ARKANSAS STATE MEDICAL BOARD

LICENSURE DEPARTMENT
1401 W. Capitol Ave., Suite 340, Little Rock, AR 72201
Phone (501) 296-1802 Fax (501) 296-1972 www.armedicalboard.org
Emails with attachments must be sent in PDF format to support@armedicalboard.org

Are you utilizing FCVS for your Arkansas license? [XX] Yes [ ] No
Are you a current or former member of the U.S. military or a spouse of a current or former member of the U.S. military? [ ] Yes [XX] No

APPLICATION FOR MEDICAL LICENSURE IN ARKANSAS
& Centralized Credentials Verification Service

1. Please read the IMPORTANT INFORMATION and ALL INSTRUCTIONS included in the application packet.
2. Type or print legibly (in dark blue or black ink) all application documents. (One sided documents only.)
3. Provide exact dates whenever possible, in *mm/dd/yyyy* format.
4. All questions must be answered. If a question does not apply to you, please write "n/a" in the space provided.
5. Give careful thought to each answer because you are certifying that the information you provide is truthful, complete and correct.
6. If you answer "Yes" to any question in Parts IV or V of the application, you MUST submit a signed and dated explanation.
7. Failure to answer all questions completely and accurately; omitting or falsifying information, may be cause for denial of your application or disciplinary action if you are subsequently granted a license. *When in doubt, disclose and explain all information.*

TYPE OF LICENSE YOU ARE APPLYING FOR (check one)

[XX] Medicine/Surgery (MD) [ ] Osteopathic Medicine/Surgery (DO) [ ] Educational License

Are you requesting that a temporary license be issued prior to full licensure? [ ] Yes [XX] Not at this time

PART I - PERSONAL IDENTIFICATION INFORMATION

1a. Full Legal Name (Last, First, Middle, Suffix, Degree)
Diedrich, Justin Thomas - MD, FACOG

1b. Other Names Used (including Maiden Name)

2a. Social Security Number	2b. Driver's License State & Number	2c. Gender	2d. Date of Birth (mm/dd/yyyy)
		[XX] Male [ ] Female	

3a. Place of Birth	3b. Country of Citizenship
SAINT LOUIS, MISSOURI	UNITED STATES OF AMERICA
3c. Immigration Status (if not U.S. citizen)	3d. How long have you been in the U.S.? (if not U.S. citizen)
3e. Ethnicity [XX] Non-Hispanic [ ] Hispanic	3f. Race [ ] American Indian/Alaska Native [ ] Asian [ ] Black/African American [X] White [ ] Hawaiian/Pacific Islander [ ] Hispanic

4a. Public Address (Street, City, State, Zip Code)
254 N. LAKE AVE #161, PASADENA, CA 91101

4b. Private Address (Street or PO Box, City, State, Zip Code)
ABOVE

4c. Private Phone #	4d. Work Phone #	4e. Fax #	4f. Mobile Phone #
	818-444-4244	818-584-8874	

4g. Personal E-mail Address	5a. If not currently living in Arkansas, do you plan to relocate?
	[XX] No [ ] Yes - Approx. date:

5b. Intended Practice Location in Arkansas: Name and Address of Hospital, Clinic, Group or Private Practice
Little Rock Family Planning Services, 4 Office Park Dr, Little Rock, AR 72211

5c. Will you be providing telemedicine services from outside the state of Arkansas?
[XX] No [ ] Yes - Name of Telemedicine Contract Firm: _____ Phone _____

6a. NPI Number	6b. Accept Medicaid/Medicare Patients?
	[ ] Medicare [XX] Medicaid [ ] Neither [ ] Unknown/Undecided

FOR ASMB USE ONLY

Name Justin Thomas Diedrich, MD, DH 6102
License Number
License Issued
Basis for License Exam

Application Received 5/23/19
Fees Received $ 500.00
Application Declined
PHIDNo. ASMB 215940

RECEIVED ASMB

PART II - EDUCATION

MEDICAL SCHOOL EDUCATION

List all medical school(s) you attended (attach additional sheets if necessary). If you attended more than one medical school, provide the reason you changed medical schools on a separate sheet of paper, signed and dated by you. If you completed medical school in more or less than four years, provide the reason on a separate sheet of paper, signed and dated by you.

7a. Institution Name	7b. Country of Medical School
Case Western Reserve University	USA

7c. Mailing Address (Street Address, City, State/Country, Zip Code): 10900 Euclid Ave, Cleveland, Ohio 44110

7d. Start Date	7e. End Date	7f. Graduated?	7g. Degree Awarded
7/1/2003	1/18/2008	XX Yes ☐ No	XX M.D. (or foreign equivalent) ☐ D.O. ☐ None

8a. Institution Name	8b. Country of Medical School

8c. Mailing Address (Street Address, City, State/Country, Zip Code)

8d. Start Date	8e. End Date	8f. Graduated?	8g. Degree Awarded
/ /	/ /	☐ Yes ☐ No	☐ M.D. (or foreign equivalent) ☐ D.O. ☐ None

POSTGRADUATE EDUCATION, US OR FOREIGN

List internships, residencies, fellowships and other postgraduate training chronologically (attach additional sheets if necessary). If you did not complete a program or changed schools between years, provide the reason on a separate sheet of paper, signed and dated by you. If program still in process, enter anticipated completion date as end date.

9a. Full Name of Training Program	9b. Program ID (if known)
University of California, Irvine Medical Center	

9c. Program Type (Internship, Residency, etc)	9d. Specialty/Subspecialty	9e. Department Name
Residency	Obstetrics & Gynecology	OBGYN

9f. Mailing Address (Street Address, City, State/Country, Zip Code): 101 The City Drive, DEPT OBGYN, Orange, CA 92868

9g. Start Date	9h. End Date	9i. Anticipated End Date	9j. Completed?	9k. Chief resident?
07/01/2009	06/30/2013	/ /	XX Yes ☐ No ☐ In Process	☐ Yes XX No

9a. Full Name of Training Program	9b. Program ID (if known)
Washington University in Saint Louis School of Medicine	

9c. Program Type (Internship, Residency, etc)	9d. Specialty/Subspecialty	9e. Department Name
Fellowship	Family Planning	OBGYN

9f. Mailing Address (Street Address, City, State/Country, Zip Code): 660 S Euclid Ave, OBGYN Family Planning Division, Saint Louis, MO 63110

9g. Start Date	9h. End Date	9i. Anticipated End Date	9j. Completed?	9k. Chief resident?
07/01/2013	06/30/2015	/ /	XX Yes ☐ No ☐ In Process	☐ Yes ☐ No N/A

9a. Full Name of Training Program	9b. Program ID (if known)

9c. Program Type (Internship, Residency, etc)	9d. Specialty/Subspecialty	9e. Department Name

9f. Mailing Address (Street Address, City, State/Country, Zip Code)

9g. Start Date	9h. End Date	9i. Anticipated End Date	9j. Completed?	9k. Chief resident?
/ /	/ /	/ /	☐ Yes ☐ No ☐ In Process	☐ Yes ☐ No

9a. Full Name of Training Program	9b. Program ID (if known)

9c. Program Type (Internship, Residency, etc)	9d. Specialty/Subspecialty	9e. Department Name

9f. Mailing Address (Street Address, City, State/Country, Zip Code)

9g. Start Date	9h. End Date	9i. Anticipated End Date	9j. Completed?	9k. Chief resident?
/ /	/ /	/ /	☐ Yes ☐ No ☐ In Process	☐ Yes ☐ No

EXAMINATION HISTORY	Please specify exam series USMLE, NBME, FLEX, NBOME, COMLEX, LMCC (or State Exam prior to 1975). *If you failed any step of any examination, even once, you must submit a separate, signed and dated explanation of the circumstances.* Attach additional sheets if necessary.		
10a. Exam Series & Step USMLE Step 1	10b. Number of Attempts 1	10c. Number of times failed 0	10d. Date PASSED 6 / 23 / 2005
10a. Exam Series & Step USMLE Step 2 CK	10b. Number of Attempts 1	10c. Number of times failed 0	10d. Date PASSED 12 / 6 / 2006
10a. Exam Series & Step USMLE Step 2 CS	10b. Number of Attempts 2	10c. Number of times failed 1	10d. Date PASSED 5 / 21 / 2007
10a. Exam Series & Step USMLE Step 3	10b. Number of Attempts 1	10c. Number of times failed 0	10d. Date PASSED 2 / 4 / 2010

10e. Have you ever taken the SPEX or COMVEX examination? ☐ Yes ☒ No If Yes, you must provide a signed and dated explanation.

11a. If you are an International medical graduate, do you hold an ECFMG certification? ☐ Yes ☐ No ☒ N/A (If No, you must provide a signed and dated explanation)	11b. ECFMG Certificate No.	11c. Date Issued / /

SPECIALTY/ BOARD CERTIFICATION	Please list all specialties, including self-designated. Attach additional sheets if necessary.		
12a. Primary Practice Specialty/Subspecialty Obstetrics & Gynecology	12b. Board Certified? ☒ Yes ☐ No	12c. Certification Type ☐ Lifetime ☐ Time-Limited ☒ MOC	
12d. Name of Specialty Board, if certified American Board of Obstetrics & Gynecology	12e. Certification Date 11 / 6 / 2015	12f. Recertification Date 12 / 5 / 2018	12g. Expiration Date 12 / 31 / 2019
13a. Secondary Specialty/Subspecialty	13b. Board Certified? ☐ Yes ☐ No	13c. Certification Type ☐ Lifetime ☐ Time-Limited ☐ MOC	
13d. Name of Specialty Board, if certified	13e. Certification Date / /	13f. Recertification Date / /	13g. Expiration Date / /
14a. Tertiary Specialty/Subspecialty	14b. Board Certified? ☐ Yes ☐ No	14c. Certification Type ☐ Lifetime ☐ Time-Limited ☐ MOC	
14d. Name of Specialty Board, if certified	14e. Certification Date / /	14f. Recertification Date / /	14g. Expiration Date / /

PART III - PROFESSIONAL ACTIVITIES

PROFESSIONAL LICENSURE List all states or territories of the United States or other countries in which you hold or have **ever held** a medical license. Include all temporary, instructional and training permits/licenses. Attach additional sheets if necessary. If none, enter "N/A."

15a. Jurisdiction (State, Country)	15b. License No.	15c. Issue Date	15d. Expiration Date	15e. Current Status
California	A114859	11 / 24 / 2010	10 / 31 / 2020	Active
Missouri	2013023316	7/6/2013	1 / 31 / 2020	Active
Illinois	036-145127	2/15/2018	7 / 31 / 2020	Active
Texas	R7709	6/15/2018	8 / 31 / 2019	Active
		/ /	/ /	
		/ /	/ /	
		/ /	/ /	
		/ /	/ /	

MILITARY SERVICE Submit a copy of your separation papers (DD Form 214) with your application. If Active Duty, have the Verification of Current Military Service sent to this office or have your current Commanding Officer submit a verification letter directly to this office.

16a. Have you ever been in the armed forces? ☐ Yes ☒ No

16b. Country & Branch of Service	16c. Date of Entry	16d. Date of Discharge	16e. Type of Discharge
	/ /	/ /	
	/ /	/ /	

WORK HISTORY Please provide a chronological listing for all medical and non-medical work history and other activities, including hospitals, faculty appointments, private practice, employment corporations, military assignments, government agencies, locum tenens and telemedicine assignments, and leaves of absence since graduation from medical school. Do not include Medical School or Postgraduate Education/Training. **Do not write, "See CV;" you must complete this section AND attach your curriculum vitae. If none, enter "N/A."**

17a. Date From	17b. Date To	17c. Type of Affiliation (Primary or Previous Practice, Employment, Staff Appointment, etc.)
8 / 15 / 2007	6 / 30 / 2009	Employment

17d. Name of Institution/Facility: University of California San Francisco ☐ Primary Practice ☒ Previous Practice

17e. Institution Mailing Address (Street or PO Box, City, State/Country, Zip Code): 1001 Potrero Ave, Dept OBGYN, San Francisco, CA 94110

17f. Title/Position/Staff Category	17g. Specialty practiced or granted privileges in
Research Coordinator	Non-clinical (Dept of OBGYN)

17a. Date From	17b. Date To	17c. Type of Affiliation (Practice, Employment, Staff Appointment, etc.)
7 / 1 / 2009	6 / 30 / 2013	Residency

17d. Name of Institution/Facility: University of California Irvine Medical Center ☐ Primary Practice ☒ Previous Practice

17e. Institution Mailing Address (Street or PO Box, City, State/Country, Zip Code): 101 The City Drive, Dept OBGYN, Orange, CA 94547

17f. Title/Position/Staff Category	17g. Specialty practiced or granted privileges in
Resident Physician	Obstetrics & Gynecology

17a. Date From	17b. Date To	17c. Type of Affiliation (Practice, Employment, Staff Appointment, etc.)
7 / 1 / 2013	6 / 30 / 2015	Fellowship

17d. Name of Institution/Facility: Washington University in St Louis School of Medicine ☐ Primary Practice ☒ Previous Practice

17e. Institution Mailing Address (Street or PO Box, City, State/Country, Zip Code): 660 S Euclid Ave, Dept OBGYN - Div Family Planning; St Louis, MO 63110

17f. Title/Position/Staff Category	17g. Specialty practiced or granted privileges in
Fellow in Family Planning & Clinical Instructor of Gynecology	Gynecology

17a. Date From	17b. Date To	17c. Type of Affiliation (Practice, Employment, Staff Appointment, etc.)
7 / 1 / 2015	Current	Independent Contractor

17d. Name of Institution/Facility: Planned Parenthood of Saint Louis Region ☐ Primary Practice ☐ Previous Practice

17e. Institution Mailing Address (Street or PO Box, City, State/Country, Zip Code): 4251 Forest Park Ave, St Louis, MO 63108

17f. Title/Position/Staff Category	17g. Specialty practiced or granted privileges in
Independent Contractor	Gynecology

17a. Date From	17b. Date To	17c. Type of Affiliation (Practice, Employment, Staff Appointment, etc.)
8 / 1 / 2015	6 / 30 / 2017	Practice

17d. Name of Institution/Facility: University of California Riverside School of Medicine ☐ Primary Practice ☒ Previous Practice

17e. Institution Mailing Address (Street or PO Box, City, State/Country, Zip Code): 900 University Ave, Dept OBGYN, Riverside CA 92508

17f. Title/Position/Staff Category	17g. Specialty practiced or granted privileges in
Assistant Professor of Gynecology	Obstetrics & Gynecology

WORK HISTORY, continued

17a. Date From: 8 / 15 / 2015 | 17b. Date To: Current / | 17c. Type of Affiliation (Practice, Employment, Staff Appointment, etc.): Independent Contractor

17d. Name of Institution/Facility: Planned Parenthood of Orange & San Bernardino Counties — [X] Primary Practice [ ] Previous Practice

17e. Institution Mailing Address (Street or PO Box, City, State/Country, Zip Code): 700 S Tustin St; Orange, CA 92866

17f. Title/Position/Staff Category: Independent Contractor | 17g. Specialty practiced or granted privileges in: Gynecology

17a. Date From: 2 / 1 / 2016 | 17b. Date To: Current / | 17c. Type of Affiliation (Practice, Employment, Staff Appointment, etc.): Independent Contractor

17d. Name of Institution/Facility: Planned Parenthood of Los Angeles — [ ] Primary Practice [ ] Previous Practice

17e. Institution Mailing Address (Street or PO Box, City, State/Country, Zip Code): 400 W 30th St, Los Angeles, CA 90007

17f. Title/Position/Staff Category: Independent Contractor | 17g. Specialty practiced or granted privileges in: Gynecology

17a. Date From: 12 / 1 / 2016 | 17b. Date To: Current | 17c. Type of Affiliation (Practice, Employment, Staff Appointment, etc.): Independent Contractor

17d. Name of Institution/Facility: Eden Surgical Services (Carmenta Surgical Center) — [ ] Primary Practice [ ] Previous Practice

17e. Institution Mailing Address (Street or PO Box, City, State/Country, Zip Code): 29525 Canwood St, Suite 220, Agoura Hills, CA 91301

17f. Title/Position/Staff Category: Associate Director of Family Planning Services | 17g. Specialty practiced or granted privileges in: Gynecology

17a. Date From: 8 / 1 / 2017 | 17b. Date To: Current | 17c. Type of Affiliation (Practice, Employment, Staff Appointment, etc.): Independent Contractor

17d. Name of Institution/Facility: Planned Parenthood Pacific Southwewst — [ ] Primary Practice [ ] Previous Practice

17e. Institution Mailing Address (Street or PO Box, City, State/Country, Zip Code): 1075 Camino del Rio South, San Diego, CA 92108

17f. Title/Position/Staff Category: Independent Contractor | 17g. Specialty practiced or granted privileges in: Gynecology

17a. Date From: 8 / 1 / 2018 | 17b. Date To: Current / | 17c. Type of Affiliation (Practice, Employment, Staff Appointment, etc.): Independent Contractor

17d. Name of Institution/Facility: Planned Parenthood of Greater Texas — [ ] Primary Practice [ ] Previous Practice

17e. Institution Mailing Address (Street or PO Box, City, State/Country, Zip Code): 7424 Greenville Ave, Suite 206; Dallas, TX 75231

17f. Title/Position/Staff Category: Independent Contractor | 17g. Specialty practiced or granted privileges in: Gynecology

17a. Date From: / / | 17b. Date To: / / | 17c. Type of Affiliation (Practice, Employment, Staff Appointment, etc.):

17d. Name of Institution/Facility: [ ] Primary Practice [ ] Previous Practice

17e. Institution Mailing Address (Street or PO Box, City, State/Country, Zip Code):

17f. Title/Position/Staff Category: | 17g. Specialty practiced or granted privileges in:

FEDERAL DEA & STATE-ISSUED CONTROLLED SUBSTANCE REGISTRATIONS

List all current and previous Federal DEA and state-issued controlled substance registrations. If none, enter N/A.

