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

Pete Ricketts, Governor

Public Health Licensure Unit
Certification of Licensure

This certificate serves as primary source verification of licensure in the State of Nebraska as of the close of the business day before 7/30/2020.

Name:	Jessika Ann Ralph MD
Type:	Physician
Number:	31823
Status:	Active
Issued:	05/30/2019
Expiration:	10/01/2020
Education:	05/23/2013 NORTHWESTERN UNIVERSITY MEDICAL SCHOOL

Disciplinary/Non-Disciplinary Information:

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

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

RECEIVED

APR 29 2019

LICENSURE UNIT

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

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

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

Lic# 31823
Date 04/30/2019
Office Use Only
Revised 12/2018

APPLICATION FOR A LICENSE TO PRACTICE MEDICINE

☑ Medicine and Surgery ☐ Osteopathic Medicine and Surgery

Fee: $300 (see fee schedule)

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

SECTION A – PERSONAL INFORMATION: Items 1 and 2 are public information. Name and Licensure information will be displayed on the INTERNET at http://www.nebraska.gov/LISSearch/search.cgi

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

1	Legal Name	First: Jessika	Middle Name: Ann	Last: Ralph
	Maiden Name	Hopson	Other Names you are known as (AKA):	
2	Mailing Address	Street/PO/Route: 1310 N. Ritchie Ct. #18D		
		City: Chicago	State or Country: IL	Zip: 60610
3	Date of Birth (M/D/Y): 02/18/1987	Place of Birth (city/state/country): Phoenix, AZ, USA		Gender: M ☐ F ☑
4	Check the Appropriate Box(es)	☑ Social Security Number (SSN); ☐ Alien Registration Number ("A#"); ☐ Form I-94 (Arrival-Departure Record) number	SSN# [redacted]	
			A#	
			I-94 #	
	If you have both a SSN and an A# or I-94 number, you must report both. Neb. Rev. Stat. §38-123 mandates disclosure of your social security number to DHHS. Although your number is not public information, DHHS may disclose it for child support enforcement purposes and to the Nebraska Department of Revenue.			
	Phone 480-495-0602		Fax (optional)	
	Licensee E-mail Address jessika.ralph@northwestern.edu		Credentialing contact e-mail Address (optional)	
5	☐ Check here if you are the spouse of an active duty member of the U.S. Armed Forces stationed in Nebraska.			

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

SECTION B – EXAMINATION

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

Application by Examination:

☑ USMLE ☐ NBME ☐ FLEX ☐ NBOME ☐ LMCC

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

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

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

Foreign medical graduates must indicate their ECFMG number: _____

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

PRELIMINARY AND PRE-MEDICAL EDUCATION

NAME OF HIGH SCHOOL	Tempe Preparatory Academy	
City/State/Country	Tempe, AZ, USA	
Diploma/Certificate	Diploma	
Date: (MO/YR)	May 2005	
NAME OF PRE-MEDICAL COLLEGE	University of Chicago	
City/State/Country	Chicago, IL, USA	
Diploma/Certificate	Diploma	
Date: (MO/YR)	June 2009	
NAME OF PRE-MEDICAL COLLEGE		
City/State/Country		
Diploma/Certificate		
Date: (MO/YR)		

MEDICAL EDUCATION

NAME OF MEDICAL SCHOOL	Northwestern University	
City/State/Country	Chicago, IL, USA	
Attended	From (M/D/Y): August 1, 2009	To (M/D/Y): May 23, 2013
Degree Conferred	Medical Doctor	Date Conferred (M/D/Y): May 23, 2013
NAME OF MEDICAL SCHOOL		
City/State/Country		
Attended	From (M/D/Y):	To (M/D/Y):
Degree Conferred		Date Conferred (M/D/Y):

SECTION D- POST-GRADUATE MEDICAL EDUCATION: Indicate whether service was Internship, Residency or Fellowship.

