EMERGENCY	EL191002	ISSUED: 1/23/19	EXPIRES: 5/3/19
CURRENT LICENSE: TN-Expires 7/20		EMERGENCY APPROVED BY: TT 1/23/19	
START DATE: 1/24/19 ☒LON Bridgton Hospital			
PERMANENT	MD22864	ISSUED: 3/15/19 EXPIRES: 7/31/20	

DATE APP REC'D: 1/16/19

NAME: THOMPSON, CAROLYN C

PLACE OF BIRTH: [redacted] DOB: [redacted]

MEDICAL SCHOOL: UNIVERSITY OF TENNESSEE CENTER OF HEALTH

YEAR GRAD: 1993 SPECIALTY: Obstetrics and Gynecology

EXPECTED MAINE LOCATION LEWISTON

MALPRACTICE ☒YES ☐NO ☒OPEN 1 ☐DISMISSED ____ ☐SETTLEMENT ____

OTHER PERSONAL DATA ☐YES ☒NO

☒CV ☐REFERENCES N/A

☒DATE OF LAST CLINICAL PRACTICE Practicing

NPDB 1/19/19 GOOGLE RESULTS ☐YES ☒NO

☒FCVS PDC 2/10/19 ABMS ☒YES ☐NO

☒WRITTEN EXAM 98 %

POST GRADUATE TRAINING:	ACGME	ON FILE	TIME
☒ UNIVERSITY OF MISSOURI	☒	☐	4YEAR(S)

COMMENTS: 1/30/19 Dennis reviewed malpractice - no records needed

PRELIMINARY REVIEW: LIST A ____ LIST B ____ *REVIEWED BY:* TIMOTHY TERRANOVA *APPROVED BY:* ☐ LOUISA BARNHART, M.D.

TT 3/14/19

Central Maine Medical Family

Jan 18, 2019

Board of Licensure in Medicine
161 Capitol Street
137 State House Station
Augusta, Maine 04333-0137

To Whom ItMay Concern:

RE: Caroline Thompson, MD

This letter is to request temporary/permanent licensing for Caroline Thompson, MD (OB/GYN) Practice) who is scheduled to practice at Bridgton Hospital at Bridgton in Maine beginning January 24th, 2019.

This request is to facilitate Caroline Thompson, MD ability to fill a need regionally at Bridgton to help support our patients in need.

Thank you for your assistance. Please do not hesitate to contact me at 207-795-7159.

Sincerely,

[redacted]

Basudhaa Dasgupta
System Director, Medical Staff Office
Central Main Healthcare

Crowley, Elena I

From: Carolyn Thompson [redacted]
Sent: Tuesday, January 22, 2019 10:13 AM
To: Crowley, Elena I
Subject: [EXTERNAL SENDER] Re: MAINE APPLICATION

Ms. Crawley,

I see that my public address is still pending on your status site. It is: P.O. Box 158072 Nashville, TN 37215

Thank you,

Carolyn Thompson, MD

On Jan 17, 2019, at 9:28 AM, Crowley, Elena I <Elena.I.Crowley@maine.gov> wrote:

Dear Carolyn C. Thompson, MD:

For a current list of items that have **not** been received for your application for licensure in the State of Maine please use the following link: https://www.pfr.maine.gov/ALMSOnline/ALMSQuery/SearchIndividual.aspx?Board=376

Please do not contact the Board unless otherwise specified.

All requested documents may be emailed or faxed except for those that require notarization or originals.

THE INFORMATION HIGHLIGHTED IS NEEDED BEFORE WE CAN START THE EMERGENCY DOCTOR APPLCIATION

- An open-book exam passed with a score of at least 75. The written exam can be taken online athttps://www1.maine.gov/cgi-bin/online/licensing/begin.pl?board_number=376 You will need to log into the online Exam by using MD22864 for the license number and on the second page use the LAST 6 digits of your SSN for your access code.
- Letter of need from the facility.
- In your application you state that you have practiced as a consultant from 7/04 to present. Please provide a detailed explanation of your clinical duties as a consultant.

Pd 1100.00 CK # 2091289

Maine Board of Licensure in Medicine
137 State House Station
Augusta, ME 04333-0137

RECEIVED
JAN 16 2019
BOARD OF LICENSURE IN MEDICINE

1. I hereby apply for **(check appropriate license (s))**:

Permanent ($700) ___ Emergency/Permanent ($1,100) ✓ Temporary ($400) ___ Youth Camp ($100) ___

Educational ($100/yr) ___ Consultative Telemedicine ($500) ___ Administrative ($700) ___

licensure to practice medicine and/or surgery in the State of Maine and in support of this, submit the following information.
Note: Locums Company addresses will not be accepted.

NAME: Thompson (Last) Carolyn (First) Crump (Middle)

Home Address: [redacted] (Number and Street)
[✓] **Use this as my contact address**

[redacted] (City, State, Zip/Postal Code)

Work Address: _____ (Number and Street)
[ ] **Use this as my contact address**

_____ (City, State, Zip/Postal Code)

Home Telephone: _____ Work Telephone: _____

Cell Phone: [redacted]

Place of Birth: [redacted] Date of Birth: [redacted] (Month Day Year)

Social Security Number: [redacted] Email Address: [redacted]
[ ] **Use this to contact me about my license**

Please list any specialties or subspecialties, and if you are ABMS board certified in any specialty, check the box.

Primary Specialty: _____ ☐ Specialty2: _____ ☐

Specialty3: _____ ☐ Specialty4: _____ ☐

Will you practice in Maine within the next year? ☑ Yes ☐ No If yes, in what community? Lewiston

2. MEDICAL LICENSURE

List all states, provinces, or countries where you have held, now hold, or have applied for a medical license.

