Submission Date and Time: 3/19/2020 10:48 AM

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. Demographic and workforce data collected for some licensed healthcare professions is used to enhance the state's capacity for healthcare workforce forecasting, policy development, and research. This data is used to analyze the supply and demand of the healthcare workforce serving Ohio. If you do not have an Individual Provider Identifier (NPI) number please enter nine zeroes.

Title
Dr
First Name
Emily
Middle Name
Ann
Last Name
Cassell
Maiden Name
No Response
Social Security Number
REDACTE
Date of Birth
12/15/1989
Email Address
emily.cassell@osumc.edu
Phone Number
(740) 398-0648
Other Phone Number
No Response
What is your U.S. Residency status related to your employment?
United States Citizen
Do you consider yourself Hispanic, Latino/a or of Spanish origin?
No
What do you consider your race?
White
List languages you personally use to communicate with patients excluding an interpreter or software
English
Other Language
No Response
Individual National Provider Identifier - if N/A enter all zeroes
1902254113
Enter home US zip-code. Enter NA if unavailable
43212

Additional Information

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

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

Employment Status

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

What is your primary employment status
Actively working in a position(s) that does not require this license
Which of the following best describes your five-year employment plan?
Move to another practice location in Ohio
Are you currently employed outside of USA?
No

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.

1781 Northwest Blvd
Columbus
OH
43212-1638
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.

395 W 12th Ave 5th Fl
Columbus
OH
43210-1267
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
If you answered "Yes", are you currently serving in the military?
No
Has your spouse served in the military?
Not Applicable
If you answered "Yes", are they currently serving in the military?
No Response
I declined to answer these questions

Secondary Email Recipient

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

Secondary Email Address:

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. If you did not receive a degree, please select "Not Applicable" as the degree type and do not enter a graduation date.

Educational Institution - Miami University
Degree Type - Bachelor's
Degree - Bachelor of Science in Zoology
Enrollment date - 8/11/2008

Graduation date - 5/18/2012

Educational Institution - University of Cincinnati College of Medicine
Degree Type - Doctoral
Degree - Doctor of Medicine
Enrollment date - 8/12/2012
Graduation date - 6/5/2016

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 - Ohio State University Wexner Medical Center
Job Title - Obstetrics and Gynecology Resident
Start Date - 6/19/2016
End Date - 6/19/2020
Average Hours/Week- 60
Street Address - 395 W 12th Ave, 5th Floor
Employment City - Columbus
Employment County - Franklin
Employment State - Ohio
Employment Zipcode - 43210
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.

57.028595
Doctor of Medicine (MD)
Medical Board
Active
United States
Ohio

Examination Tracking

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

Examination - USMLE Step 1
Status - Passed
Exam date - 6/11/2014
Number of Attempts - 1

Examination - USMLE Step 2 CK
Status - Passed
Exam date - 7/29/2015
Number of Attempts - 1

Examination - USMLE Step 3
Status - Passed
Exam date - 2/2/2017
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 - RES29838
Hospital Name - Ohio State University/Mt Carmel Hospital
Address - 395 W 12th Ave, 5th Floor
City - Columbus
State - OH
ZipCode - 43210
Country - United States
PG Years - 4
PG Type - Residency
Department/Specialty - Obstetrics and Gynecology
Start Date - 6/19/2016
End Date - 6/19/2020

Successfully Completed? - true

Current Employment Location(s)

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

Name of Practice Site - Ohio State Wexner Medical Center
Practice Settings - Hospital - Inpatient
Street Address - 395 W 12th Ave
City - Columbus
State - OH
Zip Code - 43210
Major Area of Focus or Specialty - Obstetrics & Gynecologic Surgery
Total Hours Worked at this practice site, per Week - 60

Percent of time spent per week in each of the following at this practice site:
Direct Patient Care - 80
Teaching/Academic - 10
Research - 1
Professional Services - 1
Administrative Activities - 8
Other - 0
Total Hours- 100

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

Questions

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

Question - 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 investigated, warned, censured, put on probation, terminated, or disciplined by any employer, hospital, group practice, nursing home, clinic, health maintenance organization, or other similar institution, for any reason?
Answer - No

Question - Have you ever had admissions monitored, had clinical privileges or other similar institutional authority limited, restricted, suspended, revoked, terminated, or placed on probation for any reason, or have resigned privileges at any institution?
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 - Yes

Question - Have you engaged in conduct prohibited by the Medical Board's rules regarding sexual misconduct and impropriety (chapter 4731-26 of the Administrative Code)?

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 - 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

Title - License Verification
Description - I attest that I have disclosed all professional licenses, registrations, or certifications that I hold, or have ever held.
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 - 3/19/2020 10:48 AM
Type your First Name and Last Name as they appear on the application to sign electronically.
Emily Cassell
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:	**Cassell, Emily Ann**
Social Security Number:	REDACTED
Date of Birth:	**December 15, 1989**
FID#:	**300166022**
Recipient:	**OH - State Medical Board of Ohio**
Delivery Date:	**03/03/2020**

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.

FCVS FEDERATION CREDENTIALS VERIFICATION SERVICE

Affidavit and Release

fsmb

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.

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

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.

JULIA A. GLADSTONE
Notary Public, State of Ohio
My Commission Expires 06-07-2021

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

CASSELL
Applicant's **Printed** Last Name

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

2/7/2020
Date of Signature (**must** correspond to date of notarization)

State of Ohio, County of Franklin,

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 7th day of February, 20 21.

Notary Public Signature: Julia Gladstone

My Notary Commission Expires: June 7, 2021

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

FCVS ID Number

FID Number

300 166 022

FCVS FEDERATION CREDENTIALS VERIFICATION SERVICE

Identity

fsmb

Biographic Information

Medical professional Name(s): **Cassell, Emily Ann**

Date of Birth: December 15, 1989

Place of Birth: Mount Vernon, Ohio, UNITED STATES

Contact Information

Home Address: 1781 Northwest Blvd
Columbus, OH 43212
UNITED STATES

Mobile Phone: (740) 398-0648

Email: casselea@mail.uc.edu

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: Cassell Emily Ann
Last First Middle

FCVS ID Number: 300166022

Notary – Please complete the section below:

State of Ohio County of Franklin

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 Valid 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) 7th, of (Month) February, (Year) 2020.

Notary Public Signature: Julia Gladstone

Commission Expiration Date* (Month) June / (Day) 7th / (Year) 2021

*** The notary's commission expiration date must be current and legible. If no expiration date, such as 'lifetime', an explanation must be provided. If you are in California, the notary may attach a California All-Purpose Acknowledgement form to this document.**

Notary Stamp Here

JULIA A. GLADSTONE
Notary Public, State of Ohio
My Commission Expires 06-07-2021

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
Euless, TX 76039-3856

FCVS ID Number FID Number

300166022 PP

We The People

Of the United States,
in Order to form a more perfect Union, establish Justice, insure domestic Tranquility, provide for the common defence, 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.

Emily Cassell

SIGNATURE OF BEARER / SIGNATURE DU TITULAIRE / FIRMA DEL TITULAR

3

PASSPORT
PASSEPORT
PASAPORTE

USA

UNITED STATES OF AMERICA

Type / Type / Tipo: P
Code / Code / Código: USA
Passport No / No. du passeport: 500895189

Surname / Nom / Apellidos
CASSELL

Given Names / Prénoms / Nombres
EMILY ANN

Nationality / Nationalité / Nacionalidad
UNITED STATES OF AMERICA

Date of birth / Date de naissance / Fecha de nacimiento
15 Dec 1989

Place of birth / Lieu de naissance / Lugar de nacimiento
OHIO, U.S.A.

