APP-SENT
9/3/92

STATE MEDICAL BOARD OF OHIO

77 South High Street, 17th Floor • Columbus, Ohio 43266-0315 • (614) 466-3934

REQUEST FOR APPLICATION FORMS
(MEDICAL OR OSTEOPATHIC LICENSURE)

PLEASE TYPE OR PRINT CLEARLY

I hereby submit the following information in order to receive an application for licensure:

NAME: LAST (Surname): Corwin FIRST: Jeanne MIDDLE: Marie SUFFIX (Jr., II):

ADDRESS: STREET & NUMBER: 6316 Kincaid Rd

CITY: Cincinnati STATE: Ohio ZIP CODE: 45213 COUNTRY: USA

TELEPHONE: BUSINESS: AREA CODE & NUMBER (513) 558-1000 HOME: AREA CODE & NUMBER (513) 531-7320

BIRTH DATE: MO/DAY/YR 07/05/63 BIRTHPLACE: CITY Cincinnati STATE Ohio COUNTRY USA

MEDICAL OR OSTEOPATHIC EDUCATION

MEDICAL SCHOOL OF GRADUATION: SCHOOL NAME: University of Cincinnati College of Medicine

STREET ADDRESS: 231 Bethesda Avenue

CITY: Cincinnati STATE: Ohio COUNTRY: USA

DATES ATTENDED: FROM: MO/DAY/YR 08/ /87 TO: MO/DAY/YR 06/ /91

DEGREE RECEIVED: MD DATE RECEIVED: MO/DAY/YR 06/16/91

Revised 05/26/92

OVER ⇨

OTHER MEDICAL SCHOOLS ATTENDED: (IF NONE, ENTER "NONE")

SCHOOL NAME NONE

STREET ADDRESS

CITY | STATE | COUNTRY

DATES ATTENDED: FROM: MO/DAY/YR / / TO: MO/DAY/YR / /

REASON DEGREE NOT RECEIVED AT THIS SCHOOL:

SCHOOL NAME

STREET ADDRESS

CITY | STATE | COUNTRY

DATES ATTENDED: FROM: MO/DAY/YR / / TO: MO/DAY/YR / /

REASON DEGREE NOT RECEIVED AT THIS SCHOOL:

FIFTH PATHWAY

FIFTH PATHWAY PROGRAM AT: (IF NONE, ENTER "NONE") N/A

HOSPITAL OR INSTITUTION

AFFILIATED WITH: NAME OF MEDICAL SCHOOL

ADDRESS: STREET & NUMBER

CITY | STATE | ZIP CODE

DATES ATTENDED: FROM: MO/DAY/YR / / TO: MO/DAY/YR / /

QUALIFYING EXAM TAKEN:

DATE TAKEN: MO/DAY/YR / /

CONTINUED ⇨

GRADUATE MEDICAL EDUCATION

List ALL graduate medical education (internship, residency, or clinical fellowship), undertaken in the U.S. or Canada. If additional space is needed, please attach an extra sheet. If none, enter "NONE")

month/year	Hospital, University or Other:	Position & Department	Level of Training (check one only)
07 / 91 month/year TO present month/year	University Hospital Complete Street Address: 234 Goodman St. Street & Number Cinti OH 45267 City State/Country Zip	Resident Department of Obstetrics and Gynecology	☐ 1st year ☒ 2nd year ☐ 3rd year or above
month/year TO month/year	Hospital, University or Other: Complete Street Address: Street & Number City State/Country Zip	Position & Department	☐ 1st year ☐ 2nd year ☐ 3rd year or above
month/year TO month/year	Hospital, University or Other: Complete Street Address: Street & Number City State/Country Zip	Position & Department	☐ 1st year ☐ 2nd year ☐ 3rd year or above
month/year TO month/year	Hospital, University or Other: Complete Street Address: Street & Number City State/Country Zip	Position & Department	☐ 1st year ☐ 2nd year ☐ 3rd year or above

OVER ➪

WRITTEN EXAMINATIONS TAKEN

List each and every written (FLEX or State Board except National Boards) exam taken whether in Ohio or any other state, territory or province. If additional space is needed, please attach an extra sheet. (If none, enter "NONE").

STATE	DATE TAKEN	WRITTEN EXAM TAKEN	FINAL RESULTS	TYPE OF EXAM
NONE	MO/YR /	❑ FLEX ❑ STATE BOARD	❑ PASS ❑ FAIL	❑ FULL ❑ PARTIAL
	/	❑ FLEX ❑ STATE BOARD	❑ PASS ❑ FAIL	❑ FULL ❑ PARTIAL
	/	❑ FLEX ❑ STATE BOARD	❑ PASS ❑ FAIL	❑ FULL ❑ PARTIAL
	/	❑ FLEX ❑ STATE BOARD	❑ PASS ❑ FAIL	❑ FULL ❑ PARTIAL
	/	❑ FLEX ❑ STATE BOARD	❑ PASS ❑ FAIL	❑ FULL ❑ PARTIAL

LICENSES IN THE UNITED STATES & CANADA

List **ALL** states/provinces **whether the license is current or not** in which you are or have been licensed to practice medicine and surgery or osteopathic medicine and surgery. Indicate the license number, date of issuance, and the basis of licensure (e.g., FLEX, state board exam, endorsement of another state license, endorsement of diplomate status, etc.). If additional space is needed, please attach an extra sheet (If none, enter "NONE").

STATE	ISSUE DATE	LICENSE #	BASIS OF LICENSE	LICENSE CURRENT
	MO/YR /			❑ YES ❑ NO
	/			❑ YES ❑ NO
	/			❑ YES ❑ NO
	/			❑ YES ❑ NO
	/			❑ YES ❑ NO

AMERICAN MEDICAL ASSOCIATION NATIONAL PHYSICIAN CREDENTIALS VERIFICATION SERVICE

The American Medical Association (AMA) has recently implemented a National Physician Credentials Verification Service (NPCVS), which for a fee will verify a physician's possessive credentials.

Are you currently a member of the AMA'S NPCVS? ❑ YES ☒ NO

For further information contact the AMA at the address below:

AMERICAN MEDICAL ASSOCIATION
NATIONAL PHYSICIAN CREDENTIALS VERIFICATION SERVICE
515 N. STATE STREET, 4TH FLOOR
CHICAGO, IL 60610
(312)464-5000

CONTINUED ⇨

ADDITIONAL ELIGIBILITY INFORMATION - ANSWER ALL QUESTIONS

Are you a diplomate of the National Board of Medical Examiners?
❑ PENDING ☒ YES ❑ NO DATE: 04 / 92
MO/YR

Are you a diplomate of the National Board of Osteopathic Medical Examiners?
❑ PENDING ❑ YES ☒ NO DATE: /
MO/YR

Are you a licentiate of the Medical Council of Canada? ❑ YES ☒ NO

Are you applying to sit for the FLEX exam in Ohio?
❑ YES ☒ NO IF YES, ❑ JUNE OR ❑ DECEMBER YEAR: 199___

Do you have a valid ECFMG Certificate?
❑ YES ☒ NO NUMBER: ______ DATE ISSUED: /
MO/YR

If you are a graduate of a Mexican Medical School indicate degree: (CHECK ONLY ONE) N/A
❑ ACTA ❑ TITULO ❑ MEDICO CIRUJANO

During the five (5) years immediately preceding the date of your last application have you held an unrestricted license in the US and have you been actively practicing medicine and surgery or osteopathic medicine and surgery in the US?
❑ YES ☒ NO

Have you applied for or taken the Test of Spoken English (TSE)* of the Educational Testing Service (ETS)?
❑ YES ☒ NO LAST DATE TAKEN OR SCHEDULED /
MO/YR

Have you achieved a score of at least two hundred ten (210) on TSE* of the ETS?
❑ YES ☒ NO SCORE: ______ DATE TAKEN: /
MO/YR

* (THE TOEFL, ECFMG EXAM, ETC., ARE NOT EQUIVALENT AND CANNOT BE SUBSTITUTED FOR THE TEST OF SPOKEN ENGLISH (TSE)

CERTIFICATION

I HEREBY CERTIFY THAT I AM THE PERSON REFERRED TO IN THE FOREGOING REQUEST FOR APPLICATION FORMS AND THAT THE STATEMENTS HEREIN ARE STRICTLY TRUE IN EVERY RESPECT.

Jeanne Corwin 8/30/92
SIGNATURE DATE

RETURN TO: STATE MEDICAL BOARD OF OHIO
77 SOUTH HIGH STREET, 17TH FLOOR
COLUMBUS, OH 43266-0315

Revised 05/26/92

CONTINUED ⇨

1-10
4-33-55
1-8-93
180.00 fee
147

STATE MEDICAL BOARD OF OHIO

77 South High Street, 17th Floor • Columbus, Ohio 43266-0315 • (614) 466-3934

STATE MEDICAL BOARD OF OHIO
93 JAN -7 PM 4:17

APPLICATION FOR CERTIFICATE - MEDICINE OR OSTEOPATHIC MEDICINE

PLEASE TYPE OR PRINT CLEARLY

1. Social Security Number: REDACTED

2. Full Name (Use no initials):

LAST (Surname)	FIRST	MIDDLE	SUFFIX(Jr., II)
CORWIN	Jeanne	Marie	

3. Name (As you prefer it inscribed on your Ohio license):

LAST (Surname)	FIRST	MIDDLE	SUFFIX(Jr., II)
CORWIN	Jeanne	Marie	

4. Maiden Name Or Other Names Used (If none, enter "NONE"):

LAST (Surname)	FIRST	MIDDLE	SUFFIX(Jr., II)
NONE			

5. Current Address:

STREET & NUMBER: 6316 Kincaid Road

CITY	STATE	ZIP CODE	COUNTRY
Cincinnati	OHIO	45213	USA

6. Physical Description:

HEIGHT	WEIGHT	HAIR COLOR	EYE COLOR	IDENTIFYING MARKS
5'3"	115 lbs	blond	green	

7. Sex: ❑ MALE ☒ FEMALE For statistics only (optional)

8. City In Ohio Where You Plan To Practice:

CITY	OR	COUNTY
Cincinnati		Hamilton

PLANS OF PRACTICE:

9. Specialty Boards (U.S.A., Canada and foreign countries):

Name of Specialty Board	Board Certified Yes	Board Certified No	Year Certified	Country
N/A	❑	❑		
	❑	❑		
	❑	❑		

FOR OFFICE USE ONLY ❑ 34 ☒ 35 ❑ Examination ❑ Endorsement

PAPERCLIP (DO NOT STAPLE) YOUR CHECK OR MONEY ORDER HERE

RESUME - MEDICINE OR OSTEOPATHIC MEDICINE

List **ALL** activities in chronological order from the date of medical school graduation to the present time using **MONTH** and **YEAR**. For any non-working time, you must state on the resume exactly what your activities were, such as "looking for residency program" or "vacation", as well as your permanent address for this period. If in private practice, indicate the hospitals where you hold or have held privileges and include complete dates and addresses. For any time in which you worked for an "emergency medical group" or did locum tenens, you must list all hospitals where you worked and include complete dates and addresses. If in private practice, indicate the hospitals where you hold or have held privileges and include complete dates and addresses. **DO NOT SUBSTITUTE ANY OTHER RESUME FOR THIS FORM.** Be sure to indicate the percentage of working time spent in clinical and administrative duties. If you require more space, attach separate sheets.

A.

month/year TO month/year	Hospital, University or Other / Complete Street Address	Position & Department	% Clinical / % Admin.
07 91 TO present	Hospital, University or Other: University Hospital of Cincinnati Complete Street Address: Street & Number: 234 Goodman Street City / State/Country / Zip: Cincinnati Ohio 45267	Resident Dept of Obstetrics and Gynecology	% Clinical: 100 % Admin.:

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B.

month/year TO month/year	Hospital, University or Other / Complete Street Address	Position & Department	% Clinical / % Admin.
TO	Hospital, University or Other: Complete Street Address: Street & Number City / State/Country / Zip		% Clinical % Admin.

C.

month/year TO month/year	Hospital, University or Other / Complete Street Address	Position & Department	% Clinical / % Admin.
TO	Hospital, University or Other: Complete Street Address: Street & Number City / State/Country / Zip		% Clinical % Admin.

D.

month/year TO month/year	Hospital, University or Other / Complete Street Address	Position & Department	% Clinical / % Admin.
TO	Hospital, University or Other: Complete Street Address: Street & Number City / State/Country / Zip		% Clinical % Admin.

