385234/88 F#14,197

This form may be completed online and mailed to the address listed below.

NEBRASKA
Good Life. Great Mission.
DEPT. OF HEALTH AND HUMAN SERVICES

Department of Health and Human Services
Division of Public Health - Licensure Unit
301 Centennial Mall South
P.O. Box 94986 - Lincoln, Nebraska 68509
Telephone #: 402-471-2118

LICENSURE UNIT
APR 27 2017
RECEIVED

Lic# 8043
Date: 7-1-17
Office Use Only
Revised 01/2015

APPLICATION FOR TEMPORARY EDUCATION PERMIT

Fee $25.00

SECTION A – PERSONAL INFORMATION: (All applicants must complete this section) Items 1 and 2 are public information. Name and Licensure information will be displayed on the INTERNET at http://www.nebraska.gov/LISSearch/search.cgi

NOTE: All mailings will be sent to the address you indicate below– if you change your address, you must advise this office.

1	Legal Name	First: GARTH	Middle Name: KELLOGG	Last: SUMMERS	
	Maiden Name		Other Names you are known as (AKA):		
2	Mailing Address	Street/PO/Route: 5411 SW Dover Ct.			
		City: Portland	State or Country: Oregon	Zip: 97225	
3	Date of Birth: Month/Day/Year: 08/18/1988	Place of Birth (city/state/country): Portland, Oregon, USA		Gender: (M) F	
4	Check the Appropriate Box(es)	☑ Social Security Number (SSN); ☐ Alien Registration Number ("A#"); ☐ Form I-94 (Arrival-Departure Record) number	SSN# [redacted]		
			A#		
			I-94 #		
	If you have both a SSN and an A# or I-94 number, you must report both. Neb. Rev. Stat. §38-123 mandates disclosure of your social security number to DHHS. Although your number is not public information, DHHS may disclose it for child support enforcement purposes and to the Nebraska Department of Revenue.				
	Phone 503-830-7994		Fax (optional)		
	Licensee E-mail Address GARTH.SUMMERS@GMAIL.COM		Credentialing contact e-mail Address (optional)		

Office Use Only

Office Use Only			Federation	Yes	No
BOARD	Yes	No	NPDB	Yes	No
			NDEN	Yes	No

SECTION B – PRELIMINARY AND PRE-MEDICAL EXAMINATION Give the name and location of institutions attended, beginning with high school. List diplomas or certifications and date received for preliminary and pre-medical education.	
NAME OF HIGH SCHOOL	JESUIT
City/State/Country	Portland, Oregon, USA
Diploma/Certificate	Diploma
Date: (MO/YR)	06/2007
NAME OF PRE-MEDICAL COLLEGE	UNIVERSITY OF DENVER
City/State/Country	Denver, Colorado, USA
Diploma/Certificate	B.S. Biochemistry
Date: (MO/YR)	03/2011
NAME OF PRE-MEDICAL COLLEGE	
City/State/Country	
Diploma/Certificate	
Date: (MO/YR)	

Foreign medical graduates must indicate their ECFMG number: _____

SECTION C – MEDICAL EDUCATION List in chronological order, beginning with high school and ending with medical school, the name and location of all institutions attended. List the diplomas or certificates earned and dates received for all preliminary (high school), pre-medical education and medical education. (Attach additional pages if necessary).

MEDICAL EDUCATION Name of Institution	Des Moines University College of Osteopathic Medicine	
Degree Earned/ Date Conferred	Degree: D.O.	Date Conferred: 05/26/2017
City/State/Country	Des Moines, Iowa, USA	
Attended From:	(M/D/Y) 08/04/2012	
Attended To:	(M/D/Y) 05/26/2017	
MEDICAL EDUCATION Name of Institution		
Degree Earned/ Date Conferred	Degree:	Date Conferred:
City/State/Country		
Attended From:	(M/D/Y)	
Attended To:	(M/D/Y)	
GRADUATE MEDICAL EDUCATION Name of Institution		
Name of Specialty		☐ Internship ☐ Residency ☐ Fellowship
City/State/Country		
Attended From:	(M/D/Y)	
Attended To:	(M/D/Y)	

SECTION D - PROFESSIONAL ACTIVITIES List in chronological order all of your medical activities for the last ten years, or since graduation from medical college if less than ten years ago to present. Also list all periods of non-professional activity or employment for periods of non-medical activity of more than three months. Please account for all time and explain all gaps of more than three months. (Attach additional pages if necessary). This information must be completed below. Do not attach CV or other work history forms.