18a. DEA or State Registration #	18b. State	18c. Your Address Associated with this Registration	18d. Expiration Date
[redacted]	FED	29525 Canwood St, #220, Agoura Hills, CA 91301	6/30/2022
	FED	4251 Forest Park Ave, St Louis, MO 63108	6/30/2022
	IL	254 N Lake Ave #161, Pasadena, CA 91101	7/31/2020
			/ /
			/ /
			/ /

TIME GAPS

Please provide an explanation for ALL time gaps of 30 days or more since the start of medical school. If none, enter N/A.

19a. Did you have a time gap in excess of 30 days between medical school and post-graduate training? ☒ Yes ☐ No

19b. Dates of time gap: January 2008 to June 2009

19c. Explanation for time gap: (e.g. traveling, vacation, moving, prepared for residency)

Between medical school and beginning residency I worked as a Research Coordinator for UCSF.

19d. Additional time gap. Provide dates and explanation.

19e. Additional time gap. Provide dates and explanation. Use additional sheets if necessary.

MALPRACTICE CLAIMS

List **all** malpractice claims ever filed against you, regardless of disposition. If none, enter "n/a". Use additional sheets if necessary.

20a. Date of Claim	20b. Jurisdiction	20c. Disposition (Dismissed, Settled, Pending, etc.)	20d. Amount of Settlement Paid
01/29/2019	Los Angeles, CA	Pending	$ N/A
/ /			$
/ /			$
/ /			$
/ /			$
/ /			$
/ /			$
/ /			$
/ /			$
/ /			$

DIEDRICH, JUSTIN T., M.D.

PART IV - ATTESTATION QUESTIONS

21. Do you currently maintain individual or group Professional Liability Insurance (malpractice) coverage? ☐ No ☒ Yes
If no, list reason: _____
Insurance Carrier Name: _____
Policy Number(s): _____
Expiration Date: _____ Coverage Amounts: _____
If Group policy, list group name: _____

SPECIAL INSTRUCTIONS FOR QUESTIONS 22-44

- **Please mark the appropriate box next to each question. Do not leave any questions blank.**
- For each "Yes" response to questions 22-44, you must provide a separate, signed and dated statement giving full details including date, location, type of action, organization or parties involved, and specific circumstances. If you are not sure about how to respond to a question, it is best to disclose and provide an explanation.
- **Failure to answer these questions accurately may result in disciplinary action or denial of license application.**
- Confidentiality: The contents of licensing files are generally considered public records under the Freedom of Information Act. If you believe that the additional information you are attaching to explain a "Yes" answer should be considered confidential, state that in the attachment. Be advised, however, that not all requests for confidentiality can be granted.

22. Has your application for examination or licensure ever been rejected, denied or withdrawn? *If yes, explain.* ☒ No ☐ Yes

23. Has any medical licensing board ever placed your license on probation, suspension, or has it revoked a license or certificate it had granted you? *If yes, explain and provide name and address of Board.* ☒ No ☐ Yes

24. Have you ever been ordered to appear before a state medical board for any reason other than licensure? *If yes, explain.* ☒ No ☐ Yes

25. Has a medical board or hospital ever initiated disciplinary procedures against you? *If yes, explain.* ☒ No ☐ Yes

26. Have your privileges at any hospital ever been denied, suspended, diminished, voluntarily or involuntarily relinquished, revoked or not renewed, or is any such action pending? *If yes, explain.* ☒ No ☐ Yes

27. Have you ever voluntarily surrendered your medical license in any state? *If yes, explain.* ☒ No ☐ Yes

28. Since the start of medical school, have you been charged or convicted (including a plea of nolo contendere) of a misdemeanor or felony (including DWI (Driving While Intoxicated) or DUI (Driving Under the Influence)? (NOTE: ***You must answer "Yes" even if records, charges, or convictions have been pardoned, expunged, plead down, released, or sealed.***) *If yes, explain.* ☒ No ☐ Yes

29. Have you ever been denied provider participation in any state or federal Medicaid program? *If yes, explain.* ☒ No ☐ Yes

30. Have you ever been warned, censured by, or requested to withdraw from any hospital in which you have been trained, been a staff member, or held hospital privileges? *If yes, explain.* ☒ No ☐ Yes

31. Have you ever been disciplined or dismissed from any professional activity or training program? Have you ever received a warning, reprimand, or been placed on probation during an internship, residency, or fellowship program? *If yes, explain.* ☒ No ☐ Yes

32. Have you ever voluntarily or involuntarily left a training institution program before completing it? *If yes, explain.* ☒ No ☐ Yes

PART IV - ATTESTATION QUESTIONS, continued

33.	Have you ever been reported to the National Practitioner Data Bank or subject to NPDB adverse action reporting? *If yes, explain.*	XX ☐ No ☐ Yes
34.	Have you ever resigned or surrendered clinical privileges from any medical staff while under investigation for possible incompetence or improper professional conduct, or in return for such an investigation not being conducted? *If yes, explain.*	XX ☐ No ☐ Yes
35.	Have you ever been denied membership, renewal thereof, or been subject to disciplinary action in any medical organization, or is any such action pending? *If yes, explain.*	XX ☐ No ☐ Yes
36.	Have you ever been terminated, sanctioned, penalized or had to repay money to any State Medicaid or Federal Medicare/Medicaid program? *If yes, explain.*	XX ☐ No ☐ Yes
37.	Have you ever been cited by a peer review organization? *If yes, explain.*	XX ☐ No ☐ Yes
38.	Have you ever had to discontinue practice for any reason for a period longer than one (1) month? *If yes, explain.*	XX ☐ No ☐ Yes
39.	Since the age of 21, have you been, or are you currently, being treated for alcoholism or substance abuse in an inpatient or outpatient setting? *If yes, explain.*	XX ☐ No ☐ Yes
	39a. If Yes, was this the result of a medical board action?	☐ No ☐ Yes
40.	Are you currently suffering from any condition for which you are not being appropriately treated that impairs your judgment or that would otherwise adversely affect your ability to practice medicine or to perform professional or medical staff duties in a competent, ethical, and profession manner? *If yes, explain.*	XX ☐ No ☐ Yes
41.	Are you currently being, or have you ever been monitored by a Physicians Health Committee in any state? *If yes, explain, and ask the Physician Health Committee to send documentation of your status.*	XX ☐ No ☐ Yes
42.	Has your license to practice medicine or Drug Enforcement Administration registration in any jurisdiction been denied, reduced, limited, suspended, revoked, placed on probation, not renewed voluntarily, or involuntarily relinquished, or is any such action pending? *If yes, explain.*	XX ☐ No ☐ Yes
43.	Have you ever defaulted on any Health Education Assistance loan? *If yes, explain.*	XX ☐ No ☐ Yes
44.	To your knowledge, are you currently the subject of an investigation by any licensing board as of the date of this application? *If yes, explain.* **If, during the application process, you become aware of any such investigation, you are required to report it to this office.**	XX ☐ No ☐ Yes

Justin Diedrich, M.D.

PART V - AFFIDAVIT OF APPLICANT

I, the undersigned applicant, after being duly sworn, hereby certify that I have read the complete application and know the full content thereof. I declare, under penalty of perjury, that all of the information contained herein and evidence or other credentials submitted herewith are true, correct, current, and complete to the best of my knowledge. I attest that I am the lawful holder of the degree of Doctor of Medicine or Doctor of Osteopathy, and that said degree was procured in the regular course of instruction and examination, and that it, together with all the credentials submitted, were procured without fraud or misrepresentation or any mistake of which I am aware. I certify that the photograph that appears below is a true likeness of me, taken within the past sixty (60) days. I understand that any falsification or misrepresentation of any item or response in this application, or any documentation supporting this application, even if submitted separately, is sufficient grounds for denying, revoking, or otherwise disciplining a license or permit to practice medicine in the State of Arkansas.

PLEASE SEE NOTARY SEAL ON ATTACHED PAGE

Justin Diedrich

Applicant's Signature (in ink)
(must be signed in the presence of a Notary Public)

5-17-2019

Date Signed
(must include the month, day and year signed)

SUBSCRIBED AND SWORN TO before me, a Notary Public in and for the State of _____, this _____ day of _____, 20 _____.
(Notary date must be the same as the applicant's signature date above)

My commission expires: _____

Notary Signature
(Notary seal must be below the photograph at left)

DO NOT WRITE BELOW THIS LINE - FOR OFFICE USE ONLY

2019 MAY 23 PM 12:33

JURAT

A notary public or other officer completing this certificate verifies only the identity of the individual who signed the document to which this certificate is attached, and not the truthfulness, accuracy, or validity of that document.

State of California
County of Los Angeles

Subscribed and sworn to (or affirmed) before me on this 17 day of May, 2019,

by Justin THOMAS DieDRiCH,

proved to me on the basis of satisfactory evidence to be the person(s) who appeared before me.

JONATHAN A. URQUIDI
Notary Public - California
Los Angeles County
Commission # 2269661
My Comm. Expires Dec 4, 2022

Signature (Seal)

OPTIONAL INFORMATION

DESCRIPTION OF THE ATTACHED DOCUMENT

Title or description of attached document:

_____

_____

_____

Number of Pages _____ Document Date_____

_____

Additional information

INSTRUCTIONS

The wording of all Jurats completed in California after January 1, 2015 must be in the form as set forth within this Jurat. There are no exceptions. If a Jurat to be completed does not follow this form, the notary must correct the verbiage by using a jurat stamp containing the correct wording or attaching a separate jurat form such as this one with does contain the proper wording. In addition, the notary must require an oath or affirmation from the document signer regarding the truthfulness of the contents of the document. The document must be signed AFTER the oath or affirmation. If the document was previously signed, it must be re-signed in front of the notary public during the jurat process.

- State and county information must be the state and county where the document signer(s) personally appeared before the notary public.
- Date of notarization must be the date the signer(s) personally appeared which must also be the same date the jurat process is completed.
- Print the name(s) of the document signer(s) who personally appear at the time of notarization.
- Signature of the notary public must match the signature on file with the office of the county clerk.
- The notary seal impression must be clear and photographically reproducible. Impression must not cover text or lines. If seal impression smudges, re-seal if a sufficient area permits, otherwise complete a different jurat form.
- Additional information is not required but could help to ensure this jurat is not misused or attached to a different document.
- Indicate title or type of attached document, number of pages and date.
- Securely attach this document to the signed document with a staple.

2019 MAY 23 PM 12:33

PDC PHYSICIAN DATA CENTER

fsmb

PRACTITIONER PROFILE

Prepared for:	Arkansas State Medical Board	As of Date:5/24/2019
Practitioner Name:	Diedrich, Justin Thomas	

ABMS® CERTIFICATION HISTORY

Certifying Board:	American Board of Obstetrics and Gynecology
Certificate:	Obstetrics and Gynecology
Certification Type:	General
Certification Status:	Certified
Participating in MOC:	Yes

Status	Duration	Effective Date	Expiration Date	Reverification Date	Occurrence	Last Reported
Active	Time Limited	12/31/2018	12/31/2019		Recertification	04/25/2019
Expired	Time Limited	12/31/2017	12/31/2018		Recertification	04/25/2019
Expired	Time Limited	12/31/2016	12/31/2017		Recertification	04/25/2019
Expired	Time Limited	11/06/2015	12/31/2016		Initial	04/25/2019

AOA® CERTIFICATION HISTORY

No AOA Certifications found.

FCVS FEDERATION CREDENTIALS VERIFICATION SERVICE

Verification of Medical Education

Federation of STATE MEDICAL BOARDS

Instruction to the Dean

Please complete both pages of this form, sign date and seal on the front page then return to:

Federation Credentials Verification Service
400 Fuller Wiser Road
Suite 300
Euless, TX 76039

The individual identified on the attached Authorization for Release of Information, Documents and Records form has authorized your medical school to provide to the Federation Credentials Verification Service (FCVS) any and all information pertaining to their education at your institution.

Please note: If your institution processes transcript requests through another office, FCVS has likely made such a request under separate cover.

If your office also processes transcript requests, please attach the individual's official transcript (which indicates courses taken, dates and hours of attendance, and scores, grades, or evaluation).

Institution Name: Case Western Reserve University School of Medicine

Address Line 1: Office of the Registrar, T-408

Address Line 2: 10900 Euclid Avenue

City: Cleveland **State/Province:** OH **Zip Code (Postal Code):** 441064968

Country: US

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

Premedical Education:
Years of education required for admission to your medical school: 4
Credential/degree presented by the applicant for admission to your medical school: Bachelor's Degree

Enrollment and Participation: Our records indicate that Diedrich, Justin Thomas
(type/print individual's name: Last, First, Middle, Suffix)
attended our medical school for total of 180 weeks of medical education on the following dates: **From:** 08/07/2003 **To:** 01/18/2008
Month Day Year Month Day Year

This individual
Was awarded the degree of Doctor of Medicine on 01/18/2008
Month Day Year
Was NOT awarded a degree because: (please explain - additional page if necessary)

Attestation

Affix Institutional Seal Here

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

Watermark
For FCVS internal use only.

ELECTRONIC SEAL VERIFIED

Name: Erin Zawolowycz

Signature: *Erin Zawolowycz*

ENTERED MAY 31 2019

Title: Dept. Asst. Office of the Registrar
Date of Signature: 01/23/2018 **Phone:** (216) 368-5497
Fax: (216) 368-4621 **Email:** eez6@case.edu

215138280 186 215138280

Unusual Circumstances

1. Do this individual's official records reflect (an) interruption(s) or extension(s) in his/her medical education? **Yes**

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

	From Date:	To Date:	
Personal/Family			
Academic remediation			
Health			
Financial			
Participation in joint degree Program (e.g., MD/PhD)			
Participation in non-research special study (e.g., fellowship, international experience)			
Participation in non-degree research			
Other: Graduation requirements	05/21/2007	01/18/2008	Approved
Other:			

Please Specify:

Student was approved to extend graduation until January 2008 in order to complete graduation requirements, which he did so successfully.