State or Country	Cert. #	Status	Date Expires
KS	9404335	Inactive	06/30/1997
MO	103692	Expired	
TN	29044	Active	07/31/2020

State or Country	Cert. #	Status	Date Expires

3. MEDICAL SCHOOL

A. University of Tennessee Center for the Health Sciences College of Medicine (NAME OF SCHOOL) 06/04/1993 (GRADUATION DATE)
Memphis, TN USA (CITY, STATE, COUNTRY)

B. _____ (NAME OF SCHOOL) _____ (GRADUATION DATE)
_____ (CITY, STATE, COUNTRY)

4. POSTGRADUATE TRAINING

A. University of Missouri — 1-4
NAME OF INSTITUTION — PGY (e.g., 1, 2, 3, etc.)
Kansas City, MO USA
CITY, STATE, COUNTRY
FROM 07 (MONTH) 1993 (YEAR) TO 06 (MONTH) 1997 (YEAR) SUCCESSFULLY COMPLETED? ✓ In Progress

B. _____ _____
NAME OF INSTITUTION — PGY (e.g., 1, 2, 3, etc.)
CITY, STATE, COUNTRY
FROM _____ (MONTH) _____ (YEAR) TO _____ (MONTH) _____ (YEAR) SUCCESSFULLY COMPLETED? _____ In Progress _____

C. _____ _____
NAME OF INSTITUTION — PGY (e.g., 1, 2, 3, etc.)
CITY, STATE, COUNTRY
FROM _____ (MONTH) _____ (YEAR) TO _____ (MONTH) _____ (YEAR) SUCCESSFULLY COMPLETED? _____ In Progress _____

D. _____ _____
NAME OF INSTITUTION — PGY (e.g., 1, 2, 3, etc.)
CITY, STATE, COUNTRY
FROM _____ (MONTH) _____ (YEAR) TO _____ (MONTH) _____ (YEAR) SUCCESSFULLY COMPLETED? _____ In Progress _____

E. _____ _____
NAME OF INSTITUTION — PGY (e.g., 1, 2, 3, etc.)
CITY, STATE, COUNTRY
FROM _____ (MONTH) _____ (YEAR) TO _____ (MONTH) _____ (YEAR) SUCCESSFULLY COMPLETED? _____ In Progress _____

5. LIABILITY INSURANCE DATA

Information you supply here is required for the Maine Rural Health Access Program {24-A M.R.S. § 6304(3)}. The information will be reported to the Maine Superintendent of Insurance for administration of this program as provided in that law. Maintenance of professional liability insurance is not a requirement to maintain a Maine medical license in force. Please select 'Self Insured' if you have no professional liability insurance, or if you only pay a portion of the premium.

Please check the appropriate box to indicate the method you employ to secure professional medical malpractice liability insurance.

☐ Self Insured ☐ Physician Paid ☑ Employer Paid

If you checked off "Employer Paid", please enter the name of the employer who or which paid your premiums here: Medicus Healthcare Solutions, LLC

Insurance Company (Name/Address):
ProAssurance Specialty Insurance
3131 Eastside Street, Suite 600
Houston, TX 77098

Policy #: [redacted]

6. PERSONAL DATA

Check off (X) each appropriate response. **Every 'YES' response must be fully explained by written statement on a separate 8.5" x 11" sheet of white paper. Each such explanation must be cross-referenced with the question number, and must be signed, dated, and enclosed with your application.**

YES NO

☐ ☑ 1. Have you EVER had ANY licensing authority (INCLUDING MAINE) deny your application for any type of license, or take any disciplinary action against the license issued to you in that jurisdiction, including but not limited to warning, reprimand, fine, suspension, revocation, restrictions in permitted practice, probation with or without monitoring?

☐ ☑ 2. Have you EVER agreed with any licensing authority to voluntarily follow practice limitations, restrictions, guidelines, to make reports or to complete specific continuing education or course work?

☐ ☑ 3. Have you EVER been notified of the existence of allegations, investigations and/or complaints involving you, filed with or by ANY licensing authority (INCLUDING MAINE), which allegations, investigations and/or complaints remain open as of the date of this application?

☐ ☑ 4. Have you EVER left a medical licensing jurisdiction (INCLUDING MAINE) while a complaint, investigation or allegation was pending?

5. Have you EVER been denied registration, or had your ability to prescribe or dispense controlled substances modified, restricted, suspended, revoked, or voluntarily suspended by, or surrendered to:

☐ ☑ a) The U. S. Drug Enforcement Administration (US DEA)?

☐ ☑ b) Any state/territory of the U. S., INCLUDING MAINE?

☐ ☑ 6. Has there EVER been a finding by any state or federal court or governmental agency that you violated any rule or law regulating the practice of health care?

☐ ☑ 7. Has there EVER been a finding against you in any inquiry, investigation, or administrative or judicial proceeding by an employer, educational institution, professional organization, or licensing authority, or in connection with an employment disciplinary or termination procedure?

☐ ☑ 8. Have you EVER received a sanction or entered into any settlement agreement or integrity agreement related to Medicare, TRICARE or any state Medicaid program?

9. The purpose of the following questions is to determine the current fitness of the applicant to practice medicine. The following inquiries concern medical, mental health, and substance misuse issues. This information is treated confidentially by the Board. The mere fact of treatment for medical, mental health or substance misuse is not, in itself, a basis on which an applicant is ordinarily denied licensure when he/she has demonstrated personal responsibility and maturity in dealing with these issues. The Board encourages applicants who may benefit from such treatment to seek it. The Board may deny a license to applicants whose ability to function in the practice of medicine or whose behavior, judgment, and understanding is impaired by substance misuse or a medical or mental health condition.

[redacted]

a. Do you have a mental or physical condition that currently impairs your ability to safely and competently practice medicine?

b. Within the last five (5) years have you been diagnosed with or treated for any medical or mental health disorder that impaired your behavior, judgment, understanding, or ability to function in school, work or other important life activities?

