NEBRASKA
Good Life. Great Mission.
DEPT. OF HEALTH AND HUMAN SERVICES

Pete Ricketts, Governor

Public Health Licensure Unit
Certification of Licensure

This certificate serves as primary source verification of licensure in the State of Nebraska as of the close of the business day before 6/11/2020.

Name:	Shana Melody Miles MD
Type:	Physician
Number:	29308
Status:	Active
Issued:	06/10/2016
Expiration:	10/01/2020
Education:	05/19/2012 UNIFORMED SERVICES U THE HEALTH SCIENCE

Disciplinary/Non-Disciplinary Information:

No disciplinary/non-disciplinary actions taken against this license.

If you have questions about this information, please contact the Licensure Unit at (402) 471-2115 or DHHS.LicensureUnit@nebraska.gov.

X

This form may be completed online and mailed to the address listed below.

Department of Health & Human Services
DHHS
NEBRASKA

Department of Health and Human Services
Division of Public Health - Licensure Unit
301 Centennial Mall South
P.O. Box 94986 - Lincoln, Nebraska 68509
Telephone #: 402-471-2118

Lic# 29308
Date 04-10-16
Office Use Only
Revised 11/2015

APPLICATION FOR A LICENSE TO PRACTICE:

☑ Medicine and Surgery ☐ Osteopathic Medicine and Surgery

(Please print or type application)
Fee: $300 – must be submitted with application
Payable to: Nebraska Licensure Unit
ORIGINAL SIGNATURE REQUIRED

$75

Do you currently have a FCVS profile? Yes ☐ No ☑

LICENSURE UNIT
APR 21 2016
RECEIVED

SECTION A – PERSONAL INFORMATION: (All applicants must complete this section) Items 1 and 2 are public information. Name and Licensure information will be displayed on the INTERNET at http://www.nebraska.gov/LISSearch/search.cgi

NOTE: All mailings will be sent to the address you indicate below– if you change your address, you must advise this office.

1	Legal Name	First: SHANA	Middle Name: MELODY	Last: MILES	
	Maiden Name	N/A	Other Names you are known as (AKA):		
2	Mailing Address	Street/PO/Route: 5750 BOU AVE #1304			
		City: ROCKVILLE	State or Country: MD	Zip: 20852	
3	Date of Birth:	Month/Day/Year: 09/01/1986	Place of Birth (city/state/country): MIAMI, FL USA		Gender: M ☐ F ☑
4	Check the Appropriate Box(es)	☑ Social Security Number (SSN); ☐ Alien Registration Number ("A#"); ☐ Form I-94 (Arrival-Departure Record) number	[redacted]		
			A#		
			I-94 #		

If you have both a SSN and an A# or I-94 number, you must report both. Neb. Rev. Stat. §38-123 mandates disclosure of your social security number to DHHS. Although your number is not public information, DHHS may disclose it for child support enforcement purposes and to the Nebraska Department of Revenue.

Phone 305-989-3338	Fax (optional)
Licensee E-mail Address smiles8642@gmail.com	Credentialing contact e-mail Address (optional)

Office Use Only					
Board	Yes	No	**Federation**	Yes	No X
Cards	Yes	No	**NPDB**	Yes	No X
			NDEN	Yes	No X

SECTION B – EXAMINATION (All application must complete this section)

☑ I have requested that an official copy of my score reports for any and all of the national examinations that I have taken (check ALL that apply) be sent to your office:

Application by Examination:

☑ USMLE ☐ NBME ☐ FLEX ☐ NBOME ☐ LMCC

☐ Combination of USMLE/FLEX ☐ Combination of USMLE/NBME

Application Based on License in Another State or Territory of the United States:

☐ State Exam (list state) _____ ☐ I have requested a copy of my state examination from that Board

Foreign medical graduates must indicate their ECFMG number: _____

SECTION C – EDUCATION (All applicants must complete this section) List in chronological order, beginning with high school and ending with medical school, the name and location of all institutions attended. List the diplomas or certificates earned and dates received for all preliminary (high school), pre-medical education and medical education. (Attach additional pages if necessary).

PRELIMINARY AND PRE-MEDICAL EDUCATION

NAME OF HIGH SCHOOL	SCHOOL FOR ADVANCED STUDIES	
City/State/Country	MIAMI, FL USA	
Diploma/Certificate	HIGH SCHOOL DIPLOMA	
Date: (MO/YR)	06/2004	
NAME OF PRE-MEDICAL COLLEGE	MIAMI-DADE COLLEGE	
City/State/Country	MIAMI, FL USA	
Diploma/Certificate	ASSOCIATE OF ARTS	
Date: (MO/YR)	06/2004	
NAME OF PRE-MEDICAL COLLEGE	UNIVERSITY OF MIAMI	
City/State/Country	MIAMI, FL USA	
Diploma/Certificate	BACHELORS OF SCIENCE	
Date: (MO/YR)	05/2005	

MEDICAL EDUCATION

NAME OF MEDICAL SCHOOL	UNIFORMED SERVICES UNIVERSITY OF THE HEALTH SCIENCES	
City/State/Country	BETHESDA, MD USA	
Attended	From (M/D/Y): 06/20/2005	To (M/D/Y): 05/19/2012
Degree Conferred	MD, PhD	Date Conferred (M/D/Y): 05/19/2012
NAME OF MEDICAL SCHOOL		
City/State/Country		
Attended	From (M/D/Y):	To (M/D/Y):
Degree Conferred		Date Conferred (M/D/Y):

