FOR BOARD USE ONLY:	APP, AMA, FORM 2, TSE MAILED: 2-4-99

State Medical Board of Ohio

77 S. High Street, 17th Floor • Columbus, Ohio 43266-0315 • 614/ 466-3934 • Website: www.state.oh.us/med/

REQUEST FOR APPLICATION FORMS
MEDICAL OR OSTEOPATHIC

PLEASE TYPE OR PRINT CLEARLY

Check one: ☒ I am ☐ I am not applying for Step 3 of the USMLE in May 1999 (Fill in year) December _____ (Fill in year)

The following information must be completed by **ALL** applicants, whether or not you are applying to take the USMLE for Ohio.

PERSONAL INFORMATION

	Last (Surname)	First	Middle	Suffix (Jr., II)
NAME:	SLOTTA	CHRISTINE	MARIE	

	Number & Street			
ADDRESS:	29386 PARKWOOD DR.			
	City: WICKLIFFE	State: OH	Zip Code: 44092	Country: USA

		Area Code & Number		Area Code & Number
TELEPHONE:	BUSINESS:	(216) 778-5341	HOME:	(440) 944-1629

	MO/DAY/YR		City	State	Country
BIRTH DATE:	02/28/70	BIRTH PLACE:	WARRENSVILLE HTS.	OH	USA

MEDICAL OR OSTEOPATHIC EDUCATION

	School Name		
MEDICAL OR OSTEOPATHIC SCHOOL OF GRADUATION	MEDICAL COLLEGE OF OHIO AT TOLEDO		
	Street Address: 3000 ARLINGTON AVE. / PO BOX 10008		
	City: TOLEDO	State: OH	Country: USA

		MO/YR		MO/YR
DATES ATTENDED:	FROM:	8/93	TO:	6/97

DEGREE RECEIVED:	DOCTOR OF MEDICINE	DATE RECEIVED:	MO/DAY/YR 6/6/97

OVER ⇨

OTHER MEDICAL OR OSTEOPATHIC SCHOOLS ATTENDED **(IF NONE, ENTER "NONE"):**

School Name: NONE

Street Address:

City | State | Country

DATES ATTENDED: FROM: MO/YR / TO: MO/YR /

Reason degree not received at this school:

School Name: NONE

Street Address:

City | State | Country

DATES ATTENDED: FROM: MO/YR / TO: MO/YR /

Reason degree not received at this school:

FIFTH PATHWAY PROGRAM

FIFTH PATHWAY PROGRAM **(IF NONE, ENTER "NONE"):**

Hospital or Institution: NONE

Name of Medical School:

City | State

DATES ATTENDED: FROM: MO/YR / TO: MO/YR /

QUALIFYING EXAM TAKEN: DATE TAKEN: MO/YR /

CONTINUED ⇨

SLOTTA

MD/DO REQUEST FOR APPLICATION FORMS
PAGE 3

GRADUATE MEDICAL EDUCATION

List **ALL** graduate medical education (internship, residency or clinical fellowship), undertaken in the U.S. or Canada. If additional space is needed, attach an extra sheet. **(If none, enter "NONE")**

month/year	Hospital, University or Other: / Complete Street Address: / Number & Street / City / State/Country / Zip Code	Position & Department	Level of Training *(check one only)*
8 97 — TO — 6 01	METROHEALTH MEDICAL CENTER 2500 METROHEALTH DR. CLEVELAND OH 44109	RESIDENT OBSTETRICS & GYNECOLOGY	☐ 1st year ☒ 2nd year ☐ 3rd year or above
TO			☐ 1st year ☐ 2nd year ☐ 3rd year or above
TO			☐ 1st year ☐ 2nd year ☐ 3rd year or above
TO			☐ 1st year ☐ 2nd year ☐ 3rd year or above

OVER ⇨

WRITTEN EXAMINATIONS TAKEN

List each and every written exam (FLEX, National Boards, USMLE, State Board, LMCC) taken, whether in Ohio or any other state, territory or province. Use one section for each exam portion taken. If additional space is needed, attach an extra sheet.

STATE/PROVINCE	DATE TAKEN	TYPE OF EXAM	SECTIONS TAKEN	FINAL RESULTS
OHIO	(MO/YR) 6/95	(✓ ONE ONLY) ☐ FLEX (pre-1985) ☐ FLEX (1985-1994) ☐ National Boards (MD or DO) ☒ USMLE ☐ State Board ☐ LMCC	(✓ ONE ONLY) ☐ Partial ☐ Full Component: ☐ I ☐ II Part: ☐ 1 ☐ 2 ☐ 3 Step: ☒ 1 ☐ 2 ☐ 3 ☐ Partial ☐ Full ☐ Partial ☐ Full	(✓ ONE ONLY) ☒ PASS ☐ FAIL
OHIO	(MO/YR) 3/97	(✓ ONE ONLY) ☐ FLEX (pre-1985) ☐ FLEX (1985-1994) ☐ National Boards (MD or DO) ☐ USMLE ☐ State Board ☐ LMCC	(✓ ONE ONLY) ☐ Partial ☐ Full Component: ☐ I ☐ II Part: ☐ 1 ☐ 2 ☐ 3 Step: ~~1~~ ☒ 2 ☐ 3 ☐ Partial ☐ Full ☐ Partial ☐ Full	(✓ ONE ONLY) ☒ PASS ☐ FAIL
	(MO/YR)	(✓ ONE ONLY) ☐ FLEX (pre-1985) ☐ FLEX (1985-1994) ☐ National Boards (MD or DO) ☐ USMLE ☐ State Board ☐ LMCC	(✓ ONE ONLY) ☐ Partial ☐ Full Component: ☐ I ☐ II Part: ☐ 1 ☐ 2 ☐ 3 Step: ☐ 1 ☐ 2 ☐ 3 ☐ Partial ☐ Full ☐ Partial ☐ Full	(✓ ONE ONLY) ☐ PASS ☐ FAIL
	(MO/YR)	(✓ ONE ONLY) ☐ FLEX (pre-1985) ☐ FLEX (1985-1994) ☐ National Boards (MD or DO) ☐ USMLE ☐ State Board ☐ LMCC	(✓ ONE ONLY) ☐ Partial ☐ Full Component: ☐ I ☐ II Part: ☐ 1 ☐ 2 ☐ 3 Step: ☐ 1 ☐ 2 ☐ 3 ☐ Partial ☐ Full ☐ Partial ☐ Full	(✓ ONE ONLY) ☐ PASS ☐ FAIL
	(MO/YR)	(✓ ONE ONLY) ☐ FLEX (pre-1985) ☐ FLEX (1985-1994) ☐ National Boards (MD or DO) ☐ USMLE ☐ State Board ☐ LMCC	(✓ ONE ONLY) ☐ Partial ☐ Full Component: ☐ I ☐ II Part: ☐ 1 ☐ 2 ☐ 3 Step: ☐ 1 ☐ 2 ☐ 3 ☐ Partial ☐ Full ☐ Partial ☐ Full	(✓ ONE ONLY) ☐ PASS ☐ FAIL
	(MO/YR)	(✓ ONE ONLY) ☐ FLEX (pre-1985) ☐ FLEX (1985-1994) ☐ National Boards (MD or DO) ☐ USMLE ☐ State Board ☐ LMCC	(✓ ONE ONLY) ☐ Partial ☐ Full Component: ☐ I ☐ II Part: ☐ 1 ☐ 2 ☐ 3 Step: ☐ 1 ☐ 2 ☐ 3 ☐ Partial ☐ Full ☐ Partial ☐ Full	(✓ ONE ONLY) ☐ PASS ☐ FAIL

CONTINUED ⇨

SLOTTA

STATE MEDICAL BOARD OF OHIO

99 FEB -3 PM 3:13

MD/DO REQUEST FOR APPLICATIONS FORMS
PAGE 5

LICENSES IN THE UNITED STATES & CANADA

List **ALL** states/provinces, **whether the license is current or not**, in which you are or have been licensed (except temporary, educational permits) to practice medicine and surgery or osteopathic medicine and surgery. Indicate the license number, date of issuance and the basis of licensure. If additional space is needed, attach an extra sheet. **(If none, enter "NONE")**

STATE/PROVINCE	ISSUE DATE	LICENSE #	BASIS OF LICENSE	LICENSE CURRENT
NONE	(MO/YR)		(✓ ONE ONLY) ❑ National Boards ❑ FLEX ❑ USMLE ❑ LMCC ❑ State Board exam ❑ Other:____	(✓ ONE ONLY) ❑ YES ❑ NO Expiration Date:____
	(MO/YR)		(✓ ONE ONLY) ❑ National Boards ❑ FLEX ❑ USMLE ❑ LMCC ❑ State Board exam ❑ Other:____	(✓ ONE ONLY) ❑ YES ❑ NO Expiration Date:____
	(MO/YR)		(✓ ONE ONLY) ❑ National Boards ❑ FLEX ❑ USMLE ❑ LMCC ❑ State Board exam ❑ Other:____	(✓ ONE ONLY) ❑ YES ❑ NO Expiration Date:____
	(MO/YR)		(✓ ONE ONLY) ❑ National Boards ❑ FLEX ❑ USMLE ❑ LMCC ❑ State Board exam ❑ Other:____	(✓ ONE ONLY) ❑ YES ❑ NO Expiration Date:____
	(MO/YR)		(✓ ONE ONLY) ❑ National Boards ❑ FLEX ❑ USMLE ❑ LMCC ❑ State Board exam ❑ Other:____	(✓ ONE ONLY) ❑ YES ❑ NO Expiration Date:____
	(MO/YR)		(✓ ONE ONLY) ❑ National Boards ❑ FLEX ❑ USMLE ❑ LMCC ❑ State Board exam ❑ Other:____	(✓ ONE ONLY) ❑ YES ❑ NO Expiration Date:____
	(MO/YR)		(✓ ONE ONLY) ❑ National Boards ❑ FLEX ❑ USMLE ❑ LMCC ❑ State Board exam ❑ Other:____	(✓ ONE ONLY) ❑ YES ❑ NO Expiration Date:____

OVER ⇨

ADDITIONAL ELIGIBILITY INFORMATION FOR GRADUATES OF NON ACCREDITED LCME/AOA SCHOOLS

ANSWER ALL QUESTIONS	YES	NO
Do you have a valid ECFMG Certificate? Number:_____ Date Issued:____/____ MO/YR	☐	☐
Have you held a current and unrestricted license in the U.S. for **at least five years or more**? *(Refer to the TSE section in the Eligibility Packet for more information)*	☐	☐
Have you been actively practicing medicine and surgery or osteopathic medicine and surgery (approved training included) in the U.S. for **at least five years or more**? *(Refer to the TSE section in the Eligibility Packet for more information)*	☐	☐
Have you applied for or taken the Test of Spoken English (TSE*) of the Educational Service (ETS)? Date Taken:____/____ MO/YR Score:_____	☐	☐

***THE TOEFL, ECFMG EXAM, ETC. ARE NOT EQUIVALENT AND CANNOT BE SUBSTITUTED FOR THE TEST OF SPOKEN ENGLISH (TSE)**

FEDERATION CREDENTIALS VERIFICATION SERVICE

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

If yes, date forwarded: 1/25/99

CERTIFICATION

I hereby certify that I am the person referred to in the foregoing Request for Application forms and that the statements herein are strictly true in every respect.

