Physician and Surgeon Application Summary

66149
PY DOM

Lockley, April Marie
[redacted]

Application #: 125299
Application Rec'd: 05/24/2019
Board Date:
Basis: COMLEX
Legal:

Deposit # : H7B-19364
Amt Paid : 425.25

Birthdate [redacted]1984
Birthplace: San Antonio, TX USA

Received:	Completed:	
		Exam
05/06/2019	05/01/2019	COMLEX1 478 10/24/2011;COMLEX2 480 08/04/2014;COMLEX3 469 11/24/2015;
		Competency
		Medical School
05/24/2019	05/24/2019	Diploma
05/20/2019	05/14/2019	PHILADELPHIA COL OSTEO Philadelphia PA USA - D.O. 06/07/2015
		Medical Training
		Certificate None issued
05/06/2019		Bryn Mawr Hospital 07/01/2016-06/30/2019 Bryn Mawr PA USA Family Medicine- Family Medicine Form not dated
07/30/2019	07/24/2019	St John's Episcopal Hospital 07/01/2015-06/30/2016 Far Rockaway NY USA Traditional Rotating AOA Website
		Licenses
05/13/2019	05/08/2019	NY, USA 02/28/2021
05/02/2019	05/02/2019	PA, USA 06/30/2019
07/09/2019	07/09/2019	MN Computer Check
		Hospital Privileges
		Recommendations
05/10/2019	05/07/2019	Stephen Wakulailes, MD
05/10/2019	05/07/2019	Joseph Greco, MD
		Databank Searches

		AMA Not listed on AMA
07/05/2019	07/05/2019	Federation
05/24/2019	04/30/2019	the DataBank - NPDB
07/05/2019	07/05/2019	AOA Report

Miscellaneous

07/17/2019	07/17/2019	Accounting of time
05/24/2019	05/06/2019	Photo
05/24/2019	05/06/2019	Release
05/24/2019	04/30/2019	Malpractice history report NONE
05/24/2019	04/30/2019	Facilities list NONE
		Military papers Branch -
05/24/2019	04/30/2019	Addendum To Application Click Profile to update, if any
05/24/2019	05/24/2019	Driver's License
07/24/2019	07/24/2019	Treating Physician Statement N/A
06/11/2019	06/11/2019	CBC Fingerprint Results Received, Reviewed and Returned
05/24/2019	05/24/2019	Name Change document

APPLICATION FOR MEDICAL LICENSE

MINNESOTA BOARD OF MEDICAL PRACTICE
UNIVERSITY PARK PLAZA
2829 UNIVERSITY AVENUE SE, SUITE 500
MINNEAPOLIS, MINNESOTA 55414-3246
612-617-2130 or www.bmp.state.mn.us
Hearing Impaired-Minnesota Relay Service
Metro Area 297-5353
Outside Metro Area 1-800-627-3529

425.25

MAY 1 0 2019

APPLICATION #: 125299
CHECK/RECEIPT #: 364-25
AMT PAID:
LICENSE #: 66149

425.25

MAY 2 4 2019

ACCOUNT CODE	AMOUNT
635009 lic	192.00
635010 app	200.00
635064 cbc	33.25

Instructions to Applicant

1. The application will be returned if the fee is not included or the questions are not answered completely, accurately, and legibly.
2. Account for all time from the beginning of high school, whether spent in school, practice, or otherwise. Dates must include Month and Year. Attach separate sheet if necessary.
3. Failure to answer all questions completely and accurately, omission or falsification of material facts, alteration of application may be cause for denial of your application, or disciplinary action if you are subsequently licensed by the Board.
4. Incomplete applications may be destroyed after six months of inactivity.

Medical Professional Name If your name has changed at any time during your life and you are not using FCVS, submit a copy of the legal documentation (marriage certificate, divorce decree, etc.).

Last Name Lockley
First Name April
Middle Name marie
Maiden Name
All Other Names Used April Elder - divorce decree attached

Designated Address (Public, **required by Minn. Stat. 13.41, Subd. 2,** will be placed on license and on our website)

Street 135 S. Bryn Mawr Ave.
City Bryn Mawr State PA Zip Code 19010 Country U.S.
Phone 610-325-1390 Email (optional)

Private Address (cannot be accessed by public)

Street [redacted]
City [redacted] State [redacted] Zip Code [redacted] Country U.S.
Phone [redacted] Email (REQUIRED) [redacted]

Intended Address (if known) Effective Date
Street
City State Zip Code Country

Applicant Name April Lockley Last 4 digits of SSN [redacted] Date 4/30/19

Identification Submit a notarized copy of your US/Canadian driver's license.

Date of Birth (mm/dd/yyyy) [redacted]1984 Birth City San Antonio Birth State TX

Birth County Bexar Birth Country U.S. Gender Female

Driver's license: State PA Number [redacted] SSN [redacted] NPI 1548648538

Height (ft/in) 5'3 Weight (lbs) 170 Hair Color Black Eye Color Brown

Minn. Stat. § 147.091 Subd. 7(d) requires all applicants to provide their social security number on their license application for the administration of the state tax code. Your social security number is private. Your social security number is also required to facilitate reporting of the DataBank and for accurate identification under the federal and state child support enforcement law. The National Provider Identifier (NPI) is a Health Insurance Portability and Accountability Act (HIPAA) Administrative Simplification Standard and a unique number for covered health care providers.

Medical School List all medical schools you have attended including those from which you did not graduate. If you are not using FCVS, complete the "Medical Education Verification" form and send to all medical schools you have attended. Include a copy of your diploma for the medical school to attach their seal prior to forwarding to the Minnesota Board.

1. School Name Philadelphia College of Osteopathic Medicine

Address 4170 City Ave.

City Philadelphia State PA Zip Code 19131 Country U.S.

Attended from 08/01/2009 (mm/dd/yyyy) to 06/01/2015 (mm/dd/yyyy) Graduation Date 06/01/2015 (mm/dd/yyyy) Degree D.O.

2. School Name _____

Address _____

City _____ State _____ Zip Code _____ Country _____

Attended from _____ (mm/dd/yyyy) to _____ (mm/dd/yyyy) Graduation Date _____ (mm/dd/yyyy) Degree _____

ECFMG Certification If ECFMG is applicable and you are not using FCVS, log on to www.ecfmg.org/cvs/index.html for the request form or to submit the request online. Confirmations are sent directly to the Minnesota Board. .

Certificate Number _____ Issue Date _____ Valid Through Date _____

Military Service. Submit a notarized copy of military discharge papers (DD Form 214), if applicable.

Branch of Service _____ Entry Date (mm/dd/yyy) _____ Release Date (mm/dd/yyyy) _____

Rank at Discharge _____ Type of Discharge _____

Exam History. Contact the appropriate examination entity (see instructions) and arrange to have a certified transcript of your scores sent **DIRECTLY** to this Board. See Fact Sheet for exam requirements. Please check all that apply:

___ FLEX ___ LMCC ___ National Board (NBME) ___ USMLE ✓ NBOME/COMLEX

___ State Board Exam (prior to 1973) Which State? _____ Date(s) passed? _____

Applicant Name April Lockley Last 4 digits of SSN [redacted] Date 4/30/19

Proposed practice plans in Minnesota (if any):_____

Current* specialty board certification (check one):

____American Board of Medical Specialties
____Royal College of Physicians and Surgeons of Canada
____College of Family Physicians of Canada
____American Osteopathic Association Bureau of Professional Education
✓ None of the above

Specialty_____
Issue Date_____
Expiration Date_____

*If it has been more than 10 years since your initial licensing exam, the SPEX exam is required unless currently specialty board certified.

US/Canadian Licensure Complete the attached "Licensure Verification" form and forward to US/Canadian board issuing any type of medical license including training, locum tenens, and temporary permit even if license is not current. Attach an additional sheet as necessary. The verifying entity must forward all documentation **DIRECTLY** to this Board. Some boards charge a fee for this information.

State_____ License Number_____ Date Issued_____
State PA License Number OT-017227 Date Issued Renewed each year 7/1/16 to present
State NY License Number 297889 Date Issued 2/28/19
State_____ License Number_____ Date Issued_____
State_____ License Number_____ Date Issued_____
State_____ License Number_____ Date Issued_____
State_____ License Number_____ Date Issued_____

Countries (other than U.S. and Canada) in which you have ever been licensed:

Country_____ License Number_____ Date Issued_____
Country_____ License Number_____ Date Issued_____
Country_____ License Number_____ Date Issued_____

High school (attach a separate sheet, if necessary)

From (mo/yr): 8/98 High School Leonardtown High School
To (mo/yr): 6/02 City Leonardtown State MD Country U.S.

