Bernard, Caitlin, M.D. **Constit ID: 060710**

PH License: 33568 Date Issued: 3/9/20

TP License: _____ TP Approval: _____ Date TP Issued: _____

Application/Fee Received: **12/16/2018** Application Statement and Fingerprint Cards Mailed: 12/26/18

Email: caitlinb@iu.edu Authorized Person(s): Emily Theis

PH Licensure Requirements:

- ✓ FCVS
- ✓ Application Appendix
- ___ License Verifications ~~MD AA/EM~~
- ✓ Release and Waiver Form with Photo
- ✓ Category I & II
- ✓ Temporary Permit Request
- ✓ Hospital/ Clinic Affiliation List
- ✓ NPDB/HIPDB
- ✓ CME Form

- ☐ Medical School Entered
- ☐ State Licensure Entered
- ☐ Endorsement Entered
- ☐ Merge Code Changed/Added
- ☐ Board Location Entered

Criminal Background Checks:

- _____ Date fingerprint card & fee received by KBML
- _____ Date mailed to KSP
- ~~_____ Date reports received from KSP/FBI~~

Board Meeting: Mar/ June/ Sep/ Dec Board Date Input _____

Board Approved Date _____ Due Process/Special Invite Letter _____
(If Applicable)

Special Licensure Item:

Louisville

Kentucky Board of Medical Licensure
310 Whittington Parkway, #1B
Louisville, KY 40222
(502) 429-7150
www.kbml.ky.gov

Application for Medical/Osteopathic License

The following information was entered by the applicant as part of the online application on 12/16/2018. Applicant's required addendums will follow this page.

Notice: Failure to truthfully and completely answer any question on this application (electronic or manual), including intentional and inadvertent non-disclosure, will result in a minimum fine of $1,000.00.

Name: Caitlin Bernard M.D.

Date of Birth: [redacted]

Birth Place: [redacted]

Gender: [redacted]

Address Information:

Mailing Address: [redacted]

Practice Address: 842 South 7th Street
Louisville, KY 40203

Work Number: (317) 880-3944

Home Number:

Email Address: caitlinb@iu.edu

Practice Information:

Specialty: Obstetrics/Gynecology

Medical Status: Obstetrics/Gynecology

Date: 12/16/18

Name: Caitlin Bernard
Constit ID: 060710

Category I Questions:

NOTE: Intentional false answers or misrepresentation in applying for or procuring a license, registration or reactivation in Kentucky are grounds for disciplinary action, including denial or revocation of license, and are reported to the National Practitioner Data Bank and/or appropriate national professional credentialing organization. You must answer 'yes' to any question if the event(s) described in that question has actually occurred. You must answer 'yes' in such circumstance even if you have been advised by an attorney or other person that you may answer 'no'. You must also answer 'yes' in such circumstance even if the record of the event has been sealed or expunged by Court order, or has been designated 'confidential' by the body involved. After answering 'yes' to the appropriate question(s), you may advise the Board of any additional relevant information pertaining to your answer (i.e., record has been sealed or expunged, record is designated 'confidential,' attorney has advised that you properly answer 'no'). The Board will consider this additional information, along with your answer(s), in determining the appropriate action. If you have any question about whether or not you should answer 'yes' to a question, you should err in favor of answering 'yes' and providing an explanation, because any non-disclosure violation will likely result in denial of your application or disciplinary action against your license. This application may not be altered in any way.

1. Have you ever been dismissed from, resigned while under investigation, been placed on a disciplinary probation or reprimanded at a medical school or a postgraduate training program?
(Academic probation is not reportable.)
No

2. Are you currently in default on any student loan repayment obligations payable to the financial aid programs administered by the Kentucky Higher Education Assistance Authority?
No

3. Have you ever been denied a license or denied the privilege of taking a licensure examination by any State, Federal or International licensure jurisdiction?
No

Date: 12/16/18

Name: Caitlin Bernard
Constit ID: 060710

4. Have you ever had any license, certificate, registration or other privilege as a health care professional denied, revoked, suspended, probated, restricted or limited, or subjected to any other disciplinary action, by a State medical/osteopathic licensing board, or Federal, or International authority?
No