RESUME- MEDICINE OR OSTEOPATHIC MEDICINE
PAGE TWO

E.

month/year TO month/year	Hospital, University or Other:	Position & Department	% Clinical
	Complete Street Address: Street & Number / City State/Country Zip		% Admin.

F.

month/year TO month/year	Hospital, University or Other:	Position & Department	% Clinical
	Complete Street Address: Street & Number / City State/Country Zip		% Admin.

G.

month/year TO month/year	Hospital, University or Other:	Position & Department	% Clinical
	Complete Street Address: Street & Number / City State/Country Zip		% Admin.

H.

month/year TO month/year	Hospital, University or Other:	Position & Department	% Clinical
	Complete Street Address: Street & Number / City State/Country Zip		% Admin.

STATE MEDICAL BOARD OF OHIO

77 South High Street, 17th Floor • Columbus, Ohio 43266-0315 • (614) 466-3934

MEDICINE OR OSTEOPATHIC MEDICINE

FORM 1 - CERTIFICATE OF RECOMMENDATION

This form is to be completed by a physician fully licensed in the STATE IN WHICH THE FORM IS NOTARIZED. The recommending physician must be sufficiently acquainted with the applicant for at least **SIX** months. Relatives may not serve as recommending physicians. Recommending physicians are strongly urged to include additional comments. This form must be notarized. ALL questions must be answered. This form is not intended to standardize the recommendation or restrict it in any way. However, its form is designed to insure that certain information is included.

DO NOT COMPLETE UNLESS A *COLOR* PHOTO OF APPLICANT IS ATTACHED TO THE BACK OF THIS FORM

BLACK & WHITE PHOTOS ARE NOT ACCEPTABLE

STATE MEDICAL BOARD OF OHIO
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I, Nancy J. Cossler, MD, a licensed and practicing physician in the state of
(recommending physician)

Ohio, affirm that Jeanne Corwin
(state of residence) (applicant)

has been known to me personally for _______ years and that he/she is of good moral character. Further, the photograph affixed hereto is a genuine likeness of the applicant. I offer the following in support of his/her application for full licensure:

*I rate his/her medical knowledge and technique as: ____________

*His/her relationship with patients is: ____________

*I rate his/her ability to work well with peers and medical staff as: ____________

*His/her command of the English language is: ____________

*Additional comments: ____________

I hereby recommend him/her for full licensure to practice in the State of Ohio.

OVER ⇨

FORM 1 - CERTIFICATE OF RECOMMENDATION - MEDICINE OR OSTEOPATHIC MEDICINE
PAGE TWO

Nancy Gossler MD
Signature of Recommending Physician
(name stamps not acceptable)

Nancy J. Gossler MD
Name of Recommending Physician
(please type or print clearly)

(513) 558-8446
Telephone Number
(include area code)

231 Bethesda Ave, Cincinnati, OH 45267
Address of Recommending Physician
(include city, state and zip code)

Ohio 59172
State of Licensure & License Number of Recommending Physician
(please type or print clearly)

(NOTARY SEAL)

Subscribed and sworn to before me this 4 day of January, 1993.

Carole A. Arend
Notary Public Signature

May 2, 1997
Date Commission Expires

CAROLE A. AREND
Notary Public, State of Ohio
My Commission Expires May 2, 1997

PHOTOGRAPH

Staple a recent passport-type COLOR photo of applicant here; must have been taken within the last six months
(black & white photos are not acceptable)

Jeanne Corwin
Signature of Applicant

Date Photo Taken: 11/92
Mo./Yr.

RETURN TO: STATE MEDICAL BOARD OF OHIO
77 SOUTH HIGH STREET, 17TH FLOOR
COLUMBUS, OH 43266-0315

STATE MEDICAL BOARD OF OHIO

77 South High Street, 17th Floor • Columbus, Ohio 43266-0315 • (614) 466-3934

MEDICINE OR OSTEOPATHIC MEDICINE

FORM 2 - CERTIFICATE OF GRADUATE MEDICAL EDUCATION

MAIL TO HOSPITAL OR INSTITUTION OF GRADUATE MEDICAL EDUCATION IN THE U.S. OR CANADA

Dear Sir:

I am applying for a license to practice in the State of Ohio. The State Medical Board of Ohio requires that my graduate medical education be certified. Please complete the form and return it directly to the State Medical Board of Ohio.

93 JAN -6 PM 4:17
STATE MEDICAL BOARD OF OHIO

TO BE COMPLETED BY APPLICANT

Jeanne Marie Corwin
Name in full (last, first, middle, suffix)

09/05/63
Date of birth (mo/day/yr)

6316 Kincaid Rd Cinti, OH 45213
Complete address (street, city, state & zip)

University of Cincinnati
Medical school of graduation

I HEREBY AUTHORIZE MY HOSPITAL OR INSTITUTION OF GRADUATE MEDICAL EDUCATION TO FURNISH THE FOLLOWING INFORMATION TO THE STATE MEDICAL BOARD OF OHIO.

Jeanne Corwin
Signature of applicant

12-29-92
Date

TO BE COMPLETED BY HOSPITAL OR TRAINING INSTITUTION

I offer the following in support of his/her application for full licensure:

I rate his/her medical knowledge and technique as: ____________________

His/her relationship with patients is: ____________________

I rate his/her ability to work well with peers and medical staff as: ____________________

His/her command of the English language is: ____________________

Additional comments: ____________________

OVER ⇨

FORM 2 - CERTIFICATE OF GRADUATE EDUCATION - MEDICINE OR OSTEOPATHIC MEDICINE
PAGE TWO

This certifies that Jeanne Corwin has successfully completed
(name of applicant)

not less than 12 months of graduate medical education through the:
☒ 1st year level
☐ 2nd year level
☐ 3rd year level or above

as a(n):
☐ intern
☒ resident
☐ clinical fellow

in Obstetrics & Gynecology
(department)

at University of Cincinnati (name of hospital) 234 Goodman Ave, Cincinnati, OH (complete street address of hospital)

from 07-01-91 beginning (mo/day/yr) to 06-30-95 ending (mo/day/yr).

It is further certified that the above named:
☒ will be awarded a certificate on} 6-30-95 mo/day/yr
☐ was awarded a certificate on} ______ mo/day/yr
☐ was not awarded a certificate
please explain: ______

and that the training:
☒ was accredited by ACGME/AOA
☐ was not accredited by ACGME/AOA

I hereby recommend him/her for full licensure to practice in the State of Ohio.

(SEAL OF HOSPITAL)*

Robert W Rebar
Signature of Medical Director or Program Director
(Original signature only, names stamps will not be accepted)

*If hospital has no seal, please indicate and have form notarized.

University Hospital has no seal.

Subscribed and sworn to before me this 31st DAY OF December 199 2

Notary Signature Carole A. Arend

Date Commission Expires May 2, 1997

CAROLE A. AREND
Notary Public, State of Ohio
My Commission Expires May 2, 1997

Robert W. Rebar, MD
Name (please print or type)

12/31/92
Date

RETURN TO: STATE MEDICAL BOARD OF OHIO
77 SOUTH HIGH STREET, 17TH FLOOR
COLUMBUS, OH 43266-0315

Revised 05/26/92

ADDITIONAL INFORMATION - MEDICINE OR OSTEOPATHIC MEDICINE

If you answer "YES" to any of the following questions, you are required to furnish complete details, including date, place, reason and disposition of the matter. All affirmative answers must be thoroughly explained on a separate sheet of paper.

(Please place a ✔ in the yes or no box)

	Question	YES	NO
1.	Have you ever been denied staff membership at any hospital, nursing home, clinic, health maintenance organization, or similar institution?	☐	☒
2.	Have you ever been warned, censured, disciplined, had admissions monitored, had privileges limited, had privileges suspended or terminated, been put on probation, or been requested to withdraw from or resign privileges at any hospital, nursing home, clinic, health maintenance organization, or other similar institution in which you have trained, been a staff member, or held privileges, for reasons other than failure to maintain records on a timely basis, or failure to attend staff or section meetings?	☐	☒
3.	Have you ever resigned from, withdrawn from, or terminated, or have you ever been requested to resign from, withdraw from, or otherwise been terminated from, a position with a medical partnership, professional association, corporation, health maintenance organization, or other medical practice organization, either private or public?	☐	☒
4.	Have you ever resigned from, withdrawn from, or have you ever been warned by, censured by, disciplined by, been put on probation by, been requested to withdraw from, dismissed from, been refused renewal of a contract by, or expelled from, a medical school, clinical clerkship, externship, preceptorship, or graduate medical education?	☐	☒
5.	Have you ever transferred from one graduate medical education to another?	☐	☒
6.	Have you ever, for any reason, lost specialty board certification in the U.S. or elsewhere, or been denied such certification, or denied examination for such certification?	☐	☒
7.	Has any board, bureau, department, agency or other body, including those in Ohio, in any way limited, restricted, suspended, or revoked any professional license, certificate or registration granted to you; placed you on probation; or imposed a fine, censure or reprimand against you?	☐	☒

STATE MEDICAL BOARD OF OHIO
93 JAN -6

OVER ⇨

		YES	NO
8.	Have you ever voluntarily surrendered, resigned, or otherwise forfeited any professional license, certificate or registration issued to you by any board, bureau, department, agency, or other body; or have you ever withdrawn any application for licensure, relicensure, or examination, in any state (including Ohio), territory, province, or country?	☐	☒
9.	Have you ever, for any reason, been denied licensure or relicensure, application for licensure or relicensure, or the privilege of taking an examination, in any state (including Ohio), territory, province, or country?	☐	☒
10.	Have you ever been requested to appear before any board, bureau, department, agency, or other body, including those in Ohio, concerning allegations against you?	☐	☒
11.	Have you ever entered into an agreement of any kind, whether oral or written, with respect to a professional license, in lieu of or in order to avoid formal disciplinary action, with any board, bureau, department, agency, or other body, including those in Ohio?	☐	☒
12.	Have you ever been notified of any investigation concerning you by, or have you ever been notified of, any charges, allegations, or complaints filed against you with, any board, bureau, department, agency, or other body, including those in Ohio, with respect to a professional license?	☐	☒
13.	Are you now or have you ever been, addicted to or excessively used alcohol, drugs, or other substances which may cause physical or psychological dependence, or impairment of the ability to practice?	☐	☒
14.	Have you ever been a patient (voluntary or otherwise) in any institution for the treatment of emotional or mental illness, drug addiction or abuse, or an alcohol problem? If yes, you must have your treating physician(s) submit a letter directly to the Board on your behalf summarizing dates of treatment, etc.	☐	☒
15.	Have you ever been treated but not hospitalized for emotional or mental illness, drug addiction or abuse, or an alcohol problem? If yes, you must have your treating physician(s) submit a letter directly to the Board on your behalf summarizing dates of treatment, etc.	☐	☒
16.	Have you ever been denied, or surrendered, a state or federal controlled substance or drug registration; had it revoked, terminated, or restricted in any way; or been warned, reprimanded, or fined by, or been requested to appear before, the responsible agency?	☐	☒

CONTINUED

		YES	NO
17.	Have you ever been convicted or found guilty of a violation of federal law, state law, or municipal ordinance other than a minor traffic violation?	☐	☒
18.	Have you ever forfeited collateral, bail, or bond for breach or violation of any law, police regulation, or ordinance other than for a minor traffic violation; been summoned into court as a defendant or had any lawsuit filed against you (other than a malpractice suit)?	☐	☒
19.	Have you been a defendant in a legal action involving professional liability (malpractice), or had a professional liability claim paid on your behalf, or paid such a claim yourself? If yes, include the case name, case number, court and address, date filed, and a summary of the underlying events. Indicate current status, including amount of settlement or judgment, if any.	☐	☒
20.	Have you ever been denied professional liability insurance or coverage, or had such insurance or coverage cancelled, limited, or restricted in any way?	☐	☒
21.	Have you ever been denied or relinquished participation in any third party reimbursement program, whether governmental or private, including Medicaid and Medicare; or had such participation limited, restricted, suspended, or revoked; or been warned, reprimanded, requested to appear before, or fined by the responsible body?	☐	☒
22.	Have you ever been denied privileges, or had privileges revoked, suspended, restricted, reduced, or terminated by the Department of Defense, the Veteran's Administration, or any of their respective components?	☐	☒

STATE MEDICAL BOARD
OF OHIO
93 JAN 5 PM 4:

AFFIDAVIT AND RELEASE OF APPLICANT

The affidavit and release below MUST be completed by **ALL** applicants. The form must be notarized. Failure of any applicant to submit the affidavit completed and notarized with the application will result in your application being considered as incomplete.

ss STATE OF Ohio
COUNTY OF Hamilton

I, Jeanne Corwin, hereby certify under oath that I am the person named in this application for a license to practice medicine or osteopathic medicine in the State of Ohio; that all statements I have or shall make with respect thereto are true; that I am original and lawful possessor and person named in the various forms and credentials furnished or to be furnished to this Board 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 respect.