SECTION D- POST-GRADUATE MEDICAL EDUCATION (All applicants must complete this section) Indicate whether service was Internship, Residency or Fellowship.	
Name of Institution	WALTER REED NATIONAL MILITARY MEDICAL CENTER
Name of Specialty	OB/GYN ☑ Internship ☐ Residency ☐ Fellowship
City/State/Country	BETHESDA, MD USA
Attended From:	(M/D/Y) 07/01/2012
Attended To:	(M/D/Y) 06/30/2013
Name of Institution	WALTER REED NATIONAL MILITARY MEDICAL CENTER
Name of Specialty	OB/GYN ☐ Internship ☑ Residency ☐ Fellowship
City/State/Country	BETHESDA, MD USA
Attended From:	(M/D/Y) 07/01/2013
Attended To:	(M/D/Y) 06/10/2016
Name of Institution	
Name of Specialty	☐ Internship ☐ Residency ☐ Fellowship
City/State/Country	
Attended From:	(M/D/Y)
Attended To:	(M/D/Y)
Name of Institution	
Name of Specialty	☐ Internship ☐ Residency ☐ Fellowship
City/State/Country	
Attended From:	(M/D/Y)
Attended To:	(M/D/Y)

SECTION E – COMPETENCY (All applicants must complete this section) Indicate that, within the three years immediately preceding the application for licensure, you have met **ONE** of the following:	
☑	**I have been in the active practice of the profession of medicine and surgery in some other state, a territory, the District of Columbia, or Canada for a period of one year.**
☑	**I have had at least one year of approved graduate medical education.**
☐	**I have completed continuing medical education.** Submit proof of attendance at continuing education, as well as information about the content for Board approval. *See below*
☐	**I have completed a refresher course in medicine and surgery.** Submit proof of attendance at a refresher course, as well as information about the content for Board approval. *See below*
☐	**I have completed a special purposes examination.** Have your score sent directly to this office for Board approval. *See below*

*Neb. Rev. Stat. 38-2026(4) states that an applicant for a license in medicine and surgery must present proof satisfactory to the Department that he or she, within the three years immediately preceding the application for licensure, (a) has been in the active practice of the profession of medicine and surgery in some other state, a territory, the District of Columbia, or Canada for a period of one year, (b) has had at least one year of graduate medical education, (c) has completed continuing education in medicine and surgery approved by the board, (d) has completed a refresher course in medicine and surgery approved by the board, or (e) has completed the special purposes examination approved by the board.

Be advised that the Board of Medicine and Surgery **does not routinely accept continuing education or the special purposes examination alone as acceptable to meet the experience requirement in the absence of recent practice or other evidence of continued competency.**

Neb. Rev. Stat. 38-2026.01 gives the Department, with the recommendation of the Board, authority to issue a reentry license to a physician who has not actively practiced medicine for the two-year period immediately preceding the filing of an application for a license or who has not otherwise maintained continued competency during such period as determined by the Board.

Following is the website to the Statutes Relating to Medicine and Surgery where you can read the complete language regarding the reentry license.
http://dhhs.ne.gov/publichealth/Documents/Medicine%20and%20Surgery.pdf

The Board of Medicine and Surgery will review applications for a license, either initial application or reinstatement of license, which do not clearly meet the requirements for experience (continued competency) as outlined in the statutes listed above. The Board will make a recommendation to the Department to either issue the license, deny the application or offer a reentry license to the applicant. (This assumes there are no

matters whereby discipline would be appropriate.) **Please be aware, that if a reentry license is decided upon by the Board and Department, the process would be that the application be denied if the applicant does not accept the reentry license.**

SECTION F - PROFESSIONAL ACTIVITIES (All applicants must complete this section) List in chronological order all of your medical activities for the last ten years, or since graduation from medical college if less than ten years ago to present. Also list all periods of non-professional activity or employment for periods of non-medical activity of more than three months. Please account for all time and explain all gaps of more than three months. (Attach additional pages if necessary). This information must be completed below. Do not attach CV or other work history forms.			
From: Month/Year		To: Month/Year	
Name of Facility			
City/State/Country			
Activity			
From: Month/Year		To: Month/Year	
Name of Facility			
City/State/Country			
Activity			
From: Month/Year		To: Month/Year	
Name of Facility			
City/State/Country			
Activity			
From: Month/Year		To: Month/Year	
Name of Facility			
City/State/Country			
Activity			
From: Month/Year		To: Month/Year	
Name of Facility			
City/State/Country			
Activity			

SECTION G – CONTROLLED SUBSTANCES REGISTRATION (Check one that applies)			
1	☑	I have enclosed a photocopy of my current Federal Controlled Substances Registration.	
		Federal Controlled Substances Registration #: [redacted]	Expiration Date: 1-31-2019
2	☐	I am currently applying for a Federal Controlled Substances Registration, and will send a photocopy of such when I receive the registration.	
3	☐	I do not have nor am I applying for a Federal Controlled Substances Registration and I will not be prescribing, administering or dispensing controlled substances in Nebraska. I understand that at such time that I do intend to prescribe, administer or dispense controlled substances in Nebraska, I will first need to have a Federal Controlled Substances Registration issued to me. At that time, I am to supply a photocopy of the registration to the State of Nebraska.	

