242203-17006
#330
#633
12/1/03

State Medical Board of Ohio

77 S. High St., 17th Floor • Columbus, OH 43215-6127 • (614) 466-3934 • Website: www.state.oh.us/med/

FOR BOARD USE ONLY		
BK:_____	PG:_____	LN:_____
DATE:_____	FEE: $335.00	PMT:_____

APPLICATION FOR CERTIFICATE - MEDICINE OR OSTEOPATHIC MEDICINE

PLEASE TYPE OR PRINT CLEARLY

☐ Check here if you wish to apply for a Telemedicine certificate

IDENTIFICATION

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): Lowenthal	First: Rebecca	Middle: –	Suffix (Jr., II): –
Name (As you prefer it inscribed on your Ohio license)	Last (Surname): Lowenthal	First: Rebecca	Middle: –	Suffix (Jr., II): –
Maiden Name or Other Names Used (If none, enter "NONE")	Last (Surname): NONE	First:	Middle:	Suffix (Jr., II):
Current Home Address IMPORTANT Notify the Board office immediately in writing of any change in address	Number and Street: 23105 Ranch Rd		Apt.:	
	City: Beachwood	State: OH	Zip Code: 44122	Country: USA
Telephone Number	Business: Area Code & Number (216) 778-7800		Home: Area Code & Number (216) 691-1656	
Birth Date	month/day/year: 12/07/70	**Birth Place** City: Minneapolis	State: MN	Country: USA
Physical Description	Height: 5'7"	Weight: 180	Hair Color: Brown	Eye Color: Hazel
	Identifying marks:			
Gender	☐ Male	☑ Female	For statistics only (optional)	

Are you or will you be in an accredited training program in Ohio? ☑ Yes ☐ No

If yes, please identify name of training program and location:

Metro Health Medical Center — Name of Hospital/Training Program

Cleveland OH — Location

Starting Date: 7/1/02 (month/day/year)

OVER ⇨

WRITTEN EXAMINATION

Indicate which licensing examination(s) you have passed:

- ☑ National Boards (MD or DO)
- ☑ USMLE Steps 1, 2, 3
- ☐ FLEX (Pre-1985)
- ☐ LMCC
- ☐ FLEX Components 1 & 2
- ☐ Other: explain:_____
- ☐ State Board exam:_____
  State & Date Taken (mo/yr)

LICENSES IN THE UNITED STATES AND CANADA

List ALL states/provinces in which you hold or have held a license to practice medicine and surgery or osteopathic medicine and surgery, including a temporary license, training certificate, educational permit, or other license or certificate, ***whether the license is current or <u>not</u>***. If additional space is needed, attach an extra sheet. **(If none, enter "N/A"). A Form 2, Verification of License, must be sent to each state listed.**

STATE/PROVINCE	ISSUE DATE (MO/YR)	LICENSE NO.	LICENSE CURRENT YES	LICENSE CURRENT NO	EXPIRE(S)
NONE N/A			☐	☐	
			☐	☐	
			☐	☐	
			☐	☐	
			☐	☐	
			☐	☐	
			☐	☐	
			☐	☐	

SPECIALTY BOARDS

NAME OF SPECIALTY BOARD (If none, enter "N/A")	YEAR CERTIFIED	COUNTRY
N/A		

CONTINUED ⇨

FEDERATION CREDENTIALS VERIFICATION SERVICE

Ohio requires verification of your core credentials directly through the Federation Credentials Verification Service (FCVS).

Have you completed and forwarded the FEDERATION CREDENTIALS VERIFICATION SERVICE (FCVS) application packet to FCVS? ☑ YES ☐ NO

If yes, date forwarded: 11/20/03 FCVS Packet ID Number (if known): 36154

ECFMG CERTIFICATE
(International Medical School Graduates only)

ECFMG Number		Date Issued		Expiration Date	

TEST OF SPOKEN ENGLISH
(International Medical School Graduates only)

THE TOEFL, TWE, ECFMG'S ENGLISH EXAM (PRIOR TO 7/1/98), ETC., ARE NOT EQUIVALENT AND CANNOT BE SUBSTITUTED FOR THE TEST OF SPOKEN ENGLISH

Graduates of medical schools located outside the United States and Canada must achieve a score of at least 40 (230 if taken prior to 7/95) on the Educational Testing Services Test of Spoken English (TSE), regardless of citizenship or country of birth, unless you meet one of the following:

	YES	NO
Have you completed two years of undergraduate college work in the United States?	☐	☐
Have you held a current medical license in the United States **AND** have you been actively practicing medicine in the United States for the **last five years**?	☐	☐
Have you been participating in a graduate medical education program and since that time held an unrestricted license and actively practiced medicine in the United States for **the last five years**?	☐	☐
Have you completed a Fifth Pathway program?	☐	☐
Have you passed the Clinical Skills Assessment examination given by ECFMG on or after July 1, 1998?	☐	☐

If you answered **NO** to all of the above questions you **must** take the TSE. Refer to the application instructions for contacting the Educational Testing Service. The Board cannot waive this requirement.

RESUME OF ACTIVITIES - MEDICINE OR OSTEOPATHIC MEDICINE

List ALL activities in chronological order beginning with 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", as well as your permanent address.* If in private practice, indicate the hospitals where you hold or have held privileges and include complete dates and addresses. If you worked for a physician staffing group or did locum tenens, you must list all facilities where you worked and include complete dates and addresses. **DO NOT SUBSTITUTE ANY OTHER RESUME FOR THIS FORM.** Be sure to indicate the percentage of working time spent in clinical and administrative duties. If you require more space, please attach separate sheets.

From Month/Year	Hospital, University or Other / Complete Street Address / City / State/Country / Zip Code	Position & Department	% Clinical / % Admin.
From Month/Year 7/02 To Month/Year /	METROHEALTH 2500 METROHEALTH DRIVE CLEVELAND OH 44109	FAMILY PRACTICE RESIDENT	100% /
From Month/Year / To Month/Year /			/
From Month/Year / To Month/Year /			/
From Month/Year / To Month/Year /			/
From Month/Year / To Month/Year /			/

OVER ⇨

LOWENTHAL REBECCA (NMN)

RESUME OF ACTIVITIES - MEDICINE OR OSTEOPATHIC MEDICINE

List ALL activities in chronological order beginning with 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", as well as your permanent address.* If in private practice, indicate the hospitals where you hold or have held privileges and include complete dates and addresses. If you worked for a physician staffing group or did locum tenens, you must list all facilities where you worked and include complete dates and addresses. **DO NOT SUBSTITUTE ANY OTHER RESUME FOR THIS FORM.** Be sure to indicate the percentage of working time spent in clinical and administrative duties. If you require more space, please attach separate sheets.

From Month/Year	To Month/Year	Hospital, University or Other / Complete Street Address / City / State/Country / Zip Code	Position & Department	% Clinical / % Admin.
7/02	present 12/03	METROHEALTH 2500 METROHEALTH DRIVE CLEVELAND OH 44109	Family Practice Resident	100%
/	/			
/	/			
/	/			
/	/			

OHIO STATE MEDICAL BOARD
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ADDITIONAL INFORMATION
MEDICINE OR OSTEOPATHIC MEDICINE

If you answer "YES" to any of the following questions, you are required to furnish complete details, including date, place, reason and disposition of the matter. All affirmative answers must be thoroughly explained on a separate sheet of paper. You must submit copies of all relevant documentation, such as court pleadings, court or agency orders, and institutional correspondence and orders. Please note that some questions require very specific and detailed information. Make sure all responses are complete.

(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?	☐	☑

OVER ⇨

		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?	☐	☑
16	Have you ever 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)?	☐	☑
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, include the case name, case number, court and address, date filed, and a summary of the underlying events. Indicate current status, including amount of settlement or judgment, if any. 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?	☐	☑

CONTINUED ⇨

		YES	NO
21.	Have you ever been diagnosed as having, or have you been treated for, pedophilia, exhibitionism, or voyeurism?	☐	☑
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? **You may answer "NO" to this question if** you hold a current training certificate to pursue training in Ohio and the only such medical condition is chemical dependency or substance abuse, and you have successfully completed or are currently receiving treatment at a program approved by this board and have adhered to all statutory requirements as contained in Sections 4731.224 and 4731.25, O.R.C., and related provisions. Any questions concerning approval can be directed to the board offices.	☐	☑
	a) Are the limitations or impairment caused by your medical condition reduced or ameliorated because you receive ongoing treatment or received treatment in the past (with or without medication) or participate in a monitoring program? If you receive such ongoing treatment or participate in such monitoring program the board will make an individualized assessment of the nature, severity, and duration of the risk associated with an ongoing medical condition so as to determine whether an unrestricted license should be issued, whether conditions should be imposed, or whether you are not eligible for licensure. Have each treating physician submit a letter detailing the dates of treatment, diagnosis and prognosis.	☐	☑
	b) Are the limitation or impairments caused by your medical condition reduced or ameliorated because of the field of practice, the setting, or the manner in which you have chosen to practice?	☐	☑

OVER ⇨

"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?	☐	☑
	a) Are the limitations or impairment caused by your use of chemical substances reduced or ameliorated because you receive ongoing treatment (with or without medication) or participate in a monitoring program? If you receive such ongoing treatment or participate in such monitoring program the board will make an individualized assessment of the nature, severity, and duration of the risk associated with an ongoing medical condition so as to determine whether an unrestricted license should be issued, whether conditions should be imposed, or whether you are not eligible for licensure. Have each treating physician submit a letter detailing the dates of treatment, diagnosis and prognosis.	☐	☑
	b) Are the limitation or impairments caused by your use of chemical substances reduced or ameliorated because of the field of practice, the setting, or the manner in which you have chosen to practice?	☐	☑

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

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

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

		YES	NO
25.	Are you currently engaged in the illegal use of controlled substances?	☐	☑
	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.	☐	☐

State Medical Board of Ohio

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FORM 1 - CERTIFICATE OF RECOMMENDATION MEDICINE OR OSTEOPATHIC MEDICINE

This form is to be completed by a physician fully licensed in the STATE IN WHICH THE FORM IS NOTARIZED. The recommending physician must have known the applicant for at least **SIX months**. Relatives may not serve as recommending physicians. Recommending physicians are strongly urged to include additional comments. **This form must be notarized by the recommending physician.** ALL questions must be answered. This form is not intended to standardize the recommendation or restrict it in any way. However, its form is designed to ensure that certain information is included. Please complete the form and return directly to the State Medical Board of Ohio at the above address.