I acknowledge that I have read the general information and instructions for all applicants and that I have answered all questions in compliance with these instructions and understand that the fee I submitted is not refundable nor transferable.

I further state that by filing this application for a license to practice medicine or osteopathic medicine in the State of Ohio, I hereby authorize and consent to have an investigation made as to my moral character, professional reputation and fitness for the practice of medicine or osteopathic medicine. I agree to give any further information which may be required in reference to my past record. I understand that I will not receive a copy of any reports or know their contents and I further understand that the contents of any investigative report will be privileged.

I further understand that my application for a license to practice medicine or osteopathic medicine in the State of Ohio is an ongoing process. I will immediately notify the State Medical Board of Ohio in writing of any changes to the answers to any of the questions contained in the ADDITIONAL INFORMATION section of the application if such a change in an answer is warranted at any time prior to licensure being granted to me by the State Medical Board of Ohio. I further understand that failure to complete this application as requested by the Board within six months can be considered abandonment of any request for licensure and that any fee I submitted is not refundable nor transferable.

I authorize and request every person, hospital, clinic, governmental agency (local, state, federal or foreign), court, association, institution, or law enforcement agency having control of any documents, records and other information pertaining to me to furnish to the State Medical Board of Ohio 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 State Medical Board of Ohio or any of its agents or representatives to inspect and make copies of such documents, records, and other information in connection with this application, subsequent licensure or practice thereunder.

I hereby release, discharge, and exonerate the State Medical Board of Ohio, 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 State Medical Board of Ohio. I authorize the State Medical Board of Ohio to release information, material, documents, orders or the like relating to me or to this application to any other governmental agency (local, state, federal or foreign); or to any hospital, nursing home, clinic, health maintenance organization or similar institution; or to any professional association.

I further understand that issuance of a certificate to practice medicine or osteopathic medicine in Ohio will be considered on the truth of the statements and documents contained herein or to be furnished, which if false, can subject me to denial of said certificate.

(NOTARY SEAL)

Jeanne Corwin
Signature of Applicant

Subscribed and sworn to before me this 11th day of January 1993.

Carole A Arend
Notary Public Signature

CAROLE A. AREND
Notary Public, State of Ohio
My Commission Expires May 2, 1997

May 2, 1997
Date Commission Expires

Revised 05/26/92

STATE MEDICAL BOARD
93 JAN 14 PM 12:46

STATE MEDICAL BOARD OF OHIO

77 South High Street, 17th Floor • Columbus, Ohio 43266-0315 • (614) 466-3934

DATE 1/22/93

Dear Doctor:

Dr. Jeanne M. Corwin who is/was Resident/OB/GYN 7/91-Present is applying for licensure in the State of Ohio. We would appreciate your assistance in filling out the following evaluation so that we can process his/her application for licensure. **This form must be completed and returned to our office within two (2) weeks to ensure processing of the doctor's application.** Your immediate attention to this matter will be greatly appreciated by the doctor as well as by us. Information provided is considered confidential under Section 149.43(A)(2)(a), Ohio Revised Code. Thank you for your time and assistance.

(1) How long have you known the doctor? > 2 yrs

(2) What is/was your supervisory capacity? Residency director of her residency program

(3) At what hospital? The University of Cincinnati Medical Center

(4) How would you rate this doctor's medical knowledge and techniques? Very good

(5) In your opinion, is this doctor a person of good moral and ethical character? Yes

(6) Does this doctor work well with peers and medical staff? Yes

(7) Does he/she relate well to patients? Yes

(8) How is his/her command of the English language? (if applicable) Excellent

(9) Would you recommend this doctor for licensure? Yes

Additional comments, please: (if needed, an extra sheet of paper may be used)

A fine young physician

Please return this form to the Ohio State Medical Board at the above address,

Sincerely,

Mindy Booth

Mindy Booth
Licensure Assistant

Robert W Rebar

Signature of Doctor, please type or print name legibly beneath

ROBERT W. REBAR, MD

Professor & Chair, Dept of Ob Gyn

Position

Telephone No. 513 558-8440 (Include Area Code)

NATIONAL BOARD OF MEDICAL EXAMINERS® • 3930 CHESTNUT STREET, PHILADELPHIA, PA 19104

ENDORSEMENT OF CERTIFICATION

NATIONAL BOARD OF MEDICAL EXAMINERS
OF THE
UNITED STATES OF AMERICA

Jeanne Marie Corwin, MD

having satisfied all the requirements and having successfully passed the examinations is hereby declared a Diplomate of the National Board of Medical Examiners.

Attest Edward J Stemmler, MD
Chairman of the Board

SEAL L. Thompson Bowles, MD, PhD
President of the Board

Philadelphia, Pa.
07/01/92

Certificate # 400239

It is certified that the above is a facsimile of the Diplomate Certificate which has been or will be* awarded to the physician named above, who graduated from Univ of Cincinnati College of Medicine in JUNE 1991 and whose birth date is 07/05/1963. This physician has successfully completed all examinations required for certification by the National Board of Medical Examiners. The scores obtained by this physician upon which his/her certification is based are as follows:

	Standard Score	Scale Score
PART I passed 06/89		
Anatomy	565	86
Physiology	570	86
Biochemistry	695	94
Pathology	520	83
Microbiology	570	86
Pharmacology	610	88
Behavioral Sciences	560	85
TOTAL TEST (Minimum Passing Score 380/75)	605	88
PART II passed 04/91		
Medicine	500	82
Surgery	495	81
Obstetrics and Gynecology	635	87
Public Health and Preventive Medicine	425	78
Pediatrics	445	79
Psychiatry	440	79
TOTAL TEST (Minimum Passing Score 290/75)	485	81
PART III passed 03/92		
A General Test of Clinical Competence		
TOTAL TEST (Minimum Passing Score 315/75)	485	81

STATE MEDICAL BOARD
OF OHIO
93 JAN -4 PM 4:37

*For those individuals who have not yet satisfactorily completed one full year of post-M.D. training the date shown on the facsimile is the date which has been certified by the physician's residency program director as the date on which this requirement for certification by the National Board will be fulfilled and such certification will be awarded.

SEE OTHER SIDE FOR SCORE INFORMATION

Melanie Valente
Secretary for Certification

SEAL

12/24/92
Date

CH0239

INTERPRETATION OF SCORES

STANDARD SCORES

Part I and Part II Examinations Passed Prior to June 1991

Total test score **and** subject scores are reported. The total test score is based on the number of questions answered correctly on the entire examination and is not the average of the subject scores. There are no minimum pass requirements for individual subjects within a Part. Scores are reported on a scale with a mean of 500 and a standard deviation of 100, in increments of 5.

Part I Examination - June & September 1991 Part II Examination - September 1991 & April 1992

Only total test score is reported. The total test score is based on the total number of questions answered correctly on the entire examination. Scores are reported on a scale with a mean of 200 and a standard deviation of 20, in increments of 1.

All Part III Examinations

Only total test score is reported. The total test score is based on the total number of questions answered correctly on the entire examination. Scores are reported on a scale with a mean of 500 and a standard deviation of 100, in increments of 5.

SCALE SCORES

For all examinations, the scale score mean is 82 and the minimum pass total scale score is 75. Scale scores are reported in increments of 1.

The Board of Trustees of the

University of Cincinnati

on the recommendation of the Faculty of the

College of Medicine

of the University, does hereby confer upon

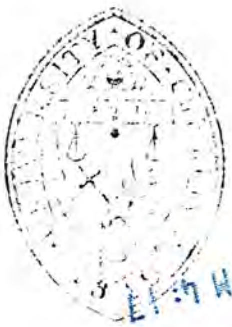
Jeanne Marie Corwin

the degree of

Doctor of Medicine

with all the rights and privileges appertaining thereto. Given at Cincinnati, Ohio

this sixteenth day of June, nineteen hundred and ninety-one.



Chairman of the Board of Trustees

Secretary of the Board of Trustees

President of the University

Dean of the College

STATE MEDICAL BOARD
OF OHIO
93 JAN -6 PM 4:17

433

MD/DO PRELIMINARY EDUCATION FORM

NAME:

LAST (Surname)	FIRST	MIDDLE	SUFFIX(Jr., II)
Corwin	Jeanne	Marie	

HIGH SCHOOL OR EQUIVALENT:

SCHOOL NAME	CITY	STATE	COUNTRY
New Richmond HS	New Richmond	OH	USA

DATES ATTENDED: FROM: MO/DAY/YR 09 / / ~~87~~ 77 TO: MO/DAY/YR 06 / / 81

UNDERGRADUATE COLLEGE OR EQUIVALENT:

SCHOOL NAME	CITY	STATE	COUNTRY
Miami University	Oxford	OHIO	USA

DATES ATTENDED: FROM: MO/DAY/YR 08 / / 81 TO: MO/DAY/YR 08 / / 85 DEGREE RECEIVED: Bachelor of Arts

SCHOOL NAME	CITY	STATE	COUNTRY

DATES ATTENDED: FROM: MO/DAY/YR / / TO: MO/DAY/YR / / DEGREE RECEIVED:

MEDICAL OR OSTEOPATHIC SCHOOL OF GRADUATION:

SCHOOL NAME	CITY	STATE	COUNTRY
University of Cincinnati	Cinti	OH	USA

DATES ATTENDED: FROM: MO/DAY/YR 08 / / 87 TO: MO/DAY/YR 06 / / 91 DEGREE RECEIVED: MD

FOR BOARD USE ONLY

CERTIFICATE OF PRELIMINARY EDUCATION

NO: 819609 DATE ISSUED: 3.8.93

This is to certify that this applicant has met the preliminary education requirements for study in conformity with the statutes of Ohio and the regulations of the State Medical Board of Ohio.

Ray Q. Bumgarner

Entrance Examiner

Secretary

STATE MEDICAL BOARD OF OHIO

77 South High Street, 17th Floor • Columbus, Ohio 43266-0315 • (614) 466-3934

MEDICINE OR OSTEOPATHIC MEDICINE

FORM 1 - CERTIFICATE OF RECOMMENDATION

This form is to be completed by a physician fully licensed in the STATE IN WHICH THE FORM IS NOTARIZED. The recommending physician must be sufficiently acquainted with the applicant for at least **SIX** months. Relatives may not serve as recommending physicians. Recommending physicians are strongly urged to include additional comments. This form must be notarized. ALL questions must be answered. This form is not intended to standardize the recommendation or restrict it in any way. However, its form is designed to insure that certain information is included.

STATE MEDICAL BOARD OF OHIO
93 JAN -6 PM 4:17

DO NOT COMPLETE UNLESS A *COLOR* PHOTO OF APPLICANT IS ATTACHED TO THE BACK OF THIS FORM

BLACK & WHITE PHOTOS ARE NOT ACCEPTABLE

I, Laurence R. McLain, MD, a licensed and practicing physician in the state of
(recommending physician)

Ohio, affirm that Jeanne Corwin
(state of residence) (applicant)

has been known to me personally for 4 years and that he/she is of good moral character. Further, the photograph affixed hereto is a genuine likeness of the applicant. I offer the following in support of his/her application for full licensure:

*I rate his/her medical knowledge and technique as: Excellent

*His/her relationship with patients is: Excellent

*I rate his/her ability to work well with peers and medical staff as: Excellent

*His/her command of the English language is: Excellent

*Additional comments: She is one of our most outstanding Residents in Training.

I hereby recommend him/her for full licensure to practice in the State of Ohio.