YES NO

[redacted]

c. Do you currently use any chemical substance(s), including alcohol, which in any way impairs or limits your ability to practice your profession with reasonable skill and safety?

If any of your answers to questions 9(a-c) is "Yes," are the limitations or impairments caused by your medical, mental health, or substance misuse condition reduced or improved because you receive ongoing professional treatment (with or without medication) or because you participate in a professional monitoring program? Current voluntary participation in the Medical Professionals Health Program or similar program will be kept confidential.

☐ ☑ d. Are you currently engaged in the illegal use of illicit drugs or prescription drugs that have not been prescribed to you pursuant to a legitimate physician-patient relationship? "Legitimate" means "Being in compliance with the law or in accordance with established and accepted standards."

☐ ☑ e. Have you EVER used illegal drugs or prescription drugs that have not been prescribed to you pursuant to a legitimate physician-patient relationship?

☐ ☑ f. Have you ever obtained illegal drugs or prescription drugs that were not prescribed to you pursuant to a legitimate physician-patient relationship?

☐ ☑ g. Have you EVER furnished or provided illegal drugs to anyone other than medical marijuana per applicable state law?

☐ ☑ h. Have you EVER furnished prescription drugs to or written a prescription for anyone without having a legitimate physician-patient relationship (This includes conduct for which you may NOT have been adjudicated in any civil, administrative or criminal proceeding)?

i. Have you EVER been found in any civil, administrative or criminal proceeding to have:

☐ ☑ Possessed, used, prescribed for use, or distributed any drugs in any way other than for legitimate or therapeutic purposes?

☐ ☑ Diverted any drugs?

☐ ☑ Violated any drug law?

☐ ☑ Prescribed any controlled substances for yourself or family/household members?

[redacted]

j. Within the last five (5) years have you EVER raised the issue of consumption of drugs or alcohol or the issue of a medical, mental health or substance misuse disorder as a defense or in mitigation of, or as an explanation for your actions in the course of any administrative or judicial proceeding or investigation; any inquiry or other proceeding; or any proposed termination action (educational, employer, government agency, professional organization, or licensing authority)?

☐ ☑ 10. Have you EVER been charged, summonsed, indicted, arrested, or convicted of any criminal offense, including when those events have been deferred, set aside, dismissed, expunged or issued a stay of execution? Please include motor vehicle offenses such as Operating Under the Influence, but not minor traffic or parking violations.

☐ ☑ 11. Have you EVER applied for hospital, HMO or other health care entity privileges which were denied?

☐ ☑ 12. Have you EVER had your staff privileges or employment at any hospital, long term care facility, HMO, or other health care entity terminated, revoked, reduced, restricted in any way, suspended, made subject to probation, limited in any way, or withdrawn involuntarily?

YES	NO	
☐	☑	13. Have you EVER voluntarily surrendered privileges or resigned from staff membership during peer review or investigation or to avoid peer review or investigation?
☐	☑	14. Have you EVER resigned from employment in lieu of termination or while under investigation?
☐	☑	15. Have you EVER been terminated or suspended from any employment?
☐	☑	16. Have you EVER been deselected from a managed care organization physician panel?
☐	☑	17. Have you EVER been disciplined by a professional society or resigned while an accusation was pending?
☐	☑	18. Have you EVER endangered the safety of others, breached fiduciary obligations, or violated workplace conduct rules?
☑	☐	19. Have you EVER been named in any medical malpractice liability claim or lawsuit adjudicated by a court in favor of the other party, or settled by you or your insurance company/representatives with or without your express consent?
☐	☑	20. Do you have any open/pending malpractice claims?
☐	☑	21. Do you intend to practice medicine within the State of Maine without active medical staff privileges at a Maine hospital?
☐	☑	22. Do you plan to practice telemedicine in Maine? If so, please provide a short description of your plan to practice with Maine Patients, including your practice protocols, your physical practice location, your publicly available telemedicine website portal, and whether you will be combining in-person medical practice with telemedicine.
☐	☑	23. Has it been longer than 24 months since you last practiced clinical medicine?

7. AFFIDAVIT OF APPLICANT

I, Carolyn C. Thompson, being duly sworn, depose and say that I am the person described and identified in this application. I have carefully read the questions in this application and have answered them completely, without reservations of any kind, and declare under penalty of law that my answers and all statements made by me herein are true and correct. Should I furnish any false information in this application, I hereby agree that such act shall constitute cause for the denial, suspension or revocation of my license to practice medicine and surgery in the state of Maine, or other discipline as the Board may determine.

I certify that I have read and understand all the requirements for Maine Licensure and further certify that I meet those requirements. I will immediately notify the Board in writing of any changes to the answers to any questions contained in this application if such a change occurs at any time prior to a license to practice medicine being granted to me by the Board.

I hereby authorize all hospitals, medical institutions or organizations, my references, personal physicians, employers (past and present), business and professional associates (past and present) and all governmental agencies and instrumentalities (local, state, federal, and foreign) to release to this licensing Board any information, files or records required by the Board for its evaluation of any professional and ethical qualifications for licensure in the state of Maine. I hereby release any and all entities from responsibility regarding the information they release to the Board of Licensure in Medicine.

I hereby authorize the Board of Licensure in Medicine to transmit any information contained in the application, or information that may otherwise become available to them, to any agency, organization, hospital, or individual, who, in the judgement of the Board, has a legitimate interest in such information.