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

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

	From Date:	To Date:
Academic Probation		
Probation for unprofessional conduct/behavioral		
Other:		

Please specify a reason:

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

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

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

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

5. Do this individual's official records reflect that there were any limitations or special requirements imposed on the individual because of questions of academic incompetence, disciplinary problems, or any other reason? **No**

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

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

FCVS FEDERATION CREDENTIALS VERIFICATION SERVICE

Applicant Reported Unusual Circumstances

Federation of STATE MEDICAL BOARDS

Medical School

Medical Professional Name: Diedrich, Justin Thomas

Case Western Reserve University School of Medicine

Unusual Circumstances

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

End of Applicant Reported Unusual Circumstances report for: Diedrich, Justin Thomas

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

May 31, 2019

To Whom it May Concern:

My medical education was extended because I failed USMLE Step 2 CS. I was unable to retake the test before our May 2007 graduation date. I did retake the exam and pass it on my second attempt. The next graduation date was January 18, 2008, which is when I received my official diploma.

Please let me know if you have any additional questions or concerns.

Sincerely,

Justin Diedrich MD

CASE
SCHOOL OF MEDICINE

The Emily Blackwell Society

Case Western Reserve University
10900 Euclid Avenue
Cleveland, Ohio 44106-4915

Phone 216-368-0324
Fax 216-368-0564
www.case.edu

November 1, 2006

Re: Justin Thomas Diedrich

Dear Colleague:

It is a pleasure to prepare this Medical Student Performance Evaluation for Justin Thomas Diedrich, who is applying for a residency position in your program.

Academic History

Date of Expected Graduation from Medical School:	May 2007
Date of Initial Matriculation to Medical School:	August 2003
Area of Concentration:	
Extensions, Leaves of Absence:	: Not Applicable
For Transfer Students:	: Not Applicable
Date of Initial Matriculation to Prior Medical School	
Date of Transfer from Prior Medical School	
For Dual/Joint/Combined Degree Students:	: Not Applicable
Date of Initial Matriculation in Other Degree Program:	
Date of (Expected) Graduation from Other Degree Program:	
Type of Other Degree Program:	
Repeated Courses, Adverse Actions:	: Not Applicable

Academic Progress

Undergraduate School

Justin Diedrich began Case Western Reserve University in Cleveland, Ohio as a Pre-Professional Scholar. This gave him a confirmed place in the medical school class after he finished his pre-medical studies. He was awarded the President's Scholarship for academic merit and made Dean's List every semester. During his undergraduate years he studied Spanish and requisite pre-medical coursework and was very involved in the College Scholars Program. That program emphasizes broad interdisciplinary learning and leadership both on the Case campus and the community at-large. For his broad interests and academic achievements, he was inducted into Phi Beta Kappa. Mr. Diedrich finished his undergraduate coursework in three years, then spent his senior year "in professional studies" as a first-year medical student. He graduated *summa cum laude* with a Bachelor of Arts degree in Spanish at the end of his first year of medical school.

Medical School

Years One and Two

Mr. Diedrich's performance in the basic science curriculum in the first two years is evaluated on a pass/fail basis. There is no calculation of class rank. Mr. Diedrich received Honors in the Patient-Based

Program, Foundations of Clinical Medicine. His preceptor wrote, "As a member of a very strong small group, Justin participated in an outstanding fashion and has been consistently an exceptional student. He is responsible, takes initiative, and he has a wonderful sense of humor. Interpersonally and intellectually, Justin excels."

Mr. Diedrich applied to and was one of 19 students in the Class of 2007 accepted into the school's Primary Care Track (PCT) Program. This track, now in its thirteenth year, was originally part of the school's Robert Wood Johnson Generalist Physician Initiative. With the completion of the Johnson Foundation's participation in June 2000, PCT continues as a special program within the School of Medicine. The program features not only clinical training but also a focus on research and education in primary care and instruction in health policy. For the first two years, students in the PCT Program have the same curriculum as the other students in their class with an additional series of introductory seminars on primary care, longitudinal physical diagnosis instruction with specially selected PCT faculty, and early experience with patients and their families. A PCT Health Promotion and Disease Prevention research project is conducted in the summer between Years One and Two. Mr. Diedrich conducted research funded by the PCT on Honduran folk remedies entitled, "Los Remedios Catrachos: Alternative Medicine in Rural Honduras." This work won an award at the Annual Primary Care Track Research Day, 2004.

Years Three and Four

The distribution of core clerkship grades by specialty can be found in the cover letter (Appendix E).

Medicine (MetroHealth Medical Center): **Satisfactory.** "[Comments regarding Mr. Diedrich's performance include:] 'Justin functioned as an integral part of the team. He took his responsibilities seriously and displayed intellectual curiosity. Justin sought feedback and made improvements in his analysis of patients' problems.' 'Of the many students I have worked with this year, Dr. Diedrich is among the elite. I was very impressed by his work ethic, keen interest in learning, and compassion for patients. He is a tremendous student. During this month he was an integral member of our team and did a tremendous job presenting patients in an organized manner, formulating a differential diagnosis based on clinical presentation, and gathering information. It was indeed a pleasure to work with him. He will make an excellent physician.' 'Overall, Justin is an extremely compassionate student and spent a lot of time with his patients and families of which they greatly appreciated. He assisted his fellow residents.' 'Justin showed a great baseline knowledge and during his rotation he was constantly looking for information regarding his patients and trying to learn more. He would carry a book with multiple choice questions all the time and would ask questions during rounds. He functioned very well with the team; he is easy going and has a good sense of humor. His relationship with patients was great.' 'It was a pleasure working with Justin in our physical diagnosis small group. He is dedicated to his work, dependable, and motivated to learn.'"

Family Medicine (Other): **Commendable.** "Justin Diedrich had a commendable overall performance during Family Medicine Clerkship. Preceptor's evaluation rated this student's clinical performance at an honors level showing the ability to provide conscientious patient care and self-directed learning. Specific preceptor comments include: 'Justin's clinical skills are exemplary. He has, however, a skill most physicians nowadays lack, the ability to "talk" to patients. He will make an excellent doctor regardless of the specialty he chooses.' An in-depth Family Medicine Project reflected these clinical skills through applying medical literature to formulate a comprehensive care plan for a patient. This project was insightful and very well done. Performance eon the cognitive exam, which emphasized commonly-encountered problems, demonstrated a solid knowledge base of the course material. Justin Diedrich's clinical skills exam demonstrated a high functioning level of clinical work. With such fine clinical and interpersonal skills as well as the continuing expansion of his medical knowledge base, Justin Diedrich will develop into a very fine physician."

Pediatrics (MetroHealth Medical Center): **Satisfactory.** "[Comments regarding Mr. Diedrich's performance include:] 'Always enthusiastic and inquisitive. Did a great job.' 'Communicates well with hospital staff and family members.' 'Works very hard, asks good questions, interested in learning. Positive attitude, nice personality. Very complete, concise and understandable notes. Excellent medical student. No doubt he will be an excellent doctor.' 'He would make a great pediatrician.'"

Preterm Clinic (Preterm Outpatient Facility): **Honors.** "Can see no area in need of improvement. Mr. Diedrich is highly motivated and an enthusiastic learner. His interactions with patients and staff have been exemplary. He integrates and applies new information well; displays a natural talent for the practice of medicine. Mr. Diedrich will be an asset to the medical profession and any community he inhabits."

Obstetrics/Gynecology (MetroHealth Medical Center): **Commendable.** "Justin performed several gynecologic procedures with me. His clinical skills were excellent. He arranged to work with me on a few occasions when he was scheduled to be free. He showed remarkable initiative in accomplishing self-directed goals. Very good with patients of all backgrounds. Knew the material before presenting. Knew patient histories when involved in OR cases, often better than the residents involved. Very concerned and sensitive around the subject of women's health care One of the most motivated students I've worked with in the last year. Very strong interest in women's health is obvious. He will be a strong clinician. Very enthusiastic team member and always dependable. Showed good knowledge base. Justin had a good attitude about coming to work, and he is very sensitive about delicate patient care issues. He showed a great deal of empathy in dealing with clinic patients and asked good questions in the operating room. Justin showed great commitment for caring for the patients. He communicated well with patients and their families. He was dependable and showed great initiative. Justin is a hard working individual that worked well w/ the OB team and well w/ patients. He is kind and compassionate and patients love him. He will be a great physician in any area that he decides to pursue. An asset to our team and especially helpful as an advocate for Spanish-speaking patients due to his language skills. Was always available to help and took an active interest in plan of care for our patients."

Neuroscience (University Hospitals): **Commendable.** "[Comments regarding Mr. Diedrich include:] 'Student functioned at an appropriate level for level of training. He demonstrated excellent patient communication skills and generally performed good evaluations. He worked well within the health care team.' 'Justin was able to successfully plan out a treatment plan for a multiple sclerosis patient within 2 weeks of being on the service. This patient population can prove to be very challenging. He seemed at home examining neurological patients within the first week, and learned very quickly some of nuances, and was able to apply them to other patients. Personally, he was extremely pleasant and worked well within the team.' 'I was impressed how he was loved and trusted by his patients.'"

Surgery (University Hospitals): **Satisfactory.** "Justin satisfactorily completed all aspects of his surgical clerkship."

OB/GYN Subspecialties (University Hospitals): **Honors.** "Excellent student".

Family Planning (San Francisco General Hospital): **Honors.** "Justin did an excellent job overall during his Family Planning elective. He was extremely motivated to improve his skills and knowledge. He was clearly committed to providing thoughtful, compassionate care to our clinics patients. Having done abortions before he came to the rotation with better technical skills than most sub-interns and he built upon that foundation. He was hardworking and energetic, demonstrating unusual initiative in pursuing a research topic on uterine artery embolization. The counselors appreciated his talk on that topic, which they thought was outstanding. He went out of the way to request feedback and was responsive to suggestions. He was great with patients. My suggestions to Justin were to be more detail oriented and not to aim to be so efficient that small issues get overlooked. Also, it took him some time to catch on to the admittedly confusing flow of the clinic. Once he did feel comfortable he was great at being independent and helping keep the flow moving."

Psychiatry (Veterans Administration): This clerkship will be completed in the Fall.

Unique Characteristics and Accomplishments

Mr. Diedrich came to Case School of Medicine from Case Western Reserve University having graduated *summa cum laude* with a degree in Spanish. Mr. Diedrich sought out opportunities and leadership positions to improve his knowledge throughout medical school. He was accepted into the Primary Care Track and received funding to travel to Honduras and study how and what kind of complementary and alternative medicine was being used. He created a survey, designed and ran his clinical research project while also working in a rural health center in rural Honduras. This work entitled, "Los Remedios Catrachos: Alternative Medicine in Rural Honduras" won an award at the Annual Primary Care Track Research Day, 2004. Mr. Diedrich was the Chairperson of the Family Medicine Interest Group from 2004 to 2005, and in this position he raised funds and organized programs. For this work he received the Outstanding Leadership Award by the Department of Family Practice. Mr. Diedrich created his own elective in family planning when he felt the curriculum was not thorough enough in this area. He received "Honors" in this elective, and many other students have since taken this program. In addition, Mr. Diedrich applied for, and was awarded, a Slepian Award for training in reproductive health. The Slepian Fund awards money to health professionals training in family planning. Mr. Diedrich used this money to fund his elective month at the Women's Options Center at the University of California at San Francisco. Mr. Diedrich's clinical preceptors commented repeatedly on his exemplary clinical skills, his compassion and ability to work well with patients of all backgrounds, his remarkable initiative, and desire to improve and learn.

Summary

In summary, Mr. Diedrich is a very bright, highly motivated, energetic senior medical student who has excelled in our curriculum. He is intellectually curious and has shown outstanding professionalism and patient skills. He is fluent in Spanish and is an articulate advocate for the health of underserved populations. His enthusiasm and good humor will be missed.

It is a great pleasure to present Mr. Justin Thomas Diedrich to you as a very good candidate for residency training.

Sincerely,

Elizabeth D. McKinley, M.D., M.P.H.
Dean, Emily Blackwell Society
Co-Director Core Physician Development Program
Assistant Professor of Medicine

EDM:crh:ayh

For your information, the School of Medicine will elect students from the Class of 2007 to the Alpha Omega Alpha Honor Medical Society in December of 2006.

Federation of STATE MEDICAL BOARDS

Federation Credentials Verification Service (FCVS)

400 Fuller Wiser Rd, Euless, TX 76039
Tel (817) 868-5000 Fax (817) 868-5099 Email: fcvsgme@fsmb.org

Verification of Postgraduate Medical Education

Institution: University of California (Irvine) Program
Specialty: Obstetrics & Gynecology
Address: Orange, CA

Attention: **Program Director**
Affiliated University: University of California, Irvine

Verification For:

Name: Justin Thomas Diedrich
DOB:
Individual's Name on Record (If different from above)

Program Participation:

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

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

Report Internships, Residencies and Fellowships separately

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

PGY: 1-4
☒ Internship
☒ Residency
☐ Chief Residency
☐ Fellowship
☐ Research
Specialty/Subspecialty: Obstetrics & Gynecology
From: 6/23/2009 To: 6/22/2013
Successfully Completed?: ☒ Yes ☐ No ☐ In Progress
Accredited by: ☒ ACGME ☐ AOA ☐ LCGME ☐ RSC ☐ CFPC ☐ RCPSC ☐ APPAP ☐ None of these

PGY:
☐ Internship
☐ Residency
☐ Chief Residency
☐ Fellowship
☐ Research
Specialty/Subspecialty:
From: To:
Successfully Completed?: ☐ Yes ☐ No ☐ In Progress
Accredited by: ☐ ACGME ☐ AOA ☐ LCGME ☐ RSC ☐ CFPC ☐ RCPSC ☐ APPAP ☐ None of these

PGY:
☐ Internship
☐ Residency
☐ Chief Residency
☐ Fellowship
☐ Research
Specialty/Subspecialty:
From: To:
Successfully Completed?: ☐ Yes ☐ No ☐ In Progress
Accredited by: ☐ ACGME ☐ AOA ☐ LCGME ☐ RSC ☐ CFPC ☐ RCPSC ☐ APPAP ☐ None of these

Unusual Circumstances:

Check the correct response. Omitted responses require written explanation

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

ELECTRONIC SEAL VERIFIED

1. Did this individual ever take a leave of absence or break from his/her training? ☐ Yes ☒ No
2. Was this individual ever placed on probation? ☐ Yes ☒ No
3. Was this individual ever disciplined or placed under investigation? ☐ Yes ☒ No
4. Were any negative reports for behavioral reasons ever filed by instructors? ☐ Yes ☒ No
5. Were any limitations or special requirements placed upon this individual because of questions of academic incompetence, disciplinary problems or any other reason? ☐ Yes ☒ No

Please explain any "Yes" response from above:

ENTERED
MAY 31 2019

Certification:

Affix your institutional seal in this space. If no seal is available, you must have this form notarized

Completion of the following is certification that the information above is an accurate account of this individual's records and is true and correct. The signature line must contain the original signature, or the electronic typed signature, of the program director (M.D./D.O. only)

Name: Laura Fitzmaurice, MD
Signature:
Title: Residency Program Director
Date of Signature: 1/16/18
Tel: 714-456-5816 Fax: 714-456-8360 E-Mail: lfitzmau@uci.edu

Rev 01/21/2015

FID: 215138280
ACGME ID: 2200521031
GME CODE:

FCVS | FEDERATION CREDENTIALS VERIFICATION SERVICE

Applicant Reported Unusual Circumstances

Federation of STATE MEDICAL BOARDS

Graduate Medical Education

Medical Professional Name:	Diedrich, Justin Thomas
Accreditation ID:	2200521031
Institution:	University of California (Irvine) Program
Specialty:	Obstetrics & Gynecology

Unusual Circumstances

Training Period: 7/1/2009 - 6/30/2013 **Internship/Residency**

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

End of Applicant Reported Unusual Circumstances report for: Diedrich, Justin Thomas

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

UNIVERSITY OF CALIFORNIA, IRVINE
SCHOOL OF MEDICINE

THIS CERTIFICATE OF POSTGRADUATE MEDICAL TRAINING

IS HEREBY AWARDED TO

JUSTIN THOMAS DIEDRICH, M.D.

