AC#

COPY

STATE OF FLORIDA
DEPARTMENT OF HEALTH
DIVISION OF MEDICAL QUALITY ASSURANCE

DATE	LICENSE NO.	CONTROL NO.
05/02/2020	**ME 145339**	**713068**

THE MEDICAL DOCTOR

QUALIFICATION(S):
Dispensing Practitioner

NAMED BELOW HAS MET ALL REQUIREMENTS OF
THE LAWS AND RULES OF THE STATE OF FLORIDA.

Expiration Date: **JANUARY 31, 2022**
ROBYN SCHICKLER
236 EAST BEARSS AVENUE
TAMPA, FL - 33613

AC#
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DEPARTMENT OF HEALTH
DIVISION OF MEDICAL QUALITY ASSURANCE

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ROBYN SCHICKLER

COPY - NOT A VALID LICENSE - COPY

LICENSEE SIGNATURE

COPY - NOT A VALID LICENSE - COPY

GOVERNOR

State Surgeon General

DISPLAY IF REQUIRED BY LAW

EXPIRATION DATE: **JANUARY 31, 2022**

Your license number is ME 145339. Please use it in all correspondence with your board/council. Each licensee is solely responsible for notifying the Department in writing of the licensee's current mailing address and practice location address. If you have not received your renewal notice 90 days prior to the expiration date shown on this license, please visit www.FLHealthSource.gov and click "Renew A License" to renew online.

The Medical Quality Assurance Online Services Portal gives you the ability to manage your license to perform address updates, name changes, request duplicate licenses and much more.

It's simple. Log onto your MQA Online Services account today at http://flhealthsource.gov/. Select the "Account Login" button to access your account. For changes to your name, address or to request duplicate licenses, choose your selection from the dropdown list under "Manage My License". Your profession will open for renewal 90 days prior to your expiration date. When the renewal cycle opens for your profession, the "Renew My License" header will automatically display on your license Dashboard.

IMPORTANT ANNOUNCEMENTS

ARE YOU RENEWAL READY?

The Department of Health will now review your continuing education records at the time of license renewal.

To learn more, please visit
www.FLHealthSource.gov/AYRR

GROUNDS FOR DISCIPLINE

You should be familiar with the Grounds for Discipline found in Section 456.072(1), Florida Statutes, and in the practice act for the profession in which you are licensed. Florida Statutes can be accessed at www.leg.state.fl.us/Statutes

DEPARTMENT OF HEALTH
DIVISION OF MEDICAL QUALITY ASSURANCE
LICENSURE SUPPORT SERVICES UNIT
4052 BALD CYPRESS WAY, BIN #C-10
TALLAHASSEE, FLORIDA 32399-3260

MAILED FROM ZIP CODE 32301
May 05
2020

PRSRT. FIRST-CLASS
U.S. POSTAGE
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TALLAHASSEE, FL-32301
PERMIT NO. 552

********** AUTO **********

ROBYN SCHICKLER
PO BOX 1984
CLEVELAND, OH - 44106-0184

8_2_00001935

2.0.1.4

Application

Application Detail

License Type:	**Medical Doctor**
Profession Number:	**1501 - Medical Doctor**
File Number:	**147983**
Application:	**Medical Doctor by Exam Application**
Application Date:	**03/15/2020**

Suitability Question(s)

Have you passed all parts of a United States national examination (NBME, FLEX, or USMLE)? OR Are you licensed on the basis of a state board examination and currently hold a license in at least one other jurisdiction of the United States or Canada, have practiced pursuant to such licensure for a period of at least 10 years, and have received a passing score on the Special Purpose Examination of the Federation of State Medical Boards of the United States (SPEX)? OR Were you licensed prior to 1974 on the basis of a state board examination, are currently licensed in at least three other jurisdictions of the United States or Canada, and have practiced pursuant to such licensure for a period of at least 20 years	**Yes**

Application Questions

Military Veteran Fee Waiver - I have been honorably discharged from a branch of the United States Armed Forces within the previous 60 months.	**No**
I am selecting NICA Non-Participating - (I understand that a $250.00 fee will be included if I select this option.)	**Yes**