College education (attach a separate sheet, if necessary)

From (mo/yr): 8/02 College Longwood University
To (mo/yr): 6/06 City Farmville State VA Country U.S.

See attached Sheet

Applicant Name April Lockley Last 4 digits of SSN [redacted] Date 4/30/19

Post-baccalaureate Pre-medical Certificate
Towson University
Towson, MD
U.S.
From 7/06 until 07/07

April Lockley SSN: [redacted] Date: 4/30/19

Activities (copy and attach additional pages as needed) List below **all medical and non-medical activities** beginning with your graduation from high school to the present date including periods of unemployment and military duty and excluding post graduate training listed on page 5. For any non-working time, state on the form what your activities were (e.g. vacation, seeking employment). If you did locum tenens, list facilities where you worked.

From (mo/yr): 07/07
To (mo/yr): 06/09
Activity: Employment: Richmond Behavioral Health Authority
Address: 107 S. 5th St.
City: Richmond State: VA Country: U.S.
Position: Case Manager % Clinical: ____ %Administrative: 100

From (mo/yr): 06/09
To (mo/yr): 08/09
Activity: moving to Philadelphia / vacation
Address: ____
City: ____ State: ____ Country: ____
Position: ____ % Clinical: ____ %Administrative: ____

From (mo/yr): ____
To (mo/yr): ____
Activity: ____
Address: ____
City: ____ State: ____ Country: ____
Position: ____ % Clinical: ____ %Administrative: ____

From (mo/yr): ____
To (mo/yr): ____
Activity: ____
Address: ____
City: ____ State: ____ Country: ____
Position: ____ % Clinical: ____ %Administrative: ____

From (mo/yr): ____
To (mo/yr): ____
Activity: ____
Address: ____
City: ____ State: ____ Country: ____
Position: ____ % Clinical: ____ %Administrative: ____

From (mo/yr): ____
To (mo/yr): ____
Activity: ____
Address: ____
City: ____ State: ____ Country: ____
Position: ____ % Clinical: ____ %Administrative: ____

From (mo/yr): ____
To (mo/yr): ____
Activity: ____
Address: ____
City: ____ State: ____ Country: ____
Position: ____ % Clinical: ____ %Administrative: ____

Applicant Name: April Lockley Last 4 digits of SSN [redacted] Date: 4/30/19

Postgraduate Training: List **all** postgraduate programs you have attended, even those you did not complete. If you are not using FCVS, you must complete the attached "Post graduate Training Verification" form and send to **all** postgraduate training programs you have attended. Submit a copy of your certificate of program completion. The post graduate program must forward the documentation **DIRECTLY** to this Board. Copy and attach additional pages if necessary

1. Hospital Name St. John's Episcopal Hospital
Hospital Address 327 Beach 19th St.
City Far Rockaway State NY Zip Code 11691 Country U.S.
PGY: (e.g., 1, 2, 3, etc.) ✓ Internship ___Residency ___Fellowship ___Research ___Other
Department/Specialty Traditional Rotating Internship
From 07 / 15 To 07 / 16 Successfully Completed? ✓ Yes ✓ No ___In Progress
Month Year Month Year
error (al)

---

2. Hospital Name Bryn Mawr Family Practice
Hospital Address 135 S. Bryn Mawr Ave Suite 200
City Bryn Mawr State PA Zip Code 19010 Country U.S.
PGY: (e.g., 1, 2, 3, etc.) ___ Internship ✓ Residency ___Fellowship ___Research ___Other
Department/Specialty Family Medicine
From 07 / 16 To 07 / 19 Successfully Completed? ___Yes ___No ✓ In Progress
Month Year Month Year

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3. Hospital Name ___
Hospital Address ___
City ___ State ___ Zip Code ___ Country ___
PGY: (e.g., 1, 2, 3, etc.) ___ Internship ___Residency ___Fellowship ___Research ___Other
Department/Specialty ___
From ___/___ To ___/___ Successfully Completed? ___Yes ___No ___In Progress
Month Year Month Year

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4. Hospital Name ___
Hospital Address ___
City ___ State ___ Zip Code ___ Country ___
PGY: (e.g., 1, 2, 3, etc.) ___ Internship ___Residency ___Fellowship ___Research ___Other
Department/Specialty ___
From ___/___ To ___/___ Successfully Completed? ___Yes ___No ___In Progress
Month Year Month Year

Applicant Name April Lockley Last 4 digits of SSN [redacted] Date 4/30/19

Attestation questions Except for questions 1-4, please answer all questions by selecting Yes or No and provide an explanation when requested. Questions 1-4 do not have "No" as an option for confidentiality reasons. If you have a condition addressed by questions 1-4 and you are NOT participating in Health Professionals Services Program (HPSP) for monitoring of the condition, you must answer "Yes" to the applicable question(s). If you do not have this condition, OR if you are participating in HPSP for monitoring of this condition, do not answer the applicable question(s). For questions 1-2, the terms "impaired" and "limited" include but are not limited to impairments or limitations related to physical, psychological, or emotional disorders or conditions, or chemical dependency or chemical abuse. The purpose and intended use of this information is to enable the Board to determine whether you meet statutory and rule requirements for licensure. This information is classified as private while your application is pending and public after your license is granted. Exception: "Yes" answers are confidential during any investigation and private thereafter. This information will NOT be included in the profiling. If responses to questions change during the time your application is pending, you must make the board aware of the new information. If additional space is necessary please attach a separate sheet.

Yes 1. Is your cognitive, communicative, or physical capability to engage in the practice of medicine or surgery with reasonable skill and safety impaired or limited in any way? Please describe.

_____

_____

Yes No 1a. If yes, are the limitations or impairments reduced or ameliorated because you receive ongoing treatment (with or without medications) or participate in a monitoring program? Please describe._____

_____

Yes No 1b. If yes, are the limitations or impairments reduced or ameliorated because of the field of practice, the setting, or the manner in which you have chosen to practice? Please describe._____

_____

Yes 2. Does your use of alcohol or chemical substance(s), including prescription medications, in any way impair or limit your ability to practice medicine with reasonable skill and safety? Please describe.

_____

_____

Yes 3. Are you engaged in any illegal use of controlled substances including the use of illegal controlled substances (e.g. heroin, cocaine) or illegal use of legal controlled substances (i.e. not obtained pursuant to a valid prescription of a licensed health care provider)? Please describe.

_____

_____

Yes No 3a. If yes, have you taken any steps (i.e. treatment, psychotherapy, participation in a support group) to discontinue or reduce such use? Please describe.

_____

_____

Yes No 3b. If yes, are you not participating in a supervised rehabilitation program or professional assistance program which has as a component a monitoring regimen designed to assure that you are not currently engaging in the use of illegal controlled substances? Please describe._____

_____

Yes 4. Have you within the past five years been advised by your treating physician that you have a mental, physical, or emotional condition, which, if untreated, would be likely to impair your ability to practice medicine with reasonable skill and safety? I you answer this question "yes", please answer the following:

Yes No 4a. With regard to any condition referenced above, are you being treated so that such impairment is avoided?

Yes No 4b. With regard to any condition referenced above, are you in compliance with the recommended treatment?

Yes No 4c. With regard to any condition referenced above, has your treating physician advised you that you are able to practice medicine with reasonable skill and safety?

4d. Please explain_____

4e. Identify your treating physician_____

[redacted] 5. Have you ever been diagnosed as having or have you ever been treated for pedophilia, exhibitionism, voyeurism, or other sexual behavior disorders? Please describe.

_____

_____

[redacted] . Have you ever been the subject of an investigation by any Federal, State, or Local agency having jurisdiction over controlled substances? If so, give particulars.

_____

_____

[redacted] 7. Have you ever been denied a license, or the privilege of taking an examination before any medical examining board, or has a conditioned license been issued to you by any state medical board or licensing authority? If so, give particulars.

_____

_____

[redacted] 8. Has your license to practice medicine in any state or country been voluntarily or involuntarily (i.e. by medical Board Order or any other form of disciplinary action) revoked, suspended, restricted, or conditioned by a Medical Board or other licensing authority? If so, give particulars.

_____

_____

[redacted] 9. Have you ever been notified of any investigation by any state medical board, medical society, or any hospital of any complaints against you relative to the practice of medicine, or have you been reprimanded or censure by any medical society or licensing board? If so, give particulars.