SECTION H – LICENSURE IN OTHER STATE (All applicants must complete this section)

Have you ever been licensed as a physician, physician in training license/permit, educational or residency license/permit or any other license or permit allowing you to practice medicine in another state or jurisdiction?	☑ YES	☐ NO

List all other states, jurisdictions, or territories of the U.S. where you have been or are currently licensed, including license number, issue date, and expiration date. **(Include educational training/permit licenses). Attach list if needed.**

State	License #	Issue Date	Expiration Date
VIRGINIA	0101254578	07/19/2013	09/30/2016

SECTION I – CONVICTION AND LICENSURE INFORMATION (All applicants must complete this section) **Failure to disclose any such conviction or disciplinary action, regardless of when the action occurred, could result in disciplinary action, include, but not limited to, payment of a civil penalty.**

Answer the following questions either yes or no by placing a (✓) in the appropriate box. **All 'yes' responses MUST be explained in detail and you must submit the requested documentation (see pages 8 & 9 of application).** Additional documentation may be requested by the Board/Department after submission of initial information.

	Section I		
1	Have you ever had any disciplinary or adverse action imposed against a professional license or permit in any state or jurisdiction?	☐ YES	☑ NO
2	Have you ever voluntarily surrendered or voluntarily limited in any way a license or permit issued to you by a licensing or disciplinary authority?	☐ YES	☑ NO
3	Have you ever been requested to appear before any licensing agency?	☐ YES	☑ NO
4	Have you ever been notified of any charges, complaints or other actions filed against you by any licensing or disciplinary authority?	☐ YES	☑ NO
5	Are you aware of any pending disciplinary actions or of any on-going investigations of a complaint against your license or permit in any jurisdiction?	☐ YES	☑ NO
6	Have you ever been asked to and/or permitted to withdraw an application for licensure or permit with any Board or jurisdiction?	☐ YES	☑ NO
7	Has any state or jurisdiction refused to issue, refused to renew or denied you a license or permit to practice?	☐ YES	☑ NO
	Section II		
1	Are you currently, or have you ever been, addicted to, dependent upon or chronically impaired by alcohol, narcotics, barbiturates, or other drugs which may cause physical and/or psychological dependence?	☐ YES	☑ NO
2	Within the past 5 years, have you received any therapy/treatment or been admitted to any hospital or other in-patient care facility for reasons relating to your use/abuse of alcohol, narcotics, barbiturates, or other drugs?	☐ YES	☑ NO
3	Do you currently, or have you ever had, any physical, mental, or emotional condition which impaired, or does impair your ability to practice your health care profession safely and competently?	☐ YES	☑ NO
4	Within the past 5 years, has any licensing agency or credentialing organization initiated any inquiry into your physical, mental or emotional health?	☐ YES	☑ NO

Weiand, Heidi

From: S Miles <smiles8642@gmail.com>
Sent: Friday, May 20, 2016 3:04 PM
To: Weiand, Heidi
Subject: RE: Nebraska Physician Application

For questions 4/5 answers are both no.
The program director was different during my intern year, do you want my current program director to sign the form?

Thank you for your help.

From: Weiand, Heidi
Sent: 5/20/2016 3:58 PM
To: 'smiles8642@gmail.com'
Subject: Nebraska Physician Application

Please find attached deficiency letter

Thank you-

Heidi Weiand
Health Licensing Specialist
Licensure Unit
PO Box 94986
Lincoln NE 68509
☎ 402-471-2118
402-742-8355

SECTION I (CONTINUED) – CONVICTION AND LICENSURE INFORMATION (All applicants must complete this section) **Failure to disclose any such conviction or disciplinary action, regardless of when the action occurred, could result in disciplinary action, include, but not limited to, payment of a civil penalty.**

Answer the following questions either yes or no by placing a (✓) in the appropriate box. **All 'yes' responses MUST be explained in detail and you must submit the requested documentation (see pages 15 & 16 of application).** Additional documentation may be requested by the Board/Department after submission of initial information.

	Section III		
1	Have you ever been restricted, suspended, terminated, requested to voluntarily resign, placed on probation, counseled, received a warning or been subject to any remedial or disciplinary action during medical school or postgraduate training?	☐ YES	☑ NO
2	Have you ever had hospital or institutional privileges denied, reduced, restricted, suspended, revoked, terminated or placed on probation?	☐ YES	☑ NO
3	Have you ever voluntarily resigned or suspended your hospital or institutional privileges while under investigation from a hospital, clinic, institution, or other medically related employment?	☐ YES	☑ NO
4	Have you ever been notified that any action against your hospital or institutional privileges is pending or proposed?	☐ YES	☐ NO
5	Have you ever been allowed to withdraw your staff privileges from a hospital or institution?	☐ YES	☐ NO
6	Have you ever been subject to staff disciplinary action or non-renewal of an employment contract?	☐ YES	☑ NO
	Section IV		
1	Have you ever been convicted of a felony? **Failure to disclose any such convictions regardless of when the conviction occurred could result in disciplinary action, including but not limited to a minimum of $500 civil fine.**	☐ YES	☑ NO
2	Have you ever been convicted of a misdemeanor? **Failure to disclose any such convictions regardless of when the conviction occurred could result in disciplinary action, including but not limited to a minimum of $500 civil fine.**	☐ YES	☑ NO
3	Have you ever been notified of any charges, complaints or other actions filed against you by any criminal prosecution authority?	☐ YES	☑ NO
	Section V		
1	Have you ever been denied a Federal Drug Enforcement Administration (DEA) Registration or state controlled substances registration?	☐ YES	☑ NO
2	Have you ever been called before any licensing agency or lawful authority concerned with DEA controlled substances?	☐ YES	☑ NO
3	Have you ever surrendered your state or federal controlled substances registration?	☐ YES	☑ NO
4	Have you ever had your state or federal controlled substances registration restricted or disciplined in any way?	☐ YES	☑ NO
	Section VI		
1	Have you ever been notified of any professional liability claim that resulted in an adverse judgment, settlement, or award, including settlements made prior to suit in which the patient releases any professional liability claim against the applicant?	☐ YES	☑ NO
2	Are you aware of any professional liability claims currently pending against you?	☐ YES	☑ NO

SECTION J – PRACTICE PRIOR TO CREDENTIAL (All applicants must complete this section) An individual who practices prior to issuance of a credential is subject to assessment of an Administrative Penalty of $10 per day up to $1,000, or such other action as provided in the statutes and regulations governing the credential.

