Submission Date and Time: 5/16/2022 1:48 PM

New License Application

License Type - Doctor of Osteopathic Medicine (DO)

Application/License Number - APP-000589916

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. If you do not have an Individual Provider Identifier (NPI) number please enter nine zeroes.

Title
Dr
First Name
Emily
Middle Name
Ann
Last Name
Freeman
Maiden Name
Freeman
Social Security Number
*****[redacted]
Date of Birth
5/30/1988
Email Address
emil.freeman@gmail.com
Phone Number
(618) 830-9589
Other Phone Number
No Response
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 N/A enter all zeroes

1750735056
Enter home US zip-code. Enter NA if unavailable
63105

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?
Emily Freeman
What is your gender?
Female
In which country were you born?
United States
In which state were you born (if United States)?
Missouri
In which city were you born?
ST LOUIS

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
Are you currently employed outside of USA?
No

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.

239 Crandon Dr
Saint Louis
MO
63105-3607
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.

9500 Euclid Ave
Cleveland
OH
44195-0001
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?
No
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:

Education History

List all undergraduate, graduate, and Medical Schools you have attended, including those from which you did not graduate. As you type, the name of your school should auto-populate. Once it does, click on it to select. If your school does not auto-populate, type and select Other. You will then enter your school's name and address in the fields that appear. If you did not receive a degree, please select "Not Applicable" as the degree type and do not enter a graduation date.

Educational Institution - Montana State University-Bozeman
Degree Type - Bachelor's
Degree - Cell Biology and Neuroscience
Enrollment date - 8/1/2006
Graduation date - 5/8/2010

Educational Institution - Montana State University-Bozeman
Degree Type - Masters
Degree - Health Sciences
Enrollment date - 8/1/2010
Graduation date - 5/5/2011

Educational Institution - Kansas City University of Medicine and Biosciences
Degree Type - Masters
Degree - Bioethics
Enrollment date - 1/1/2013
Graduation date - 5/7/2016

Educational Institution - Kansas City University of Medicine and Biosciences
Degree Type - Doctoral
Degree - Doctorate of Osteopathic Medicine
Enrollment date - 8/1/2012
Graduation date - 5/7/2016

Employment History

List your employment history for the past five years including medical, non-medical, and post-graduate training. For any non-working time, you must indicate exactly what your activities were, such as vacation or seeking employment as well as your permanent address. If you worked for a physician staffing group or did locum tenens, you must list all facilities where you worked and include complete dates and addresses. Be sure to indicate the percentage of working time spent in clinical or other duties.

Employer / Non-Working Activity - Cleveland Clinic Akron General
Job Title - Resident Physician
Start Date - 7/1/2016
End Date - 6/30/2020
Average Hours/Week- 80
% Clinical or Environmental- 100
Street Address - 1 Akron General Ave
Employment City - Akron
Employment State - Ohio
Employment Zipcode - 44307
Employment Country - United States

Employer / Non-Working Activity - Washington University in St. Louis
Job Title - Complex Family Planning Fellow
Start Date - 7/7/2020
Average Hours/Week- 80
% Clinical or Environmental- 100

Street Address - 660 S Euclid Ave
Employment City - ST LOUIS
Employment State - Missouri
Employment Zipcode - 63110
Employment Country - United States

License Verification

You must complete the License Verification component if you hold or have ever held a professional license or certification in a state or Canadian Province. You must request verification of all your applicable licenses and certifications from the issuing state or Canadian province to be sent to the State Medical Board of Ohio. Please include both active and inactive professional licenses or certifications.

036152218
Doctor of Osteopathic Medicine (DO)
Physician and Surgeons
Active
United States
Illinois

2020009021
Doctor of Osteopathic Medicine (DO)
Healing Arts
Active
United States
Missouri

Examination Tracking

List each licensure examination you have taken (USMLE, NBME, COMLEX USA, NBOME, LMCC, PMLEXIS, etc.)

Examination - COMLEX Level 1
Status - Passed
Exam date - 6/12/2014
Number of Attempts - 1

Examination - COMLEX Level 2 CE
Status - Passed
Exam date - 6/30/2015
Number of Attempts - 1

Examination - COMLEX Level 2 PE

Status - Passed
Exam date - 6/4/2015
Number of Attempts - 1

Examination - COMLEX Level 3
Status - Passed
Exam date - 10/5/2017
Number of Attempts - 1

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.