_____

_____

[redacted] 0. Have you ever been a defendant in any malpractice lawsuits, had any malpractice settlement, or have any pending? If so, give a detailed clinical explanation of each case on the Malpractice Liability Claims Information form as well as documentation of outcome (insurance papers or court documents).

[redacted] 1. Have your hospital privileges been restricted or revoked? If so, give particulars.

_____

_____

[redacted] 12. Have there ever been any criminal charges filed against you? This includes charges of disorderly conduct, assault or battery, or domestic abuse, whether the charges were misdemeanor, gross misdemeanor, or felony. This also includes any offenses which have been expunged or otherwise removed from your record by executive pardon. If so, submit a personal statement regarding the date of conduct, state and local jurisdiction in which the charges were filed, date of closure, what role you played, and the outcome.

[redacted] 13. Have there ever been any charges or Driving While Intoxicated (DWI) or Driving Under the Influence (DUI) or other impaired driving offenses involving alcohol or other chemical filed against you? If so, submit a detailed personal statement regarding the date of conduct, state and local jurisdiction in which the charges were filed, explaining in detail the incident and consequences including whether a CD evaluation was done (if so, submit results), and description of current drinking habits.

[redacted] 14. Have you ever voluntarily or involuntarily surrendered your DEA certificate or the right to prescribe controlled substances? If so, give particulars.

_____

_____

IN THE COURT OF COMMON PLEAS OF FIFTY-NINTH JUDICIAL DISTRICT OF PENNSYLVANIA CIVIL ACTION-DIVORCE

APRIL M. LOCKLEY [redacted] Plaintiff	:	Cameron County
vs.	:	Civil Action - Divorce
[redacted] Defendant	:	Court No.:2014-1262

AFFIDAVIT OF INTENTION TO RETAKE MAIDEN (OR PRIOR) NAME

April M. Elder, being duly sworn according to law, deposes and says that a divorce action was filed on July 17, 2014 in Cameron County in which she is the Plaintiff in the above suit; that **April M. Elder** elects to retake and hereafter use her maiden name (or prior name) **April M. Lockley** and therefore gives this written notice avowing said intention in accordance with the provisions of 54 Pa.C.S.A. § 704(a).

April M. Elder

To be known as: April M. Lockley
(Printed Name)

April M. Lockley

Sworn to and subscribed before me this 19th day of November, 2014.

Notary

My Commission Expires 2017

CLAIR M. STEWART, ESQUIRE
ID# 86967
21 SOUTH 12TH STREET, SUITE #100
PHILADELPHIA, PA 19107
(215) 564-5150
215-405-8055 (fax)
clairstewart@cstewartlaw.com

ATTORNEY FOR PLAINTIFF

IN THE COURT OF COMMON PLEAS OF FIFTY-NINTH JUDICIAL DISTRICT OF PENNSYLVANIA CIVIL ACTION-DIVORCE

APRIL M. LOCKLEY
[redacted]
Plaintiff

vs.

[redacted]
Defendant

Cameron County

Civil Action - Divorce

Court No.:2014-1262

DECREE AND ORDER

AND NOW, this 1st day of December, 2014, the Court by virtue of the authority vested in it by law, **DECREES** that **APRIL M. LOCKLEY** and **JOSHUA L. ELDER** are hereby divorced from the bonds of matrimony, and the said parties shall be at liberty to marry again.

AND IT IS FURTHER ORDERED, ADJUDGED AND DECREED that the terms, provisions and conditions of a certain Property Settlement Agreement between the parties dated _____ and attached hereto, is hereby incorporated in this Decree and Order as reference as fully as though the same were set forth herein at length. Said agreement shall not merge with, but shall survive this Decree and Order.

BY THE COURT:

/S/RICHARD A. MASSON J.
PRESIDENT JUDGE

True and Correct Copy
certified from the
Records of Cameron Co.
Penna.
Deputy Prothonotary

Certificate of Ethical and Moral Character

This certificate must be signed by **two** licensed physicians who are personally acquainted with the applicant.

1.

I certify that the photograph attached is a recent one and likeness of Dr. Lockley

And that s/he is a person of good ethical and moral character.

SIGNATURE	DATE	LICENSE NUMBER	STATE OF ISSUE
[signature]	5/7/19	MD034104	PA

Stephen D Lockley
PRINT OR TYPE FULL NAME

CERTIFICATION OF IDENTIFICATION
Certification of Notary Public is required.

State: Pennsylvania County: Montgomery

I certify that on the date set forth below, the individual named above did appear Personally before me and that I did identify this applicant by: (a) comparing his/her physical appearance with the photograph on the identifying document presented by the applicant and with the photograph affixed hereto, and (b) comparing the applicant's signature made in my presence on this form with the signature on his/her identifying document. Sworn to before me by the applicant on this 6th day of May, 2019.

Notary Public Signature [signature] Shelby M Young

Expiration Date 02 / 14 / 2023
Month Day Year

SEAL
The impre
of the s
must b
partly
upon the

Applicant's Signature

2.

I certify that the photograph attached is a recent one and likeness of Dr. Lockley

And that s/he is a person of good ethical and moral character.

SIGNATURE	DATE	LICENSE NUMBER	STATE OF ISSUE
Joseph A Greco MD	5/7/2019	MD050979L	PA

Joseph A. Greco MD
PRINT OR TYPE FULL NAME

Applicant Name April Lockley Last 4 digits of SSN [redacted] Date 5/7/19

Affidavit and Release

I, the undersigned, hereby certify under oath that I am the person described and identified; that I have not engaged in any of the acts prohibited by the statutes of Minnesota: that I am the person named in the diploma, which accompanies this application; that I am the lawful holder of said diploma; that said diploma was procured in the regular course of instruction and examination without fraud or misrepresentation.

I hereby authorize all educational institutions, hospitals, medical institutions or organizations, clinics, my references, personal physicians, employers (past and present), business and professional associates (past and present), all governmental agencies and instrumentalities (local, state, federal or foreign) to release to this licensing Board any information, files, or records including (but not limited to) transcripts, medical records, personnel files, and any information, favorable or otherwise, the Board may require for its evaluation of my professional, ethical, and physical qualifications for licensure in Minnesota.

I hereby release, discharge, and exonerate the Board, its agents, and representatives, and any person furnishing information to the Board from any and all liability of every nature and kind arising out of the furnishing of oral information or of documents, records, or other information to the Board.

I have carefully read the questions in the in the foregoing application and have answered them completely, without reservations of any kind, and I declare under penalty of perjury that my answers and all statements made by me herein are true and correct. Should I furnish any false information in this application, I hereby agree that such act shall constitute cause for the denial, suspension or revocation of my license to practice medicine in Minnesota. I understand that I am required to update my application with pertinent information to cover the time period between date of application and date approved by the Board.

State of: Pennsylvania, County of: Montgomery

Sworn to before me this 6th day of May, 2019.

[signature] 5/6/19

Signature of Applicant — Date of signature (must correspond to date of notarization)

Shelby N. Young

Signature of Notary Public

My Commission Expires: February 14, 2023

Commonwealth of Pennsylvania - Notary Seal
Shelby N. Young, Notary Public
Montgomery County
My commission expires February 14, 2023
Commission number 1345493
Member, Pennsylvania Association of Notaries

RIGHTS OF SUBJECTS OF DATA

The information on your application is requested by the Minnesota Board of Medical Practice. The purpose and intended use of this information is to enable the Board to determine whether you meet statutory and rule requirements for licensure. The information is classified as private while your application is pending or if your application is denied, and as public if your license is granted You are required to submit this information. Your application will not be processed without it and the form will be returned to you for completion. This information may be used as the basis for further investigation by the Board into your qualifications. Under some circumstances, the information could become available to other agencies or persons authorized by law to have access. Attach a separate page for detailed explanations, when appropriate. Failure to answer all questions completely and accurately, omission or falsification of material fact, alteration of application may be cause for denial of your application, or disciplinary action if you are subsequently licensed by the Board.

Applicant Name April Lockley Last 4 digits of SSN [redacted] Date 4/30/19

COMPREHENSIVE OSTEOPATHIC MEDICAL LICENSING EXAMINATION - USA

Official Transcript

Minnesota Board of Medical Practice
2829 University Ave , SE
Suite 500
Minneapolis, MN 55414-3246

Examinee: Lockley, April Marie
NBOME ID: 989622 **Date of Birth:** [redacted]984

EXAMINATION	DATE COMPLETED	PASS / FAIL	3 - DIGIT STANDARD SCORE	3 - DIGIT MINIMUM PASSING	2 - DIGIT STANDARD SCORE	2 - DIGIT MINIMUM PASSING	NOTE
Level 1							
	02-Jul-2011	Fail	362	400	--		
	24-Oct-2011	Pass	478	400	--		
Level 2 Cognitive Evaluation (CE)							
	04-Aug-2014	Pass	480	400	--		
Level 2 Performance Evaluation (PE)							
	18-Dec-2014	Pass	Not Applicable		Not Applicable		
Level 3							
	24-Nov-2015	Pass	469	350	--		

The National Board of Osteopathic Medical Examiners, Inc., does hereby certify the above to be a true report of the examinee.