Name of Institution	Medical College of Wisconsin
Name of Specialty	☐ Internship ☑ Residency ☐ Fellowship
City/State/Country	Milwaukee, WI, USA
Attended From:	(M/D/Y) July 01, 2013
Attended To:	(M/D/Y) June 30, 2017
Name of Institution	Northwestern University
Name of Specialty	☐ Internship ☐ Residency ☑ Fellowship
City/State/Country	Chicago, IL, USA
Attended From:	(M/D/Y) July 01, 2017
Attended To:	(M/D/Y) June 30, 2019
Name of Institution	
Name of Specialty	☐ Residency ☐ Fellowship
City/State/Country	
Attended From:	
Attended To:	
Name of Institution	
Name of Specialty	☐ Residency ☐ Fellowship
City/State/Country	
Attended From:	
Attended To:	

Sec D- Names of specialties? See Sec F.

Military: Did you complete educ
substantially similar to the educa
required by profession) required f
armed forces of the United States, active or reserve, the National Guard of any state, the military reserves of any state, or the naval militia of any state?

Yes ☐ No ☐
If yes, include evidence with this Application.

SECTION E – COMPETENCY: Indicate that, within the three years immediately preceding the application for licensure, you have met **ONE** of the following:

☐	**I have been in the active practice of the profession of medicine and surgery in some other state, a territory, the District of Columbia, or Canada for a period of one year.**
☑	**I have had at least one year of approved graduate medical education.**
☐	**I have completed continuing medical education.** Submit proof of attendance at continuing education, as well as information about the content for Board approval. *See below*
☐	**I have completed a refresher course in medicine and surgery.** Submit proof of attendance at a refresher course, as well as information about the content for Board approval. *See below*
☐	**I have completed a special purposes examination.** Have your score sent directly to this office for Board approval. *See below*

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

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

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

Following is the website to the Statutes Relating to Medicine and Surgery where you can read the complete language regarding the reentry license.
http://dhhs.ne.gov/licensure/Documents/MedSurgPerfusionGenCouns.pdf The Board of Medicine and Surgery will review applications for a license, either initial application or reinstatement of license, which do not clearly meet the requirements for experience (continued competency) as outlined in the statutes listed above. The Board will make a recommendation to the Department to either issue the license, deny the application or offer a reentry license to the applicant. (This assumes there are no matters whereby discipline would be appropriate.) **Please be aware, that if a reentry license is decided upon by the Board and Department, the process would be that the application be denied if the applicant does not accept the reentry license.**

SECTION F - PROFESSIONAL ACTIVITIES: List in chronological order all of your medical activities for the last ten years, or since graduation from medical college if less than ten years ago to present. Also list all periods of non-professional activity or employment for periods of non-medical activity of more than three months. Please account for all time and explain all gaps of more than three months. (Attach additional pages if necessary). This information must be completed below. **Do not attach CV or other work history forms. Do not put work/employment – be specific.**

From: Month/Year	July 2013	To: Month/Year	June 2017
Name of Facility	Medical College of Wisconsin		
City/State/Country	Milwaukee, WI, USA		
Professional Activity	Residency in Obstetrics and Gynecology		
From: Month/Year	July 2017	To: Month/Year	June 2019
Name of Facility	Northwestern University		
City/State/Country	Chicago, IL, USA		
Professional Activity	Fellowship in Family Planning		
From: Month/Year		To: Month/Year	
Name of Facility			
City/State/Country			
Professional Activity			
From: Month/Year		To: Month/Year	
Name of Facility			
City/State/Country			
Professional Activity			
From: Month/Year		To: Month/Year	
Name of Facility			
City/State/Country			
Professional Activity			

SECTION G – CONTROLLED SUBSTANCES REGISTRATION: (Check one that applies)

1	☑	I have enclosed a photocopy of my current Federal Controlled Substances Registration.	
		Federal Controlled Substances Registration #: [redacted]	Expiration Date: 04/30/2020
2	☐	I am currently applying for a Federal Controlled Substances Registration, and will send a photocopy of such when I receive the registration.	
3	☐	I do not have nor am I applying for a Federal Controlled Substances Registration and I will not be prescribing, administering or dispensing controlled substances in Nebraska. I understand that at such time that I do intend to prescribe, administer or dispense controlled substances in Nebraska, I will first need to have a Federal Controlled Substances Registration issued to me. At that time, I am to supply a photocopy of the registration to the State of Nebraska.	