From: Month/Year		To: Month/Year	
Name of Facility			
City/State/Country			
Activity			
From: Month/Year		To: Month/Year	
Name of Facility			
City/State/Country			
Activity			
From: Month/Year		To: Month/Year	
Name of Facility			
City/State/Country			
Activity			

SECTION E – CONTROLLED SUBSTANCES REGISTRATION (Check one that applies)

1		I have enclosed a photocopy of my current Federal Controlled Substances Registration.	
		Federal Controlled Substances Registration #:	Expiration Date:
2	✓	I am currently applying for a Federal Controlled Substances Registration, and will send a photocopy of such when I receive the registration.	
3		I do not have nor am I applying for a Federal Controlled Substances Registration and I will not be prescribing, administering or dispensing controlled substances in Nebraska. I understand that at such time that I do intend to prescribe, administer or dispense controlled substances in Nebraska, I will first need to have a Federal Controlled Substances Registration issued to me. At that time, I am to supply a photocopy of the registration to the State of Nebraska.	

SECTION F – CONVICTION AND LICENSURE INFORMATION (All applicants must complete this section) **Failure to disclose any such conviction or disciplinary action, regardless of when the action occurred, could result in disciplinary action, include, but not limited to, payment of a civil penalty.**

Answer the following questions either yes or no by placing a (✓) in the appropriate box. **All 'yes' responses MUST be explained in detail and you must submit the requested documentation (see pages 8 & 9 of application).** Additional documentation may be requested by the Board/Department after submission of initial information.

Section I

1	Have you ever had any disciplinary or adverse action imposed against a professional license or permit in any state or jurisdiction?	☐ YES	☑ NO
2	Have you ever voluntarily surrendered or voluntarily limited in any way a license or permit issued to you by a licensing or disciplinary authority?	☐ YES	☑ NO
3	Have you ever been requested to appear before any licensing agency?	☐ YES	☑ NO
4	Have you ever been notified of any charges, complaints or other actions filed against you by any licensing or disciplinary authority?	☐ YES	☑ NO
5	Are you aware of any pending disciplinary actions or of any on-going investigations of a complaint against your license or permit in any jurisdiction?	☐ YES	☑ NO

6	Have you ever been asked to and/or permitted to withdraw an application for licensure or permit with any Board or jurisdiction?	☐ YES	☑ NO
7	Has any state or jurisdiction refused to issue, refused to renew or denied you a license or permit to practice?	☐ YES	☑ NO
	Section II		
1	Are you currently, or have you ever been, addicted to, dependent upon or chronically impaired by alcohol, narcotics, barbiturates, or other drugs which may cause physical and/or psychological dependence?	☐ YES	☑ NO
2	Within the past 5 years, have you received any therapy/treatment or been admitted to any hospital or other in-patient care facility for reasons relating to your use/abuse of alcohol, narcotics, barbiturates, or other drugs?	☐ YES	☑ NO
3	Do you currently, or have you ever had, any physical, mental, or emotional condition which impaired, or does impair your ability to practice your health care profession safely and competently?	☐ YES	☑ NO
4	Within the past 5 years, has any licensing agency or credentialing organization initiated any inquiry into your physical, mental or emotional health?	☐ YES	☑ NO
	Section III		
1	Have you ever been restricted, suspended, terminated, requested to voluntarily resign, placed on probation, counseled, received a warning or been subject to any remedial or disciplinary action during medical school or postgraduate training?	☐ YES	☑ NO
2	Have you ever had hospital or institutional privileges denied, reduced, restricted, suspended, revoked, terminated or placed on probation?	☐ YES	☑ NO
3	Have you ever voluntarily resigned or suspended your hospital or institutional privileges while under investigation from a hospital, clinic, institution, or other medically related employment?	☐ YES	☑ NO
4	Have you ever been notified that any action against your hospital or institutional privileges is pending or proposed?	☐ YES	☑ NO
5	Have you ever been allowed to withdraw your staff privileges from a hospital or institution?	☐ YES	☑ NO
6	Have you ever been subject to staff disciplinary action or non-renewal of an employment contract?	☐ YES	☑ NO
	Section IV		
1	Have you ever been convicted of a felony? **Failure to disclose any such convictions regardless of when the conviction occurred could result in disciplinary action, including but not limited to a minimum of $500 civil fine.**	☐ YES	☑ NO
2	Have you ever been convicted of a misdemeanor? **Failure to disclose any such convictions regardless of when the conviction occurred could result in disciplinary action, including but not limited to a minimum of $500 civil fine.**	☐ YES	☑ NO
3	Have you ever been notified of any charges, complaints or other actions filed against you by any criminal prosecution authority?	☐ YES	☑ NO
	Section V		
1	Have you ever been denied a Federal Drug Enforcement Administration (DEA) Registration or state controlled substances registration?	☐ YES	☑ NO
2	Have you ever been called before any licensing agency or lawful authority concerned with DEA controlled substances?	☐ YES	☑ NO
3	Have you ever surrendered your state or federal controlled substances registration?	☐ YES	☑ NO
4	Have you ever had your state or federal controlled substances registration restricted or disciplined in any way?	☐ YES	☑ NO
	Section VI		
1	Have you ever been notified of any professional liability claim that resulted in an adverse judgment, settlement, or award, including settlements made prior to suit in which the patient releases any professional liability claim against the applicant?	☐ YES	☑ NO
2	Are you aware of any professional liability claims currently pending against you?	☐ YES	☑ NO