I will qualify for "In Training" status at the approval of my licensure application.	**No**
I plan to dispense medicinal drugs in the State of Florida for a fee or other remuneration and hereby register as required by Section 465.0276,F.S. I understand that the fee for the Dispensing Practitioner is $100.00 over and above the required initial license fee and will submit it along with the license fee.	**Yes**
Military Veteran Spouse Fee Waiver - I am the spouse of a military veteran who has been honorably discharged from a branch of the United States Armed Forces within the previous 60 months.	**No**

Personal Detail

Title:	**Dr**
First Name:	**Robyn**
Last Name/Surname:	**Schickler**
Birthdate:	**08/20/1987**
Gender:	**Female**
Race:	**White**
Social Security Number:	[redacted]

Addresses

Mailing Address

Address:	**PO Box 1984** **Out of State** **CLEVELAND, OH** **44106** **US**
E-mail Address:	**rschickler94@gmail.com**

Place of Practice

Address:	**3330 West Kennedy Blvd** **HILLSBOROUGH** **TAMPA, FL** **33609**

License Attributes Selected	
Qualification	**Dispensing Practitioner**

Federal Credentials Verification Services (FCVS)	
Are you using the FCVS to verify your core credentials?	**Yes**

Education History	
School Name:	**UNIVERSITY OF SOUTH FLORIDA**
Street Address Line 1:	**12901 Bruce B Downs Blvd,**
Street Address Line 2:	**N/A**
City:	**Tampa**
State:	**FLORIDA**
Postal/Zip:	**33612**
Country:	**UNITED STATES OF AMERICA**
Date of Graduation (mm/dd/yyyy):	**05/10/2013**
Attended From (mm/dd/yyyy):	**07/01/2009**
Attended To (mm/dd/yyyy):	**05/10/2013**

Additional Education Questions	
Are you currently in default on any health education loan or scholarship obligation?	**No**
Have you completed the equivalent of 2 academic years of preprofessional, postsecondary education including, courses in anatomy, biology, and chemistry prior to entering medical school?	**Yes**

Fifth Pathway	
Did you attend an international medical school and do not possess a valid ECFMG Certificate?	**No**
Did you receive a bachelor's degree from an accredited United States college or University?	**No**
Did you study at a medical school which is recognized by the World Health Organization?	**No**

Did you complete all of the formal requirement of the International medical school, except the internship or social service requirements, and pass part I of the National board of Medical examination or the Education Commission for Foreign Medical Graduates Examination equivalent?	**No**
Did you complete an academic year of supervised clinical training in a hospital affiliated with a medical school approved by the Council on Medical Education of the American Medical Association and upon completion passed part II of the National Board of Medical Examiners examination or the Education Commission for Foreign Medical Graduates examination Equivalent?	**No**

Postgraduate Training 1

Program Name:	**University of South Florida**
Mailing Address:	**2 Tampa General Circle 6th floor Tampa, FL 33606**
Program City:	**Tampa**
Program State or Country:	**FLORIDA**
Program Type:	**RESIDENCY**
Specialty Area:	**OBG - OBSTETRICS AND GYNECOLOGY**
Attended From (mm/dd/yyyy):	**07/01/2013**
Attended To (mm/dd/yyyy):	**06/30/2017**
Did you receive credit?	**Yes**

Postgraduate Training 2

Program Name:	**University of Southern California**
Mailing Address:	**2020 Zonal Avenue IRD Room 220**
Program City:	**Los Angeles**
Program State or Country:	**CALIFORNIA**
Program Type:	**FELLOWSHIP**
Specialty Area:	**OTHER**
Attended From (mm/dd/yyyy):	**07/01/2017**
Attended To (mm/dd/yyyy):	**06/30/2019**
Did you receive credit?	**Yes**

Exam History

Examination:	**USMLE/US/CANADA**

Date Passed (mm/dd/yyyy):	**11/18/2013**

United States Military and/or Public Health

Have you ever been in the United States Military and/or Public Health Service?	**No**
Have you ever been disciplined by any branch of the United States Armed Services or Public Health Service?	**No**

Practice Employment 1

Place of Employment:	**Planned Parenthood of Greater Ohio**
Address Line 1:	**25350 Rockside Road**
Address Line 2:	**N/A**
City:	**Bedford Heights**
State:	**OH**
Begin Date (mm/dd/yyyy):	**08/05/2019**
End Date (mm/dd/yyyy):	**03/15/2020**

If 'to present', enter today's date.