DO NOT COMPLETE UNLESS A COLOR PHOTO OF APPLICANT IS ATTACHED TO THE BOTTOM OF THIS FORM
BLACK & WHITE PHOTOS ARE NOT ACCEPTABLE

I, Wayne Forde (recommending physician, print name), a licensed and practicing physician in the state of OH (state of residence),

affirm that Rebecca Lowenthal (applicant, print name) has been known to me personally for 2 years

and that he/she is of good moral character. Further, the photograph affixed hereto is a genuine likeness of the applicant. I offer the following in support of his/her application for licensure:

- I rate his/her medical knowledge and technique as: Good
- His/her relationship with patients is: Good
- I rate his/her ability to work well with peers and medical staff as: Good
- His/her command of the English language is: Good
- Additional comments: No Reservations

I hereby recommend the applicant for a license to practice medicine or osteopathic medicine in the State of Ohio.

Address of Recommending Physician	Number & Street: 2500 MetroHealth Dr. City: Cleveland State: OH Zip Code: 44109	Telephone Number (include area code)	216-778-8085
Signature of Recommending Physician (name stamps not acceptable)	Wayne Forde	State of Licensure & License Number	35073283F

Signature of Applicant

Date Photo Taken: 6/03 (Mo/Yr)

Subscribed and sworn to before me this 21st day of October, 2003.

Catherine McFadden Rutti

Notary Public Signature

July 29, 2004

Date Commission Expires

CATHERINE MCFADDEN RUTTI
NOTARY PUBLIC, STATE OF OHIO
NOTARY SEAL
Recorded in Cuyahoga County
My Comm. Expires Jul. 29, 2004

OHIO STATE MEDICAL BOARD
NOV 28 2003

State Medical Board of Ohio

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FORM 1 - CERTIFICATE OF RECOMMENDATION
MEDICINE OR OSTEOPATHIC MEDICINE

This form is to be completed by a physician fully licensed in the STATE IN WHICH THE FORM IS NOTARIZED. The recommending physician must have known the applicant for at least **SIX months**. Relatives may not serve as recommending physicians. Recommending physicians are strongly urged to include additional comments. **This form must be notarized by the recommending physician**. ALL questions must be answered. This form is not intended to standardize the recommendation or restrict it in any way. However, its form is designed to ensure that certain information is included. Please complete the form and return directly to the State Medical Board of Ohio at the above address.

DO NOT COMPLETE UNLESS A COLOR PHOTO OF APPLICANT IS ATTACHED TO THE BOTTOM OF THIS FORM
BLACK & WHITE PHOTOS ARE NOT ACCEPTABLE

I, Dr Christina Antenucci (recommending physician, print name), a licensed and practicing physician in the state of OHIO (state of residence),

affirm that Rebecca Lowenthal (applicant, print name) has been known to me personally for 2 (two) years

and that he/she is of good moral character. Further, the photograph affixed hereto is a genuine likeness of the applicant. I offer the following in support of his/her application for licensure:

- I rate his/her medical knowledge and technique as: excellent
- His/her relationship with patients is: excellent
- I rate his/her ability to work well with peers and medical staff as: excellent
- His/her command of the English language is: fluent
- Additional comments: She is an excellent, skilled physician

I hereby recommend the applicant for a license to practice medicine or osteopathic medicine in the State of Ohio.

Address of Recommending Physician	Number & Street: 3380 Chalfant Rd City: Shaker Ht · State: OH · Zip Code: 44120	Telephone Number (include area code)	H 216 767 0304 W 216 778 5731
Signature of Recommending Physician (name stamps not acceptable)	Antenucci MD	State of Licensure & License Number	OH 35 07 6277A

Signature of Applicant: R L Lowen

Date Photo Taken: 6/03 (Mo/Yr)

Subscribed and sworn to before me this 21st day of October, 2003.

Cathie McFadden Rutti
Notary Public Signature

July 29, 2004
Date Commission Expires

OHIO STATE MEDICAL BOARD
NOV 28 2003

CATHERINE MCFADDEN RUTTI
NOTARY PUBLIC, STATE OF OHIO
NOTARY SEAL
Recorded in Cuyahoga County
My Comm. Expires Jul. 29, 2004

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MEDICINE OR OSTEOPATHIC MEDICINE
PRELIMINARY EDUCATION FORM

TO BE COMPLETED BY ALL APPLICANTS

Full Name	Last (Surname)	First	Middle	Suffix (Jr., II)
	LOWENTHAL	REBECCA	-	-

High School or Equivalent

School Name: SHAKER HTS HIGH SCHOOL

City: SHAKER HTS | State: OH | Country: USA

Dates Attended From: MO/YR 9/84 To: MO/YR 6/88

Undergraduate College or Equivalent

School Name: GRINNELL COLLEGE

City: GRINNELL | State: IA | Country: USA

Dates Attended From: MO/YR 9/88 To: MO/YR 5/92 | Degree Received: B.A.

School Name: BOSTON UNIVERSITY

City: BOSTON | State: MA | Country: USA

Dates Attended From: MO/YR 9/95 To: MO/YR 8/96 | Degree Received: MPH

Medical or Osteopathic School of Graduation

School Name: JOHNS HOPKINS MEDICAL SCHOOL

City: BALTIMORE | State: MD | Country: USA

Dates Attended From: MO/YR 9/96 To: MO/YR 5/02 | Degree Received: MD

FOR BOARD USE ONLY

CERTIFICATE OF PRELIMINARY EDUCATION

NO: 104624 DATE ISSUED: 12/23/03

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

Entrance Examiner

Secretary

OHIO STATE MEDICAL BOARD
NOV 28 2003

24203-17006

MEDICINE OR OSTEOPATHIC MEDICINE
PRELIMINARY EDUCATION FORM

TO BE COMPLETED BY ALL APPLICANTS

Full Name	Last (Surname)	First	Middle	Suffix (Jr., II)
	LOWENTHAL	REBECCA	-	-

High School or Equivalent

School Name: SHAKER HTS HIGH SCHOOL

City: SHAKER HTS | State: OH | Country: USA

Dates Attended From: MO/YR 9/84 To: MO/YR 6/88

Undergraduate College or Equivalent

School Name: GRINNELL COLLEGE

City: GRINNELL | State: IA | Country: USA

Dates Attended From: MO/YR 9/88 To: MO/YR 5/92 | Degree Received: BA

School Name: BOSTON UNIVERSITY

City: BOSTON | State: MA | Country: USA

Dates Attended From: MO/YR 9/95 To: MO/YR 8/96 | Degree Received: MPH

Medical or Osteopathic School of Graduation

School Name: JOHNS HOPKINS MEDICAL SCHOOL

City: BALTIMORE | State: MD | Country: USA

Dates Attended From: MO/YR 9/96 To: MO/YR 5/02 | Degree Received: MD

FOR BOARD USE ONLY

CERTIFICATE OF PRELIMINARY EDUCATION

NO:_____ DATE ISSUED:_____

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

_____ Entrance Examiner

_____ Secretary

OHIO STATE MEDICAL BOARD

NOV 28 2003

AFFIDAVIT AND RELEASE OF APPLICANT
MEDICINE OR OSTEOPATHIC MEDICINE

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

ss STATE OF: Ohio

COUNTY OF: Cuyahoga

I, Rebecca Lowenthal, hereby certify under oath that I am the person named in this application for a license to practice medicine or osteopathic medicine in the State of Ohio; 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 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 license to practice medicine or osteopathic medicine 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 a license to practice 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 license to practice medicine or osteopathic medicine 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 occurs at any time prior to a license to practice medicine or osteopathic medicine 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 license to practice medicine or osteopathic medicine 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 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 issuance of a certificate to practice medicine or osteopathic medicine in Ohio will be considered based 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.

R Lowenthal

Signature of Applicant

Subscribed and sworn to before me this 13th day of October 20 03.

Carole E Grady

Signature of Notary Public

(NOTARY SEAL)

CAROLE E. GRADY
NOTARY PUBLIC, STATE OF OHIO
Recorded in Cuyahoga County
My Comm. Expires Nov. 25, 2008

Date Commission Expires

State Medical Board of Ohio

77 S. High St., 17th Floor • Columbus, OH 43215-6127 • (614) 466-3934 • Website: www.state.oh.us/med/

December 15, 2003

Rebecca Ann Lowenthal MD
23105 Ranch Road
Beachwood, OH 44122

Your application for Ohio licensure has been reviewed. As of this date the following has not been completed/received:

We have not received your core credentials packet from the Federation Credentials Verification Service (FCVS). To inquire about the status of your core credentials packet contact FCVS at (888) 275-3287. You may also check the status of your FCVS application by logging onto their website. Their website address is www.fsmb.org/. Click on "Credentials Verification Service" then "FCVS Online Application" and follow the instructions given.

We have not received the Physician Profile from the American Medical Association (AMA). If you have already requested this information contact the AMA at (800) 665-2882 or (312) 464-5199 to inquire about the status of your profile. The profile may also be ordered from the AMA website. Their website address is www.ama-assn.org/AMAPhysicianProfiles.