1	I have practiced as a physician/osteopathic physician & surgeon in Nebraska before issuance of the Nebraska license.	☐ YES	☑ NO
2	If yes, what are the actual number of days you practiced in Nebraska and what is the business name, location and telephone number of the practice: ***Students of medicine and surgery enrolled in an accredited college of medicine who gratuitously practice medicine and surgery under the supervision of a licensed physician are exempt from needing a Permit or License in the State of Nebraska, pursuant to Neb. Rev. Stat. 38-2025(4)). Once an individual has graduated from medical school, however, a Permit or License is required in the State of Nebraska in order to practice medicine and surgery. The question above, therefore, refers to the time since you have graduated from medical school until such time as you have received a Permit or License to practice medicine and surgery in the State of Nebraska.***	# of days: _____ Name of Business: City: Telephone #:	

SECTION K – ATTESTATION (All applicants must complete this section)

Lawful Presence in the United States Attestation: For the purpose of complying with Neb. Rev. Stat. §38-129, I attest as follows:

Please check only one of the boxes below:

☑ I am a citizen of the United States; or

☐ I am an alien lawfully admitted into the United States who is eligible for a credential under the Uniform Credentialing Act; or

☐ I am a non-immigrant lawfully present in the United States who is eligible for a credential under the Uniform Credentialing Act.

Alien or Non-Immigrant Status: If you are a qualified alien lawfully admitted into the United States OR a non-immigrant lawfully present in the United States, you must submit evidence of lawful presence which may include a copy of:

1. A "Green Card" otherwise known as a Permanent Resident Card (Form I-551), both front and back of the card; or
2. An unexpired foreign passport with an unexpired Temporary I-551 stamp bearing the same name as the passport; or
3. A document showing an Alien Registration Number ("A#"), an Employment Authorization Card/Document is **NOT** acceptable; or
4. A Form I-94 (Arrival-Departure Record).

If you are an Alien or Non-Immigrant, your credential will **NOT** be issued until such proof is received by our office and your documents are verified by our office through the Department of Homeland Security. This process may take four to six weeks.

Criminal Background Check Notification: Pursuant to Neb. Rev. Stat. §38-131, an applicant for an initial license to practice a profession which is authorized to prescribe controlled substances shall be subject to a criminal background check. I understand that I am able to receive any national criminal history record that may pertain to me directly from the FBI, pursuant to 28 CFR Sections 16.30-16.34, and that I could then freely disclose any such information to whomever I choose. By signing this application, it is my intent to authorize the dissemination of any national criminal history record that may pertain to me to the Department of Health and Human Services (DHHS) with whom I am applying for licensure. I understand that I am entitled to challenge the accuracy and completeness of any information contained in any such report, and that you will provide me a copy of the criminal history background report, if any, you receive on me if I appear at the DHHS in person and present proper identification. Information on how to challenge your federal report can be found at FBI.gov. To challenge your Nebraska state record, contact the Nebraska State Patrol-Criminal Identification Division. I may obtain a prompt determination as to the validity of my challenge before you make a final decision about my application for licensure.

Application Attestation: I further attest that:

1. I have read the application or have had the application read to me;
2. All statements on the application are true and complete; and
3. I am of good character.

Print Name SHANA MILES Signature _____ Date 07APR2016

ORIGINAL SIGNATURE REQUIRED

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

This document was prepared by the
Federation of State Medical Boards of the United States, Inc.
Federation Place, 400 Fuller Wiser Road, Suite 300, Euless, TX 76039-3856 --Telephone (817)868-4000

Recipient: NEBRASKA BOARD OF MEDICINE AND SURGERY

Date: 04/07/2016

Examinee: Miles, Shana Melody

Examinee ID: 51967073

Alt Name(s):

Date of Birth: 09/01/1986

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

USMLE STEP 1

Test Date	Pass/Fail	Total	MP	Comments
6/6/2007	Pass	210	(185)	

USMLE STEP 2

Clinical Knowledge (CK)

Test Date	Pass/Fail	Total	MP	Comments
6/27/2011	Pass	230	(189)	

Clinical Skills (CS)*

Test Date	Pass/Fail	Total	MP	Comments
5/2/2011	Pass			

USMLE STEP 3

Test Date	Pass/Fail	Total	MP	Comments
10/1/2012	Pass	214	(190)	

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

State of Nebraska, Department of Health and Human Services
Division of Public Health, Licensure Unit
301 Centennial Mall South,
PO Box 94986, Lincoln NE 68509-4986 (402) 471-2118

LICENSURE UNIT
MAY 26 2016
RECEIVED

CERTIFICATE OF POST-GRADUATE MEDICAL EDUCATION

Applicants must have the **current Program Director** of the institution where they completed their post-graduate medical education complete the following form and **affix the Official School Seal**. An original signature from the Program Director is required. Please mail the form directly to the address printed above.

Print Name SHANA MILES **SS#** [redacted]

NOTE: The information below must be completed ONLY by an official of the program/facility and not the applicant.