Practice Employment 2

Place of Employment:	**LA County Hospital-University of Southern California**
Address Line 1:	**2020 Zonal Ave**
Address Line 2:	**IRD room 220**
City:	**Los Angeles**
State:	**CA**
Begin Date (mm/dd/yyyy):	**07/01/2017**
End Date (mm/dd/yyyy):	**06/30/2019**

If 'to present', enter today's date.

Practice Employment 3

Place of Employment:	**University of South Florida**
Address Line 1:	**2 Tampa General Circle**
Address Line 2:	**6th floor**
City:	**Tampa**
State:	**FL**
Begin Date (mm/dd/yyyy):	**07/01/2013**
End Date (mm/dd/yyyy):	**06/30/2017**

If 'to present', enter today's date.

Other State License

Do you now hold or have you ever held a license to practice medicine or any other profession in any US State or territory? **Yes**

Request verification of licensure status directly from the licensing entity or www.veridoc.org. Request international license verification(s) if you have practiced outside of the U.S. for at least two of the previous four years.

License Number: **35.134996**

Type: **Doctor of Medicine**

Jurisdiction - Country: **UNITED STATES**

Jurisdiction - State: **Ohio**

Additional Employment Questions

Have you practiced medicine in any jurisdiction for two of the last four years or completed a board approved post-graduate training program within the last two years? **Yes**

Graduate Education

Do you currently, or have you had, responsibility for graduate medical education within the last 10 years? **Yes**

Initial Graduate Medical Education Responsibility and Faculty Appointments

List all institutions where you have had responsibility for graduate medical education or faculty appointment(s) at any medical school.

Name of Institution: **UNIVERSITY OF SOUTHERN CALIFORNIA SCHOOL**

Staff Privileges

Do you currently hold staff privileges in any hospital, health institution, clinic or medical facility? **Yes**

The facilities listed are Florida facilities. If your privileges are for a facility in another state, select "Out of State".

Name of Facility: **OUT OF STATE**

Out of State Facility: **Planned Parenthood of Greater Ohio**

Specialty Board Certifications

Are you certified by any specialty board recognized by the American Board of Medical Specialties or specialty board approved by the Florida Board of Medicine? **Yes**

Specialty Brd: **AMERICAN BOARD OF OBSTETRICS & GYNECOLOG**

Specialty Cert: **OBG - OBSTETRICS AND GYNECOLOGY**

Date Certified: **01/21/2020**

DEA

Have you ever been denied, or surrendered, a DEA registration?	**No**

Criminal History

Have you ever been convicted of, or entered a plea of guilty, nolo contendere, or no contest to, a crime in any jurisdiction other than a minor traffic offense?	**No**

You must include all misdemeanors and felonies, even if adjudication was withheld. Driving under the influence (DUI) or driving while impaired (DWI) are not minor traffic offenses for purposes of this question.

Medicaid / Medicare

1. Have you been convicted of, or entered a plea of guilty or nolo contendere to, regardless of adjudication, a felony under Chapter 409, F.S. (relating to social and economic assistance), Chapter 817, F.S. (relating to fraudulent practices), Chapter 893, F.S. (relating to drug abuse prevention and control) or a similar felony offense(s) in another state or jurisdiction?	**No**
2. Have you been convicted of, or entered a plea of guilty or nolo contendere to, regardless of adjudication, a felony under 21 U.S.C. ss. 801-970 (relating to controlled substances) or 42 U.S.C. ss. 1395-1396 (relating to public health, welfare, Medicare and Medicaid issues)?	**No**
3. Have you ever been terminated for cause from the Florida Medicaid Program pursuant to Section 409.913, F.S.?	**No**
4. Have you ever been terminated for cause, pursuant to the appeals procedures established by the state, from any other state Medicaid program?	**No**
5. Are you currently listed on the United States Department of Health and Human Services Office of Inspector General's List of Excluded Individuals and Entities?	**No**

Health History

In the last five years, have you been enrolled in, required to enter into, or participated in any drug and/or alcohol recovery program or impaired practitioner program for treatment of drug or alcohol abuse that occurred within the past five years?	■
In the last five years, have you been admitted or referred to a hospital, facility or impaired practitioner program for treatment of a diagnosed mental disorder or impairment?	■

