF OSTEOPATHIC MEDICINE**

Staff Privileges 1

Do you currently hold staff privileges in any hospital, health institution, clinic or medical facility? **Yes**

The facilities listed are Florida facilities. If your privileges are for a facility in another state, select "Out of State".

Name of Facility: **OUT OF STATE**

Out of State Facility: **Nebraska Medicine**

Staff Privileges 2

Do you currently hold staff privileges in any hospital, health institution, clinic or medical facility? **Yes**

The facilities listed are Florida facilities. If your privileges are for a facility in another state, select "Out of State".

Name of Facility: **OUT OF STATE**

Out of State Facility: **Nebraska Orthopedic Hospital**

Specialty Board Certifications 1

Are you certified by any specialty board recognized by the American Board of Medical Specialties or specialty board approved by the Florida Board of Medicine? **Yes**

Specialty Brd: **AMERICAN BOARD OF PATHOLOGY**

Specialty Cert: **PTH - BLOOD BANKING/TRANSFUSION MEDICINE**

Date Certified: **09/23/2013**

Specialty Board Certifications 2

Are you certified by any specialty board recognized by the American Board of Medical Specialties or specialty board approved by the Florida Board of Medicine? **Yes**

Specialty Brd: **AMERICAN BOARD OF PATHOLOGY**

Specialty Cert: **PTH - PATHOLOGY-ANATOMIC AND CLINICAL**

Date Certified: **11/19/2010**

Specialty Board Certifications 3

Are you certified by any specialty board recognized by the American Board of Medical Specialties or specialty board approved by the Florida Board of Medicine? **Yes**

Specialty Brd: **AMERICAN BOARD OF PATHOLOGY**

Specialty Cert: **PTH - CYTOPATHOLOGY**

Date Certified: **09/21/2011**

DEA

Have you ever been denied, or surrendered, a DEA registration? **No**

Criminal History

Have you ever been convicted of, or entered a plea of guilty, nolo contendere, or no contest to, a crime in any jurisdiction other than a minor traffic offense? **No**

You must include all misdemeanors and felonies, even if adjudication was withheld. Driving under the influence (DUI) or driving while impaired (DWI) are not minor traffic offenses for purposes of this question.

Medicaid / Medicare

1. Have you been convicted of, or entered a plea of guilty or nolo contendere to, regardless of adjudication, a felony under Chapter 409, F.S. (relating to social and economic assistance), Chapter 817, F.S. (relating to fraudulent practices), Chapter 893, F.S. (relating to drug abuse prevention and control) or a similar felony offense(s) in another state or jurisdiction?	**No**
2. Have you been convicted of, or entered a plea of guilty or nolo contendere to, regardless of adjudication, a felony under 21 U.S.C. ss. 801-970 (relating to controlled substances) or 42 U.S.C. ss. 1395-1396 (relating to public health, welfare, Medicare and Medicaid issues)?	**No**
3. Have you ever been terminated for cause from the Florida Medicaid Program pursuant to Section 409.913, F.S.?	**No**
4. Have you ever been terminated for cause, pursuant to the appeals procedures established by the state, from any other state Medicaid program?	**No**
5. Are you currently listed on the United States Department of Health and Human Services Office of Inspector General's List of Excluded Individuals and Entities?	**No**

Health History

In the last five years, have you been enrolled in, required to enter into, or participated in any drug and/or alcohol recovery program or impaired practitioner program for treatment of drug or alcohol abuse that occurred within the past five years?	[redacted]
In the last five years, have you been admitted or referred to a hospital, facility or impaired practitioner program for treatment of a diagnosed mental disorder or impairment?	[redacted]
During the last five years, have you been treated for or had a recurrence of a diagnosed mental disorder that has impaired your ability to practice medicine within the past five years?	[redacted]
During the last five years, have you been treated for or had a recurrence of a diagnosed physical disorder that has impaired your ability to practice medicine?	[redacted]
In the last five years, were you admitted or directed into a program for the treatment of a diagnosed substance-related (alcohol/drug) disorder or, if you were previously in such a program, did you suffer a relapse within the last five years?	[redacted]

During the last five years, have you been treated for or had a recurrence of a diagnosed substance-related (alcohol/drug) disorder that impaired your ability to practice medicine within the last five years?	[redacted]

Electronic Fingerprinting

I have been provided and read the statement from the Florida Department of Law Enforcement regarding the sharing, retention, privacy and right to challenge incorrect criminal history records and the 'Privacy Statement' document from the Federal Bureau of Investigation.	**Yes**
Enter in today's date	**09/06/2018**

Medical Malpractice Question

Have you ever had a judgment entered against you for medical malpractice where the incident(s) of malpractice occurred after November 2, 2004?	**No**

Liability Claims

Within the last 10 years have you had any liability claim(s) or action(s) for damages for personal injury settled or finally adjudicated in an amount that exceeds $100,000.00?	**No**

