

VOID IF ALTERED OR ERASE

CERTIFICATE OF BIRTH

STATE OF INDIANA

Certificate of Birth

This Certifies that according to the records of the State of Indiana

Name JOHN WILLIAM STUTSMAN

Sex

Was born in

Child of

Birthplace of father

Birthplace of mother

Record was filed

Certificate Number 113-1965-069010



Issuing Authority:

Issued By: KMILLER

Issued Date: JULY 18, 2013

SEAL

VERIFIED

Roxanne Rogers, MD

State Form 35431 (R3/2-07)

2510578 28786

IT IS UNLAWFUL TO REPRODUCE THIS RECORD

WARNING:

ORIGINAL DOCUMENT HAS A MULTICOLORED BACKGROUND ON SPECIAL WHITE SECURITY PAPER AND THE GREAT SEAL OF THE STATE OF INDIANA ON BACK THAT TURNS FROM ORANGE TO YELLOW WHEN RUBBED. ORIGINAL DOCUMENT HAS HIDDEN VOID ON FRONT THAT APPEARS WHEN PHOTO COPIED.

STATE OF INDIANA

VOID IF ALTERED OR ERASED

FCVS

FEDERATION CREDENTIALS
VERIFICATION SERVICE

**Medical Professional
Information Profile**

Federation of
**STATE
MEDICAL
BOARDS**

Section IV

Medical Education

FCVSFEDERATION CREDENTIALS
VERIFICATION SERVICE**Verification of
Medical Education**Federation of
**STATE
MEDICAL
BOARDS**

Page 1

Instruction to the DeanPlease 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 76039The 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: Indiana University School of Medicine Indianapolis

Address Line 1: 635 Barnhill Drive

Address Line 2: MS164

City: Indianapolis

State/Province: IN

Zip Code (Postal Code): 46202-5120

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: Entrant met LCME requirements prior to admission.

Enrollment and Participation: Our records indicate that Stutsman, John William
(type/print individual's name: Last, First, Middle, Suffix)attended our medical school for total of 4 years of medical education on the following dates: From: 08/31/1987 To: 03/31/1991
Month Day Year Month Day YearThis individual Was awarded the degree of Doctor of Medicine on 03/31/1991
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.	Name: Deal Dennis Signature: <i>Dennis Deal</i> Title: Director Academic Records Date of Signature: 07/15/2013 Phone: (317) 274-7895 Fax: (317) 278-4755 Email: ksandric@iu.edu
--	---	--

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**ELECTRONIC
SEAL VERIFIED**

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

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FEDERATION CREDENTIALS
VERIFICATION SERVICE

Verification of Medical Education



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:

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FEDERATION CREDENTIALS
VERIFICATION SERVICE

**Applicant Reported
Unusual Circumstances**

Federation of
**STATE
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BOARDS**

Page 1 of 1

Medical School

Medical Professional Name: John William Stutsman
Indiana University School of Medicine Indianapolis

Unusual Circumstances

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

End of report for: John William Stutsman

**PROVIDED BY
APPLICANT**

Indiana University School of Medicine

635 Barnhill Drive
Indianapolis, Indiana 46202-5120

Academic Record

Name: John William Stetsman

Soc. Sec. Number: [REDACTED]

Date: 07/15/2013

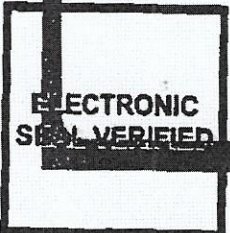
Graduated with Doctorate in Medicine - March 31, 1991