Residency Component

List all post-graduate training programs you have attended, including those you did not complete. As you type, the name of your Hospital/Institution should auto-populate. Once it does, click on it to select. If your Hospital/Institution does not auto-populate, type and select Other. You will then enter your Hospital/Institution name in the fields that appear.

Residency Number - RES55667
Hospital Name - Akron General Medical Center - NEOUCOM
Address - 1 Akron General Ave
City - Akron
State - OH
ZipCode - 44307
Country - United States
PG Years - 4
PG Type - Residency
Department/Specialty - Obstetrics and Gynecology
Start Date - 7/1/2016
End Date - 6/30/2020
Successfully Completed? - true

Residency Number - RES55668
Hospital Name - Washington University / Barnes Jewish Hospital
Address - 660 S Euclid Ave,
City - St Louis
State - MO
ZipCode - 63110
Country - United States
PG Years - Other
PG Type - Fellowship
Department/Specialty - Complex Family Planning
Start Date - 7/1/2020

End Date - 6/30/2022
Successfully Completed? - true
Other PG Years - PGY 5-6

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 - Washington University in St. Louis
Practice Settings - Hospital - Inpatient
Street Address - 660 S Euclid Ave
City - ST LOUIS
State - MO
Zip Code - 63110
Major Area of Focus or Specialty - Obstetrics and Gynecology (ABMS)
Total Hours Worked at this practice site, per Week - 40

Percent of time spent per week in each of the following at this practice site:
Direct Patient Care - 90
Teaching/Academic - 5
Research - 5
Professional Services - 0
Administrative Activities - 0
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. For any question that is answered in the affirmative you will later be required to upload a detailed explanation and supporting documents.

Question - Have you ever been denied staff membership at any hospital, nursing home, clinic, health maintenance organization, or similar institution?
Answer - No

Question - Have you ever been investigated, warned, censured, put on probation, terminated, or disciplined by any employer, hospital, group practice, nursing home, clinic, health maintenance organization, or other similar institution, for any reason?
Answer - No

Question - Have you ever had admissions monitored, had clinical privileges or other similar institutional authority denied, limited, restricted, reduced, suspended, revoked, terminated, or placed on probation for any reason, or have resigned privileges at any institution?
Answer - No

Question - Have you ever been requested to resign or withdraw from, or have resigned in lieu of investigation or termination from, a position with an employer, hospital, group practice, nursing home, clinic, health maintenance organization, or other similar institution, for any reason?
Answer - No

Question - Have you ever been investigated by, warned by, censured by, disciplined by, put on probation by, requested to resign or withdraw from, dismissed from, refused renewal of a contract by, or expelled from, a medical or podiatry school, clinical clerkship, externship, preceptorship, residency, postdoctoral training program, or graduate medical education program?
Answer - No

Question - 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?
Answer - No

Question - 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?
Answer - No

Question - 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? You may answer NO to this question if you voluntarily allowed a license, certificate, or registration to lapse or expire due to non-renewal.
Answer - No

Question - 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?
Answer - No

Question -

Are you one of the following: a medical director of an emergency medical service organization, a physician member of an advisory board of an emergency medical service organization, an employee of a community mental health service provider, an employee of a local alcohol, drug addiction, and mental health services board, an employee of ODMHAS, are involved in court-ordered patient commitments in some capacity, an employee of the State of Ohio, an employee of the Department of Corrections and have or have had contact with inmates and persons under supervision, or an employee of the Department of Youth Services?

An affirmative answer to this question provides notice to the board that your residential and familial information is exempt from disclosure under Ohio's public records laws. Failure to self-identify may result in the board releasing such information in response to public records requests. In the event that your answer to this question changes before your next license renewal, you should immediately notify the board.