Financial Responsibility/Exemption

Financial Responsibility	**Financial Exemption**

Category II: Financial Responsibility ExemptionsIf you select an exemption based on # 9, you must also complete the affidavit that will be emailed to you upon submission of this application. 6. I practice medicine exclusively as an officer, employee, or agent of the federal government, the state, or its agencies or subdivisions. 7. I hold a limited license issued pursuant to s. 458.317, F. S., and practice only under the scope of the limited license. 8. I do not practice medicine in the State of Florida. 9. I meet all of the following criteria (a) I have held an active license to practice in this state or another state or some combination thereof for more than 15 years; (b) I am retired or maintain part time practice of no more than 1000 patient contact hours per year; (c) I have had no more than two claims resulting in an indemnity exceeding $25,000 within the previous five-year period; (d) I have not been convicted of or pled guilty or nolo contendere to any criminal violation specified in Chapter 458, F. S. or the medical practice act in any other state; and (e) I have not been subject, within the past ten years of practice, to license revocation, suspension, or probation for a period of three years or longer, or a fine of $500 or more for a violation of Chapter 458, F. S., or the medical practice act of another jurisdiction. A regulatory agency's acceptance of a relinquishment of license, stipulation, consent order, or other settlement offered in response to or in anticipation of filing of administrative charges against a license is construed as action against a license. I understand if I am claiming an exception under this section that I must either post notice in a sign prominently displayed in my reception area or provide a written statement to any person to whom medical services are being provided that I have decided not to carry medical malpractice insurance. See Section 458.320(5)(f), Florida Statutes, for specific notice requirements. 10. I practice only in conjunction with my teaching duties at an accredited medical school or its teaching hospitals. (Interns and residents do not qualify for this exemption).

FDA Licensing

Have you ever had any professional license or license to practice medicine revoked, suspended, placed on probation, received a citation, or other disciplinary action taken in any state, territory or country?	**No**

FDA Institution

Have you ever had any staff privileges denied, suspended, revoked, modified, restricted, not renewed or placed on probation, or have you been asked to resign or take a temporary leave of absence or were otherwise acted against by any facility?	**No**

FDANP Denied

Have you had any application for a medical license or professional license denied by any state board or other governmental agency of any state, territory, or country?	**No**

FDANP Investigation

Are you currently under investigation in any jurisdiction for an act or offense that would constitute a violation of Section 458.331, Florida Statutes?	**No**

Specialty Board Discipline History

Have you ever had any final disciplinary action taken against you by a specialty board or other similar national organization?	**No**

Year Began Practice

Year Began Practice:	**07/01/2006**

Availability for Disaster

Are you willing to provide health care services in special need shelters or to work with disaster medical teams during times of emergency or major disasters?	**Yes**

Practice Employment 1

Place of Employment:	**Univ of NE Med Ctr / Nebraska Medicine**
Address Line 1:	**S 42nd St and Emile St**
Address Line 2:	**N/A**
City:	**Omaha**
State:	**NE**
Type of Employment:	**Assistant Professor**
Begin Date (mm/dd/yyyy):	**04/01/2015**

End Date (mm/dd/yyyy):	**09/06/2018**

If 'to present', enter today's date.

Practice Employment 2

Place of Employment:	**Lifeserve Blood Center**
Address Line 1:	**431 E Locust St**
Address Line 2:	**N/A**
City:	**Des Moines**
State:	**IA**
Type of Employment:	**Medical Director**
Begin Date (mm/dd/yyyy):	**08/29/2012**
End Date (mm/dd/yyyy):	**02/28/2015**

If 'to present', enter today's date.

Fees

Application Fee	**$350.00**
Unlicensed Activity	**$5.00**
NICA Fee	**$250.00**
Initial License	**$350.00**
Total Amount Due:	**$955.00**

Attestation

I state that these statements are true and correct. I recognize that providing false information may result in denial of licensure, disciplinary action against my license, or criminal penalties pursuant to Sections 456.067, 775.083, and 775.084, Florida Statutes. I state that I have read Chapters 456, 458 and 766.301-.316, Florida Statutes and Chapter 64B8, Florida Administrative Code.

I hereby authorize all hospitals, institutions or organizations, my references, personal physicians, employers (past and present), and all governmental agencies and instrumentalities (local, state, federal, or foreign) to release to the Florida Board of Medicine information which is material to my application for licensure.

I have carefully read the questions in the foregoing application and have answered them completely, without reservations of any kind. I state that my answers and all statements made by me herein are true and correct.

Should I furnish any false information in this application, I hereby agree that such act constitutes cause for denial, suspension, or revocation of my license to practice Medicine in the State of Florida. If there are any changes to my status or any change that would affect any of my answers to this application I must notify the board within 30 days.

I understand that my records are protected under federal and state regulations governing Confidentiality of Mental Health Patient Records and cannot be disclosed without my written consent unless otherwise provided in the regulations. I understand that my records are protected under federal and state regulations governing Confidentiality of Alcohol and Drug Abuse Patient Records, 42CFR Part 2, and cannot be disclosed without my written consent unless otherwise provided in the regulations. I also understand that I may revoke this consent at any time except to the extent that action has been taken in reliance upon it.

Attestation Answer: Yes