Academic Year	Center	Course/Credit	Title	Grade	Enrollment	% Distribution of Grades*					
						H	HP	P	F		
I Aug 31 87-May 6 88	BLOOMINGTON	C580/-	BIOCHEMISTRY	-	22	33	43	24			
		C583/6	MEDICAL BIOCHEMISTRY	HP	22	32	45	23			
		A530/-	GROSS ANATOMY	-	21	33	43	24			
		A531/8	GROSS ANATOMY	P	21	33	43	24			
		A560/4	HISTOLOGY	P	23	14	50	36			
		M533/5	NEUROBIOLOGY	HP	24	39	39	22			
		P531/-	PHYSIOLOGY	-	22	14	57	24	5		
		P532/8	PHYSIOLOGY	HP	22	14	59	23	5		
		M540/5	MICROBIOLOGY	HP	22	27	68	5			
		M506/1	BEHAVIORAL SCIENCE	P	23	48	39	13			
		M501/1	EMERGENCY MEDICINE	HP	23	65	35				
		II Aug 29 88-May 16 89	BLOOMINGTON	C601/6	GENERAL PATHOLOGY	HP	23	9	52	39	
				C602/6	SYSTEMIC PATHOLOGY	HP	22	18	36	45	
F603/-	PHARMACOLOGY			-	22	14	33	52			
F606/8	PHARMACOLOGY			HP	22	14	36	50			
M605/-	INTRODUCTION TO MEDICINE			-	22	23	36	41			
M606/10	INTRODUCTION TO MEDICINE			P	22	23	36	41			
M305/2	MEDICAL GENETICS			HP	22	45	45	9			
X603/1	BIOSTATISTICS			HP	28	36	50	14			
III Jun 21 89-May 25 90	INDIANAPOLIS			L704/2	ANESTHESIA CLERKSHIP	HP	246	20	39	42	
		G733/6	OBSTETRICS AND GYNECOLOGY	HP	248	14	50	36			
		K710/8	PEDIATRICS CLERKSHIP	P	243	18	37	44			
		L702/2	ORTHOPAEDIC SURG CLKSHIP	HP	246	15	57	27			
		M720/12	MEDICINE CLERKSHP	P	244	13	38	49			
		X700/4	NEUROSENSORY CLERKSHIP	P	249	14	54	31			
		NE30/1	CHILD/ADOL PSYCHIATRY	HP	245	7	38	56			
		H730/3	PSYCHIATRIC CLERKSHIP	P	246	10	55	35			
		S700/8	SURGERY CLERKSHIP	P	246	10	58	32			
		L700/2	UROLOGY CLERKSHIP	P	246	8	35	58			
		X702/1	CURRENT ISSUES IN MED	P	244	61	24	15			
		IV Jun 1 90-May 31 91		49CA744/4	SURGICAL PATH	H	11	36	55	9	
				93GO710/4	EXTRNSHP OB AND GYNECOLOG	HP	23	56	36	8	
	49MI754/4		ADULT CRITICAL CARE	HP	21		90	10			
	93GO990/4		SP ELEC OB/GYN	H	10	70	30				
	93GO990/4		SP ELEC OB/GYN	HP	10	70	30				
	49MD704/4		CLIN INFECTIOUS DISEASE	HP	12	42	42	17			
	93KI740/4		PEDIATRICS HEMA/ONCOLOGY	HP	3	33	33	33			
	49RA706/4		GEN RADIOLOGY	HP	10	70	30				
	93YX700/4		PRIMAMB CARE: FAMILY MED	HP	116	62	33	4			

* Percentage totals may not sum to 100 because of rounding Courses X600 (first year) and X802 and 93ZH820 (fourth year) are pass/fail

THE NAME OF THE UNIVERSITY APPEARS IN RED ACROSS THE FACE OF THIS PRINTED DOCUMENT

DOCUMENT GUIDE PRINTED ON BACK A BLACK & WHITE DOCUMENT IS NOT OFFICIAL



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INDIANA UNIVERSITY

SCHOOL OF MEDICINE

To all to whom these Presents may come, Greeting.

By vote of the Faculty and with the consent of the Board of Trustees, Indiana University hereby confers upon

John William Stutsman

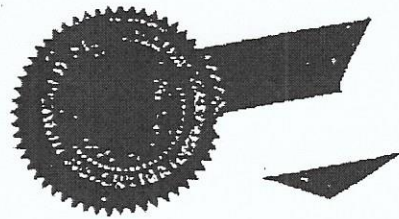
who has complied with all the requirements of the University and has successfully completed the studies prescribed for graduation in the School of Medicine the degree of

Doctor of Medicine,

with all the rights and privileges thereunto appertaining.

In Testimony Whereof, this Diploma is issued, sealed with the Seal of the University, signed by the President of the University, Vice President, and by the Dean of the School of Medicine, and attested by the Secretary of the Trustees.

Done at Indiana University - Purdue University at Indianapolis, Indiana, this thirty-first day of March 1991.



Walter J. Dealy
President

Thomas E. Smith
Vice President

J. Evan Carvick
Secretary of the Trustees

[Signature]
Dean

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FEDERATION CREDENTIALS
VERIFICATION SERVICE

**Medical Professional
Information Profile**

Federation of
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Section V

Graduate Medical Education

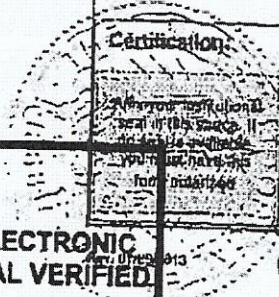


Federation Credentialing Verification Service (FCVS)

