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State Medical Board of Ohio

med.ohio.gov   30 E. Broad St., 3rd Floor · Columbus, OH 43215-6127 · (614) 466-3934

Ohio Physician Licensure Application

1. ***Indicate License Type*** ☑ M.D. ◯ D.O. ◯ M.D. Telemedicine ◯ D.O. Telemedicine

2. ***Name: Indicate your full legal name. Please list any maiden names or other names used.***

Last	First	Middle	Suffix
Rivlin	Katherine	Lee	

Maiden Name	All other names used

3. ***Contact Information:*** *Please complete all sections*

Indicate which address you wish to use for mailings from the Medical Board. ☑ Practice Address ◯ Home Address

Practice Address

Street 1: 1800 Zollinger Rd   Phone Number:
Street 2:   Fax Number:
City: Columbus   State: OH   Zip Code: 43221   email:

Home Address

Street 1: 952 Franklin Ave   Phone Number: 601-214-1393
Street 2:   Fax Number:
City: Columbus   State: OH   Zip Code: 43205   email: katyriv@gmail.com

4. ***Identification***

Date of birth	Birth City	State	Country
10/06/1982	Jackson	MS	USA

SSN: REDACTED

Gender: ◯ Male ☑ Female

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., 4762., or 4778. O.R.C. or as otherwise required by state or federal law.

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Rivlin PE# 134540

OK MA 6/7/16

5. Preliminary Education.

High School or equivalent: St. Andrews Episcopal School

City: Ridgeland State: MS Country: USA

Date From: 8/1998 Date To: 5/2001

Undergraduate College 1: Yale University

City: New Haven State: CT Country: USA

Date From: 9/2001 Date To: 5/2005 Degree: B.A. English

Undergraduate College 2:

City: State: Country:

Date From: Date To: Degree:

6. TOEFL- IBT. This section is only required to be completed by International Medical School Graduates.

THE TOEFL, TWE, ECFMG's ENGLISH EXAM (PRIOR TO 7/1/98), ETC., ARE NOT EQUIVALENT AND CANNOT BE SUBSTITUTED FOR THE TOEFL-IBT.

Graduates of medical schools located outside the United States and Canada must achieve a score of at least 26 in Speaking and 26 in Listening with a total score of 90 on the TOEFL-IBT, regardless of citizenship or country of birth. Prior to July 2006 the Test of Spoken English was required with a minimum score of 40 (between 7/95 and 7/06) or 230 (prior to 7/95). The following are the only exceptions permitted under Ohio law:

- ( ) YES ( ) NO Have you completed two years of undergraduate college work in the United States?
- ( ) YES ( ) NO During the five years immediately preceding the date of your application have you:

  Held a current medical license (i.e., unrestricted, training certificate, educational permit) in the United States **AND** Have you been actively practicing medicine (graduate medical education is included) in the United States?
- ( ) YES ( ) NO Have you completed a Fifth Pathway program?
- ( ) YES ( ) NO Have you passed the Clinical Skills Assessment exam given by the ECFMG on or after July 1, 1998?

If you answered 'NO' to all of the above, you are required to take the TOEFL-IBT. Please refer to the instructions for information on contacting the Educational Testing Service. The Board cannot waive this requirement.

7. Ohio Training Program.

( ) YES (✓) NO Are you or will you be in an accredited training program in Ohio? If yes, please identify the program below.

Program Name:

8. Military.

( ) YES (✓) NO Are you currently in the United States Military or Reserves or a Military Veteran?

( ) YES (✓) NO Are you the spouse of an individual currently serving in the United States Military or Reserves?

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9. Medical School: *List all medical schools you have attended, including those from which you did not graduate in chronological order. Attach and additional sheet if necessary.*

1. School Name: University of Mississippi Medical Center
Address: 2500 N. State St
City: Jackson State: MS Zip Code: 39216
Country: USA
Date From: 8/2005
Date To: 6/2009
Graduation Date: 6/2009
Degree: M.D.

2. School Name:
Address:
City: State: Zip Code:
Country:
Date From:
Date To:
Graduation Date:
Degree:

10. Postgraduate Training: *List all postgraduate programs you have attended, including those you did not complete. Copy and attach additional pages if necessary.*

1. Hospital Name: NYU Medical Center
Address: 550 1st Avenue
City: New York State: NY Zip Code: 10016
Country: USA
Department/Specialty: Ob-Gyn
Date From: 7/2009
Date To: 6/2013
Successfully Completed? ☑ Yes ☐ No
PGY ☑ 1 ☑ 2 ☑ 3 ☑ 4 ☐ 5 ☐ other
PGT ☐ Internship ☑ Residency ☐ Fellowship ☐ Research ☐ other

2. Hospital Name: Columbia University Medical Center
Address: 650 W 168th St
City: New York State: NY Zip Code: 10032
Country: USA
Department/Specialty: Family Planning
Date From: 7/2013
Date To: 6/2015
Successfully Completed? ☑ Yes ☐ No
PGY ☐ 1 ☐ 2 ☐ 3 ☐ 4 ☐ 5 ☐ other
PGT ☐ Internship ☐ Residency ☑ Fellowship ☐ Research ☐ other

3. Hospital Name:
Address:
City: State: Zip Code:
Country:
Department/Specialty:
Date From:
Date To:
Successfully Completed? ☐ Yes ☐ No
PGY ☐ 1 ☐ 2 ☐ 3 ☐ 4 ☐ 5 ☐ other
PGT ☐ Internship ☐ Residency ☐ Fellowship ☐ Research ☐ other

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4. Hospital Name		Date From	
Address		Date To	
City	State	Zip Code	
Country		Successfully Completed?	◯ Yes ◯ No
Department/Specialty:			

PGY ◯ 1 ◯ 2 ◯ 3 ◯ 4 ◯ 5 ◯ other

PGT ◯ Internship ◯ Residency ◯ Fellowship ◯ Research ◯ other

5. Hospital Name		Date From	
Address		Date To	
City	State	Zip Code	
Country		Successfully Completed?	◯ Yes ◯ No
Department/Specialty:			

PGY ◯ 1 ◯ 2 ◯ 3 ◯ 4 ◯ 5 ◯ other

PGT ◯ Internship ◯ Residency ◯ Fellowship ◯ Research ◯ other

11. Examination History: *List each licensure examination you have taken (USMLE, NBME, NBOME, LMCC, Etc.). If additional space is necessary, copy and attach an additional sheet.*

Examination	Date Taken (mm,yyyy)	Pass / Fail	No. of Attempts
USMLE Step 1	5 / 2007	✓ Pass ◯ Fail	1
USMLE Step 2 CK	6 / 2008	✓ Pass ◯ Fail	1
USMLE Step 2 CS	7 / 2008	✓ Pass ◯ Fail	1
USMLE Step 3	2 / 2011	✓ Pass ◯ Fail	1
COMLEX Level 1		◯ Pass ◯ Fail	
COMLEX Level 2 CE		◯ Pass ◯ Fail	
COMLEX Level 2 PE		◯ Pass ◯ Fail	
COMLEX Level 3		◯ Pass ◯ Fail	
NBME Part I		◯ Pass ◯ Fail	
NBME Part II		◯ Pass ◯ Fail	
NBME Part III		◯ Pass ◯ Fail	
NBOME Part I		◯ Pass ◯ Fail	
NBOME Part II		◯ Pass ◯ Fail	
NBOME Part III		◯ Pass ◯ Fail	
LMCC Part I		◯ Pass ◯ Fail	
LMCC Part II		◯ Pass ◯ Fail	
FLEX Componet 1		◯ Pass ◯ Fail	
FLEX Componet 2		◯ Pass ◯ Fail	
FLEX Pre-1985		◯ Pass ◯ Fail	

State Board Exam	Date Taken	State taken for	No. of Attempts	Pass / Fail
				◯ Pass ◯ Fail

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12. ECFMG and Fifth Pathway

Certificate Number		Issue Date	

School Name		Date From	
Address		Date To	
City	State / Zip Code	Graduation Date	
Country		Degree	