OVER ⇨

FORM 1 - CERTIFICATE OF RECOMMENDATION - MEDICINE OR OSTEOPATHIC MEDICINE
PAGE TWO

Clarence R. McLain

Signature of Recommending Physician
(name stamps not acceptable)

CLARENCE R. McLAIN MD

Name of Recommending Physician
(please type or print clearly)

(513) 558-8440

Telephone Number
(include area code)

231 Bethesda Ave, Cincinnati, OH 45267

Address of Recommending Physician
(include city, state and zip code)

OHIO 38987

State of Licensure & License Number of Recommending Physician
(please type or print clearly)

(NOTARY SEAL)

Subscribed and sworn to before me this 4 day of January, 199 3.

Carole A. Arend

Notary Public Signature

May 2, 1997

Date Commission Expires

CAROLE A. AREND
Notary Public, State of Ohio
My Commission Expires May 2, 1997

Jeanne Corwin

Signature of Applicant

Date Photo Taken: 11 / 92
Mo./Yr.

RETURN TO: STATE MEDICAL BOARD OF OHIO
77 SOUTH HIGH STREET, 17TH FLOOR
COLUMBUS, OH 43266-0315

STATE MEDICAL BOARD OF OHIO

77 South High Street, 17th Floor • Columbus, Ohio 43266-0315 • (614) 466-3934

STATE MEDICAL BOARD OF OHIO
93 JAN 29 PM 2:

MEDICINE OR OSTEOPATHIC MEDICINE

FORM 1 - CERTIFICATE OF RECOMMENDATION

This form is to be completed by a physician fully licensed in the STATE IN WHICH THE FORM IS NOTARIZED. The recommending physician must be sufficiently acquainted with the applicant for at least SIX months. Relatives may not serve as recommending physicians. Recommending physicians are strongly urged to include additional comments. This form must be notarized. ALL questions must be answered. This form is not intended to standardize the recommendation or restrict it in any way. However, its form is designed to insure that certain information is included.

DO NOT COMPLETE UNLESS A *COLOR* PHOTO OF APPLICANT IS ATTACHED TO THE BACK OF THIS FORM

BLACK & WHITE PHOTOS ARE NOT ACCEPTABLE

I, NANCY J Cossler, MD, a licensed and practicing physician in the state of
(recommending physician)

OHIO, affirm that Jeanne M. Corwin
(state of residence) (applicant)

has been known to me personally for 2 years and that he/she is of good moral character. Further, the photograph affixed hereto is a genuine likeness of the applicant. I offer the following in support of his/her application for full licensure:

*I rate his/her medical knowledge and technique as: excellent for her level of training

*His/her relationship with patients is: excellent

*I rate his/her ability to work well with peers and medical staff as: excellent

*His/her command of the English language is: excellent

*Additional comments: ____________________

I hereby recommend him/her for full licensure to practice in the State of Ohio.

OVER ⇨

Nancy J Cossler MD
Signature of Recommending Physician
(name stamps not acceptable)

NANCY J Cossler, MD
Name of Recommending Physician
(please type or print clearly)

(513) 558-8440
Telephone Number
(include area code)

231 Bethesda Ave, Cincinnati, OH 45267-0526
Address of Recommending Physician
(include city, state and zip code)

OHIO 59172
State of Licensure & License Number of Recommending Physician
(please type or print clearly)

(NOTARY SEAL)

Subscribed and sworn to before me this 26th day of January, 1993.

Cheryl E. Treinen
Notary Public Signature
CHERYL E. TREINEN
Notary Public, State of Ohio
My Commission Expires Aug. 4, 1994

Date Commission Expires

Signature of Applicant

Date Photo Taken: ____ / ____
Mo./Yr.

RETURN TO: STATE MEDICAL BOARD OF OHIO
77 SOUTH STREET, 17TH FLOOR
COLUMBUS, OH 43266-0315

DETACH HERE AND REMIT THIS PORTION WITH FEE

STATE MEDICAL BOARD OF OHIO

77 SOUTH HIGH STREET, 17TH FLOOR, COLUMBUS, OHIO 43266 - 0315

CERTIFICATION

I CERTIFY, UNDER PENALTY OF LOSS OF MY RIGHT TO PRACTICE IN THE STATE OF OHIO, THAT I HAVE COMPLETED OR WILL HAVE COMPLETED DURING THE 1992-1994 BIENNIUM THE REQUISITE HOURS OF CONTINUING MEDICAL EDUCATION CERTIFIED BY THE OHIO STATE MEDICAL ASSOCIATION AND APPROVED BY THE STATE MEDICAL BOARD, AND THAT THE INFORMATION PROVIDED ON THIS APPLICATION FOR RENEWAL IS TRUE AND CORRECT IN EVERY RESPECT.

X Jeanne Corwin 4/17/94

(SIGNATURE OF APPLICANT) (DATE)

IDENTIFICATION NUMBER	AMOUNT DUE	DATE DUE
35-06-4667	$250.00	05/01/94

JEANNE MARIE CORWIN,M.D.
6316 KINCAID RD
CINCINNATI OH 45213

MD & DO SPECIALTY CODES CURRENTLY ON RECORD

NOT ON FILE
NOT ON FILE
NOT ON FILE

☐ SPECIALTY CODE(S) CORRECT AS LISTED

IF CORRECTIONS ARE NECESSARY, PLEASE ENTER ALL SPECIALTY CODES. CODE1 CODE2 CODE3

REPORT ANY CHANGE OF ADDRESS

STREET

STREET

CITY STATE ZIP CODE

COUNTY

⑆969696962⑆ 0935064667⑈ ⑈0000025000⑈

PRINCIPAL PRACTICE ADDRESS - IF DIFFERENT FROM THE ADDRESS SHOWN ON FRONT:

Street

Street

City | State | Zip Code

County

AT ANY TIME SINCE SIGNING YOUR LAST APPLICATION FOR RENEWAL OF YOUR CERTIFICATE HAVE YOU :

YES ☐ NO ☒ 1.) Been found guilty of, or pled guilty or no contest to a felony or misdemeanor.

YES ☐ NO ☒ 2.) Been found guilty of, or pled guilty or no contest to a federal or state law regulating the possession, distribution or use of any drug?

YES ☐ NO ☒ 3.) Been addicted to or dependent upon alcohol or any chemical substance; or been treated for, or been diagnosed as suffering from, drug or alcohol dependency or abuse? You may answer "no" to this question if you have successfully completed treatment at a program approved by this board and have subsequently adhered to all statutory requirements as contained in sections 4731.224 and 4731.25 O.R.C., and related provisions, or you are currently enrolled in a board approved program. Any questions concerning approval can be directed to the board offices.

YES ☐ NO ☒ 4.) Had malpractice insurance cancelled or limited for other than failure to pay premiums?

YES ☐ NO ☒ 5.) Had any disciplinary action taken or initiated against you by any state licensing board other than the State Medical Board of Ohio?

YES ☐ NO ☒ 6.) Surrendered, or consented to limitation upon: a) A license to practice medicine; OR b) State or federal privileges to prescribe controlled substances?

YES ☐ NO ☒ 7.) Had any clinical privileges suspended, restricted or revoked for reasons other than failure to maintain records or attend staff meetings?

YES ☐ NO ☒ 8.) After January 14, 1993, referred a patient, or participated in an arrangement or scheme for referral of a patient, for clinical laboratory services to a person or facility in which either you or a member of your immediate family has an ownership or investment interest, or any compensation arrangement?

SOCIAL SECURITY NUMBER
(Optional for purposes of identification)

DETACH HERE AND REMIT THIS PORTION WITH FEE

STATE MEDICAL BOARD OF OHIO
77 SOUTH HIGH STREET, 17TH FLOOR, COLUMBUS, OHIO 43266 - 0315

MD & DO SPECIALTY CODES CURRENTLY ON RECORD

NOT ON FILE

CERTIFICATION

I CERTIFY, UNDER PENALTY OF LOSS OF MY RIGHT TO PRACTICE IN THE STATE OF OHIO, THAT I HAVE COMPLETED OR WILL HAVE COMPLETED DURING THE 1994-1996 BIENNIUM THE REQUISITE HOURS OF CONTINUING MEDICAL EDUCATION CERTIFIED BY THE OHIO STATE MEDICAL ASSOCIATION AND APPROVED BY THE STATE MEDICAL BOARD, AND THAT THE INFORMATION PROVIDED ON THIS APPLICATION FOR RENEWAL IS TRUE AND CORRECT IN EVERY RESPECT.

X Jeanne Corwin 3/22/96
(SIGNATURE OF APPLICANT) (DATE)

PROCESSED [illegible] 95
SPECIALTY CODES CORRECT AS LISTED

IF CORRECTIONS ARE NECESSARY, PLEASE ENTER ALL SPECIALTY CODES.

CODE1	CODE2	CODE3
06		

REPORT ANY CHANGE OF ADDRESS

STREET: 3219 CLIFTON AVENUE
STREET: SUITE 125
CITY: CINCINNATI STATE: OH ZIP CODE: 45220
COUNTY: HAMILTON

IDENTIFICATION NUMBER	AMOUNT DUE	DATE DUE
35-06-4667	$250.00	05/01/96

JEANNE MARIE CORWIN,M.D.
6316 KINCAID RD
CINCINNATI OH 45213

⑆969696962⑆ 0935064667⑈ ⑈0000025000⑈

PRINCIPAL PRACTICE ADDRESS - IF DIFFERENT FROM THE ADDRESS SHOWN ON FRONT:

Street

Street

City | State | Zip Code

County

AT ANY TIME SINCE SIGNING YOUR LAST APPLICATION FOR RENEWAL OF YOUR CERTIFICATE HAVE YOU :

YES [ ] NO [x] 1.) Been found guilty of, or pled guilty or no contest to a felony or misdemeanor.

YES [ ] NO [x] 2.) Been found guilty of, or pled guilty or no contest to a federal or state law regulating the possession, distribution or use of any drug?

YES [ ] NO [x] 3.) Been addicted to or dependent upon alcohol or any chemical substance; or been treated for, or been diagnosed as suffering from, drug or alcohol dependency or abuse? You may answer "no" to this question if you have successfully completed treatment at a program approved by this Board and have subsequently adhered to all aftercare requirements as contained in sections 4731.224 and 4731.25 O.R.C., and related provisions, or you are currently enrolled in a board approved program. Any questions concerning approval can be directed to the board offices.

YES [ ] NO [x] 4.) Had malpractice insurance cancelled or limited for other than failure to pay premiums?

YES [ ] NO [x] 5.) Had any disciplinary action taken or initiated against you by any state licensing board other than the State Medical Board of Ohio?

YES [ ] NO [x] 6.) Surrendered, or consented to limitation upon: a) A license to practice medicine; OR b) State or federal privileges to prescribe controlled substances?

YES [ ] NO [x] 7.) Had any clinical privileges suspended, restricted or revoked for reasons other than failure to maintain records or attend staff meetings?

YES [ ] NO [x] 8.) Referred a patient, or participated in an arrangement or scheme for referral of a patient, for clinical laboratory services to a person or facility in which either you or a member of your immediate family has an ownership or investment interest, or any compensation arrangement?

[REDACTED]

SOCIAL SECURITY NUMBER
(Optional for purposes of identification)

888 00112 040296 [illegible]
TAX BATCH P. [illegible]
FEE
250.00 AMOUNT
040296 BATCH DATE
[illegible] ACCOUNT #

DETACH HERE AND REMIT THIS PORTION WITH FEE

STATE MEDICAL BOARD OF OHIO
77 SOUTH HIGH STREET, 17TH FLOOR, COLUMBUS, OHIO 43266 - 0315

CERTIFICATION

I CERTIFY, UNDER PENALTY OF LOSS OF MY RIGHT TO PRACTICE IN THE STATE OF OHIO, THAT I HAVE COMPLETED OR WILL HAVE COMPLETED DURING THE 1996-1998 BIENNIUM THE REQUISITE HOURS OF CONTINUING MEDICAL EDUCATION CERTIFIED BY THE OHIO STATE MEDICAL ASSOCIATION AND APPROVED BY THE STATE MEDICAL BOARD, AND THAT THE INFORMATION PROVIDED ON THIS APPLICATION FOR RENEWAL IS TRUE AND CORRECT IN EVERY RESPECT.