Signature of Applicant — Date: 1/25/99

RETURN TO: STATE MEDICAL BOARD OF OHIO
77 SOUTH HIGH STREET, 17TH FLOOR
COLUMBUS, OH 43266-0315

Revised 5/20/97

CONTINUED ⇨

State Medical Board of Ohio

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FOR BOARD USE ONLY
☐ 34 ☑ 35
BK: _____ PG: _____ LN: _____
DATE: _____ FEE: **$35.00** PMT: _____

APPLICATION FOR EXAMINATION - MEDICINE OR OSTEOPATHIC MEDICINE

PLEASE TYPE OR PRINT CLEARLY

5-17-30
1903
$ 35.00
2-22-99

1. Social Security Number: [REDACTED]

2. Full Name (Use no initials): LAST (Surname) SLOTTA | FIRST CHRISTINE | MIDDLE MARIE | SUFFIX (Jr., II)

3. Maiden Name or other names used If none, enter "NONE"): LAST (Surname) SIMCICH | FIRST CHRISTINE | MIDDLE MARIE | SUFFIX(Jr., II)

4. Current Address: STREET & NUMBER 29386 PARKWOOD DR.
CITY WICKLIFFE | STATE OHIO | ZIP CODE 44092 | COUNTRY USA

5. Physical Description: HEIGHT 5'6" | WEIGHT 140# | HAIR COLOR BLOND | EYE COLOR GREEN | IDENTIFYING MARKS —

6. Sex: ☐ MALE ☒ FEMALE For statistics only (optional)

7. Specialty Boards (U.S.A., Canada and foreign countries):

Name of Specialty Board	Board Certified Yes	Board Certified No	Year Certified	Country
	☐	☐		
	☐	☐		
	☐	☐		

OHIO STATE MEDICAL BOARD
FEB 19 1999

CONTINUED ⇨

RESUME - MEDICINE OR OSTEOPATHIC MEDICINE

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

A

6 | 97 month/year

TO

6 | 01 month/year

Hospital, University or Other: MetroHealth Medical Center

Complete Street Address: 2500 MetroHealth Dr.

Number & Street

Cleveland OH 44109

City State/Country Zip Code

Position & Department: OB/GYN Resident

% Clinical: 100 %

% Admin.

B

month/year

TO

month/year

Hospital, University or Other:

Complete Street Address:

Number & Street

City State/Country Zip Code

Position & Department

% Clinical

% Admin.

C

month/year

TO

month/year

Hospital, University or Other:

Complete Street Address:

Number & Street

City State/Country Zip Code

Position & Department

% Clinical

% Admin.

D

month/year

TO

month/year

Hospital, University or Other:

Complete Street Address:

Number & Street

City State/Country Zip Code

Position & Department

OHIO STATE MEDICAL BOARD

FEB 19 1999

% Clinical

% Admin.

OVER ⇨

E

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

F

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

G

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

H

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

CONTINUED ⇨

ADDITIONAL INFORMATION - MEDICINE OR OSTEOPATHIC MEDICINE

If you answer "YES" to any of the following questions, you are required to furnish complete details, including date, place, reason and disposition of the matter. All affirmative answers must be thoroughly explained on a separate sheet of paper.

(Please place a ☑ in the YES or NO box)

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

OVER ⇨

ADDITIONAL INFORMATION - MEDICINE OR OSTEOPATHIC MEDICINE
PAGE TWO

		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?	☐	☑
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?	☐	☑
10.	Have you ever been requested to appear before any board, bureau, department, agency, or other body, including those in Ohio, concerning allegations against you?	☐	☑
11.	Have you ever entered into an agreement of any kind, whether oral or written, with respect to a professional license, in lieu of or in order to avoid formal disciplinary action, with any board, bureau, department, agency, or other body, including those in Ohio?	☐	☑
12.	Have you ever been notified of any investigation concerning you by, or 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?	☐	☑
13.	Are you now or have you ever been, addicted to or excessively used alcohol, drugs, or other substances which may cause physical or psychological dependence, or impairment of the ability to practice?	☐	☑
14.	Have you ever been a patient (voluntary or otherwise) in any institution for the treatment of emotional or mental illness, drug addiction or abuse, or an alcohol problem? If yes, you must have your treating physician(s) submit a letter directly to the Board on your behalf summarizing dates of treatment, etc.	☐	☑
15.	Have you ever been treated but not hospitalized for emotional or mental illness, drug addiction or abuse, or an alcohol problem? If yes, you must have your treating physician(s) submit a letter directly to the Board on your behalf summarizing dates of treatment, etc.	☐	☑

CONTINUED ⇨

ADDITIONAL INFORMATION - MEDICINE OR OSTEOPATHIC MEDICINE
PAGE THREE

		YES	NO
16.	Have you ever been denied, or 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?	☐	☑
17.	Have you ever been convicted or found guilty of a violation of federal law, state law, or municipal ordinance other than a minor traffic violation?	☐	☑
18.	Have you ever forfeited collateral, bail, or bond for breach or violation of any law, police regulation, or ordinance other than for a minor traffic violation; been summoned into court as a defendant or had any lawsuit filed against you (other than a malpractice suit)?	☐	☑
19.	Have you been a defendant in a legal action involving professional liability (malpractice), or had a professional liability claim paid on your behalf, or paid such a claim yourself? If yes, include the case name, case number, court and address, date filed, and a summary of the underlying events. Indicate current status, including amount of settlement or judgment, if any. In addition, ask your malpractice insurance carrier(s) to provide a complete claims history report for the last 10 years to the State Medical Board of Ohio. If your current carrier has provided coverage for less than 10 years, ask your previous carrier to submit a claims history report to the Board.	☐	☑
20.	Have you ever been denied professional liability insurance or coverage, or had such insurance or coverage cancelled, limited, or restricted in any way?	☐	☑
21.	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?	☐	☑
22.	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?	☐	☑

State Medical Board of Ohio

77 S. High Street, 17th Floor • Columbus, Ohio 43266-0315 • 614/ 466-3934 • Website: www.state.oh.us/med/

Applicant check one: I am applying to sit for Step 3 of the USMLE in ☒ May or ☐ December _____ (fill in year)

MEDICINE OR OSTEOPATHIC MEDICINE

FORM 1 - CERTIFICATE OF RECOMMENDATION

This form is to be completed by a physician fully licensed in the STATE IN WHICH THE FORM IS NOTARIZED. The recommending physician must be sufficiently acquainted with the applicant for at least SIX months. Relatives may not serve as recommending physicians. Recommending physician are strongly urged to include additional comments. This form must be notarized. ALL questions must be answered. This form is not intended to standardize the recommendation or restrict it in any way. However, its form is designed to insure that certain information is included.

DO NOT COMPLETE UNLESS A *COLOR* PHOTO OF APPLICANT IS ATTACHED TO THE BACK OF THIS FORM

BLACK & WHITE PHOTOS ARE NOT ACCEPTABLE

I, Robert Williams MD a licensed and practicing physician in the state of
(recommending physician)

OHIO, affirm that Christin Slotta
(state of residence) (applicant)

has been known to me personally for 2 years and that he/she is of good moral character.

Further, the photograph affixed hereto is a genuine likeness of the applicant. I offer the following in support of his/her application:

*I rate his/her medical knowledge and technique as: Very Good

*His/her relationship with patients is: Excellent

*I rate his/her ability to work well with peers and medical staff as: Excellent

*His/her command of the English language is: Excellent

*Additional comments: _____

I hereby recommend him/her to take the examination in the State of Ohio.

OVER ⇨

FORM 1 - CERTIFICATE OF RECOMMENDATION
MEDICINE OR OSTEOPATHIC MEDICINE

[signature]
Signature of Recommending Physician
(name stamps not acceptable)

Robert Pollard
Name of Recommending Physician
(please type or print clearly)

(216) 778-4876
Telephone Number
(include area code)

MetroHealth Medical Center
2500 MetroHealth Dr.
Cleveland, OH 44109
Address of Recommending Physician
(include city, state and zip code)

OHIO 35-07-4961 P
State of Licensure & License Number of Recommending Physician
(please type or print clearly)

Subscribed and sworn to before me this 12 day of February, 1999.