Date of issue / Date de délivrance / Fecha de expedición
08 Jan 2013

Date of expiration / Date d'expiration / Fecha de caducidad
07 Jan 2023

Endorsements / Mentions Spéciales / Anotaciones
SEE PAGE 27

Sex / Sexe / Sexo
F

Authority / Autorité / Autoridad
United States
Department of State

USA

P<USACASSELL<<EMILY<ANN<<<<<<<<<<<<<<<<<<<<<<<<

500895189 3USA8912156F2301077252788099<993768

300 166 022

FCVS FEDERATION CREDENTIALS VERIFICATION SERVICE

Chronology of Activities

fsmb

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
08/10/2012	06/24/2016	Medical Education	University of Cincinnati College of Medicine Cincinnati Ohio UNITED STATES
06/27/2016	06/29/2020	Postgraduate Training	Ohio State University/Mt Carmel Hospital Program Columbus Ohio UNITED STATES

End of Chronology of Activities report for: Cassell, Emily Ann

Medical Education

Medical Education

Medical School: **University of Cincinnati College of Medicine**

Location: Cincinnati, OH
UNITED STATES

Credentials Analysis Information for Medical Education

There is no Omission/Discrepancy/Miscellaneous information identified.

FCVS FEDERATION CREDENTIALS VERIFICATION SERVICE

fsmb

Institution Name: University of Cincinnati College of Medicine

City: Cincinnati **State/Province:** Ohio **Country:** UNITED STATES

Premedical Education:

Years of education required for admission to your medical school: 4

Credential/degree presented by the applicant for admission to your medical school: BS

Enrollment and Participation:

Our records indicate that Cassell, Emily Ann

attended our medical school for a total of 163 weeks of medical education on the following dates: From MM/DD/YYYY: 08/13/2012 To MM/DD/YYYY: 05/20/2016

This individual was awarded the degree of Doctor of Medicine on 06/03/2016

DS GB

Unusual circumstances

1. Do this individual's official records reflect (an) interruption(s) in his/her medical education? **YES** **NO** X **N/A**

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.

			From MM/DD/YYYY:	To MM/DD/YYYY:
Personal/Family	Applicable	N/A	/ /	/ /
Academic remediation	Applicable	N/A	/ /	/ /
Health	Applicable	N/A	/ /	/ /
Financial	Applicable	N/A	/ /	/ /
Participation in joint degree program (e.g., MD/PhD)	Applicable	N/A	/ /	/ /
Other	Applicable	N/A	/ /	/ /

Other Explanation:

Medical School Code: 036020 FID: 300166022

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** X **N/A**

If YES, please select the reason(s) for the probation and indicate the date(s) of placement on and removal from probation.

			From MM/DD/YYYY:	To MM/DD/YYYY:
Academic Probation	Applicable	N/A	/ /	/ /
Probation for unprofessional conduct/behavior	Applicable	N/A	/ /	/ /
Probation for other reason	Applicable	N/A	/ /	/ /

Other Reason Explanation:

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** X **N/A**

If YES, please provide detailed 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** X **N/A**

If YES, please provide detailed 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** X **N/A**

If YES, please provide detailed information about the nature of the limitations or special requirements:

6. Attach Transcript **7. Attach Diploma** **8. Do you have a Dean's Letter to Attach?** **YES** X **NO** **9. Would you like to upload an additional attachment?** **YES** **NO** X

Attestation of Person completing Verification of Medical Education document: I hereby attest that the information contained herein accurately reflects the training records of the above-named physician.

ELECTRONIC SEAL VERIFIED	Name: Barbara A. Gadzinski Title: Registrar Signature: DocuSigned by: Gadzinski, Barbara A E63A7C0FDEC6424... Date of Signature: 2/25/2020 Email: mdregistrar@uc.edu

Medical School Code: 036020 FID: 300166022

FCVS FEDERATION CREDENTIALS VERIFICATION SERVICE

Applicant Reported Unusual Circumstances

Medical School

Medical Professional Name: Cassell, Emily Ann

University of Cincinnati 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: Cassell, Emily Ann

UNIVERSITY OF Cincinnati

Medical Student Performance Evaluation

for

Emily Ann Cassell

October 1, 2015

Identifying Information

Emily Ann Cassell is a fourth-year student at the University of Cincinnati College of Medicine in Cincinnati, Ohio.

Unique Characteristics

Emily Cassell graduated from Miami University in 2012 with a Bachelor of Science in Zoology. During her undergraduate years she developed a strong interest in medical research. She studied the role of inactivity in relation to insulin resistance in the Department of Zoology and had the opportunity to co-present her work at the Experimental Biology Conference in 2011. She furthered her passion for research while studying cystic fibrosis proteomics and gene therapy over the course of two summers at Case Western Reserve University. Outside of academics, Emily learned the importance of communication and teamwork during her time playing for the Miami University Women's Club Volleyball team.

Emily matriculated to University of Cincinnati College of Medicine in 2012 where she immediately sought ways to further her interest in medical research. At Cincinnati Children's Medical Center, she worked to improve cell culture techniques for human airway epithelial cells in order to allow individualized treatments for patients with cystic fibrosis. She presented this work at the National Student Research Forum in 2014 where her project was chosen as the top pediatric research study. Also during medical school, Emily cultivated another of her passions through service opportunities. As the Community Service Chair of the Medical Student Association she organized a free community health fair at a local homeless shelter; in addition, she planned and hosted a holiday festival for local urban elementary schools. She also made an impact as a mentor to a local school-aged girl throughout her four years in medical school.

Emily's broad range of experiences throughout medical school have not taken away from her dedicated commitment to academic excellence. Rather, they have molded her into a compassionate future physician who will value patient-centered care, service to her community, and the advancement of medicine through medical research.

Academic History

Date of Expected Graduation from Medical School:	06/03/2016
Date of Initial Matriculation in Medical School:	08/13/2012

Please explain any extensions, leave(s) of absence, gap(s), or break(s) in the student's educational program:

N/A

For transfer students:

Date of Initial Matriculation in Prior Medical School:

Date of Transfer from Medical School:

For dual/joint/combined degree students:

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
Was this student the recipient of any adverse action(s) by the medical school or its parent institution?:	No

Appendix A

Comparative Overall Performance for Class of 2016

Appendix B

Performance in Year 1 Courses

Appendix C

Performance in Year 2 Courses

Appendix D

Comparative Performance in Year 3 Core Clinical Clerkships

Appendix E

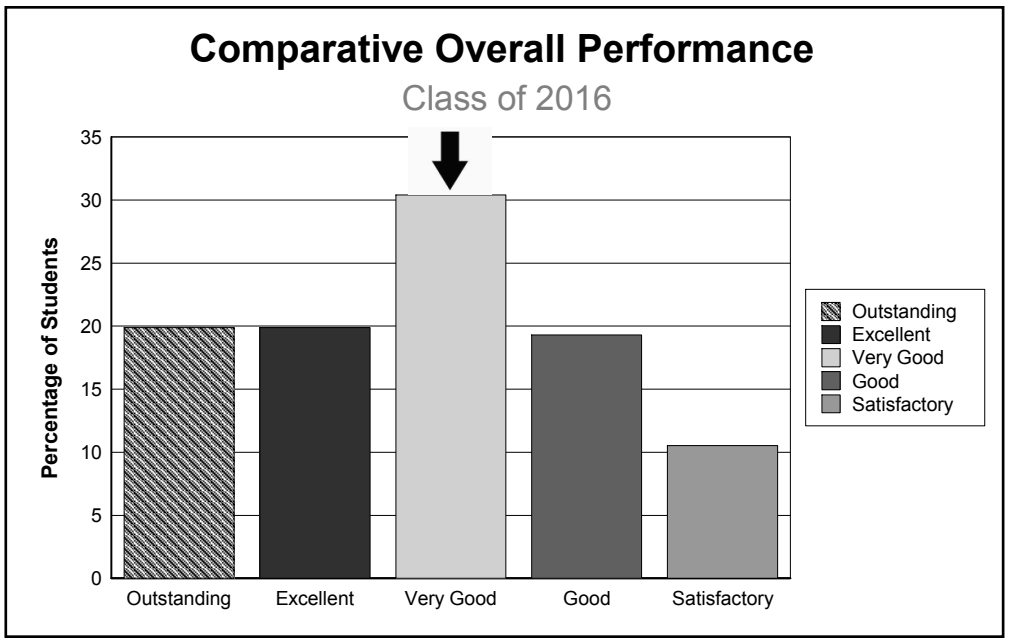
Narrative Evaluation Comments from Year 3 Core Clinical Clerkships

Appendix F

Medical School Information Page

Appendix A

Emily Cassell



A modified Pass/Fail grading system is used in years 1 and 2. A percentage score for each course is derived to calculate the student's quintile ranking.