400 Palter Wicks Road, Suite 300, Dallas, TX 76239
Tel: (817) 868-6000 Fax: (817) 878-5009

Verification of Graduate Medical Education

Institution: <u>University of California/University Medical Center</u>		Attention: <u>Program Director</u>		
Specialty: <u>Transitional</u>		Allotted University: _____		
Address: <u>Fresno, CA</u>				
Verification For:	Name: <u>Stidman, John William</u> DOB: _____ Individual's Name on Record (if different from above): _____			
Program Participation: Report incomplete Training Levels (years) separate from those that were successfully completed. If the training level (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.	Training Level: <u>1</u> (e.g., 1, 2, 3, etc.) <input checked="" type="checkbox"/> Internship <input type="checkbox"/> Residency <input type="checkbox"/> Chief Residency <input type="checkbox"/> Fellowship <input type="checkbox"/> Research	Specialty/Subspecialty: <u>Transitional Internship</u> From: <u>6/24/1991</u> To: <u>6/24/1992</u> Successfully Completed?: <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> In Progress Accredited by: <input checked="" type="checkbox"/> ACGME <input type="checkbox"/> AOA <input type="checkbox"/> LCGME <input type="checkbox"/> RSC <input type="checkbox"/> CFPC <input type="checkbox"/> RCPSC <input type="checkbox"/> APPAP <input type="checkbox"/> None of these		
	Training Level: _____ (e.g., 1, 2, 3, etc.) <input type="checkbox"/> Internship <input type="checkbox"/> Residency <input type="checkbox"/> Chief Residency <input type="checkbox"/> Fellowship <input type="checkbox"/> Research	Specialty/Subspecialty: _____ From: <u>1/1</u> To: <u>1/1</u> Successfully Completed?: <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> In Progress Accredited by: <input type="checkbox"/> ACGME <input type="checkbox"/> AOA <input type="checkbox"/> LCGME <input type="checkbox"/> RSC <input type="checkbox"/> CFPC <input type="checkbox"/> RCPSC <input type="checkbox"/> APPAP <input type="checkbox"/> None of these		
	Training Level: _____ (e.g., 1, 2, 3, etc.) <input type="checkbox"/> Internship <input type="checkbox"/> Residency <input type="checkbox"/> Chief Residency <input type="checkbox"/> Fellowship <input type="checkbox"/> Research	Specialty/Subspecialty: _____ From: <u>1/1</u> To: <u>1/1</u> Successfully Completed?: <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> In Progress Accredited by: <input type="checkbox"/> ACGME <input type="checkbox"/> AOA <input type="checkbox"/> LCGME <input type="checkbox"/> RSC <input type="checkbox"/> CFPC <input type="checkbox"/> RCPSC <input type="checkbox"/> APPAP <input type="checkbox"/> None of these		
Unusual Circumstances: Check the correct response. Omit responses require written explanation. If necessary, you may continue your explanation on a separate sheet of paper.	1. Did this individual ever take a leave of absence or break from his/her training? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No 2. Was this individual ever placed on probation? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No 3. Was this individual ever disciplined or placed under investigation? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No 4. Were any negative reports for behavioral reasons ever filed by instructors? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No 5. Were any limitations or special requirements placed upon this individual because of questions of academic incompetence, disciplinary problems or any other reason? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No Please explain any "Yes" response from above: _____ _____			
Certification: 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: <u>Jim Comes</u> Title of Signatory: <u>Program Director</u> Signature: _____ Date of Signature: <u>7/31/13</u> Tel: _____ Fax: _____ E-Mail: _____			



FCVS ID: 287816 FID: 209220003 CODE: 113506

Rotation Schedule for John Stutsman

Transitional year resident 6/24/1991 – 6/21/1992

6/24/1991	7/21/1991	Trauma Surgery
7/22/1991	8/18/1991	Elective Surgery
8/19/1991	9/15/1991	Emergency Medicine
9/16/1991	10/13/1991	Medicine (Wards)
10/14/1991	11/10/1991	OB/GYN
11/11/1991	12/08/1991	Burns/Plastics
12/9/1991	1/5/1992	Medicine Clinics
1/6/1992	2/2/1992	OB/GYN
2/3/1992	3/1/1992	NICU
3/2/1992	3/29/1992	Trauma Surgery
3/30/1992	4/26/1992	OB/GYN
4/27/1992	5/24/1992	MICU
5/25/1992	6/21/1992	Elective Anesthesiology

Graduate Medical Education

Medical Professional Name: John William Stutsman
University of California/University Medical Center
Transitional

Unusual Circumstances

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

End of report for: John William Stutsman

**PROVIDED BY
APPLICANT**

UNIVERSITY OF CALIFORNIA
SCHOOL OF MEDICINE

SAN FRANCISCO

Fresno-Central San Joaquin Valley Medical Education Program

THIS CERTIFIES THAT

John William Stutzman, M.D.