It is hereby certified that: Shana Miles
(Name of Applicant)

Has successfully complete) Obstetrics and Gynecology Internship
(Name of Residency/Internship/Fellowship)

located at : Walter Reed National Military Medical Center **in** Bethesda, MD, USA
(Name of Hospital/Teaching Institution) (City, State, Country)

From 07/01/2012 **to** 06/30/2013
(Month/Day/Year) (Month/Day/Year)

At the time this applicant was enrolled in this Program, this Program was:

x **ACGME* or AOA* accredited** *ACGME - Accreditation Council for Graduate Medical Education
*AOA – American Osteopathic Association

____ **RCPSC* or CFPC* accredited** *RCPSC – Royal College of Physicians and Surgeons of Canada
*CFPC – College of Family Physicians of Canada

____ **was not accredited by any of the above listed entities**

Any Disciplinary Action? Yes ____ No ✓ If yes, provide details of the disciplinary action.

Any Derogatory Information? Yes ____ No ✓ If yes, provide details of the derogatory information.

Signature of CURRENT PROGRAM DIRECTOR
(Signature stamp **NOT** acceptable)

Print Name Scott Petersen

Title Residency PD

Date (month/day/year) 5/23/16

Phone # 240-481-3700

E-mail scott.m.petersen.mil@mail.mil

INSTITUTIONAL SEAL

(If your institution does not have an official seal, this form must be notarized)

Maryland SS
Subscribed and Sworn to before me
this 24 day of May, 2016
_____ Notary Public, MD
My commission expires [illegible] 2018

State of Nebraska, Department of Health and Human Services
Division of Public Health, Licensure Unit
301 Centennial Mall South,
PO Box 94986, Lincoln NE 68509-4986 (402) 471-2118

CERTIFICATE OF POST-GRADUATE MEDICAL EDUCATION

Applicants must have the **current Program Director** of the institution where they completed their post-graduate medical education complete the following form and **affix the Official School Seal**. An **original** signature from the Program Director is required. Please mail the form directly to the address printed above.

Print Name SHANA MILES **SS#** [redacted]

NOTE: The information below must be completed ONLY by an official of the program/facility and not the applicant.

It is hereby certified that: Shana M. Les
(Name of Applicant)

Has successfully complete) National Capital Consortium
(Name of Residency/Internship/Fellowship)

located at : WALTER REED NMMC **in** Bethesda, MD USA
(Name of Hospital/Teaching Institution) (City, State, Country)

From 7/1/2012 **to** 6/30/2012
(Month/Day/Year) (Month/Day/Year)

At the time this applicant was enrolled in this Program, this Program was:

✓ **ACGME* or AOA* accredited** *ACGME - Accreditation Council for Graduate Medical Education
*AOA – American Osteopathic Association

_____ **RCPSC* or CFPC* accredited** *RCPSC – Royal College of Physicians and Surgeons of Canada
*CFPC – College of Family Physicians of Canada

_____ **was not accredited by any of the above listed entities**

Any Disciplinary Action? Yes _____ No ✓ If yes, provide details of the disciplinary action.

Any Derogatory Information? Yes _____ No ✓ If yes, provide details of the derogatory information.

Signature of CURRENT PROGRAM DIRECTOR
(Signature stamp **NOT** acceptable)

Print Name SCOTT PETERSEN

Title Residency PD

Date (month/day/year) 4/13/16

Phone # 240-481-3700

E-mail oregonduck@verizon.net

INSTITUTIONAL SEAL

(If your institution does not have an official seal, this form must be notarized)

COMMONWEALTH of VIRGINIA

VERIFICATION

Re: **Shana Melody Miles**
5750 BOU AVE
1304
ROCKVILLE, MD20852

From: Alan Heaberlin
Deputy Director, Licensure
Virginia Board of Medicine

Subj: Licensure Verification

Date: April 08, 2016

Profession:	**Medicine & Surgery**
License Number:	**0101254578**
Issued On:	**07/19/2013**
Expires:	**09/30/2016 ***

This license has not been the subject of an administrative proceeding. If you have any questions, please call 804-367-4451.

The information above is the only verification provided by this board. If other information is needed, please do not hesitate to contact this office. To expedite the verification process, the above format is the standard format prepared for all professions regulated by this board.

Verifications may also be obtained by our website at www.dhp.virginia.gov or our interactive phone system at 804-270-6836 with fax back option.

* The expiration date of 1956 indicates that there is no recorded date of expiration for this license, and that it expired sometime prior to 1980.

NOTE: The Board of Medicine no longer provides a raised seal on this document.

MILES, SHANA MELODY, MD
ATTN: CREDENTIALS OFFICE
WRNMMC, BLDG 17, RM 3143
8901 WISCONSIN AVENUE
BETHESDA, MD 20889-5600-000

10014538/001494

DEA REGISTRATION NUMBER	THIS REGISTRATION EXPIRES	FEE PAID
[redacted]	01-31-2019	FEE EXEMPT

SCHEDULES	BUSINESS ACTIVITY	ISSUE DATE
2,2N, 3,3N,4,5,	PRACTITIONER-MILITARY	12-10-2015

MILES, SHANA MELODY, MD
ATTN: CREDENTIALS OFFICE
WRNMMC, BLDG 17, RM 3143
8901 WISCONSIN AVENUE
BETHESDA, MD 20889-5600

CONTROLLED SUBSTANCE REGISTRATION CERTIFICATE
UNITED STATES DEPARTMENT OF JUSTICE
DRUG ENFORCEMENT ADMINISTRATION
WASHINGTON D.C. 20537

Restricted to Government personnel for official duties only.

Sections 304 and 1008 (21 USC 824 and 958) of the Controlled Substances Act of 1970, as amended, provide that the Attorney General may revoke or suspend a registration to manufacture, distribute, dispense, import or export a controlled substance.