Calculation of Quintile

The quintiles are calculated by averaging the percentage score for each of the courses in Years 1-3. Percentage scores in Years 1 and 2, combined, are equally weighted with scores in Year 3 in calculating the student's cumulative score at the end of the 3 years.

Outstanding [80-99th percentile]

These students have surpassed most requirements and have consistently demonstrated exemplary performance across competency domains.

Excellent [60-79th percentile]

These students have met all requirements without difficulties and have excelled in the majority of their competency domains.

Very Good [30-59th percentile]

These students have met all requirements without difficulties and have excelled in several of their competency domains.

Good [10-29th percentile]

These students have generally met all requirements without difficulties and have met their competency domains.

Satisfactory [1-9th percentile]

These students have had some difficulties meeting all requirements but have remediated these and are on target to meet their competency domains.

Performance in Year 1 Courses

Emily Cassell

Clinical Skills 101	P
Physician and Society 101	P
Fundamentals of Medical Science	P
Clinical Skills 102	P
Physician and Society 102	P
Longitudinal Primary Care Clerkship 101	P
Musculoskeletal-Integumentary	P
Interprofessional Experiences 101	P
Gastrointestinal/Nutrition/Endocrine/Reproduction	P
Human Growth & Development	P

The Year 1 courses are graded Pass/Fail. Remediation of failed courses is required to progress to Academic Year 2.
The Year 1 pass rate for students in this class is 98.87%.

Appendix C

Performance in Year 2 Courses

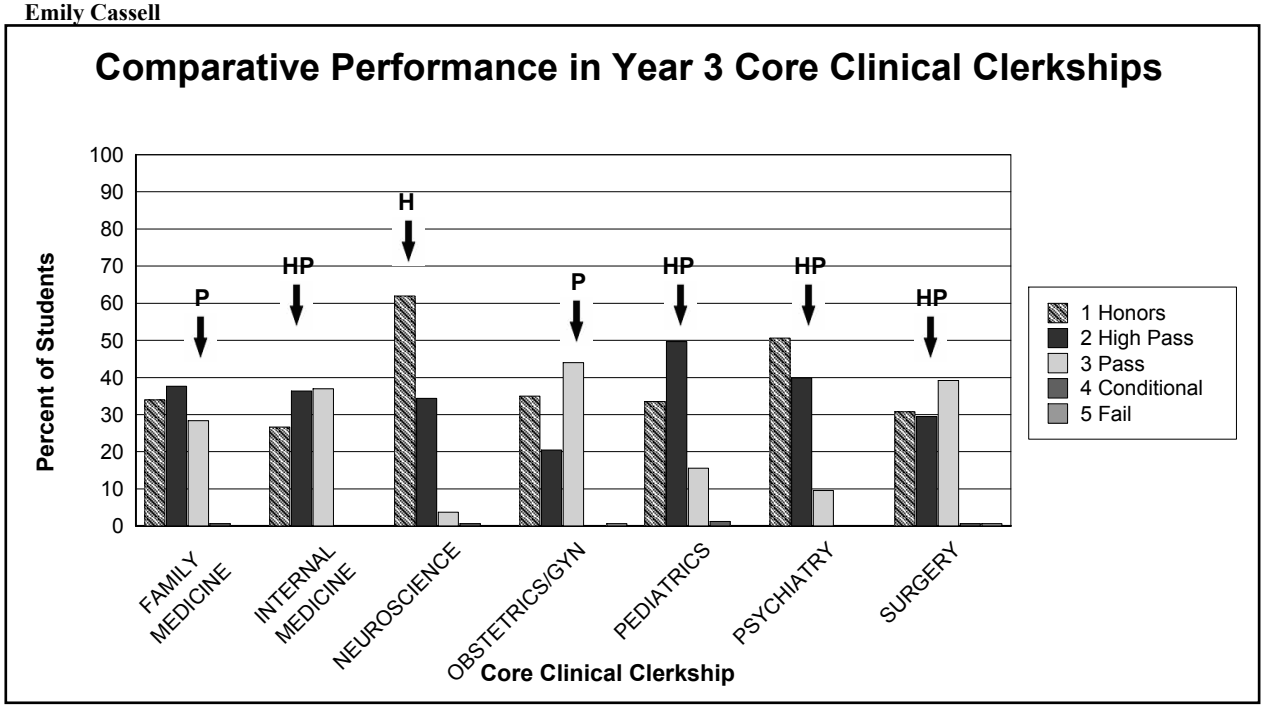
Emily Cassell

Brain, Mind and Behavior	P
Physician and Society 201	P
Physician and Society 202	P
Clinical Skills 201	P
Clinical Skills 202	P
Longitudinal Primary Care Clerkship 201	P
Longitudinal Primary Care Clerkship 202	P
Interprofessional Experiences 201	P
Clinical Experience 201	P
Multi-Systems	P
Hematology and Cardiovascular	P
Renal and Pulmonary	P

The Year 2 courses are graded Pass/Fail. Remediation of failed courses is required to progress to Academic Year 3.
The Year 2 pass rate for students in this class is 99.4%.

Appendix D

Emily Cassell



The Year 3 clerkships are graded Honors, High Pass, Pass, Conditional, Fail. Final clerkship grade earned is depicted on this graph.

Appendix E

Core Clinical Clerkships and Specialty Clerkships:

Following are the unedited narrative evaluations of Emily Cassell's performance on the successive clerkships. Appendix D summarizes the clerkship grades.

OTOLARYNGOLOGY SPEC CLKSP: Honors

Emily was a pleasure to have on the ENT team. Despite this being her very first clinical rotation, she quickly figured out how to function effectively on the team and was always well prepared for rounds and cases in the operating room.

PSYCHIATRY CORE CLKSP: High Pass

Emily Cassell completed her rotation in the Psychiatry Core Clerkship.

One of the Attendings from her Inpatient experience noted that Emily did an excellent job on this rotation. She became involved in patient care right from the beginning, and was knowledgeable about every patient on the team. She was able to develop a good rapport and conduct good interviews with the patients she followed. Her fund of knowledge was above average, and she was thoughtful about patient problems. She asked good questions and had some good ideas about patient care. She was reliable and made a real effort to be helpful with patient care. Another Attending noted that she was hardworking, easy to get along with, humble, and independent. The Attending from her Outpatient experience noted that she is an excellent medical student with capabilities exceeding expectation.

Emily received 94.00 on the Standardized Patient Oral Examination.

Grade: High Pass

FAMILY MEDICINE CORE CLKSP: Pass

Emily performed well on the Family Medicine Clerkship earning a Pass. She had the opportunity to complete her clerkship at an NCQA Level 3 Patient Centered Medical Home where she took an active role in patient care. Her

preceptor commented: "Emily Cassell was an outstanding medical student. She possessed a superior fund of knowledge and applied these to her fine clinical skills. She interacted extremely well with patient's and staff. She will make a superior physician in any specialty she chooses." She had a standardized score of 62 (National Mean: 72) on the NBME Family Medicine CCM Modular Exam. This places her at the 18th percentile nationally based on the academic quarter the clerkship was taken. She and her team members gave a high quality presentation on one of the key tenants of the Patient Centered Medical Home earning 91%. Through this, she demonstrated a high level of understanding of this new innovative model of care to improve the healthcare triple aim.

NEUROSCIENCE CORE CLKSP: Honors

Emily Cassell did her clinical neuroscience clerkship on the Pediatric Neurology team at the Cincinnati Children's Hospital. Her overall performance was very good.

Clinical Work: Emily was organized, industrious and worked up a very large number of patients. Her case presentations were thorough, well-reasoned and succinct.

Academics: Emily demonstrated a solid fund of knowledge by scoring 76 on the neurology shelf exam (average 75). She performed very well on the observed neurological examination (161 /161). Emily's diagnostic skills, test utilization and treatment strategies were demonstrated by her very fine score on the Clinical Decision-making Exam.

Personal: Emily was an active participant in all of our conferences – engaging, appropriately decisive and collegial. She wrote a thoughtful ethics essay dealing with the issues surrounding poor communication and a medication error .