Date Prepared: May 01, 2019

1137695311140515

-- please see reverse for information and description of notes -- v3.0

National Board of Osteopathic Medical Examiners, Inc.
8765 West Higgins Road Suite 200 Chicago IL 60631-4174
Phone: 773/714-0622 Fax: 773/714-0631

COMLEX-USA Score Interpretation

COMLEX-USA is the series of examinations used by state medical and osteopathic medical boards for the licensure of osteopathic physicians in the United States. It consists of three levels: Level 1, Level 2-Cognitive Evaluation (CE) & Level 2-Performance Evaluation (PE), and Level 3.* The COMLEX-USA Level 2-PE is a clinical skills examination with a Pass/Fail scoring format. The scores reported for the COMLEX-USA computer-based cognitive examinations are 3-digit standard scores for Levels 1, 2-CE, and 3.

The NBOME COMLEX-USA Percentile Score Conversion tool converts 3-digit standard scores to percentile scores and is available on the NBOME website www.nbome.org.

COMLEX-USA Level 1, Level 2-CE, Level 3

Standard scores (3-digit): The mean of the 3-digit standard score for all three computer-based cognitive examinations has historically been in the 500-550 range. For up to date normed data, the performance of first time candidates in recent administrations on COMLEX-USA cognitive examinations are reported as follows: beginning in May 2015, the mean score for Level 1 first time candidates is approximately 520 and the standard deviation is approximately 85; beginning in June 2014, the mean score for Level 2-CE first time candidates is approximately 540 and the standard deviation is approximately 100; beginning in March 2015, the mean score for Level 3 first time candidates is approximately 550 and the standard deviation is approximately 125. The minimum passing 3-digit standard score for Level 1 and Level 2-CE is 400, and for Level 3 is 350, regardless of when the examination was taken. The minimum passing 3-digit standard score for COMLEX-USA Level 1, Level 2-CE and Level 3 is equivalent to a minimum passing 2-digit standard score of 75.

Level 1		*Level 2-CE*		*Level 3*	
Exam Date	*Standard Deviation*	*Exam Date*	*Standard Deviation*	*Exam Date*	*Standard Deviation*
1998 – 2001	*71*	*1997 – 2000*	*85*	*1995 – 1999*	*111*
2002 – 2005	*79*	*2001 – 6/2005*	*83*	*2000 – 2005*	*120*
5/2006 – 4/2010	*79*	*7/2005 – 5/2009*	*83*	*9/2005 – 1/2010*	*123*
5/2010 – 4/2015	*81*	*6/2009 – 5/2014*	*89*	*2/2010 – 2/2015*	*121*
5/2015 - Present	*85*	*6/2014 – Present*	*100*	*3/2015 – Present*	*125*

Standard deviations of COMLEX-USA computer-based cognitive examination 3-digit standard scores are Level-specific and time-specific.

Standard scores (2-digit): The NBOME discontinued the reporting of 2-digit standard scores for COMLEX-USA Level 1, Level 2-CE and Level 3 in 2015. A COMLEX-USA minimum passing scores of 400 for Level 1 and Level 2-CE and 350 for Level 3 is equivalent to a minimum passing 2-digit standard score of 75.

COMLEX-USA Level 2-Performance Evaluation

The Level 2-PE examination is required for all candidates graduating in 2005 or after and for those who graduated before July 1, 2004 and did not pass Level 2-CE by June 30, 2005. Candidates graduating in 2004 who passed Level 2-CE by June 30, 2005 were not required to take Level 2-PE.

Scores for Level 2-PE are reported as PASS or FAIL as one overall score. In order to receive a passing score, candidates must perform adequately in two separate domains. These are the Humanistic Domain (doctor-patient communication, interpersonal skills and professionalism), and the Biomedical/Biomechanical Domain (medical history-taking, physical examination, osteopathic principles and osteopathic manipulative treatment, SOAP notes, which assess synthesizing information garnered in the clinical encounter, clinical problem-solving and integrated differential diagnosis.) A passing score requires demonstration of minimum competence in fundamental clinical skills required for entry in graduate medical education.

*Part I, Part II, & Part III

COMLEX-USA Level 1, Level 2-CE, and Level 3 examinations replaced the Part I, Part II, and Part III examinations in 1998, 1997, and 1995 respectively.

The scores reported for Parts I, II, and III after 1988 are 3-digit standard scores for the whole examinations. Scores reported for Parts I and II before 1987 are the minimum scaled scores (2-digit) among all the component scores of the examinations. Scores reported for Part III are scaled scores (2-digit) for the whole examination.

Standard Scores (3-digit). The standard scores for all three Part examinations are reported on a scale with a mean of 500 and a standard deviation of 100. The minimum passing score for Part I and Part II is 400. The minimum passing score for Part III is 350.

Scaled Scores (2-digit). Scaled scores are reported on a scale with a mean of 80. The minimum passing score for Parts I and II is 75 for any of the components of the examinations. The minimum passing score for Part III is 75 for the whole examination.

Score Interpretation Annotations/Notes:

I – Irregular Conduct occurred on the part of the candidate. Candidate conduct which may be "Irregular Conduct" is described in the NBOME Bulletin of Information (see www.nbome.org). Authorized persons may obtain further information regarding this annotation by contacting the NBOME.

O – Other condition(s) which occurred during the administration of an examination beyond the control of the candidate (e.g. candidate illness, computer malfunction, etc.) which resulted in the examination not being scored, or the examination was scored after being administered or taken by the candidate under different or unusual conditions. Authorized persons may obtain further information regarding this notation by contacting the NBOME.

Philadelphia College of Osteopathic Medicine

Be it known that

April Marie Lockley

having satisfied the requirements for the degree of

Doctor of Osteopathic Medicine

has accordingly been admitted to that degree with all the rights, privileges,
and responsibilities thereunto appertaining.
In testimony whereof, the seal of the college and the signatures authorized
by the Board of Trustees are hereunto affixed.
Signed this seventh day of June, Anno Domini,
two thousand and fifteen.

Jay H. Feldstein DO
President and Chief Executive Officer

John P. Kearney
Chairman, Board of Trustees

Mark O. Wiet D.O
Provost, Senior Vice President for Academic Affairs and Dean

MINNESOTA BOARD OF MEDICAL PRACTICE

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Telephone (612) 617-2130 • Fax (612) 617-2166 • www.bmp.state.mn.us
MN Relay Service for Hearing Impaired (800) 627-3529

CERTIFICATION OF MEDICAL EDUCATION

This form is for certification of medical education and must be completed and mailed by the facility directly to the **Minnesota Board of Medical Practice**. Any processing fees are applicant's responsibility. The applicant's signature authorizes release of information, favorable or otherwise, directly to the Board.

Print Name April Lockley Birthdat[redacted]84 Last 4 digits of SSN[redacted]

Signature April Lockley Date 4/30/19

Date of Degree 06/01/2015 Degree Received D.O.

THE SCHOOL COMPLETES THE FOLLOWING INFORMATION:

IT IS HEREBY CERTIFIED THAT: (Name of Physician) April M. Lockley, DO

MATRICULATED IN:(Name of School) Philadelphia College of Osteopathic Medicine

AT:(Location of School) 4190 City Avenue, Philadelphia, PA 19131

AND RECEIVED A DIPLOMA CONFERRING:(Degree) Doctor of Osteopathic Medicine

ON:(Month, Day, Year) June 7, 2015

ANY DISCIPLINARY ACTION? Yes*_____ No X
(N/A is not an acceptable response)

ANY DEROGATORY INFORMATION ON FILE? Yes*_____ No X
(N/A is not an acceptable response)

PHILADELPHIA COLLEGE OF OSTEOPATHIC MEDICINE CORPORATE SEAL 1911 PENNSYLVANIA

President, Secretary, Dean, Registrar:

Print Name Deborah Castellano - Registrar

Signature Deborah A. Castellano

Date May 14, 2019

Phone Number 215-871-6704

Fax Number 215-871-6649

*Please attach letter of explanation.