During the last five years, have you been treated for or had a recurrence of a diagnosed mental disorder that has impaired your ability to practice medicine within the past five years?	■
During the last five years, have you been treated for or had a recurrence of a diagnosed physical disorder that has impaired your ability to practice medicine?	■
In the last five years, were you admitted or directed into a program for the treatment of a diagnosed substance-related (alcohol/drug) disorder or, if you were previously in such a program, did you suffer a relapse within the last five years?	■
During the last five years, have you been treated for or had a recurrence of a diagnosed substance-related (alcohol/drug) disorder that impaired your ability to practice medicine within the last five years?	■

Electronic Fingerprinting

I have been provided and read the statement from the Florida Department of Law Enforcement regarding the sharing, retention, privacy and right to challenge incorrect criminal history records and the 'Privacy Statement' document from the Federal Bureau of Investigation.	**Yes**
Enter in today's date	**03/15/2020**

Medical Malpractice Question

Have you ever had a judgment entered against you for medical malpractice where the incident(s) of malpractice occurred after November 2, 2004?	**No**

Liability Claims

Within the last 10 years have you had any liability claim(s) or action(s) for damages for personal injury settled or finally adjudicated in an amount that exceeds $100,000.00?	**No**

Financial Responsibility/Exemption

Financial Responsibility	**4. LIABILITY NOT LESS THAN $250,000**

FDA Licensing

Have you ever had any professional license or license to practice medicine revoked, suspended, placed on probation, or other disciplinary action taken in any state, territory or country?	**No**

FDA Institution

Have you ever had any staff privileges denied, suspended, revoked, modified, restricted, not renewed or placed on probation, or have you been asked to resign or take a temporary leave of absence or were otherwise acted against by any facility?	**No**

FDANP Denied

Have you had any application for a medical license or professional license denied by any state board or other governmental agency of any state, territory, or country?	**No**

FDANP Investigation

Are you currently under investigation in any jurisdiction for an act or offense that would constitute a violation of Section 458.331, Florida Statutes?	**No**

Specialty Board Discipline History

Have you ever had any final disciplinary action taken against you by a specialty board or other similar national organization?	**No**

Year Began Practice

Year Began Practice: **07/01/2013**

Availability for Disaster

Are you willing to provide health care services in special need shelters or to work with disaster medical teams during times of emergency or major disasters?	**Yes**

Attachments

Document Type: Miscellaneous Documents File Name: NPDB Self Query.pdf

Document Type: Education Documents File Name: Medicine degree.pdf

Document Type: Education Documents File Name: Residency completion.pdf

Fees

Application Fee	**$350.00**
Unlicensed Activity	**$5.00**
Dispensing Fee	**$100.00**
Initial License	**$350.00**
NICA Fee	**$250.00**
Total Amount Due:	**$1055.00**

Attestation

I state that these statements are true and correct. I recognize that providing false information may result in denial of licensure, disciplinary action against my license, or criminal penalties pursuant to Sections 456.067, 775.083, and 775.084, Florida Statutes. I state that I have read Chapters 456, 458 and 766.301-.316, Florida Statutes and Chapter 64B8, Florida Administrative Code.

I hereby authorize all hospitals, institutions or organizations, my references, personal physicians, employers (past and present), and all governmental agencies and instrumentalities (local, state, federal, or foreign) to release to the Florida Board of Medicine information which is material to my application for licensure.

I have carefully read the questions in the foregoing application and have answered them completely, without reservations of any kind. I state 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 constitutes cause for denial, suspension, or revocation of my license to practice Medicine in the State of Florida. If there are any changes to my status or any change that would affect any of my answers to this application I must notify the board within 30 days.

I understand that my records are protected under federal and state regulations governing Confidentiality of Mental Health Patient Records and cannot be disclosed without my written consent unless otherwise provided in the regulations. I understand that my records are protected under federal and state regulations governing Confidentiality of Alcohol and Drug Abuse Patient Records, 42CFR Part 2, and cannot be disclosed without my written consent unless otherwise provided in the regulations. I also understand that I may revoke this consent at any time except to the extent that action has been taken in reliance upon it.

Attestation Answer: Yes

Application

Application Detail

License Type:	**1501 - Medical Doctor**
Profession Number:	**1501 - Medical Doctor**
File Number:	**147983**
Application:	**Request Address Change**
Application Date:	**04/11/2020**

Personal Detail

Title:	**Dr**
First Name:	**Robyn**
Last Name/Surname:	**Schickler**
Birthdate:	**08/20/1987**
Gender:	**Female**

Addresses

Mailing Address

Address:	**PO Box 1984** **Out of State** **CLEVELAND, OH** **44106** **US**
E-mail Address:	**rschickler94@gmail.com**

Place of Practice

Address:	**236 East Bearss Avenue** **HILLSBOROUGH** **TAMPA, FL** **33613** **US**

Attestation

I affirm that the provided address information is correct.