Joan Wasdovitch
Notary Public Signature

(NOTARY SEAL)

2/28/2002
Date Commission Expires

Date Photo Taken: 2/99
Mo/Yr

RETURN TO: STATE MEDICAL BOARD OF OHIO
77 SOUTH HIGH STREET
17TH FLOOR
COLUMBUS, OH 43266-0315

OHIO STATE MEDICAL BOARD
FEB 19 1999

Revised 10/21/96

State Medical Board of Ohio

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Applicant check one: I am applying to sit for Step 3 of the USMLE in ☐ May or ☐ December _____ (fill in year)

MEDICINE OR OSTEOPATHIC MEDICINE

FORM 1 - CERTIFICATE OF RECOMMENDATION

This form is to be completed by a physician fully licensed in the STATE IN WHICH THE FORM IS NOTARIZED. The recommending physician must be sufficiently acquainted with the applicant for at least SIX months. Relatives may not serve as recommending physicians. Recommending physician are strongly urged to include additional comments. This form must be notarized. ALL questions must be answered. This form is not intended to standardize the recommendation or restrict it in any way. However, its form is designed to insure that certain information is included.

DO NOT COMPLETE UNLESS A *COLOR* PHOTO OF APPLICANT IS ATTACHED TO THE BACK OF THIS FORM

BLACK & WHITE PHOTOS ARE NOT ACCEPTABLE

I, LEROY DIERKER (recommending physician), a licensed and practicing physician in the state of Ohio (state of residence), affirm that C. Slotta (applicant) has been known to me personally for 2 years and that he/she is of good moral character.

Further, the photograph affixed hereto is a genuine likeness of the applicant. I offer the following in support of his/her application:

*I rate his/her medical knowledge and technique as: Excellent

*His/her relationship with patients is: Superior

*I rate his/her ability to work well with peers and medical staff as: Excellent

*His/her command of the English language is: Excellent

*Additional comments: _____

I hereby recommend him/her to take the examination in the State of Ohio.

OVER ⇒

FORM 1 - CERTIFICATE OF RECOMMENDATION
MEDICINE OR OSTEOPATHIC MEDICINE

LeRoy J. Diercer MD
Signature of Recommending Physician
(name stamps not acceptable)

LEROY J. DIERCER MD
Name of Recommending Physician
(please type or print clearly)

(216) 778-5901
Telephone Number
(include area code)

2500 Metro Health Drive
Address of Recommending Physician
(include city, state and zip code)
Cleveland OH 44109

OHIO 35-03-9642-D
State of Licensure & License Number of Recommending Physician
(please type or print clearly)

Subscribed and sworn to before me this 12 day of February, 1997.

Joan Wasilevich
Notary Public Signature

(NOTARY SEAL)

2/28/2002
Date Commission Expires

Date Photo Taken: 2/99
Mo/Yr

RETURN TO: STATE MEDICAL BOARD OF OHIO
77 SOUTH HIGH STREET
17TH FLOOR
COLUMBUS, OH 43266-0315

THE STATE MEDICAL BOARD

Revised 10/21/96

Certified Copy of Marriage Record

STATE OF OHIO

COUNTY OF

I, FRA

the follo

are by l

THE
Lake

AFFIDAVIT AND RELEASE OF APPLICANT

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

ss STATE OF: Ohio
COUNTY OF: Cuyahoga

I, Christine M. Slotta M.D., hereby certify under oath that I am the person named in this application to take the examination in the State of Ohio; that all statements I have or shall make with respect thereto are true, that I am the original and lawful possessor and person named in the various forms and credentials furnished or to be furnished to this Board with respect to my application; and that all documents, forms, or copies thereof furnished or to be furnished with respect to my application are strictly true in every respect.

I acknowledge that I have read the general information and instructions for all applicants and that I have answered all questions in compliance with these instructions and understand that the fee I submitted is not refundable nor transferable.

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

I further understand that my application to take the examination in the State of Ohio is an ongoing process. I will immediately notify the State Medical Board of Ohio in writing of any changes to the answers to any of the questions contained in the ADDITIONAL INFORMATION section of the application if such a change in an answer is warranted at any time prior to admission to the examination being granted to me by the State Medical Board of Ohio. I further understand that failure to complete this application as requested by the Board within six months can be considered abandonment of any request to take the examination and that any fee I submitted is not refundable nor transferable.

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

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

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

Signature of Applicant

Subscribed and sworn to before me this 12 day of February 1999.

(NOTARY SEAL)

Signature of Notary Public

OHIO STATE MEDICAL BOARD

2/28/2002

Date Commission Expires

FEB 19 1999

Revised 10/21/96

State Medical Board of Ohio

77 S. High Street, 17th Floor • Columbus, Ohio 43266-0313 • 614/ 466-3934 • Website: www.state.oh.us/med/

APPLICATION FOR CERTIFICATE ISSUANCE FOLLOWING EXAMINATION MEDICINE OR OSTEOPATHIC MEDICINE

PLEASE TYPE OR PRINT CLEARLY

21-8-54
2085
$ 200.00
9-1-99

1. Social Security Number: REDACTED

2. Full Name (Use no initials):

Last (Surname)	First	Middle	Suffix (Jr., II)
SLOTTA	CHRISTINE	MARIE	

3. Name (As you prefer it inscribed on your Ohio license):

Last (Surname)	First	Middle	Suffix (Jr., II)
SLOTTA	CHRISTINE	MARIE	

4. Current Address:

Number & Street			
29386 PARKWOOD DR.			
City	**State**	**Zip Code**	**Country**
WICKLIFFE	OH	44092	USA

5. Telephone Number:

	Area Code & Number
Work:	(216) 778-5341
Home:	(440) 944-1629

6. City in Ohio Where You Plan to Practice (If known):

City	or	County

Plans of Practice (If known):

OHIO STATE MEDICAL BOARD
AUG 25 1999

CONTINUED ⇨

AFFIDAVIT AND RELEASE OF APPLICANT

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

ss STATE OF OHIO
COUNTY OF LAKE

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

I acknowledge that I have read the general information and instructions for all applicants and that I have answered all questions in compliance with these instructions and understand that any fee I submit is not refundable nor transferable.

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

I further understand that my application for said certificate in the State of Ohio is an ongoing process. I will immediately notify the State Medical Board of Ohio in writing of any changes to the answers to any of the questions contained in the ADDITIONAL INFORMATION section of the application if such a change in an answer is warranted at any time prior to a certificate being issued. I further understand that failure to complete this application as requested by the Board within six months can be considered abandonment of any request for a certificate to practice medicine or osteopathic medicine and that any fee I submit is not refundable nor transferable.

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

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

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

Signature of Applicant

Subscribed and sworn to before me this day 20 of August 199 9.

Notary Public Signature

(NOTARY SEAL)

LESLIE J. D'ANNA, Notary Public
State of Ohio, Lake County
My Commission Expires Feb. 11, 2001

Date Commission Expires

5-1730

MEDICINE OR OSTEOPATHIC MEDICINE - PRELIMINARY EDUCATION FORM

TO BE COMPLETED BY ALL APPLICANTS

NAME:

LAST (Surname)	FIRST	MIDDLE	SUFFIX (Jr., II)
SLOTTA	CHRISTINE	MARIE	

HIGH SCHOOL OR EQUIVALENT:

SCHOOL NAME		
MENTOR HIGH SCHOOL		
CITY: MENTOR	STATE: OH	COUNTRY: USA

DATES ATTENDED: FROM: MO/YR 1/86 TO: MO/YR 6/88

STATE MEDICAL BOARD OF OHIO 99 FEB -3 PM

UNDERGRADUATE COLLEGE OR EQUIVALENT:

SCHOOL NAME		
MIAMI UNIVERSITY		
CITY: OXFORD	STATE: OH	COUNTRY: USA

DATES ATTENDED: FROM: MO/YR 8/88 TO: MO/YR 12/91 DEGREE RECEIVED: BACHELOR OF ARTS

BJS Dec

SCHOOL NAME		
CITY	STATE	COUNTRY

DATES ATTENDED: FROM: MO/YR / TO: MO/YR / DEGREE RECEIVED:

MEDICAL OR OSTEOPATHIC SCHOOL OF GRADUATION:

SCHOOL NAME		
MEDICAL COLLEGE OF OHIO AT TOLEDO		
CITY: TOLEDO	STATE: OH	COUNTRY: USA

DATES ATTENDED: FROM: MO/YR 8/93 TO: MO/YR 6/97 DEGREE RECEIVED: DOCTOR OF MEDICINE

FOR BOARD USE ONLY

CERTIFICATE OF PRELIMINARY EDUCATION

NO: 96616 DATE ISSUED: APR 29 1999

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

Entrance Examiner

Secretary

Revised 05/20/97

US·MLE
United States
Medical
Licensing
Examination
™

UNITED STATES MEDICAL LICENSING EXAMINATION™

Federation of State Medical Boards of the U.S., Inc.
400 Fuller Wiser Road, Suite 300, Euless, TX 76039-3855
Telephone: (817) 571-2949

OH-2

STEP 3 SCORE REPORT

Slotta, Christine Marie

29386 Parkwood Dr
Wickliffe, OH 44092

USMLE ID: 4-058-880-8

Test Date: May 1999

The USMLE is a single examination program for all applicants for medical licensure in the United States; it replaced the Federation Licensing Examination (FLEX) and the certifying examinations of the National Board of Medical Examiners (NBME Parts I, II and III). The program consists of three Steps designed to assess an examinee's understanding of and ability to apply concepts and principles that are important in health and disease and that constitute the basis of safe and effective patient care. **Step 3** is designed to assess whether an examinee possesses the medical knowledge and understanding of clinical science considered essential for the unsupervised practice of medicine, with an emphasis on patient management in ambulatory-care settings. Results of the examination are reported to medical licensing authorities in the United States and its territories for use in granting an initial license to practice medicine. The two numeric scores shown below are equivalent; each state or territory may use either score in making licensing decisions. These scores represent your results for the administration of Step 3 on the test date shown above.

PASS	This result is based on the minimum passing score recommended by USMLE for Step 3. Individual licensing authorities may accept the USMLE-recommended pass/fail result or may establish a different passing score for their own jurisdictions.

207	This score is determined by your overall performance on Step 3. For recent administrations, the mean and standard deviation for first-time examinees from U.S. and Canadian medical schools are approximately 207 and 18, respectively, with most scores falling between 140 and 260. A score of 177 is recommended by USMLE to pass Step 3. The standard error of measurement (SEM)‡ for this scale is approximately five points.