**If there is no school seal, attach letter of explanation on letterhead.

03/15

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This form is for certification of medical education and must be completed and mailed by the facility directly to the **Minnesota Board of Medical Practice**. Any processing fees are applicant's responsibility. The applicant's signature authorizes release of Information, favorable or otherwise, directly to the Board.

Print Name April Lockley Birthda [redacted]84 Last 4 digits of SSN [redacted]

Signature [signature] Date 4/30/19

Date of Degree 06/01/2015 Degree Received D.O.

THE SCHOOL COMPLETES THE FOLLOWING INFORMATION:

IT IS HEREBY CERTIFIED THAT: (Name of Physician) April M. Lockley, DO

MATRICULATED IN:(Name of School) Philadelphia College of Osteopathic Medicine

AT:(Location of School) 4190 City Avenue, Philadelphia, PA 19131

AND RECEIVED A DIPLOMA CONFERRING:(Degree) Doctor of Osteopathic Medicine

ON:(Month, Day, Year) June 7, 2015

ANY DISCIPLINARY ACTION? Yes* _____ No X
(N/A is not an acceptable response)

ANY DEROGATORY INFORMATION ON FILE? Yes* _____ No X
(N/A is not an acceptable response)

PHILADELPHIA COLLEGE OF OSTEOPATHIC MEDICINE CORPORATE SEAL 1911 PENNSYLVANIA

President, Secretary, Dean, Registrar:

Print Name Deborah Castellano - Registrar

Signature [signature]

Date May 14, 2019

Phone Number 215-871-6704

Fax Number 215-871-6649

*Please attach letter of explanation.

**If there is no school seal, attach letter of explanation on letterhead.

03/15

Philadelphia College of Osteopathic Medicine

Be it known that

April Marie Lockley

having satisfied the requirements for the degree of

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has accordingly been admitted to that degree with all the rights, privileges, and responsibilities thereunto appertaining.

In testimony whereof, the seal of the college and the signatures authorized by the Board of Trustees are hereunto affixed.

Signed this seventh day of June, Anno Domini, two thousand and fifteen.

Jay S. Feldstein D.O.
President and Chief Executive Officer

John P. Kearney
Chairman, Board of Trustees

Neal W. Weir D.O.
Dean and Executive Vice President for Academic Affairs and Provost

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VERIFICATION OF POSTGRADUATE MEDICAL TRAINING

(Copy this form for multiple programs)

This form is for verification of all US/Canadian post graduate medical training (i.e. internship, residency and fellowship) and must be completed and mailed by the facility **DIRECTLY** to the **Minnesota Board of Medical Practice**. The applicant's signature authorizes release of information, favorable or otherwise, **DIRECTLY** to the Board.

Print Name April Lockley Birthdate [redacted]84 Last 4 digits of SS [redacted]

Signature April Lockley Date 4/30/19

Training Dates (Month,Day,Year) 07/01/16 – present

This section is to be completed by the Program Director or Graduate Medical Education Representative

It is hereby certified that:(Name of Applicant) April Lockley

Received credit for post graduate training:(# Months) 36 from date: 7/1/2016 to date: 6/30/2019

The program was accredited to provide graduate, clinical, medical training during the dates above by: (Check One)
ACGME ✓ AOA___ RCPSC___ CFPC___ None of the above___ (explain)___

at:(Name of Hospital or Institution) Bryn Mawr Hospital

located at 130 S. Bryn Mawr Ave, Bryn Mawr 19010
(Street Address, City, State, Zip, Country)

Affiliated Medical School Name___ Specialty Family Medicine

Training Program (Check One): Internship___ Resident ✓ Chief Resident___ Fellowship___ Research___

Did the applicant complete all required years of the post graduate training program?
___Program was completed ✓ Anticipated date of completion 6/30/2019

___Program was not completed because___

Was this individual issued a certificate as proof completion of training? ....letter..... Yes X No ___

Did the individual take a leave of absence or break during training? ..... Yes*___ No X

Was this individual ever placed on probation or remediation?..... Yes*___ No X

Was this individual ever disciplined or placed under investigation? ..... Yes*___ No X

Were any limitations or special requirements placed upon this individual due to academic incompetence, disciplinary problems or any other reason? ..... Yes*___ No X

Institutional Seal

If the institution does not have an official seal, the form must be notarized.

Completed by Program Director or Graduate Medical Education Representative:

Print Name Christine Black-Langenau, DO

Signature ___

Date ___ Phone 484-337-2885

Fax 610-325-1395 Email Black-LangenauC@MLHS.ORG

*Attach letter of explanation

1/2011

THE UNIVERSITY OF THE STATE OF NEW YORK
THE STATE EDUCATION DEPARTMENT
DIVISION OF PROFESSIONAL LICENSING SERVICES
89 WASHINGTON AVENUE
ALBANY, NEW YORK 12234

This is to certify that according to the records of the Division of Professional Licensing Services, New York State Education Department Albany, New York, LOCKLEY APRIL MARIE
was issued license/certificate number 297889 for the practice of MEDICINE on 03/05/2019.

Our records also indicate the following information:
Date of birth: [redacted]1984
School attended: PHILADELPHIA COL OF OSTEO
Date of graduation: 06/07/15
Degree earned: DO

Program was acceptable in accordance with the NYS Regulations of the Commissioner of Education. Requirements met at the time of licensure.

Basis of licensure:

DATE	FLEX1	NBME1	USML1	NBME2	FLEX2	USML2	NBME3	USML3	OTHER
11/15							0000P		OSTEO
08/14				0000P					
10/11		0000P							

EXMS TAKEN=03
A license is valid during the life of the holder unless revoked, annulled or suspended by the Board of Regents. A licensee must register periodically with this Department to practice in this state.

Currently Registered: YES Reg period ends: 02/28/21
Address: 1425 N 28TH ST PHILADELPHIA PA 19121-0000

Disciplinary information: No charges have been preferred against this licensee
Comments:

I, Audrey Bell, Education Program Assistant 1, Division of Professional Licensing Services of the New York State Education Department, do hereby state that as Education Program Assistant 1 of said Division, I have legal custody of the official records of the Division of Professional Licensing Services and to the best of my knowledge, the aforesaid information is true and correct.

SEAL

Audrey Bell
05/08/19
Education Program Assistant 1

COMMONWEALTH OF PENNSYLVANIA
DEPARTMENT OF STATE

BUREAU OF PROFESSIONAL AND OCCUPATIONAL AFFAIRS
POST OFFICE BOX 2649
HARRISBURG, PA 17105-2649

www.dos.pa.gov

05/02/2019

Verification/Certification of License

This is to certify that the individual or business named below is licensed by the Department of State, Bureau of Professional and Occupational Affairs:

NAME:	APRIL MARIE LOCKLEY
LICENSE TYPE:	Graduate Osteopathic Trainee
LICENSE #:	OT017227
LICENSE STATUS:	Active
LICENSE ISSUE DATE:	06/03/2016
LICENSE EXPIRATION DATE:	06/30/2019
DISCIPLINARY HISTORY:	No Disciplinary Action Exists

K. Kalonji Johnson, Acting Commissioner
Bureau of Professional and Occupational Affairs

MINNESOTA BOARD OF MEDICAL PRACTICE

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MN Relay Service for Hearing Impaired (800) 627-3529

PHYSICIAN RECOMMENDATION FORM (1)

This form must be completed and mailed directly to the **Minnesota Board of Medical Practice** by two US or Canadian licensed physicians with whom applicant has worked during the last five years, has known applicant for more than one year and who can testify to applicant's character, personal reputation, background and professional ability. This form does not have to be filled out by the same physicians you have listed on page 9 of the application. The applicant's signature authorizes release of information, favorable or otherwise, directly to the Board.

Applicant Print Name April Lockley

Applicant Signature aplockley Date 5/7/19

THE PHYSICIAN SERVING AS A REFERENCE COMPLETES THE FOLLOWING:

RECOMMENDATION FOR: (Print Name of Applicant) April Lockley

1. How long have you known the applicant? 3 years
2. What has been the nature of your relationship with the applicant? Resident in Family Medicine program
3. How would you characterize the moral and professional conduct of the applicant? very professional, high moral character
4. Would you recommend that the applicant be approved for licensure for the independent, unrestricted practice of medicine? yes
5. Circle the word(s) which best describes this applicant.

A.	Marginal*	(Fully Meets Standards)	A. Clinical skills
B.	Yes*	(No)	B. Any indication of chemical dependency?
C.	Yes*	(No)	C. Any indication of malprescribing?

*Please attach letter of explanation.