[redacted]

Signature of Applicant

1/11/19

Date

Notary Public

Signature of Notary

Notary Commission Expires:

MARCH 16 2020

[redacted]

Notary's Seal

1) APPLICANTS MUST SIGN THEIR FULL NAME IN THE PRESENCE OF A NOTARY PUBLIC.
2) NOTARY PUBLIC MUST COMPLETE THE AFFIDAVIT AND AFFIX A NOTARIAL SEAL OVERLAPPING A PORTION OF THE PHOTOGRAPH BUT NOT COVERING ABOVE THE NECK.

8. PROFESSIONAL EXPERIENCE/HOSPITAL AFFILIATIONS/ WORK HISTORY

List **in chronological order** all professional experience including full work history of practice, and all healthcare entities where you have held or now hold privileges. Include all periods of time (Month and Year) from the date of completion of residency to the present, whether or not engaged in activities related to medicine. Be certain to report **COMPLETE ADDRESSES**. Failure to do so will delay the application process. You may photocopy this page, if necessary.

From Mo./Yr.	To Mo./Yr.	Name of Hospital, Institution, or Practice	**Complete** Address (Street, City, State, Zip)	Nature of Experience	Office Use Only S	Office Use Only R
08/1997	11/1999	Women's Health Alliance/ Carolyn C. Thompson, MD; PC	*CLOSED* Nashville, TN	OB-Gyn		
11/1999	11/2007	Private Practice/ Carolyn C. Thompson, MD; ~~PC~~	2201 Murphy Avenue, Suite 310 Nashville, TN 37203	OB-Gyn		
05/2005	04/2009	Summit Medical Center	5655 Frist Boulevard Hermitage, TN 37076	Chair/ OB-Gyn		
07/2010	06/2015	Tristar Centennial Women's Hospital	2221 Murphy Avenue Nashville, TN 37203	Emergency OB-Gyn		
07/2004	Present	Private Practice/ Carolyn C. Thompson, MD; ~~PC~~	2201 Murphy Avenue, Suite 310 Nashville, TN 37203	Consultant		
01/2018	Present	National Clinic Center for Family Planning	2464 Charlotte Street Kansas City, MO 64108	Consultant		

REFERENCE QUESTION #19

T.H. ON ALLEGES FAILURE TO PERFORM CESAREAN SECTION IN A TIMELY MANNER. I WAS NAMES AS CO. DEFENDANT WITH TRUMAN MEDICAL CENTER. PATIENT WAS A POORLY-CONTROLLED INSULIN-DEPENDENT DIABETIC ADMITTED TO LABOR + DELIVERY FOR INDUCTION OF LABOR. DIFFICULTY WAS ENCOUNTERED MAINTAINING FETAL MONITORING, AND A BEDSIDE ULTRASOUND REVEALED AN AGONAL FETAL HEART RHYTHM. PATIENT WAS TAKEN DIRECTLY TO THE OR FOR CESAREAN, BUT A STILL-BORN INFANT WAS DELIVERED.

THE CARRIER OF MALPRACTICE INSURANCE ELECTED TO SETTLE THE CASE WITHOUT MY INPUT. A SETTLEMENT OF $60,000 WAS PAID IN TOTAL, WITH $35,000 IN MY NAME.

[redacted]

1/11/19

CURRICULUM VITAE

Carolyn Crump Thompson, M.D.
[redacted]
https://www.linkedin.com/in/carolyn-thompson-md-facog-600b498/

Employment

National Clinical Training Center for Family Planning 1/2018 – present
Consultant and trainer
Planned Parenthood of Tennessee and North Mississippi 2/2018 – 11/2018
Affiliated Assistant Professor, University of Tennessee Health Science Center, College of Medicine, Department of Clinical Medical Education 10/2014-present
Carolyn C. Thompson, MD; PC 11/1999 – 11/2017
Private practice of Obstetrics and Gynecology
Medical litigation consultant 7/2004 – present
OB/Gyn Management 7/2010 - 6/2015
Part-time physician in OB/Gyn Emergency Department
Women's Health Alliance 8/1997 - 11/1999
Private practice of Obstetrics and Gynecology

Specialty Training

University of Missouri, Kansas City 7/1993-6/1997
Department of Obstetrics and Gynecology
Internship and Residency

Professional Appointments

Chair, Department of Obstetrics and Gynecology
Summit Medical Center 5/2005–4/2009
Member, Medical Executive Committee
Summit Medical Center 5/2005-4/2009
Instructor, University of Missouri, Kansas City 7/1993-6/1997
Department of Obstetrics and Gynecology

National Professional Certification

Diplomate, National Board of Medical Examiners 1994

Specialty Certification

Diplomate, American Board of Obstetrics and Gynecology 1999

State Licensure

States of Tennessee (active), Missouri and Kansas (expired)

Medical Education

University of Tennessee Center for the Health Sciences College of Medicine
Doctor of Medicine 6/1993

Undergraduate Education

University of Tennessee, Knoxville 1985-1988
Bachelor of Arts, Cum Laude 6/1988

Professional Organizations

Fellow, American College of Obstetricians and Gynecologists
Fellow, American Congress of Obstetricians and Gynecologists
Member, American Society of Colposcopy and Cervical Pathology
Member, American Urogynecological Society
Member, Society of Laparoendoscopic Surgeons
Member, Kansas City Gynecological Society
Founding Fellow, Youngblood Society
Health Information and Management Systems Society 8/2018-present
Women in Technology, Tennessee 10/2018-present

Professional Service

Credentials Committee, TriStar Centennial Medical Center 1/2012-11/2017
Ad hoc surgical peer review committees 2012, 2014, 2015, 2017
Robotic Excellence Committee, TriStar Centennial Medical Center 1/2013-11/2017
Perinatal Care Committee, TriStar Summit Medical Center 5/2005-4/2009
Ad hoc surgical peer review committees 2004, 2006, 2007, 2009, 2010
Credentials Committee, TriStar Summit Medical Center 1/1998-8/2011