Attestation Answer: Yes

University of South Florida

has conferred on

Robyn Schickler

the degree of

Doctor of Medicine

together with all the rights, privileges and honors appertaining thereto in consideration of the satisfactory completion of the course prescribed by the Faculty of the

Morsani College of Medicine

In Witness Thereof the undersigned have affixed their names and the seal of the University at Tampa, Florida, this tenth day of May, 2013.

University of South Florida
Morsani College of Medicine
Affiliated Hospitals

This is to certify that

ROBYN LYNN SCHICKLER, MD

has served honorably and with proficiency as

Resident in Obstetrics & Gynecology

from July 1, 2013 *to* June 30, 2017

James M. Ruhnke, MD MS
Program Director

Charles Pailet MD, MBA
Vice Dean, Clinical Affairs
and Graduate Medical Education

UNIVERSITY of SOUTH FLORIDA

Charles Lockwood
Senior Vice President, USF Health
Dean, Morsani College of Medicine

Johanne Morhouse
Chairman

Keck School of
Medicine of USC

DEPARTMENT OF OBSTETRICS AND GYNECOLOGY

April 7, 2020

RE: Robyn Schickler, MD

This letter is to verify that Robyn Schickler, MD, successfully completed a two-year Family Planning fellowship program with the Department of Obstetrics and Gynecology at the Los Angeles County + University of Southern California Medical Center, from July 1, 2017 to June 30, 2019. Dr. Schickler completed her fellowship training in good standing.

If you have any questions or need additional information, please contact me at iodonnel@usc.edu and/or 323-409-3416.

Sincerely,

Ian O'Donnell

Ian O'Donnell
Fellowship Program Coordinator
LAC+USC Medical Center
Keck School of Medicine

University of Southern California
2020 Zonal Ave. IRD 220 Los Angeles, California 90033 • Tel: 323 409 3416 • Fax: 323 226 3509

May 1, 2020

Robyn Schickler, M.D.
Po Box 1984
Cleveland, OH 44106

Dear Dr. Schickler:

Congratulations! You have completed the application process for licensure as a Medical Doctor in the State of Florida. Your license number is ME 145339. You will receive your printed license within two weeks. Within 24 hours, you can verify your license online at www.FLHealthSource.gov.

The current license biennium expires 01/31/2022. It is your obligation to complete any continuing education (CE) that is required. You must have completed the required CEs prior to renewing your license. Visit www.FLHealthSource.gov/AYRR and become familiar with the renewal process. Your CE requirements can be found at www.FLHealthSource.gov/requirements.

Licenses are renewed on a biennial basis. Approximately 90 days prior to the expiration date shown on your license, a postcard reminder will be mailed to the last known address on file for you. The U.S. Post Office does NOT forward state mail. Address changes may be submitted electronically through your MQA Online Services Portal account. If you have not registered for an account in the new system, go to www.FLHealthSource.gov/mqa-services and select "No" to get started. If you are a returning user, select "Yes" and enter the user ID and password you selected during the registration process under Returning User.

Practitioner Profile – Section 456.041, Florida Statutes, requires specific information be complied and published online about you. In carrying out this legislative mandate to publish practitioner profiles, we want to ensure the information that we publish is accurate. You should receive your license within two weeks. You can review your practitioner profile by accessing your MQA Online Services Account at http://www.flhealthsource.gov/. Please select "Account Login" from the top of the page. In order to use the online services portal, you will need to complete a one-time registration process if you have not done so already. Once you have gained entry onto your account, please select "Review, Update & Confirm Profile" under "Manage My License". You are **required to review** and confirm or make changes to the information that will be published in your practitioner profile. If you see the statement "The practitioner did not provide this mandatory information," you are **required to provide** the missing information. We cannot accept curriculum vitae or resumes in place of your providing specific information. Changes, excluding education and training, year began practicing, and liability claims, can be made to your profile electronically. You may also submit changes by mail to the Department of Health, Licensure Support Services, 4052 Bald Cypress Way Bin #C10, Tallahassee, Florida 32399-3260. If you have questions, please call (850) 488-0595, option 3, Monday through Friday, 8:00 a.m. to 6:00 p.m., EST. You may also email us at MQAOnlineService@flhealth.gov.