SECTION G – LICENSURE IN OTHER STATE (All applicants must complete this section)		
Have you ever been licensed as a physician, physician in training license/permit, educational or residency license/permit or any other license or permit allowing you to practice medicine in another state or jurisdiction?	☐ YES	☒ NO

List all other states, jurisdictions, or territories of the U.S. where you have been or are currently licensed, including license number, issue date, and expiration date. **(Include educational training/permit licenses). Attach list if needed.**

State	License #	Issue Date	Expiration Date

SECTION H – REQUESTING INSTITUTION

The institution listed below accepts GARTH K SUMMERS (Name of Applicant) into a graduate medical education program, a fellowship, or a refresher course.

As Dean of the School of Medicine, Associate Dean of Graduate Medical Education or other authorized official, I understand that the issuance of this permit does not entitle the holder to engage in the practice of Medicine and Surgery outside of the assigned graduate medical education program, fellowship, or refresher course.

Name of Institution:	University of Nebraska Medical Center		
Mailing Address	Street: 983255 Nebraska Medical Center	City/State Omaha, NE	Zip 68198-3255
Name of Graduate Medical Education Program	Obstetrics & Gynecology Residency		
Is the program ACGME Accredited?* (select one)	☑ YES	☐ NO *Programs not accredited by ACGME must submit an outline of the intended coursework for Board approval	
Type of Program (select one)	☑ Graduate Medical Education	☐ Fellowship	☐ Refresher Course
Duration of Program	Begin Date (Month/Day/Year) 07/01/2017	End Date (Month/Day/Year) 06/30/2021	
Location of Training Areas	On File		
Official Signature (Dean/Associate Dean/Official)	Chandra Are, MD		
Official Title of Signee	Associate Dean for Graduate Medical Education		
Please Print Name of Signee	Chandra Are, M.D.		

SECTION I – PRACTICE PRIOR TO CREDENTIAL (All applicants must complete this section) An individual who practices prior to issuance of a credential is subject to assessment of an Administrative Penalty of $10 per day up to $1,000, or such other action as provided in the statutes and regulations governing the credential.

1	I have practiced as a physician/osteopathic physician & surgeon in Nebraska before issuance of the Nebraska license.	☐ YES	☑ NO
2	If yes, what are the actual number of days you practiced in Nebraska and what is the business name, location and telephone number of the practice: ***Students of medicine and surgery enrolled in an accredited college of medicine who gratuitously practice medicine and surgery under the supervision of a licensed physician are exempt from needing a Permit or License in the State of Nebraska, pursuant to Neb. Rev. Stat. 38-2025(4)). Once an individual has graduated from medical school, however, a Permit or License is required in the State of Nebraska in order to practice medicine and surgery. The question above, therefore, refers to the time since you have graduated from medical school until such time as you have received a Permit or License to practice medicine and surgery in the State of Nebraska.***	# of days: _____ Name of Business: City: Telephone #:	

SECTION J – ATTESTATION (All applicants must complete this section)

Lawful Presence in the United States Attestation: For the purpose of complying with Neb. Rev. Stat. §38-129, I attest as follows:

Please check only one of the boxes below:

☑ I am a citizen of the United States; or
☐ I am an alien lawfully admitted into the United States who is eligible for a credential under the Uniform Credentialing Act; or
☐ I am a non-immigrant lawfully present in the United States who is eligible for a credential under the Uniform Credentialing Act.

Alien or Non-Immigrant Status: If you are a qualified alien lawfully admitted into the United States OR a non-immigrant lawfully present in the United States, you must submit evidence of lawful presence which may include a copy of:

1. A "Green Card" otherwise known as a Permanent Resident Card (Form I-551), both front and back of the card; or
2. An unexpired foreign passport with an unexpired Temporary I-551 stamp bearing the same name as the passport; or
3. A document showing an Alien Registration Number ("A#"), an Employment Authorization Card/Document is **NOT** acceptable; or
4. A Form I-94 (Arrival-Departure Record).