Your Resume of Activities was not completed properly. Indicate your activities from 8/02 to the present time on the enclosed copy of your resume.

ALL RESPONSES MUST BE IN WRITING. NO INFORMATION WILL BE TAKEN BY PHONE.

Periodically during the license application process the Licensure Department will send you status updates to keep you informed of the progress of your application. You may also inquire about the status of your application by e-mailing the Board at the e-mail address listed below.

The application processing time is ordinarily 10 to 12 weeks after receipt of an application by the Board. An incomplete application or any unusual circumstances may delay processing time.

Be sure to notify the Board, in writing, of any address change.

Thank you,

Licensure Department

Direct Dial (614) 728-3055
Fax (614) 644-1464
E-Mail Address: Penny.Grubb@med.state.oh.us

The Federation of State Medical Boards of the United States, Inc.
Federation Credentials Verification Service
P.O. Box 619850
Dallas, Texas 75261-9850
Telephone: (817) 868-4000
Fax: (817) 868-4099

Physician Information Profile

This report is compiled exclusively for:

Name:	**Rebecca Lowenthal**
SSN:	Redacted
DOB:	**12/07/1970**
Recipient:	**State Medical Board of Ohio**

NOTICE:

The Federation Credentials Verification Service (FCVS) was retained by the above referenced physician 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. All documents bearing the official FCVS seal are ceritified 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.

Physician Information Profile is compiled and published by the Federation of State Medical Boards of the United States, Inc. as a reference source for its member boards and other authorized entities. Physician Information Profile may not be republished, sold, resold or duplicated, in whole or in part, for commercial or any other purposes, or for purposes of compiling lists or files without the express written consent of the Federation's Executive Vice President as authorized by its Board Of Directors. The use of this Physician Information Profile to establish independent data files or compendiums or information is strictly prohibited.

Table of Contents

Section I

FCVS Reports

FEDERATION CREDENTIALS VERIFICATION SERVICE

Physician Information Report

Identity:

Name:	**Rebecca Lowenthal**	
Other Name Used:	**N/A**	
Gender:	**Female**	
Date of Birth:	**12/07/1970**	
Place of Birth:	**Minneapolis, MN USA**	
SSN:	Redacted	
Current Address:	**14302 Shaker Boulevard** **Shaker Heights, OH 44120**	
Permanent Address:	**Same**	
Telephone Numbers:	Bus:	**216-778-7800**
	Fax:	**N/A**
	Home:	**216-561-2053**
	Other:	**N/A**
Physical Description:	Height:	**5' 07"**
	Weight:	**185 lbs**
	Eye Color:	**Hazel**
	Hair Color:	**Brown**
Physical Marks:	Description:	**N/A**
	Location:	**N/A**

Premedical Education (Reported by physician. Not verified by FCVS)**:**

Institution:	**Grinnell College, Grinnell, IA 50112**
Dates of Attendance:	**09/1988 - 05/1992**
Degree Awarded:	**Bachelor of Arts**

Medical Education:

Current, valid ECFMG	**N/A**
ECFMG Number:	**N/A**
Date Issued:	**N/A**
Medical School:	**Johns Hopkins University School of Medicine** **720 Rutland Avenue Room 119** **Baltimore, MD 21205**
Dates of Attendance:	**09/03/1996 - 05/22/2002**
Graduation Date:	**05/23/2002**
Degree Awarded:	**Doctor of Medicine**
Unusual Circumstance:	**Leave** **See Form**

Post Graduate Medical Education:

Institution:	**MetroHealth Medical Center** **Department of Family Practice** **2500 MetroHealth Drive** **Cleveland, OH 44109-1998**
Post Graduate Year:	**1**
Program Type:	**Internship**
Department:	**Family Practice**
Dates of Attendance:	**06/23/2002 - 06/22/2003**
Completion:	**Yes**
Accreditation:	**ACGME**
Post Graduate Year:	**2**
Program Type:	**Residency**
Department:	**Family Practice**
Dates of Attendance:	**07/01/2003 - 06/30/2004**
Completion:	**To Be Completed On 06/30/2004**
Accreditation:	**ACGME**
Unusual Circumstance:	**None**

Fifth Pathway:

N/A

Examination History:

Transcripts Enclosed For:	**USMLE Step 1** **USMLE Step 2** **USMLE Step 3**

Board Action:

A Report of the results from a search of the Board Action Data Bank is enclosed.

Omission / Discrepancy Report

Physician Identification:

Name:	Rebecca Lowenthal
DOB:	12/07/1970
SSN:	Redacted
Packet ID:	36154
Request ID:	12546067

REPORT OF OMISSIONS

Omission 1:

Section of Profile:	**Medical Education**
Omission:	Johns Hopkins U Sch Med did not respond to the Credential/Degree question in the Premedical Education section of the Medical Education form.
Follow-Up:	Left to Recipient`s discretion.

Omission 2:

Section of Profile:	**Medical Education**
Omission:	Johns Hopkins U Sch Med did not report the date of signature on the Medical Education form.
Follow-Up:	FCVS received the completed verification form on 12/01/2003.

REPORT OF DISCREPANCIES

Discrepancy 1:

Section of Profile:	**Medical Education**
Discrepancy:	The applicant responded Yes to the Limits questions(s) in the Unusual Circumstances Section of the application for attendance at Johns Hopkins U Sch Med (documentation provided). The institution responded Yes to the Leave question(s) in the Unusual Circumstances Section of the verification form.
Follow-Up:	See Comments on Verification of Medical Education Form. A copy of the FCVS application page reporting unusual circumstances at this institution is included following the Medical Education form.

Discrepancy 2:

Section of Profile:	**Examination History**
Discrepancy:	The applicant reports sitting for USMLE Steps 1, 2, and 3 as `Dates Unknown`. The USMLE transcript reports the examination dates were 06/28/2001, 10/01/2001, and 07/08/2003; respectively.
Follow-Up:	Left to Recipient`s discretion.

MISCELLANEOUS INFORMATION

Miscellaneous 1:

Section of Profile:	**Continuity of Education**
Issue:	There is a gap of approximately 4 years between completion of premedical education at Grinnell College (ends 05/1992) and entrance into medical school at Johns Hopkins U Sch Med (begins 09/03/1996).
Follow-Up:	Provided as information only. No follow up performed.

End of report for Rebecca Lowenthal

Packet Id: 36154 Request Id: 12546067 Report Created By: AAB

Board Action Databank Search

State Queried For:	**State Medical Board of Ohio**
Physician's Name:	**Lowenthal, Rebecca**
Date of Birth:	**12/07/1970**
Medical School:	**021010 - Johns Hopkins U Sch Med**
Year of Graduation:	**2002**
Social Security Number:	Redacted
ECFMG Number:	**N/A**

Results:

WE HAVE NO UNFAVORABLE INFORMATION
REGARDING THE ABOVE NAMED PHYSICIAN

DEC 19 2003

DALE L. AUSTIN
SENIOR VICE PRESIDENT
AND CHIEF OPERATING OFFICER

Section II

Identity

AFFIDAVIT AND RELEASE

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 read and understand the "INSTRUCTIONS FOR COMPLETING THE FCVS APPLICATION" and have answered all questions contained in the application truthfully and completely. I further acknowledge that failure on my part to answer questions truthfully and completely may lead to my being prosecuted under appropriate federal and state laws.

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

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

R Lowenthal

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

Lowenthal

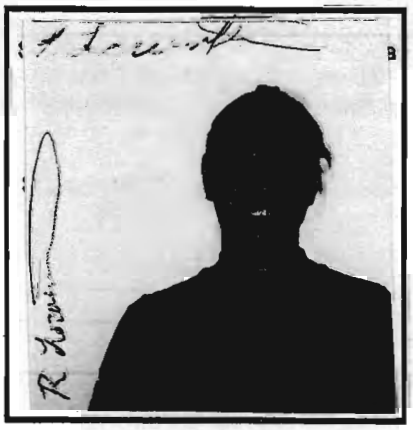
Applicant's **Printed** Last Name

Rebecca

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

10/22/03

Date of Signature (must correspond to date of notarization)



State of Ohio, County of Cuyahoga,
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 22nd day of October, 2003.

Notary Public signature: Carole E Grady

CAROLE E. GRADY
NOTARY PUBLIC, STATE OF OHIO
Recorded in Cuyahoga County
My Comm. Expires Nov. 14, 2003

My commission expires:

Notary:
The Physician has been instructed to sign the front of the photograph. Your seal (or stamp) must be partly upon the photo and partly upon the signature of the applicant.