THIS CERTIFICATE IS NOT TRANSFERABLE ON CHANGE OF OWNERSHIP, CONTROL, LOCATION, OR BUSINESS ACTIVITY, AND IT IS NOT VALID AFTER THE EXPIRATION DATE.

CONTROLLED SUBSTANCE REGISTRATION CERTIFICATE
UNITED STATES DEPARTMENT OF JUSTICE
DRUG ENFORCEMENT ADMINISTRATION
WASHINGTON D.C. 20537

DEA REGISTRATION NUMBER	THIS REGISTRATION EXPIRES	FEE PAID
[redacted]	01-31-2019	FEE EXEMPT

SCHEDULES	BUSINESS ACTIVITY	ISSUE DATE
2,2N, 3,3N,4,5,	PRACTITIONER-MILITARY	12-10-2015

MILES, SHANA MELODY, MD
ATTN: CREDENTIALS OFFICE
WRNMMC, BLDG 17, RM 3143
8901 WISCONSIN AVENUE
BETHESDA, MD 20889-5600

Restricted to Government personnel for official duties only.

Sections 304 and 1008 (21 USC 824 and 958) of the Controlled Substances Act of 1970, as amended, provide that the Attorney General may revoke or suspend a registration to manufacture, distribute, dispense, import or export a controlled substance.

THIS CERTIFICATE IS NOT TRANSFERABLE ON CHANGE OF OWNERSHIP, CONTROL, LOCATION, OR BUSINESS ACTIVITY, AND IT IS NOT VALID AFTER THE EXPIRATION DATE.

Form DEA-223 (4/07)

DEA REGISTRATION NUMBER	THIS REGISTRATION EXPIRES	FEE PAID
[redacted]	01-31-2019	FEE EXEMPT

SCHEDULES	BUSINESS ACTIVITY	ISSUE DATE
2,2N, 3,3N,4,5,	PRACTITIONER-MILITARY	12-10-2015

MILES, SHANA MELODY, MD
ATTN: CREDENTIALS OFFICE
WRNMMC, BLDG 17, RM 3143
8901 WISCONSIN AVENUE
BETHESDA, MD 20889-5600

CONTROLLED SUBSTANCE/REGULATED CHEMICAL REGISTRATION CERTIFICATE
UNITED STATES DEPARTMENT OF JUSTICE
DRUG ENFORCEMENT ADMINISTRATION
WASHINGTON D.C. 20537

Restricted to Government personnel for official duties only.

Sections 304 and 1008 (21 USC 824 and 958) of the Controlled Substances Act of 1970, as amended, provide that the Attorney General may revoke or suspend a registration to manufacture, distribute, dispense, import or export a controlled substance.

THIS CERTIFICATE IS NOT TRANSFERABLE ON CHANGE OF OWNERSHIP, CONTROL, LOCATION, OR BUSINESS ACTIVITY, AND IT IS NOT VALID AFTER THE EXPIRATION DATE.

Form DEA-223/511 (4/07)