84	This score is also determined by your overall performance on the examination. A score of 82 on this scale is equivalent to a score of 200 on the scale described above. A score of 75 on this scale, which is equivalent to a score of 177 on the scale described above, is recommended by USMLE to pass Step 3. The SEM‡ for this scale is approximately one and a half points.

‡Your score is influenced both by your general understanding of clinical medicine and by the specific set of items selected for this Step 3 examination. The standard error of measurement (SEM) provides an estimate of the range within which your scores might be expected to vary by chance if you were tested repeatedly using similar tests.

361VC191

State Medical Board of Ohio

77 S. High Street, 17th Floor • Columbus, Ohio 43266-0315 • 614/ 466-3934 • Website: www.state.oh.us/med/

July 16, 1999

Christine Marie Slotta MD
29386 Parkwood Dr.
Wickliffe, OH 44092

Dear Dr. Slotta:

We are pleased to inform you that as a result of your recent examination before the State Medical Board of Ohio, you are eligible to apply for a certificate to practice medicine or osteopathic medicine and surgery in Ohio. Your USMLE Step 3 score report is enclosed.

The passing score acceptable to the Board for the USMLE Step 3 will be that figure recommended by the Federation of State Medical Boards (Rule 4731-6-07, Ohio Administrative Code).

However, before a certificate to practice medicine or osteopathic medicine and surgery can be issued you must complete the enclosed Application for Certificate Issuance Following Examination and return it to the Board at the above address, along with the required fee.

As you may well know, instances of cheating have been uncovered in various states relating to past examinations. You should be aware that Section 4731.22(A), Ohio Revised Code, provides that the State Medical Board may revoke a license issued to a person who is found by the Board to have committed fraud in passing the examination. Furthermore, Section 4731.22(A), Ohio Revised Code, requires any licensee to report to the Board information which is believed to indicate a violation of the Medical Practice Act.

Sincerely,

Penny E. Grubb

Penny E. Grubb
Chief, Licensure

Enclosures:

State Medical Board of Ohio

77 S. High Street, 17th Floor • Columbus, Ohio 43266-0315 • 614/ 466-3934 • Website: www.state.oh.us/med/

DATE: 4/16/99

Dear Doctor:

Dr. Christine Marie Slotta , MD who is/was Resident Ob/Gyn 7/98 - present is applying to sit for 5/11-12/99 USMLE Step 3 in the State of Ohio. We would appreciate your assistance in filling out the following evaluation so that we can process his/her application for the examination. ***To ensure processing of the physicians application please complete this form and return to the Ohio State Medical Board within two (2) weeks by either mail or FAX***. Your immediate attention to this matter will be greatly appreciated by the applicant as well as by us. Information provided is considered confidential under Section 149.42 (A)(2)(a), Ohio Revised Code. Thank you for your time and assistance.

(1) How long have you known him/her? **2 years**

(2) What is/was your supervisory capacity? **Dept. Chairperson & Residency Program Director**

(3) At what hospital? **MetroHealth Medical Center**

(4) How would you rate his/her medical knowledge and techniques? **Very good**

(5) In your opinion is he/she a person of good moral and ethical character? **Yes**

(6) Does he/she work well with peers and medical staff? **Yes**

(7) Does he/she relate well to patients? **Yes**

(8) How is his/her command of the English language (if applicable)? **n/a**

(9) Would you recommend him/her to take the examination? **Yes**

Additional comments, please: (if needed, an extra sheet of paper may be used)

Dr. Slotta is a compassionate physician. Her skills are appropriate for her level of training.

Sincerely,

Penny E. Grubb

Penny E. Grubb
Chief, Licensure

Signature of Physician

Patrick M. Catalano, M.D.
Name of Physician (please type or print clearly)

Chairperson, Dept. Ob/Gyn
Position

216-778-4876
Telephone number (include area code)

1999 MAY -5 AM 9:47

Direct Dial: (614) 466-9234
FAX: (614) 644-1464

The Federation of State Medical Boards of the United States, Inc.
Federation Credentials Verification Service
Federation Place
400 Fuller Wiser Road, Suite 300
Euless, Texas 76039-3855
Telephone: (817) 868-4000
Fax: (817) 868-4099

Physician Information Profile

This report is compiled exclusively for:

Name:	**Christine Marie Slotta**
SSN:	REDACTED
DOB:	**02/28/1970**
Recipient:	**State Medical Board of Ohio**

NOTICE:

The Federation Credentials Verification Service (FCVS) was retained by the above referenced physician to verify his/her medical credentials for submission to your agency/organization. Unless noted otherwise, all documents contained in this report were received directly from the issuing institution per written request made by FCVS. All documents bearing the official FCVS seal are ceritified to be an exact reproduction of the original. Where required, original documents are provided according to the agreements with the institution issuing such document. FCVS maintains all original documents (excluding third-party examination transcripts) in the physician's source file.

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

Table of Contents

Section I

FCVS Reports

FEDERATION CREDENTIALS VERIFICATION SERVICE

Physician Information Report

Identity:

Name:	**Christine Marie Slotta**	
Other Name Used:	**Christine Marie Simcich**	
Gender:	**Female**	
Date of Birth:	**02/28/1970**	
Place of Birth:	**Warrensville Heights, OH**	
SSN:	REDACTED	
Current Address:	**29386 Parkwood Drive** **Wickliffe, OH 44092**	
Permanent Address:	**Same**	
Telephone Numbers:	Bus.:	**N/A**
	Fax:	**N/A**
	Home:	**(440) 944-1629**
	Other:	**N/A**
Physical Description:	Height:	**5' 6"**
	Weight:	**140 lbs**
	Eye Color:	**Hazel**
	Hair Color:	**Blond**
Physical Marks:	Location:	**N/A**
	Description:	**N/A**

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

Institution:	**Miami University** **Oxford, OH**
Dates of Attendance:	**08/1988 - 12/1991**
Degree Awarded:	**Bachelor of Arts**
Institution:	**Cleveland State University** **Cleveland, OH**
Dates of Attendance:	**06/1992 - 08/1992**
Degree Awarded:	**Did not Graduate**
Institution:	**Kent State Unversity** **Kent, OH**
Dates of Attendance:	**06/1999 - 08/1999**
Degree Awarded:	**Did not Graduate**

Medical Education:

Current, valid ECFMG	**N/A**
ECFMG Number:	**N/A**
Date Issued:	**N/A**
Medical School:	**Medical College of Ohio** **Registrar`s Office** **Mulford Library Building** **3045 Arlington Avenue** **Toledo, OH 43614-5805**
Dates of Attendance:	**08/30/1993 - 06/06/1997**
Graduation Date:	**06/06/1997**
Degree Awarded:	**Doctor of Medicine**
Unusual Circumstance:	**Not reported by the Primary Source**

Post Graduate Medical Education:

Institution:	**MetroHealth Medical Center** **Department of Obstetrics & Gynecology** **2500 MetroHealth Drive** **Cleveland,, OH 44109-1998**
Post Graduate Year:	**1**
Program Type:	**Internship**
Department:	**Obstetrics/Gynecology**
Dates of Attendance:	**07/01/1997 - 06/30/1998**
Completion:	**To Be Completed On 06/30/1998**
Accreditation:	**ACGME**
Post Graduate Year:	**2**
Program Type:	**Residency**
Department:	**OB/Gyn**
Dates of Attendance:	**07/01/1998 - 06/30/1999**
Completion:	**Yes**
Accreditation:	**ACGME**
Unusual Circumstance:	**None**

Clinical Clerkships:

N/A

Fifth Pathway:

N/A

Examination History:

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

Board Action:

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

Omission / Discrepancy Report

Physician Identification:

Name:	Christine Marie Slotta
DOB:	02/28/1970
SSN:	REDACTED
Packet ID:	10023

REPORT OF OMISSIONS

Omission 1:

Section of Profile: **Medical Education**

FCVS Interpretation: Med Col Of Ohio did not complete the Unusual Circumstances and the Premedical Education sections of the Medical Education form.

Solution: Institute states "Office of the Registrar only provides academic information".

Omission 2:

Section of Profile: **Post-Graduate Education**

FCVS Interpretation: The Postgraduate Medical Education form completed by MetroHealth Medical Center was not sealed or notarized. A statement from the institution is included to explain this omission.

Solution: FCVS has contacted the institute and requested that the seal/notarization be added to the completed verification form.

REPORT OF DISCREPANCIES

Discrepancy 1:

Section of Profile: **Continuity of Education**

FCVS Interpretation: There is a gap of approximately 1 year between completion of premedical education at Cleveland State Univ (ends 08/1992) and entrance into medical school at Med Col Of Ohio (begins 08/30/1993).

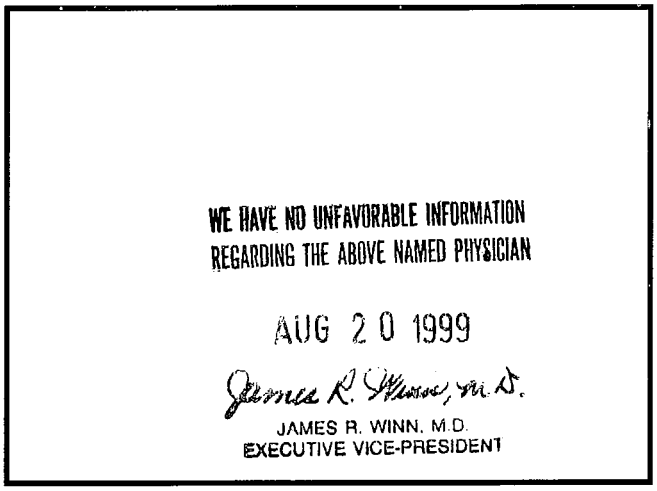
Solution: Left to Recipient discretion.