Specialty Procedures

Robotic-assisted laparoscopic surgical procedures
Single-incision pelvic floor repair procedures
Transobturator suburethral sling placement
Essure hysteroscopic sterilization

Volunteer and Community Activities

DB Peru Board of Directors 8/2018-present

Advocates for Women's and Kid's Equality (AWAKE) Steering Committee 1/2018-present
Nashville Women's Breakfast Club 2/2015-present
Board of Directors 1/2018-present
Women's Political Collaborative 8/2014-present
Tennessee Women in Medicine 4/2014-present
Board of Directors, Planned Parenthood of Middle and East Tennessee 8/2012 – 2/2018
Executive Committee 1/2013-2/2018
Television spokesperson for Vote NO on 1 Campaign 9/2014
Board of Directors, First Steps 7/2012-6/2017
Executive Committee 1/2014-12/2016
Volunteer, Gilda's Club 4/2013-present
University of Tennessee Alumni Association Network Board 2013-2014
Volunteer surgeon Chikondi Health Foundation Liwonde, Malawi 6/2015
Volunteer surgeon Health Talents International, Clinica Ezell Montellano, Guatemala 9/2006, 9/2007, 9/2008, 9/2012
Susan G. Komen Nashville Affiliate Grant Review Board 2007-2009
Volunteer physician West End United Methodist Church mission trips to Honduras, Nicaragua and Guatemala 7/2002, 1/2005

Research

Prevalence of Certain Sexually Transmitted Diseases in Women on DepoProvera with Abnormal Bleeding Patterns Resident research project presented to Kansas City Gynecologic Society 5/1997

National Institute of Health Medical Student Research Grant
The Effects of the Inhibition of Phospholipase A2 on Cerebrovascular Reactivity in the Newborn Pig (under direction of C.W. Leffler, Ph.D., Professor of Physiology and Biophysics, University of Tennessee, Memphis, June-August 1990)

Catheter-Associated Fungemia in Patients with Acquired Immunodeficiency Syndrome: Species Verification with Molecular Probing (research assistant for W.S. Riggsby, Ph.D., Professor of Microbiology, University of Tennessee, Knoxville, June-December 1988)

Scientific Publications

Peppler, R.D., and C.C. Thompson. "Anatomy, Embryology, and Physiology of the Fallopian Tube" in: Extrauterine Pregnancy: Clinical

Diagnosis and Management. T.G. Stovall and F.W. Ling, eds. McGraw-Hill, Inc., New York. 1993. Chapter 2.

Leffler, C.W., C.C. Thompson, W.M. Armstead, R. Mirro, M. Shibata, D.W. Busija. Superoxide scavengers do not prevent ischemia-induced alteration of cerebral vasodilation in piglets. Pediatr Res. 1993 Feb;33(2):164-70.

Leffler, C.W., R. Mirro, C.C. Thompson, W.M. Armstead, M. Shibata, M. Pourcyrous, and O. Thelin. Activated Oxygen Species Do Not Mediate Hypercapnia-Induced Cerebral Vasodilation in Newborn Pigs. *American Journal of Physiology*. 261 (Heart Circ. Physio. 30): H335-H342. 1991.

Please list 3 References and their contact information. I will then forward to the Maine Medical Board on your behalf and they will collect the references. This is a requirement for the Maine Medical License Application.

S L
11/18 ✓

Reference Name: Steven Staggs, MD

Email: [redacted] Fax: _____

11/18

Reference Name: Kristin Rayer, MD

Email: [redacted] Fax: _____

11/18

Reference Name: Julie Moore, MD

Email: [redacted] Fax: _____

Professional Reference Questionnaire

Professional Evaluation re: CAROLYN C. THOMPSON, MD
Refetence Provided by: STEVEN STAGGS, MD

Please answer all questions based on your personal knowledge and direct observation. Your candor will be greatly appreciated and your answers will remain confidential, except as necessary for accomplishing the licensing process.

Relationship of Reference Source to Applicant

What is your relationship with the applicant? We were in the same hospital and covered for each other._____
_____

During what time period, **if any**, did you have the opportunity to observe the applicant's practice of his/her specialty?

From:_2008_____to:__2018(not sure of dates_)_____

Indicate method: by Direct Observation y☐ Peer Review y☐ Referrals ☐y Reputation

Was your observation done in connection with any official professional title or position? (i.e., Dept. Chair, Director, Supervisor) **If yes or other, please indicate title:** Yes y☐ No☐_____

At what facility is your professional relationship based?__ **Fellow ob/gyn and I was department chief**
_____ at Saint Thomas Midtown & Centennial Medical Center

A. Actions, Conduct & Health Status

If any of the following questions are answered "yes", please provide complete details on a separate sheet.

To the best of your knowledge, has this applicant ever been subject to any disciplinary action, such as imposition of consultation requirements, suspension or termination? _____Yes___ No_no__ Don't know___

Are/were such actions, listed above, in process or pending against the applicant?_____ Yes___ No_no__ Don't know___

To the best of your knowledge, has the applicant evet been under investigation by any governmental or other legal body?_____ Yes___ Nono__ Don't know___

Do you know of any malpractice actions instituted within the past two years or in process against the applicant?_____ Yes___ No__no_ Don't know___

To the best of your knowledge, does the applicant have any behavior, physical or mental condition (including dependence on drugs or alcohol) that could affect his or her exercise of clinical privileges or provision of quality, safe patient care?_____ Yes___ No_no__ Don't know___

Professional Reference Questionnaire – Page 2

Professional Evaluation re: CAROLYN C. THOMPSON, MD
Reference Provided by: STEVEN STAGGS, MD

B. Evaluation of Clinical, Communication/Interpersonal Skills, and Professionalism

This evaluation should be based on demonstrated performance compared to that reasonably expected of a practitioner with a similar level of training experience and background as this one. If you do not have knowledge to answer a particular question, please indicate "no information".