OBSTETRICS/GYN CORE CLKSP: Pass

Ms. Cassell performed her OB/GYN Clerkship at the Good Samaritan Hospital, which included an ambulatory preceptorship in the outpatient clinic of that hospital. Her clinical evaluations were at the High Pass to Honors level, with a grade of 86% for her performance on the gynecology service, and 99% for her performance on the obstetrics service. She demonstrated particular strengths in the areas of history taking, interpersonal communication skills, self-education and learning habits, and problem-solving.

Those who worked with Emily praised her attention to detail and her ability to quickly build rapport with patients, residents, faculty and nurses. She has exemplary self-education habits and knows how to use her time wisely. She actively demonstrates her fund of knowledge by applying it to clinical care and participating in team discussions. During her rotation she gave an outstanding presentation on fertility sparing options for severe uterine prolapse in reproductive-aged women. This is a clinical situation that is rarely encountered, but Emily performed a broad search and gave a very well-informed presentation.

On the objective measures of the rotation she received a grade of 97% for her small group quiz average, 74% on the SHELF exam, and 77% on the Observed Skilled Clinical Exam (OSCE).

In summary, Emily performed at the Honors level clinically and academically. However, her NBME SHELF exam score was below the national mean, and departmental policy dictates that she receive a final grade of Pass for the clerkship. In spite of this, we feel confident that she has the initiative and drive to become an outstanding house officer in any field she chooses to enter.

EMERGENCY MEDICINE SPEC CLKSP: High Pass

Emily Cassell performed well during her emergency medicine clerkship. She demonstrated very good patient care skills, including taking a patient history and performing a physical exam. She also showed solid procedural skills when compared to her colleagues. Her medical knowledge was above students of similar training, both with determining a plan of care and interpreting results of testing. Ms. Cassell demonstrated good initiative in attempting to fill gaps in her knowledge base by reading and asking questions. She showed very good communication skills with both patients and other medical providers. Ms. Cassell was very professional and enthusiastic with her interactions and overall performed above the expected level for her training and should perform very well in whatever field in which she decides to specialize.

PEDIATRICS CORE CLKSP: High Pass

Emily was an inquisitive learner on the pediatric clerkship. If the service was slow or there was down time, she used the time to ask insightful questions or research assigned topics. She always displayed a willingness to learn more. Emily's manner was professional and organized. She had excellent rapport with patients and families. She was patient and thorough with her physical examinations. Her oral presentations were organized as well, never missing data or pertinent information that was important for developing a plan. She could present complex patients clearly. Emily's written notes were also excellent. She was well prepared for both patient care and formal teaching sessions. Emily was a pleasure to have on the clerkship.

SURGERY CORE CLKSP: High Pass

Emily passed the departmental quizzes. She scored a 74 on the NBME Surgery exam. The mean score on the written exam for this clerkship was 79.4.

On the clinical rotations (General Surgery 78.44, Surgical Oncology 86.67), Emily did a great job. Her first rotation was on General Surgery at Christ. Here she was a productive member of the team that was highly motivated. She was eager to learn surgical technique and improved over the course of the rotation. Her second rotation was on Surgical Oncology where she demonstrated the ability to accurately assess patients and come up with a plan with ease. She is confident, reliable and an independent learner. The senior resident stated that she will do well leading a team one day as a chief resident and will be a competitive candidate during match.

Overall Emily received a High Pass for her 3rd year surgery clerkship. Her performance on the NBME Surgery exam was good. Her performance clinically on each of her rotations was well above average and expectations.

INTERNAL MEDICINE CORE CLKSP: High Pass

Inpatient: Emily's fund of knowledge, written skills, self-education skills, problem solving skills, and clinical judgment were above average. Her history and physical examination skills, oral presentation skills, and communication skills were outstanding. Emily had a good work ethic. She was always ready and willing to take on additional responsibilities. She practiced medicine in a very patient-oriented fashion, and was proactive and well organized. Emily demonstrated good enthusiasm and was an excellent team player. She established good rapport with patients.

Ambulatory: Both the student clinic preceptor and the community preceptor rated the majority of Emily's clinical skills in the above average to outstanding categories. Her fund of knowledge, problem solving, clinical judgment were at the expected level. Emily had a great bedside manner and excellent rapport with patients. She was enthusiastic, energetic, sincere, kind, and poised. She took thorough and detailed histories and physicals and performed well thought out assessments and plans in a busy ambulatory setting.

Standardized Patient: The Standardized Patient appreciated Emily's excellent delivery of the diagnosis and her clear and easy to follow explanation that still provided lots of details. Both her words and facial expressions exhibited empathy.

AI - OBSTETRICS: Honors

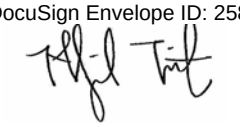
Emily Cassell completed her Acting Internship on the obstetrics service at the University of Cincinnati Hospital. She provided care to postpartum patients, saw patients in triage, and reviewed and presented the daily planned procedures for the obstetrics service. Her four week rotation was equally divided between the day and the night service team.

Those who worked with Emily praised her work ethic and enthusiasm. She was extremely thorough and detail oriented in patient care. She would follow up with patients at the level of an intern or second year resident. She integrated herself into the Labor and Delivery team and was accepted by the nursing staff. She was efficient and effective with her time and appropriately assertive. Emily has a natural “feel” for OB. She covered Labor & Delivery one morning with a faculty member while the residents were attending a didactic conference. When the residents returned, she presented the L&D board, triage patients, and information about two expected admissions. The clinical information was accurate, up to date. Her check out was impressive for an AI and was above the level of some of our interns! One faculty physician noted that Emily "out-performed some of my current interns." At the conclusion of her rotation, she gave a great presentation on appendicitis in pregnancy that was well-received and appreciated by all.

In summary, Emily was an outstanding addition to the Labor and Delivery team. We anticipate she will make a highly recruited house office candidate. We would be thrilled to have her among our intern class next year.

Summary:

In summary, based on the information provided above, and on behalf of the University of Cincinnati College of Medicine, it is a pleasure to recommend Emily Cassell as a **VERY GOOD** candidate for a residency position. Please refer to Appendix A for a Comparative Overall Performance for the Class of 2016.



Signature of School Official

Abbigail Tissot, Ph.D.

Name of School Official

Director Recruitment Programs

Title

Abbigail.Tissot@uc.edu

E-mail address

Appendix F

Medical School Information Page

University of Cincinnati College of Medicine
Medical School Name

Cincinnati, Ohio
City, State

Special programmatic emphases, strengths, mission/goal(s) of the medical school:

The UCCOM provides both outstanding research facilities and strong clinical and teaching experiences. Graduates are ranked as highly competitive by national residency program directors and choose careers in a broad range of specialty areas, as well as primary care fields. Extensive research opportunities are available.

Special characteristics of the medical school's educational program:

Using an integrated curricular approach, including laboratory, small group discussions, team-based learning and lectures, the first two years provide students with scientific and humanistic principles of medicine. Clinical exposure begins in the first year, using a state of the art standardized patient clinical skills laboratory and an 18-month longitudinal clinical experience at an outpatient primary care site. During the third year, students rotate through seven core clerkships and begin exploring career options by participating in subspecialty electives. Year four includes two required Acting Internships. Students choose from over 100 elective offerings.

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

4
Years Months

Description of the evaluation system used at the medical school:

Evaluation system includes both objective and subjective evaluations. Students are required to take NBME shelf exams during all of the major core clerkships in the third year and also must pass a required clinical skills examination.

Medical school requirements for successful completion of USMLE Step 1, Step 2CK and Step 2CS (check all that apply):

USMLE Step 1:

- [x] Required for promotion
- [x] Required for graduation
- [ ] Required, but not for promoting/graduation
- [ ] Not required

USMLE Step 2 CK, 2 CS:

- [ ] Required for promotion
- [x] Required for graduation
- [ ] Required, but not for promoting/graduation
- [ ] Not required

Medical school requirements for successful completion of Objective/Observed Structured Clinical Evaluation (OSCE) at medical school. OSCEs are used for (check all that apply):

- [x] Completion of course
- [x] Completion of clerkship
- [x] Completion of third year
- [x] Graduation
- [ ] Other:

Utilization of the course, clerkship, or elective director's narrative comments in composition of the MSPE. The narrative comments contained in the attached MSPE can best be described as (check one):

- [x] Reported exactly as written
- [ ] Edited for length or grammar but not for content
- [ ] Edited for content or included selectively

Utilization by the medical school of the AAMC "Guidelines for Medical Schools Regarding Academic Transcripts." This medical school is:

- [x] Completely in compliance with Guidelines' recommendations
- [ ] Partially in compliance with Guidelines' recommendations
  Exceptions:
- [ ] Not in compliance with Guidelines' recommendations

Description of the process by which the MSPE is composed at the medical school (including number of school personnel involved in composition of the MSPE).