SECTION H – LICENSURE IN OTHER STATE

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

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

State	License #	Issue Date	Expiration Date
IL	036.142418	2/15/2017	07/30/2020

SECTION I – CONVICTION AND LICENSURE INFORMATION:

Failure to disclose any such conviction or disciplinary action, regardless of when the action occurred, could result in disciplinary action, include, but not limited to, payment of a civil penalty. Answer the following questions either yes or no by placing a (✓) in the appropriate box. **All 'yes' responses MUST be explained in detail.** Additional documentation may be requested by the Board/Department after submission of initial information.

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

SECTION I CONTINUED – CONVICTION AND LICENSURE INFORMATION: Failure to disclose any such conviction or disciplinary action, regardless of when the action occurred, could result in disciplinary action, include, but not limited to, payment of a civil penalty. Answer the following questions either yes or no by placing a (✓) in the appropriate box. **All 'yes' responses MUST be explained in detail.** Additional documentation may be requested by the Board/Department after submission of initial information.

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

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

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

Attestation: For the purpose of complying with Neb. Rev. Stat. §§4-108 through 4-114 and 38-129 (*check only **ONE** of the boxes below):* **I attest that**:

☑ I am a citizen of the United States.

OR

☐ I am a qualified alien under the Federal Immigration and Nationality Act (i.e.: permanent resident (green) card, I-94 document, asylum, etc.) **YOU MUST SUBMIT A COPY OF THIS DOCUMENT WITH YOUR APPLICATION**

☐ I am a nonimmigrant lawfully present in the United States. (i.e.: permanent resident (green) card, I-94 document, asylum, etc.) **YOU MUST SUBMIT A COPY OF THIS DOCUMENT WITH YOUR APPLICATION**

☐ Check this box if you are **NOT** a citizen of the United States, a nonimmigrant, nor a qualified alien under the Federal Immigration and Nationality Act. **YOU MUST SUBMIT A COPY OF THIS DOCUMENT WITH YOUR APPLICATION**

NOTE: You may still be eligible for a certificate if you provide a photocopy of your unexpired Employment Authorization Document (EAD) and evidence of meeting section 202(c)(2)(B)(i) through (ix) of the Federal REAL ID Act of 2005.(i.e.: DACA, pending asylum, pending refugee, etc.)

Signature and Application Attestation: I attest that:

1. I have read the application or have had the application read to me; and
2. All statements on this application are true and complete.

Print Name: Jessika Ralph

Original Signature (required): Jessika Ralph

Date: Apr 10, 2019

Email (Optional): jessika.ralph@northwestern.edu

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

CERTIFICATE OF POST-GRADUATE MEDICAL EDUCATION

Applicants must have the **current Program Director** of the institution where they completed their post-graduate medical education complete the following form and **affix the Official School Seal**. An **original** signature from the Program Director is required. **Forms need to be sent to the Licensure Unit directly from the program. Do not submit with your application. These forms cannot be completed, mailed or signed in advance of your completion of one/two years of post-graduate medical education.**

Print Name _____ SS# _____

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

It is hereby certified that: _____
(Name of Applicant)

Has successfully completed _____
(Name of Residency/Internship/Fellowship)

located at : _____ **in** _____
(Name of Hospital/Teaching Institution) (City, State, Country)

From _____ **to** _____
(Month/Day/Year) (Month/Day/Year)

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

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

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

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

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

Any Probation/Remediation Action? Yes _____ No_____ If yes, provide details of the probationary information.