Federation Credentials Verification Service

MINNESOTA DEPARTMENT OF HEALTH
Section of Vital Statistics

CERTIFICATE OF LIVE BIRTH

174

LOCAL FILE NUMBER — STATE FILE NUMBER

1. CHILD – NAME: Rebecca NMN Lowenthal			2a. DATE OF BIRTH: December 7, 1970		2b. HOUR: cst 1:48 am
3. SEX: Female	4a. THIS BIRTH SINGLE, TWIN, TRIPLET ETC.: Single	4b. IF NOT SINGLE BIRTH, BORN FIRST, SECOND, ETC.		5a. COUNTY OF BIRTH: Hennepin	
5b. LOCATION OF BIRTH CITY, VILLAGE OR TOWNSHIP: Minneapolis	5c. INSIDE CORPORATE LIMITS: Yes	5d. HOSPITAL – NAME (IF NOT IN HOSPITAL, GIVE STREET AND NUMBER): Northwestern Hospital			
6a. FATHER – NAME: Gilbert NMN Lowenthal			6b. AGE (AT TIME OF THIS BIRTH): 31	6c. BIRTHPLACE (STATE OR FOREIGN COUNTRY): Massachusetts	
7a. MOTHER – MAIDEN NAME: Carol Avonne Cross			7b. AGE (AT TIME OF THIS BIRTH): 28	7c. BIRTHPLACE (STATE OR FOREIGN COUNTRY): Missouri	
8a. RESIDENCE OF MOTHER – STATE: Minnesota	8b. COUNTY: Hennepin		8c. CITY, VILLAGE OR TOWNSHIP: Minneapolis		8d. INSIDE CORPORATE LIMITS: Yes
9. ADDRESS OF MOTHER STREET AND NUMBER: 1618 Calhoun Place	POST OFFICE: 55408	10. I CERTIFY THAT THIS CERTIFICATE IS CORRECT: x Carol Avonne Lowenthal (SIGNATURE OF PARENT)			
11a. CERTIFICATION I CERTIFY THAT I ATTENDED THE BIRTH OF THIS CHILD WHO WAS BORN ALIVE AT THE PLACE AND ON THE DATE STATED ABOVE. SIGNATURE: D L Hill		11b. DATE SIGNED: 8 Dec 70		11c. ATTENDANT (M.D., D.O., MIDWIFE, OTHER) SPECIFY: M.D.	
11d. CERTIFIER – NAME (TYPE OR PRINT): D. Hill, M.D.		11e. MAILING ADDRESS STREET AND NUMBER: 312 Doctors Building		POST OFFICE: 55402	
12a. REGISTRAR – SIGNATURE: Eleanor M. Parker		DEPUTY: Minneapolis	12b. DATE FILED: DEC 16 1970		

I, Ruth M. Carroll, Deputy Local Registrar of Vital Records for the City of Minneapolis, Minnesota, hereby certify that the above is a true and correct photo-copy of the record on file in the Minneapolis Health Department.

Dated: APR 5 1977

Ruth M. Carroll
Deputy Local Registrar

SEAL VERIFIED

Any alterations shown were made under the authority of Minnesota Statutes 1969, Section 144.172 and the regulations of the State Board of Health.

Section III

Medical Education

FEDERATION CREDENTIALS VERIFICATION SERVICE (FCVS)

VERIFICATION OF MEDICAL EDUCATION

(This form must be completed by the medical school)

INSTRUCTIONS TO THE DEAN

The individual identified on the attached Authorization For Release of Information, Documents and Records form has authorized your medical school to provide to the Federation Credentials Verification Service (FCVS) any and all information pertaining to their education at your institution. **Please complete this form and forward it to FCVS in the enclosed postage-paid, self-addressed envelope.**

Please note: If your institution processes transcript requests through another office, FCVS has likely made such a request under separate cover. **If your office also processes transcript requests, please attach the individual's official transcript (which indicates courses taken, dates and hours of attendance, and scores, grades, or evaluation).**

VERIFICATION OF MEDICAL EDUCATION

Name of Institution: Johns Hopkins University School of Medicine

Complete Address: 733 N. Broadway, Sute 147

Street Address:

City: Baltimore **State:** MD **ZIP Code (Postal Code):** 21205

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

Premedical Education:

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

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

Enrollment and Participation: Our records indicate that Rebecca Lowenthal
(type/print individual's name: Last, First, Middle, Suffix)

attended our medical school for total of *180 weeks of medical education on the following dates (mm/dd/yy):

From *9 (Month) / 3 (Date) / 1996 (Year) **To** *5 (Month) / 22 (Date) / 2002 (Year)

9/3/96-6/9/97 & 9/2/97-6/12/98: Required to repeat First year. 3/1/01-2/28/02: Student-In

This individual (check one): Residence status to participate in Emergency Medicine Research with Dr. Michael Van Rooyen, JHUSOM

[XX] was awarded the degree of Doctor of Medicine on 5 (Month) / 23 (Date) / 2002 (Year)

[ ] was NOT awarded a degree (please attach an explanation)

Certification: By my signature, I, Mary E. Foy (type/print name), certify that the above information is an accurate account of the above named individual's official records maintained in this and is true and correct to my knowledge.

SEAL VERIFIED

Affix Institutional Seal Here. If no seal is available, this form must be notarized.

Signature:

Title: Associate Dean/Registrar

Date of Signature:

Phone: (410) 955-3080 **Fax:** (410) 955-0826

Email: mfoy@jhmi.edu

VERIFICATION OF MEDICAL EDUCATION

Unusual Circumstances: The following questions apply to unusual circumstances that occurred during any part of the individual's medical education. Please check the appropriate response and provide dates and requested information. "Yes" responses to any of these questions require a copy of explanatory records or a written explanation (attach additional pages as necessary).

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

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

	From Mo/Yr	To Mo/Yr	Approved	Unapproved
Personal/Family			☐	☐
Academic remediation			☒	☐
Health			☐	☐
Financial			☐	☐
Participation in joint degree Program (e.g., MD/PhD)			☐	☐
Participation in non-research special study (e.g., fellowship, international experience)			☐	☐
Participation in non-degree research			☐	☐
Other			☐	☐

   Please Specify: Required to repeat First year

2. Do this individual's official records reflect that he/she was ever placed on academic or disciplinary probation during his/her medical education? Response YES ☐ NO ☒

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

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

   Please specify reason: _____

3. Do this individual's official records reflect that he/she was ever disciplined for unprofessional conduct/behavioral reasons by the medical school or parent university? Response YES ☐ NO ☒

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

4. Do this individual's official records reflect that he/she was ever the subject of negative reports or an investigation by the medical school or parent university? Response YES ☐ NO ☒

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

5. Do this individual's official records reflect that there were any limitations or special requirements imposed on the individual because of questions of academic imcompetence, disciplinary problems, or any other reason?
   Response YES ☐ NO ☒

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

Medical Education:

Medical School:	021010 - Johns Hopkins University School of Medicine 720 Rutland Avenue Room 119 Baltimore, MD 21205
Date of Attendance:	09/1996 - 05/2002
Graduated?:	Y
Graduation Date:	05/23/2002
Degree Awarded:	Doctor of Medicine
Airborne Express # (Foreign):	
Return via Airborne Express:	

Unusual Circumstances:

Leave:	N
Probation:	N
Discipline:	N
Negative Reports:	N
Limitations:	Y

repeated the first year of medical school

THE JOHNS HOPKINS UNIVERSITY
SCHOOL OF MEDICINE
Baltimore, Maryland 21205

CONFIDENTIAL RECORD
If you have no further use for this record please return it to the Johns Hopkins University School of Medicine but under no circumstances to the student

Office of the Registrar
720 Rutland Avenue

Transcript record of REBECCA LOWENTHAL
B.A,, Grinnell College, 1992
M.P.H., Boston University, 1996

First Year 9/3/96-6/9/97 &*9/2/97-6/12/98

	HOURS	GRADE
Organ Systems (inc. Immunology)	255	C
Human Anatomy (inc. Dev. Biol.)	242	C
Molecules and Cells	228	C
Neuroscience /Behavior Sci.	191	C
Introduction to Medicine I	76	P
Physician & Society	76	A
Clinical Epidemiology	52	B

*Required to Repeat First Year

Second Year 9/1/98-5/26/99

	HOURS	GRADE
Human Pathophysiology	328	B
Pathology	237	C
Introduction to Medicine II-Clinical Skills	128	B
Pharmacology	85	B
Physician & Society	50	A

Third Year 9/8/99- 6/2/00

Fourth Year 9/6/00-2/28/01 & 3/1/02-5/22/02

	HOURS	GRADE	ACADEMIC YEAR	QUARTER
Required Clerkships				
Surgery	351	B-	1998-99	4th
Medicine	351	B-	1999-00	1st
Pediatrics/Neonatology	351	C+	Summer, 1999	---
Gynecology/Obstetrics	234	B	2000-01	2nd
Psychiatry	159	B	2000-01	3rd
Neurology	159	B	2000-01	1st
Ophthalmology	33	P	2000-01	3rd
Emergency Medicine	175	B+	Summer, 2000	---
Ambulatory Internal Medicine	175	B	Summer, 2000	---
Physician & Society (3rd. yr.)	39	A	1999-00	1st-4th
Physician & Society (4th. yr.)	39	A	2001-02	1st-4th
Rational Therapeutics	39	A	2000-01	1st-4th

Grading System: See attached key

Remarks: Received the degree Doctor of Medicine on May 23, 2002.

SEAL
VERIFIED

Transcript of record of RE[illegible]CA LOWENTHAL

* = Elective graded under Honors, Pass, Fail system.
Elective [illegible]es listed without * indicates taken under
High Ho[illegible]s, Honors, Pass, Fail system.