The MSPE for individual students is the cumulative product of all objective and subjective formal evaluations during the undergraduate medical education period. Additional information is obtained from our student database. All MSPEs are prepared by the Associate Dean for Student Affairs and the Assistant Dean for Diversity and Inclusion and selected members of their staff.

Student are permitted to review the MSPE prior to its transmission:

- [x] Yes
- [ ] No

Academic Record of: EMILY A. CASSELL

Student ID: M04941107
Student SSN: REDAC
Date of Birth: 12/15/xxxx
Program: MD

University of Cincinnati College of Medicine

Office of the Registrar
231 Albert Sabin Way
Cincinnati, Ohio 45267-0552

COURSES OF INSTRUCTION

FIRST YEAR 8/13/2012 - 6/7/2013

COURSE INFORMATION		CR HRS	GRADE
26950111	CLINICAL SKILLS 101	19	P
26950112	PHYSICIAN AND SOCIETY 101	6	P
26950113	FUND OF MED SCIENCE	15	P
26950121	GI/ENDO/REPRO	11	P
26950120	INTERPROFESSIONAL EXP 101	4	P
26950115	CLINICAL SKILLS 102	4	P
26950116	PHYSICIAN AND SOCIETY 102	4	P
26950117	LONG PRIM CARE CLKSP 101	4	P
26950119	MUSCULOSKELETAL/INTEG	9	P
26950122	HUMAN GROWTH & DEVELOPMENT	1	P

SECOND YEAR 8/12/2013 - 5/30/2014

COURSE INFORMATION		CR HRS	GRADE
26950213	BRAIN, MIND AND BEHAVIOR	14	P
26950216	PHYSICIAN AND SOCIETY 201	4	P
26950218	CLINICAL SKILLS 201	4	P
26950220	LONG PRIM CARE CLKSP 201	4	P
26950222	INTERPROFESSIONAL EXP 201	4	P
26950225	HEMATOLOGY AND CARDIOVASCULAR	9	P
26950221	LONG PRIM CARE CLKSP 202	4	P
26950219	CLINICAL SKILLS 202	4	P
26950217	PHYSICIAN AND SOCIETY 202	4	P
26950223	CLINICAL EXPERIENCE 201	4	P
26950227	RENAL AND PULMONARY	10	P
26950224	MULTI-SYSTEMS	4	P
26950276	IND STUDY/USMLE STEP 1 REV	0	NG

THIRD YEAR 6/30/2014 - 6/26/2015

COURSE INFORMATION		CR HRS	GRADE
26952375	OTOLARYNGOLOGY SPEC ELECTIVE	4	H
26963371	PSYCHIATRY CORE CLKSP	12	HP
26920371	FAMILY MED CORE CLKSP	8	P
26940373	NEUROSCIENCE CORE CLKSP	8	H
26946374	OB/GYN CORE CLKSP	12	P
26923375	EMERGENCY MED SPEC ELECTIVE	4	HP
26961373	PEDIATRICS CORE CLKSP	16	HP
26980373	SURGERY CORE CLKSP	16	HP
26931373	INT MED CORE CLKSP	16	HP

FOURTH YEAR 7/6/2015 - 5/20/2016

COURSE INFORMATION		CR HRS	GRADE
26950442	HCEM IV: DISASTER MEDICINE*	0	P
26946473	AI - OBSTETRICS	12	H
26950402	ICP IV: CLIN COMPETENCY EXAM	0	P
110199	OBSTETRICS & GYNECOLOGY AWAY	8	H
110199	OBSTETRICS & GYNECOLOGY AWAY	8	H
060111	PRECEPTORSHIP IN FAMILY MEDICINE - AHEC	8	H
070301	CLINICAL CARDIOLOGY UH	8	HP
26931472	ACTING INTERNSHP-INT MED	12	H
071502	HEMATOLOGY-ONCOLOGY ELECTIVE - VAMC	8	HP
280106	DISSECTION OF THE HUMAN BODY*	8	P
280121	CLINICAL CAPSTONE: GET READY FOR RESIDENCY	8	H
110132	OB LABORIST	4	H

ELECTRONIC SEAL VERIFIED

* PASS/FAIL GRADING SYSTEM

Date:	M.D. Conferred:
2/25/2020	06/03/2016

AN OFFICIAL SIGNATURE IS WHITE WITH A GREEN BACKGROUND REJECT DOCUMENT IF SIGNATURE BELOW IS DISTORTED

Barbara A. Gadzinski, Medical Registrar

RAISED SEAL NOT REQUIRED
This official transcript is printed on green SCRIP-SAFE® security paper and does not require a raised seal.
For electronic purposes only.

University of Cincinnati
College of Medicine
231 Albert Sabin Way
P. O. Box 670552
Cincinnati, OH 45267

Grade Policy

Grade	Description	Effective Dates
H	Honors	discontinued 2011 years 1 & 2
HP	High Pass	added 1989 years 3 & 4; added 1990 years 1 & 2; discontinued 2011 years 1 & 2
P	Pass	added 2011 P/F grading system years 1 & 2
RP	Remediated Pass	added 1990, discontinued 1996
C	Conditional	added 2011
R	Remediate	added 1996; discontinued 2011
F	Fail	added 2011 P/F grading system years 1 & 2
E	Exempt	discontinued 2011
I	Incomplete	
W	Withdraw	
WP	Withdraw Passing	added 1989
WF	Withdraw Failing	added 1989
AU	Audit	added 1989; discontinued 2011

Curriculum

The University of Cincinnati College of Medicine implemented a revised curriculum in August of 2011 that integrated biomedical, clinical, and psychosocial sciences with clinical skills and professional identity throughout the four-year curriculum. The first and second year medical students are evaluated using a pass/fail system. Third and fourth year students are evaluated using an honors/high pass/pass/fail system. The 2015 Graduation class is the inaugural class of this revised curriculum.

USMLE Statement

Passing Score on USMLE Step 1, Step 2 CK and Step 2 CS required for graduation.

FERPA Statement

Disclosure of information contained in this transcript may not be made to another party without prior written consent of the student whose name appears herein. This information may be used solely by the individual or institution to which it was originally released for the purpose for which the disclosure was made.

Accreditation Statement

University of Cincinnati is accredited by the North Central Association of Colleges and Schools as a degree-granting institution at the associate, baccalaureate, master's, professional and doctoral levels. In addition to this comprehensive accreditation, the University of Cincinnati College of Medicine is accredited by the Liaison Committee on Medical Education (LCME) as a degree-granting institution for the MD degree.

The Board of Trustees of the

University of Cincinnati

on the recommendation of the Faculty of the

College of Medicine

of the University, does hereby confer upon

Emily Ann Cassell

the degree of

Doctor of Medicine

with all the rights and privileges appertaining thereto. Given at Cincinnati, Ohio, this third day of June, two thousand and sixteen.

STATE OF OHIO)
) SS:
COUNTY OF HAMILTON)

Signed in my presence by Molly McDermott
this 6th day of February, 2020.

DEEANNE FREDERICK
Notary Public, State of Ohio

I hereby certify this is a true and authentic Diploma copy issued to Emily Ann Cassell by the University of Cincinnati on June 3rd, 2016.

MOLLY MCDERMOTT
Associate Registrar

Chairman of the Board of Trustees

Secretary of the Board of Trustees

President of the University

Senior Vice President for Health Affairs and Dean of the College

ELECTRONIC SEAL VERIFIED

FCVS FEDERATION CREDENTIALS VERIFICATION SERVICE

Postgraduate Training

fsmb

Postgraduate Training

Accreditation ID: **2203811234**

Institution: **Ohio State University/Mt Carmel Hospital Program**

Location: Columbus, OH
UNITED STATES

Credentials Analysis Information for Postgraduate Training

There is no Omission/Discrepancy/Miscellaneous information identified.