13. State or Professional Licensure: *List all state and Canadian provinces where you currently hold or have ever held any type of medical/osteopathic license. You must complete the attached "Licensure Verification" form (Form #1) and forward it to all states in which you have held any healthcare license or certification. The verifying entity must forward all documentation directly to the Board. Some state boards charge a fee for this information. Contact the state board where you hold or held a license to determine their requirements. (Attach additional pages if necessary).*

	State / Province	License Type	License Number	License Status	Issue Date
1	New York	Medical	207862-1	✓ Active ◯ Inactive	11/1/2014 - 9/30/2016
2				◯ Active ◯ Inactive	
3				◯ Active ◯ Inactive	
4				◯ Active ◯ Inactive	
5				◯ Active ◯ Inactive	
6				◯ Active ◯ Inactive	
7				◯ Active ◯ Inactive	
8				◯ Active ◯ Inactive	
9				◯ Active ◯ Inactive	
10				◯ Active ◯ Inactive	
11				◯ Active ◯ Inactive	
12				◯ Active ◯ Inactive	
13				◯ Active ◯ Inactive	
14				◯ Active ◯ Inactive	
15				◯ Active ◯ Inactive	

14. Specialty Board Certification: *Are you ABMS and / or AOA certified?* ◯ Yes ✓ No

*If **Yes** complete information below*

Name of Board		Certificate Number		Issue Date	
Name of Board		Certificate Number		Issue Date	
Name of Board		Certificate Number		Issue Date	

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15. *Chronology of Activities:* *List ALL activities (medical, non-medical, and postgraduate training) in chronological order beginning with medical school graduation to the PRESENT date, using* ***MONTH*** *and* ***YEAR****. For any non-working time, you MUST state on the form exactly what your activities were, such as "vacation" or "seeking employment," as well as your permanent address. If you worked for a physician-staffing group or did locum tenens, you must list all facilities where you worked and include complete dates and addresses.* ***DO NOT SUBSTITUTE ANY OTHER RESUME FOR THIS FORM****. Be sure to indicate the percentage of working time spent in clinical /administrative duties.*

Dates: From/To | Activity *(medical, non-medical and post graduate training)*

FROM: Month: 7 Year: 2009
TO: Month: 6 Year: 2013
○ In Progress

Activity/Employer Name *(Non-Working*)*: NYU Medical Center Ob Gyn Residency
Activity Address: 550 1st Avenue
City: New York State: NY Zip Code: 10016
Position / Department: Residency in Ob Gyn
Percent Clinical: 100 Percent Administrative:

✓ Employment ○ Staff Privileges ○ Administrative ○ Other, Please describe below

Dates: From/To | Activity *(medical, non-medical and post graduate training)*

FROM: Month: 7 Year: 2013
TO: Month: 6 Year: 2015
○ In Progress

Activity/Employer Name *(Non-Working*)*: Columbia Univ Med Center
Activity Address: 650 W 168th St
City: New York State: NY Zip Code: 10032
Position / Department: Family Planning Fellowship
Percent Clinical: 100 Percent Administrative:

✓ Employment ✓ Staff Privileges ○ Administrative ○ Other, Please describe below

Dates: From/To | Activity *(medical, non-medical and post graduate training)*

FROM: Month: 7 Year: 2015
TO: Month: Year:
✓ In Progress

Activity/Employer Name *(Non-Working*)*: NYU Medical Center
Activity Address: 550 1st Avenue
City: New York State: NY Zip Code: 10016
Position / Department: Ob-Gyn
Percent Clinical: 60 Percent Administrative: 40

✓ Employment ✓ Staff Privileges ✓ Administrative ✓ Other, Please describe below

Ob-Gyn Residency Associate Program director

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Dates: From/To | Activity *(medical, non-medical and post graduate training)*

FROM: *Month* [ ] *Year* [ ]
TO: *Month* [ ] *Year* [ ]
( ) In Progress

Activity/Employer Name *(Non-Working*)* [ ]
Activity Address [ ]
City [ ] State [ ] Zip Code [ ]
Position / Department [ ]
Percent Clinical [ ] Percent Administrative [ ]

( ) Employment ( ) Staff Privileges ( ) Administrative ( ) Other, Please describe below

Dates: From/To | Activity *(medical, non-medical and post graduate training)*

FROM: *Month* [ ] *Year* [ ]
TO: *Month* [ ] *Year* [ ]
( ) In Progress

Activity /Employer Name *(Non-Working*)* [ ]
Activity Address [ ]
City [ ] State [ ] Zip Code [ ]
Position / Department [ ]
Percent Clinical [ ] Percent Administrative [ ]

( ) Employment ( ) Staff Privileges ( ) Administrative ( ) Other, Please describe below

16. Malpractice: *List of all claims or suits for medical malpractice made against you. A claim is any fomal or informal demand for payment to any person or organization. If you do not have any such claims or suits, this section will be blank. Please provide a detailed written description of the background and medical issues involved in each case. Attach additional sheets if necessary.*

Name of patient involved: [ ] State action took place [ ]
Name of Court [ ] Case Number (if applicable: [ ]

Current status of claim: ( ) Open (pending) ( ) Closed (settled or judgment) ( ) Dismissed (no money paid out)

Amount of judgment or settlement: [ ] Amount paid on your behalf [ ]
Month and Year of incident [ ] Month and Year of lawsuit [ ]
Insurance carrier at the time [ ]

What is / was your status: ( ) Primary Defendant ( ) Co-defendant ( ) Other

Name of patient involved: [ ] State action took place [ ]
Name of Court [ ] Case Number (if applicable: [ ]

Current status of claim: ( ) Open (pending) ( ) Closed (settled or judgment) ( ) Dismissed (no money paid out)

Amount of judgment or settlement: [ ] Amount paid on your behalf [ ]
Month and Year of incident [ ] Month and Year of lawsuit [ ]
Insurance carrier at the time [ ]

What is / was your status: ( ) Primary Defendant ( ) Co-defendant ( ) Other

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Ohio Addendum to Application
ADDITIONAL INFORMATION QUESTIONS

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.

( ) Yes (✓) No 1. Have you ever been denied staff membership at any hospital, nursing home, clinic, health maintenance organization, or similar institution?

( ) Yes (✓) No 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?

( ) Yes (✓) No 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?

( ) Yes (✓) No 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?

( ) Yes (✓) No 5. Have you ever transferred from one graduate medical education program to another?

( ) Yes (✓) No 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?

( ) Yes (✓) No 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?

( ) Yes (✓) No 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?

( ) Yes (✓) No 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?

( ) 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?

Yes No 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?

Yes No 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?

Yes No 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?

Yes No 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?

Yes No 15. Have you ever pled guilty to, been found guilty of a violation of any law, or been granted intervention or treatment in lieu of conviction regardless of the legal jurisdiction in which the act was committed, other than a minor traffic violation? If yes, submit copies of all relevant documentation, such as police reports, certified court records and any institutional correspondence and orders. Photocopies will not be accepted.

Yes No 16. Have you ever been arrested, forfeited collateral, bail, or bond for breach or violation of any law, police regulation, or ordinance other than for a minor traffic violation; been summoned into court as a defendant or had any lawsuit filed against you (other than a malpractice suit)? If yes, submit copies of all relevant documentation, such as police reports, certified court records and any institutional correspondence and orders. Photocopies will not be accepted.

Yes No 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? 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.

Yes No 18. Have you ever been denied professional liability insurance or coverage, or had such insurance or coverage canceled, limited, or restricted in any way?

Yes No 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?

Yes No 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?

Yes No 21. Have you ever been diagnosed as having, or have you been treated for, pedophilia, exhibitionism, or voyeurism?

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Yes No 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?

Yes No 22. 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 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.

Yes No 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.

Yes No 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?

"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?

Yes No 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.

(Yes (✓ No 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 illègally (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?

(Yes (No 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

med.ohio.gov 30 E. Broad St., 3rd Floor · Columbus, OH 43215-6127 · (614) 466-3934

Affidavit and Authorization for Release of Information: You must attach a recent (less than 6 months old) passport quality, color photograph of yourself to this form. Take the form to a notary public and sign the form in the presence of the notary public. The notarized form then must be sent directly to this Board.