IN RECOGNITION OF DISCIPLINES UNDERTAKEN AT

THE AFFILIATED HOSPITALS AND THE SCHOOL OF MEDICINE

IN THE CAPACITY OF

RESIDENT IN OBSTETRICS AND GYNECOLOGY

JUNE 23, 2009 TO JUNE 23, 2013

CHANCELLOR

DEAN, SCHOOL OF MEDICINE

DEPARTMENT CHAIRMAN

PROGRAM DIRECTOR

ARKANSAS STATE MEDICAL BOARD

LICENSURE DEPARTMENT
1401 W. Capitol Ave., Suite 340, Little Rock, AR 72201
Phone: (501) 296-1802 Fax: (501) 296-1972
Emails with attachments must be sent in PDF format to support@armedicalboard.org

DATE OF REQUEST:

VERIFICATION OF POSTGRADUATE TRAINING

PART I – PROGRAM NAME AND MAILING ADDRESS - PART I AND PART II TO BE FILLED OUT BY APPLICANT - REQUIRED FOR VERIFICATION TO BE ACCEPTED

PGE Program Name: Washington University School of Medicine in St. Louis
Dept. or Program Director:
Address Line 1: 660 S. Euclid Ave.
Address Line 2:
City, State, ZIP Code: St. Louis, MO 63110

PART II – PHYSICIAN INFORMATION

Full Name (Last, First, Middle)	Social Security Number	Date of Birth (mm/dd/yyyy)
Diedrich, Justin Thomas, M.D.		
Other Names Used		Date of Completion (mm/dd/yyyy) 06/30/2015

AUTHORIZATION & RELEASE: I hereby authorize the entity named above, its staff or representative, to provide the Arkansas State Medical Board any and all information requested below, whether such information is favorable or unfavorable, and I hereby release from any and all liability the above-named entity for any and all acts performed in fulfilling this request, provided that such acts are performed in good faith and without malice.

Physician Signature	Date Signed (mm/dd/yyyy)
See attached A&R	/ /

PART III – VERIFICATION (TO BE COMPLETED BY PROGRAM DIRECTOR OR AUTHORIZED STAFF ONLY)

Please complete the information below (or your equivalent verification letter) and return directly to the Arkansas State Medical Board. Verifications sent to the physician cannot be accepted for verification purposes. Please provide exact dates if possible.

Name of Postgraduate Training Program: Washington University School of Medicine — Chief Resident? ☐ Yes ☐ No Date 7/2013 - 6/2015

Type of Program:
☐ Internship ☐ Residency ☒ Clinical Fellowship ☐ Research Fellowship ☐ Assistantship ☐ Clerkship ☐ Externship
☐ Observership ☐ Other (please specify):

Date Training Began	Date Training Ended or Anticipated Completion Date	Program Specialty or Subspecialty
07/01/2013	06/30/2015	Family Planning

If program was completed in more or less than the customary program length, please provide explanation (use additional sheets if necessary).

Was program completed successfully? *(If No, please explain (use additional sheets if necessary))* ☐ In Process ☒ Yes ☐ No

During the program, was this physician ever investigated or disciplined for any reason? ☐ Yes ☒ No
(Disciplinary actions include but are not limited to being placed on probation, issued a letter of reprimand, censured, suspended, restricted or otherwise disciplined. If you respond "Yes" to this question, please provide copies of the training records/evaluations and summary letter from the Program Director.)

PART IV - VERIFIED BY

Verification provided by (Signature)	Signature Date
Notarized	6/3/2019

Type or legibly print name	Position/Title
Tessa Madden, MD, MPH	Associate Professor, Director of Fellowship & Family Planning Division
Phone Number	**Fax Number**
314-747-6495	314-747-6722
E-mail Address	
maddent@wustl.edu	

PLEASE RETURN THIS FORM DIRECTLY TO THE ARKANSAS STATE MEDICAL BOARD BY MAIL, FAX OR E-MAIL
(E-mail attachments must be in PDF format and sent to support@armedicalboard.org only)

ENTERED
JUN 03 2019

PDC PHYSICIAN DATA CENTER

fsmb

PRACTITIONER PROFILE

Prepared for: Arkansas State Medical Board As of Date:5/24/2019

PRACTITIONER INFORMATION

Name:	Diedrich, Justin Thomas
DOB:	
Medical School:	Case Western Reserve University School of Medicine Cleveland, Ohio, UNITED STATES
Year of Grad:	2008
Degree Type:	MD
NPI:	

BOARD ACTIONS

To date, there have been no actions reported to the FSMB

LICENSE HISTORY

Jurisdiction	License Number	Issue Date	Expiration Date	Last Updated
CALIFORNIA	A-114859	11/24/2010	10/31/2020	05/22/2019
ILLINOIS	036145127	02/15/2018	07/31/2020	04/01/2019
MISSOURI	2013023316	07/06/2013	01/31/2020	05/02/2019
TEXAS	R7709	06/15/2018	08/31/2019	05/06/2019

ENTERED
MAY 28 2019

400 FULLER WISER ROAD EULESS, TX 76039 | TEL(817)868 4000 | FAX (817)868 4099

MEDICAL BOARD
OF CALIFORNIA

Protecting consumers by advocating high quality, safe medical care.

Licensing Program
2005 Evergreen Street, Suite 1200
Sacramento, CA 95815-5401
Phone: (916) 263-2382
Fax: (916) 263-2487
www.mbc.ca.gov

Gavin Newsom, Governor, State of California | Business, Consumer Services and Housing Agency | Department of Consumer Affairs

May 17, 2019

Arkansas State Medical Board
2100 Riverfront Dr
Little Rock, AR 72202

To Whom It May Concern:

This is to certify that as of May 17, 2019, the records of the Medical Board of California (Board) indicate the following information:

Physician:	JUSTIN THOMAS DIEDRICH
License Number:	A114859
Issued Date:	November 24, 2010
Exam Type:	A Written Examination
Expiration Date:	October 31, 2020
License Status:	CURRENT
Board Discipline and/or Administrative Action:	No

If Board Discipline and/or Administrative Action is indicated, public records may be available at http://www.mbc.ca.gov; or you may contact the Board's Enforcement Program, Central File Room by email at central.fileroom@mbc.ca.gov, by fax at (916) 263-2420 or by mail at 2005 Evergreen Street, Suite 1200, Sacramento, CA 95815, to obtain information concerning the action.

April Alameda

April Alameda
Chief of Licensing

ENTERED
MAY 28 2019

Illinois Department of Financial and Professional Regulation

Division of Professional Regulation

Deborah Hagan
Acting Secretary

JB Pritzker
Governor

Division of
Professional
Regulation

CERTIFICATION OF LICENSURE

254 N Lake Ave # 161
Pasadena, CA 91101-1829

Licensee: License	Justin Thomas Diedrich MD
Number:	036.145127
Profession:	LICENSED PHYSICIAN AND SURGEON
Date of Issuance:	02/15/2018
Expiration Date:	07/31/2020
License Status:	ACTIVE
License Method:	ENDORSEMENT
Disciplinary History:	Has not been disciplined

This document is a certified copy of the records maintained and kept by this department in the regular course of business as of 05/17/2019

Division of Professional Regulation

05/17/2019
Date

Refer to the Department's Web Site at www.idfpr.com to verify professional licenses via License Look-Up.

ENTERED
MAY 28 2019

Missouri Division of Professional Registration

PR Home (https://pr.mo.gov/)

Detail

Primary Source Verification

The licensee search function of this website provides data extracted from our database and constitutes a Primary Source Verification.

Licensee Name:	Diedrich, Justin Thomas
Profession Name:	Medical Physician & Surgeon
Licensee Number:	2013023316
Expiration Date:	1/31/2020
Original Issue Date:	7/6/2013
Primary Business Address:	254 N Lake Avenue
Address Con't:	#161
City, State Zip:	Pasadena, CA 91101
County:	Unknown/Out of State
Other Business Addresses:	**View addresses (licensee-search-detail-branch.asp?passkey=2380321)**
Board Certification:	
	Board certification is provided by the licensee. It has not been verified by the Board of Registration for the Healing Arts. To verify visit ABMS (http://www.abms.org/About_ABMS/member_boards.aspx) and AOA (http://www.osteopathic.org/osteopathic-health/about-dos/do-certification/Pages/default.aspx).
Professional School:	Case Western Reserve University
Other Actions:	
Current Discipline Status:	None

ENTERED
MAY 28 2019

PUBLIC VERIFICATION / PHYSICIAN PROFILE

PHYSICIAN

NAME: JUSTIN THOMAS DIEDRICH MD **DATE:** 05/28/2019

THE INFORMATION IN THIS BOX HAS BEEN VERIFIED BY THE TEXAS MEDICAL BOARD

Date of Birth:
License Number: R7709 Full Medical License
Issuance Date: 06/15/2018
Expiration Date of Physician's Registration Permit: 08/31/2019

Registration Status: ACTIVE
Disciplinary Status: NONE
Licensure Status: NONE

Registration Date: 06/20/2018
Disciplinary Date: NONE
Licensure Date: NONE

Medical School of Graduation:
At the time of licensure, TMB verified the physician's graduation from medical school as follows:
CASE WESTERN RESERVE UNIV SCH OF MED, CLEVELAND

Medical School Graduation Year: 2008

TMB Filings, Actions and License Restrictions

The Texas Medical Board has the following board actions against this physician. (This may include any formal complaints filed by TMB, as well as petitions and/or responses related to licensure contested matters, at the State Office of Administrative Hearings.)

NONE

Investigations by TMB of Medical Malpractice

Section 164.201 of the Act requires that: the board review information relating to a physician against whom three or more malpractice claims have been reported within a five year period. Based on these reviews, the following investigations were conducted with the listed resolutions.

ENTERED MAY 28 2019

NONE

Status History

Status history contains entries for any updates to the individual's registration, licensure or disciplinary status types (beginning with 1/1/78, when the board's records were first automated). Entries are in reverse chronological order; new entries of each type supersede the previous entry of that same type. These records do not display status type. Should you have any questions, please contact our Customer Information Center at 512-305-7030 or verifcic@tmb.state.tx.us

Status Code: AC **Effective Date:** 06/20/2018
Description: ACTIVE

Status Code: LI **Effective Date:** 06/15/2018
Description: LICENSE ISSUED

THE INFORMATION IN THIS BOX WAS REPORTED BY THE LICENSEE AND HAS NOT BEEN VERIFIED BY THE TEXAS MEDICAL BOARD

Gender: MALE

Current Primary Practice Address:
7989 W. VIRGINIA DRIVE
DALLAS , TX 75237

Years of Active Practice in the U.S. or Canada:
The physician reports that he/she has actively practiced medicine in the United States or Canada for **10** year(s).

Years of Active Practice in Texas:
The physician reports that, of the above years he/she has actively practiced in the State of Texas for **0** year(s).

Specialty Board Certification

The physician reports that he/she holds the following specialty certifications issued by a board that is a member of the American Board of Medical Specialties or the Bureau of Osteopathic Specialists:

Specialty Certification: AMERICAN BOARD OF OBSTETRICS & GYNECOLOGY
Date: 2015

Primary Specialty

The physician reports his/her primary practice is in the area of GYNECOLOGY.

ENTERED MAY 28 2019

Secondary Specialty

The physician did not report a secondary practice area.

Name, Location and Graduation Date of All Medical Schools Attended

Name: CASE WESTERN RESERVE UNIV SCH OF MED, CLEVELAND
Location:
Graduation Date: 01/2008

Graduate Medical Education In The United States Or Canada

Program Name: UNIVERSITY OF CALIFORNIA IRVINE MEDICAL CENTER
Location: IRVINE
Begin Date: 07/2009
Type: RESIDENCY
End Date: 07/2013
Specialty: OBGYN

Hospital Privileges

The physician reports that he/she has hospital privileges in the following in the State of Texas:

NONE

Utilization Review

The physician did not report whether he/she provides utilization review.

NONE REPORTED

Patient Services

Accessibility: The physician reports that the patient service area **is** accessible to persons with disabilities as defined by federal law.

Language Translation Services: The physician reports that the following language translation services are provided for patients: SPANISH

Medicaid Participant: The physician reports that he/she **does** participate in the Medicaid program.

Awards, Honors, Publications and Academic Appointments

Optional Information
The physician may optionally report descriptions of up to five such honors and has reported the following:

NONE

Malpractice Information

Section 154.006(b)(16) of the Act requires that: a physician profile display a description of any medical malpractice claim against the physician, not including a description of any offers by the physician to settle the claim, for which the physician was found liable, a jury awarded monetary damages to the claimant, and the award has been determined to be final and not subject to further appeal. The physician has the following reportable claims.

Description: NONE

Criminal History

Self-Reported Criminal Offenses: The physician is required to report a description of (1) "any conviction for an offense constituting a felony, a Class A or Class B misdemeanor, or a Class C misdemeanor involving moral turpitude" and (2) "any charges reported to the board to which the physician has pleaded no contest, for which the physician is the subject of deferred adjudication or pretrial diversion, or in which sufficient facts of guilt were found and the matter was continued by a court of competent jurisdiction."

The physician has reported the following:

Description: NONE

Criminal history information is also obtained by TMB from the Texas Department of Public Safety. Resulting action, if any, will be reported under the TMB Action and Non-Disciplinary Restrictions section above.

Disciplinary Actions By Other State Medical Boards

The physician has reported the following:

Description: NONE

Physician Assistant Supervision

To obtain primary source verifications, click name

Description: NONE

Advanced Practice Nurse Delegation

To obtain primary source verifications, click name

Description: NONE

Summary of all License/Permit Types

Issue Date:	Type:
06/15/2018	LICENSED PHYSICIAN

ARKANSAS STATE MEDICAL BOARD

LICENSURE DEPARTMENT
1401 W. Capitol Ave., Suite 340, Little Rock, AR 72201
Phone: (501) 296-1802 Fax: (501) 296-1972
Emails with attachments must be sent in PDF format to support@armedicalboard.org

DATE OF REQUEST: _____

VERIFICATION OF EMPLOYMENT (Non-Medical)

(for verification of employment that did not involve patient care)
PART I AND PART II TO BE FILLED OUT BY THE APPLICANT - REQUIRED FOR VERIFICATION TO BE ACCEPTED

PART I – EMPLOYER NAME AND MAILING ADDRESS

Name of Employer: University of California San Francisco
ATTN: Jody Steinauer, MD
Address Line 1: 1001 Portrero Ave, Dept OBGYN
Address Line 2:
City, State, ZIP Code: San Francisco, CA 94110

PART II – PHYSICIAN INFORMATION

Full Name (Last, First, Middle)	Social Security Number	Date of
Diedrich, Justin Thomas		

AUTHORIZATION & RELEASE: I hereby authorize the entity named above, its staff or representative, to provide the Arkansas State Medical Board any and all information requested below, whether such information is favorable or unfavorable, and I hereby release from any and all liability the above-named entity for any and all acts performed in fulfilling this request, provided that such acts are performed in good faith and without malice.

Physician Signature: Justin Diedrich — Date Signed (mm/dd/yyyy): 5/31/2019

PART III – VERIFICATION (TO BE COMPLETED BY EMPLOYER AUTHORIZED STAFF ONLY)

Please complete the information below (or your equivalent verification letter) and return directly to the Arkansas State Medical Board. Verifications sent to the physician cannot be accepted for verification purposes. Please provide exact dates if possible.