FCVS FEDERATION CREDENTIALS VERIFICATION SERVICE

fsmb

Verification of Postgraduate Medical Education

Accreditation Code: 2203811234

Institution Name: Ohio State University/Mt Carmel Hospital Program

Affiliated University: Ohio State University Hospital

City: Columbus **State:** Ohio **Country:** United States

Verification For: Emily Ann Cassell **Date of Birth:** 12/15/1989

Program Participation:

PGY: 1	Accredited By: ACGME	Status: Complete
Specialty: Obstetrics & Gynecology		
From: 06/27/2016	To: 06/26/2017	Program Type: Residency

PGY: 2	Accredited By: ACGME	Status: Complete
Specialty: Obstetrics & Gynecology		
From: 06/27/2017	To: 06/26/2018	Program Type: Residency

PGY: 3	Accredited By: ACGME	Status: Complete
Specialty: Obstetrics & Gynecology		
From: 06/27/2018	To: 06/26/2019	Program Type: Residency

PGY: 4	Accredited By: ACGME	Status: In Progress
Specialty: Obstetrics & Gynecology		
From: 06/27/2019	To: 06/26/2020	Program Type: Residency

PGY:	Accredited By:	Status:
Specialty:		
From:	To:	Program Type:

PGY:	Accredited By:	Status:
Specialty:		
From:	To:	Program Type:

FID: 300166022

PGY:	Accredited By:	Status:
Specialty:		
From:	To:	Program Type:

To report additional training, include training as an attachment at the end of page 2.

Unusual Circumstances

1. Did this individual ever take a leave of absence from his/her training?	Yes	No x	Not Available
2. Was this individual ever placed on probation?	Yes	No x	Not Available
3. Was this individual ever disciplined or placed under investigation?	Yes	No x	Not Available
4. Were any negative reports for behavioral reasons ever filed by instructors?	Yes	No x	Not Available
5. Were any limitations or special requirements placed upon this individual because of academic incompetence, disciplinary problems, or any other reason?	Yes	No x	Not Available

Attestation of Person completing Verification of Postgraduate Training document (Program Director): I hereby attest that the information contained herein accurately reflects the training records of the above-named physician.

ELECTRONIC SEAL VERIFIED	Name: Rachel Thibaut Title: Program Coordinator Degree: None Signature: DocuSigned by: Rachel Thibaut F21C30C9CD6E4F0... Date of Signature: 3/2/2020

Would you like to upload an additional attachment (e.g. Rotation Schedule)? Yes No x
If reporting additional years in the attachment, include PGY year, specialty, start date, end date, status and program type.

FID: 300166022

FCVS FEDERATION CREDENTIALS VERIFICATION SERVICE

Applicant Reported Unusual Circumstances

fsmb

Graduate Medical Education

Medical Professional Name:	Cassell, Emily Ann
Accreditation ID:	2203811234
Institution:	Ohio State University/Mt Carmel Hospital Program
Specialty:	Obstetrics & Gynecology

Unusual Circumstances

Training Period: 6/27/2016 - 6/29/2020 **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: Cassell, Emily Ann

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: 03/03/2020

Federation Credentials Verification Service
ATTN: FCVS

FCVSID: 518237

Examinee: Cassell, Emily Ann
Alt Name(s):

Examinee ID: 5-312-238-8
Date of Birth: 12/15/1989

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
06/11/2014	Pass	223	(192)	

USMLE STEP 2

Clinical Knowledge (CK)

Test Date	Pass/Fail	Score	Minimum Pass	Comments
07/29/2015	Pass	237	(209)	

Clinical Skills (CS)

Test Date	Pass/Fail	Comments
11/23/2015	Pass	

USMLE STEP 3

Test Date	Pass/Fail	Score	Minimum Pass	Comments
02/02/2017	Pass	225	(196)	

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.

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

Examinee: Cassell, Emily Ann

Examinee ID: 5-312-238-8
Date of Birth: 12/15/1989

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.

148589

028595

State Medical Board of Ohio

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

APPLICATION FOR TRAINING CERTIFICATE

PLEASE TYPE OR PRINT CLEARLY

NOTE: Application fee is $75.00. Fees submitted are neither refundable nor transferable.

PERSONAL INFORMATION

Check only one: ☑ MD ☐ DO

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

U.S. Social Security Number: REDACTED

Full Name (Use no initials):

Last (Surname)	First	Middle	Suffix (Jr., II)
Cassell	Emily	Ann	

Maiden Name Or Other Names Used (If none, enter "NONE"):

Last (Surname)	First	Middle	Suffix (Jr., II)
NONE			

Physicians Address (Be sure to notify the Board of any change in address):

Number & Street			
13079 Upper Fredericktown Rd			
City	**State**	**Zip Code**	**Country**
Mount Vernon	OH	43050	USA

TRAINING PROGRAM INFORMATION

Ohio Training Program Address (Hospital in Ohio where you will be starting your training):

Hospital & Department		
The Ohio State University Wexner Medical Center - OB/GYN		
Number & Street		
395 W. 12th Ave, 5th Fl		
City	**State**	**Zip Code**
Columbus	OH	43210

Dates of Training: Beginning Date: Mo/Day/Yr 6/20/16 Ending Date: Mo/Day/Yr 6/30/20

J-1 and H-1B VISA

To be completed by International medical school graduates only:

Are you currently applying for a J-1 or an H-1B Visa? ☐ YES ☐ NO

If YES check which one? ☐ J-1 ☐ H-1B

MEDICAL BOARD

MAY 13 2016

MEDICAL OR OSTEOPATHIC EDUCATION

Medical or Osteopathic School of Graduation:

School Name: University of Cincinnati College of Medicine
City: Cincinnati | State: OH | Country: USA

Dates Attended: From: Mo/Yr 08 / 2012 To: Mo/Yr 05 / 2016

Degree Received: MD Date Received: Mo/Day/Yr 06 / 06 / 2016

Other Medical or Osteopathic Schools Attended **(If none, enter "NONE")**

School Name: NONE
City | State | Country

Dates Attended: From: Mo/Yr / To: Mo/Yr /

Reason degree not received at this school:

FIFTH PATHWAY PROGRAM

Fifth Pathway Program **(if none, enter "NONE")**:

Hospital or Institution: NONE
Name of Medical School
City | State | Country

Dates Attended: From: Mo/Yr / To: Mo/Yr /

ECFMG CERTIFICATE

To be completed by International medical school graduates only:

Do you have a valid ECFMG certificate? ☐ YES ☐ NO

Number:_____ Date Issued: Mo/Day/Yr / / Expires: Mo/Day/Yr / /

Applicant Name: Emily Cassell Date: 3/23/16

PHYSICAL DESCRIPTION

Staple a recent (taken within the last six months) passport-type **COLOR** photograph of applicant in the space provided below. Black and white photographs cannot be accepted.

Birth Date: Mo/Day/Yr 12/15/1989

Birth Place: City Mount Vernon State OH Country USA

Gender: ☐ Male ☑ Female For statistics only (optional)

PHYSICAL DESCRIPTION

Height 5'11"

Weight 160

Hair Color brown w/ blonde

Eye Color brown

Identifying Marks _____

Date Photo Taken: 12/15 mo/yr

LICENSES IN THE UNITED STATES & CANADA

List ALL states/provinces, whether the license is current or not, in which you are or have been licensed, including temporary, educational permits, limited licenses, etc., to practice medicine and surgery or osteopathic medicine and surgery. Indicate license number, date of issuance and the type of license. If additional space is needed, attach an extra sheet. **(If none, enter "NONE") A Form 2, Verification of License form must be sent to each state listed.**

STATE/PROVINCE	ISSUE DATE	LICENSE #	TYPE OF LICENSE	LICENSE CURRENT
	MO/YR		*✓ ONLY ONE*	*✓ ONLY ONE*
NONE			☐ Full, unrestricted ☐ Temporary ☐ Educational ☐ Limited ☐ Other:_____ *(please specify)*	☐ YES ☐ NO Expiration Date:
			☐ Full, unrestricted ☐ Temporary ☐ Educational ☐ Limited ☐ Other:_____ *(please specify)*	☐ YES ☐ NO Expiration Date:
			☐ Full, unrestricted ☐ Temporary ☐ Educational ☐ Limited ☐ Other:_____ *(please specify)*	☐ YES ☐ NO Expiration Date:

Applicant Name: Emily Cassell Date: 3/23/16

Emily Cassell

TRAINING CERTIFICATE - MEDICINE OR OSTEOPATHIC MEDICINE
RESUME OF ACTIVITIES

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

☑ **Check here if you are a new graduate (within 3 months). You DO NOT need to complete this form.**

From / Month/Year To / Month/Year	Hospital/University name, Other or non-working activity Complete Number & Street Address City State/Country Zip Code	Position & Department	%Clinical %Admin.
From / Month/Year To / Month/Year	Hospital/University name, Other or non-working activity Complete Number & Street Address City State/Country Zip Code	Position & Department	%Clinical %Admin.
From / Month/Year To / Month/Year	Hospital/University name, Other or non-working activity Complete Number & Street Address City State/Country Zip Code	Position & Department	%Clinical %Admin.
From / Month/Year To / Month/Year	Hospital/University name, Other or non-working activity Complete Number & Street Address City State/Country Zip Code	Position & Department	%Clinical %Admin.
From / Month/Year To / Month/Year	Hospital/University name, Other or non-working activity Complete Number & Street Address City State/Country Zip Code	Position & Department	%Clinical %Admin.

Applicant Name: Emily Cassell Date: 3/23/16

From / Month/Year To / Month/Year	Hospital/University name, Other or non-working activity; Complete Number & Street Address; City State/Country Zip Code	Position & Department	%Clinical %Admin.
From / Month/Year To / Month/Year	Hospital/University name, Other or non-working activity; Complete Number & Street Address; City State/Country Zip Code	Position & Department	%Clinical %Admin.
From / Month/Year To / Month/Year	Hospital/University name, Other or non-working activity; Complete Number & Street Address; City State/Country Zip Code	Position & Department	%Clinical %Admin.
From / Month/Year To / Month/Year	Hospital/University name, Other or non-working activity; Complete Number & Street Address; City State/Country Zip Code	Position & Department	%Clinical %Admin.
From / Month/Year To / Month/Year	Hospital/University name, Other or non-working activity; Complete Number & Street Address; City State/Country Zip Code	Position & Department	%Clinical %Admin.
From / Month/Year To / Month/Year	Hospital/University name, Other or non-working activity; Complete Number & Street Address; City State/Country Zip Code	Position & Department	%Clinical %Admin.

Applicant Name: Emily Cassell Date: 3/23/16

TRAINING CERTIFICATE - MEDICINE OR OSTEOPATHIC MEDICINE
ADDITIONAL INFORMATION

If you answer "YES" to any of the following questions, you are required to furnish complete details, including date, place, reason and disposition of the matter. All affirmative answers must be thoroughly explained on a ***separate sheet of paper (DO NOT write explanations on these pages)***. Please note that some questions require very specific and detailed information. Make sure all responses are complete.

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

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

Applicant Name: Emily Cassell Date: 3/23/16

		YES	NO
10.	Have you ever been requested to appear before any board, bureau, department, agency, or other body, including those in Ohio, concerning allegations against you?	☐	☑
11.	Have you ever entered into an agreement of any kind, whether oral or written, with respect to a professional license, in lieu of or in order to avoid formal disciplinary action, with any board, bureau, department, agency, or other body, including those in Ohio?	☐	☑
12.	Have you ever been notified of any investigation concerning you by any board, bureau, department, agency, or other body, including those in Ohio, with respect to a professional license?	☐	☑
13.	Have you ever been notified of any charges, allegations, or complaints filed against you with, any board, bureau, department, agency, or other body, including those in Ohio, with respect to a professional license?	☐	☑
14.	Have you ever been denied, or have you ever surrendered, a state or federal controlled substance or drug registration; had it revoked, terminated, or restricted in any way; or been warned, reprimanded, or fined by, or been requested to appear before, the responsible agency?	☐	☑
15.	Have you ever pled guilty to, been found guilty of a violation of any law, or been granted intervention or treatment in lieu of conviction regardless of the legal jurisdiction in which the act was committed, other than a minor traffic violation? If yes, submit copies of all relevant documentation, such as police reports, ***certified*** court records and any institutional correspondence and orders. ***Photocopies will not be accepted.***	☐	☑
16	Have you ever been arrested or 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)? Please be advised that you are required to submit copies of all relevant documentation, such as police reports, ***certified*** court records and any institutional correspondence and orders. ***Photocopies will not be accepted***. If case has been expunged you must submit certified letter from court.	☐	☑
17.	Have you been a defendant in a legal action involving professional liability (malpractice), or had a professional liability claim paid on your behalf, or paid such a claim yourself? If yes, you must complete the enclosed malpractice claim information form. In addition, ask your malpractice insurance carrier(s) to provide a complete claims history report for the last 10 years to the State Medical Board of Ohio. If your current carrier has provided coverage for less than 10 years, ask your previous carrier to submit a claims history report to the Board.	☐	☑
18.	Have you ever been denied professional liability insurance or coverage, or had such insurance or coverage canceled, limited, or restricted in any way?	☐	☑
19.	Have you ever been denied or relinquished participation in any third party reimbursement program, whether governmental or private, including Medicaid and Medicare; or had such participation limited, restricted, suspended, or revoked; or been warned, reprimanded, requested to appear before, or fined by the responsible body?	☐	☑
20.	Have you ever been denied privileges, or had privileges revoked, suspended, restricted, reduced, or terminated by the Department of Defense, the Veteran's Administration, or any of their respective components?	☐	☑

Applicant Name: Emily Cassell Date: 3/23/16

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

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

* *

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

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

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

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

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

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

		YES	NO
	b) Are the limitations or impairments caused by your medical condition reduced or ameliorated because of the field of practice, the setting, or the manner in which you have chosen to practice? If yes, please explain.	☐	☐

Applicant Name: Emily Cassell Date: 3/23/16

MAY 13 2016

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

		YES	NO
24.	Do you use chemical substance(s) which in any way impair or limit your ability to practice medicine with reasonable skill and safety? If yes, please explain.	☐	☑
	a) Are the limitations or impairment caused by your use of chemical substances reduced or ameliorated because you receive ongoing treatment (with or without medication) or participate in a monitoring program? If yes, please explain.	☐	☐

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

		YES	NO
	b) Are the limitations or impairments caused by your use of chemical substances reduced or ameliorated because of the field of practice, the setting, or the manner in which you have chosen to practice? if yes, please explain.	☐	☐

* *

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

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

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

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

Applicant Name: Emily Cassell Date: 3/23/16

MEDICAL BOARD

MAY 1 3 2016

TRAINING CERTIFICATE - MEDICINE OR OSTEOPATHIC MEDICINE
AFFIDAVIT AND RELEASE OF APPLICANT

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

ss STATE OF: Ohio

COUNTY OF: Franklin

I, Emily Cassell, hereby certify under oath that I am the person named in this application for a training certificate in the State of Ohio; that all statements I have made or shall make with respect thereto are true, that I am the original and lawful possessor and person named in the various forms and credentials furnished or to be furnished to this Board with respect to my application; and that all documents, forms, or copies thereof furnished or to be furnished with respect to my application are strictly true in every respect.

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

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

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

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

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

I further understand that I must limit my activities under the certificate to the programs of the hospitals or facilities for which the training certificate is issued; and that I may train only under the supervision of the physicians responsible for supervision as part of the internship, residency, or clinical fellowship program.

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

Emily Cassell
Signature of Applicant

Subscribed and sworn to before me this 23 day of March 20 16.

Julia Gladstone
Signature of Notary Public

June 7 2016
Date Commission Expires

(NOTARY SEAL)

JULIA A. GLADSTONE
NOTARY PUBLIC
STATE OF OHIO
Comm. Expires
June 07, 2016
Recorded in
Franklin County

THIS FORM CANNOT BE FAXED

MEDICAL BOARD
MAY 13 2016

State Medical Board of Ohio

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

TRAINING CERTIFICATE - MEDICINE OR OSTEOPATHIC MEDICINE
CERTIFICATION OF TRAINING PROGRAM

I am applying for a training certificate in the State of Ohio. The State Medical Board of Ohio requires that this form be completed by the Ohio training program in which I will be training. Please complete the form and return it directly to the State Medical Board of Ohio at the above address.