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

Print Name_____

Title _____

Date (month/day/year) _____

Phone # _____

E-mail _____

INSTITUTIONAL SEAL

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

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

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

Date: 04/17/2019

Federation Credentials Verification Service
ATTN: FCVS

FCVSID: 449482

Examinee: Ralph, Jessika Ann
Alt Name(s): Hopson, Jessika Ann
Ralph, Jessika

Examinee ID: 5-267-422-3
Date of Birth: 02/18/1987

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

USMLE STEP 1

Test Date	Pass/Fail	Score	Minimum Pass	Comments
06/14/2011	Pass	239	(188)	

USMLE STEP 2

Clinical Knowledge (CK)

Test Date	Pass/Fail	Score	Minimum Pass	Comments
12/13/2012	Pass	251	(196)	

Clinical Skills (CS)

Test Date	Pass/Fail	Comments
11/08/2012	Pass	

USMLE STEP 3

Test Date	Pass/Fail	Score	Minimum Pass	Comments
08/05/2014	Pass	243	(190)	

End of Exam History

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

Illinois Department of Financial and Professional Regulation

Division of Professional Regulation

JB Pritzker
Governor

Deborah Hagan
Secretary

Deborah Hagan
Secretary
Division of Professional Regulation

CERTIFICATION OF LICENSURE

State Board of Medicine
301 Centennial Mall South
Lincoln NE 68509-5007

RECEIVED
JUN 04 2019
LICENSURE UNIT

Licensee:	JESSIKA ANN RALPH MD
License Number:	036.142418
Profession:	LICENSED PHYSICIAN AND SURGEON
Date of Issuance:	02/15/2017
Expiration Date:	07/31/2020
License Status:	ACTIVE
License Method:	ENDORSEMENT---USMLE
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 today's date.

SEAL
IL DEPT. OF FINANCIAL & PROFESSIONAL REGULATION
DIV. OF PROFESSIONAL REGULATION

Deborah Hagan
Secretary
Division of Professional Regulation

May 29, 2019
Date

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

State of Illinois
Department of Financial and Professional Regulation
Division of Professional Regulation
320 W. Washington St., 3rd Floor, Springfield, IL 62786

ATTENTION

The attached document is an official
State of Illinois
Licensure certification/verification, prepared by the
Illinois Department of Financial and Professional Regulation.