End of report for Christine Marie Slotta

Board Action Databank Search

State Queried For:	**State Medical Board of Ohio**
Physician's Name:	**Slotta, Christopher Marie**
Date of Birth:	**02/28/1970**
Medical School:	**036030 - Med Col Of Ohio**
Year of Graduation:	**1997**
Social Security Number:	REDACTED
ECFMG Number:	**N/A**

Results:



Section II

Identity

AFFIDAVIT AND RELEASE

I, the undersigned, hereby certify under oath that I am the person named in this application, that all statements I have or shall make are true, that I am the 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 I furnish with my application are strictly true.

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

I authorize every person, hospital, clinic, government agency (local, state, federal or foreign), 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, or true and correct copies of documents or records.

I hereby release, discharge and hold harmless the Federation Credentials Verification Service, its agents or representatives and any person furnishing information, records or documents of any and all liability. 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.

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

SLOTTA

Applicant's **Printed** Last Name

CHRISTINE, M

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

4/30/99

Date of Signature (must correspond to date of notarization)

State of Ohio, County of Lake,

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 30th day of April, 1999.

Notary Public signature: Caroline Simone NKA Caroline Jakus

My commission expires: CAROLINE SIMONE, Notary Public
State of Ohio, Lake County
My Commission Expires April 6, 2000

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

PACKET ID: 10023

OHIO DEPARTMENT OF HEALTH
DIVISION OF VITAL STATISTICS
CERTIFICATE OF LIVE BIRTH

18835

Registrar's No. 223 W

Birth No. 134 -

1a. CHILD'S NAME: First: Christine	Middle: Marie	Last: Simcich	2a. DATE OF BIRTH (Month, Day, Year): February 28, 1970	2b. HOUR: 2:05P
3. SEX: Female	4a. SINGLE, TWIN, TRIPLET, etc.: Single	4b. IF NOT SINGLE BIRTH — Born first, second, third, etc. (Specify): ----------	5a. COUNTY OF BIRTH: Cuyahoga	
5b. CITY, VILLAGE, OR LOCATION OF BIRTH: Warrensville Heights	5c. INSIDE CITY LIMITS (Specify yes or no): Yes	6a. HOSPITAL NAME (If not in hospital, give street and number): Brentwood Hospital		
7a. MOTHER'S MAIDEN NAME: First: Phyllis	Middle: Ann	Last: Currey	7b. AGE (At time of this birth): 23	7c. STATE OF BIRTH (If not in U.S.A., name country): Ohio
7d. RESIDENCE: Ohio	7e. Cuyahoga	7f. CITY, VILLAGE, OR LOCATION: Cleveland	7g. INSIDE CITY LIMITS (Specify yes or no): Yes	7h. STREET AND NUMBER: 10501 Parkview Ave.
8a. FATHER'S NAME: First: Thomas	Middle: ------	Last: Simcich	8b. AGE (At time of this birth): 23	8c. STATE OF BIRTH (If not in U.S.A., name country): Ohio
9a. INFORMANT'S NAME OR SIGNATURE: Phyllis A. Simcich				9b. RELATION TO CHILD: Mother
I hereby certify that I attended the birth of this child who was born alive at the place and time and on the date stated above.		10b. DATE SIGNED: 3-12-70	10c. ATTENDANT — M.D., D.O., midwife, other (specify): D.O.	
10a. SIGNATURE OF CERTIFIER — NAME (Type or Print): W. B. Grigg		10d. MAILING ADDRESS (Street or R.F.D. No., City or Village, State, Zip): 4120 Warrensville Cr. Rd. Cleveland, Ohio 44122		
11a. REGISTRAR — SIGNATURE: Ed Klein			11b. DATE RECEIVED BY LOCAL REGISTRAR: MAR 18 1970	

CONFIDENTIAL INFORMATION FOR MEDICAL AND HEALTH USE ONLY

JAN 13 1998

EXPLANATION OF ALTERNATE NAME FORM

Use this form to explain the use of an Alternate Name(s). Do not write on the back of this form. If additional space is required, please photocopy this form.

Current Name

The name you report here must be the name under which your FCVS application is submitted.

SLOTTA
Last Name (Surname) and Generational Suffix

CHRISTINE MARIE
First and Middle Name(s)

Alternate Name

SIMCICH
Last Name (Surname) and Generational Suffix

CHRISTINE MARIE
First and Middle Name(s)

Explanation of Use of Name:
maiden name
change to current name on 11/4/95
because of marriage

Alternate Name

Last Name (Surname) and Generational Suffix

First and Middle Name(s)

Explanation of Use of Name:

Alternate Name

Last Name (Surname) and Generational Suffix

First and Middle Name(s)

Explanation of Use of Name:

Signature

Signature

Date

PACKET ID:

Section III

Medical Education

RECEIVED MAY 17 1999

FED ~ .TION CREDENTIALS VERIFICATION SERV (FCVS)

VERIFICATION OF MEDICAL EDUCATION

(This form must be completed by the medical school)

INSTRUCTIONS TO THE DEAN

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

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

VERIFICATION OF MEDICAL EDUCATION

Name of Institution: Medical College of Ohio

Complete Address:

Street Address

Street Address

City State Zip Code(Postal Code)

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

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

attended our medical school for total of 59 more ~~weeks~~ of continuous on-campus education on the following dates (mm/dd/yy):

From	To
8 / 30 / 93	6 / 6 / 97
/ /	/ /
/ /	/ /
/ /	/ /
/ /	/ /

This individual (check one):

✓ was awarded the degree of Doctor of Medicine on 6 / 6 / 97 (mm/dd/yy)

____ was NOT awarded a degree (please attach an explanation)

VERIFICATION OF MEDICAL EDUCATION (continued)

Unusual Circumstances: The following questions apply to unusual circumstances that occurred during any part of the individual's medical education. Please circle the appropriate response. **"Yes" responses to any of these questions requires a written explanation.**

Questions	Response	
Did this individual ever take a leave of absence or break from their medical education?	Yes	No
Was this individual ever placed on probation?	Yes	No
Was this individual ever disciplined or under investigation?	Yes	No
Were any negative reports regarding this individual ever filed by instructors?	Yes	No
Were any limitations or special requirements imposed on the individual because of questions or academic incompetence, disciplinary problems or any other reason?	Yes	No

Premedical Education: Does your school have a premedical education requirement? Yes (No)

If yes, include where your records indicate the individual completed his/her premedical education and the basic science courses taken (attach additional pages if necessary):

Premedical Institution(s): _____

_____

_____

Check Courses Taken: _____ Physics _____ Biology/Zoology

_____ Organic Chemistry _____ Inorganic Chemistry

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

SEAL
VERIFIED
AFFIX INSTITUTIONAL SEAL HERE

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

Signature: Dennis W Bicknell

Title: Registrar

Date of Signature: 5-11-99

Telephone: (419) 383-4198

MEDICAL COLLEGE OF OHIO
3045 ARLINGTON AVENUE, TOLEDO, OHIO 43614-5805
STUDENT TRANSCRIPT

STUDENT ID: REDACTED

NAME: Dr. Christine Marie Slotta
29386 Parkwood Dr.
Wickliffe, OH 44092

MATRICULATION DATE : 08/30/93

MCO DEGREES CONFERRED :	AWARDED :	MAJOR :	CONCENTRATION :
Doctor of Medicine	06/06/97	Medicine	ME

COURSE NUMBER	COURSE TITLE	GRADE
	Fall 1993	
01-678	Gross Anatomy	P
03-675	Biochemistry I	In Progress
13-675	Physiology I	In Progress
21-670	Comp Applic Medic	P
21-675	Intr:Clin Medic	In Progress
23-600	Basic Life Support	CR
	Winter 1994	
01-682	Microanatomy	HP
03-676	Biochemistry II	In Progress
13-676	Physiology II	In Progress
14-680	Behav Science I	In Progress
21-676	Intr:Clin Medic	In Progress
	Spring 1994	
01-681	Neuroscience	P
01-683	Embryology	HP
03-677	Biochemistry	HP
13-677	Physiology	HP
14-681	Behavioral Science	P
21-677	Intr:Clin Medic	P
21-680	Subst Use Disorders	P
	Summer 1994	
20-673	Res:Biomed Science	S
	Fall 1994	
07-675	Microbiology I	In Progress
10-675	Pathology	In Progress
21-675	Intr:Clin Medic	In Progress
21-680	Subst Use Disorders	P
21-702	Med Dec Making	HP
23-687	Reach Out Kids	CR

COURSE NUMBER	COURSE TITLE			GRADE
	Winter 1995			
07-676	Microbiology			In Progress
10-676	Pathology			In Progress
12-680	Pharmacology I			In Progress
21-678	Phy Diagnosis I			H
	Spring 1995			
07-677	Microbiology			HP
07-682	Infectious Diseases			HP
10-677	Pathology			P
12-681	Pharmacology			HP
21-601	Adv Cardiac Life Support			P
21-677	Intr:Clin Medic			HP
23-693	Domestic Violence			CR
	Summer 1995			
04-701	Medicine I			
	07/03/95	07/30/95	BLOCK 01	
04-702	Medicine II			
	07/31/95	08/27/95	BLOCK 02	
04-703	Medicine			H
	08/28/95	09/24/95	BLOCK 03	
	FALL 1995			
14-701	Psychiatry I			P
	09/25/95	10/22/95	BLOCK 16	
04-706	Dermatology			P
	10/23/95	11/19/95	BLOCK 17	
05-701	Family Med I			HP
	11/20/95	12/15/95	BLOCK 06	
	Winter 1996			
18-701	Surgery I			
	01/02/96	01/28/96	BLOCK 07	
18-702	Surgery II			
	01/29/96	02/25/96	BLOCK 08	

MEDICAL COLLEGE OF OHIO
3045 ARLINGTON AVENUE, TOLEDO, OHIO 43614-5805
STUDENT TRANSCRIPT

STUDENT ID: REDACTED

NAME: Dr. Christine Marie Slotta
29386 Parkwood Dr.
Wickliffe, OH 44092

MATRICULATION DATE : 08/30/93

MCO DEGREES CONFERRED :	AWARDED :	MAJOR :	CONCENTRATION :
Doctor of Medicine	06/06/97	Medicine	ME