ELECTIVE PROGRAM	QUARTER & YEAR	HOURS	GRADE
Clinical Clerkship in Endocrinology-Consult Service Dept. - Medicine Preceptor - Dr. P. Ladenson	Summer 1999	175	
Elective in Tropical Medicine Dept. - Internationl Health, JHUSPH Preceptor - Dr. R. Gilman	Qtr. 2 1999-00	351	P
Subinternship in Geriatric Medicine Dept. - Medicine, Bayview Preceptor - Dr. M. Bellantoni	Qtr. 3 1999-00	175	P
Advanced Clinical Clerkship in Rheumatology Dept. - Medicine, Good Samaritan Hospital Preceptor - Dr. C. Ziminski	Qtr. 3 1999-00	175	P
Diagnostic Radiology Tutorial Dept. - Radiology Preceptor - Dr. D, Magid	Qtr. 4 1999-00	175	P
Clinical Clerkship in Family Practice Dept. - Family Practice-Case Western Reserve, Medical School, Willoughby, OH Preceptor - Dr. R. Whitehouse	Qtr. 4 1999-00	175	H
Subinternship in Emergency Medicine Dept. - Emergency Medicine Preceptor - Dr. B. Blok	Qtr. 1 2000-01	175	H
Clinical Clerkship in Outpatient Cardiology Dept. - Medicine Preceptor - Dr. R. Riley	Qtr. 2 2000-01	117	H
Clinical Clerkship in Anesthesiology Dept. - Anesthesiology & Critical Care Medicine Preceptor - Dr. J. Kirsch	Qtr. 3 2001-02	78	P
Ultrasound Elective Dept. - Radiology Preceptor - Dr. U. Hamper	Qtr. 3 2001-02	78	
Clinical Clerkship in Emergency Medicine Dept. - Emergency Medicine, Summa Health System, Akron, OH Preceptor - Dr. S. Jwayyed	Qtr. 2 2001-02	137	H
3/1/01-2/28/02 Student-in-Residence status to participate in Emergency Medicine Research with Dr. Michael VanRooyen, Johns Hopkins University School of Medicine			
PH.223.666.11: Health and Medicine in Tropics	Summer 1997	---	A

NOT OFFICIAL UNLESS SIGNED AND IMPRESSED WITH THE SEAL OF THE UNIVERSITY

NOVEMBER 20, 2003

RECEIVED
DEC 01 2003
BY

Mary E. Foy, Associate Dean/Registra

JOHNS HOPKINS
UNIVERSITY

School of Medicine

119 Medical Administration Building
720 Rutland Avenue / Baltimore MD 21205-2196
(410) 955-3080 / FAX (410) 955-0826

Office of the Dean
Registrar

KEY TO TRANSCRIPT
MD Graduates 1981-2003

GRADING SYSTEM – Effective March 30, 1981 through March 31, 2002 (Qtr. 3, 2001-02)

Grades in required courses and basic clerkships are designated A, B, C, D, and F (fail).
(+/- modifiers used for basic clerkships for Classes of 2001, 2002 and 2003, if taken before Qtr. 3 2002)

The A grade indicates exceptional performance, the
B grade indicates good to very good performance, the
C grade indicates satisfactory performance, the
D grade indicates that minimal course requirements have been fulfilled but that the achievement was marginal (grade initiated in March, 1981), the
F grade indicates failure to attain course requirements.

Grades in elective courses are given on an Honors-Pass-Fail basis. High Honors was added to the elective course grading system for graduates in the classes of 2001 and 2002.

GRADING SYSTEM - Effective April 1, 2002 (Qtr. 4, 2001-02)

Grades in required courses and basic clerkships are designated as follows: Honors(H), High Pass(HP), Pass(P), and Fail(F).

The	Honors	grade is awarded if a student demonstrates outstanding performance in all components of a course with achievement beyond the expected level of training, or extraordinary effort beyond the basic requirements of the curriculum. This grade identifies those students who have been consistently outstanding in their scholarship and professionalism.
The	High Pass	grade is awarded if a student has demonstrated an excellent performance.
The	Pass	The faculty are aware of the intellectual achievement of the students and have designed a rigorous and challenging curriculum. Students who fulfill requirements at the passing level are to be congratulated for this achievement.
The	Fail	grade is used for students who have failed to meet the minimum performance requirements of the coursework/clerkship as defined by the course director.

Honors- Pass-Fail grading is used occasionally in a required course, when in the judgement of the course director, the available information is insufficient for the finer distinctions needed for letter grades.

An Incomplete (Inc.) is given in lieu of a grade when a student has not completed all components of a course.

Advanced Placement (AP) is awarded to students who show evidence of satisfactory knowledge of the material of a required course.

7530

The Johns Hopkins University

Upon the recommendation of the Faculty of

THIS IS A TRUE AND EXACT COPY OF THE DIPLOMA AWARDED TO REBECCA LOWENTHAL ON MAY 23, 2002.

Mary E. Foy, Associate Dean/Registrar

The School of Medicine

has conferred upon

Rebecca Lowenthal

the degree of

Doctor of Medicine

with all the rights, honors and privileges appertaining thereto.

Given under the seal of the University at Baltimore, Maryland on May twenty-third, two thousand and two.

SEAL VERIFIED

Edward D. Miller, M.D.
Dean

William R. Brody
President

A. J. Mason
Chairman of the Board of Trustees

Section IV

Postgraduate Training

Federation Credentials Verification Service (F)

Federation Place, P.O. Box 619850, Dallas, TX 75261-9850
Tel: (817) 868-5000 Fax: (817) 868-5099

Verification of Postgraduate Medical Education

Institution: **MetroHealth Medical Center**

Address: Department of Family Practice
Cleveland, OH 44109-1998

Attention: Program Director

University: Case Western Reserve University, School of Medicine

Verification For:

Name: **Lowenthal, Rebecca**
SSN: Redacted
DOB: **12/07/1970**

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

Program Participation:
Important:
Report incomplete postgraduate years (PGY) separate from those that were successfully completed.

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

Report Internships, Residencies and Fellowships separately.

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

Section 1
PGY: 1
✓ Internship
__ Residency
__ Fellowship
__ Research

Department/Specialty: Family Practice
From: 6 / 23 / 02 To: 6 / 22 / 03
Successfully Completed?: ✓ Yes __ No __ In Progress
Accredited by: ✓ ACGME __ AOA __ LCGME __ RSC __ CFPC __ RCPSC __ APPAP __ None of these

Section 2
PGY: 2
__ Internship
✓ Residency
__ Fellowship
__ Research

Department/Specialty: Family Practice
From: 7 / 1 / 03 To: 6 / 30 / 04
Successfully Completed?: __ Yes __ No ✓ In Progress
Accredited by: ✓ ACGME __ AOA __ LCGME __ RSC __ CFPC __ RCPSC __ APPAP __ None of these

Section 3
PGY: ____
__ Internship
__ Residency
__ Fellowship
__ Research

Department/Specialty: ____
From: __/__/__ To: __/__/__
Successfully Completed?: __ Yes __ No __ In Progress
Accredited by: __ ACGME __ AOA __ LCGME __ RSC __ CFPC __ RCPSC __ APPAP __ None of these

Unusual Circumstances:
Circle the correct response. Omitted responses require written explanation.

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

Did this individual ever take a leave of absence or break from his/her training? Yes (No)
Was this individual ever placed on probation? Yes (No)
Was this individual ever disciplined or placed under investigation? Yes (No)
Were any negative reports ever filed by instructors? Yes (No)
Were any limitations or special requirements placed upon this individual because of questions of academic incompetence, disciplinary problems or any other reason? Yes (No)

Please explain any "Yes" response from above:

Catherine McFadden Rutti

CATHERINE MCFADDEN RUTTI
NOTARY PUBLIC, STATE OF OHIO
Recorded in Cuyahoga County
My Comm. Expires Jul. 29, 2004

State of Ohio
County of Cuyahoga
Sworn and confirmed in my presence on the 26 of November, 2003.

Certification:
Affix your institutional seal in this space. If none available, you must have this form notarized.

SEAL VERIFIED

Completion of the following is certification that the information above is an accurate account of this individual's records and is true and correct. This section MUST be signed by the Program Director (M.D./D.O. only).

Name: Christine A. Alexander, MD Signature: CAlexander MD
Title: Program Director Date of Signature: 11/26/03
Tel: (216) 778-5415 Fax: (216) 778-8225 E-Mail: calexander@metrohealth.org

Rev. 07/02/02 Packet ID: 36154 Request ID: 12546067 TAG [14032]

Section V

Examination History/Score Transcripts

USMLE
United States
Medical
Licensing
Examination™

United States Medical Licensing Examination™ (USMLE™)
Certified Transcript of Scores

This Transcript was prepared by the Federation of State Medical Boards

Date of Certification: 12/08/2003

Federation Credentials Verification Service
ATTN: Ohio

Packet ID: 36154

Examinee: Lowenthal, Rebecca
USMLE ID#: 5-044-506-3
DOB: 12 / 07 / 1970
Alt Name(s):

Results for all 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. Scores are reported on two scales. The recommended minimum passing score ("Passing") on each scale is shown in parentheses.

STEP1	Test Date	Pass/ Fail	Three-Digit Score	Three-Digit (Passing)	Two-Digit Score	Two-Digit (Passing)	Comments
	6/28/2001	PASS	193	(182)	79	(75)	
	9/5/2000	FAIL	173	(179)	73	(75)	

STEP2	Test Date	Pass/ Fail	Three-Digit Score	Three-Digit (Passing)	Two-Digit Score	Two-Digit (Passing)	Comments
	10/1/2001	PASS	199	(174)	81	(75)	

STEP3 State Board	Test Date	Pass/ Fail	Three-Digit Score	Three-Digit (Passing)	Two-Digit Score	Two-Digit (Passing)	Comments
OHIO	7/8/2003	PASS	209	(182)	85	(75)	

A search of the Board Action Data Bank of the Federation of State Medical Boards (FSMB) reveals no reported information on the above-named examinee.

Authenticity of USMLE Transcripts

An original, certified transcript of United States Medical Licensing Examination scores is printed using black ink on blue safety paper and is produced only by the Educational Commission for Foreign Medical Graduates, Federation of State Medical Boards, or National Board of Medical Examiners. The TamperSafe® Hologram in the lower left corner certifies the authenticity of this document. Alteration or forgery of a USMLE transcript may result in appropriate legal action and/or a determination of irregular behavior, as described below.

To Test for Authenticity: Touch, rub or breathe on TouchSafe® Fingerprint and the word **VALID** will appear. When liquid bleach is applied to the face of the document, the paper will turn brown. Also, when photocopied, a security statement containing the words **UNOFFICIAL COPY, NOT AN ORIGINAL DOCUMENT**, will appear prominently across the face of the entire document.