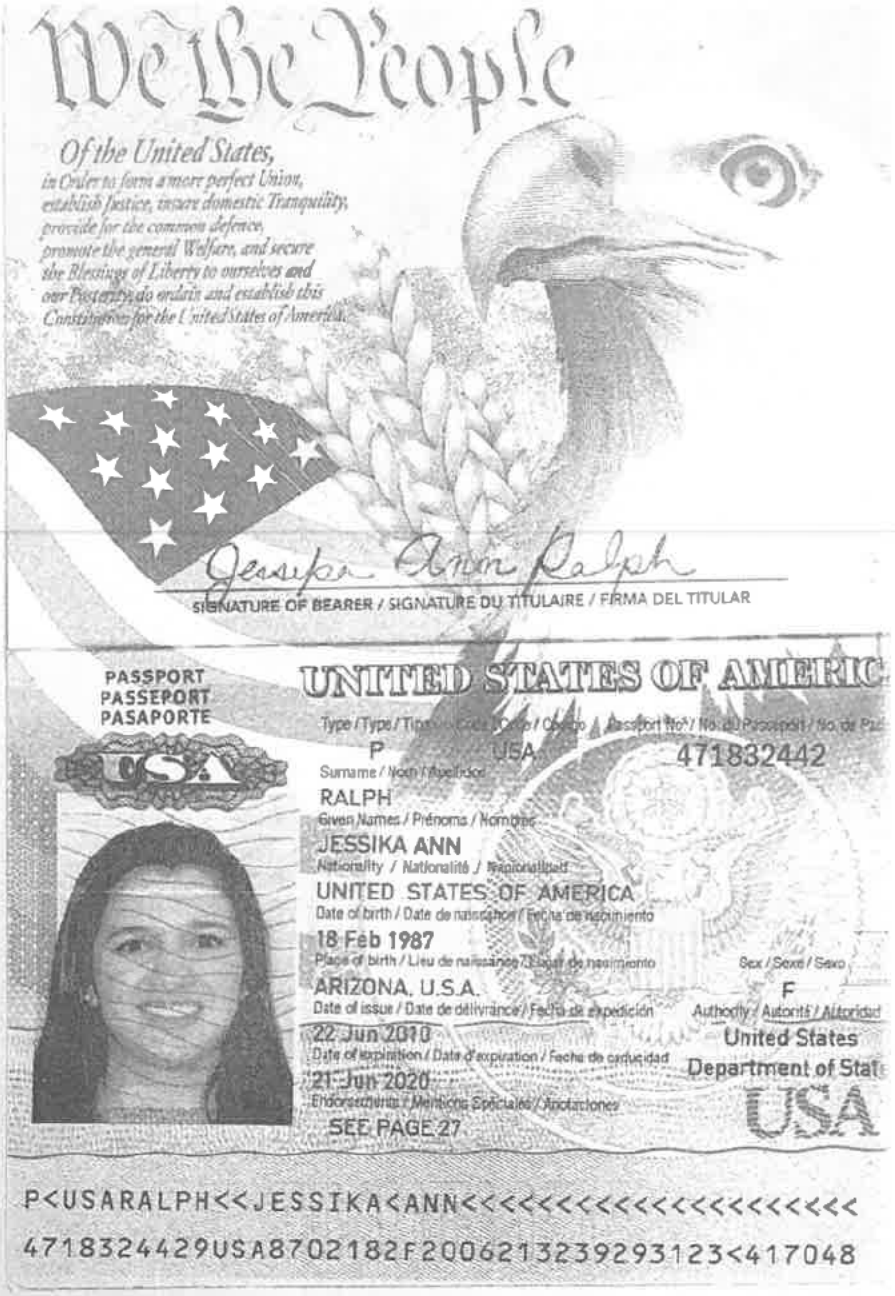
This certifies that the named individual has met all of the education/examination requirements by law in order to receive the credential that is being verified.

The Department has eliminated specific examination status from certifications/verifications of licensure, as passage of an examination is a requirement for licensure.

This information is the **ONLY** certification information provided by this Department. If other information is needed, it **MUST** be obtained from the applicant.

THANK YOU

IL486-2066 8/12 Printed by authority of the State of Illinois FY19-121, 1500


We The People
Of the United States,
in Order to form a more perfect Union,
establish Justice, insure domestic Tranquility,
provide for the common defence,
promote the general Welfare, and secure
the Blessings of Liberty to ourselves and
our Posterity, do ordain and establish this
Constitution for the United States of America.
SIGNATURE OF BEARER / SIGNATURE DU TITULAIRE / FIRMA DEL TITULAR
PASSPORT
PASSEPORT
PASAPORTE
USA
UNITED STATES OF AMERIC
P
USA
471832442
Surname / Nom / Apellidos
RALPH
Given Names / Prénoms / Nombres
JESSIKA ANN
Nationality / Nationalité / Nacionalidad
UNITED STATES OF AMERICA
Date of birth / Date de naissance / Fecha de nacimiento
18 Feb 1987
Place of birth / Lieu de naissance / Lugar de nacimiento
ARIZONA, U.S.A.
Sex / Sexe / Sexo
F
Date of issue / Date de délivrance / Fecha de expedición
22 Jun 2010
Authority / Autorité / Autoridad
United States
Department of Stat
Date of expiration / Date d'expiration / Fecha de caducidad
21 Jun 2020
Endorsements / Mentions Spéciales / Anotaciones
SEE PAGE 27
USA
P<USARALPH<<JESSIKA<ANN<<<<<<<<<<<<<<<<<<<<<
4718324429USA8702182F2006213239293123<417048

CERTIFICATION OF VITAL RECORD

"VERIFICATION BOX" (HOLD BETWEEN THUMB AND FOREFINGER, OR BREATHE ON IT. COLOR WILL CHANGE TO BLUE AND THEN RETURN.)