REPORT

CHANGES

PROMPTLY

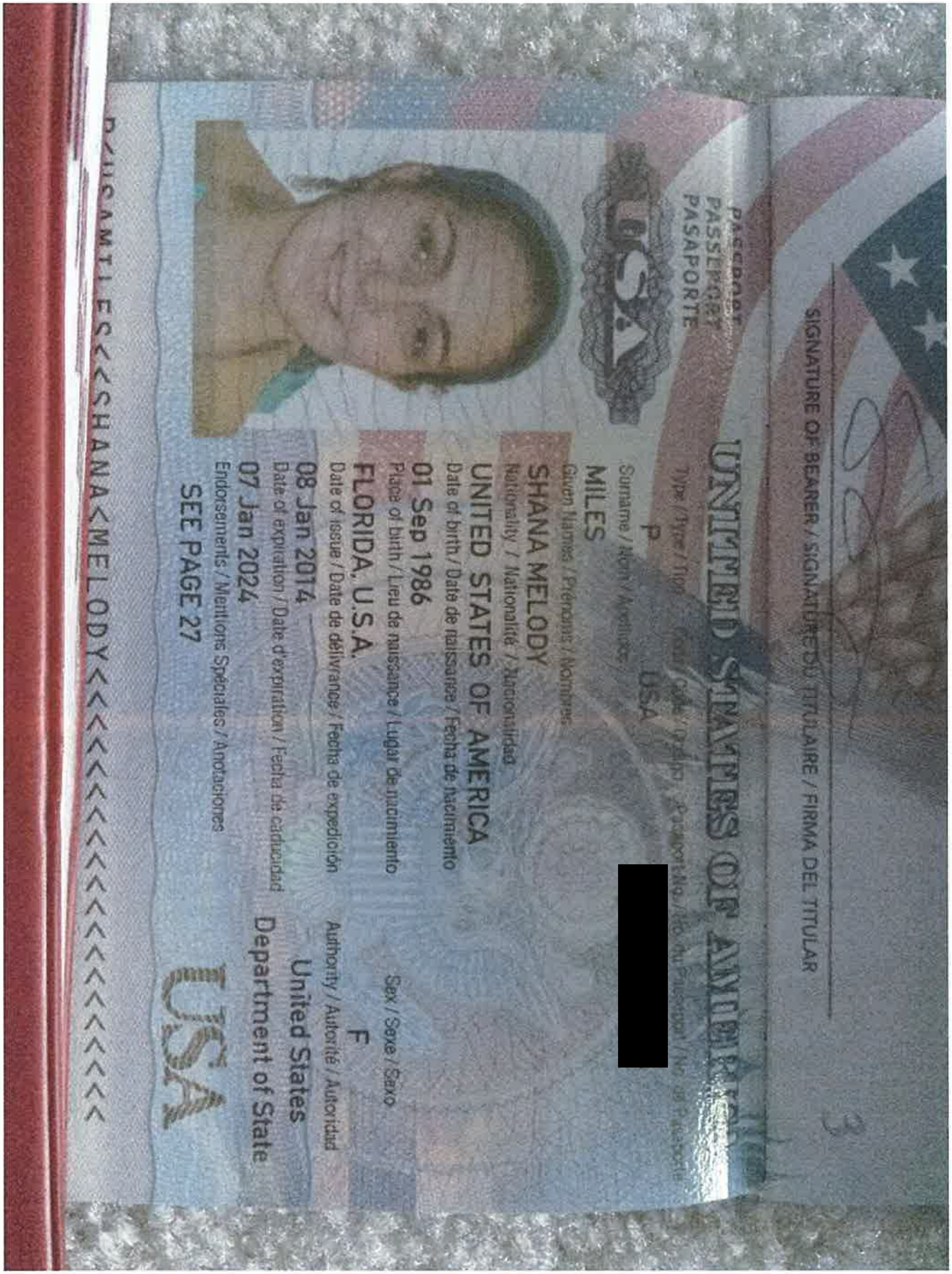
REQUESTING MODIFICATIONS TO YOUR REGISTRATION CERTIFICATE

To request a change to your registered name, address, the drug schedule or the drug codes you handle, please

1. visit our web site at **deadiversion.usdoj.gov** - or
2. call our customer Service Center at **1-(800) 882-9539** - or
3. submit your change(s) in writing to:
   Drug Enforcement Administration
   P.O. Box 28083
   Washington, DC 20083

See Title 21 Code of Federal Regulations, Section 1301.51 for complete instructions.

You have been registered to handle the following chemical/drug codes:


SIGNATURE OF BEARER / SIGNATURE DU TITULAIRE / FIRMA DEL TITULAR
PASSPORT
PASSEPORT
PASAPORTE
UNITED STATES OF AMERICA
P
USA
[redacted]
Surname
MILES
Given Names / Prénoms / Nombres
SHANA MELODY
Nationality / Nationalité / Nacionalidad
UNITED STATES OF AMERICA
Date of birth / Date de naissance / Fecha de nacimiento
01 Sep 1986
Sex / Sexe / Sexo
F
Place of birth / Lieu de naissance / Lugar de nacimiento
FLORIDA, U.S.A.
Date of issue / Date de délivrance / Fecha de expedición
08 Jan 2014
Authority / Autorité / Autoridad
United States
Department of State
Date of expiration / Date d'expiration / Fecha de caducidad
07 Jan 2024
Endorsements / Mentions Spéciales / Anotaciones
SEE PAGE 27
USA
SHANA<MELODY<<<<<<<<<<<<<<<<<<<<<<<

Oberthur ID One 128 v5.5 Dual 4820-502B-1029-0688-39550001412 5
Benefits Number 012219566-00
Geneva Conv. Category IV
DoD ID Number 1367819681
DODCAC170001080
Blood Type: A+
4086SEP04

United States Government
OCT20
Affiliation
Uniformed Services
Agency/Department
Air Force
Expires
2018OCT07
MILES,
SHANA M
Pay Grade
O4
Rank
MAJ
Medical
Geneva Conventions Identification Card

Department of Health & Human Services
DHHS
NEBRASKA

Division of Public Health

State of Nebraska
Pete Ricketts, Governor

May 20, 2016

Shana Melody Miles, MD
5750 Bou Ave #1304
Rockville MD 20852

Dear Dr. Miles:

Our office is in receipt of your application for a Physician license. A review of your file indicates the following is needed to complete your application:

Certification of Post-Graduate Medical Education form completed by the program director after completion of one year of the program. We did receive the PGE from Walter Reed but the dates were from 7/1/12 to 6/30/12 and it wasn't signed by the current program director. Please have a new one filled out and mailed back to me.

Section III #4 and #5 were not answered. Please provide your answers.
#4: Have you ever been notified that any action against your hospital or institutional privileges is pending or proposed?
#5: Have you ever been allowed to withdraw your staff privileges from a hospital or institution?

We have received your fingerprint cards. They have been sent to the Nebraska State Patrol for processing. Therefore, the criminal background check has not been completed.

If you have not done so already, please make sure that you have paid the $28.75 fee to the Nebraska State Patrol for processing. **Please be aware that standard processing time is 8-10 weeks for the background check. Please refrain from contacting the Patrol regarding status of prints.**

A final review of your application for licensure eligibility will not occur until the above referenced materials are received. All supporting documentation required to complete your application must be submitted within 150 days of the date of this letter. If such documentation is not submitted within this time, your application and supporting documentation will be destroyed and a refund will be processed, less the administrative fee of $25.00.