INTERPRETATION OF SCORES

USMLE transcripts include a complete score history and notations of any examinations for which the examinee sat and no scores were reported, such as "Incomplete" or "Indeterminate." Scores are reported on two different scales. For each Step, the mean and standard deviation of scores on the three-digit scale for the original anchor group of first-time examinees from medical schools in the United States was 200 and 20, respectively. Most scores fall between 140 and 280. An equivalent value score on a two-digit scale is also provided. A score of 75 on the two-digit scale is the recommended minimum passing score. The recommended minimum passing score on each scale is shown on the right of the transcript next to the examinee's score for each examination administration. The level of proficiency required to pass the recommended minimum passing level for each USMLE Step is reviewed periodically and is subject to change.

Factors which influence an examinee's score include the examinee's general understanding of the subject matter being tested and the specific set of test items used for an administration. The Standard Error of Measurement (SEM) provides an index of the variation in scores that would be expected to occur if an examinee were tested repeatedly using different sets of items covering similar content. The SEM for a USMLE score is usually in the range of 4 to 8 score points on the three-digit scale and 1 to 2 score points on the two-digit scale.

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 that cannot be certified as representing a valid measure of the examinee's knowledge or competence as sampled by the examination. Decisions to classify results as indeterminate may be made on the basis of factors that include, but are not limited to, unexplained inconsistency of performance within the examination or between administrations of the same Step. **No score is reported.** Information regarding the nature of the indeterminate score and the determination of the Committee on Score Validity 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 on Irregular Behavior 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.

Test Accommodations - Following review and approval of a request from the examinee, test accommodations were provided in the administration of the examination.

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.

BOARD ACTION DATA BANK INFORMATION APPEARING AS "NOTE"

The Board Action Data Bank of the Federation of State Medical Boards (FSMB) contains actions reported to the FSMB by U.S. licensing and disciplinary boards, Canadian licensing authorities, the U.S. Armed Forces, the U.S. Department of Health and Human Services, and other credentialing entities. To be included in the Bank, 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 Board Action Data Bank 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".

State Medical Board of Ohio

77 S. High St., 17th Floor • Columbus, OH 43215-6127 • (614) 466-3934 • Website: www.med.ohio.gov

January 16, 2004

Rebecca Ann Lowenthal MD
23105 Ranch Road
Beachwood, OH 44122

This is to notify you that you are now licensed to practice medicine or osteopathic medicine and surgery in the State of Ohio. The Board approved your request and your license number **83797** was issued on **January 16, 2004** and will expire on **July 1, 2006**. A wallet card and wall certificate will be mailed to you in approximately 3 - 4 weeks.

Please be advised that verification of your Ohio license must be obtained directly from the Board's website at http://www.state.oh.us/med/. The website is updated approximately 7-10 business days after the date of licensure; therefore, you must maintain this letter in the interim for purposes of verifying your Ohio license for hospitals, insurance companies, etc.

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

SECTION 4731.281, OHIO REVISED CODE REQUIRES WRITTEN NOTICE TO THE BOARD OF ANY CHANGE OF PRINCIPAL PRACTICE ADDRESS OR RESIDENCE ADDRESS WITHIN THIRTY DAYS OF THE CHANGE.

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

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

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

Sincerely,

Penny E. Grubb
Chief, Licensure

Date Posted: 2/21/2006 10:54:51 AM

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

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

Address Information

CREDENTIAL MAIL ADDRESS
C/O METRO HLTH MED CTR-RES SUPP
6835 Broadway Avenue
CLEVELAND, OH 44105
Cuyahoga County
United States of America
216-957-1600

License Information

License Number 35.083797
License Name REBECCA LOWENTHAL
Email Address

Fees

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

Specialty Codes

1. Please select one specialty from the field below
. . . . . FAMILY PRACTICE
2. Please select one specialty from the field below, if applicable.
. . . . . *{not Answered}*
3. Please select one specialty from the field below, if applicable.
. . . . . *{not Answered}*

CME-Physicians

1. Have you met the above CME requirements for your license?
. . . . . YES

Discipline

1. Have you been found guilty of, or pled guilty or no contest to, or received treatment or intervention in lieu of conviction of, a misdemeanor or felony?
. . . . . NO
2. Have you surrendered, consented to limitation of, or to suspension, reprimand or probation concerning, a license to practice any healthcare profession or state or

federal privileges to prescribe controlled substances in any jurisdiction other than Ohio?

. . . . . NO

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

. . . . . NO

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

. . . . . NO

5. Have you had any clinical privileges or other similar institutional authority suspended, restricted or revoked for reasons **other than failure to maintain records on a timely basis or to attend staff meetings?**

. . . . . NO

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

. . . . . NO

Social Security Number

1.

. . . . . REDACTED

Nurse Collaboration Info

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

. . . . . NO

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

. . . . . *{not Answered}*

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

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

Date Posted: 2/4/2008 2:58:20 PM

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

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

Address Information

CREDENTIAL MAIL ADDRESS

C/O METRO HLTH MED CTR
6835 Broadway Avenue
CLEVELAND, OH 44105
Cuyahoga County
United States of America
216-957-1600

License Information

License Number	35.083797
License Name	REBECCA LOWENTHAL
Email Address	drrebecca613@hotmail.com

Fees

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

Specialty Codes

1. Please select one specialty from the field below
   . . . . . FAMILY PRACTICE
2. Please select one specialty from the field below, if applicable.
   . . . . . *{not Answered}*
3. Please select one specialty from the field below, if applicable.
   . . . . . *{not Answered}*

CME-Physicians

1. Have you met the above CME requirements for your license?
   . . . . . YES

Discipline

1. Have you been found guilty of, or pled guilty or no contest to, or received treatment or intervention in lieu of conviction of, a misdemeanor or felony?
   . . . . . NO
2. Have you surrendered, consented to limitation of, or to suspension, reprimand or probation concerning, a license to practice any healthcare profession or state or

federal privileges to prescribe controlled substances in any jurisdiction other than Ohio?

. . . . . NO

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

. . . . . NO

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

. . . . . NO

5. Have you had any clinical privileges or other similar institutional authority suspended, restricted or revoked for reasons **other than failure to maintain records on a timely basis or to attend staff meetings?**

. . . . . NO

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

. . . . . NO

Social Security Number

1.

. . . . . REDACTED

Nurse Collaboration Info

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

. . . . . YES

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

. . . . . Christine Williams CNP

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

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

Date Posted: 3/17/2010 11:47:59 AM

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

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

License Information

License Number 35.083797

License Name REBECCA LOWENTHAL

Fees

Relicensure Fee $305.00

========

Total Fees **$305.00**

Specialty Codes

1. Please select one specialty from the field below

. . . . . FAMILY MEDICINE

2. Please select one specialty from the field below, if applicable.

. . . . . *{not Answered}*

3. Please select one specialty from the field below, if applicable.

. . . . . *{not Answered}*

CME-Physicians

1. Have you met the above CME requirements for your license?

. . . . . YES

Discipline

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

. . . . . NO

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

. . . . . NO

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

. . . . . NO

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

. . . . . NO

5. Have you had any clinical privileges or other similar institutional authority suspended, restricted, revoked or placed on probation for reasons **other than failure to maintain records on a timely basis or to attend staff meetings?**

. . . . . NO

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

. . . . . NO

Social Security Number

1.

. . . . . REDACTED

Nurse Collaboration Info

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

. . . . . YES

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

. . . . . father mirolovich, cnp; heidi yoho, CNP; nancy lyberger CNP; robert walker CNP; jean ronyak CNP

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

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

Date Posted: 2/7/2012 12:45:13 PM

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

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

Address Information

MAIN

23105 RANCH ROAD
BEACHWOOD, OH 44122
Cuyahoga County
lowenthal_R@yahoo.com

License Information

License Number 35.083797
License Name REBECCA LOWENTHAL

Fees

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

Medical Board Correspondence Email

1. **Did you provide a Credential email address? Please note this information is a public record.**

. . . . . YES

Specialty Codes

1. Please select one specialty from the field below

. . . . . FAMILY MEDICINE

2. Please select one specialty from the field below, if applicable.

. . . . . *{not Answered}*

3. Please select one specialty from the field below, if applicable.

. . . . . *{not Answered}*

CME-Physicians

1. Have you met the above CME requirements for your license?

. . . . . YES

Discipline

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

. . . . . NO

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

. . . . . NO

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

. . . . . NO

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

. . . . . NO

5. Have you had any clinical privileges or other similar institutional authority suspended, restricted, revoked or placed on probation for reasons **other than failure to maintain records on a timely basis or to attend staff meetings?**

. . . . . NO

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

. . . . . NO

Social Security Number

1.