HAS SERVED AS

*Transitional Resident
June 24, 1991 ~ June 21, 1992*



Robert M. Haligman, D.
PROGRAM CHAIRMAN

David D. Coltrane, M.D.
ASSOCIATE DEAN, FRESNO

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113506

Verification of Graduate Medical Education

Institution: Phoenix Hospitals/Maricopa Medical Center
Specialty: Obstetrics and Gynecology
Address: Phoenix, AZ
Attention: Program Director
Affiliated University: U. of Arizona

Verification For: Name: Stutsman, John William
DOB: [REDACTED]
Individual's Name on Record (if different from above): _____

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JUL 29 2013

Program Participation: Important: Report Incomplete Training Levels (years) separate from those that were successfully completed.

Training Level: 1 (e.g., 1, 2, 3, etc.)
 Internship
 Residency
 Chief Residency
 Fellowship
 Research

Specialty/Subspecialty: Obstetrics/Gynecology
From: 6/23/94 To: 6/30/95
Successfully Completed?: Yes No In Progress
Accredited by: ACGME AOA LCGME RSC CFPC
 RCPC APPAP None of these

Training Level: 2 thru 4 (e.g., 1, 2, 3, etc.)
 Internship
 Residency
 Chief Residency
 Fellowship
 Research

Specialty/Subspecialty: Obstetrics/Gynecology
From: 7/1/95 To: 6/30/98
Successfully Completed?: Yes No In Progress
Accredited by: ACGME AOA LCGME RSC CFPC
 RCPC APPAP None of these

Training Level: _____ (e.g., 1, 2, 3, etc.)
 Internship
 Residency
 Chief Residency
 Fellowship
 Research

Specialty/Subspecialty: _____
From: 1/1 To: 1/1
Successfully Completed?: Yes No In Progress
Accredited by: ACGME AOA LCGME RSC CFPC
 RCPC APPAP None of these

Unusual Circumstances: Check the correct response. Omitted responses require written explanation.

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: 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: Michael Brady, MD Signature: [Signature]
Title of Signatory: Program Director Date of Signature: 8/23/13
(e.g., Program Director)
Tel: 602 344 5366 Fax: 602 344 1185 E-Mail: _____

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

SEAL
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VERIFICATION SERVICE**Applicant Reported
Unusual Circumstances**Federation of
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Page 1 of 1

Graduate Medical Education

Medical Professional Name: John William Stutsman
Phoenix Hospitals/Maricopa Medical Center
Obstetrics and Gynecology

Unusual Circumstances

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

End of report for: John William Stutsman

**PROVIDED BY
APPLICANT**

Phoenix Integrated Residency In Obstetrics and Gynecology at
Maricopa Medical Center and St. Joseph's Hospital and Medical Center

Phoenix, Arizona



Be it known that

John William Stutsman, M.D.

has successfully completed 48 months of
Graduate Medical Education in an

Obstetrics and Gynecology Residency

from June 23, 1994 to June 30, 1998

in Testimony Whereof the undersigned have hereto affixed their signatures this
30th day of June, 19 98

John D. Fishburne, Jr.
Program Director

Beverly D. Rowley
Director, Medical Education
Maricopa Medical Center

Fred S. Lane
President, Maricopa Medical Center

John J. Brown
Associate Program Director

Charles P. Washburn
Director, Medical Education
St. Joseph's Hospital and Medical Center

Mary G. Gorbunoff
President, Mercy Healthcare Arizona

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FEDERATION CREDENTIALS
VERIFICATION SERVICE

**Medical Professional
Information Profile**

Federation of
**STATE
MEDICAL
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Section VI

Licensure Examination History

(State Licensing Authorities Only)

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



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) 590-9709

Recipient: To Whom It May Concern

Date: 11/04/2013

Examinee: Shulman, John W

Examinee ID: 3-400-485-3
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)	Individual Subject Scores						
					Anat	Phys	Bioc	Path	Micr	Phar	Beh Sci
06/13/1989	Pass	Three-Digit	485	(380)	430	480	415	625	455	610	425
		Two-Digit	81	(75)	77	80	76	89	79	88	77

NBME PART II

Test Date	Pass/Fail	Score Scale	Total Score	(Min. Pass)	Individual Subject Scores					
					Med	Surg	ObGyn	Prev	Peds	Psych
09/25/1990	Pass	Three-Digit	515	(290)	540	580	650	415	485	390
		Two-Digit	82	(75)	83	85	88	78	81	77

NBME PART III

Test Date	Pass/Fail	Score Scale	Total Score	(Min. Pass)
03/04/1992	Pass	Three-Digit	565	(315)
		Two-Digit	84	(75)

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70461
Patent 5636674

SEE REVERSE SIDE FOR EXPLANATION OF INFORMATION REPORTED ABOVE.