Answer - No

Question - 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?
Answer - No

Question - Have you ever been notified of any charges, allegations, or complaints filed against you with, been notified of any investigation concerning you by, or been requested to appear before, any board, bureau, department, agency, or other body, including those in Ohio, with respect to a professional license?
Answer - No

Question - Have you ever been denied or have you ever 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?
Answer - No

Question - Have you, in any jurisdiction, ever pled guilty to, been found guilty of, or forfeited collateral, bail, or bond for, violation of any law, police regulation, or ordinance (other than minor traffic violations), or been granted intervention or treatment in lieu of conviction? Minor traffic violations do not include driving while impaired, reckless operation of a motor vehicle, or other traffic offense that required a court appearance.
Answer - No

Question - Have you, in any jurisdiction, ever been arrested for violation of any law, police regulation, or ordinance; been summoned into court as a defendant, or had any lawsuit filed against you (other than a malpractice suit)?
Answer - No

Question - Within the last ten years have you had a professional liability (malpractice) claim paid on your behalf, or paid such a claim yourself?

Answer - No

Question - Have you ever been denied professional liability insurance or coverage, or had such insurance or coverage canceled, limited, or restricted in any way?
Answer - No

Question - Have you ever been denied or relinquished participation as a provider 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?
Answer - No

Question - Have you ever been diagnosed as having, or have you been treated for, pedophilia, exhibitionism, or voyeurism?
Answer - No

Question - In the past five years, have you been diagnosed as having, or been hospitalized for a medical condition which in any way impairs or limits your ability to practice medicine with reasonable skill and safety? Medical condition includes both physical and mental conditions. You may answer "NO" to this question if you hold a current training certificate to pursue training in Ohio and the only such medical condition is an alcohol or other substance use disorder, and you have been found to be eligible for the One-Bite Program and are in compliance with or have completed a monitoring agreement with the One-Bite monitoring organization. Any questions concerning approval can be directed to the board offices.
Answer - No

Question - Do you use chemical substance(s) which in any way impair or limit your ability to practice medicine with reasonable skill and safety?
Answer - No

Question - Are you currently engaged in the illegal use of controlled substances?
Answer - No

Question - Are you an International Medical School Graduate?
Answer - No

Question - Are you or will you be in an accredited training program in Ohio?
Answer - No

Question - Have you engaged in conduct prohibited by the Medical Board's rules regarding sexual misconduct and impropriety (chapter 4731-26 of the Administrative Code)?
Answer - No

Attachments

If applicable, upload the Attachments for your license application by clicking the Add Attachment button(s). Attachments related to affirmative answers must include a detailed explanation and supporting documentation. 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.

Title - License Verification
Description - I attest that I have disclosed all professional licenses, registrations, or certifications that I hold, or have ever held.
Attested - Attestation complete

Title - BCI Report
Description - I acknowledge as an applicant I am required to complete an Ohio BCI criminal records check and the results should be sent directly to the State Medical Board of Ohio.
Attested - Attestation complete

Title - FBI Report
Description - I acknowledge as an applicant I am required to complete an FBI criminal records check and the results should be sent directly to the State Medical Board of Ohio.
Attested - Attestation complete

Review + Submit

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

Application Review - Completed

Attestation
I hereby certify and attest that I am the person named in this application, that all statements I have or shall

make with respect thereto are true, that I am the original and lawful possessor and person named in the various forms and credentials furnished or to be furnished 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 aspect.

I acknowledge that I have read and understand this application and have answered all questions contained in this application truthfully and completely. I further acknowledge that failure on my part to answer questions truthfully and completely may lead to my being prosecuted under appropriate federal and state laws.

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

I hereby release, discharge and exonerate the Board, its agents or representatives and any person, hospital, clinic, government agency (local, state, federal or foreign), court, association, institution or law enforcement agency having custody or control of any documents, records and other information pertaining to me of any and all liability of every nature and kind arising out of investigation made by the Board.

I will immediately notify the board in writing of any changes to the answers to any of the questions contained in this application if such a change occurs at any time prior to the credential for which I have applied being granted to me by the board.

I understand my failure to answer questions contained in this application truthfully and completely may lead to denial, revocation, or other disciplinary sanction of the credential for which I have applied.

Consent to Electronic Signature - **Consented**
Date/Time Stamp - 5/16/2022 1:48 PM
Type your First Name and Last Name as they appear on the application to sign electronically.
Emily Freeman
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.