Name of Employer (if not correct above): University of California

Employment Status
☐ Current ☒ Inactive ☐ Leave of Absence ☐ Other

Date Employment Began	Date Employment Ended	
8/1/2007	6/30/2009	☐ If exact dates are not available, please check here. If currently employed, please write "Present" in the space for end date.

Note: Breaks in employment should be listed as separate entries. If the Employee was there intermittently, a listing of each time period he/she was employed at your facility should be provided, either by copying this form for each time period, or by attaching a separate sheet detailing employment dates.

Current or Most Recent Position/Title: Research assistant

To your knowledge, during the stated period of time, was the Employee in good standing? If No, please explain (attach additional sheets if needed).
☒ Yes ☐ No ☐ Unknown/Unable to comment

PART IV - VERIFIED BY

ENTERED JUN 10 2019

Verification provided by (Signature)	Signature Date
Jody Steinauer	6/7/19

Type or legibly print name	Position/Title
Jody Steinauer	Professor

Phone Number	Fax Number	E-mail Address
4153780008		jody.steinauer@ucsf.edu

PLEASE RETURN THIS FORM DIRECTLY TO THE ARKANSAS STATE MEDICAL BOARD BY MAIL, FAX OR E-MAIL
(E-mail attachments must be in PDF format and sent to support@armedicalboard.org only)

ARKANSAS STATE MEDICAL BOARD

MISC

LICENSURE DEPARTMENT
1401 W. Capitol Ave., Suite 340, Little Rock, AR 72201
Phone: (501) 296-1802 Fax: (501) 296-1972
Emails with attachments must be sent in PDF format to support@armedicalboard.org

DATE OF REQUEST: _____

VERIFICATION OF EMPLOYMENT (Medical)

(for verification of employment that involved patient care) PART I AND PART II TO BE FILLED OUT BY THE APPLICANT–REQUIRED FOR VERIFICATION TO BE ACCEPTED **(NOT FOR HOSPITAL VERIFICATION)**

PART I – EMPLOYER NAME AND MAILING ADDRESS

Name of Employer: PLANNED PARENTHOOD LOS ANGELES
ATTN: DAVID STEISER
Address Line 1: 400 W. 30TH ST,
Address Line 2:
City, State, ZIP Code: LOS ANGELES, CA 90007

PART II – PHYSICIAN INFORMATION

Full Name (Last, First, Middle)	Social Security Number	Date of Birth (mm/dd/yyyy)
DIEDRICH, JUSTIN THOMAS	?	

AUTHORIZATION & RELEASE: I hereby authorize the entity named above, its staff or representative, to provide the Arkansas State Medical Board any and all information requested below, whether such information is favorable or unfavorable, and I hereby release from any and all liability the above-named entity for any and all acts performed in fulfilling this request, provided that such acts are performed in good faith and without malice.

Physician Signature	Date Signed (mm/dd/yyyy)
[signature]	5/17/2019

PART III – VERIFICATION (TO BE COMPLETED BY EMPLOYER AUTHORIZED STAFF ONLY)

Please complete the information below (or your equivalent verification letter) and return directly to the Arkansas State Medical Board. Verifications sent to the physician cannot be accepted for verification purposes. Please provide exact dates if possible.

Name of Employer (if not correct above)

Employment Status

☐ Current ☐ Inactive ☐ Leave of Absence ☒ Other Independent Contractor

Date Employment Began	Date Employment Ended	☐ If exact dates are not available, please check here. If currently employed, please write "Present" in the space for end date.
08/01/2012	/ /	

Note: Breaks in employment should be listed as separate entries. If the Employee was there intermittently, a listing of each time period he/she was employed at your facility should be provided, either by copying this form for each time period, or by attaching a separate sheet detailing employment dates.

Current or Most Recent Position/Title
MD

To your knowledge, during the stated period of time, was the Employee in good standing? If No, please explain (attach additional sheets if needed).

☒ Yes ☐ No ☐ Unknown/Unable to comment

PART IV - VERIFIED BY

Verification provided by (Signature)	Signature Date
[signature]	05/22/2019

Type or legibly print name	Position/Title
Josh Maciel	HR Manager

Phone Number	Fax Number	E-mail Address
213 284 3200	213 284 3353	

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MAY 31 2019

ARKANSAS STATE MEDICAL BOARD

LICENSURE DEPARTMENT
1401 W. Capitol Ave., Suite 340, Little Rock, AR 72201
Phone: (501) 296-1802 Fax: (501) 296-1972
Emails with attachments must be sent in PDF format to support@armedicalboard.org

DATE OF REQUEST: _____

VERIFICATION OF EMPLOYMENT (Medical)

(for verification of employment that involved patient care) PART I AND PART II TO BE FILLED OUT BY THE APPLICANT-REQUIRED FOR VERIFICATION TO BE ACCEPTED **(NOT FOR HOSPITAL VERIFICATION)**

PART I – EMPLOYER NAME AND MAILING ADDRESS

Name of Employer: REPRODUCTIVE HEALTH SERVICES, PPSLR
ATTN: CATHY WILLIAMS
Address Line 1: 4251 FOREST PARK AVE
Address Line 2:
City, State, ZIP Code: ST LOUIS, MO 63108

PART II – PHYSICIAN INFORMATION

Full Name (Last, First, Middle)	Social Security Number	Date of Birth (mm/dd/yyyy)
DIEDRICH, JUSTIN THOMAS	.	

AUTHORIZATION & RELEASE: I hereby authorize the entity named above, its staff or representative, to provide the Arkansas State Medical Board any and all information requested below, whether such information is favorable or unfavorable, and I hereby release from any and all liability the above-named entity for any and all acts performed in fulfilling this request, provided that such acts are performed in good faith and without malice.

Physician Signature	Date Signed (mm/dd/yyyy)
Justin Diedrich	5/17/19

PART III – VERIFICATION (TO BE COMPLETED BY EMPLOYER AUTHORIZED STAFF ONLY)

Please complete the information below (or your equivalent verification letter) and return directly to the Arkansas State Medical Board. Verifications sent to the physician cannot be accepted for verification purposes. Please provide exact dates if possible.

Name of Employer (if not correct above)

Employment Status
☑ Current ☐ Inactive ☐ Leave of Absence ☐ Other _____

Date Employment Began	Date Employment Ended	☐ If exact dates are not available, please check here. If currently employed, please write "Present" in the space for end date.
7/13/2013	/ /	

Note: Breaks in employment should be listed as separate entries. If the Employee was there intermittently, a listing of each time period he/she was employed at your facility should be provided, either by copying this form for each time period, or by attaching a separate sheet detailing employment dates.

Current or Most Recent Position/Title
PHYSICIAN

To your knowledge, during the stated period of time, was the Employee in good standing? If No, please explain (attach additional sheets if needed)
☑ Yes ☐ No ☐ Unknown/Unable to comment

PART IV - VERIFIED BY

Verification provided by (Signature)		Signature Date
Kristina Winkelman		5/20/2019
Type or legibly print name		Position/Title
KRISTINA WINKELMAN		HR COORDINATOR
Phone Number	Fax Number	E-mail Address
314-531-7626	314-531-9731	Kristina.Winkelman@ppslr.org

PLEASE RETURN THIS FORM DIRECTLY TO THE ARKANSAS STATE MEDICAL BOARD BY MAIL, FAX OR E-MAIL
(E-mail attachments must be in PDF format and sent to support@armedicalboard.org only)

ENTERED
KW
MAY 31 2019

UCI Health

UC Riverside Credentialing

May 31, 2019

Arkansas State Medical Board
Licensure Department
1401 W. Capital Avenue, Suite 340
Little Rock, AR 72201

Practitioner Name: Diedrich, Justin T., MD

To whom it may concern:

This letter is in response to your request for information on the above-named physician.

Medical Staff Status: Attending
Specialty: Obstetrics & Gynecology
Disciplinary Actions: None

Dates of Membership: 07/13/2015 - 06/30/2017

- All members of the UCI Medical Staff & Medical Group, including Allied Health Professional Staff, are subject to ongoing professionalpractice evaluation (OPPE). With respect to OPPE, there are no significant issues in his/her credentials file.
- To the best of our knowledge, this practiotioner has not recently exhibited any physical/ mental health/drug or alcohol dependencies or other problems that have or could potentially impair ability to exercise clinical privileges.
- This practitioner has not had his/her privileges to treat patients or admit to the hospital (if applicable) restricted, suspended (other than possibly for expired licenses or delinquent medical records), revoked or withdrawn.
- There is no documentation of a criminal record in this practitioner's credentials file.
- This practitioner is a member in good standing, defined in our Bylaws as; a member [who] is currently not under supervision for disciplinary reasons or serving with any limitation of voting or other prerogatives imposed by operation of the bylaws, rules and regulations or policy of the medical staff [or medical group].

Sincerely,

UCR Health Credentialing

ENTERED
JUN 03 2019

A signed document is on file for all members of the medical staff acknowledging the following: Medicare payment to hospitals is based in part on each patient's principal and secondary diagnoses and the major procedures performed on the patient as attested to by the patient's attending physician by virtue of his or her signature in the medical record. Anyone who misrepresents, falsifies or conceals essential information required for payment of Federal funds, may be subject to fine, imprisonment or civil penalty under applicable Federal laws.

UCI Health Credentialing
101 The City Drive, Route 54, Orange CA 92868
Phone: 714.456.5521 Fax: 714.456.5060

ARKANSAS STATE MEDICAL BOARD

LICENSURE DEPARTMENT
1401 W. Capitol Ave., Suite 340, Little Rock, AR 72201
Phone: (501) 296-1802 Fax: (501) 296-1972
Emails with attachments must be sent in PDF format to support@armedicalboard.org

DATE OF REQUEST: _____

VERIFICATION OF ~~EMPLOYMENT~~ SERVICES (Medical)

(for verification of employment that involved patient care) PART I AND PART II TO BE FILLED OUT BY THE APPLICANT–REQUIRED FOR VERIFICATION TO BE ACCEPTED (NOT FOR HOSPITAL VERIFICATION)

PART I – ~~EMPLOYER~~ CLINICAL SERVICES CONTACT NAME AND MAILING ADDRESS

Name of ~~Employer~~: PLANNED PARENTHOOD ORANGE + SAN BERNARDINO COUNTIES
ATTN: DR. J. RUSSO
Address Line 1: 700 S. TUSTIN ST.
Address Line 2:
City, State, ZIP Code: ORANGE, CA 92866

PART II – PHYSICIAN INFORMATION

Full Name (Last, First, Middle)	Social Security Number	Date of Birth (mm/dd/yyyy)
DIEDRICH, JUSTIN THOMAS		

AUTHORIZATION & RELEASE: I hereby authorize the entity named above, its staff or representative, to provide the Arkansas State Medical Board any and all information requested below, whether such information is favorable or unfavorable, and I hereby release from any and all liability the above-named entity for any and all acts performed in fulfilling this request, provided that such acts are performed in good faith and without malice.

Physician Signature: [signature] Date Signed (mm/dd/yyyy): 5/17/2019

PART III – VERIFICATION (TO BE COMPLETED BY ~~EMPLOYER~~ CLINICAL SERVICES CONTACT AUTHORIZED STAFF ONLY)

Please complete the information below (or your equivalent verification letter) and return directly to the Arkansas State Medical Board. Verifications sent to the physician cannot be accepted for verification purposes. Please provide exact dates if possible.

Name of ~~Employer~~ (if not correct above): Not an Employer (Independent Contractor) → Planned Parenthood OSBC

~~Employment~~ Status: ☒ Current ☐ Inactive ☐ Leave of Absence ☐ Other

Date ~~Employment~~ Began	Date ~~Employment~~ Ended	☐ If exact dates are not available, please check here. If currently employed, please write "Present" in the space for end date.
08/01/2015	PRESENT	

Note: Breaks in employment should be listed as separate entries. If the Employee was there intermittently, a listing of each time period he/she was employed at your facility should be provided, either by copying this form for each time period, or by attaching a separate sheet detailing employment dates.

Current or Most Recent Position/Title: Independent Contractor – Physician

To your knowledge, during the stated period of time, was the ~~Employee~~ in good standing? If No, please explain (attach additional sheets if needed).

☐ Yes ☐ No ☐ Unknown/Unable to comment

PART IV - VERIFIED BY

Verification provided by (Signature)		Signature Date
Tyler James		05/28/2019
Type or legibly print name: Tyler James	Position/Title: Recruitment Coordinator	
Phone Number: (714) 633-6373	Fax Number: (714) 633-1443	E-mail Address: tyler.james@ppsbc.org

PLEASE RETURN THIS FORM DIRECTLY TO THE ARKANSAS STATE MEDICAL BOARD BY MAIL, FAX OR E-MAIL
(E-mail attachments must be in PDF format and sent to support@armedicalboard.org only)

ENTERED MAY 31 2019

MISC

Riverside University HEALTH SYSTEM

MEDICAL STAFF SERVICES/ADMINISTRATION

May 21, 2019

Josie Barron
RUHS
26520 Cactus Avenue
Moreno Valley, CA 92555

Subject: Justin Thomas Diedrich, MD

We have received your request for information regarding the above-named practitioner. Because of the volume of requests for information received by the Medical Staff Office, it is our policy to release information listed below if the practitioner was or continues to be in good standing on our Attending Medical Staff, and if he has had no corrective action while a member of our Attending Medical Staff and/or while granted clinical privileges.

DATES ON STAFF	08/13/2015 - 02/09/2017
TEMPORARY PRIVILEGE DATE:	
Current Staff Status:	Voluntary Resignation
SPECIALTY/DEPARTMENT:	Obstetrics & Gynecology / Obstetrics & Gynecology
DISCIPLINARY ACTION:	None of File

As of January 1, 2016, Riverside County Regional Medical Center (RCRMC) became Riverside University Health System (RUHS). On April 1, 1998, Riverside General Hospital-University Medical Center. Medical staff appointment and privileges valid at RGH-UMC & RCRMC are also valid at RUHS. We trust the above information will assist your facility in its credentialing activities. Please contact RUHS Medical Staff Administration at 951-486-5913 if you should have any questions.

Sincerely,

Geoffrey W. Leung MD EdM

Geoffrey W. Leung, MD, EdM
Chief of Medical Staff

cb

26520 Cactus Avenue, Moreno Valley , California 32555
TELEPHONE: 951-486-5913 • FAX: 951-486-5911 • TDD: 951-486-4397

ENTERED
MAY 31 2019

ARKANSAS STATE MEDICAL BOARD

LICENSURE DEPARTMENT
1401 W. Capitol Ave., Suite 340, Little Rock, AR 72201
Phone: (501) 296-1802 Fax: (501) 296-1972
Emails with attachments must be sent in PDF format to support@armedicalboard.org

DATE OF REQUEST: _____

VERIFICATION OF EMPLOYMENT (Medical)

(for verification of employment that involved patient care) PART I AND PART II TO BE FILLED OUT BY THE APPLICANT–REQUIRED FOR VERIFICATION TO BE ACCEPTED **(NOT FOR HOSPITAL VERIFICATION)**

PART I – EMPLOYER NAME AND MAILING ADDRESS

Name of Employer: PLANNED PARENTHOOD PASADENA & SAN GABRIEL VALLEY
ATTN: NOAH NATTELL
Address Line 1: 1045 N. LAKE AVE
Address Line 2:
City, State, ZIP Code: PASADENA CA 91104

PART II – PHYSICIAN INFORMATION

Full Name (Last, First, Middle)	Social Security Number	Date of Birth (mm/dd/yyyy)
DIEDRICH, JUSTIN THOMAS		

AUTHORIZATION & RELEASE: I hereby authorize the entity named above, its staff or representative, to provide the Arkansas State Medical Board any and all information requested below, whether such information is favorable or unfavorable, and I hereby release from any and all liability the above-named entity for any and all acts performed in fulfilling this request, provided that such acts are performed in good faith and without malice.