Affidavit and Authorization For Release of Information

I, the undersigned, being duly sworn, 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 Application for Physician Licensure 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 Board any such information, including documents, records regarding charges or complaints filed against me, formal or informal, pending or closed, or any other pertinent data and to permit the Board or any of its agents or representatives to inspect and make copies of such documents, records, and other information in connection with this application.

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

I will immediately notify the board in writing of any changes to the answers to any of the questions contained in this application if such a change occurs at any time prior to a license to practice medicine being granted to me by the board

I understand my failure to answer questions contained in this application truthfully and completely may lead to denial, revocation, or other disciplinary sanction of my licensure or permit to practice medicine.

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

Rivlin
Applicant's Printed Last Name

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

5/24/2016
Date of Signature

[signature]
Notary Public Signature

1/25/18
Date Commission Expires

Subscribed and Sworn to before me on this 24th day of May ,20 16

LESLIE M. SIMONS
NOTARY PUBLIC-STATE OF NEW YORK
No. 01SI6216816
Qualified In Orange County
My Commission Expires January 25, 18

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State Medical Board of Ohio

30 E. Broad St., 3rd Floor • Columbus, OH 43215-6127 • (614) 466-3934 • Fax (614) 644-1464

Ohio Addendum to Application
EMPLOYER RECOMMENDATION FORM

Dr. Katherine Rivlin
(PLEASE PRINT APPLICANTS FIRST NAME AND LAST NAME)

is applying for licensure in the State of Ohio. We would appreciate your assistance in filling out the following evaluation so that we can process their application for licensure. To ensure processing of the physicians application, please complete and return this form to the State Medical Board of Ohio at the above address within two (2) weeks. **The form may also be faxed to the Board at (614) 644-1464.** Your immediate attention to this matter will be greatly appreciated by the applicant as well as by us. Thank you for your time and assistance.

Position(s) held: Associate Residency Director

Dates of Employment: July 1, 2015 - June 30, 2016

1. How long have you known the applicant? 6 years
2. What is/was your supervisory capacity? Earlier as supervising attending and then as Residency Director
3. At what hospital/clinic? Bellevue Hospital Center
4. How would you rate their medical knowledge and techniques? Excellent.
5. In your opinion is the applicant of good moral and ethical character? Absolutely.
6. Does the applicant work well with peers and medical staff? Very well.
7. Does the applicant relate well to patients? Very well.
8. How is the applicant's command of the English language (If applicable)? Perfect.
9. Would you recommend the applicant for licensure? Absolutely.

Additional comments (An additional sheet may be added if needed): Ohio is lucky to have Dr. Rivlin!

[signature]
Signature of Physician

Abigail Ford Winkel
Name of Physician (Please type or print clearly)

Vice Chair, Education
Position

(212) 263-8683
Telephone number (include area code)

abigail.winkel@nyumc.org
E-Mail

(212) 263-8251
Fax number (include area code)

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THE UNIVERSITY OF THE STATE OF NEW YORK
THE STATE EDUCATION DEPARTMENT
DIVISION OF PROFESSIONAL LICENSING SERVICES
89 WASHINGTON AVENUE
ALBANY, NEW YORK 12234

This is to certify that according to the records of the Division of Professional Licensing Services, New York State Education Department Albany, New York, RIVLIN KATHERINE LEE was issued license/certificate number 267862 for the practice of MEDICINE on 11/30/12.

Our records also indicate the following information:
Date of birth: 10/06/82
School attended: UNIVERSITY OF MISSISSIPPI
Date of graduation: 05/22/09
Degree earned: MD

Program was acceptable in accordance with the NYS Regulations of the Commissioner of Education. Requirements met at the time of licensure.

Basis of licensure:

DATE	FLEX1	NBME1	USML1	NBME2	FLEX2	USML2	NBME3	USML3	OTHER
02/11								00083	OOSCT
06/08						00096			
05/07			00087						

EXMS TAKEN=03
A license is valid during the life of the holder unless revoked, annulled or suspended by the Board of Regents. A licensee must register periodically with this Department to practice in this state.

Currently Registered: YES Reg period ends: 09/30/16
Address: APT 45A 7-13 WASHINGTON SQ N
NEW YORK NY 10003-0000

Disciplinary information: No charges have been preferred against this licensee
Comments:

I, Cathy Hanczaryk, Principal Clerk, Division of Professional Licensing Services of the New York State Education Department, do hereby state that as Principal Clerk of said Division, I have legal custody of the official records of the Division of Professional Licensing Services and to the best of my knowledge, the aforesaid information is true and correct.

SEAL

Cathy Hanczaryk 06/14/16
Office Assistant Three

MEDICAL BOARD
JUN 20 2016

FCVS FEDERATION CREDENTIALS VERIFICATION SERVICE

Medical Professional Information Profile

This report provides credentialing information for

Name: **Katherine Rivlin**

Social Security Number: REDACTED

Date of Birth: **October 06, 1982**

FID#: **215428210**

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

ABOUT THIS PROFILE

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

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

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

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FCVS FEDERATION CREDENTIALS VERIFICATION SERVICE

Credentials Analysis Summary Report

Federation of STATE MEDICAL BOARDS

Note: *Your board may wish to review the unresolved items below marked by an "X"*
Please review the Credentials Analysis Report for further details on the unresolved items

Medical Professional Name: **Katherine Rivlin**
Date of Birth: **October 06, 1982**
Social Security Number: REDACTED
FID: **215428210**

I. FCVS Reports

II. FSMB and Other Reports

III. Identity

A. Certified Birth Certificate OR Copy w/ Cert. of Identification

IV. Medical Education

A. Pre-medical Schools

B. Medical Schools

University of Mississippi School of Medicine
1. Medical Education Form
2. Medical Education Transcript
3. Medical Education Diploma

C. Fifth Pathway Program

D. ECFMG Certification

V. Graduate Medical Education

New York University School of Medicine
1. GME Form
2. GME Completion Certificate

VI. Licensure Examination History

A. FSMB Exam Transcript

End of report for: Katherine Rivlin

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Table of Contents

I. FCVS Reports

A. Physician Information Report
B. Credentials Analysis Report
C. Chronology of Activities

II. FSMB and Other Reports

A. Board Action Data Bank Report

III. Identity

A. Affidavit
B. Certified Birth Certificate or Original Passport or Cert. of Identification with Photocopy
C. Documentation to Support Name Variation

IV. Medical Education

A. Verification of Medical Education
B. Clinical Clerkships (if applicable)
C. Verification of Fifth Pathway (if applicable)
D. ECFMG Certification (if applicable)

V. Graduate Medical Education

A. Verification of Graduate Medical Education

VI. Licensure Examination History (State Licensing Authorities Only)

A. LMCC Transcript
B. State Medical Board Transcript
C. NCCPA Transcript
D. NBME Transcript
E. NBOME Transcript
F. FSMB Transcript

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Section I

FCVS Reports

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Identity

Medical Professional Name: **Katherine Rivlin**

Documentation: Certified Birth Certificate OR Copy w/ Cert. of Identification

Variation of Name: **Katherine Lee Rivlin**

Documentation: Certified Birth Certificate OR Copy w/ Cert. of Identification

Katerine Lee Rivlin

Explanation: My name is not Katerine Lee Rivlin, that is a typo. It is Katherine Lee Rivlin.

Gender: Female

Date of Birth: October 06, 1982

Place of Birth: Jackson, MS, UNITED STATES

Social Security Number: REDACTED

FID: 215428210

Physical Description:

Height:	5 ft. 4 in.
Weight:	125 lbs.
Eye Color:	Brown
Hair Color:	Brown

Contact Information

Mailing Address: 7-13 WASHINGTON SQ N APT 45A
NEW YORK, NY 10003-6623
UNITED STATES

Permanent Address: 7-13 WASHINGTON SQ N APT 45A
NEW YORK, NY 10003-6623
UNITED STATES

Telephone Numbers:

Primary:	(601) 214-1393
Secondary:	N/A
Fax:	N/A
Other:	N/A

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Pre-medical Education

(Provided by Applicant. Not verified with the primary source.)