Basic Medical Knowledge:	Unsatisfactory*	Marginal*	Satisfactory	Excellent	N/A
Professional Judgment	☐	☐	☐	☐y	☐
Sense of Responsibility	☐	☐	☐	☐y	☐
Clinical Competence	☐	☐	☐	☐y	☐
Ethical Conduct	☐	☐	☐	y☐	☐
Patient Management	☐	☐	☐	☐y	☐
Physician/Patient Relationships	☐	☐	☐	☐y	☐
Relationship w/Peers & Staff	☐	☐	☐	☐y	☐
Communication & Rapport with Patients	☐	☐	☐	☐y	☐
Ability to Understand, Speak & Write English	☐	☐	☐	☐y	☐

Is there any additional information that would assist the Board in evaluating the clinical abilities and other skills of this applicant for Licensure? _____

_____

C. Recommendation

y☐ Recommend without reservation
☐ Recommend with the following reservations
☐ Do not recommend

Would you hire or rehire this applicant? y☐ **Yes** ☐ **No** ☐ **N/A**

Comments: She is competent and careful.

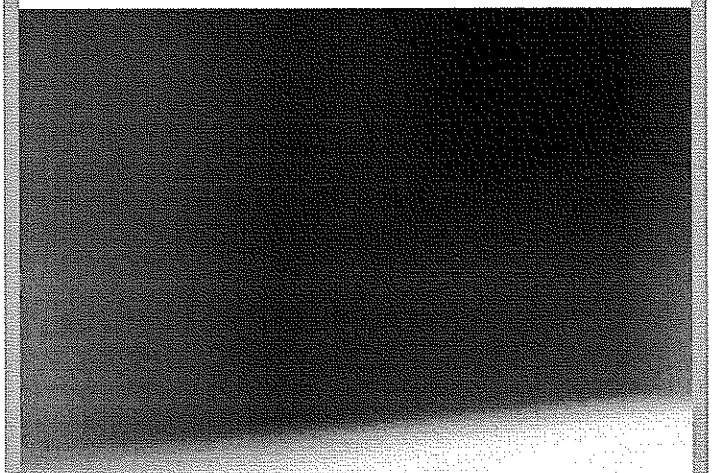
Please provide any additional information or comments on a separate sheet of paper.

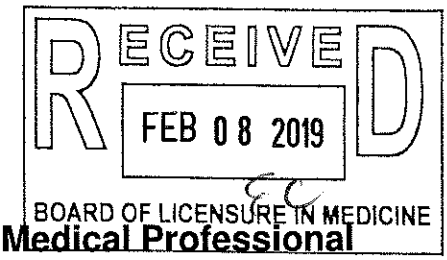
Date: 2/19/2019 Stephen Staggs M.D., M.T.S. [redacted] Signature:

Contact Phone:615-373-1255 **Contact email: Stephen.Staggs@HCAhealthcare.com**

FCVS

FEDERATION CREDENTIALS VERIFICATION SERVICE





Medical Professional Information Profile

This report provides credentialing information for:

Name: **Thompson, Carolyn**

Social Security Number: [redacted]

Date of Birth: [redacted]

FID#: [redacted]

Recipient: **ME - Maine Board of Licensure in Medicine**

Delivery Date: **02/06/2019**

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

FCVS FEDERATION CREDENTIALS VERIFICATION SERVICE

Affidavit and Release

fsmb

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.

[redacted]

[redacted]

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

THOMPSON

Applicant's Printed Last Name

CAROLYN C.

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

1/11/19

Date of Signature (must correspond to date of notarization)

State of Tennessee, County of Davidson

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 11 day of January, 20 19.

Notary Public Signature: [redacted]

My Notary Commission Expires: MARCH 16 2020

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

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

FCVS ID Number
FCVS

FID Number
2124539923

212 453 923

FCVS FEDERATION CREDENTIALS VERIFICATION SERVICE

Identity

fsmb

Biographic Information

Medical professional Name(s): **Thompson, Carolyn**

Thompson, Carolyn Crump

Date of Birth: [redacted]

Place of Birth: [redacted]

Contact Information

Home Address: [redacted]

Mobile Phone:

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: THOMPSON (Last) CAROLYN (First) CRUMP (Middle)

FCVS ID Number: FCVS

Notary – Please complete the section below:

State of Tennessee County of DAVIDSON

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) 11, of (Month) January, (Year) 2019.

Notary Public Signature: [redacted]

Commission Expiration Date* (Month) MARCH / (Day) 16 / (Year) 2020

*** 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

JULIE ANN HULLETT
STATE OF TENNESSEE NOTARY PUBLIC
DAVIDSON COUNTY

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
212453823

[redacted]

FCVS FEDERATION CREDENTIALS VERIFICATION SERVICE

Chronology of Activities

fsmb

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
08/01/1989	06/04/1993	Medical Education	University of Tennessee Memphis College of Medicine Memphis Tennessee UNITED STATES
07/01/1993	06/30/1997	Postgraduate Training	University of Missouri-Kansas City School of Medicine Program Kansas City Missouri UNITED STATES

End of Chronology of Activities report for: Thompson, Carolyn

FCVS FEDERATION CREDENTIALS VERIFICATION SERVICE

Medical Education

Medical Education

Medical School: **University of Tennessee Memphis College of Medicine**

Location: Memphis, TN

UNITED STATES

Credentials Analysis Information for Medical Education

There is no Omission/Discrepancy/Miscellaneous information identified.