Physician Signature	Date Signed (mm/dd/yyyy)
Justin Diedrich	5/17/2019

PART III – VERIFICATION (TO BE COMPLETED BY EMPLOYER AUTHORIZED STAFF ONLY)

Please complete the information below (or your equivalent verification letter) and return directly to the Arkansas State Medical Board. Verifications sent to the physician cannot be accepted for verification purposes. Please provide exact dates if possible.

Name of Employer (if not correct above)

Employment Status
☒ Current ☐ Inactive ☐ Leave of Absence ☐ Other _____

Date Employment Began	Date Employment Ended	☐ If exact dates are not available, please check here. If currently employed, please write "Present" in the space for end date.
4/26/2016	PRESENT	

Note: Breaks in employment should be listed as separate entries. If the Employee was there intermittently, a listing of each time period he/she was employed at your facility should be provided, either by copying this form for each time period, or by attaching a separate sheet detailing employment dates.

Current or Most Recent Position/Title
Physician Contractor

To your knowledge, during the stated period of time, was the Employee in good standing? If No, please explain (attach additional sheets if needed).
☒ Yes ☐ No ☐ Unknown/Unable to comment

PART IV - VERIFIED BY

Verification provided by (Signature)	Signature Date
	6/3/19

Type or Clearly print name	Position/Title
NOAH NATTELL	MEDICAL DIRECTOR

Phone Number	Fax Number	E-mail Address
626-794-5737	626-798-4706	nnattell@ppsgv.org

PLEASE RETURN THIS FORM DIRECTLY TO THE ARKANSAS STATE MEDICAL BOARD BY MAIL, FAX OR E-MAIL
(E-mail attachments must be in PDF format and sent to support@armedicalboard.org only)

ENTERED
JUN 04 2019

ARKANSAS STATE MEDICAL BOARD

LICENSURE DEPARTMENT
1401 W. Capitol Ave., Suite 340, Little Rock, AR 72201
Phone: (501) 296-1802 Fax: (501) 296-1972
Emails with attachments must be sent in PDF format to support@armedicalboard.org

DATE OF REQUEST: _____

VERIFICATION OF EMPLOYMENT (Medical)

(for verification of employment that involved patient care) PART I AND PART II TO BE FILLED OUT BY THE APPLICANT–REQUIRED FOR VERIFICATION TO BE ACCEPTED (NOT FOR HOSPITAL VERIFICATION)

PART I – EMPLOYER NAME AND MAILING ADDRESS

Name of Employer: EDEN SURGICAL / CARMENTA SURGICAL
ATTN: ADAM ADAIR
Address Line 1: 29525 CANWOOD ST, SUITE 220
Address Line 2:
City, State, ZIP Code: AGOURA HILLS, CA 91301

PART II – PHYSICIAN INFORMATION

Full Name (Last, First, Middle)	Social Security Number	Date of Birth (mm/dd/yyyy)
DIEDRICH, JUSTIN THOMAS		

AUTHORIZATION & RELEASE: I hereby authorize the entity named above, its staff or representative, to provide the Arkansas State Medical Board any and all information requested below, whether such information is favorable or unfavorable, and I hereby release from any and all liability the above-named entity for any and all acts performed in fulfilling this request, provided that such acts are performed in good faith and without malice.

Physician Signature	Date Signed (mm/dd/yyyy)
[signature]	5/17/2019

PART III – VERIFICATION (TO BE COMPLETED BY EMPLOYER AUTHORIZED STAFF ONLY)

Please complete the information below (or your equivalent verification letter) and return directly to the Arkansas State Medical Board. Verifications sent to the physician cannot be accepted for verification purposes. Please provide exact dates if possible.

Name of Employer (if not correct above):

Employment Status
☒ Current ☐ Inactive ☐ Leave of Absence ☐ Other

Date Employment Began	Date Employment Ended	☐ If exact dates are not available, please check here. If currently employed, please write "Present" in the space for end date.
12/29/2016	PRESENT	

Note: Breaks in employment should be listed as separate entries. If the Employee was there intermittently, a listing of each time period he/she was employed at your facility should be provided, either by copying this form for each time period, or by attaching a separate sheet detailing employment dates.

Current or Most Recent Position/Title: Associate Director of Family Planning

To your knowledge, during the stated period of time, was the Employee in good standing? If No, please explain (attach additional sheets if needed).
☒ Yes ☐ No ☐ Unknown/Unable to comment

PART IV - VERIFIED BY

Verification provided by (Signature)		Signature Date
[signature]		5/23/2019
Type or legibly print name: Adam Adair	Position/Title: Administrator	
Phone Number: 818 722 3262	Fax Number: 818 584 5882	E-mail Address: adam@carmentasurgical.com

PLEASE RETURN THIS FORM DIRECTLY TO THE ARKANSAS STATE MEDICAL BOARD BY MAIL, FAX OR E-MAIL
(E-mail attachments must be in PDF format and sent to support@armedicalboard.org only)

ENTERED
MAY 31 2019

ARKANSAS STATE MEDICAL BOARD

LICENSURE DEPARTMENT
1401 W. Capitol Ave., Suite 340, Little Rock, AR 72201
Phone: (501) 296-1802 Fax: (501) 296-1972
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DATE OF REQUEST: _____

VERIFICATION OF EMPLOYMENT (Medical)

(for verification of employment that involved patient care) PART I AND PART II TO BE FILLED OUT BY THE APPLICANT–REQUIRED FOR VERIFICATION TO BE ACCEPTED **(NOT FOR HOSPITAL VERIFICATION)**

PART I – EMPLOYER NAME AND MAILING ADDRESS

Name of Employer: PLANNED PARENTHOOD PACIFIC SOUTH WEST
ATTN: ANTOINETTE MARENGO, M.D.
Address Line 1: 1075 CAMINO DEL RIO SOUTH
Address Line 2:
City, State, ZIP Code: SAN DIEGO, CA 92108

PART II – PHYSICIAN INFORMATION

Full Name (Last, First, Middle)	Social Security Number	Date of Birth (mm/dd/yyyy)
DIEDRICH, JUSTIN THOMAS		1

AUTHORIZATION & RELEASE: I hereby authorize the entity named above, its staff or representative, to provide the Arkansas State Medical Board any and all information requested below, whether such information is favorable or unfavorable, and I hereby release from any and all liability the above-named entity for any and all acts performed in fulfilling this request, provided that such acts are performed in good faith and without malice.

Physician Signature	Date Signed (mm/dd/yyyy)
	5/17/2019

PART III – VERIFICATION (TO BE COMPLETED BY EMPLOYER AUTHORIZED STAFF ONLY)

Please complete the information below (or your equivalent verification letter) and return directly to the Arkansas State Medical Board. Verifications sent to the physician cannot be accepted for verification purposes. Please provide exact dates if possible.

Name of Employer (if not correct above)

Employment Status
☒ Current ☐ Inactive ☐ Leave of Absence ☐ Other Contract Physician

Date Employment Began	Date Employment Ended	☐ If exact dates are not available, please check here. If currently employed, please write "Present" in the space for end date.
07/11/2017	Present	

Note: Breaks in employment should be listed as separate entries. If the Employee was there intermittently, a listing of each time period he/she was employed at your facility should be provided, either by copying this form for each time period, or by attaching a separate sheet detailing employment dates.

Current or Most Recent Position/Title: Contract Physician

To your knowledge, during the stated period of time, was the Employee in good standing? If No, please explain (attach additional sheets if needed).
☒ Yes ☐ No ☐ Unknown/Unable to comment

PART IV - VERIFIED BY

Verification provided by (Signature)	Signature Date
	5/21/19

Type or legibly print name	Position/Title
Antoinette Marengo, MD	MEDICAL DIRECTOR

Phone Number	Fax Number	E-mail Address
619 380 8157	619-291-0959	AMarengo@planned.org

PLEASE RETURN THIS FORM DIRECTLY TO THE ARKANSAS STATE MEDICAL BOARD BY MAIL, FAX OR E-MAIL
(E-mail attachments must be in PDF format and sent to support@armedicalboard.org only)

ENTERED
MAY 31 2019

ARKANSAS STATE MEDICAL BOARD

LICENSURE DEPARTMENT
1401 W. Capitol Ave., Suite 340, Little Rock, AR 72201
Phone: (501) 296-1802 Fax: (501) 296-1972
Emails with attachments must be sent in PDF format to support@armedicalboard.org

DATE OF REQUEST:

VERIFICATION OF HOSPITAL OR SURGERY CENTER AFFILIATION

PART I AND PART II TO BE FILLED OUT BY THE APPLICANT- REQUIRED FOR VERIFICATION TO BE ACCEPTED

RECEIVED
MAY 20 2019
MEDICAL STAFF SERVICES

PART I – FACILITY NAME AND MAILING ADDRESS

Name of Facility: Barnes-Jewish Hospital
ATTN: Medical Staff
Address Line 1: 4590 Children's Place
Address Line 2: Mailstop 90-29-932
City, State, ZIP Code: St Louis, Mo. 63110

PART II – PHYSICIAN INFORMATION

Full Name (Last, First, Middle)	Social Security Number	Date of Birth (mm/dd/yyyy)
DIEDRICH, JUSTIN THOMAS	X –	

AUTHORIZATION & RELEASE: I hereby authorize the entity named above, its staff or representative, to provide the Arkansas State Medical Board any and all information requested below, whether such information is favorable or unfavorable, and I hereby release from any and all liability the above-named entity for any and all acts performed in fulfilling this request, provided that such acts are performed in good faith and without malice.

Physician Signature	Date Signed (mm/dd/yyyy)
Justin Diedrich	5/19/2019

PART III – VERIFICATION (TO BE COMPLETED BY FACILITY AUTHORIZED STAFF ONLY)

Please complete the information below (or your equivalent verification letter) and return directly to the Arkansas State Medical Board. Verifications sent to the physician cannot be accepted for verification purposes. Please provide exact dates if possible.

Name of Facility (if not correct above)

Current Staff Status: ☑ Current ☐ Inactive ☐ Leave of Absence

Current or Most Recent Staff Category: ☑ Active ☐ Consulting ☐ Courtesy ☐ Temporary ☐ _____

Specialties and/or Subspecialties in which clinical privileges were last held: OB/GYN

Department: OB/GYN

Date Privileges Began (including temp or provisional): 07/20/2017 avo 8/5/13 to 7/1/16

Date Privileges Ended: PRESENT

☐ If exact dates are not available, please check here. If currently appointed, please write "Present" in the space for end date.

Note: Breaks in appointment should be listed as separate entries. If the physician was there intermittently, a listing of each time period he/she was employed at your facility should be provided, either by copying this form for each time period, or by attaching a separate sheet detailing appointment dates.

Did this physician act as a TELEMEDICINE physician for your facility? *[Did the physician, while physically located outside your region and through the use of an electronic or other medium, perform acts that are part of a patient care service initiated at your facility?]* ☐ Yes ☑ No

To the best of your knowledge, are/were the physician's clinical privileges in good standing during the stated period of time? *(if No, please attach detailed explanation)* ☑ Yes ☐ No

Were the clinical privileges of this physician ever denied, revoked, limited or suspended? *(if Yes, please attach detailed explanation)* ☐ Yes ☑ No

PART IV - VERIFIED BY

Verification provided by (Signature)	Signature Date
Linda Hill	05/20/2019

Type or legibly print name	Position/Title
LINDA HILL	Medical Staff Coordinator

Phone Number	Fax Number	E-mail Address
314-454-8082	314-454-7625	linda.hill@bjc.org

PLEASE RETURN THIS FORM DIRECTLY TO THE ARKANSAS STATE MEDICAL BOARD BY MAIL, FAX OR E-MAIL

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ENTERED
MAY 31 2019

ARKANSAS STATE MEDICAL BOARD

LICENSURE DEPARTMENT
1401 W. Capitol Ave., Suite 340, Little Rock, AR 72201
Phone: (501) 296-1802 Fax: (501) 296-1972
Emails with attachments must be sent in PDF format to support@armedicalboard.org

DATE OF REQUEST:

VERIFICATION OF EMPLOYMENT (Medical)

(for verification of employment that involved patient care) PART I AND PART II TO BE FILLED OUT BY THE APPLICANT–REQUIRED FOR VERIFICATION TO BE ACCEPTED **(NOT FOR HOSPITAL VERIFICATION)**

PART I – EMPLOYER NAME AND MAILING ADDRESS

Name of Employer: PLANNED PARENTHOOD GREATER TEXAS
ATTN: AMNA DERMISH
Address Line 1: 7424 GREENVILLE AVE STE 206
Address Line 2:
City, State, ZIP Code: DALLAS, TX 75231

PART II – PHYSICIAN INFORMATION

Full Name (Last, First, Middle)	Social Security Number	Date of Birth (mm/dd/yyyy)
DIEDRICH, JUSTIN THOMAS	[illegible]	

AUTHORIZATION & RELEASE: I hereby authorize the entity named above, its staff or representative, to provide the Arkansas State Medical Board any and all information requested below, whether such information is favorable or unfavorable, and I hereby release from any and all liability the above-named entity for any and all acts performed in fulfilling this request, provided that such acts are performed in good faith and without malice.

Physician Signature	Date Signed (mm/dd/yyyy)
Justin Diedrich	5/17/2019

PART III – VERIFICATION (TO BE COMPLETED BY EMPLOYER AUTHORIZED STAFF ONLY)

Please complete the information below (or your equivalent verification letter) and return directly to the Arkansas State Medical Board. Verifications sent to the physician cannot be accepted for verification purposes. Please provide exact dates if possible.

Name of Employer (if not correct above)

Employment Status

☒ Current ☐ Inactive ☐ Leave of Absence ☐ Other

Date Employment Began	Date Employment Ended	
/ /	present	☒ If exact dates are not available, please check here. If currently employed, please write "Present" in the space for end date.

Note: Breaks in employment should be listed as separate entries. If the Employee was there intermittently, a listing of each time period he/she was employed at your facility should be provided, either by copying this form for each time period, or by attaching a separate sheet detailing employment dates.

Current or Most Recent Position/Title: contract provider

To your knowledge, during the stated period of time, was the Employee in good standing? If No, please explain (attach additional sheets if needed).

☒ Yes ☐ No ☐ Unknown/Unable to comment

PART IV - VERIFIED BY

Verification provided by (Signature)	Signature Date
[signature]	5/30/19

Type or legibly print name	Position/Title
Amna Dermish	Regional Medical Director

Phone Number	Fax Number	E-mail Address
512 276 8000	512 441 6189	amna.dermish@ppgt.org

PLEASE RETURN THIS FORM DIRECTLY TO THE ARKANSAS STATE MEDICAL BOARD BY MAIL, FAX OR E-MAIL
(E-mail attachments must be in PDF format and sent to support@armedicalboard.org only)

ENTERED
JUN 07 2019

UCI Health

UCI Health Credentialing

May 31, 2019

Arkansas State Medical Board
Licensure Department
1401 W. Capital Avenue, Suite 340
Little Rock, AR 72201

Practitioner Name: Diedrich, Justin T., MD

To whom it may concern:

This letter is in response to your request for information on the above-named physician.

Medical Staff Status: Attending **Dates of Membership:** 01/17/2019 - 11/30/2020
Medical Group Status: Associate Member **Dates of Membership:** 01/14/2019 - 11/30/2020

Specialty: Obstetrics & Gynecology
Disciplinary Actions: None

- All members of the UCI Medical Staff & Medical Group, including Allied Health Professional Staff, are subject to ongoing professionalpractice evaluation (OPPE). With respect to OPPE, there are no significant issues in his/her credentials file.
- To the best of our knowledge, this practiotioner has not recently exhibited any physical/ mental health/drug or alcohol dependencies or other problems that have or could potentially impair ability to exercise clinical privileges.
- This practitioner has not had his/her privileges to treat patients or admit to the hospital (if applicable) restricted, suspended (other than possibly for expired licenses or delinquent medical records), revoked or withdrawn.
- There is no documentation of a criminal record in this practitioner's credentials file.
- This practitioner is a member in good standing, defined in our Bylaws as; a member [who] is currently not under supervision for disciplinary reasons or serving with any limitation of voting or other prerogatives imposed by operation of the bylaws, rules and regulations or policy of the medical staff [or medical group].