X J. Corwin 3/9/97
(SIGNATURE OF APPLICANT) (DATE)

IDENTIFICATION NUMBER	AMOUNT DUE	DATE DUE
35-06-4667-C	$339.00	05/01/98

JEANNE MARIE CORWIN,M.D.
6272 GRAND VISTA AVE
CINCINNATI OH 45213

MD & DO SPECIALTY CODES CURRENTLY ON RECORD

OBG OBSTETRICS & GYNECOLOGY

☐ SPECIALTY CODE(S) CORRECT AS LISTED

IF CORRECTIONS ARE NECESSARY, PLEASE ENTER ALL SPECIALTY CODES. CODE1 CODE2 CODE3

REPORT ANY CHANGE OF ADDRESS

3219 Clifton Ave #125
STREET

STREET

Cincinnati
CITY

OH
STATE

45220
ZIP CODE

HAMILTON
COUNTY

⑆96969696 2⑆ 0935064667⑈ ⑈0000033900⑈

PRINCIPAL PRACTICE ADDRESS - IF DIFFERENT FROM THE ADDRESS SHOWN ON FRONT:

3219 CLIFTON AVE SUITE 125
Street

Street

CINCINNATI OH 45213
City State Zip Code

HAMILTON
County

AT ANY TIME SINCE SIGNING YOUR LAST APPLICATION FOR RENEWAL OF YOUR CERTIFICATE HAVE YOU :

YES ☐ NO ☑ 1.) Been found guilty of, or pled guilty or no contest to a felony or misdemeanor.

YES ☐ NO ☑ 2.) Been found guilty of, or pled guilty or no contest to a federal or state law regulating the possession, distribution or use of any drug?

YES ☐ NO ☑ 3.) Been addicted to or dependent upon alcohol or any chemical substance; or been treated for, or been diagnosed as suffering from, drug or alcohol dependency or abuse? You may answer "no" to this question if you have successfully completed treatment at a program approved by this board and have subsequently adhered to all statutory requirements as contained in sections 4731.224 and 4731.25 O.R.C., and related provisions, or you are currently enrolled in a board approved program. Any questions concerning approval can be directed to the board offices.

YES ☐ NO ☑ 4.) Had malpractice insurance cancelled or limited for other than failure to pay premiums?

YES ☐ NO ☑ 5.) Had any disciplinary action taken or initiated against you by any state licensing board other than the State Medical Board of Ohio?

YES ☐ NO ☑ 6.) Surrendered, or consented to limitation upon: a) A license to practice medicine; OR b) State or federal privileges to prescribe controlled substances?

YES ☐ NO ☑ 7.) Had any clinical privileges suspended, restricted or revoked for reasons other than failure to maintain records or attend staff meetings?

YES ☐ NO ☑ 8.) Referred a patient, or participated in an arrangement or scheme for referral of a patient, for clinical laboratory services to a person or facility in which either you or a member of your immediate family has an ownership or investment interest, or any compensation arrangement?

REDACTED

SOCIAL SECURITY NUMBER
(Optional for purposes of identification)

DETACH HERE AND REMIT THIS PORTION WITH FEE

STATE MEDICAL BOARD OF OHIO
77 SOUTH HIGH STREET, 17TH FLOOR, COLUMBUS, OHIO 43266 - 0315

CERTIFICATION

I CERTIFY, UNDER PENALTY OF LOSS OF MY RIGHT TO PRACTICE IN THE STATE OF OHIO, THAT I HAVE COMPLETED OR WILL HAVE COMPLETED DURING THE 1998-2000 REGISTRATION PERIOD THE REQUISITE HOURS OF CONTINUING MEDICAL EDUCATION CERTIFIED BY THE
OHIO STATE MEDICAL ASSOCIATION
AND APPROVED BY THE STATE MEDICAL BOARD, AND THAT THE INFORMATION PROVIDED ON THIS APPLICATION FOR RENEWAL IS TRUE AND CORRECT IN EVERY RESPECT.

X Corwin 10/9/00
(SIGNATURE OF APPLICANT) (DATE)

IDENTIFICATION NUMBER	AMOUNT DUE	DATE DUE
35-06-4667-C	$305.00	01/01/2001

JEANNE MARIE CORWIN,M.D.
3219 CLIFTON AVE #125
CINCINNATI OH 45220

OCT 13 2000

MD & DO SPECIALTY CODES CURRENTLY ON RECORD

OBG OBSTETRICS & GYNECOLOGY

☐ SPECIALTY CODE(S) CORRECT AS LISTED

IF CORRECTIONS ARE NECESSARY, PLEASE ENTER ALL SPECIALTY CODES. CODE1 CODE2 CODE3

RESIDENCE ADDRESS-THIS MUST BE ENTERED AT EACH RENEWAL.

STREET

STREET

CITY STATE ZIP CODE

COUNTY

⑆969696962⑆ 0935064667⑈ ⑇0000030500⑇

PRINCIPAL PRACTICE ADDRESS - THIS ADDRESS MUST BE ENTERED AT EACH RENEWAL.

☐ Check this Box if you have NO principle Practice address.

Street

Street

City State Zip Code

County

AT ANY TIME SINCE SIGNING YOUR LAST APPLICATION FOR RENEWAL OF YOUR CERTIFICATE :

YES ☐ NO ☒ 1.) Have you been found guilty of, or pled guilty or no contest to, or received treatment or intervention in lieu of conviction of, a misdemeanor or felony?

YES ☐ NO ☒ 2.) Have you been addicted to or dependent upon alcohol or any chemical substance; or been treated for, or been diagnosed as suffering from, drug or alcohol dependency or abuse? ***You may answer "NO" to this question if*** you have successfully completed treatment at a program approved by this board and have subsequently adhered to all statutory requirements as contained in sections 4731.224 and 4731.25 O.R.C., and related provisions, or you are currently enrolled in a board approved program. Any questions concerning approval can be directed to the board offices.

YES ☐ NO ☒ 3.) Have any malpractice awards been paid by you or on your behalf for acts occurring in any state other than Ohio?

YES ☐ NO ☒ 4.) Has any board, bureau, department, agency, or other body, including those in Ohio, ***other than this board,*** filed any charges, allegations or complaints against you?

YES ☐ NO ☒ 5.) Have you surrendered, or consented to limitation of a license to practice any healthcare profession or state or federal privileges to prescribe controlled substances in any jurisdiction? You may answer "NO" to this question if the only such surrender or consent was given to this board.

YES ☐ **NO** ☒ 6.) Have you had any clinical privileges or other similar institutional authority suspended, restricted or revoked for reasons ***other than failure to maintain records on a timely basis or to attend staff meetings?***

REQUIRED:

REDACTED

SOCIAL SECURITY NUMBER

DETACH HERE AND REMIT THIS PORTION WITH FEE

STATE MEDICAL BOARD OF OHIO

77 SOUTH HIGH STREET, 17TH FLOOR, COLUMBUS, OHIO 43215 - 6127

CERTIFICATION

I CERTIFY, UNDER PENALTY OF LOSS OF MY RIGHT TO PRACTICE IN THE STATE OF OHIO, THAT I HAVE COMPLETED OR WILL HAVE COMPLETED DURING THE 2001 - 2003 REGISTRATION PERIOD THE REQUISITE HOURS OF CONTINUING MEDICAL EDUCATION CERTIFIED BY THE

OHIO STATE MEDICAL ASSOCIATION

AND APPROVED BY THE STATE MEDICAL BOARD, AND THAT THE INFORMATION PROVIDED ON THIS APPLICATION FOR RENEWAL IS TRUE AND CORRECT IN EVERY RESPECT.

X J Corwin 11/04/02

(SIGNATURE OF APPLICANT) (DATE)

IDENTIFICATION NUMBER	AMOUNT DUE	DATE DUE	$50 Late Fee Due After
35-06-4667-C	$305.00	01/01/03	04/01/03

JEANNE MARIE CORWIN,M.D.
3219 CLIFTON AVE #125
CINCINNATI OH 45220

MD & DO SPECIALTY CODES CURRENTLY ON RECORD

OBG OBSTETRICS & GYNECOLOGY

SPECIALTY CODE(S) CORRECT AS LISTED

IF CORRECTIONS ARE NECESSARY, PLEASE ENTER ALL SPECIALTY CODES. CODE1 CODE2 CODE3

RESIDENCE ADDRESS-THIS MUST BE ENTERED AT EACH RENEWAL.

STREET: 6331 GRANDVISTA AVE

STREET:

CITY: CINCINNATI STATE: OH ZIP CODE: 45213

COUNTY: HAMILTON

0935064667 30500

AT ANY TIME SINCE SIGNING YOUR LAST APPLICATION FOR RENEWAL OF YOUR CERTIFICATE :

11072002 711798
0093 047
064667
1 SE 00000305.00

YES	NO	
☐	☒	1.) Have you been found guilty of, or pled guilty or no contest to, or received treatment or intervention in lieu of conviction of, a misdemeanor or felony?
☐	☒	2.) Have you been addicted to or dependent upon alcohol or any chemical substance; or been treated for, or been diagnosed as suffering from, drug or alcohol dependency or abuse? ***You may answer "NO" to this question*** if you have successfully completed treatment at, or are currently enrolled in, a program approved by this Board and have adhered to all statutory requirements during and subsequent to treatment. You must answer "YES" if you have ever relapsed. Any questions concerning program approval or concerning this question can be directed to the board offices.
☐	☒	3.) Have any malpractice awards been paid by you or on your behalf for acts occurring in any state other than Ohio?
☐	☒	4.) Has any board, bureau, department, agency, or other body, including those in Ohio, ***other than this board,*** filed any charges, allegations or complaints against you?
☐	☒	5.) Have you surrendered, or consented to limitation of, or to reprimand or probation concerning, a license to practice any healthcare profession or state or federal privileges to prescribe controlled substances in any jurisdiction? You may answer "NO" to this question if the only such surrender or consent was given to this board.
☐	☒	6.) Have you had any clinical privileges or other similar institutional authority suspended, restricted or revoked for reasons ***other than failure to maintain records on a timely basis or to attend staff meetings?***

PRINCIPAL PRACTICE ADDRESS - THIS ADDRESS MUST BE ENTERED AT EACH RENEWAL.

☐ Check this Box if you have NO principal Practice address.

3219 CLIFTON AVE
Street

STE 125
Street

CINCINNATI OH 45220
City State Zip Code

HAMILTON
County

REQUIRED:

SOCIAL SECURITY NUMBER

Date Posted: 11/4/2004

License Number	35.064667
License Name	JEANNE CORWIN
Email Address	

Fees

Relicensure Fee	$305.00
Late Fee	$0.00
Online Renewal Surcharge	$0.00
	=============
Total Fees	**$305.00**

Address Information Section

BUSINESS ADDRESS

10475 Reading Rd.
SUITE 307
CINCINNATI, OH 45241
513 563 2030
Hamilton County
United States of America

CREDENTIAL MAIL ADDRESS

10475 Reading Rd.
Ste 307
CINCINNATI, OH 45241
513 563 2030
Hamilton County
United States of America

MAIN

6331 GRAND VISTA AVE
CINCINNATI, OH 45213
Hamilton County

Specialty Codes Section

1. Please select one specialty from the field below

   . . . . OBSTETRICS & GYNECOLOGY

2. Please select one specialty from the field below, if applicable.

   . . . . *{not Answered}*

3. Please select one specialty from the field below, if applicable.

   . . . . *{not Answered}*

CME Section

1. Have you met the above CME requirements for your license?

   . . . . YES

Discipline Section

1. Have you been found guilty of, or pled guilty or no contest to, or received treatment or intervention in lieu of conviction of, a misdemeanor or felony?

. . . . NO

2. Have you surrendered, consented to limitation of, or to suspension, reprimand or probation concerning, a license to practice any healthcare profession or state or federal privileges to prescribe controlled substances in any jurisdiction other than Ohio?

. . . . NO

3. Have any malpractice awards been paid by you or on your behalf for acts occurring in any state other than Ohio?

. . . . NO

4. Has any board, bureau, department, agency, or any other body, including those in Ohio **other than this board,** filed any charges, allegations or complaints against you?

. . . . NO

5. Have you had any clinical privileges or other similar institutional authority suspended, restricted or revoked for reasons **other than failure to maintain records on a timely basis or to attend staff meetings?**

. . . . NO

6. Have you been addicted to or dependent upon alcohol or any chemical substance; or been treated for, or been diagnosed as suffering from, drug or alcohol dependency or abuse?

. . . . NO

Date Posted: 10/3/2006 2:16:55 PM

Please review all information you have provided. Click on the "Review" button to change any information given or click on the "I Agree" button to verify that all information posted below is correct and to proceed to payment options.

Please note that knowingly providing false information may result in denial of registration.