Institution: **Yale University**
Address: New Haven, CT 06520-8215
UNITED STATES
Dates of Attendance: 08/--/2001 To 05/--/2005
Degree Conferred/Issued: Bachelor of Arts

ECFMG

There are none identified or not applicable.

Medical Education

Medical School: **University of Mississippi School of Medicine**
Address: 2500 North State Street
Jackson, MS 39216
UNITED STATES

Dates of Attendance: 08/10/2005 to 05/22/2009
Date Certificate Issued: 05/22/2009
Degree Conferred/Issued: Doctor of Medicine

Unusual Circumstances
Leave of Absence/Extension: **No**
Probation: **No**
Disciplined: **No**
Negative Reports: **No**
Limitations: **No**

Fifth Pathway

There are none identified or not applicable.

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Graduate Medical Education

Institution: **New York University Medical Center**
Address: 550 First Avenue Suite 9E2

New York, NY 10016
UNITED STATES

Training Level: 1 - 4
Program Type: Internship/Residency
Specialty: Obstetrics and Gynecology
Dates of Attendance: 07/01/2009 To 06/30/2013
Completed Successfully: Yes
Accreditation: ACGME

Unusual Circumstances
Leave of Absence/Extension: **No**
Probation: **No**
Disciplined: **No**
Negative Reports: **No**
Limitations: **No**

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Licensure Examinations

Examination	Date	Result
FSMB Transcript USMLE Step 1	Date: 05/2007	Passed the Exam
FSMB Transcript USMLE Step 2 CK	Date: 06/2008	Passed the Exam
FSMB Transcript USMLE Step 2 CS	Date: 07/2008	Passed the Exam
FSMB Transcript USMLE Step 3	Date: 02/2011	Passed the Exam

Board Action

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

End of report for: Katherine Rivlin FID: 215428210

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Credentials Analysis Report

Federation of STATE MEDICAL BOARDS

The Credentials Analysis Report is a comparative report of a medical professional's credentials as reported to FCVS by the applicant and the primary source (Medical School, Post Graduate Training program, etc.). It will also list particular missing documentation, if any, as outlined in the FCVS Policies and Procedures.

Medical Professional Identification

Medical Professional Name: **Katherine Rivlin**

Date of Birth: **October 06, 1982**

Social Security Number: REDACTED

FID: **215428210**

Omissions

There are no omissions identified.

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Discrepancies

There are no discrepancies identified.

Miscellaneous Information

Miscellaneous 1:

Section of Profile:	**Post Graduate Training**
Miscellaneous:	**Verification of the Graduate Medical Education at Columbia University Medical Center dated 07/--/2013 to 06/--/2015 reported by the applicant in the Chronology of Activities is not included in the Medical Professional Information Profile.**
Action Taken:	**FCVS does not obtain verification of non-accredited Fellowship/Research programs.**

End of report for: Katherine Rivlin

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FCVS FEDERATION CREDENTIALS VERIFICATION SERVICE

Chronology of Activities

Federation of STATE MEDICAL BOARDS

The Chronology of Activities is a comprehensive report of a medical professional's activities as reported to FCVS by the medical-professional applicant.

Medical Professional Name: **Katherine Rivlin**
Date of Birth: **October 06, 1982**
Social Security Number: REDACTED
FID#: **215428210**

Start Date	End Date	Activity	Location	Overlap Explanation	Program Length Explanation
08/2005	05/2009	Medical Education Record	University of Mississippi School of Medicine,2500 North State Street Jackson, MS 39216 UNITED STATES		
07/2009	06/2013	GME Record	New York University Medical Center,550 First Avenue Suite 9E2 New York, NY 10016 UNITED STATES		
07/2013	06/2015	GME Record	Columbia University Medical Center,622 W. 168th Street New York, NY 10032 UNITED STATES		

End of report for: Katherine Rivlin

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Section II

FSMB and Other Reports

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Section III

Identity

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Affidavit and Release

Federation of STATE MEDICAL BOARDS

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

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

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

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

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

LESLIE M. SIMONS
NOTARY PUBLIC-STATE OF NEW YORK
No. 01SI6216816
Qualified In Orange County
My Commission Expires January 25, 2018

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

Rivlin
Applicant's **Printed** Last Name

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

5/3/2016
Date of Signature (**must** correspond to date of notarization)

State of New York, County of New York,

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 3rd day of May, 2016.

Notary Public Signature: [signature]

My Notary Commission Expires: January 25, 2018

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

400 FULLER WISER ROAD | SUITE 300 | EULESS, TX 76039 | TEL(817)868-4000

LESLIE M. SIMONS
NOTARY PUBLIC-STATE OF NEW YORK
No. 01SI6216816
Qualified In Orange County
My Commission Expires January 25, 2018

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364218

CERTIFICATION OF IDENTIFICATION

Certification by Notary Public Is Required

Applicant Full Legal Name: Rivlin (Last) Katherine (First) Lee (Middle)

FCVS ID Number: 364218

Notary – Please complete the section below:

State of New York County of New York

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

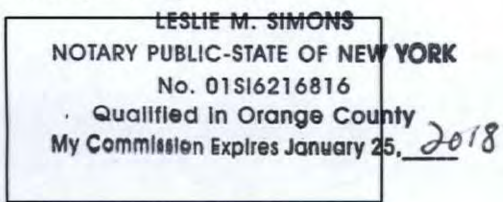
The statements on this document are subscribed and sworn to before me by the applicant on this (Day) 3rd, of (Month) May, (Year) 2016.

Notary Public Signature: [signature]

Commission Expiration Date* (Month) January /(Day) 25 /(Year) 2018

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

Notary Stamp Here



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

Federation of State Medical Boards
ATTN: FCVS
400 Fuller Wiser Rd., Suite 300
Euless, TX 76039-3856

364218 BC

STATE OF MISSISSIPPI

MISSISSIPPI STATE DEPARTMENT OF HEALTH
VITAL RECORDS

CERTIFICATE OF LIVE BIRTH
STATE OF MISSISSIPPI

REGISTRAR'S NUMBER

STATE FILE NUMBER 123- 82-34271

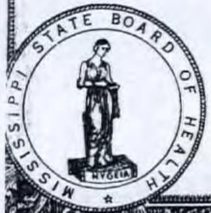
Field	Entry
1 CHILD — NAME (First, Middle, Last)	Katherine Lee Rivlin
2a DATE OF BIRTH (Month, Day, Year)	October 6, 1982
2b HOUR OF BIRTH	12:20 P. m.
3 SEX	Female
4a THIS BIRTH SINGLE, TWIN, TRIPLET, ETC (Specify)	Single
4b IF NOT SINGLE BIRTH, BORN FIRST, SECOND, ETC (Specify)	
5 BIRTH WEIGHT (Enter only in the type of measure on the scales used) lbs ozs OR grams	3720 grams
6a HOSPITAL OR CLINIC — NAME (If not in either, give street address or route number)	University Hospital 25 U
6b CITY OR TOWN OF BIRTH	Jackson
6c COUNTY OF BIRTH	Hinds
7a FATHER — NAME (First, Middle, Last)	Michel Elias Rivlin
7b RACE (Specify White, Black, American Indian, etc.)	White
7c AGE AT TIME OF THIS BIRTH	46
7d STATE OF BIRTH	Transvaal(State) S. Africa(Country)
8a MOTHER — NAME (First, Middle, Maiden)	Jane Ann Britt
8b RACE (Specify White, Black, American Indian, etc.)	White
8c AGE AT TIME OF THIS BIRTH	29
8d STATE OF BIRTH	Indiana
9a RESIDENCE — STATE	Mississippi
9b COUNTY	Rankin
9c CITY OR TOWN	Brandon
9d INSIDE CITY LIMITS (Specify Yes or No)	No
9e STREET AND NUMBER OR RURAL LOCATION	47 Westridge Dr.
10a MAILING ADDRESS — STREET AND NUMBER OR ROUTE AND BOX NUMBER	47 Westridge Dr.
10b CITY OR TOWN	Brandon
10c STATE AND ZIP CODE	Mississippi 39042
11a I CERTIFY THAT THE PERSONAL INFORMATION PROVIDED ON THIS CERTIFICATE IS CORRECT — SIGNATURE OF EITHER PARENT	Jane B Rivlin
11b DATE SIGNED (Month, Day, Year)	Oct 8 1982
12a I CERTIFY THAT THE STATED INFORMATION CONCERNING THIS CHILD IS TRUE TO THE BEST OF MY KNOWLEDGE AND BELIEF — SIGNATURE	J McDonald
12b DATE SIGNED (Month, Day, Year)	10/6/82
12c NAME AND TITLE OF PERSON WHO DELIVERED CHILD IF OTHER THAN CERTIFIER (Type or print)	
12d CERTIFIER — NAME AND TITLE (Type or print)	J. McDonald, M. D.
12e MAILING ADDRESS (Street and number or box number, City or town, State, ZIP code)	University Hospital, Jackson, Ms. 39216
13a REGISTRAR SIGNATURE	Vera Boykin
13b DATE CERTIFICATE RECEIVED (Month, Day, Year)	OCT 12 1982