COURSE NUMBER	COURSE TITLE		GRADE
	Winter 1996 (cont.)		
18-703	Surgery		P
	02/26/96 03/22/96	BLOCK 09	
	Spring 1996		
11-701	Pediatrics		H
	04/01/96 05/12/96	BLOCK 10	
17-701	Obstetrics Gyn		H
	05/03/96 06/21/96	BLOCK 12	
	Summer 1996		
04-705	Cardiology		HP
	07/01/96 07/28/96	BLOCK 13	
04-704	Act Intern: Medicine		H
	07/29/96 08/25/96	BLOCK 14	
17-712	Sr Clerkship:Ob		HP
	08/26/96 09/22/96	BLOCK 15	
	Fall 1996		
04-707	Endocrinology		H
	09/23/96 10/20/96	BLOCK 16	
14-702	Psychiatry II		P
	10/21/96 11/17/96	BLOCK 17	
00-000	Free Time		
	11/18/96 12/13/96	BLOCK 18	
	Winter 1997		
00-000	Free Time		
	12/30/96 01/26/97	BLOCK 19	
04-706	Dermatology		H
	01/27/97 02/09/97	BLOCK 20	
18-708	Ophthalm: Surgery		HP
	02/10/97 02/23/97	BLOCK 20	
08-701	Neurology:Adult		HP
	02/24/97 03/23/97	BLOCK 21	
	Spring 1997		
15-702	Diag Imag: Radiology		HP
	03/31/97 04/27/97	BLOCK 22	
05-702	Family Med II		HP
	04/28/97 05/25/97	BLOCK 23	

E N D ------- O F ------- T R A N S C R I P T

MEDICAL COLLEGE OF OHIO

P.O. Box 10008
Toledo, Ohio 43699

In accordance with the Family Educational Rights and Privacy Act of 1974, as amended, this information is released on the condition that you will not permit any other party to have access to this information without the written consent of the individual, whose academic record is being released.

EXPLANATION OF GRADES

SCHOOL OF MEDICINE

15 September 1969 – 25 August 1986

H	=	Honors
P	=	Pass
F	=	Fail
I	=	Incomplete
W	=	Withdrawal
AU	=	Audit
CR	=	Credit

26 August 1986 – 21 June 1987

H	=	Honors
P	=	Pass
F	=	Fail
I	=	Incomplete
Df	=	Defer
W	=	Withdrawal
AU	=	Audit
CR	=	Credit

22 June 1987 – present

H	=	Honors
HP	=	High Pass
P	=	Pass
F	=	Fail
I	=	Incomplete
DF	=	Defer
W	=	Withdrawal
AU	=	Audit
CR	=	Credit
IP	=	In Progress

GRADUATE SCHOOL

01 September 1975 – present

Grades Affecting the Grade Point Average

A	=	4.00	
B	=	3.00	
C	=	2.00	
D	=	1.00	
F	=	0.00	
PR	=	0.00	Progress (grade eliminated Summer Quarter 1978)
WF	=	0.00	Withdrawal Failing

Grades Not Affecting the Grade Point Average

S	=	Satisfactory
U	=	Unsatisfactory
I	=	Incomplete
WP	=	Withdrawal Passing
AU	=	Audit

The following School of Medicine courses are graded on a Pass/Fail basis:

21601	Adv. Cardiac Support
21670	Computer Apps Medicine
21675	Intro Clinical Medicine
21677	Intro Clinical Medicine
21680	Substance Use Disorders

Medical College of Ohio
At Toledo

MEDICAL COLLEGE OF OHIO AT TOLEDO
1964

SEAL
VERIFIED

THE MEDICAL COLLEGE OF OHIO SEAL IMPRINTED UPON THIS STATEMENT CERTIFIES THIS IS A TRUE AND EXACT COPY OF THE ORIGINAL DOCUMENT.

The Faculty and The Board of Trustees
of the Medical College of Ohio at Toledo
hereby confer the degree of

Doctor of Medicine

upon

Christine Marie Slotta

Who has complied with all requirements of The School of Medicine of The Medical College of Ohio at Toledo
and is entitled to all the honors, rights, and privileges pertaining thereunto.

In testimony whereof, this degree is conferred, sealed with the seal of
The Medical College of Ohio at Toledo, Ohio,
this Sixth Day of June in the year Nineteen Hundred and Ninety-Seven.

Bruce G. Langston
Chairman of the Board of Trustees

Allan Block
Secretary of the Board of Trustees

President

Amira F. Boulara M.D.
Dean, School of Medicine

Section IV

Postgraduate Training

RECEIVED MAY 1 0 1999

FED TION CREDENTIALS VERIFICATION SERV (FCVS)

VERIFICATION OF POSTGRADUATE MEDICAL EDUCATION

(This form must be completed by the Program Director)

INSTRUCTIONS TO THE PROGRAM DIRECTOR

The individual identified on the attached Authorization For Release of Information, Documents and Records form has authorized your postgraduate training program to provide to the Federation Credentials Verification Service (FCVS) any and all information pertaining to their education at your institution. **Please complete this form and forward it, together with an official copy of the individual's record (indicating rotations, dates, and hours of training, scores, grades or evaluations), to FCVS in the enclosed postage-paid, self-addressed envelope.**

POSTGRADUATE MEDICAL EDUCATION HISTORY

Name of Institution: MetroHealth Medical Center

Complete Address: 2500 MetroHealth Drive
Street Address

Street Address

Cleveland, Ohio 44109-1998
City State Zip Code(Postal Code)

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

Name and complete address of affiliated university/college: Case Western Reserve University School of Medicine
Institution

10900 Euclid Avenue
Street Address

Street Address

Cleveland, Ohio 44106-7001
City State Zip Code(Postal Code)

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

participated in the following:

Program Type (Internship,Residency, Fellowship)	PGY (1,2,3,4)	Department (Pathology, Internal Medicine, etc.)	Dates Attended (month/day/year) From	To	Completed (Yes/No)	Accredited By (ACGME, RSC, AOA or Not Accredited)
Internship	1	Ob/Gyn	6 /20 /97	6 /30 /98	Y	ACGME
Residency	2	Ob/Gyn	7 / 1 /98	6 /30 /99	N	ACGME
			/ /	/ /		
			/ /	/ /		
			/ /	/ /		

FEDERATION CREDENTIALS VERIFICATION SERVICE (FCVS)

VERIFICATION OF POSTGRADUATE MEDICAL EDUCATION (continued)

Unusual Circumstances: The following questions apply to unusual circumstances that occurred during any part of the individual's medical education. Please circle the appropriate response.

Questions	Response	
Did this individual ever take a leave of absence or break from their medical education?	Yes	(No)
Was this individual ever placed on probation?	Yes	(No)
Was this individual ever disciplined or under investigation?	Yes	(No)
Were any negative reports regarding this individual ever filed by instructors?	Yes	(No)
Were any limitations or special requirements imposed on the individual because of questions or academic incompetence, disciplinary problems or any other reason?	Yes	(No)

"Yes" responses to any of the questions above concerning unusual circumstances require a written explanation.

Certification: By my signature below, I, Patrick M. Catalano, M. D. (type/print name), certify that the information contained in this report is an accurate account of the above named individual's official records maintained by this institution and is true and correct to my knowledge.

AFFIX INSTITUTIONAL SEAL HERE

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

Signature: Patrick M Cat

Title: Chairperson, OB/GYN and Residency Program Director

Date of Signature: 7/06/99 PMC/pm

Telephone: (216) 778-4262

Federation of State Medical Boards of the U.S., Inc.
Federation Credentials Verification Service
Federation Place
400 Fuller Wiser Road, Suite 300
Euless, TX 76039 3855
Toll Free Number: 1-888-275-3287
Fax Number: 1-817-868-5099

Fax Cover Sheet

TO: Name: Dr. Patrick M. Catalano, OB/G Residency
Institution: MetroHealth
Fax Number: 216-778-8847

DATE: 8-11-99

FROM: Denise Bransford

Packet ID#10023

The form you recently submitted to FCVS for Dr. **Christine M. Slotta** was either incomplete or requires further clarification. Please address these items listed below, initial the change and return by fax to the above number.

Please mail a hard copy of your changes to my attention.

• Attendance Dates	Please indicate the correct begin and end dates for each year of reported postgraduate training following: Year 07/01/1997 to __/__/__ 7/01/97 to 6/30/98 __/__/__ to 06/30/1999 7/01/98 - 6/30/99
• Completed	Please circle Yes or No to indicate completion of each PGY year listed below : PGY 1 Yes No PGY 2 (Yes) No
• Date of Signature	The signature on the form attached was not dated. Please date the signature on page 2 of the document attached. done
• Institutional Seal	Please affix your institutional seal on page 2 of the attached document or have the form notarized. Stamped & Sealed

3 pages

Section V

Examination History/Score Transcripts

USMLE
United States
Medical
Licensing
Examination

United States Medical Licensing Examination™
Certified Transcript of Scores

This Transcript was prepared by the Federation of State Medical Boards

Date of Certification: 07/27/1999

Federation Credentials Verification Service
ATTN: Ohio

Examinee: Slotta, Christine Marie
USMLE ID#: 4-058-880-8
DOB: 02 / 28 / 1970
Alt Name(s): Simcich, Christine M

STEP1 **The recommended minimum passing score on the three-digit scale, and the equivalent value on the two-digit scale is shown below.**

Test Date	Pass/ Fail	Three-Digit Score	Three-Digit Passing	Two-Digit Score	Two-Digit Passing	Comments
6 /1995	PASS	205	176	83	75	

STEP2 **The recommended minimum passing score on the three-digit scale, and the equivalent value on the two-digit scale is shown below.**

Test Date	Pass/ Fail	Three-Digit Score	Three-Digit Passing	Two-Digit Score	Two-Digit Passing	Comments
3 /1997	PASS	210	170	84	75	

STEP3 **The recommended minimum passing score on the three-digit scale, and the equivalent value on the two-digit scale is shown below.**

State Board	Test Date	Pass/ Fail	Three-Digit Score	Three-Digit Passing	Two-Digit Score	Two-Digit Passing	Comments
OHIO	5 /1999	PASS	207	177	84	75	

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

10023

See reverse side for explanation of information reported above.