License Information

License Number	35.064667
License Name	JEANNE CORWIN
Email Address	FrWmnWebb@hotmail.com

Fees

Relicensure Fee	$305.00
	========
Total Fees	**$305.00**

Specialty Codes

1. Please select one specialty from the field below
 .... GYNECOLOGY
2. Please select one specialty from the field below, if applicable.
 .... *{not Answered}*
3. Please select one specialty from the field below, if applicable.
 .... *{not Answered}*

CME-Physicians

1. Have you met the above CME requirements for your license?
 .... YES

Discipline

1. Have you been found guilty of, or pled guilty or no contest to, or received treatment or intervention in lieu of conviction of, a misdemeanor or felony?
 .... NO
2. Have you surrendered, consented to limitation of, or to suspension, reprimand or probation concerning, a license to practice any healthcare profession or state or federal privileges to prescribe controlled substances in any jurisdiction other than Ohio?
 .... NO
3. Have any malpractice awards been paid by you or on your behalf for acts occurring in any state other than Ohio?
 .... NO
4. Has any board, bureau, department, agency, or any other body, including those in Ohio **other than this board,** filed any charges, allegations or complaints against you?

. . . . NO

5. Have you had any clinical privileges or other similar institutional authority suspended, restricted or revoked for reasons **other than failure to maintain records on a timely basis or to attend staff meetings?**

. . . . NO

6. Have you been addicted to or dependent upon alcohol or any chemical substance; or been treated for, or been diagnosed as suffering from, drug or alcohol dependency or abuse?

. . . . NO

Social Security Number

1.

. . . . REDACTED

Nurse Collaboration Info

1. Are you currently in a collaboration agreement with any Clinical Nurse Specialists, Certified Nurse-Midwives or Certified Nurse Practitioners?

. . . . NO

2. List the name/names and type of licensure for each nurse with whom you are collaborating. **For example: Jane Doe, CNP; Mary Smith, CNS.**

. . . . *{not Answered}*

I understand that submitting a false, fraudulent, or forged statement or document or omitting a material fact in obtaining licensure may be grounds for disciplinary action against my license.

Under penalty of law, I hereby swear or affirm that the information I have provided in the application is complete and correct, and that I have complied with all criteria for applying on line.

Date Posted: 10/31/2008 2:25:10 PM

Please review all information you have provided. Click on the "Review" button to change any information given or click on the "I Agree" button to verify that all information posted below is correct and to proceed to payment options.

Please note that knowingly providing false information may result in denial of registration.

License Information

License Number	35.064667
License Name	JEANNE CORWIN
Email Address	FrWmnWebb@hotmail.com

Fees

Relicensure Fee	$305.00
	========
Total Fees	**$305.00**

Specialty Codes

1. Please select one specialty from the field below

   . . . . GYNECOLOGY
2. Please select one specialty from the field below, if applicable.

   . . . . *{not Answered}*
3. Please select one specialty from the field below, if applicable.

   . . . . *{not Answered}*

CME-Physicians

1. Have you met the above CME requirements for your license?

   . . . . YES

Discipline

1. Have you been found guilty of, or pled guilty or no contest to, or received treatment or intervention in lieu of conviction of, a misdemeanor or felony?

   . . . . NO
2. Have you surrendered, consented to limitation of, or to suspension, reprimand or probation concerning, a license to practice any healthcare profession or state or federal privileges to prescribe controlled substances in any jurisdiction other than Ohio?

   . . . . NO
3. Have any malpractice awards been paid by you or on your behalf for acts occurring in any state other than Ohio?

   . . . . NO
4. Has any board, bureau, department, agency, or any other body, including those in Ohio **other than this board,** filed any charges, allegations or complaints against you?

. . . . NO

5. Have you had any clinical privileges or other similar institutional authority suspended, restricted, revoked or placed on probation for reasons **other than failure to maintain records on a timely basis or to attend staff meetings?**

. . . . NO

6. Have you been addicted to or dependent upon alcohol or any chemical substance; or been treated for, or been diagnosed as suffering from, drug or alcohol dependency or abuse?

. . . . NO

Social Security Number

1.

. . . . REDACTED

Nurse Collaboration Info

1. Are you currently in a collaboration agreement with any Clinical Nurse Specialists, Certified Nurse-Midwives or Certified Nurse Practitioners?

. . . . NO

2. List the name/names and type of licensure for each nurse with whom you are collaborating. **For example: Jane Doe, CNP; Mary Smith, CNS.**

. . . . *{not Answered}*

I understand that submitting a false, fraudulent, or forged statement or document or omitting a material fact in obtaining licensure may be grounds for disciplinary action against my license.

Under penalty of law, I hereby swear or affirm that the information I have provided in the application is complete and correct, and that I have complied with all criteria for applying on line.

Date Posted: 3/9/2011 10:48:17 AM

Please review all information you have provided. Click on the "Review" button to change any information given or click on the "I Agree" button to verify that all information posted below is correct and to proceed to payment options.

Please note that knowingly providing false information may result in denial of registration.

Address Information

BUSINESS ADDRESS

10475 Reading Rd.
SUITE 307
CINCINNATI, OH 45241
Hamilton County
United States of America
513 563 2030
pwebb@forwomeninc.net

CREDENTIAL MAIL ADDRESS

10475 Reading Rd.
Ste 307
CINCINNATI, OH 45241
Hamilton County
United States of America
513 563 2030
pwebb@forwomeninc.net

License Information

License Number 35.064667

License Name JEANNE CORWIN

Fees

Relicensure Fee $305.00

========

Total Fees **$305.00**

Medical Board Correspondence Email

1. **Did you provide a Credential email address? Please note this information is a public record.**

   . . . . YES

Specialty Codes

1. Please select one specialty from the field below

   . . . . GYNECOLOGY

2. Please select one specialty from the field below, if applicable.

   . . . . *{not Answered}*

3. Please select one specialty from the field below, if applicable.

. . . . *{not Answered}*

CME-Physicians

1. Have you met the above CME requirements for your license?

. . . . YES

Discipline

1. Have you been found guilty of, or pled guilty or no contest to, or received treatment or intervention in lieu of conviction of, a misdemeanor or felony?

. . . . NO

2. Have you surrendered, consented to limitation of, or to suspension, reprimand or probation concerning, a license to practice any healthcare profession or state or federal privileges to prescribe controlled substances in any jurisdiction other than Ohio?

. . . . NO

3. Have any malpractice awards been paid by you or on your behalf for acts occurring in any state other than Ohio?

. . . . NO

4. Has any board, bureau, department, agency, or any other body, including those in Ohio **other than this board,** filed any charges, allegations or complaints against you?

. . . . NO

5. Have you had any clinical privileges or other similar institutional authority suspended, restricted, revoked or placed on probation for reasons **other than failure to maintain records on a timely basis or to attend staff meetings?**

. . . . NO

6. Have you been addicted to or dependent upon alcohol or any chemical substance; or been treated for, or been diagnosed as suffering from, drug or alcohol dependency or abuse?

. . . . NO

Social Security Number

1.

. . . . REDACTED

Nurse Collaboration Info

1. Are you currently in a collaboration agreement with any Clinical Nurse Specialists, Certified Nurse-Midwives or Certified Nurse Practitioners?

. . . . NO

2. List the name/names and type of licensure for each nurse with whom you are collaborating. **For example: Jane Doe, CNP; Mary Smith, CNS.**

. . . . *{not Answered}*

Ohio Employment

1. Do you practice in Ohio?

. . . . YES

Ohio Workforce Questions

1. "Clinical" - direct patient care

. . . . 25-29

2. "Research" - study of a treatment, procedure or medication done in a medical setting or for a medical purpose

. . . . 0

3. "Administration" - activities related generally to patient care other than direct contact with a patient (e.g. recordkeeping, clerical tasks, chart review, prior authorizations with insurers, claims, billing issues, etc.)

. . . . 1-4

4. "Education" - preceptor, mentor, etc.

. . . . 1-4

5. "Volunteering" - providing medical and medical-related services at no cost

. . . . 0

6. "Other" - medical professional activities not included in above categories

. . . . 0

Clinical - Practice setting

1. Enter the number of hours per week spent in "Office/Clinic/Ambulatory care" (out-patient care).

. . . . 20-24

2. Enter the number of hours per week spent in "Hospital (in-patient care)".

. . . . 1-4

3. Enter the number of hours per week spent in "Emergency Room".

. . . . 0

4. Enter the number of hours per week spent in "Urgent Care".

. . . . 0

5. Enter the number of hours per week spent in "Other".

. . . . 0

Workforce Counties

1. Enter the first zip code:

. . . . 45241

2. Enter the first county:

. . . . Hamilton

3. Enter the second zip code:

. . . . 45220

4. Enter the second county:

. . . . Hamilton

5. Enter the third zip code:

. . . . *{not Answered}*

6. Enter the third county:

. . . . *{not Answered}*

Practice Arrangement (size)

1. Solo practitioner

. . . . NO

2. Single-specialty Group

. . . . 5-10

3. Multi-specialty Group

. . . . N/A

4. Employee of a clinical facility or hospital? (Clinical facility is an urgent care, industrial clinic or similar entity)

. . . . NO

Workforce Language Question

1. Do practitioners or staff in your practice communicate in sign language or in a language other than spoken English?

. . . . NO

ABMS Certified

1. Are you certified by an ABMS Board?

. . . . YES

ABMS Specialty

1. Choose specialty from the dropdown list.

. . . . Obstetrics and Gynecology

2. Choose specialty from the dropdown list.

. . . . *{not Answered}*

3. Choose specialty from the dropdown list.

. . . . *{not Answered}*

I understand that submitting a false, fraudulent, or forged statement or document or omitting a material fact in obtaining licensure may be grounds for disciplinary action against my license.

Under penalty of law, I hereby swear or affirm that the information I have provided in the application is complete and correct, and that I have complied with all criteria for applying on line.

Date Posted: 10/7/2012 6:30:29 PM

Please review all information you have provided. Click on the "Review" button to change any information given or click on the "I Agree" button to verify that all information posted below is correct and to proceed to payment options.

Please note that knowingly providing false information may result in denial of registration.

Address Information

BUSINESS ADDRESS	10475 Reading Rd. SUITE 307 CINCINNATI, OH 45241 Hamilton County United States of America 513 563 2030 jcorwin@forwomeninc.net
CREDENTIAL MAIL ADDRESS	10475 Reading Rd. Ste 307 CINCINNATI, OH 45241 Hamilton County United States of America 513 563 2030 jcorwin@forwomeninc.net
MAIN	6331 GRAND VISTA AVE CINCINNATI, OH 45213 Hamilton County 513-720-3683 corwinjeanne@yahoo.com

License Information

License Number	35.064667
License Name	JEANNE CORWIN

Fees

Relicensure Fee	$305.00
	========
Total Fees	**$305.00**

Medical Board Correspondence Email

1. **Did you provide a Credential email address? Please note this information is a public record.**

   . . . . YES

Specialty Codes

1. Please select one specialty from the field below

   .... OBSTETRICS & GYNECOLOGY

2. Please select one specialty from the field below, if applicable.

   .... *{not Answered}*

3. Please select one specialty from the field below, if applicable.

   .... *{not Answered}*

CME-Physicians

1. Have you met the above CME requirements for your license?

   .... YES

Discipline

1. Have you been found guilty of, or pled guilty or no contest to, or received treatment or intervention in lieu of conviction of, a misdemeanor or felony?

   .... NO

2. Have you surrendered, consented to limitation of, or to suspension, reprimand or probation concerning, a license to practice any healthcare profession or state or federal privileges to prescribe controlled substances in any jurisdiction other than Ohio?

   .... NO

3. Have any malpractice awards been paid by you or on your behalf for acts occurring in any state other than Ohio?

   .... NO

4. Has any board, bureau, department, agency, or any other body, including those in Ohio **other than this board,** filed any charges, allegations or complaints against you?

   .... NO

5. Have you had any clinical privileges or other similar institutional authority suspended, restricted, revoked or placed on probation for reasons **other than failure to maintain records on a timely basis or to attend staff meetings?**

   .... NO

6. Have you been addicted to or dependent upon alcohol or any chemical substance; or been treated for, or been diagnosed as suffering from, drug or alcohol dependency or abuse?

   .... NO

Social Security Number

1.

   .... REDACTED

Nurse Collaboration Info

1. Are you currently in a collaboration agreement with any Clinical Nurse Specialists, Certified Nurse-Midwives or Certified Nurse Practitioners?