According to section 456.041(8), Florida Statutes, you have thirty (30) days from receipt of this letter to submit changes to the department. If you do not make changes within thirty (30) days, your profile will be automatically published.

Thank you for applying for licensure in Florida. If you have additional questions, you may contact the board office at (850) 245-4131 or at the address listed below

Welcome to Florida,

Board of Medicine Staff

March 19, 2020

Robyn Schickler , M.D.
Po Box 1984
Cleveland, OH 44106

Dear Dr. Schickler:
File: 147983

Thank you for considering Florida for physician licensure. Your application for medical licensure has been received. The application is incomplete for the reasons set out in the attached deficiency notice. Please address these deficiencies as soon as possible to avoid delay in processing your application.

Information received by this office may require additional explanation or documentation to determine licensure eligibility. After all requested documentation is received, your application will be submitted for supervisory review. We will notify you if additional information is required.

Applicants with a history of malpractice, criminal activity, discipline, physical or mental impairment, unfavorable evaluations, or other matters that need explanation may require a personal appearance before the Board of Medicine Credentials Committee for determination of licensure eligibility. If your appearance is required, you will be notified in writing once your application is complete.

You can now follow the progress of your application through our website at: www.FLHealthSource.gov/mqa-services. If you are a returning user, select “Yes” and enter the user ID and password you selected during the registration process under Returning User. If you did not apply for licensure through this screen, select “No” and follow the prompts to create an account. You must have a valid email address to create your account.

Once you are logged in, you will be prompted to add your application to your account. Once you have successfully added your application, you will be directed to your dashboard. Under the “Additional Activities” section, select “Check Application Status” to review any open deficiencies, upload documents or print out instructional documents.

THIS IS IMPORTANT: Your application will remain incomplete until all deficiencies are completed. In addition, you are required to notify the Board office immediately in writing of any occurrence(s) that would in any way change or affect any answer given in the application or an answer provided in response to any of our direct questions to you.

If you have any questions, please contact me at Curtis.Turner@flhealth.gov, call 850-617-1919, or fax 850-412-1298.

Sincerely,

Curtis Turner

Curtis Turner
Regulatory Specialist II

Enclosure(s)

Dr Robyn Schickler **Date: March 19, 2020**

REMINDER: Chapter 456.013(1)(a), Florida Statutes, provides that an incomplete application shall expire one year after initial filing with the department.

YOUR APPLICATION'S EXPIRATION DATE IS MARCH 14, 2021

APPLICATION SUBMITTED REMAINS DEFICIENT FOR LACK OF THE FOLLOWING:

1. Pursuant to F.S. 458.311., Any person desiring to be licensed as a physician, who does not hold a valid license in any state, shall apply by examination. According to your application, you hold an unrestricted license in Ohio. Please clairify.

2. Direct verification of your Medical License from the state of Ohio has not been received.

3. Direct verification of your medical school has not been received.

4. Direct verification of your postgraduate training has not been received.

5. Direct verification of your USMLE examination results has not been received.

6. Your FCVS Profile has not been received. Please contact FCVS to check the status of your profile.

If you have any questions, please contact me at Curtis.Turner@flhealth.gov, call 850-617-1919, or fax 850-617-1919. The Florida Board of Medicine has assigned **147983** as your **tracking number**. Please indicate this number if you leave a message, and try to ensure that other sources include it on their communications to us as well.

Application

Application Detail

License Type:	**Medical Doctor**
Profession Number:	**1501 - Medical Doctor**
License Number:	**145339**
Application:	**Request Address Change**
Application Date:	**09/17/2020**

Personal Detail

Title:	**Dr**
First Name:	**Robyn**
Last Name/Surname:	**Schickler**
Birthdate:	**08/20/1987**
Gender:	**Female**

Addresses

Mailing Address

Address:

101 West Beach Place
Apt 1819
HILLSBOROUGH
Tampa, FL
44106
US

E-mail Address: **rschickler94@gmail.com**

Place of Practice

Address:

236 East Bearss Avenue
HILLSBOROUGH
TAMPA, FL
33613

Attestation

I affirm that the provided address information is correct.

Attestation Answer: Yes