Sincerely,
UCI Health Credentialing

ENTERED
JUN 03 2019

A signed document is on file for all members of the medical staff acknowledging the following: Medicare payment to hospitals is based in part on each patient's principal and secondary diagnoses and the major procedures performed on the patient as attested to by the patient's attending physician by virtue of his or her signature in the medical record. Anyone who misrepresents, falsifies or conceals essential information required for payment of Federal funds, may be subject to fine, imprisonment or civil penalty under applicable Federal laws.

UCI Health Credentialing
101 The City Drive, Route 54, Orange CA 92868
Phone: 714.456.5521 Fax: 714.456.5060

ARKANSAS STATE MEDICAL BOARD

LICENSURE DEPARTMENT
1401 W. Capitol Ave., Suite 340, Little Rock, AR 72201
Phone (501) 296-1802 Fax (501) 296-1972 www.armedicalboard.org
Emails with attachments must be sent in PDF format to support@armedicalboard.org

ARKANSAS MEDICAL PRACTICES ACT and RULES AND REGULATIONS AFFIDAVIT

I AFFIRM THAT I HAVE READ THE ARKANSAS MEDICAL PRACTICES ACT, ARKANSAS CODE ANNOTATED SECTION 17-95-101, et. seq., AND THE RULES AND REGULATIONS OF THE ARKANSAS STATE MEDICAL BOARD.

Justin Thomas Diedrich, MD, FACOG

Physician's Full Name (First Middle Last, Suffix, Degree)

Justin T. Diedrich

Physician's Signature (no rubber stamps)

5/17/2019

Signature Date

ENTERED
MAY 29 2019

THIS IS A REQUIREMENT FOR LICENSURE.
YOUR LICENSURE APPLICATION WILL NOT BE PROCESSED WITHOUT THIS COMPLETED FORM.

2019 MAY 23 PM 12:33
RECEIVED

ARKANSAS STATE MEDICAL BOARD

& CENTRALIZED CREDENTIALS VERIFICATION SERVICE
1401 W. Capitol Ave., Suite 340, Little Rock, AR 72201
Phone (501) 296-1802 Fax (501) 296-1972 www.armedicalboard.org
Emails with attachments must be sent in PDF format to support@armedicalboard.org

AUTHORIZATION AND RELEASE

To Whom It May Concern:

This document will authorize and direct any physicians with whom I have been associated; employees and medical staff members of any medical facility or hospital where I have been employed, on staff, or associated; any employees of any malpractice insurance carriers; any state medical licensing boards where I have been licensed or have applied for a license; any medical clinics where I have been employed or associated; and any medical schools where I have attended, to give to, copy for, or permit the personal inspection by employees or representatives of the Arkansas State Medical Board of any and all personnel records, disciplinary records, work records, military records, professional performance reviews, and/or evaluations of my performances.

I hereby release and discharge you and any other individuals or organizations referred to in this Authorization, and release you of any confidentiality requirements that might bind you, so that you may carry out the purposes of this document.

A copy of this document* may be provided to entities listed above, and this Authorization shall remain in effect for a period not to exceed two (2) years or until specifically revoked by me in writing.

Typed or Printed Name of Physician: Justin Thomas Diedrich, MD, FACOG

Social Security Number: _____

Signature of Physician: _____
Dark Blue or Black Ink Only - No Signature Stamps

Signature Date: 5/17/2019

ENTERED
MAY 2 0 2019

**** This document does not authorize the Arkansas State Medical Board to release information collected to third parties except as later authorized by the above physician and Arkansas State Law.***

2019 MAY 23 PM 12:33

RECEIVED

Prepared: 5.17.2019

Curriculum Vitae

Justin Thomas Diedrich, M.D., M.S.C.I., F.A.C.O.G.

PERSONAL HISTORY

Business 254 N. Lake Ave, #161
Pasadena, CA 91101

Home
Pasadena, CA 91101

Languages English, Spanish

EDUCATION

B.A.	5/00 – 5/04	Case Western Reserve University *Cleveland, Ohio*
M.D.	7/1/03 – 1/18/08	Case Western Reserve School of Medicine *Cleveland, Ohio*
Residency	7/09 – 6/13	Obstetrics & Gynecology University of California, Irvine *UCI Medical Center*
M.S.C.I.	8/13 – 5/15	Washington University in St. Louis *St. Louis, Missouri*
Fellowship	7/13 – 6/15	Family Planning Washington University in St. Louis *Barnes-Jewish Hospital*

LICENSURE

NPI	1396978037
California	A114859, Originally Issued 11/24/2010, Exp. 10/31/2020
Missouri	2013023316, Originally Issued 7/6/2013, Exp. 1/31/2020
Illinois	036-145127, Originally Issued 2/15/2018, Exp. 7/31/2020
Texas	R7709, Originally Issued 6/15/2018, Exp. 8/31/2019
ACLS	eCard Code 186508102342, Issued 11/9/2018, Exp. 11/2020
DEA	Eden: FD2371881, Issued 5/11/2016, Exp. 6/30/2022 PPSLR: FD4033217, Issued 5/9/2016, Exp. 6/30/2022

BOARD CERTIFICATION

Diplomate of the American Board of Obstetrics & Gynecology (ABOG ID 9027000)
Original certification: November 6, 2015

PROFESSIONAL EXPERIENCE

01/19 – present Assistant Clinical Professor
Department of Obstetrics & Gynecology
University of California, Irvine

07/17 – present	Associate Director of Family Planning Services Eden Surgical Center
07/17 – present	Independent Abortion Provider: Planned Parenthood of San Bernardino & Orange Counties (PPOSBC) Planned Parenthood of St Louis Region (PPSLR), Reproductive Health Services Planned Parenthood of Los Angeles (PPLA) Planned Parenthood of Pasadena San Gabriel Valley (PPPSGV) Planned Parenthood of Pacific Southwest (PPPSW) Planned Parenthood of Mar Monte (PPMM) Planned Parenthood of Greater Texas (PPGT) Family Planning Associates (FPA)
07/17 – present	Volunteer Clinical Faculty Assistant Professor Department of Obstetrics & Gynecology University of California, Riverside
11/17 – 5/19	Primary Investigator, Planned Parenthood of St Louis Region (PPSLR)
8/15 – 6/17	Assistant Professor Department of Obstetrics & Gynecology University of California, Riverside
8/07 – 6/09	Family Planning Research Coordinator Department of Obstetrics, Gynecology and Reproductive Sciences University of California, San Francisco

PROFESSIONAL ACTIVITIES

2018–Present	CHAT Study Clinical Consulting Committee, UCSF, *Consultant*
2017–Present	Volunteer Clinical Faculty, UC Riverside Department of OBGYN, *Assistant Professor*
2016–2017	University of California Family Planning Collaborative, *Chair*
2016	Z-CAN (Zika Contraceptive Access Network), Centers for Disease Control and Prevention and CDC Foundation, Puerto Rico, *Trainer and Proctor*
2015–Present	American Congress of Obstetricians & Gynecologists (ACOG), *Full Fellow*
2015–2016	Leadership Training Academy, Physicians for Reproductive Health
2013–Present	Society of Family Planning (SFP), *Full Fellow*
2013–2016	American Society for Colposcopy and Cervical Pathology (ASCCP), *Member*
2011–Present	Unite for Reproductive and Gender Equity (URGE), *Board of Directors*
2008–Present	Association of Reproductive Health Professionals (ARHP), *Member*
2007–Present	Physicians for Reproductive Health, *Member*
2006–Present	National Abortion Federation, *Member*

Peer Reviewer for the following journals

- American Journal of Obstetrics and Gynecology
- Contraception
- Contraception and Reproductive Medicine
- International Journal of Obstetrics and Gynecology
- Infectious Disease Society of Obstetrics and Gynecology
- Journal of Women's Health
- Expert Review of Endocrine and Metabolism
- Reproductive Sciences

Teaching and Mentoring

2013-2015	*Pelvic Inflammatory Disease*, Advanced STD Intensive Course (Lecturer) St. Louis STD/HIV Prevention Training Center
2013-2015	MS3 Didactics: *Clinical Research Design and Evidence Based Medicine* Washington University School of Medicine
2014-2015	MS3 Preceptor for OBGYN Rotation Washington University School of Medicine
2014-2015	Values Clarification Workshop (Co-facilitator) Washington University School of Medicine
2014-2015	Papaya Gynecologic Procedural Workshop (Co-facilitator) Washington University School of Medicine
2015-2017	UCR MS3 Didactics: Contraception University of California, Riverside School of Medicine
2015-2017	UCR MS3 Didactics: Sexually transmitted infections University of California, Riverside School of Medicine
2015-2017	UCR MS3 Didactics: Sexually transmitted infections University of California, Riverside School of Medicine
2015-2017	RUHS Family Practice Didactics: Sexually transmitted infections University of California, Riverside School of Medicine
2015-present	Faculty Sponsor for UCR Medical Students for Choice University of California, Riverside School of Medicine

HONORS & AWARDS

2014	Best Scientific Poster	ASCCP Biennial Meeting (Scottsdale, AZ)
2013	Resident Teaching Award	UCI School of Medicine
2012	Best Scientific Poster	ASCCP Biennial Meeting (San Francisco, CA)
2009	Excellence in Leadership	CHOICE USA (Washington, DC)
2008	Preserving Core Values in Science Award	ARHP
2008	Wyeth New Leader Award	ARHP
2007	Elizabeth Karlin Early Achievers Award	National Abortion Federation
2006	Reproductive Health Externship Grant	Medical Students for Choice
2006	Dr. Barnett A. Slepian Memorial Scholarship	Pro-Choice Network of Western New York

RESEARCH GRANTS & FELLOWSHIPS RECEIVED

Society of Family Planning Grant ($69,000)
LUCID: Long-term utilization and continuation of intrauterine devices
Principal investigator

LECTURES & PRESENTATIONS

International, Invited

- *Contraceptive Counseling: Results from the CHOICE Project*, National Abortion Federation, First Latin American Congress. November 2014. Bogotá, Colombia. [Presented in Spanish]

- *Abortion Complications and How to Avoid Them*, National Abortion Federation, Second Latin American Congress. November 2017. Lima, Peru. [Presented in Spanish]
- *Contraception Myths*, National Abortion Federation, Second Latin American Congress. November 2017. Lima, Peru. [Presented in Spanish]

National, Invited

- *Reducing Unintended Pregnancy with Long Acting Reversible Contraception (LARC)*. Annual Meeting, National Abortion Federation. April 2008. Minneapolis, MN.
- *Postabortal insertion of a contraceptive implant.* Annual Meeting, National Abortion Federation. April 2009. Portland, OR.
- *Gynecologic Procedures Papaya Workshop*. Annual Meeting, National Medical Students Association. February 2011. Irvine, CA.
- *Contribution of Random Biopsy, ECC, Colposcopic Appearance, and Referral Patterns in Diagnosing Occult High Grade CIN*, Oral Scientific Presentation at Biennial Meeting, American Society for Colposcopy and Cervical Pathology. March 2012. San Francisco, CA.
- *Is Diagnostic Colposcopy also Therapeutic for Exocervical and Endocervical Intraepithelial Neoplasia*? Oral Scientific Presentation at Biennial Meeting, American Society for Colposcopy and Cervical Pathology. March 2012. San Francisco, CA.
- *Evidence for more excision at colposcopic referral*, Oral Scientific Presentation at Biennial Meeting, American Society for Colposcopy and Cervical Pathology. April 2014. Scottsdale, AZ.
- *Uniting Leaders of Tomorrow's Reproductive Justice Movement with Providers of Today.* Annual Meeting, National Abortion Federation. April 2014. San Francisco, CA.
- *Continuation of reversible contraception: 36-month follow-up from the Contraceptive CHOICE Project.* North American Forum on Family Planning. October 2014. Miami, FL.

Other invited presentations

- *Post-Abortion Hemorrhage and the Art of Saving a Uterus with Jell-O*. Grand Rounds, UCSF. October 28, 2008. San Francisco, CA.
- *Gynecologic Procedures Papaya Workshop*. Medical Students for Choice, West Regional Conference, OHSU. April 25, 2009. Portland, OR.
- *Gynecologic Issues in the Patient with Sickle Cell Disease*. CME Course: Sickle Cell Disease-practical approaches for the care and treatment of children and adults. Washington University School of Medicine. September 12, 2014. St Louis, MO
- *Contraception for Women with Chronic Medical Conditions*. Department of Medicine Lunchtime Lecture Series. Washington University School of Medicine. November 19, 2014. St. Louis, MO
- *The Pill: Progress and Controversy.* Department of Obstetrics & Gynecology, Grand Rounds. UC Irvine. December 12, 2014. Orange, CA
- *Managing complications of legal interruption of pregnancy*. Marie Stopes Mexico. February 2015. Mexico City, Mexico [Presented in Spanish]
- *The Pill: Progress and Controversy.* Department of Obstetrics & Gynecology, Grand Rounds. UC Riverside. April 15, 2015. Moreno Valley, CA
- *The Pill: Progress and Controversy.* Department of Obstetrics & Gynecology, Grand Rounds. Washington University in St. Louis. April 29, 2015. St. Louis, MO
- Keynote Speaker at Annual Benefit Dinner for NARAL Pro-Choice Missouri. September 10, 2016. St. Louis, MO.
- Signs and Symptoms: Medicine is Humanities. Panel on Reproductive Health. October 13, 2016. University of California, Riverside. Riverside, CA.
- Reproductive Health Advocacy Panel. October 23, 2017. University of Southern California. Los Angeles, CA.
- *The Future of Roe v Wade*. Department of Obstetrics & Gynecology, Grand Rounds. Cleveland Clinic Foundation. September 19, 2018. Cleveland, OH.

- *The Future of Roe v Wade*. Department of Obstetrics & Gynecology, Grand Rounds. University of California Irvine. November 16, 2018. Orange, CA.