If you are an Alien or Non-Immigrant, your credential will **NOT** be issued until such proof is received by our office and your documents are verified by our office through the Department of Homeland Security. This process may take four to six weeks.

Criminal Background Check Notification: Pursuant to Neb. Rev. Stat. §38-131, an applicant for an initial license to practice a profession which is authorized to prescribe controlled substances shall be subject to a criminal background check. I understand that I am able to receive any national criminal history record that may pertain to me directly from the FBI, pursuant to 28 CFR Sections 16.30-16.34, and that I could then freely disclose any such information to whomever I choose. By signing this application, it is my intent to authorize the dissemination of any national criminal history record that may pertain to me to the Department of Health and Human Services (DHHS) with whom I am applying for licensure. I understand that I am entitled to challenge the accuracy and completeness of any information contained in any such report, and that you will provide me a copy of the criminal history background report, if any, you receive on me if I appear at the DHHS in person and present proper identification. Information on how to challenge your federal report can be found at FBI.gov. To challenge your Nebraska state record, contact the Nebraska State Patrol-Criminal Identification Division. I may obtain a prompt determination as to the validity of my challenge before you make a final decision about my application for licensure.

Application Attestation: I further attest that:

1. I have read the application or have had the application read to me;
2. All statements on the application are true and complete; and
3. I am of good character.

Print Name GARTH K. SUMMERS Signature Garth K. Summers Date 04/10/2017
ORIGINAL SIGNATURE REQUIRED


We the People
Of the United States,
SIGNATURE OF BEARER / SIGNATURE DU TITULAIRE / FIRMA DEL TITULAR
PASSPORT
PASSEPORT
PASAPORTE
USA
UNITED STATES OF AMERICA
P
USA
570443539
SUMMERS
GARTH KELLOGG
UNITED STATES OF AMERICA
18 Aug 1988
OREGON, U.S.A.
07 Mar 2017
06 Mar 2027
SEE PAGE 27
M
United States
Department of State
USA
P<USASUMMERS<<GARTH<KELLOGG<<<<<<<<<<<<<<<<
5704435392USA8808187M2703062336967900<783816

LICENSURE UNIT

JUN 02 2017

RECEIVED

Des Moines University
Osteopathic Medical Center

upon recommendation of the faculty of the

College of Osteopathic Medicine

and by the authority of the State of Iowa

hereby confers upon

Garth Kellogg Summers

the degree of

Doctor of Osteopathic Medicine

with all the honors, rights and privileges thereunto appertaining,
in recognition of the satisfactory completion of the requirements for this degree.
In witness whereof the Board of Trustees has caused the seal of the University
to be affixed at Des Moines, Iowa, this twenty-sixth day of May, 2017.

DES MOINES UNIVERSITY 1898

Chairman of the Board

Secretary of the Board

President of the University

Dean of the College

State of Nebraska
County of Douglas

This is to certify that this is a true copy of the original document. Subscribed before me on this May 30, 2017 at Omaha, Nebraska.

Rachel V. Nelsen
Notary Public

GENERAL NOTARY

RACHEL V. NELSEN
My Commission Expires
November 15, 2017

NEBRASKA

Good Life. Great Mission.

DEPT. OF HEALTH AND HUMAN SERVICES

Pete Ricketts, Governor

June 16, 2017

Garth Kellogg Summers, DO
UNMC - Obstetrics & Gynecology Residency
983255 Nebraska Medical Center
Omaha NE 68198-3255

Dear Dr. Summers:

Your Temporary Educational Permit to Practice Medicine and Surgery in the State of Nebraska has been approved. Your permit number is 8043 and the effective date is 07/01/2017. Please find your Temporary Educational Permit enclosed.

This permit will expire on 07/01/2018, and is renewable. The annual renewal fee is $25.00. You will receive a renewal notice at least thirty days prior to the expiration date of your permit.

Your Temporary Educational Permit may be used **only** for your present program as indicated on the permit. If you should leave your educational program, educational institution **OR** if you transfer educational programs within the same educational institution, you must notify this office.

Please contact your Graduate Medical Education Office for a copy of the Nebraska Statutes and Regulations relating to the practice of your profession for your reference.

If at a future date you apply for a permanent medical license, please note that when your permanent license is issued your Temporary Educational Permit will be made null and void

May we extend our congratulations and best wishes for the successful practice of your profession in Nebraska.

Sincerely,

Becky Wisell

Becky Wisell, Administrator
Licensure Unit

BW/vb

Enclosure