DETACH HERE AND REMIT THIS PORTION WITH FEE

STATE MEDICAL BOARD OF OHIO
77 SOUTH HIGH STREET, 17TH FLOOR, COLUMBUS, OHIO 43215 - 6127

CERTIFICATION

I CERTIFY, UNDER PENALTY OF LOSS OF MY RIGHT TO PRACTICE IN THE STATE OF OHIO, THAT I HAVE COMPLETED OR WILL HAVE COMPLETED DURING THE 1999-2001 REGISTRATION PERIOD THE REQUISITE HOURS OF CONTINUING MEDICAL EDUCATION CERTIFIED BY THE
OHIO STATE MEDICAL ASSOCIATION
AND APPROVED BY THE STATE MEDICAL BOARD, AND THAT THE INFORMATION PROVIDED ON THIS APPLICATION FOR RENEWAL IS TRUE AND CORRECT IN EVERY RESPECT.

X _____ 9/20/01
(SIGNATURE OF APPLICANT) (DATE)

IDENTIFICATION NUMBER	AMOUNT DUE	DATE DUE
35-07-7565-S	$305.00	10/01/01

CHRISTINE MARIE SLOTTA,M.D.
29386 PARKWOOD DR
WICKLIFFE OH 44092

MD & DO SPECIALTY CODES CURRENTLY ON RECORD
OBG OBSTETRICS & GYNECOLOGY

☐ SPECIALTY CODE(S) CORRECT AS LISTED

IF CORRECTIONS ARE NECESSARY, PLEASE ENTER ALL SPECIALTY CODES. CODE1 CODE2 CODE3

RESIDENCE ADDRESS-THIS MUST BE ENTERED AT EACH RENEWAL.

2037 BERINGER PLACE
STREET
STREET
HARPERSFIELD OH 44041
CITY STATE ZIP CODE
ASHTABULA
COUNTY

:969696962: 0935077565 :0000030500:

PRINCIPAL PRACTICE ADDRESS - THIS ADDRESS MUST BE ENTERED AT EACH RENEWAL.

☐ Check this Box if you have NO principal Practice address.

2421 LAKE AVENUE
Street

Street

ASHTABULA | OH | 44004
City | State | Zip Code

ASHTABULA
County

AT ANY TIME SINCE SIGNING YOUR LAST APPLICATION FOR RENEWAL OF YOUR CERTIFICATE :

YES ☐ NO ☑ 1.) Have you been found guilty of, or plec guilty or no contest to, or receivec treatment or intervention in lieu c conviction of, a misdemeanor or felony?

YES ☐ NO ☑ 2.) 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 a program approved by this board and have subsequently adhered to all statutory requirements as contained in sections 4731.224 and 4731.25 O.R.C., and related provisions, or you are currently enrolled in a board approved program. Any questions concerning approval can be directed to the board offices.

YES ☐ NO ☑ 3.) Have any malpractice awards been paid by you or on your behalf for acts occurring in any state other than Ohio?

YES ☐ NO ☑ 4.) Has any board, bureau, department, agency, or other body, including those in Ohio, **other than this board,** filed any charges, allegations or complaints against you?

YES ☐ NO ☑ 5.) Have you surrendered, or consented to limitation of, or to reprimand or probation concerning, a license to practice any healthcare profession or state or federal privileges to prescribe controlled substances in any jurisdiction? You may answer "NO" to this question if the only such surrender or consent was given to this board.

YES ☐ **NO** ☑ 6.) Have you had any clinical privileges or other similar institutional authority suspended, restricted or revoked for reasons **other than failure to maintain records on a timely basis or to attend staff meetings?**

REQUIRED: [redacted] REDACTED

SOCIAL SECURITY NUMBER

Date Posted: 12/23/2005 8:39:49 AM

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

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

License Information

License Number	35.077565
License Name	CHRISTINE SLOTTA
Email Address	

Fees

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

Specialty Codes

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

CME-Physicians

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

Discipline

1. Have you been found guilty of, or pled guilty or no contest to, or received treatment or intervention in lieu of conviction of, a misdemeanor or felony?
   . . . . . NO
2. Have you surrendered, consented to limitation of, or to suspension, reprimand or probation concerning, a license to practice any healthcare profession or state or federal privileges to prescribe controlled substances in any jurisdiction other than Ohio?
   . . . . . NO
3. Have any malpractice awards been paid by you or on your behalf for acts occurring in any state other than Ohio?
   . . . . . NO
4. Has any board, bureau, department, agency, or any other body, including those in Ohio **other than this board,** filed any charges, allegations or complaints against you?

. . . . . NO

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

. . . . . NO

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

. . . . . NO

Social Security Number

1.

. . . . . REDACTED

Nurse Collaboration Info

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

. . . . . YES

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

. . . . . Sandy Piecuch RN, MSN

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

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

Date Posted: 12/4/2007 2:18:51 PM

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

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

Address Information

BUSINESS ADDRESS	35040 Chardon Road Bldg 7 Suite 205 Willoughby Hills, OH 44094 Lake County (440)918-4630
CREDENTIAL MAIL ADDRESS	2419 Michelle Court Willoughby Hills, OH 44094 Lake County (440) 953-3124
MAIN	2419 Michelle Court Willoughby Hills, OH 44094 Lake County (440) 953-3124

License Information

License Number	35.077565
License Name	CHRISTINE SLOTTA
Email Address	cslotta@sbcglobal.net

Fees

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

Specialty Codes

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

CME-Physicians

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

. . . . . YES

Discipline

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

. . . . . NO

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

. . . . . NO

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

. . . . . NO

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

. . . . . NO

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

. . . . . NO

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

. . . . . NO

Social Security Number

1.

. . . . . REDACTED

Nurse Collaboration Info

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

. . . . . NO

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

. . . . . *{not Answered}*

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

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

Date Posted: 12/13/2009 5:24:04 PM

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

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

Address Information

CREDENTIAL MAIL ADDRESS

2419 Michelle Court
Willoughby Hills, OH 44094
Lake County
(440) 953-3124
cslotta@sbcglobal.net

License Information

License Number 35.077565
License Name CHRISTINE SLOTTA

Fees

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

Specialty Codes

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

CME-Physicians

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

Discipline

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

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

. . . . . NO

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

. . . . . NO

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

. . . . . NO

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

. . . . . NO

Social Security Number

1.

. . . . . REDACTED

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

. . . . . NO

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

. . . . . *{not Answered}*

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

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

Date Posted: 12/29/2011 9:41:26 PM

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

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

License Information

License Number 35.077565

License Name CHRISTINE SLOTTA

Fees

Relicensure Fee $305.00

========

Total Fees **$305.00**

Medical Board Correspondence Email

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

. . . . . YES

Specialty Codes

1. Please select one specialty from the field below

. . . . . OBSTETRICS & GYNECOLOGY

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

. . . . . *{not Answered}*

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

. . . . . *{not Answered}*

CME-Physicians

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

. . . . . YES

Discipline

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

. . . . . NO

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

. . . . . NO

3. Have any malpractice awards been paid by you or on your behalf for acts

occurring in any state other than Ohio?

. . . . . NO

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

. . . . . NO

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

. . . . . NO

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

. . . . . NO

Social Security Number

1.

. . . . . REDACTED

Nurse Collaboration Info

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

. . . . . YES

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

. . . . . Stacy Rose, CNP

Ohio Employment

1. Do you practice in Ohio?

. . . . . YES

Ohio Workforce Questions

1. "Clinical" - direct patient care

. 45-49

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

. 0

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

. 10-14

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

. 0

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

. 0

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

. 0

Clinical - Practice setting

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

. 20-24

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

. 20-24

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

. 1-4

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

. 0

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

. 1-4

Workforce Counties

1. Enter the first zip code:

. 44094

2. Enter the first county:

. . . . . Lake

3. Enter the second zip code:

. . . . . *{not Answered}*

4. Enter the second county:

. . . . . *{not Answered}*

5. Enter the third zip code:

. . . . . *{not Answered}*

6. Enter the third county:

. . . . . *{not Answered}*

Practice Arrangement (size)

1. Solo practitioner

. . . . . NO

2. Single-specialty Group

. 5-10

3. Multi-specialty Group

. . . . . N/A

4. Employee of a clinical facility or hospital? (Clinical facility is an urgent care,

industrial clinic or similar entity)

. . . . . YES

Workforce Language Question

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

. . . . . NO

ABMS Certified

1. Are you certified by an ABMS Board?

. . . . . YES

ABMS Specialty

1. Choose specialty from the dropdown list.

. . . . . Obstetrics and Gynecology

2. Choose specialty from the dropdown list.

. . . . . *{not Answered}*

3. Choose specialty from the dropdown list.

. . . . . *{not Answered}*

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

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

Date Posted: 12/3/2013 2:03:20 PM

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

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

License Information

License Number 35.077565

License Name CHRISTINE SLOTTA

Fees

Relicensure Fee $305.00

========

Total Fees **$305.00**

Medical Board Correspondence Email

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

. . . . . YES

Specialty Codes

1. Please select one specialty from the field below

. . . . . OBSTETRICS & GYNECOLOGY

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

. . . . . OBSTETRICS & GYNECOLOGY

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

. . . . . OBSTETRICS & GYNECOLOGY

CME-Physicians

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

. . . . . YES

Discipline

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

. . . . . NO

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

. . . . . NO

3. Have any malpractice awards been paid by you or on your behalf for acts

occurring in any state other than Ohio?

. . . . . NO

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

. . . . . NO

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

. . . . . NO

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

. . . . . NO

Social Security Number

1.