STATE OF ARIZONA

STATE OF ARIZONA
DEPARTMENT OF HEALTH SERVICES - OFFICE OF VITAL RECORDS

CERTIFICATE OF LIVE BIRTH

BIRTH NO. B 102- 87-007275

1. NAME OF CHILD A. First: Jessika	B. Middle: Ann	C. Last: Hopson	
2. SEX: Female	3A. TYPE OF BIRTH (Single, twin, triplet, etc.) SPECIFY: Single	3B. IF MULTIPLE BIRTH (Born first, second, etc.) SPECIFY:	4A. DATE OF BIRTH Month Day Year: February 18, 1987 — 4B. Hour: 0730
5. PLACE OF BIRTH A. County: Maricopa	B. Town or City: Phoenix	C. Hospital or Clinic (If home birth, give street address): St. Joseph's Family Childbirth Center	
6. FATHER'S NAME A. First	B. Middle	C. Last	7. DATE OF BIRTH Month Day Year — 8. PLACE OF BIRTH State or Country
9. MOTHER'S MAIDEN NAME A. First: Theresa	B. Middle: Jo	C. Last: Hopson	10. DATE OF BIRTH Month Day Year: January 17, 1957 — 11. PLACE OF BIRTH State or Country: Arizona
12. MOTHER'S USUAL RESIDENCE A. State: Arizona	B. County: Maricopa	C. Town or City: Mesa	D. Zip Code: 85204
12E. STREET ADDRESS OR R.F.D.: 2502 E. Carol	12F. IN CITY LIMITS? ☒ YES ☐ NO	13. MOTHER'S MAILING ADDRESS (If different from Item 12): Same	
14. THE INFORMATION LISTED IN ITEMS 1-13 IS TRUE AND CORRECT TO THE BEST OF MY KNOWLEDGE.	14A. PARENT OR INFORMANT'S SIGNATURE: Theresa J Hopson	15. RELATIONSHIP TO CHILD: Mother	16. DATE SIGNED: Feb. 18, 1987
17. I ATTENDED THE BIRTH OF THIS CHILD WHO WAS BORN ALIVE AT THE PLACE, TIME, AND DATE ENTERED ABOVE.	17A. ATTENDANT'S SIGNATURE (Type name below line): Filippo Santoro, M.D.	18. TITLE ☒ M.D. ☐ D.O. ☐ OTHER (specify)	19. DATE SIGNED: Feb. 18, 1987
20. SUPPLEMENTARY ENTRIES			
21. DATE REGISTERED: MAR 03 1987	22. REG. FILE NO.: 5330	23. REGISTRAR'S SIGNATURE: Patricia L. Bazzell, Deputy	24. REG. DISTRICT: 0706 — 25. DATE RECVD. IN STATE OFFICE: APR 02 [illegible]

7/1/2010

Patricia Adams
PATRICIA ADAMS
ASSISTANT STATE REGISTRAR

This is a true certification of the facts on file with the OFFICE OF VITAL RECORDS, ARIZONA DEPARTMENT OF HEALTH SERVICES, PHOENIX, ARIZONA issued under the authority of A.R.S. 36-341, and by direction of:

This copy not valid unless prepared on a form displaying the State Seal and impressed with the seal of the issuing agency.

Arizona Department of Health Services

ANY ALTERATION OR ERASURE VOIDS THIS DOCUMENT

CONTROLLED SUBSTANCE REGISTRATION CERTIFICATE

UNITED STATES DEPARTMENT OF JUSTICE
DRUG ENFORCEMENT ADMINISTRATION
WASHINGTON D.C. 20537

DEA REGISTRATION NUMBER	THIS REGISTRATION EXPIRES	FEE PAID
[redacted]	04-30-2020	$731

SCHEDULES	BUSINESS ACTIVITY	ISSUE DATE
2,2N,	PRACTITIONER	04-18-2017

RALPH, JESSIKA
NORTHWESTERN MEMORIAL HOSPITAL
251 E. HURON ST.
CHICAGO, IL 60611-0000

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

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

Form DEA-223 (9/2016)