   .... NO

2. List the name/names and type of licensure for each nurse with whom you are collaborating. **For example: Jane Doe, CNP; Mary Smith, CNS.**

. . . . *{not Answered}*

Ohio Employment

1. Do you practice in Ohio?

. . . . YES

Ohio Workforce Questions

1. "Clinical" - direct patient care

. . . . 25-29

2. "Research" - study of a treatment, procedure or medication done in a medical setting or for a medical purpose

. . . . 0

3. "Administration" - activities related generally to patient care other than direct contact with a patient (e.g. recordkeeping, clerical tasks, chart review, prior authorizations with insurers, claims, billing issues, etc.)

. . . . 1-4

4. "Education" - preceptor, mentor, etc.

. . . . 1-4

5. "Volunteering" - providing medical and medical-related services at no cost

. . . . 1-4

6. "Other" - medical professional activities not included in above categories

. . . . 0

Clinical - Practice setting

1. Enter the number of hours per week spent in "Office/Clinic/Ambulatory care" (out-patient care).

. . . . 25-29

2. Enter the number of hours per week spent in "Hospital (in-patient care)".

. . . . 1-4

3. Enter the number of hours per week spent in "Emergency Room".

. . . . 0

4. Enter the number of hours per week spent in "Urgent Care".

. . . . 0

5. Enter the number of hours per week spent in "Other".

. . . . 0

Workforce Counties

1. Enter the first zip code:

. . . . 45241

2. Enter the first county:

. . . . Hamilton

3. Enter the second zip code:

. . . . 45219

4. Enter the second county:

. . . . Hamilton

5. Enter the third zip code:

. . . . *{not Answered}*

6. Enter the third county:

. . . . *{not Answered}*

7. Do you have more than one practice location?

. . . . YES

Workforce Practice Address

1. Please list all practice locations. Include street address, city, state and zip. Example "123 E Main St, Suite 2, Anywhere, OH 55555;" Separate multiply addresses with a semicolon.

. . . . 3219 Clifton Ave. Cincinnati, OH 45219; 10475 Reading Road, Cincinnati, OH 45241

Practice Arrangement (size)

1. Solo practitioner

. . . . NO

2. Single-specialty Group

. . . . 5-10

3. Multi-specialty Group

. . . . N/A

4. Employee of a clinical facility or hospital? (Clinical facility is an urgent care, industrial clinic or similar entity)

. . . . NO

Workforce Language Question

1. Do practitioners or staff in your practice communicate in sign language or in a language other than spoken English?

. . . . NO

ABMS Certified

1. Are you certified by an ABMS Board?

. . . . YES

ABMS Specialty

1. Choose specialty from the dropdown list.

. . . . Obstetrics and Gynecology

2. Choose specialty from the dropdown list.

. . . . *{not Answered}*

3. Choose specialty from the dropdown list.

. . . . *{not Answered}*

I understand that submitting a false, fraudulent, or forged statement or document or omitting a material fact in obtaining licensure may be grounds for disciplinary action against my license.

Under penalty of law, I hereby swear or affirm that the information I have provided in the application is complete and correct, and that I have complied with all criteria for applying on line.

Date Posted: 10/15/2014 9:49:12 AM

Please review all information you have provided. Click on the "Review" button to change any information given or click on the "I Agree" button to verify that all information posted below is correct and to proceed to payment options.

Please note that knowingly providing false information may result in denial of registration.

License Information

License Number	35.064667
License Name	JEANNE CORWIN

Fees

Relicensure Fee	$305.00
	========
Total Fees	**$305.00**

Medical Board Correspondence Email

1. **Did you provide a Credential email address? Please note this information is a public record.**

   .... YES

Specialty Codes

1. Please select one specialty from the field below

   .... GYNECOLOGY

2. Please select one specialty from the field below, if applicable.

   .... *{not Answered}*

3. Please select one specialty from the field below, if applicable.

   .... *{not Answered}*

CME-Physicians

1. Have you met the above CME requirements for your license?

   .... YES

Discipline

1. **At any time since signing your last application for renewal of your certificate** have you been found guilty of, or pled guilty or no contest to, or received treatment or intervention in lieu of conviction of, a misdemeanor or felony?

   .... NO

2. **At any time since signing your last application for renewal of your certificate** have you surrendered, consented to limitation of, or to suspension, reprimand or probation concerning, a license to practice any healthcare profession or state or federal privileges to prescribe controlled substances in any jurisdiction other than Ohio?

. . . . NO

3. **At any time since signing your last application for renewal of your certificate** have any malpractice awards been paid by you or on your behalf for acts occurring in any state other than Ohio?

. . . . NO

4. **At any time since signing your last application for renewal of your certificate** has any board, bureau, department, agency, or any other body, including those in Ohio **other than this board,** filed any charges, allegations or complaints against you?

. . . . NO

5. **At any time since signing your last application for renewal of your certificate** have you had any clinical privileges or other similar institutional authority suspended, restricted, revoked or placed on probation for reasons **other than failure to maintain records on a timely basis or to attend staff meetings?**

. . . . NO

6. **At any time since signing your last application for renewal of your certificate** have you beenaddicted to or dependent upon alcohol or any chemical substance; relapsed, been treated for, or been diagnosed as suffering from, drug or alcohol dependency or abuse?

. . . . NO

Social Security Number

1.

. . . . REDACTED

Nurse Collaboration Info

1. Are you currently in a collaboration agreement with any Clinical Nurse Specialists, Certified Nurse-Midwives or Certified Nurse Practitioners?

. . . . NO

2. List the name/names and type of licensure for each nurse with whom you are collaborating. **For example: Jane Doe, CNP; Mary Smith, CNS.**

. . . . *{not Answered}*

Ohio Employment

1. Do you practice in Ohio?

. . . . YES

Ohio Workforce Questions

1. "Clinical" - direct patient care

. . . . 35-39

2. "Research" - study of a treatment, procedure or medication done in a medical setting or for a medical purpose

. . . . 0

3. "Administration" - activities related generally to patient care other than direct contact with a patient (e.g. recordkeeping, clerical tasks, chart review, prior authorizations with insurers, claims, billing issues, etc.)

. . . . 5-9

4. "Education" - preceptor, mentor, etc.

. . . . 1-4

5. "Volunteering" - providing medical and medical-related services at no cost

. . . . 0

6. "Other" - medical professional activities not included in above categories

. . . . 0

Clinical - Practice setting

1. Enter the number of hours per week spent in "Office/Clinic/Ambulatory care" (out-patient care).

. . . . 35-39

2. Enter the number of hours per week spent in "Hospital (in-patient care)".

. . . . 0

3. Enter the number of hours per week spent in "Emergency Room".

. . . . 0

4. Enter the number of hours per week spent in "Urgent Care".

. . . . 0

5. Enter the number of hours per week spent in "Other".

. . . . 0

Workforce Counties

1. Enter the first zip code:

. . . . 45220

2. Enter the first county:

. . . . Hamilton

3. Enter the second zip code:

. . . . 45241

4. Enter the second county:

. . . . Hamilton

5. Enter the third zip code:

. . . . *{not Answered}*

6. Enter the third county:

. . . . *{not Answered}*

7. Do you have more than one practice location?

. . . . YES

Workforce Practice Address

1. Please list all practice locations. Include street address, city, state and zip. Example "123 E Main St, Suite 2, Anywhere, OH 55555;" Separate multiply addresses with a semicolon.

   .... 10475 Reading Road, Suite 307, Cincinnati, Ohio 45241; 3219 Clifton Avenue Suite 125 Cincinnati, Ohio 45220

Practice Arrangement (size)

1. Solo practitioner

   .... NO

2. Single-specialty Group

   5-10

3. Multi-specialty Group

   .... N/A

4. Employee of a clinical facility or hospital? (Clinical facility is an urgent care, industrial clinic or similar entity)

   .... NO

Workforce Language Question

1. Do practitioners or staff in your practice communicate in sign language or in a language other than spoken English?

   .... NO

ABMS Certified

1. Are you certified by an ABMS Board?

   .... NO

NPI number

1. Please enter your current NPI number

   1972582658

DEA number

1. Please enter your DEA number. Only enter one, or the primary DEA number.

   .... BC3586130

I understandthat submitting a false, fraudulent, or forged statement or document or omitting a material fact in obtaining licensure may be grounds for disciplinary action against my license.

Under penalty of law, I hereby swear or affirm that the information I have provided in the application is complete and correct, and that I have complied with all criteria for applying on line.

Date Posted: 10/27/2016 11:53:36 AM

Please review all information you have provided. Click on the "Review" button to change any information given or click on the "I Agree" button to verify that all information posted below is correct and to proceed to payment options.

Please note that knowingly providing false information may result in denial of registration.

License Information

License Number 35.064667

License Name JEANNE CORWIN

Fees

Relicensure Fee $305.00

========

Total Fees **$305.00**

Medical Board Correspondence Email

1. **Did you provide a Credential email address? Please note this information is a public record.**

 . . . . YES

Specialty Codes

1. Please select one specialty from the field below

 . . . . GYNECOLOGY

2. Please select one specialty from the field below, if applicable.

 . . . . *{not Answered}*

3. Please select one specialty from the field below, if applicable.

 . . . . *{not Answered}*

CME-Physicians

1. Have you met the above CME requirements for your license?

 . . . . YES

Discipline

1. **At any time since signing your last application for renewal of your certificate** have you been found guilty of, or pled guilty or no contest to, or received treatment or intervention in lieu of conviction of, a misdemeanor or felony?

 . . . . NO

2. **At any time since signing your last application for renewal of your certificate** have you surrendered, consented to limitation of, or to suspension, reprimand or probation concerning, a license to practice any healthcare profession or state or federal privileges to prescribe controlled substances in any jurisdiction other than Ohio?

. . . . NO

3. **At any time since signing your last application for renewal of your certificate** have any malpractice awards been paid by you or on your behalf for acts occurring in any state other than Ohio?

. . . . NO

4. **At any time since signing your last application for renewal of your certificate** has any board, bureau, department, agency, or any other body, including those in Ohio **other than this board,** filed any charges, allegations or complaints against you?

. . . . NO

5. **At any time since signing your last application for renewal of your certificate** have you had any clinical privileges or other similar institutional authority suspended, restricted, revoked or placed on probation for reasons **other than failure to maintain records on a timely basis or to attend staff meetings?**

. . . . NO

6. **At any time since signing your last application for renewal of your certificate** have you beenaddicted to or dependent upon alcohol or any chemical substance; relapsed, been treated for, or been diagnosed as suffering from, drug or alcohol dependency or abuse?

. . . . NO

Social Security Number

1.

. . . . REDACTED

Nurse Collaboration Info

1. Are you currently in a collaboration agreement with any Clinical Nurse Specialists, Certified Nurse-Midwives or Certified Nurse Practitioners?

. . . . NO

2. List the name/names and type of licensure for each nurse with whom you are collaborating. **For example: Jane Doe, CNP; Mary Smith, CNS.**

. . . . *{not Answered}*

Ohio Employment

1. Do you practice in Ohio?

. . . . YES

Ohio Workforce Questions

1. "Clinical" - direct patient care

. . . . 30-34

2. "Research" - study of a treatment, procedure or medication done in a medical setting or for a medical purpose

. . . . 1-4

3. "Administration" - activities related generally to patient care other than direct contact with a patient (e.g. recordkeeping, clerical tasks, chart review, prior authorizations with insurers, claims, billing issues, etc.)

. . . . 5-9

4. "Education" - preceptor, mentor, etc.