BIBLIOGRAPHY

RESEARCH PAPERS

Peer Reviewed

1. Steinauer JE, **Diedrich JT**, Wilson MW, Darney PD, Vargas JE, Drey EA. Uterine artery embolization in postabortion hemorrhage. Obstet Gynecol, 2008;111:881-9. PMID 19407527

2. Dehlendorf C, **Diedrich J**, Drey E, Postone A, Steinauer J. Preferences for decision-making about contraception and general health care among reproductive age women at an abortion clinic. Patient Educ Couns. 2010;81:343-8. PMID 20650593

3. Newmann SJ, Dalve-Endres A, **Diedrich JT**, Meckstroth K, Steinauer JE. Cervical preparation for second trimester dilation and evacuation. Cochrane Database Syst Rev. 2010; 4:CD007310. PMID 20687085

4. Frick AC, Drey EA, **Diedrich JT**, Steinauer JE. Effect of prior cesarean delivery on risk of second-trimester surgical abortion complications. Obstet Gynecol. 2010;115:760-4. PMID 20308836

5. **Diedrich JT**, Drey EA. Society of Family Planning Guidelines: Induction of fetal demise before abortion. Contraception, 2010; 81:462-73. PMID 20472112

6. **Diedrich JT**, Drey EA, Dehlendorf C, Steinauer JE. Women's questions after postabortion insertion of intrauterine contraception. Contraception 2013;88:396-400. PMID 23265979

7. **Diedrich JT**, Felix J, Lonky NM. Do colposcopically-direct biopsy and endocervical curettage serve to induce regression of cervical intraepithelial neoplasia? J Low Genit Tract Dis. 2014;18:322-5. PMID 25171104

8. Keegan MB, **Diedrich JT**, Peipert JF. Chlamydia trachomatis Infection: Screening and Management. J Clin Outcomes Management.2014;21:30-8. PMID 25554725

9. **Diedrich J**, Desai S, Zhao Q, Secura G, Madden T, Peipert JF. Association of Short-term Bleeding and Cramping Patterns with Long-Acting Reversible Contraceptive Satisfaction. Amer J Obstet Gynecol 2015;3212:50.e1-8. PMID 25046805

10. **Diedrich JT**, Zhao Q, Madden T, Secura G, Peipert JF. Three-year continuation of reversible contraception. Amer J Obstet Gynecol 2015; 213: 622e1-8. PMID 26259905

11. **Diedrich JT**, Madden T, Zhao Q, Peipert JF. Long-term utilization and continuation of intrauterine devices. Amer J Obstet Gynecol 2015; 213: 822e1-6. PMID 26409157

12. Steinauer JE, Upadhyay UD, Sokoloff A, Harper CC, **Diedrich JT**, Drey EA. Choice of the levonorgestrel intrauterine device, etonogestrel implant or depot medroxyprogesterone acetate for contraception after aspiration abortion. Contraception. 2015;92:553-9. PMID 26093190

13. **Diedrich JT**, Felix J, Lonky N. Contribution of exocervical biopsy, endocervical curettage, colposcopic lesion distribution in diagnosing high grade cervical intraepithelial neoplasia. J Low Genit Tract Dis. 2016;20:52-6. PMID 24477170

14. Milman KS, **Diedrich JT**, Zhao Q, Peipert JF. Changes in insurance status in CHOICE Project participants. J Reprod Med. 2016;61:63-8. PMID 26995891

15. **Diedrich JT**, Klein D, Peipert JF. Long-Acting Reversible Contraception in Adolescents: A Systematic Review and Meta-Analysis. Am J Obstet Gynecol. 2017;216:364.e1-12. PMID 28038902

16. **Diedrich JT**, Rathore S, Bentz JS. Comparison of tissue yield using frictional fabric brush versus sharp curettage for endocervical curettage. J Low Genit Tract Dis. 2017;21:304-6. PMID 28742540

17. **Diedrich JT**, Newmann SJ. UpToDate "Cervical preparation prior to abortion" Published online December 2017.

PAPERS IN PREPARATON (RESEARCH COMPLETED)

1. Diedrich JT, Newmann SJ. Society of Family Planning Guidelines on cervical preparation prior to dilation and evacuation abortion at 20 to 24 weeks of gestation

CHAPTERS

1. Vargas J, **Diedrich J**. Second-Trimester Induction of Labor. Clin Obstet Gynecol. 2009;52:188-97. PMID 19407525

2. **Diedrich J**, Steinauer J. Complications of Surgical Abortion. Clin Obstet Gynecol. 2009;52:205-12. PMID 18378747

3. Guido R, **Diedrich JT**, Lonky N. Evidence-Based Management of the Woman with Cervical Intraepithelial Neoplasia. Clin Obstet Gynecol 2014:57:302-15. PMID 24709711

4. Boison M, **Diedrich JT**, Lonky N, Guido R. Screening for Cervical Cancer and its Precursors. Clin Obstet Gynecol 2014:57:279-91. PMID 24785416

5. Lonky N, Penner KR, **Diedrich JT**. Current aims and challenges associated with cervical cancer prevention. Clin Obstet Gynecol 2014;57:241-55. PMID 24662770

6. Schmidt E, **Diedrich JT**, Eisenberg D. Surgical Procedures for Tubal Sterilization. Glob Lib Womens Med. 2014; DOI 10.3843/GLOWM.10400

7. Schmidt E, **Diedrich JT,** Eisenberg D. Laparoscopic Sterilization: Prevention of Failures. Glob Lib Womens Med. 2014. DOI 10.3843/GLOWM.10402

8. **Diedrich JT**, Schmidt E, Eisenberg D. Postpartum Sterilization Procedures. Glob Lib Womens Med. 2014. DOI 10.3843/GLOWM.10145

9. Schmidt E, **Diedrich JT**, Pachtman S. Obstetric and Gynecologic Nephrology: Women's Health Issues in the Patient with Kidney Disease. "Contraception in chronic kidney disease." [In Press]

BOOKS
No activity in this section

LETTERS TO THE EDITOR

1. Diedrich J. Letter to the Editor: Maternal Instincts. VOGUE, April 2008.

2. Diedrich J. Letter to the Editor: An Open Letter to KV Pharmaceuticals. St Louis Post-Dispatch, March 2011

ABSTRACTS/POSTER PRESENTATIONS

1. **Diedrich JT**, Ghatnekar R, Russo J. Prior cesarean delivery increases risk of failed medication abortion. Poster Presentation: Annual Meeting, North American Forum on Family Planning. October 2018 (New Orleans, LA).

MEDIA

1. Diedrich J. Contraception as empowerment. Provider to Provider. Bedsider.org. Sept 9, 2014.

OTHER
No activity in the section

FCVS | FEDERATION CREDENTIALS VERIFICATION SERVICE

2019 MAY 28 AM 1:52

Medical Professional Information Profile

This report provides credentialing information for:

Name: **Diedrich, Justin Thomas**

Social Security Number:

Date of Birth:

FID#:

Recipient: **AR - Arkansas State Medical Board**

Delivery Date: **05/17/2019**

ABOUT THIS PROFILE

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

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

fsmb
FEDERATION OF STATE MEDICAL BOARDS

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

FCVS | FEDERATION CREDENTIALS VERIFICATION SERVICE

Affidavit and Release

Federation of STATE MEDICAL BOARDS

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

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

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

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

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

PLEASE SEE NOTARY SEAL ON ATTACHED PAGE

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

DIEDRICH

Applicant's Printed Last Name

JUSTIN THOMAS

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

2/5/18

Date of Signature (must correspond to date of notarization)

State of CALIFORNIA, County of LOS ANGELES

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 5 day of FEBRUARY, 2018.

Notary Public Signature: _____

My Notary Commission Expires: _____

PLEASE SEE NOTARY SEAL ON ATTACHED PAGE

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

400 FULLER WISER ROAD | SUITE 300 | EULESS, TX 76039 | TEL(817)868-3000

215 159 3990

JURAT

A notary public or other officer completing this certificate verifies only the identity of the individual who signed the document to which this certificate is attached, and not the truthfulness, accuracy, or validity of that document.

State of California
County of Los Angeles

Subscribed and sworn to (or affirmed) before me on this 05 day of Februay, 2018,

by Justin Thomas Diedrich,

proved to me on the basis of satisfactory evidence to be the person(s) who appeared before me.

L. MANSIS
Commission # 2069896
Notary Public - California
Los Angeles County
My Comm. Expires May 31, 2018

Signature (Seal)

OPTIONAL INFORMATION

DESCRIPTION OF THE ATTACHED DOCUMENT

Title or description of attached document:
Affidavit & release

Number of Pages 1 Document Date

Additional information

INSTRUCTIONS

The wording of all Jurats completed in California after January 1, 2015 must be in the form as set forth within this Jurat. There are no exceptions. If a Jurat to be completed does not follow this form, the notary must correct the verbiage by using a jurat stamp containing the correct wording or attaching a separate jurat form such as this one with does contain the proper wording. In addition, the notary must require an oath or affirmation from the document signer regarding the truthfulness of the contents of the document. The document must be signed AFTER the oath or affirmation. If the document was previously signed, it must be re-signed in front of the notary public during the jurat process.

- State and county information must be the state and county where the document signer(s) personally appeared before the notary public.
- Date of notarization must be the date the signer(s) personally appeared which must also be the same date the jurat process is completed.
- Print the name(s) of the document signer(s) who personally appear at the time of notarization.
- Signature of the notary public must match the signature on file with the office of the county clerk.
- The notary seal impression must be clear and photographically reproducible. Impression must not cover text or lines. If seal impression smudges, re-seal if a sufficient area permits, otherwise complete a different jurat form.
  - Additional information is not required but could help to ensure this jurat is not misused or attached to a different document.
  - Indicate title or type of attached document, number of pages and date.
- Securely attach this document to the signed document with a staple.

215, 135, 80

FCVS FEDERATION CREDENTIALS VERIFICATION SERVICE

Identity

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Biographic Information

Medical professional Name(s): **Diedrich, Justin Thomas**

Date of Birth:

Place of Birth: St. Louis, MO, UNITED STATES

Contact Information

Business Address: 254 N LAKE AVE
#161
Pasadena, CA 91101
UNITED STATES

Home Phone:

Business Phone: (562) 999-4583

Email:

Email:

Credentials Analysis Information for Identity

There is no Omission/Discrepancy/Miscellaneous information identified.

CERTIFICATION OF IDENTIFICATION

Certification by Notary Public Is Required

Applicant Full Legal Name: DIEDRICH (Last), JUSTIN (First) THOMAS (Middle)

FCVS ID Number:_____

Notary – Please complete the section below:

State of California County of Los Angeles

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

The statements on this document are subscribed and sworn to before me by the applicant on this

(Day)_____, of (Month)_____, (Year)_____.

Notary Public Signature:_____

Commission Expiration Date* (Month)_____/ (Day)_____/ (Year)_____

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

Notary Stamp Here

SEE ATTACHED CERTIFICATE

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

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

FCVS ID Number
FCVS

FID Number
215138280

215 138 280

CALIFORNIA ALL-PURPOSE ACKNOWLEDGMENT **CIVIL CODE § 1189**

A notary public or other officer completing this certificate verifies only the identity of the individual who signed the document to which this certificate is attached, and not the truthfulness, accuracy, or validity of that document.

State of California)
County of Los Angeles)

On January 3, 2017 (Date) before me, Victor Macias, Notary Public (Here Insert Name and Title of the Officer),

personally appeared Justin Thomas Diedrich (Name(s) of Signer(s))

who proved to me on the basis of satisfactory evidence to be the person(s) whose name(s) is/are subscribed to the within instrument and acknowledged to me that he/she/they executed the same in his/her/their authorized capacity(ies), and that by his/her/their signature(s) on the instrument the person(s), or the entity upon behalf of which the person(s) acted, executed the instrument.

VICTOR MACIAS
Notary Public - California
Los Angeles County
Commission # 2218546
My Comm. Expires Oct 16, 2021

I certify under PENALTY OF PERJURY under the laws of the State of California that the foregoing paragraph is true and correct.

WITNESS my hand and official seal.

Signature _____
Signature of Notary Public

Place Notary Seal Above

OPTIONAL

Though this section is optional, completing this information can deter alteration of the document or fraudulent reattachment of this form to an unintended document.

Description of Attached Document
Title or Type of Document: _____
Document Date: _____ Number of Pages: _____
Signer(s) Other Than Named Above: _____

Capacity(ies) Claimed by Signer(s)

Signer's Name: _____	Signer's Name: _____
☐ Corporate Officer — Title(s): _____	☐ Corporate Officer — Title(s): _____
☐ Partner — ☐ Limited ☐ General	☐ Partner — ☐ Limited ☐ General
☐ Individual ☐ Attorney in Fact	☐ Individual ☐ Attorney in Fact
☐ Trustee ☐ Guardian or Conservator	☐ Trustee ☐ Guardian or Conservator
☐ Other: _____	☐ Other: _____
Signer is Representing: _____	Signer is Representing: _____

215 138 280

FCVS FEDERATION CREDENTIALS VERIFICATION SERVICE

Chronology of Activities

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The Chronology of Activities is a comprehensive report of a medical professional's activities as reported to FCVS in the medical professional application.

Start Date	End Date	Activity Type	Location
07/01/2003	01/18/2008	Medical Education	Case Western Reserve University School of Medicine Cleveland Ohio UNITED STATES
08/30/2007	06/30/2009	Work	UCSF, San Francisco General Hospital 1001 Portrero Ave Bixby Center San Francisco, California UNITED STATES
07/01/2009	06/30/2013	Postgraduate Training	University of California (Irvine) Program Orange California UNITED STATES
07/01/2013	06/30/2015	Postgraduate Training	Barnes Jewish Hospital Saint Louis Missouri UNITED STATES
07/01/2015	08/01/2015	Vacation	Relocating from St Louis, Missouri to Los Angeles, California
08/01/2015	06/30/2017	Work	Univeristy of California Riverside 900 University Ave School of Medicine Dept of OBGYN Riverside, California UNITED STATES
07/01/2017		Work	Justin Diedrich MD 254 N Lake Ave #161 Pasadena, California UNITED STATES

End of Chronology of Activities report for: Diedrich, Justin Thomas

FCVS FEDERATION CREDENTIALS VERIFICATION SERVICE

Medical Education

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Medical Education

Medical School: **Case Western Reserve University School of Medicine**

Location: Cleveland, OH
UNITED STATES

Credentials Analysis Information for Medical Education

Issue:
FCVS has identified a medical education Discrepancy at Case Western Reserve University School of Medicine.

Unusual Circumstances

Solution(s):
FCVS does not follow up with the Medical Professional or the institution with inconsistent information on Unusual Circumstances questions.

FCVS FEDERATION CREDENTIALS VERIFICATION SERVICE

Licensure / Examinations

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Licensure / Examinations

Exam: USMLE

Credential Analysis Information for Licensure / Examinations

There is no Omission/Discrepancy/Miscellaneous information identified.

FCVS FEDERATION CREDENTIALS VERIFICATION SERVICE

Postgraduate Training

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Postgraduate Training

Accreditation ID: **2200521031**

Institution: **University of California (Irvine) Program**

Location: Orange, CA
UNITED STATES

Accreditation ID: **None**

Institution: **Barnes Jewish Hospital**

Location: Saint Louis, MO
UNITED STATES

Credentials Analysis Information for Postgraduate Training

Issue:
The Verification of Post Graduate Training Form from Barnes Jewish Hospital dated 07/01/2013 to 06 / 30/2015 reported in the Chronology of Activities is not included in the Profile.

Solution:
FCVS does not obtain verification of non-accredited training programs.

PDC PHYSICIAN DATA CENTER

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PRACTITIONER PROFILE

Prepared for: FCVS As of Date:5/17/2019

PRACTITIONER INFORMATION

Name:	Diedrich, Justin Thomas
DOB:	
Medical School:	Case Western Reserve University School of Medicine Cleveland, Ohio, UNITED STATES
Year of Grad:	2008
Degree Type:	MD
NPI:	

BOARD ACTIONS

To date, there have been no actions reported to the FSMB

LICENSE HISTORY

Jurisdiction	License Number	Issue Date	Expiration Date	Last Updated
CALIFORNIA	A-114859	11/24/2010	10/31/2020	05/15/2019
ILLINOIS	036145127	02/15/2018	07/31/2020	04/01/2019
MISSOURI	2013023316	07/06/2013	01/31/2020	05/02/2019
TEXAS	R7709	06/15/2018	08/31/2019	05/06/2019

PDC PHYSICIAN DATA CENTER

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PRACTITIONER PROFILE

Prepared for: FCVS As of Date:5/17/2019

Practitioner Name: Diedrich, Justin Thomas

ABMS® CERTIFICATION HISTORY

Certifying Board: American Board of Obstetrics and Gynecology
Certificate: Obstetrics and Gynecology
Certification Type: General
Certification Status: Certified
Participating in MOC: Yes

Status	Duration	Effective Date	Expiration Date	Reverification Date	Occurrence	Last Reported
Active	Time Limited	12/31/2018	12/31/2019		Recertification	04/25/2019
Expired	Time Limited	12/31/2017	12/31/2018		Recertification	04/25/2019
Expired	Time Limited	12/31/2016	12/31/2017		Recertification	04/25/2019
Expired	Time Limited	11/06/2015	12/31/2016		Initial	04/25/2019

AOA® CERTIFICATION HISTORY

No AOA Certifications found.