THIS IS TO CERTIFY THAT THE ABOVE IS A TRUE AND CORRECT COPY OF THE CERTIFICATE ON FILE IN THIS OFFICE

F. E. Thompson Jr. MD
F. E. Thompson, Jr., M.D., M.P.H.
STATE HEALTH OFFICER

Nita Cox Gunter
Nita Cox Gunter
STATE REGISTRAR

MAY -8 2000



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Section IV

Medical Education

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FCVS FEDERATION CREDENTIALS VERIFICATION SERVICE

Verification of Medical Education

Federation of STATE MEDICAL BOARDS

Instruction to the Dean

Please complete both pages of this form, sign date and seal on the front page then return to: **Federation Credentials Verification Service 400 Fuller Wiser Rd Suite 300 Euless, TX 76039**	The individual identified on the attached Authorization for Release of Information, Documents and Records form has authorized your medical school to provide to the Federation Credentials Verification Service (FCVS) any and all information pertaining to their education at your institution. Please note: If your institution processes transcript requests through another office, FCVS has likely made such a request under separate cover. **If your office also processes transcript requests, please attach the individual's official transcript** (which indicates courses taken, dates and hours of attendance, and scores, grades, or evaluation).

Institution Name: University of Mississippi School of Medicine

Address Line 1:
2500 North State Street

Address Line 2:

City: Jackson **State/Province:** MS **Zip Code (Postal Code):** 39216-4505
Country: US

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: 4
Credential/degree presented by the applicant for admission to your medical school: Bachelor of Arts

Enrollment and Participation: Our records indicate that Rivlin, Katherine Lee
(type/print individual's name: Last, First, Middle, Suffix)
attended our medical school for total of 160 weeks of medical education on the following dates: **From:** 08/10/2005 (Month Day Year) **To:** 05/22/2009 (Month Day Year)

This individual
Was awarded the degree of Doctor of Medicine on 05/22/2009 (Month Day Year)
Was NOT awarded a degree because: (please explain - additional page if necessary)

Attestation Affix Institutional Seal Here. If no seal is available, this form must be notarized.	Watermark For FCVS internal use only. SEAL VERIFIED	**Name:** Barbara M. Westerfield **Signature:** [signature] **Title:** Director, Student Records & Registrar **Date of Signature:** 06/01/2016 **Phone:** (601) 984-1080 **Fax:** (601) 984-1079 **Email:** bwesterfield@umc.edu

~~363614~~ 364218 2289 2289 215830571

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FCVS FEDERATION CREDENTIALS VERIFICATION SERVICE

Verification of Medical Education

Federation of STATE MEDICAL BOARDS

Unusual Circumstances

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

If Yes, please specify the reason(s) for, indicate the date of the interruptions(s) or extension(s) and check whether the Interruption/extension was approved or unapproved:

Personal/Family________ From (Mo/Yr)___/___ To (Mo/Yr)___/___ ___ Approved ___ Unapproved

Academic remediation________ From (Mo/Yr)___/___ To (Mo/Yr)___/___ ___ Approved ___ Unapproved

Health________ From (Mo/Yr)___/___ To (Mo/Yr)___/___ ___ Approved ___ Unapproved

Financial________ From (Mo/Yr)___/___ To (Mo/Yr)___/___ ___ Approved ___ Unapproved

Participation in joint degree Program (e.g., MD/PhD) ________ From (Mo/Yr)___/___ To (Mo/Yr)___/___ ___ Approved ___ Unapproved

Participation in non-research special study (e.g., fellowship, international experience) ________ From (Mo/Yr)___/___ To (Mo/Yr)___/___ ___ Approved ___ Unapproved

Participation in non-degree research ________ From (Mo/Yr)___/___ To (Mo/Yr)___/___ ___ Approved ___ Unapproved

Other________ From (Mo/Yr)___/___ To (Mo/Yr)___/___ ___ Approved ___ Unapproved

Please Specify:

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

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

Academic Probation ________ From (Mo/Yr)___/___ To (Mo/Yr)___/___

Probation for unprofessional conduct/behavioral ________ From (Mo/Yr)___/___ To (Mo/Yr)___/___

Probation for other reason ________ From (Mo/Yr)___/___ To (Mo/Yr)___/___

Please specify a reason:

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

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

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

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

___ YES XX NO

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

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

~~383614~~ 364218 2289 215830571

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Applicant Reported Unusual Circumstances

Medical School

Medical Professional Name: Katherine Rivlin
University of Mississippi School of Medicine

Unusual Circumstances

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

End of report for: Katherine Rivlin

PROVIDED BY APPLICANT

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OFFICIAL ACADEMIC DOCUMENT

The University of Mississippi Medical Center

Name: Rivlin, Katherine Lee
Student Number: 30009179
Date of Birth: 10/06/1982

The University of Mississippi Medical Center
Jackson, Mississippi 39216
(601) 984-1080

Student Permanent Academic Record

The seal of the university and the signature of the registrar are required for an official transcript.

Degrees Awarded at University of Mississippi Medical Center

University Degree	Date
Doctor of Medicine	05/22/2009

Degrees Awarded at Previous Institutions

University: Yale University
Degree: Bachelor of Arts
Date: 05/01/2005

University of Mississippi Medical Center Coursework

Program: Doctor of Medicine
Admission Date: 08/10/2005

2005-2006

Course	Description	Grade	Hours	QPTS
ANAT 611	Medical Gross Anatomy	78.7	160.0	299.2
ANAT 613	Medical Histology & Cell	82.2	90.0	199.8
ANAT 615	Medical Neurobiology	81.8	80.0	174.4
ANAT 616	Medical Developmental Ana	78.7	20.0	37.4
BIOCH 610	Medical Biochemistry	77.5	120.0	210.0
CONJ 623	Core Concepts in Med	98.4	80.0	307.2
CONJ 624	Integrative Medicine	88.5	40.0	114.0
PHYSIO 611	Medical Physiology	86.8	150.0	402.0
PM 626	Medical Genetics	84.7	30.0	74.1
PSYCH 611	Psychiatry I	98.0	30.0	114.0

	AHRS	EHRS	QHRS	QPTS	GPA
Year	800.0	800.0	800.0	1932.1	84.1513
Cumulative	800.0	800.0	800.0	1932.1	84.1513

2006-2007

Course	Description	Grade	Hours	QPTS
CONJ 621	Introd Clinical Medicine	87.3	162.0	442.3
MICRO 611	Medical Microbiology	83.7	150.0	355.5
PATH 621	General & Systemic Path	84.1	200.0	482.0
PHARM 620	Intro To Pharm & Therapeu	86.2	152.0	398.2
PM 623	Prev Med & Public Health	95.2	36.0	126.7
PM 625	Biostatistics	95.0	24.0	84.0
PSYCH 621	Psy III-Intro To Clin Psy	85.5	12.0	30.6

	AHRS	EHRS	QHRS	QPTS	GPA
Year	736.0	736.0	736.0	1919.3	86.0777
Cumulative	1536.0	1536.0	1536.0	3851.4	85.0744