Sincerely,

Heidi A Weiand, Specialist
Licensure Unit
PO Box 94986
Lincoln, NE 68509-4986
402-471-2118
Heidi.Weiand@Nebraska.gov

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Renewal Questions for License Number 29308

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License Type	Sort Name	Question	Answer	Date
Physician	Miles, Shana Melody, MD	**(1) Inactive:** Have you selected Inactive Status? Inactive means you cannot practice your profession after the expiration date of your credential, but may represent yourself as having an inactive credential.	N	8/11/2016
Physician	Miles, Shana Melody, MD	**(2) Name Change:** Are you requesting a name change or correction to your name?	N	8/11/2016
Physician	Miles, Shana Melody, MD	**(3) Were you convicted** of a misdemeanor or felony in any jurisdiction between 10/2/14 and 10/1/16?	N	8/11/2016
Physician	Miles, Shana Melody, MD	**(4a) Have you held a license** that was issued by another jurisdiction(s) to provide health services, health-related services, or environmental services? (If you answer "No" to 4a, answer "No" to 4b)	Y	8/11/2016
Physician	Miles, Shana Melody, MD	**(4b) Has such license been denied,** refused renewal, or disciplined between 10/2/14 and 10/1/16? (If NOT credentialed in another jurisdiction answer "No")	N	8/11/2016
Physician	Miles, Shana Melody, MD	**(5a) Citizenship/Lawful Presence:** I am a citizen of the United States. If you are a US citizen answer "No" to 5b and 5c.	Y	8/11/2016
Physician	Miles, Shana Melody, MD	**(5b) I am an qualified alien** or non-immigrant lawfully admitted into the United States License (i.e.: permanent resident card, I-94 document, asylum, etc.)	N	8/11/2016
Physician	Miles, Shana Melody, MD	**(5c) I have an unexpired employment authorization documen** and documentation listed under the Federal REAL ID act (i.e.: DACA, pending asylum, pending refugee, etc.).	N	8/11/2016
Physician	Miles, Shana Melody, MD	**(6) Continuing Competency Waiver-Military:** I have served full-time duty in the active military service of the United States, or a National Guard call to active service for more than 30 consecutive days, or active service as a commissioned officer of the Public Health Service or the National Oceanic and Atmospheric Administration during part of the 24 months immediately preceding the biennial licensure renewal date (10/2/14 and 10/1/16). If you meet this	Y	8/11/2016

		exemption, you are not required to pay the renewal fee.		
Physician	Miles, Shana Melody, MD	**(7) Continuing Competency Waiver-Initial License:** : I was first licensed in Nebraska within the 24 months immediately preceding the licensure renewal date (10/2/14 and 10/1/16). (for Physicians only Credential Numbers 28172 - 5000 qualify, for Osteopathic Physicians only Credential Numbers 1233 - 2000 qualify)	Y	8/11/2016
Physician	Miles, Shana Melody, MD	**(8) Continuing Competency:** Have you completed one of the following immediately preceding the licensure renewal date (October 2, 2014 through October 1, 2016): • 50 hours of Category 1 continuing education approved by the Accreditation Council for Continuing Medical Education (ACCME) or the American Osteopathic Association (AOA). A licensee who has earned more than the 50 hours required for license renewal for the previous 24 month renewal period is allowed to carry over up to 25 hours to the next 24 month renewal period; **OR** • One year of participation in an approved graduate medical education program; **OR** • The AMA Physician's Recognition Award or the AOA CME certification (awarded within the 24 months immediately preceding the expiration date of your license). NOTE: If you answer "Yes" to question 8, you should answer "No" to the CE Waiver questions 6 or 7. If you answer "No" to question 8, you MUST answer "Yes" to at least one of the CE Waiver questions 6 or 7.	Y	8/11/2016

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Renewal Questions for License Number 29308

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License Type	Sort Name	Question	Answer	Date
Physician	Miles, Shana Melody, MD	**Inactive Status:** Did you select Inactive Status?	N	7/30/2018
Physician	Miles, Shana Melody, MD	**Continuing Education** (select one) I have completed my continuing education requirement, or will complete it by 10/01/18. • 50 hours of Category 1 continuing education approved by the Accreditation Council for Continuing Medical Education (ACCME) or the American Osteopathic Association (AOA). A licensee who has earned more than 50 hours required for license renewal for one 24 month renewal period is allowed to carry over up to 25 hours to the next 24 month renewal period; or • One year (12 months done between October 2, 2016 and October 1, 2018) of participation in an approved graduate medical education program; or • The AMA Physician's Recognition Award or the AOA CME certification (awarded within the 24 months immediately preceding the date of expiration).	Y	7/30/2018
Physician	Miles, Shana Melody, MD	I was first licensed in Nebraska after 10/01/16, so continuing education is not required.	N	7/30/2018
Physician	Miles, Shana Melody, MD	I chose Active-Military status, so continuing education is not required.	N	7/30/2018
Physician	Miles, Shana Melody, MD	**Conviction** Since 10/01/16, I was convicted of a misdemeanor or felony.	N	7/30/2018
Physician	Miles, Shana Melody, MD	**Other License(s)** Since 10/01/16, I have been licensed by another state(s) to provide health-related or environmental services.	N	7/30/2018
Physician	Miles, Shana	This license(s) has been denied, refused renewal, or disciplined since 10/01/16.	N	7/30/2018

	Melody, MD			
Physician	Miles, Shana Melody, MD	**Citizenship/Lawful Presence** (Answer Yes to only ONE of the below questions.) I am a citizen of the United States.	Y	7/30/2018
Physician	Miles, Shana Melody, MD	I am not a citizen of the United States. I am a qualified alien under the federal Immigration and Nationality Act, or a non-immigrant lawfully present in the United States, with documentation such as a permanent resident card, I-94 document, asylum, etc.	N	7/30/2018
Physician	Miles, Shana Melody, MD	I am not a citizen of the United States. I have an unexpired Employment Authorization Document (EAD) and documentation listed under the Federal REAL ID act, such as DACA, pending asylum, pending refugee, etc.	N	7/30/2018
Physician	Miles, Shana Melody, MD	**Prescription Drug Monitoring Program Enrollment** Are you interested in registering for a FREE medication history tool, the Nebraska Prescription Drug Monitoring Program? *By selecting YES to the above question you are beginning the registration process for access to the Nebraska PDMP. Once your information has been verified you will receive further instructions on how to complete the registration process*	N	7/30/2018