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: University of Tennessee Memphis College of Medicine

Address Line 1: 910 Madison Suite 105

Address Line 2:

City: Memphis **State/Province:** TN **Zip Code (Postal Code):** 38163

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: 90 credit hours of premedical education

Enrollment and Participation: Our records indicate that Thompson, Carolyn
(type/print individual's name: Last, First, Middle, Suffix)
attended our medical school for total of 152 weeks of medical education on the following dates: **From:** 08/17/1989 **To:** 06/04/1993
Month Day Year Month Day Year

This individual
Was awarded the degree of Doctor of Medicine on 06/04/1993
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: Thomas Davis

Signature: *Thomas Davis*

Title: Student Services Specialist III
Date of Signature: 01/11/2019 **Phone:** (901) 448-7703
Fax: (901) 448-7700 **Email:** tdavi104@uthsc.edu

212453823 2339 212453823

Unusual Circumstances

1. Do this individual's official records reflect (an) interruption(s) or extension(s) in his/her medical education? **No**

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

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:

Other:

Please Specify:

2. Do this individual's official records reflect that he/she was ever placed on academic or disciplinary probation during his/her medical education? **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

fsmb

Medical School

Medical Professional Name: Thompson, Carolyn

University of Tennessee Memphis College 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: Thompson, Carolyn

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

The Trustees
of
The University of Tennessee

on the recommendation of the Faculty have conferred on

Carolyn Crump Thompson

the degree of

Doctor of Medicine

with all the Rights Privileges and Honors thereunto appertaining.
In witness whereof this diploma is granted and the Seal of the
University and the signatures of the President of the University and the
Secretary of the Board of Trustees are hereunto affixed.

Given at Memphis in the State of Tennessee this fourth day of June
in the year of our Lord nineteen hundred and ninety three
and of the University the one hundred and ninety-ninth

Secretary of the Board of Trustees

President of the University of Tennessee

ELECTRONIC
SEAL
VERIFIED

FCVS FEDERATION CREDENTIALS VERIFICATION SERVICE

Postgraduate Training

Postgraduate Training

Accreditation ID: **2202821154**

Institution: **University of Missouri-Kansas City School of Medicine Program**

Location: Kansas City, MO
UNITED STATES

Credentials Analysis Information for Postgraduate Training

There is no Omission/Discrepancy/Miscellaneous information identified. ✓

fsmb

Federation Credentials Verification Service (FCVS)
400 Fuller Wiser Rd, Euless, TX 76039
Tel: (817) 868-5099 Fax: (817) 868-5099 Email: fcvsgme@fsmb.org

Verification of Postgraduate Medical Education

Institution: University of Missouri-Kansas City School of Medicine Program
Specialty: Obstetrics & Gynecology
Address: Kansas City, MO

Attention: **Program Director**
Affiliated University: Univ. of Missouri - Kansas City

Verification For:

Name: Carolyn Thompson
DOB: [redacted]
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
☒ Internship ☐ Residency ☐ Chief Residency ☐ Fellowship ☐ Research
Specialty/Subspecialty: OB-GYN
From: 07/01/93 **To:** 06/30/94
Successfully Completed?: ☒ Yes ☐ No ☐ In Progress
Accredited by: ☒ ACGME ☐ AOA ☐ LCGME ☐ RSC ☐ CFPC ☐ RCPSC ☐ APPAP ☐ None of these

PGY: 2-4
☐ Internship ☒ Residency ☐ Chief Residency ☐ Fellowship ☐ Research
Specialty/Subspecialty: OB-GYN
From: 07/01/94 **To:** 06/30/97
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:

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: Gary Sutkin, M.D. Signature: [redacted]
Title: Program Director Date of Signature: 1/11/19
Tel: 816 404-0886 Fax: _____ E-Mail: _____

FID: 212453823 ACGME ID: 2202821154 GME CODE: _____

FCVS FEDERATION CREDENTIALS VERIFICATION SERVICE

Applicant Reported Unusual Circumstances

fsmb

Graduate Medical Education

Medical Professional Name:	Thompson, Carolyn
Accreditation ID:	[redacted]
Institution:	University of Missouri-Kansas City School of Medicine Program
Specialty:	Obstetrics & Gynecology

Unusual Circumstances

Training Period: 7/1/1993 - 6/30/1997 **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: Thompson, Carolyn

University of Missouri-Kansas City
School of Medicine
Affiliated Hospitals

Carolyn Crump Thompson, M.D.

has satisfactorily completed the duties of

Resident in Obstetrics & Gynecology

for a period of 48 months ending the 30th day of June, 1997

Dean, School of Medicine

President, Board of Directors
Ayman Medical Center

Associate Dean, School of Medicine

Chief Executive Officer
Saint Luke's Hospital

Program Director

Licensure / Examinations

Exam: USMLE

Exam: NBME Part I

Exam: NBME Part II

Exam: NBME Part III

Credential Analysis Information for Licensure / Examinations

There is no Omission/Discrepancy/Miscellaneous information identified.

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: 02/06/2019

Federation Credentials Verification Service
ATTN: FCVS

FCVSID: [redacted]

Examinee: Thompson, Carolyn
Alt Name(s): Thompson, Carolyn Crump

Examinee ID: [redacted]
Date of Birth:

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 2

Clinical Knowledge (CK)

Test Date	Pass/Fail	Score	Minimum Pass	Comments
09/24/1992	Pass	201	(167)	

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.

NOTE: The National Board of Medical Examiners (NBME) records include prior Part history for this examinee. Details cannot be released by the NBME without written authorization from the examinee.

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

Examinee: Thompson, Carolyn

Examinee ID: [redacted]
Date of Birth:

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

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

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

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

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

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

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

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

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

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

03/2015

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

USMLE
United States Medical Licensing Examination®

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

This document was prepared by
National Board of Medical Examiners® (NBME®)
3750 Market Street, Philadelphia, PA 19104-3190 - Telephone (215) 590-9700

Recipient: To Whom It May Concern **Date:** 01/25/2019

Examinee: Thompson, Carolyn C **Examinee ID:** [redacted]
Date of Birth: [redacted]

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 2

Clinical Knowledge (CK)

Test Date	Pass/Fail	Score	Minimum Pass	Comments
09/24/1992	Pass	201	(167)	

End of Exam History

NOTE: NBME records include prior Part history for this examinee. The NBME Record of Scores is attached.