. . . . . REDACTED

Nurse Collaboration Info

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

. . . . . YES

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

. . . . . Stacy Rose, CNP

Ohio Employment

1. Do you practice in Ohio?

. . . . . YES

Ohio Workforce Questions

1. "Clinical" - direct patient care

. 60-64

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

. 0

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

. 1-4

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

. 0

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

. 0

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

. 0

Clinical - Practice setting

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

. 20-24

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

. 25-29

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

. 1-4

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

. 0

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

. 0

Workforce Counties

1. Enter the first zip code:

. 44094

2. Enter the first county:

. . . . . Lake

3. Enter the second zip code:

. . . . . *{not Answered}*

4. Enter the second county:

. . . . . *{not Answered}*

5. Enter the third zip code:

. . . . . *{not Answered}*

6. Enter the third county:

. . . . . *{not Answered}*

7. Do you have more than one practice location?

. . . . . NO

Practice Arrangement (size)

1. Solo practitioner

. . . . . NO

2. Single-specialty Group

. 5-10

3. Multi-specialty Group

. . . . . N/A

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

. . . . . YES

Workforce Language Question

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

. . . . . NO

ABMS Certified

1. Are you certified by an ABMS Board?

. . . . . YES

ABMS Specialty

1. Choose specialty from the dropdown list.

. . . . . Obstetrics and Gynecology

2. Choose specialty from the dropdown list.

. . . . . *{not Answered}*

3. Choose specialty from the dropdown list.

. . . . . *{not Answered}*

NPI number

1. Please enter your current NPI number

. 1700875465

DEA number

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

. . . . . BS7206370

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

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

Date Posted: 12/31/2015 12:58:41 PM

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

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

License Information

License Number 35.077565

License Name CHRISTINE SLOTTA

Fees

Relicensure Fee $305.00

========

Total Fees **$305.00**

Medical Board Correspondence Email

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

. . . . . YES

Specialty Codes

1. Please select one specialty from the field below

. . . . . OBSTETRICS & GYNECOLOGY

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

. . . . . OBSTETRICS & GYNECOLOGY

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

. . . . . OBSTETRICS & GYNECOLOGY

CME-Physicians

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

. . . . . YES

Discipline

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

. . . . . NO

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

. . . . . NO

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

. . . . . NO

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

. . . . . NO

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

. . . . . NO

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

. . . . . NO

Social Security Number

1.

. . . . . REDACTED

Nurse Collaboration Info

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

. . . . . YES

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

. . . . . Stacy Rose, CNP

Ohio Employment

1. Do you practice in Ohio?

. . . . . YES

Ohio Workforce Questions

1. "Clinical" - direct patient care

. . . . . 65+

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

. 0

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

. 1-4

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

. 5-9

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

. 1-4

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

. 5-9

Clinical - Practice setting

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

. 30-34

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

. 50-54

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

. 1-4

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

. 0

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

. 0

Workforce Counties

1. Enter the first zip code:

. 44094

2. Enter the first county:

. . . . . Lake

3. Enter the second zip code:

. . . . . *{not Answered}*

4. Enter the second county:

. . . . . *{not Answered}*

5. Enter the third zip code:

. . . . . *{not Answered}*

6. Enter the third county:

. . . . . *{not Answered}*

7. Do you have more than one practice location?

. . . . . NO

Practice Arrangement (size)

1. Solo practitioner

. . . . . NO

2. Single-specialty Group

. 5-10

3. Multi-specialty Group

. . . . . N/A

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

. . . . . YES

Workforce Language Question

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

. . . . . NO

ABMS Certified

1. Are you certified by an ABMS Board?

. . . . . YES

ABMS Specialty

1. Choose specialty from the dropdown list.

. . . . . Obstetrics and Gynecology

2. Choose specialty from the dropdown list.

. . . . . *{not Answered}*

3. Choose specialty from the dropdown list.

. . . . . *{not Answered}*

NPI number

1. Please enter your current NPI number

. . . . . *{not Answered}*

DEA number

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

. . . . . BS7206370

OARRS Registration

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

. . . . . YES

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

. . . . . YES

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

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

License Renewal Application

Submission Date: 12/02/2017

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
CHRISTINE
Middle Name
MARIE
Last Name
SLOTTA
Maiden Name
SIMCICH
Social Security Number
REDACTED
Date of Birth
2/28/1970
Email Address
cslotta@sbcglobal.net
Phone Number
4409533124
Other Phone Number
4409184630

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?
SIMCICH CHRISTINE MARIE
What is your gender?
Female
What is your ethnicity?
White
In which country were you born?
United States
In which state were you born (if United States)?

Ohio
In which city were you born?
WARRENSVILLE HTS

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.

2419 Michelle Court
Willoughby Hills
OH
44094
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.

2419 Michelle Court
Willoughby Hills
OH
44094
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 - Yes

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

Question - Primary NPI Number
Answer - 1700875465

Question - Primary DEA Number
Answer - BS7206370

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 - >60

Question - How many locations are you currently working in that require the license you are renewing?
Answer - 1

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 - LakeHealth, Willoughby OH 44094

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 - 12/02/2017 09:35:22
Type your First Name and Last Name as they appear on the application to sign electronically.
CHRISTINE SLOTTA

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: 11/5/2019 11:04 AM

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
Christine
Middle Name
Marie
Last Name
Slotta
Maiden Name
SIMCICH
Social Security Number
REDACTED
Date of Birth
2/28/1970
Email Address
cslotta@sbcglobal.net
Phone Number
4409533124
Other Phone Number
4409184630
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
Other
Other Language
English
Individual National Provider Identifier - if N/A enter all zeroes
1700875465
Enter home US zip-code. Enter NA if unavailable
44094

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?
SIMCICH CHRISTINE MARIE
What is your gender?
Female
In which country were you born?
United States
In which state were you born (if United States)?
Ohio
In which city were you born?
WARRENSVILLE HTS

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.

2419 Michelle Court
Willoughby Hills
OH
44094
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.

2419 Michelle Court
Willoughby Hills
OH
44094
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

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 - LakeHealth Women's Health Specialists
Practice Settings - Office/Clinic - Multi Specialty Group
Street Address - 4176 State Route 306
City - Willoughby
State - OH
Zip Code - 44094
Major Area of Focus or Specialty - Obstetrics & Gynecology (AOA)
Total Hours Worked at this practice site, per Week - 35

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

Questions

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

Question - 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 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 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 - 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 - BS7206370

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

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.

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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 - 11/5/2019 11:04 AM
Type your First Name and Last Name as they appear on the application to sign electronically.
Christine Slotta
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.

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Contact Audit Trail for SLOTTA CHRISTINE

Date	User	Table	Field	New	Old
12/5/2007 11:13:20 AM	Vest, P	CONTACTADDRESS	COUNTYID	Lake	Cuyahoga
12/5/2007 11:13:20 AM	Vest, P	CONTACTADDRESS	ADDRESS3	Suite 205	
12/5/2007 11:13:20 AM	Vest, P	CONTACTADDRESS	PHONE	(440)918-4630	(216) 663-7355
12/5/2007 11:13:20 AM	Vest, P	CONTACTADDRESS	ZIPCODE	44094	44125
12/5/2007 11:13:20 AM	Vest, P	CONTACTADDRESS	ADDRESS2		#B
12/5/2007 11:13:20 AM	Vest, P	CONTACTADDRESS	ADDRESS2	Bldg 7	Suite 206
12/5/2007 11:13:20 AM	Vest, P	CONTACTADDRESS	ADDRESS2		#B
12/5/2007 11:13:20 AM	Vest, P	CONTACTADDRESS	CITY	Willoughby Hills	Willoughby
12/5/2007 11:13:20 AM	Vest, P	CONTACTADDRESS	CITY	Willoughby Hills	Garfield Heights
12/5/2007 11:13:20 AM	Vest, P	CONTACTADDRESS	CITY	Willoughby Hills	Willoughby
12/5/2007 11:13:19 AM	Vest, P	CONTACTADDRESS	ADDRESS1	2419 Michelle Court	34866 South Turtle Trail
12/5/2007 11:13:19 AM	Vest, P	CONTACTADDRESS	ADDRESS1	35040 Chardon Road	12000 McCracken Road
12/5/2007 11:13:19 AM	Vest, P	CONTACTADDRESS	ADDRESS1	2419 Michelle Court	34866 South Turtle Trail
8/24/2005 4:15:16 PM	Vest, P	CONTACTADDRESS	ADDRESS1	12000 McCracken Road	524 W 24TH ST
8/24/2005 4:15:16 PM	Vest, P	CONTACTADDRESS	ADDRESS2	Suite 206	
8/24/2005 4:15:16 PM	Vest, P	CONTACTADDRESS	CITY	Garfield Heights	ASHTABULA
8/24/2005 4:15:16 PM	Vest, P	CONTACTADDRESS	ZIPCODE	44125	44004
8/24/2005 4:15:16 PM	Vest, P	CONTACTADDRESS	PHONE	(216) 663-7355	
8/24/2005 4:15:16 PM	Vest, P	CONTACTADDRESS	COUNTYID	Cuyahoga	Ashtabula
8/24/2005 4:14:04 PM	Vest, P	CONTACTADDRESS	ADDRESS2	#B	
8/24/2005 4:14:04 PM	Vest, P	CONTACTADDRESS	CITY	Willoughby	HARPERSFIELD
8/24/2005 4:14:04 PM	Vest, P	CONTACTADDRESS	ZIPCODE	44094	44041
8/24/2005 4:14:04 PM	Vest, P	CONTACTADDRESS	PHONE	(440) 953-3124	
8/24/2005 4:14:04 PM	Vest, P	CONTACTADDRESS	COUNTYID	Lake	Ashtabula
8/24/2005	Vest, P	CONTACTADDRESS	ADDRESS1	34866 South Turtle	2037 BERINGER

4:14:04 PM				Trail	PLACE
8/24/2005 4:10:30 PM	Vest, P	CONTACTADDRESS	ACTIVE	Deleted	Active