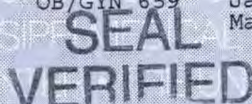
2007-2008

Course	Description	Grade	Hours	QPTS
EM 681	EMS Adv Cardiac Life Supp	P	13.5	0.0
FM 631	Family Medicine	89.4	200.0	588.0
MED 631	Medicine/Neurology	88.4	400.0	1136.0
OB/GYN 631	Obstetrics & Gynecology	92.4	200.0	648.0
PED 630	Junior Pediatrics	89.7	200.0	594.0
PSYCH 631	Jr Clerkship in Psychiatr	90.3	200.0	606.0
SURG 631	Surgery	82.1	400.0	884.0

	AHRS	EHRS	QHRS	QPTS	GPA
Year	1613.5	1613.5	1600.0	4456.0	87.8500
Cumulative	3149.5	3149.5	3136.0	8307.4	86.4905

2008-2009

Course	Description	Grade	Hours	QPTS
ANAT 653	Histology and Cell Bio	98.0	10.0	38.0
CONJ 652	Senior Seminar	P	24.0	0.0
FM 652	Fam.Med. Clerkship	89.0	10.0	29.0
MED 651	Gen Med Senior Clerkship	95.0	10.0	35.0
OB/GYN 656	Operative Gynecology	93.2	10.0	33.2
OB/GYN 656	Operative Gynecology	98.0	10.0	38.0
OB/GYN 659	Jackson Med Mall Clinic	93.0	10.0	33.0



The officially sealed and signed transcript is printed on blue script-safe paper with the name of the university printed in black type across the face of the document. When photocopied the word COPY will appear across the entire face of the transcript, and it should not be accepted as official.

REJECT DOCUMENT IF SIGNATURE BELOW IS DISTORTED

SIGNATURE *Barbara M. Westerfield*

Barbara M. Westerfield
Director, Student Records and Registrar 2289

Date Printed: 6/1/16 364218

COPY APPEARS ACROSS FACE OF ENTIRE DOCUMENT WHEN PHOTOCOPIED
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A BLACK AND WHITE DOCUMENT IS NOT OFFICIAL

OFFICIAL ACADEMIC DOCUMENT

The University of Mississippi Medical Center

Name: Rivlin, Katherine Lee
Student Number: 30009179
Date of Birth: 10/06/1982

The University of Mississippi Medical Center
Jackson, Mississippi 39216
(601) 984-1080

Student Permanent Academic Record

The seal of the university and the signature of the registrar are required for an official transcript.

Course	Description	Grade	Hours	QPTS
PED 651	Pediatric Ambulatory Care	96.0	10.0	36.0
PSYCH 653	General Psychiatry	96.5	10.0	36.5

	AHRS	EHRS	QHRS	QPTS	GPA
Year	104.0	104.0	80.0	278.7	94.8375
Cumulative	3253.5	3253.5	3216.0	8586.1	86.6981

*******No Further Entries Below This Point*******

Family Educational Rights and Privacy Act 1974

This document is being released to you on the condition that you will not release the data in personally identifiable form to any other party without obtaining written consent of the person named hereon.

Transcript Notes

First Year
Current Gpa 84.15
Second Year
Current Gpa 86.08
Overall Gpa 85.12
Third Year Ranks
Current Gpa 87.85
Overall Gpa 86.03
Fourth Year Ranks
Current Gpa 95.96
Overall Gpa 88.51

SEAL VERIFIED

The officially sealed and signed transcript is printed on blue script-safe paper with the name of the university printed in black type across the face of the document. When photocopied the word COPY will appear across the entire face of the transcript, and it should not be accepted as official.

REJECT DOCUMENT IF SIGNATURE BELOW IS DISTORTED

SIGNATURE Barbara M. Westerfield

Barbara M. Westerfield
Director, Student Records and Registrar

Date Printed: 6/1/16 364218

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OFFICIAL ACADEMIC DOCUMENT

UNIVERSITY OF MISSISSIPPI MEDICAL CENTER
TRANSCRIPT KEY

The University of Mississippi Medical Center is accredited by the Commission on Colleges of the Southern Association of Colleges and Schools to award degrees at the baccalaureate, master's and doctorate level.

The UNIVERSITY OF MISSISSIPPI SCHOOL OF MEDICINE is accredited by the Liaison Committee on Medical Education. Beginning in the Fall of 2009 the school converted to the semester calendar and began awarding credit in semester hours utilizing letter grades calculated from a numerical passing score of 70-100. Prior to that time, courses were on the quarter system, credit was awarded in clock hours, and grading was reported in numeric form. Sophomore students must pass USMLE Step I to be eligible for promotion to the junior year. Senior students must pass both parts of USMLE Step 2 to be eligible for graduation. Repeat courses are not computed in the calculation of the GPA. The minimum passing grade is 70.

The SCHOOL OF DENTISTRY is accredited by the Commission on Dental Accreditation, American Dental Association. Beginning in the Fall 2009, the school converted to the semester calendar, and began awarding credit in semester hours with letter grades. Prior to that time, the school was on the quarter system, awarded credit in clock hours, and grades were numeric. Sophomore students must pass Part I of the National Board Dental Examination to be promoted to the third year. Neither repeat courses nor courses in repeat years are computed in the calculations of the GPA. The minimum passing grade is 70.

The SCHOOL OF GRADUATE STUDIES IN THE HEALTH SCIENCES converted to the semester calendar for all programs and began awarding credit in semester hours effective Fall 2009. Prior to that time, the school was on the quarter calendar. Between 1955 and 2003 letter grades were utilized. Between Fall 2003 and Summer 2009, grades were awarded on a numeric basis. Effective August 2004, credit for the Ph.D. in Clinical Health Sciences and Ph.D. in Nursing was converted from semester hours to quarter hours.

The SCHOOL OF NURSING includes baccalaureate (BSN), master's (MSN), and doctorate of nursing practice (DNP) programs. The school is on a semester calendar; credit is awarded in semester hours, and grades are awarded on a letter basis.

GRADING SYSTEM

A -- Excellent	F -- Failure	Z -- Pass (MSN & DNP)
B -- Good	P -- Pass	T -- Transfer (MSN & DNP)
C -- Satisfactory	I -- Incomplete	IP -- In Progress
D -- Less than Satisfactory (BSN)	W -- Withdrawn	

For the BSN level, the quality point value of each grade in points is: A - 4; B - 3; C - 2; D - 1; F - 0
For the MSN and DNP level, the quality point value of each grade in points is: A - 4; B - 3; C - 2; F - 0

The SCHOOL OF HEALTH RELATED PROFESSIONS offers degree programs in Clinical Laboratory Science, Cytotechnology, Dental Hygiene, Health Informatics and Information Management, Health Science, Occupational Therapy, Physical Therapy, Radiologic Sciences, and a post-baccalaureate certificate program in Nuclear Medicine Technology. SHRP is on a semester calendar, credit is awarded in semester hours, and grades are awarded on a letter basis.

GRADING SYSTEM

A -- Excellent	F -- Failure	P -- Pass
B -- Good	W -- Withdrawn	T -- Transfer
C -- Satisfactory	I -- Incomplete	IP -- In Progress
D -- Lowest Passing Grade		

The quality point value of each grade in points is: A - 4; B - 3; C - 2; D - 1; F - 0.

The cumulative GPA shown on the transcript reflects only UMC work, and does not include transfer courses.

In all schools, the grade symbol of AUD indicates that a course was taken for audit credit only, with no hours or quality points earned.

HONORS: Dean's List - A full time undergraduate student with a semester GPA of 3.50-4.00
GRADUATION WITH HONORS:
School of Medicine: Summa Cum Laude - #1 Rank in Class, Magna Cum Laude- #2 through #4 Rank in Class, Cum Laude - #5 through #10 Rank in Class.
School of Dentistry: Summa Cum Laude - #1 Rank in Class, Magna Cum Laude- #2 Rank in Class, Cum Laude, #3 and #4 Rank in Class.
School of Nursing: (BSN) Summa Cum Laude 3.90 - 4.00, Magna Cum Laude 3.75 - 3.89, Cum Laude 3.50 - 3.74.
(MSN and DNP) Summa Cum Laude - #1 Rank in Class, Magna Cum Laude - #2 Rank in Class, Cum Laude - #3 Rank in Class.
School of Health Related Professions: Summa Cum Laude - 3.90 - 4.00, Magna Cum Laude - 3.75 - 3.89, Cum Laude - 3.50 - 3.74.