Completed By:

Printed Name Stephen D Wakefield MD Signed

Health Profession MD License # MD 034 [illegible] State PA

Date 5/7/19 Phone# 610-325-1390 Fax 610-325-1373

Email wakefields@mlhs.org

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MN Relay Service for Hearing Impaired (800) 627-3529

PHYSICIAN RECOMMENDATION FORM (2)

This form must be completed and mailed directly to the **Minnesota Board of Medical Practice** by two US or Canadian licensed physicians with whom applicant has worked during the last five years, has known applicant for more than one year and who can testify to applicant's character, personal reputation, background and professional ability. This form does not have to be filled out by the same physicians you have listed on page 9 of the application. The applicant's signature authorizes release of information, favorable or otherwise, directly to the Board.

Applicant Print Name April Lockley

Applicant Signature April Lockley Date 5/7/19

THE PHYSICIAN SERVING AS A REFERENCE COMPLETES THE FOLLOWING:

RECOMMENDATION FOR: (Print Name of Applicant) April Lockley, D.O.

1. How long have you known the applicant? 4 years
2. What has been the nature of your relationship with the applicant? Program Director of Residency Program
3. How would you characterize the moral and professional conduct of the applicant? High Integrity, Accountable, Well balanced
4. Would you recommend that the applicant be approved for licensure for the independent, unrestricted practice of medicine? Absolutely
5. Circle the word(s) which best describes this applicant.

A.	Marginal*	Fully Meets Standards	A. Clinical skills
B.	Yes*	No	B. Any indication of chemical dependency?
C.	Yes*	No	C. Any indication of malprescribing?

*Please attach letter of explanation.

Completed By:

Printed Name Joseph Greco MD Signed Joseph Greco MD

Health Profession Family Medicine License # MD30979 State PA

Date 5/7/2019 Phone# 610 325 1390 Fax 610 325 1373

Email greco@mlhs.org

PDC PHYSICIAN DATA CENTER

fsmb

PRACTITIONER PROFILE

Prepared for:	Minnesota Board of Medicine	As of Date:7/5/2019

PRACTITIONER INFORMATION

Name:	Lockley, April Marie
Alternate Name(s):	Lockley, April
DOB:	[redacted]1984
Medical School:	Philadelphia College of Osteopathic Medicine Philadelphia, Pennsylvania, UNITED STATES
Year of Grad:	2013
Degree Type:	DO
NPI:	1548648538

BOARD ACTIONS

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

LICENSE HISTORY

Jurisdiction	License Number	Issue Date	Expiration Date	Last Updated
NEW YORK	297889	03/05/2019	02/28/2021	07/03/2019
PENNSYLVANIA OSTEO	OT017227	06/03/2016	06/30/2019	06/25/2019

400 FULLER WISER ROAD EULESS, TX 76039 | TEL(817)868 4000 | FAX (817)868 4099

PDC PHYSICIAN DATA CENTER

fsmb

PRACTITIONER PROFILE

Prepared for:	Minnesota Board of Medicine	As of Date:7/5/2019
Practitioner Name:	Lockley, April Marie	

ABMS® CERTIFICATION HISTORY

No ABMS Certifications found.

AOA® CERTIFICATION HISTORY

No AOA Certifications found.

400 FULLER WISER ROAD EULESS, TX 76039 | TEL(817)868 4000 | FAX (817)868 4099

NATIONAL PRACTITIONER DATA BANK

NPDB

P.O. Box 10832
Chantilly, VA 20153-0832

https://www.npdb.hrsa.gov

5500000146386498
Process Date: 04/30/2019
Page: 1 of 1

To: LOCKLEY, APRIL MARIE

[redacted]

From: National Practitioner Data Bank
Re: Response to Your Self-Query

The enclosed information is released by the National Practitioner Data Bank (NPDB) for restricted use under the provisions of Title IV of Public Law 99-660, the Health Care Quality Improvement Act of 1986, as amended; Section 1921 of the Social Security Act; and Section 1128E of the Social Security Act.

Title IV established the NPDB as an information clearinghouse to collect and release certain information related to malpractice payment history and professional competence or conduct of physicians, dentists, and other licensed health care practitioners.

Section 1921 of the Social Security Act expanded the scope of the NPDB. Section 1921 was enacted to protect program beneficiaries from unfit health care practitioners, and to improve the anti-fraud provisions of federal and state health care programs. Section 1921 authorizes the NPDB to collect certain adverse actions taken by state licensing and certification authorities, peer review organizations, and private accreditation organizations, as well as final adverse actions taken by state law or fraud enforcement agencies (including, but not limited to, state law enforcement agencies, state Medicaid Fraud Control Units, and state agencies administering or supervising the administration of a state health care program), against health care practitioners, health care entities, providers and suppliers.

Section 1128E of the Social Security Act was added by Section 221(a) of Public Law 104-191, the Health Insurance Portability and Accountability Act of 1996. The statute established a national data collection program (formerly known as the Healthcare Integrity and Protection Data Bank) to combat fraud and abuse in health care delivery and to improve the quality of patient care. Section 1128E information is now collected and disclosed by the NPDB as a result of amendments made by Section 6403 of the Affordable Care Act of 2010, Public Law 111-148. Section 1128E information includes certain final adverse actions taken by federal agencies and health plans against health care practitioners, providers, and suppliers.

Regulations governing the NPDB are codified at 45 CFR part 60. Responsibility for operating the NPDB resides with the Secretary of the U.S. Department of Health and Human Services (HHS), and HRSA, Division of Practitioner Data Banks.

Reports from the NPDB contain limited summary information and should be used in conjunction with information from other sources in granting privileges, or in making employment, affiliation, contracting or licensure decisions. NPDB responses may contain more than one report on a particular incident, if two or more actions were taken as a result of a single incident (e.g., an exclusion from a federal or state health care program and an adverse licensure action). The NPDB is a flagging system, and a report may be included for a variety of reasons that do not necessarily reflect adversely on the professional competence or conduct of the subject named in the report.

All information received from the NPDB is considered confidential and must be used solely for the purpose for which it was disclosed. Further, ANY PERSON WHO VIOLATES THE CONFIDENTIALITY PROVISIONS AS SPECIFIED IN TITLE IV OF PUBLIC LAW 99-660, AS AMENDED, IS SUBJECT TO A CIVIL MONEY PENALTY OF UP TO $11,000 FOR EACH VIOLATION. Subjects of reports who obtain information about themselves from the NPDB are permitted to share that information with anyone they choose.

If you require additional assistance, visit the NPDB web site (https://www.npdb.hrsa.gov) or contact the NPDB Customer Service Center at 1-800-767-6732 (TDD: 1-703-802-9395). Information Specialists are available to speak with you weekdays from 8:30 a.m. to 6:00 p.m. (5:30 p.m. on Fridays) Eastern Time. The NPDB Customer Service Center is closed on all Federal holidays.

NATIONAL PRACTITIONER DATA BANK

NPDB

P.O. Box 10832
Chantilly, VA 20153-0832

https://www.npdb.hrsa.gov

5500000146386498
Process Date: 04/30/2019
Page: 1 of 1

LOCKLEY, APRIL MARIE - SELF-QUERY RESPONSE

A. SUBJECT IDENTIFICATION INFORMATION (Recipients should verify that subject identified is, in fact, the subject of interest.)

Practitioner Name: LOCKLEY, APRIL MARIE
Date of Birth: [redacted]1984 **Gender:** FEMALE
Delivery Address: [redacted]
Social Security Number: [redacted] **NPI:** 1548648538
License: OSTEOPATHIC PHYSICIAN RESIDENT (DO), 297889, NY, GENERAL PRACTICE/FAMILY PRACTICE
OSTEOPATHIC PHYSICIAN RESIDENT (DO), ot017227, PA, GENERAL PRACTICE/FAMILY PRACTICE
Professional School(s): PHILADELPHIA COLLEGE OF OSTEOPATHIC MEDICINE (2015)

B. PAYMENT INFORMATION

Credit Card Information: XXXXXXXXXXX1001 (12/2023)
NPDB Charge: $4.00 **NPDB Bill Reference Number:** N62660025
Transaction Date: 04/30/2019 **Additional Paper Copies Requested:** 0

C. SUMMARY OF REPORTS ON FILE WITH THE DATA BANK AS OF 04/30/2019

The following report types have been searched:

Medical Malpractice Payment Report(s):	No Reports	Health Plan Action(s):	No Reports
State Licensure Action(s):	No Reports	Professional Society Action(s):	No Reports
Exclusion or Debarment Action(s):	No Reports	DEA/Federal Licensure Action(s):	No Reports
Government Administrative Action(s):	No Reports	Judgment or Conviction Report(s):	No Reports
Clinical Privileges Action(s):	No Reports	Peer Review Organization Action(s):	No Reports

Copies of these reports are enclosed for restricted/limited use as prescribed by statutes listed on the preceding cover page.