. . . . 5-9

5. "Volunteering" - providing medical and medical-related services at no cost

. . . . 5-9

6. "Other" - medical professional activities not included in above categories

. . . . 0

Clinical - Practice setting

1. Enter the number of hours per week spent in "Office/Clinic/Ambulatory care" (out-patient care).

. . . . 30-34

2. Enter the number of hours per week spent in "Hospital (in-patient care)".

. . . . 0

3. Enter the number of hours per week spent in "Emergency Room".

. . . . 0

4. Enter the number of hours per week spent in "Urgent Care".

. . . . 0

5. Enter the number of hours per week spent in "Other".

. . . . 0

Workforce Counties

1. Enter the first zip code:

. . . . 45220

2. Enter the first county:

. . . . Hamilton

3. Enter the second zip code:

. . . . 45241

4. Enter the second county:

. . . . Hamilton

5. Enter the third zip code:

. . . . *{not Answered}*

6. Enter the third county:

. . . . *{not Answered}*

7. Do you have more than one practice location?

. . . . YES

Workforce Practice Address

1. Please list all practice locations. Include street address, city, state and zip. Example "123 E Main St, Suite 2, Anywhere, OH 55555;" Separate multiply addresses with a semicolon.
   .... 10475 Reading Road Suite 307 Cincinnati, Ohio 45241; 3219 Clifton Avenue Suite 125 Cincinnati, Ohio 45220

Practice Arrangement (size)

1. Solo practitioner
   .... NO
2. Single-specialty Group
   5-10
3. Multi-specialty Group
   .... N/A
4. Employee of a clinical facility or hospital? (Clinical facility is an urgent care, industrial clinic or similar entity)
   .... NO

Workforce Language Question

1. Do practitioners or staff in your practice communicate in sign language or in a language other than spoken English?
   .... NO

ABMS Certified

1. Are you certified by an ABMS Board?
   .... NO

NPI number

1. Please enter your current NPI number
   1972582658

DEA number

1. Please enter your DEA number. Only enter one, or the primary DEA number.
   .... BC3586130

OARRS Registration

1. Since signing your last renewal have you prescribed or personally furnished opioid analgesics or benzondiazepines while practicing in Ohio?
   .... YES
2. Are you registered with the Ohio Automated Rx Reporting System (OARRS)?
   .... YES

I understand that submitting a false, fraudulent, or forged statement or

document or omitting a material fact in obtaining licensure may be grounds for disciplinary action against my license.

Under penalty of law, I hereby swear or affirm that the information I have provided in the application is complete and correct, and that I have complied with all criteria for applying on line.

Submission Date and Time: 1/30/2019 11:44 AM

License Renewal Application

License Type - Doctor of Medicine (MD)

Personal Information

Provide the necessary personal information in the fields to the right. All fields with (*) are required and must be completed to continue the application process. Demographic and workforce data collected for some licensed healthcare professions is used to enhance the state's capacity for healthcare workforce forecasting, policy development, and research. This data is used to analyze the supply and demand of the healthcare workforce serving Ohio.

Title
Dr.
First Name
JEANNE
Middle Name
MARIE
Last Name
CORWIN
Maiden Name
No Response
Social Security Number
REDACTED
Date of Birth
7/5/1963
Email Address
jcorwin@forwomeninc.net
Phone Number
5135632030
Other Phone Number
5135632030
What is your U.S. Residency status related to your employment?
United States Citizen
Do you consider yourself Hispanic, Latino/a or of Spanish origin?
No
What do you consider your race?
White
List languages you personally use to communicate with patients excluding an interpreter or software
English
Other Language
No Response
Individual National Provider Identifier - if not applicable leave blank
1972582658
Enter home US zip-code. Enter NA if unavailable
45213

Additional Information

Provide the necessary additional information in the fields to the right. All fields with (*) are required and must be completed to continue the application process.

Do you have other aliases?
No Response
What is your gender?
Female
In which country were you born?
United States
In which state were you born (if United States)?
Ohio
In which city were you born?
CINCINNATI

Employment Status

Demographic and workforce data collected for some licensed healthcare professions is used to enhance the state's capacity for healthcare workforce forecasting, policy development, and research. This data is used to analyze the supply and demand of the healthcare workforce serving Ohio.

What is your primary employment status
Actively working in a position(s) that requires this license
Which of the following best describes your five-year employment plan?
Maintain practice hours as is

License Mailing Address

Select a license mailing address by clicking the appropriate checkbox to the right (this is the address used for all postal communications from the Board for this license). To add a new address, click Add Address, complete the required fields, and click Save.

10475 Reading Rd. Ste 307
CINCINNATI
OH
45241
United States

License Public Address

Select a public license mailing address by clicking the appropriate checkbox to the right (this is the address that will be viewable by the public). To add a new address, click Add Address, complete the required fields, and click Save.

10475 Reading Rd. Ste 307
CINCINNATI
OH

45241
United States

Military Service

If you have served in the military, provide the information for the type of service and duration of the service. Also, provide proof of your service.

Have you served in the military?
No
If you answered "Yes", are you currently serving in the military?
No Response
Has your spouse served in the military?
Not Applicable
If you answered "Yes", are they currently serving in the military?
No Response
I declined to answer these questions

Secondary Email Recipient

You may define another email recipient for all automated emails you receive related to your license. You may change this recipient at any time from your dashboard.

Secondary Email Address:

Specialty Tracking Component

Please list any American Board of Medical Specialties, American Osteopathic Association, or Council on Podiatric Medical Education specialty and/or subspecialty certifications that you currently hold.

Medical Speciality Certification - American Board of Medical Specialties (ABMS)
Medical Speciality - Obstetrics and Gynecology (ABMS)
Medical SubSpeciality - null

Current Employment Location(s)

Please provide the following information for all practice sites where you use this license, beginning with the locations in which you spend most of your time. If you are not actively working or volunteering in a position

that requires this license (e.g. student or recent graduate) employment location information is optional. Employment location information helps improve the accuracy and efficiency of Health Professional Shortage Area Designations and enables Ohio to identify healthcare workforce distribution.

Name of Practice Site - For Women Inc
Practice Settings - Office/Clinic - Single Specialty Group
Street Address - 10475 Reading Road Suite 307
City - Cincinnati
State - OH
Zip Code - 45241
Major Area of Focus or Specialty - Obstetrics and Gynecology (ABMS)
Total Hours Worked at this practice site, per Week - 30

Percent of time spent per week in each of the following at this practice site:
Direct Patient Care - 75
Teaching/Academic - 3
Research - 10
Professional Services - 0
Administrative Activities - 12
Other - 0
Total Hours- 100

Hospital Admitting Privileges for Patients - Yes
Current Employment Arrangement - Salaried
Other Employment Arrangement - null
Intern/Resident Position - No
Employed as Federal Employee - No
Accepting New Patients - Yes

Questions

Answer the following questions by selecting the Yes/No option for each question. Once completed, click Save and Continue.

Question - At any time since signing your last application for renewal of your certificate have you ever been denied a license to prescribe, dispense, administer, supply, or sell a controlled substance by the drug enforcement administration or appropriate issuing body of any state or jurisdiction, based, in whole or in part, on inappropriate prescribing, dispensing, administering, supplying or selling a controlled substance or other dangerous drug?
Answer -
Question - At any time since signing your last application for renewal of your certificate have you ever had a restriction of a license issued by the drug enforcement administration or a state licensing administration in any jurisdiction, under which you could prescribe, dispense, administer, supply or sell a controlled substance, that was restricted, based, in whole or in part, on inappropriate prescribing, dispensing, administering, supplying, or selling a controlled substance or other dangerous drug?
Answer -
Question - At any time since signing your last application for renewal of your certificate have you ever been

subject to disciplinary action by any licensing entity that was based, in whole or in part, on inappropriate prescribing, dispensing, diverting, administering, supplying or selling a controlled substance or other dangerous drug?
Answer -
Question - Have you completed at least two hours of continuing medical education, annually for the past two years, that were certified by the Ohio State Medical Association or the Ohio Osteopathic Association, that assist physicians in diagnosing qualifying medical conditions and treating these conditions with medical marijuana including the characteristics of medical marijuana and possible drug interaction.
Answer -
Question - At any time since signing your last application for renewal of your certificate do you have an ownership or investment interest in or compensation agreement with any medical marijuana entity or applicant?
Answer -
Question - At any time since signing your last application for renewal of your certificate have you been found guilty of, or pled guilty or no contest to, or received treatment or intervention in lieu of conviction of, a misdemeanor or felony?
Answer - No

Question - At any time since signing your last application for renewal of your certificate have you surrendered, consented to limitation of, or to suspension, reprimand or probation concerning, a license to practice any healthcare profession or state or federal privileges to prescribe controlled substances in any jurisdiction other than Ohio?
Answer - No

Question - At any time since signing your last application for renewal of your certificate has any board, bureau, department, agency, or any other body, including those in Ohio other than this board, filed any charges, allegations or complaints against you?
Answer - No

Question - At any time since submission of your last application for renewal have you been addicted to or dependent upon alcohol or any chemical substance; or been treated for, or been diagnosed as suffering from, drug or alcohol dependency or abuse? You may answer NO to this question if you have successfully completed treatment at, or are currently enrolled in, a program approved by this Board and have adhered to all statutory requirements during and subsequent to treatment. You must answer YES if you have ever relapsed.
Answer - No

Question - At any time since signing your last application for renewal of your certificate have you had any clinical privileges or other similar institutional authority suspended, restricted, revoked or placed on probation for reasons other than failure to maintain records on a timely basis or to attend staff meetings?
Answer - No

Question - At any time since signing your last application for renewal of your certificate have any malpractice awards been paid by you or on your behalf for acts occurring in any state other than Ohio?
Answer - No

Question - Are you currently in a collaboration agreement with any Clinical Nurse Specialists, Certified

Nurse-Midwives or Certified Nurse Practitioners?
Answer - No

Question - Do you currently supervise one or more Physician Assistants?
Answer - No

Question - Since signing your last renewal have you prescribed opioid analgesics or benzondiazepines while practicing in Ohio?
Answer - Yes

Question - Primary DEA Number
Answer - BC3586130

Question - Are you registered with the Ohio Automated Rx Reporting System (OARRS)?
Answer - Yes

Attachments

If applicable, upload the Attachments for your license application by clicking the Add Attachment button(s). If uploading an attachment as a submission, it is necessary that the name of the file attachment is less than 80 characters in length for it to be received successfully. The character limit does include the file attachment extension, such as (.doc) and (.pdf). The (.exe) and (.html) file extensions are not supported for submissions. For documentation that needs to be submitted directly to the Board or by hardcopy, please acknowledge by clicking the Attest button(s). If no attachment or attestation items appear, please click the Save and Continue button.

Review + Submit

Once the review has been processed, the license application will be completed.

Application Review - Completed

Attestation
I understand that submitting a false, fraudulent, or forged statement or document or omitting a material fact in obtaining licensure may be grounds for disciplinary action against my license. Under penalty of law, I hereby swear or affirm that the information I have provided in the application is complete and correct, and that I have complied with all criteria for applying.

Consent to Electronic Signature - **Consented**
Date/Time Stamp - 1/30/2019 11:44 AM
Type your First Name and Last Name as they appear on the application to sign electronically.
JEANNE CORWIN
Submit your Application -After clicking the ‘Submit’ button below, you will no longer be able to change this application. **PLEASE DO NOT USE THE BROWSER'S BACK BUTTON AS THAT MAY OVERWRITE YOUR DATA.** If you want to return to your application, simply log out and log back in.
If this application requires payment you will be prompted to begin the payment process. You must complete the payment process before the board will review your application. If this application does not require payment, you will be navigated back to the eLicense home page and the board will review your application.

Contact Audit Trail for CORWIN JEANNE

Date	User	Table	Field	New	Old
10/9/2012 7:34:09 AM	Hawk, L	CONTACTADDRESS	PHONE	513-720-3683	
11/5/2004 9:24:16 AM	Rieve, K	CONTACTADDRESS	ZIPCODE	45241	45213
11/5/2004 9:24:16 AM	Rieve, K	CONTACTADDRESS	ZIPCODE	45241	45220
11/5/2004 9:24:16 AM	Rieve, K	CONTACTADDRESS	PHONE	513 563 2030	
11/5/2004 9:24:16 AM	Rieve, K	CONTACTADDRESS	PHONE	513 563 2030	
11/5/2004 9:24:16 AM	Rieve, K	CONTACTADDRESS	COUNTRYIDNT	United States of America	
11/5/2004 9:24:16 AM	Rieve, K	CONTACTADDRESS	COUNTRYIDNT	United States of America	
11/5/2004 9:24:16 AM	Rieve, K	CONTACTADDRESS	ADDRESS1	10475 Reading Rd.	6331 GRAND VISTA AVE
11/5/2004 9:24:16 AM	Rieve, K	CONTACTADDRESS	ADDRESS1	10475 Reading Rd.	3219 CLIFTON AVE
11/5/2004 9:24:16 AM	Rieve, K	CONTACTADDRESS	ADDRESS2	Ste 307	
11/5/2004 9:24:16 AM	Rieve, K	CONTACTADDRESS	ADDRESS2	SUITE 307	SUITE 125