364218

SEAL VERIFIED

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This is certified to be a true and unaltered copy of the diploma awarded to Katherine Lee Rivlin, M.D., by the University of Mississippi on May 22, 2009.

Barbara M. Westerfield, Director
Student Records and Registrar

SEAL

University of Mississippi

On the recommendation of the Faculty
and by virtue of the authority vested in them
the Board of Trustees has conferred on

Katherine Lee Rivlin

the degree of

Doctor of Medicine

in testimony whereof is awarded this diploma duly certified by the
signatures of the proper officers and the seal of the University
Affixed this twenty-second day of May in the year of our Lord 2009.

FOR THE TRUSTEES
PRESIDENT

FOR THE FACULTY
Robert C. Khayat
CHANCELLOR

SEAL VERIFIED

FOR THE FACULTY
Daniel W. Jones, MD
VICE-CHANCELLOR FOR HEALTH AFFAIRS

Daniel W. Jones, MD
DEAN

364218

2289

Section V

Graduate Medical Education

© 1996 Federation of State Medical Boards

FCVS FEDERATION CREDENTIALS VERIFICATION SERVICE

Verification of Graduate Medical Education

Federation of STATE MEDICAL BOARDS

Institution: New York University School of Medicine **Affiliated University:** New York University Medical Center

Address Line 1: 550 First Avenue Suite 9E2

Address Line 2:

Country: US **City:** New York **State/Prov.:** NY **Zip Code:** 10016

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

Verification For: Rivlin, Katherine **Date of Birth:** October 06, 1982

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

Program Participation:

Important:

Report Incomplete Training Levels (year) separate from those that were successfully completed.

If the training level (years) 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 or Specialty is rotating or transitional, please provide a schedule of rotations.

Program Type IR
Training Level: 1-4
Specialty/Subspecialty: Obstetrics and Gynecology
From: 07/01/2009 **To:** 06/30/2013
Successfully Completed? Yes
Accredited by: ACGME

Program Type
Training Level:
Specialty/Subspecialty:
From: **To:**
Successfully Completed? **If no, was credit awarded?**
Accredited by:

Program Type
Training Level:
Specialty/Subspecialty:
From: **To:**
Successfully Completed? **If no, was credit awarded?**
Accredited by:

Unusual Circumstances

Check the correct response.

Omitted responses require written explanation.

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

1. Did this individual ever take a leave of absence or extension from his/her training? No
   If "Yes" provide start and end dates: **From:** **To:**
2. Was this individual ever placed on probation?.. No
3. Was this individual ever disciplined or placed under investigation?.. No
4. Were any negative reports for behavioral reason ever filed by instructors?.. No
5. Were any limitations or special requirements placed upon this individual because of questions of academic incompetence, disciplinary problems or any other reason? No

Please explain any "Yes" response from above:

Attestation

Affix Institutional Seal Here.

If no seal is available, this form must be notarized.

ELECTRONIC SEAL VERIFIED

Watermark

For FCVS internal use only.

Completion attests the information above is an accurate account of this individual's records and is true and correct. Signature line must contain original signature or electronic typed signature of program director

Print Name: AbigailWinkel MD **MD/DO:** Yes

Signature: *Abigail Winkel MD*

Title: Residency Program Director **Date:** 05/24/2016

Tel: (212) 263-6453 **Fax:** **Email:** Abigail.Winkel@nyumc.org

364218 108583 215428210

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Applicant Reported Unusual Circumstances

Federation of STATE MEDICAL BOARDS

Graduate Medical Education

Medical Professional Name: Katherine Rivlin
New York University Medical Center
Obstetrics and Gynecology

Unusual Circumstances

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

End of report for: Katherine Rivlin

PROVIDED BY APPLICANT

© 1996 Federation of State Medical Boards

New York University School of Medicine

This is to certify

Katherine Riblin, M.D.

has served in the resident training program of the

New York University School of Medicine and all of its Affiliated Academic Hospitals

July 1, 2009 to June 30, 2013

and has demonstrated competence and integrity in the discharge of her responsibilities as

Resident in Obstetrics & Gynecology; Categorical

In witness whereof, we have caused these presents to be signed by the appropriate officers of the School of Medicine and Hospitals under the imprint of the seal of the New York University School of Medicine in the City of New York

this 1st day of July 2013

Director of Service

Robert I. Grossman

Dean, New York University School of Medicine

Section VI

Licensure Examination History

(State Licensing Authorities Only)

400 FULLER WISER ROAD | SUITE 300 | EULESS, TX 76039 | TEL(817)868-5000 | FAX(817)868-5099

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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

Date: 06/03/2016

Federation Credentials Verification Service
ATTN: FCVS

FCVSID: 364218

Examinee: Rivlin, Katerine Lee — **Examinee ID:** 51947844

Alt Name(s): Rivlin, Katherine Lee — **Date of Birth:** 10/06/1982

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
5/26/2007	Pass	211	(185)	

USMLE STEP 2

Clinical Knowledge (CK)

Test Date	Pass/Fail	Total	MP	Comments
6/26/2008	Pass	232	(184)	

Clinical Skills (CS)*

Test Date	Pass/Fail	Total	MP	Comments
7/18/2008	Pass			

USMLE STEP 3

Test Date	Pass/Fail	Total	MP	Comments
2/17/2011	Pass	201	(187)	

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

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

This document was prepared by 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

Examinee ID: 51947844

Examinee: Rivlin, Katerine Lee

Date of Birth: 10/06/1982

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

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

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

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

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

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

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

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

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

PHYSICIAN DATA CENTER INFORMATION APPEARING AS "NOTE"
The Physician Data Center of the Federation of State Medical Boards (FSMB) contains actions reported to the FSMB by U.S. licensing and disciplinary boards, the U.S. Department of Health and Human Services, government regulatory entities and international licensing authorities. To be included in the Physician Data Center, an action must be a matter of public record or be legally releasable to state medical boards or other entities with recognized authority to review physician credentials. Certain actions reported to and released by the Physician Data Center are not disciplinary or otherwise prejudicial in nature. Such actions are reported to ensure that records are complete and to assist in preventing misrepresentation or the use of lost or stolen credentials by unauthorized persons. Once reported to the FSMB, an action becomes part of the permanent record of the individual physician, and the existence of such an action may be indicated on the USMLE transcript by a Note.
03/2015

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

Ohio
med.ohio.gov

State Medical Board of Ohio

30 East Broad Street, 3rd Floor, Columbus, Ohio 43215-6127 | (614) 466-3934

7/13/2016

Katherine Lee Rivlin
952 Franklin Ave
Columbus OH 43205

It is our pleasure 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 **129182** was issued on **07/13/2016** and will expire on **04/01/2018**.

Enclosed you will find your wall certificate. This wall certificate, by law, must be displayed in your office or the place where a major portion of your practice is conducted.

Please be advised that verification of your Ohio license must be obtained directly from the Board's website at http://med.ohio.gov in the "Licensee Profile and Status" section. The website is updated immediately to reflect newly issued licenses.

The State Medical Board of Ohio operates a "staggered renewal" system based upon the first letter of your last name at the time of licensure. A chart and information outlining the staggered medical license renewal system and continuing medical education (CME) hours required can be viewed on our website at http://med.ohio.gov in the "Renewal & CME" section under each respective license. Renewal applications are mailed approximately six months prior to the date of expiration.