---------- No Reports Found Based on the Subject Information Submitted ----------

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VERIFICATION OF POSTGRADUATE MEDICAL TRAINING

(Copy this form for multiple programs)

This form is for verification of all US/Canadian post graduate medical training (i.e. internship, residency, fellowship) and must be completed and mailed by the facility DIRECTLY to the **Minnesota Board of Medical Practice**. The applicant's signature authorizes release of information, favorable or otherwise, DIRECTLY to the Board.

Print Name April Lockley SS# [redacted]

Signature [signature] Date 6/24/2019

Training Dates (Month,Day,Year) July 1, 2015 - June 30, 2016 Birthdate [redacted]1984

This section is to be completed by the Program Director or Graduate Medical Education Representative

It is hereby certified that:(Name of Applicant) April Lockley

Received credit for post graduate training:(# Months) 12 from date: 7/1/15 to date: 6/30/16

The program was accredited to provide graduate, clinical, medical training during the dates above by: (Check One)
ACGME___ AOA ✓ RCPSC___ CFPC___ None of the above___ (explain)___

at:(Name of Hospital or Institution) ST JOHN'S EPISCOPAL HOSPITAL

located at 327 Beach 19th ST, Far Rockaway NY 11691
(Street Address, City, State, Zip, Country)

Affiliated Medical School Name LECOM Specialty Traditional Rotating Internship PGY 1

Training Program (Check One): Internship ✓ Resident___ Chief Resident___ Fellowship___ Research___

Did the applicant complete all required years of the post graduate training program?
✓ Program was completed ___ Anticipated date of completion___/___/___

___Program was not completed because___

Was this individual issued a certificate as proof completion of training? ..... Yes ✓ No ___

Did the individual take a leave of absence or break during training? ..... Yes*___ No ✓

Was this individual ever placed on probation or remediation?..... Yes*___ No ✓

Was this individual ever disciplined or placed under investigation? ..... Yes*___ No ✓

Were any limitations or special requirements placed upon this individual due to academic incompetence, disciplinary problems or any other reason? ..... Yes*___ No ✓

institutional Seal

If the institution does not have an official seal, the form must be notarized.

Completed by Program Director or Graduate Medical Education Representative:

Print Name Albert J. Strojan, DO

Signature [signature]

Date 7/24/19 Phone 718-869-7815

Fax 718-869 5820 Email GAlbrecho dhs.org

*Attach letter of explanation

1/2011

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MN Relay Service for Hearing Impaired (800) 627-3529

Treating Physician Statement

Applicant: Applicants who have a medical condition during the last five years which, if untreated, would be likely to impair their ability to practice with reasonable skill and safety must have their treating physician complete this form. A treating physician is the physician who diagnosed and provides or provided treatment for the condition and includes the current treating physician. **If not applicable, write "not applicable" on the form and submit with the application.**

Treating Physician: Complete and mail this form directly to the Minnesota Board of Medical Practice. This form is also available on our website.

Applicant's Printed Name April Lockley

Applicant's Date of Birth (Mo/Day/Yr) [redacted]84 Health Profession Medicine

I hereby authorize you, my treating physician, to disclose my medical records to the Minnesota Board of Medical Practice. I hereby release, discharge, and exonerate the Board, its agents, and representatives, and any person furnishing information to the Board from any and all liability of every nature and kind arising out of the furnishing oral information or documents, records, or other information to the Board.

Signed Not Applicable Date 7/24/19

Nature of medical condition including diagnosis and significant symptoms

Date first saw patient: _____ **Date last saw patient:** _____

Has the applicant been compliant with treatment? (If no, please explain)
☐ Yes ☐ No

What medications is the applicant taking for this condition?

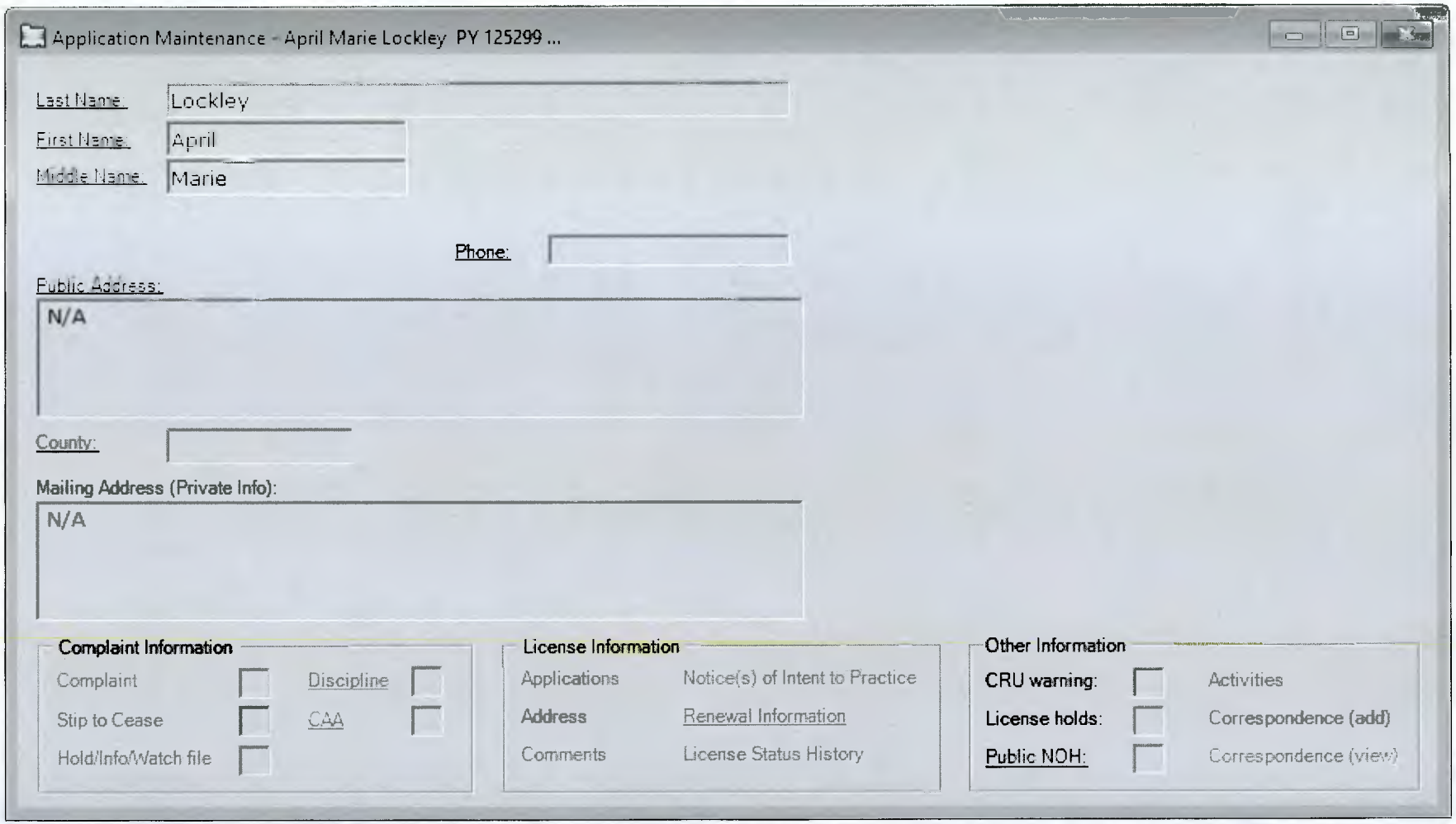
If this medical condition was untreated, would it be likely to impair the applicant's ability to practice with reasonable skill and safety? (If yes, please explain) ☐ Yes ☐ No

Should the condition be monitored? (If yes, please explain) ☐ Yes ☐ No

Treating Physician (print name)_____

Signature_____ Date_____

Phone_____ Fax_____



Application Maintenance - April Marie Lockley PY 125299 ... (BMP.ALIMS.UI.Search.frmLicenseMaintenance)

AOiA
AMERICAN OSTEOPATHIC INFORMATION ASSOCIATION

142 E. Ontario Street Chicago, Illinois 60611-2864

OFFICIAL PHYSICIAN PROFILE REPORT

Report Valid Only For MN - Minnesota Board of Medical Practice

ELECTRONIC MAIL: credentials@AOAprofiles.org

Physician Name: April M. Lockley, DO

Address: [redacted]

Work Phone: [redacted]

Birth Date: [redacted]1984

Self-Designated Major Practice Focus: Family Medicine/OMM

Self-Designated Minor Practice Focus:

AOA Memberhip Status: Member

The following information was obtained from the original issuing source of the credential, also known as the primary source

Predoctoral Education: Philadelphia College of Osteopathic Medicine
Philadelphia PA

Year of Graduation: 2013

Postdoctoral Education: (Current and/or prior osteopathic postdoctoral internship and residency training programs, as well as ACGME-accredited allopathic residency training programs that have been approved by the AOA. Additional information used for appointments and privileges is not solicited nor maintained. If more detailed information is required, contact the program director.)