. . . . . REDACTED

Nurse Collaboration Info

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

. . . . . YES

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

. . . . . Deborah Palko CNP; Robon Vanek CNP

Ohio Employment

1. Do you practice in Ohio?

. . . . . YES

Ohio Workforce Questions

1. "Clinical" - direct patient care

. 40-44

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

. 0

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

. 1-4

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

. 1-4

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

. 0

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

. 0

Clinical - Practice setting

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

. 25-29

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

. 1-4

3. Enter the number of hours per week spent in "Emergency Room".

. 0

4. Enter the number of hours per week spent in "Urgent Care".

. 10-14

5. Enter the number of hours per week spent in "Other".

. 1-4

Workforce Counties

1. Enter the first zip code:

. 44105

2. Enter the first county:

. . . . . Cuyahoga

3. Enter the second zip code:

. 44122

4. Enter the second county:

. . . . . Cuyahoga

5. Enter the third zip code:

. . . . . *{not Answered}*

6. Enter the third county:

. . . . . *{not Answered}*

Practice Arrangement (size)

1. Solo practitioner

. . . . . NO

2. Single-specialty Group

. . . . . N/A

3. Multi-specialty Group

. . . . . N/A

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

. . . . . YES

Workforce Language Question

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

. . . . . NO

ABMS Certified

1. Are you certified by an ABMS Board?

. . . . . YES

ABMS Specialty

1. Choose specialty from the dropdown list.

. . . . . Family Medicine

2. Choose specialty from the dropdown list.

. . . . . *{not Answered}*

3. Choose specialty from the dropdown list.

. . . . . *{not Answered}*

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

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

Date Posted: 5/7/2014 3:06:46 PM

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

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

Address Information

CREDENTIAL MAIL ADDRESS
C/O METRO HLTH MED CTR-RES SUPP
6835 Broadway Avenue
CLEVELAND, OH 44105
Cuyahoga County
United States of America
216-957-1600
rlowenthal@metrohealth.org

License Information

License Number 35.083797
License Name REBECCA LOWENTHAL

Fees

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

Medical Board Correspondence Email

1. **Did you provide a Credential email address? Please note this information is a public record.**

. . . . . YES

Specialty Codes

1. Please select one specialty from the field below

. . . . . FAMILY MEDICINE

2. Please select one specialty from the field below, if applicable.

. . . . . *{not Answered}*

3. Please select one specialty from the field below, if applicable.

. . . . . *{not Answered}*

CME-Physicians

1. Have you met the above CME requirements for your license?

. . . . . YES

Discipline

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

. . . . . NO

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

. . . . . NO

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

. . . . . NO

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

. . . . . NO

5. Have you had any clinical privileges or other similar institutional authority suspended, restricted, revoked or placed on probation for reasons **other than failure to maintain records on a timely basis or to attend staff meetings?**

. . . . . NO

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

. . . . . NO

Social Security Number

1.

. . . . . REDACTED

Nurse Collaboration Info

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

. . . . . YES

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

. . . . . Linda Patete CNP, Judith Nelli CNP

Ohio Employment

1. Do you practice in Ohio?

. . . . . YES

Ohio Workforce Questions

1. "Clinical" - direct patient care

. 35-39

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

. 0

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

. 5-9

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

. 1-4

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

. 0

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

. 0

Clinical - Practice setting

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

. 25-29

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

. 1-4

3. Enter the number of hours per week spent in "Emergency Room".

. 0

4. Enter the number of hours per week spent in "Urgent Care".

. 10-14

5. Enter the number of hours per week spent in "Other".

. 0

Workforce Counties

1. Enter the first zip code:

. 44105

2. Enter the first county:

. . . . . Cuyahoga

3. Enter the second zip code:

. 44122

4. Enter the second county:

. . . . . Cuyahoga

5. Enter the third zip code:

. . . . . *{not Answered}*

6. Enter the third county:

. . . . . *{not Answered}*

7. Do you have more than one practice location?

. . . . . YES

Workforce Practice Address

1. Please list all practice locations. Include street address, city, state and zip. Example "123 E Main St, Suite 2, Anywhere, OH 55555;" Separate multiply addresses with a semicolon.

. . . . . 6835 Broadway Ave, cleveland, OH 44105; 3609 Park east, Beachwood, OH 44122

Practice Arrangement (size)

1. Solo practitioner

. . . . . NO

2. Single-specialty Group

. . . . . N/A

3. Multi-specialty Group

. . . . . 10+

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

. . . . . YES

Workforce Language Question

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

. . . . . NO

ABMS Certified

1. Are you certified by an ABMS Board?

. . . . . YES

ABMS Specialty

1. Choose specialty from the dropdown list.

. . . . . Family Medicine

2. Choose specialty from the dropdown list.

. . . . . *{not Answered}*

3. Choose specialty from the dropdown list.

. . . . . *{not Answered}*

NPI number

1. Please enter your current NPI number

. 1649209438

DEA number

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

. . . . . bl8855201

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

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

Date Posted: 4/7/2016 11:08:58 AM

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

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

License Information

License Number 35.083797

License Name REBECCA LOWENTHAL

Fees

Relicensure Fee $305.00

========

Total Fees **$305.00**

Medical Board Correspondence Email

1. **Did you provide a Credential email address? Please note this information is a public record.**

. . . . . YES

Specialty Codes

1. Please select one specialty from the field below

. . . . . FAMILY MEDICINE

2. Please select one specialty from the field below, if applicable.

. . . . . FAMILY MEDICINE

3. Please select one specialty from the field below, if applicable.

. . . . . FAMILY MEDICINE

CME-Physicians

1. Have you met the above CME requirements for your license?

. . . . . YES

Discipline

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

. . . . . NO

2. **At any time since signing your last application for renewal of your certificate** have you surrendered, consented to limitation of, or to suspension, reprimand or probation concerning, a license to practice any healthcare profession or state or federal privileges to prescribe controlled substances in any jurisdiction other than Ohio?

. . . . . NO

3. **At any time since signing your last application for renewal of your certificate** have any malpractice awards been paid by you or on your behalf for acts occurring in any state other than Ohio?

. . . . . NO

4. **At any time since signing your last application for renewal of your certificate** has any board, bureau, department, agency, or any other body, including those in Ohio **other than this board,** filed any charges, allegations or complaints against you?

. . . . . NO

5. **At any time since signing your last application for renewal of your certificate** have you had any clinical privileges or other similar institutional authority suspended, restricted, revoked or placed on probation for reasons **other than failure to maintain records on a timely basis or to attend staff meetings?**

. . . . . NO

6. **At any time since signing your last application for renewal of your certificate** have you been addicted to or dependent upon alcohol or any chemical substance; relapsed, been treated for, or been diagnosed as suffering from, drug or alcohol dependency or abuse?

. . . . . NO

Social Security Number

1.

. . . . . REDACTED

Nurse Collaboration Info

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

. . . . . YES

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

. . . . . dewanda williams cnp; ellen moran cnp;erica scott cnp;

Ohio Employment

1. Do you practice in Ohio?

. . . . . YES

Ohio Workforce Questions

1. "Clinical" - direct patient care

. 30-34

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

. 0

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

. 5-9

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

. 1-4

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

. 0

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

. 0

Clinical - Practice setting

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

. 30-34

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

. 1-4

3. Enter the number of hours per week spent in "Emergency Room".

. 0

4. Enter the number of hours per week spent in "Urgent Care".

. 10-14

5. Enter the number of hours per week spent in "Other".

. 0

Workforce Counties

1. Enter the first zip code:

. 44122

2. Enter the first county:

. . . . . Cuyahoga

3. Enter the second zip code:

. 44109

4. Enter the second county:

. . . . . Cuyahoga

5. Enter the third zip code:

. . . . . *{not Answered}*

6. Enter the third county:

. . . . . *{not Answered}*

7. Do you have more than one practice location?

. . . . . YES

Workforce Practice Address

1. Please list all practice locations. Include street address, city, state and zip. Example "123 E Main St, Suite 2, Anywhere, OH 55555;" Separate multiply addresses with a semicolon.

. . . . . 3609 park east, beachwood, OH 44122; 6835 broadway avenue, cleveland oh 44109

Practice Arrangement (size)

1. Solo practitioner

. . . . . NO

2. Single-specialty Group

. . . . . N/A

3. Multi-specialty Group

. . . . . 10+

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

. . . . . YES

Workforce Language Question

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

. . . . . NO

ABMS Certified

1. Are you certified by an ABMS Board?

. . . . . YES

ABMS Specialty

1. Choose specialty from the dropdown list.

. . . . . Family Medicine

2. Choose specialty from the dropdown list.

. . . . . *{not Answered}*

3. Choose specialty from the dropdown list.

. . . . . *{not Answered}*

NPI number

1. Please enter your current NPI number

. 1649209438

DEA number

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

. . . . . bl8855201

OARRS Registration

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

. . . . . YES

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

. . . . . YES

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.

License Renewal Application

Submission Date: 04/03/2018

License Type - Doctor of Medicine (MD)

Personal Information

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

Title
Dr.
First Name
REBECCA
Middle Name
Last Name
LOWENTHAL
Maiden Name
Social Security Number
REDACTED
Date of Birth
12/7/1970
Email Address
lowenthal_r@yahoo.com
Phone Number
(216) 691-1656
Other Phone Number

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?
What is your gender?
Female
What is your ethnicity?

In which country were you born?
United States
In which state were you born (if United States)?
Minnesota
In which city were you born?
MINNEAPOLIS

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.

23105 RANCH ROAD
BEACHWOOD
OH
44122
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.

23105 RANCH ROAD
BEACHWOOD
OH
44122
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?
No
Country of Service

Service Branch

Are you still serving in the military (Active or Reserve)?

Were you honorably discharged from your service?

Service Start Date

Service End Date

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.

Medical Speciality Certification - American Board of Medical Specialties (ABMS)
Medical Speciality - Family Medicine
Medical SubSpeciality - null

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 been addicted to or dependent upon alcohol or any chemical substance; or been treated for, or been diagnosed as suffering from, drug or alcohol dependency or abuse?
Answer - No

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

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

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

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

Question - Primary NPI Number
Answer - 1649209438

Question - Primary DEA Number
Answer - AR2289646-103531

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

Question - Do you currently possess an active license other than that for which you are renewing?
Answer - No

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

Question - How many locations are you currently working in that require the license you are renewing?
Answer - 4

Question - Please provide the following information for up to 3 locations in which you use the license you are renewing, beginning with the locations you spend the most time: Facility Name, Address, City, State, Zip Code, Health Care Facility Type
Answer - 2500 metrohealth drive, cleveland, oh 44122 (hospital), 6835 Broadway ave, Cleveland OH, 44122 (office), 3609 Park east #300, beachwood, oH 44122

Question - Do you have hospital privileges?
Answer - Yes

Question - Which of the following best describes your five-year employment plan?