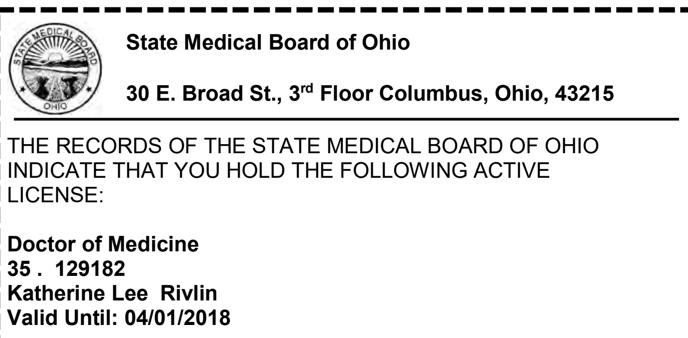
SECTION 4731.281, OHIO REVISED CODE REQUIRES WRITTEN NOTICE TO THE BOARD OF ANY CHANGE OF PRINCIPAL PRACTICE ADDRESS OR RESIDENCE ADDRESS WITHIN THIRTY DAYS OF THE CHANGE. *A CHANGE OF ADDRESS FORM IS AVAILABLE ON THE BOARD'S WEBSITE.*

This notice authorizes you to make application for a U.S. Drug Enforcement Administration certificate of registration (controlled substance permit). To make such application, please contact the Drug Enforcement Administration (DEA) at (800) 230-6844 or www.deadiversion.usdoj.gov/.

Please direct any questions regarding the DEA registration directly to the DEA office.

Sincerely,

Mitchell Alderson
Chief of Licensure



State Medical Board of Ohio

30 E. Broad St., 3rd Floor Columbus, Ohio, 43215

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

Doctor of Medicine
35 . 129182
Katherine Lee Rivlin
Valid Until: 04/01/2018

License Renewal Application

Submission Date: 02/07/2018

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
Katherine
Middle Name
Lee
Last Name
Rivlin
Maiden Name
Social Security Number
REDACTED
Date of Birth
10/6/1982
Email Address
katyriv@gmail.com
Phone Number
6012141393
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)?
Mississippi
In which city were you born?

Jackson

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.

952 Franklin Ave
Columbus
OH
43205
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.

952 Franklin Ave
Columbus
OH
43205
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 - Obstetrics and Gynecology (ABMS)
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 - 1487884946

Question - Primary DEA Number
Answer - FR3667702

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 - 2

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 - Ohio State Wexner Medical Center 410 W 10th Ave Columbus OH 43210, inpatient obgyn; Outpatient Care Upper Arlington 1800 Zollinger Road Columbus OH 43221, outpatient obgyn; Planned Parenthood East Surgical Center 3255 E Main St, Columbus OH 43213, outpatient obgyn

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 - 02/07/2018 10:41:07
Type your First Name and Last Name as they appear on the application to sign electronically.
Katherine Rivlin

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.

Submission Date and Time: 1/8/2020 4:55 PM

License Renewal Application

License Type - Doctor of Medicine (MD)

Personal Information

Provide the necessary personal information in the fields to the right. All fields with (*) are required and must be completed to continue the application process. Demographic and workforce data collected for some licensed healthcare professions is used to enhance the state's capacity for healthcare workforce forecasting, policy development, and research. This data is used to analyze the supply and demand of the healthcare workforce serving Ohio. If you do not have an Individual Provider Identifier (NPI) number please enter nine zeroes.

Title
Dr.
First Name
Katherine
Middle Name
Lee
Last Name
Rivlin
Maiden Name
No Response
Social Security Number
REDACTED
Date of Birth
10/6/1982
Email Address
katyriv@gmail.com
Phone Number
6012141393
Other Phone Number
No Response
What is your U.S. Residency status related to your employment?
United States Citizen
Do you consider yourself Hispanic, Latino/a or of Spanish origin?
No
What do you consider your race?
White
List languages you personally use to communicate with patients excluding an interpreter or software
English
Other Language
No Response
Individual National Provider Identifier - if N/A enter all zeroes
1487884946
Enter home US zip-code. Enter NA if unavailable
43205

Additional Information

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

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

Employment Status

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

What is your primary employment status
Actively working in a position(s) that requires this license
Which of the following best describes your five-year employment plan?
Maintain practice hours as is

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.

952 Franklin Ave
Columbus
OH
43205
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.

952 Franklin Ave
Columbus
OH
43205
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
If you answered "Yes", are you currently serving in the military?
No Response
Has your spouse served in the military?
No
If you answered "Yes", are they currently serving in the military?
No Response
I declined to answer these questions

Secondary Email Recipient

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

Secondary Email Address:

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 - Obstetrics and Gynecology (ABMS)
Medical SubSpeciality - null

Current Employment Location(s)

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

Name of Practice Site - The Ohio State Wexner Medical Center
Practice Settings - Hospital - Inpatient
Street Address - 395 W. 12th Ave
City - Columbus
State - OH
Zip Code - 43210
Major Area of Focus or Specialty - Obstetrics & Gynecologic Surgery
Total Hours Worked at this practice site, per Week - 25

Percent of time spent per week in each of the following at this practice site:
Direct Patient Care - 25
Teaching/Academic - 25
Research - 25
Professional Services - 0
Administrative Activities - 25
Other - 0
Total Hours- 100

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

Name of Practice Site - Ohio State University Carepoint East
Practice Settings - Office/Clinic - Single Specialty Group
Street Address - 543 Taylor Ave
City - Columbus
State - OH
Zip Code - 43203
Major Area of Focus or Specialty - Obstetrics & Gynecology (AOA)
Total Hours Worked at this practice site, per Week - 12

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

Hospital Admitting Privileges for Patients - Yes

Current Employment Arrangement - Salaried
Other Employment Arrangement - null
Intern/Resident Position - No
Employed as Federal Employee - No
Accepting New Patients - No

Name of Practice Site - Planned Parenthood East Surgical Center
Practice Settings - Hospital - Ambulatory Care Center
Street Address - 3255 E. Main St
City - Columbus
State - OH
Zip Code - 43213
Major Area of Focus or Specialty - Obstetrics & Gynecologic Surgery
Total Hours Worked at this practice site, per Week - 10

Percent of time spent per week in each of the following at this practice site:
Direct Patient Care - 50
Teaching/Academic - 50
Research - 0
Professional Services - 0
Administrative Activities - 0
Other - 0
Total Hours- 100

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

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 have you been investigated, warned, censured, put on probation, disciplined, or have had any charges, allegations or complaints filed against you, by any board, bureau, department, agency, or any other body, including those in Ohio?
Answer - No

Question - At any time since submission of your last application for renewal 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? You may answer NO to this question if you have successfully completed treatment at, or are currently enrolled in, a program approved by this Board and have adhered to all statutory requirements during and subsequent to treatment. You must answer YES if you have ever relapsed.
Answer - No

Question - At any time since signing your last application for renewal of your certificate have you had admissions monitored, had clinical privileges or other similar institutional authority limited, restricted, suspended, revoked, terminated, or placed on probation for any reason, or have resigned privileges at any institution?
Answer - No

Question - 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 - Yes

Question - Do you currently supervise one or more Physician Assistants?
Answer - No

Question - Do you prescribe controlled substances?
Answer - Yes

Question - Primary DEA Number
Answer - FR3667702

Question - At any time since signing your last application for renewal of your certificate have you been investigated, warned, censured, put on probation, terminated, or disciplined by any employer, hospital, group practice, nursing home, clinic, health maintenance organization, or other similar institution, for any reason?
Answer - No

Question - Since signing your last renewal have you prescribed opioid analgesics or benzondiazepines while

practicing in Ohio?
Answer - Yes

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

Question - At any time since signing your last application for renewal of your certificate, have you engaged in conduct prohibited by the Medical Board's rules regarding sexual misconduct and impropriety (chapter 4731-26 of the Administrative Code)?
Answer - No

Attachments

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

Title - Duty to Report
Description - I acknowledge my duty to report to the board a belief that a violation of chapters 4730., 4731. 4759., 4760., 4761., 4762., 4774., or 4778. of the Revised Code, or any rule of the board has occurred, by myself or another individual.
Attested - Attestation complete

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 - 1/8/2020 4:55 PM
Type your First Name and Last Name as they appear on the application to sign electronically.
Katherine Rivlin
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.