Internship:	LECOMT/St John's Episcopal Hospital - Internship Training Far Rockaway NY	**Dates Attended:**	07/01/2015 - 06/30/2016 Verified
Residency:	PCOM/Bryn Mawr Hospital - Family Medicine Residency Bryn Mawr PA	**Dates Attended:**	07/01/2016 - 06/30/2017 Verified
Residency:	PCOM/Bryn Mawr Hospital - Family Medicine Residency Bryn Mawr PA	**Dates Attended:**	07/01/2017 - 06/30/2018 Verified
Residency:	PCOM/Bryn Mawr Hospital - Family Medicine Residency Bryn Mawr PA	**Dates Attended:**	07/01/2018 - 06/30/2019 Verified

Please note: *Some osteopathic physicians complete all or part of their postdoctoral training in allopathic programs accredited by the ACGME. Those programs attended that have been verified with the primary source are listed below. Check with the program director if residency does not appear.*

Residency:		**Dates Attended:**	

Licenses:

State	Date Granted	Expiration Date	Status	Date Last Reported to the AOA	** Contact Board for More Information

142 E. Ontario Street Chicago, Illinois 60611-2864

ELECTRONIC MAIL: credentials@AOAprofiles.org

*** A "yes" in this column indicates that the state board has, at some time, reported final disciplinary actions taken to the AOA. Since this information is historical and never removed from the AOA physician record, the Report user should contact the state board directly for current detailed information.*

Federal Drug Enforcement Administration: None Reported

Please note: *Many states require their own controlled substance registration/license. Please check with your state licensing authority as the AOA does not maintain this information.*

Former Name(s): April M Elder

Please Note:

The content of this Official Physician Profile Report is intended to assist in the complete credentialing process by providing primary source verified information on physicians. Appropriate use of this instrument in combination with your organization's documented credentialing policies and procedures meets the primary source requirements of the Healthcare Facilities Accreditation Program (HFAP/AAHHS); the Accreditation Association for Ambulatory Health Care, Inc. (AAAHC); The Joint Commission; URAC; and the National Association of Insurance Commissioners (NAIC). The National Committee for Quality Assurance (NCQA) recognizes the information included in this Report as meeting its DNV GL requirement for primary source verification of predoctoral education, postdoctoral education and specialty board certification.

If you find any discrepancies, please mark them on a copy of this report and email to the AOIA credentials@AOAprofiles.org. Thank you.

MINNESOTA BOARD OF MEDICAL PRACTICE

University Park Plaza • 2829 University Avenue SE Suite 500 • Minneapolis, MN 55414-3246
Telephone (612) 617-2130 • Fax (612) 617-2166 • www.bmp.state.mn.us
MN Relay Service for Hearing Impaired (800) 627-3529

MALPRACTICE HISTORY REPORT

The Board is requires information on all malpractice suits. For each malpractice suit in which you have been named, complete the Malpractice Liability Claims Information form and submit insurance papers or other formal documentation of the outcome/status

NAME AND ADDRESS OF PROFESSIONAL LIABILITY INSURER IN OTHER STATE:

1. Mountain Laurel Risk Retention Group, Inc
2. 100 Bank St, Suite 610
3. Burlington, VT 05401

NUMBER, DATE, AND DISPOSITION OF ANY MEDICAL MALPRACTICE SETTLEMENT OR AWARD RELATING TO THE QUALITY OF MEDICAL TREATMENT:*

Number	Date	Disposition
		None

I hereby certify that the above is a true and accurate statement.

Print Name April Lockley

Signature April Lockley Date 4/30/19

*If you have had no malpractice suits, write **NONE**, sign and date this form.

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Malpractice Liability Claims Information
(copy the form to report additional claims)

Malpractice: Give a detailed clinical explanation of each case as well as documentation of outcome (insurance papers or court documents.

Name of patient involved N/A

In which state did the action take place?_____ Which court?_____

Current status of this claim:

___ Open (pending) ___Closed (settled) ___Dismissed (no money paid out ___Other_____

Amount of judgment of settlement $_____ Amount paid on your behalf $_____

Date of event precipitating claim_____/_____ Date of lawsuit_____/_____ Case number_____
Month Year Month Year

Insurance carrier at time_____

What is/was your status? ___Primary defendant ___Co-defendant ___Other_____

Please provide specifics in reference to the adverse even including the allegations and your role in the event.

Name of patient involved_____

In which state did the action take place?_____ Which court?_____

Current status of this claim:

___ Open (pending) ___Closed (settled) ___Dismissed (no money paid out ___Other_____

Amount of judgment of settlement $_____ Amount paid on your behalf $_____

Date of event precipitating claim_____/_____ Date of lawsuit_____/_____ Case number_____
Month Year Month Year

Insurance carrier at time_____

What is/was your status? ___Primary defendant ___Co-defendant ___Other_____

Please provide specifics in reference to the adverse even including the allegations and your role in the event.

Applicant Name April Lockley Last 4 digits of SSN [redacted] Date 4/30/19

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FACILITIES LIST

The Board requires a list of all facilities where you have had medical privileges during the last 10 years. List any facility where you are getting (have been) paid outside a post graduate internship, residency or fellowship training program. Submit a Hospital Privilege Form to each facility listed except those clinics which are strictly outpatient. If you have had no privileges, write **NONE** and sign and date the form.

CURRENT PRIVILEGES

Facility	City and State	Type of Privilege
None		

PAST PRIVILEGES (LAST 10 YEARS)

Facility	City and State	Type of Privilege
None		

I hereby certify that the above is a true and accurate list of inpatient and outpatient facilities at which I have (have had) medical privileges.

Print Name April Lockley

Signature April Lockley Date 4/30/19

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ADDENDUM TO APPLICATION

1. BUSINESS ADDRESS

Effective August 1, 2012, Minn. Stat. §214.073 requires licensees to provide their primary business address at the time of initial application and all subsequent renewals. Your primary business address is public and you are required to submit it for application purposes. Your license will not be issued without it unless you check the box below certifying that you are not currently in the workforce related to your practice.

Facility name Bryn Mawr Family Practice

Street Address 135 S. Bryn Mawr Ave. Suite 200

City Bryn Mawr State PA Zip 19010

___I certify that I am not currently in workforce related to my practice, and I don't have a business address related to my practice.

2. MILITARY STATUS

Are you or your spouse returning from active military duty (discharged less than 6 months ago) or still in active military duty?

✓ No

___Yes, discharged less than six months ago. Discharge date: _____

___ Yes, still in active military duty

3. CRIMINAL CONVICTIONS

Effective July 1, 2013, Minn. Stat. §214.072 requires the Board to collect and post on its website the names and business address of each regulated individual who has been convicted of a felony or gross misdemeanor occurring on or after July 1, 2013, in any state or jurisdiction. This information shall be posted for new licensees issued a license on or after July 1, 2013, and for current licensees upon license renewal occurring on or after July 1, 2013. This information is public and you are required to submit it for application purposes. You must notify the Board if a previously reported conviction has been expunged and provide written documentation of expungement.

If you have more than one item to report please attach additional sheets.

Conviction Date (mm/dd/yyyy): _____

Conviction Type (Check one): O Felony O Gross misdemeanor

Crime Description: _____

City: _____ State: _____ County: _____ Country: _____

Sentence: _____

✓ I certify that I have had no felony or gross misdemeanor convictions on or after July, 1, 2013.

Applicant Name (printed): April Lockley

Applicant Signature: April Lockley Date 4/30/19

Commonwealth of Pennsylvania - Notary Seal
Shelby N. Young, Notary Public
Montgomery County
My commission expires February 14, 2023
Commission number 1345493
Member, Pennsylvania Association of Notaries

Shelby N. Young

5-06-2019