Answer - Maintain practice hours as is

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

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

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

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

Attachments

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

Review + Submit

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

Application Review - Completed

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

Consent to Electronic Signature - **Consented**
Date/Time Stamp - 04/03/2018 17:16:27
Type your First Name and Last Name as they appear on the application to sign electronically.
REBECCA LOWENTHAL

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.

State Medical Board of Ohio

77 S. High St., 17th Floor • Columbus, OH 43215-6127 • (614) 466-3934 • Website: www.state.oh.us/med/

FOR BOARD USE ONLY		
FEE: $75.00		
BK: 35	PG: 30	LN: 13
DATE: 6/13/02	PMT: 270942	

APPLICATION FOR TRAINING CERTIFICATE

PLEASE TYPE OR PRINT CLEARLY

PERSONAL INFORMATION

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)
LOWENTHAL	REBECCA		

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

Last (Surname)	First	Middle	Suffix (Jr., II)

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

Number & Street			
23105 Ranch Road			
City	**State**	**Zip Code**	**Country**
Beachwood	OH	44122	USA

(As of May 19, 2002)

TRAINING PROGRAM INFORMATION

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

Hospital & Department		
MetroHealth Medical Center - Family Practice		
Number & Street		
2500 MetroHealth Drive		
City	**State**	**Zip Code**
Cleveland	OH	44109-1998

Dates of Training: Beginning Date: Mo/Day/Yr 6/23/02 Ending Date: Mo/Day/Yr 6/30/05

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

OVER ⇨

MEDICAL OR OSTEOPATHIC EDUCATION

Medical or Osteopathic School of Graduation:

School Name: Johns Hopkins Medical School

Street Address: 600 N. Wolf Street

City: Baltimore State: MD Country: 21287

Dates Attended: From: Mo/Yr 9 196 To: Mo/Yr 5 102

Degree Received: MD Date Received: Mo//Day/Yr 5/ /02

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

School Name: N/A

Street Address:

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: N/A

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 / /

CONTINUED ⇨

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 12/07/70

Birth Place: City Minneapolis State MN Country

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

PHYSICAL DESCRIPTION:

Height 5'7"

Weight 180

Hair Color Brown

Eye Color Hazel

Identifying Marks _____

Date Photo Taken: ___/___ **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")**

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: _____

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", as well as your permanent address.* 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 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 or Other: / Complete Street Address: / Number & Street / City State/Country Zip Code	Position & Department	% Clinical / % Admin.
A				
B				
C				
D				

OVER ⇨

E

FROM month/year / TO month/year /	Hospital, University or Other: / Complete Street Address: / Number & Street / City State/Country Zip Code	Position & Department	% Clinical / % Admin.

F

FROM month/year / TO month/year /	Hospital, University or Other: / Complete Street Address: / Number & Street / City State/Country Zip Code	Position & Department	% Clinical / % Admin.

G

FROM month/year / TO month/year /	Hospital, University or Other: / Complete Street Address: / Number & Street / City State/Country Zip Code	Position & Department	% Clinical / % Admin.

H

FROM month/year / TO month/year /	Hospital, University or Other: / Complete Street Address: / Number & Street / City State/Country Zip Code	Position & Department	% Clinical / % Admin.

I

FROM month/year / TO month/year /	Hospital, University or Other: / Complete Street Address: / Number & Street / City State/Country Zip Code	Position & Department	% Clinical / % Admin.

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. 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?	☐	☑

OVER ⇨

		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 been convicted or found guilty of a violation of any law, regardless of the legal jurisdiction in which the act was committed, other than a minor traffic violation?	☐	☑
16	Have you ever 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)?	☐	☑
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, include the case name, case number, court and address, date filed, and a summary of the underlying events. Indicate current status, including amount of settlement or judgment, if any. 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?	☐	☑

CONTINUED ⇨

		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.	☐	☐	N/A

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.

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.	☐	☐	N/A

OVER ⇨

"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.	☐	☐	N/A

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.

	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.	☐	☐	N/A

* *

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.	☐	☐	N/A

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. 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: Maryland

COUNTY OF: Baltimore City

I, Rebecca Lowenthal, 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 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 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.

Rebecca Lowenthal
Signature of Applicant

Subscribed and sworn to before me this 25th day of April 2002.

(NOTARY SEAL)

Marion Katz
Signature of Notary Public

July 1, 2005
Date Commission Expires

State Medical Board of Ohio

77 S. High St., 17th Floor • Columbus, OH 43215-6127 • (614) 466-3934 • Website: www.state.oh.us/med/

TRAINING CERTIFICATE - MEDICINE OR OSTEOPATHIC MEDICINE

CERTIFICATION OF HOSPITAL

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.

TO BE COMPLETED BY APPLICANT

Name of Applicant: LOWENTHAL REBECCA
Last First Middle Suffix (Jr., II)

TO BE COMPLETED BY OHIO TRAINING PROGRAM

Name of Training Program: METROHEALTH MEDICAL CENTER

Training Program Address: RESIDENCY SUPPORT OFFICE
Street Address 2500 METROHEALTH DR., A107
CLEVELAND, OHIO 44109-1998
City State Zip Code

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

Specialty Code (*see reverse side*): FP

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 06/23/02 Ending Date: MO/DAY/YR 06/22/03

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)

Signature of Medical Director or Program Director

Charles Emerman, MD
Name (please print)

05-22-02
Date

State Medical Board of Ohio

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REGISTRA

AUG 29 2002

SCHOOL OF MEDIC

TRAINING CERTIFICATE - MEDICINE OR OSTEOPATHIC MEDICINE

FORM 1A - 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.

TO BE COMPLETED BY APPLICANT

Name: LOWENTHAL (Last) REBECCA (First) (Middle) (Suffix (Jr., II))

Name of Medical/Osteopathic School: Johns Hopkins Univ. School of Medicine

Location: BALTIMORE (City) MARYLAND (State) USA (Country)

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

Rebecca Lowenthal — Signature of Applicant — 8/26/02 Date

TO BE COMPLETED BY MEDICAL OR OSTEOPATHIC SCHOOL

Our records indicate that Lowenthal, (Last) Rebecca (First) (Middle) (Suffix (Jr., II))

attended medical/osteopathic school from 09/03/96 (mo/day/yr) to 05/22/02 * (mo/day/yr)

This individual *(check one)*:

☒ was awarded the degree of Doctor of Medicine on 5/23/02 (mo/day/yr)

☐ 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

Mary E. Foy
Name (please print)

Assistant Dean/ Registrar
Title

9/3/02
Date

*Required to repeat first year 9/2/97-6/12/98
3/1/01-2/28/02 Student in Residence status to participate in research, Emergency Medicine, JHUSOM.

State Medical Board of Ohio

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ACKNOWLEDGMENT OF APPLICATION FOR TRAINING CERTIFICATE

June 4, 2002

REBECCA LOWENTHAL
C/O METRO HLTH MED CTR-RES SUPP
2500 METROHEALTH DRIVE
CLEVELAND, OHIO 44109-1998

APPLICATION RECEIVED: 6/3/2002

HOSPITAL: **METROHEALTH MED CTR-CLEVE**
Resident
FAMILY PRACTICE

ACKNOWLEDGMENT LETTER EXPIRES: 10/5/2002

Dear Doctor:

This is to notify you that your application for a training certificate was received by the Board on the above date and for the program indicated above.

Please be advised that you are hereby authorized to begin participation in the training program to which you have been appointed while your application is being processed. You are entitled to perform such acts as may be prescribed by or incidental to the internship, residency, or clinical fellowship program, but are not otherwise entitled to engage in the practice of medicine or surgery or osteopathic medicine and surgery in this state. You must limit your activities to the programs of the hospitals or facilities for which you have applied. You must train only under the supervision of the physicians responsible for supervision as part of the internship, residency, or clinical fellowship program. **The authority granted by this letter will expire on the date indicated above.**

Applications are processed in the order received. An incomplete application or any unusual circumstances discovered during processing will result in deviation from this schedule. You will be notified if the application is incomplete or contains errors; or if there is difficulty in obtaining the independently requested recommendations.

Further, the Ohio Administrative Code provides that the Board may abandon an application if you fail to complete the application process within six months of initial application filing. Submitted fees will not be refundable or transferable.

Sincerely,

Penny E. Grubb
Chief, Licensure

STATE MEDICAL BOARD OF OHIO

77 South High Street, 17th Floor • Columbus, Ohio 43215-6127 • (614) 466-3934
Website : www.state.oh.us/med/

REBECCA LOWENTHAL,
C/O METRO HLTH MED CTR-RES SUPP
2500 METROHEALTH DRIVE
CLEVELAND OH 44109-1998

09/27/2002

NUMBER : 57-00-6499
HOSPITAL : METROHEALTH MED CTR-CLEVE
RESIDENT FAMILY PRACTICE

DATES : 06/23/2002 - 06/22/2003

Dear Doctor :

This is to notify you that the above training certificate number has been issued to you in order for you to participate in the training program during the dates indicated above.

You are entitled to perform such acts as may be prescribed by or incidental to the internship, residency, or clinical fellowship program, but are not otherwise entitled to engage in the practice of medicine and surgery or osteopathic medicine and surgery in this state. You must limit your activities to the programs of the hospitals or facilities for which the training certificate is issued. You must train only under the supervision of the physicians responsible for supervision as part of the internship, residency, or clinical fellowship program. Failure to abide by these limitations could result in the revocation of this certificate or criminal prosecution.

A training certificate shall be valid for one year, but may at the discretion of the Board be renewed annually for a maximim of five years. Renewal applications are mailed approximately April 1st for those who initiated their training on July 1st. Others will receive their renewal application accordingly.

Be sure to notify the Board, in writing, of any change in address within thirty days of the change. If you change programs before the end of the training year you must immediately notify the Board.

Sincerely,

Penny E. Grubb
Chief, Licensure