THIS SECTION TO BE COMPLETED BY APPLICANT

Name of Applicant: Cassell (Last) Emily (First) Ann (Middle) ____ (Suffix (Jr., II))

THIS SECTION TO BE COMPLETED BY OHIO TRAINING PROGRAM

Name of Training Program: The Ohio State University Wexner Medical Center

Training Program Address: 395 W. 12th Avenue, 9th Floor
Street Address

Columbus (City) OH (State) 43210 (Zip Code)

Type of Program (check only one): ☐ Intern ☑ Resident ☐ Clinical Fellow

Specialty (*see reverse side*): OBG

CERTIFICATION DATES - Indicate the month, day and year for both the beginning and ending dates in which the training certificate is to be issued. **THE DATES ARE NOT TO EXCEED ONE YEAR.** If the application is received prior to the date of the appointment, the appointment date will be used. If the application is received after the appointment date, or is not completed until after the appointment date, the completion date will be the date the certificate will become effective.

Dates of Training (***not to exceed one year***): Beginning Date: MO/DAY/YR 6/20/16 Ending Date: MO/DAY/YR 6/20/17

I hereby certify that I have checked the credentials of the above applicant, that the statements, as completed, are true to the best of my knowledge and he/she is of good moral character. I further certify that he/she will limit his/her practice and training within the physical confines of the hospital, or facilities for which the training certificate to practice is sought and that he/she will practice only under the supervision of the attending medical staff of such hospital or facility for which the training certificate to practice is granted. I hereby recommend that the above applicant be granted the certificate herein applied for.

HOSPITAL SEAL

(If hospital has no seal, indicate and have form notarized)

Philip Samuels
Signature of Medical Director or Program Director

Philip Samuels, MD
Name (please print)

4-19-16
Date

MAY 13 2016

THIS FORM CANNOT BE FAXED

State Medical Board of Ohio

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

TRAINING CERTIFICATE - MEDICINE OR OSTEOPATHIC MEDICINE
FORM 1 - VERIFICATION OF MEDICAL EDUCATION
TO BE COMPLETED BY LCME OR AOA ACCREDITED SCHOOLS ONLY

THIS FORM IS NOT TO BE COMPLETED PRIOR TO GRADUATION

I am applying for a training certificate in the State of Ohio. The State Medical Board of Ohio requires that this form be completed by any medical or osteopathic schools I have attended. Please complete this form and return it *directly* to the State Medical Board of Ohio at the above address.

THIS SECTION TO BE COMPLETED BY APPLICANT

Full Name: Cassell (Last) Emily (First) Ann (Middle) _____ (Suffix (Jr., II))

Name of Medical/Osteopathic School: University of Cincinnati College of Medicine

Location: Cincinnati (City), Ohio (State)

I hereby authorize the above named medical/osteopathic school to furnish the information below to the State Medical Board of Ohio.

Emily A. Cassell (Signature of Applicant) 6/3/16 (Date)

THIS SECTION TO BE COMPLETED BY MEDICAL OR OSTEOPATHIC SCHOOL

Our records indicate that Cassell (Last), Emily (First) Ann (Middle) _____ (Suffix (Jr., II))

attended medical/osteopathic school From: 08 / 2012 (month/year) To: 05 / 2016 (month/year)

This individual *(check one)*:

☒ was awarded the degree of M.D. on 06 / 03 / 2016 (month/day/year)

☐ was not awarded a degree (please attach an explanation)

I, certify that the above information is an accurate account of the above named individual's official records maintained and is true and correct to my knowledge.

AFFIX INSTITUTIONAL SEAL

(If your institution does not have an official seal, please indicate and have form notarized)

Signature

Kimberly D. Schiesler
Name (please print)

Assistant Medical Registrar
Title

06/03/2016
Date

THIS FORM CANNOT BE FAXED

Date Posted: 4/18/2017 9:20:27 AM

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

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

Address Information

MAIN

1781 Northwest Blvd
Columbus, OH 43212
Franklin County
United States
(740) 398-0648
emily.cassell@osumc.edu

License Information

License Number 57.028595
License Name Emily Cassell

Fees

Relicensure Fee $35.00

========

Total Fees **$35.00**

TC-Change programs

1. Are you training at the program listed, **OR**, have you been appointed to the program listed for the next training year?

. . . . . YES

Discipline

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

. . . . . NO

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

. . . . . NO

3. Have you been disciplined or notified of an investigation of you by your training program for other than academic performance?

. . . . . NO

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

. . . . . NO

5. Have you had any clinical privileges or other authority to practice suspended or revoked by any institution or program or have you been placed on probation for any reason other than academic performance?

. . . . . NO

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

. . . . . NO

Social Security Number

1.

. . . . . REDACTED

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

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

Submission Date and Time: 6/8/2018 10:37 AM

License Renewal Application

License Type - Training Certificate (MD)

Personal Information

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

Title
Dr
First Name
Emily
Middle Name
Ann
Last Name
Cassell
Maiden Name
No Response
Social Security Number
REDACTED
Date of Birth
12/15/1989
Email Address
emily.cassell@osumc.edu
Phone Number
(740) 398-0648
Other Phone Number
No Response

Additional Information

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

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

Mt. Vernon

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.

Ohio State University Hospitals c/o Corporate Credentialing Office 700 Ackerman
Columbus
OH
43202
null

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.

Ohio State University Hospitals c/o Corporate Credentialing Office 700 Ackerman
Columbus
OH
43202
null

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?
Not Applicable
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:

Questions

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

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

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

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

Question - At any time since signing your last application for renewal of your certificate have you had any clinical privileges or other authority to practice suspended or revoked by any institution or program or have you been placed on probation for any reason other than academic performance?
Answer - No

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

Question - At any time since signing your last application for renewal of your certificate have you been disciplined or notified of an investigation of you by your training program for other than academic performance?
Answer - No

Question - Have you changed or are you planning to change the training, residency or clinical fellowship program that you have been appointed to in this State?
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.

Review + Submit

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

Application Review - Completed

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

Consent to Electronic Signature - **Consented**
Date/Time Stamp - 6/8/2018 10:37 AM
Type your First Name and Last Name as they appear on the application to sign electronically.
Emily Cassell
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.

Ohio State Medical Board of Ohio

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

Public Records of the State Medical Board of Ohio Concerning a Licensee or Applicant

LICENSURE RECORDS

- Original applications
- Renewal applications
- Correspondence concerning applications
- Address changes
- Name changes
- Any continuing medical education audit that may have been conducted; and
- Any request for licensure verification to be sent to another licensing agency.

MISCELLANOUS RECORDS

- Any records generated for a licensee's or applicant's request for public records.
- Any records generated for a licensee's or applicant's inquiry concerning a scope of practice question or Medical Board laws and rules.

The Medical Board's website contains a number of documents that might help you find records you seek. For example, the website contains a listing of the Medical Board's formal actions on a monthly basis, issues of the newsletter, and minutes of the Medical Board monthly meetings. The Medical Board can provide you with CDs of the Medical Board meeting minutes for additional years past.

DISCIPLINARY RECORDS

- Please note that some disciplinary records are available from the licensee/applicant's profile on the Ohio e-Licensure Center available from the Medical Board's website at https://license.ohio.gov/lookup/default.asp?division=78
- Notice of Opportunity for Hearing
- Board Order
- Consent Agreements
- Case Record File:
  - Notice of Opportunity for Hearing
  - Request for hearing
  - Scheduling letters
  - Motions
  - Entries
  - Report and Recommendation
  - Objections to the Report and Recommendation
  - Notice of appeal
  - Appellate decisions
- If there was a hearing:
  - Public version of hearing transcripts and exhibits
  - Excerpts of pertinent meeting minutes at which the formal action against the licensee/applicant was discussed
- If there was disciplinary action that included probationary terms, conditions, and limitations, there are probationary compliance records that may include:
  - Probationary modifications
  - Courses taken in compliance with the terms
  - Requests to leave Ohio
  - Approval of monitoring/supervising physician and/or treating physician
  - Requests for reinstatement
  - Audio of probationary office conferences
  - Reports from monitoring and/or supervising physicians, etc.