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

/212839/Rev 2018

Patent #7,635,079

[redacted]

ToughSafe®

SEE REVERSE SIDE FOR EXPLANATION OF INFORMATION REPORTED ABOVE.

Authenticity of USMLE Transcripts

An original, certified transcript of United States Medical Licensing Examination results is printed using black ink on blue safety paper and is produced only by the Educational Commission for Foreign Medical Graduates, Federation of State Medical Boards, or National Board of Medical Examiners. The TamperSafe® Hologram in the lower left corner certifies the authenticity of this document. Alteration or forgery of a USMLE transcript may result in appropriate legal action and/or a determination of irregular behavior, as described below.

To Test for Authenticity: Touch, rub or breathe on TouchSafe® Fingerprint and the word **VALID** will appear. When liquid bleach is applied to the face of the document, the paper will turn brown. Also, when photocopied, a security statement containing the words **UNOFFICIAL COPY, NOT AN ORIGINAL DOCUMENT**, will appear prominently across the face of the entire document.

INTERPRETATION OF RESULTS

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

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

STEP 2 CLINICAL SKILLS (CS)

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

ANNOTATIONS APPEARING UNDER "COMMENTS"

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

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

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

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

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

ANNOTATIONS APPEARING AS "NOTE"

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

PHYSICIAN DATA CENTER INFORMATION APPEARING AS "NOTE"

The Physician Data Center of the Federation of State Medical Boards (FSMB) contains actions reported to the FSMB by U.S. licensing and disciplinary boards, Canadian licensing authorities, the U.S. Armed Forces, the U.S. Department of Health and Human Services, and other credentialing entities. To be included in the Data Center, an action must be a matter of public record or be legally releasable to state medical boards or other entities with recognized authority to review physician credentials. Certain actions reported to and released by the Physician Data Center are not disciplinary or otherwise prejudicial in nature. Such actions are reported to ensure that records are complete and to assist in preventing misrepresentation or the use of lost or stolen credentials by unauthorized persons. Once reported to the FSMB, an action becomes part of the permanent record of the individual physician, and the existence of such an action may be indicated on the USMLE transcript by a Note. **2/2016**

NATIONAL BOARD OF MEDICAL EXAMINERS® (NBME®)

Record of Scores

This document was prepared by
National Board of Medical Examiners® (NBME®)
3750 Market Street, Philadelphia, PA 19104-3190 - Telephone (215) 590-9700

Recipient: To Whom It May Concern **Date:** 01/25/2019

Examinee: Thompson, Carolyn C **Examinee ID:** [redacted] **Date of Birth:** [redacted]

This record shows a complete Part history for this examinee.

NBME PART I

Test Date	Pass/Fail	Score Scale	Total Score	(Min. Pass)
06/11/1991	Pass	Three-Digit	192	(176)
		Two-Digit	79	(75)

NBME PART III

Test Date	Pass/Fail	Score Scale	Total Score	(Min. Pass)
03/02/1994	Pass	Three-Digit	405	(315)
		Two-Digit	78	(75)

NOTE: NBME records include USMLE Step history for this examinee. The USMLE transcript is attached.

/212839/Rev 2018

Patent #6,070,034

[redacted]

TouchSafe®

SEE REVERSE SIDE FOR EXPLANATION OF INFORMATION REPORTED ABOVE.

PDC PHYSICIAN DATA CENTER

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PRACTITIONER PROFILE

Prepared for: FCVS As of Date:2/6/2019

PRACTITIONER INFORMATION

Name:	Thompson, Carolyn
Alternate Name(s):	Thompson, Carolyn Crump
DOB:	[redacted]
Medical School:	University of Tennessee Memphis College of Medicine Memphis, Tennessee, UNITED STATES
Year of Grad:	1993
Degree Type:	MD
NPI:	1508853342

BOARD ACTIONS

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

LICENSE HISTORY

Jurisdiction	License Number	Issue Date	Expiration Date	Last Updated
KANSAS	94-04335	12/22/1995	06/30/1997	02/01/2019
MAINE		01/17/2019		02/05/2019
MAINE	EL191002	01/23/2019	05/03/2019	02/05/2019
TENNESSEE	0000029044	04/09/1997	07/31/2020	01/18/2019

PDC PHYSICIAN DATA CENTER

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PRACTITIONER PROFILE

Prepared for: FCVS As of Date:2/6/2019

Practitioner Name: Thompson, Carolyn

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	01/31/2019
Expired	Time Limited	12/31/2017	12/31/2018		Recertification	01/31/2019
Expired	Time Limited	12/31/2016	12/31/2017		Recertification	01/31/2019
Expired	Time Limited	12/31/2015	12/31/2016		Recertification	01/31/2019
Expired	Time Limited	12/31/2014	12/31/2015		Recertification	01/31/2019
Expired	Time Limited	12/31/2013	12/31/2014		Recertification	01/31/2019
Expired	Time Limited	12/15/2012	12/31/2013		Recertification	01/31/2019
Expired	Time Limited	12/31/2011	12/31/2012		Recertification	01/31/2019
Expired	Time Limited	12/31/2010	12/31/2011		Recertification	01/31/2019
Expired	Time Limited	12/31/2009	12/31/2010		Recertification	01/31/2019
Expired	Time Limited	11/12/1999	12/31/2009		Initial	01/31/2019

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AOA® CERTIFICATION HISTORY

No AOA Certifications found.