5. Have you ever been disciplined by any licensed hospital (including postgraduate training) or the medical staff of any licensed hospital, including removal, suspension, probation, limitation of hospital privileges or any other disciplinary action if the action was based upon what the hospital or medical staff found to be unprofessional conduct, professional incompetence, malpractice or a violation of a provision(s) of a Medical Practice Act?
No

6. Have you surrendered such credential, or placed it into an inactive status, to avoid disciplinary action or in connection with or in anticipation of a disciplinary investigation/action by the licensing authority of such jurisdiction?
No

7. Have you ever resigned your privileges or failed to renew privileges at a licensed hospital or from the medical staff of the hospital, while under investigation or while you were subject to disciplinary proceedings by the hospital?
No

8. Have you ever been removed, suspended, expelled or disciplined by any professional medical facility, association or society?
No

9. Have you ever voluntarily or involuntarily surrendered a medical or osteopathic license, or controlled substance registration certificate issued to you?
No

Date: 12/16/18

Name: Caitlin Bernard
Constit ID: 060710

10. Have you ever been or are you currently under investigation by any State, Federal or International licensure authority or any drug licensure/enforcement authority?
No

11. Are any legal proceedings regarding licensure presently pending against you by any State, Federal or International licensure authority or any drug licensure/enforcement authority?
No

12. Have you ever been convicted of a felony or misdemeanor by any State, Federal or International court?
No

13. Are any criminal charges presently pending against you in any of those courts?
No

14. To your knowledge, are you the subject of an investigation for a criminal act?
No

15. In the past ten (10) years have you had to pay a settlement or judgment in a malpractice action or other civil action against your medical practice, or are there any malpractice or other civil actions against your medical practice presently pending in any court?
No

I hereby state that the information contained in this application has not been altered in any way and is true, accurate, and complete to the best of my knowledge and belief. I understand that under Kentucky law the submission of any false, fraudulent or forged statement, document or other matter in connection with this application is grounds for criminal prosecution and the denial of licensure. I authorize the Board (KBML) or its agents to obtain from other sources any information necessary for determining my qualifications for licensure. I also authorize them to furnish any information they may now or in the future have concerning my qualifications and fitness to practice medicine/osteopathy to any person, institution, association, school, hospital or government entity.

Signature: Caitlin Bernard
Date: 12/16/18

Date: 12/16/18

Name: Caitlin Bernard
Constit ID: 060710

Category II Questions:

The answer to this question is exempt from public disclosure under KRS 61.878(1)(a) and (I) and KRS 311.619 and shall be subject to inspection only upon order of a court of competent jurisdiction, except that no court shall authorize the inspection by any party of any materials pertaining to civil litigation beyond that which is provided by the Kentucky Rules of Civil Procedure governing pretrial discovery. The answer to the question may be considered by the Board (KBML) and may be disclosed in any contested case proceeding, including a Show Cause proceeding, or appeal of a licensing decision based upon them.

1. Are you currently suffering from any condition for which you are not being appropriately treated that impairs your judgment or that would otherwise adversely affect your ability to practice medicine in a competent, ethical and professional manner?

[redacted]

I hereby state that the information contained in this application has not been altered in any way and is true, accurate, and complete to the best of my knowledge and belief. I understand that under Kentucky law the submission of any false, fraudulent or forged statement, document or other matter in connection with this application is grounds for criminal prosecution and the denial of licensure. I authorize the Board (KBML) or its agents to obtain from other sources any information necessary for determining my qualifications for licensure. I also authorize them to furnish any information they may now or in the future have concerning my qualifications and fitness to practice medicine/osteopathy to any person, institution, association, school, hospital or government entity.

Signature: Caitlin Bernard
Date: 12/16/18

MAIL FORM TO KBML

RECEIVED

JUN 17 2019

K.B.M.L.

Kentucky Board of Medical Licensure
Application Appendix

Applicant Name Bernard (Last) Caitlin (First) MD, MSCI (MI)

Applicant Signature [signature] Date: 06/10/2019

Medical School:
List name, location and dates of attendance of every college and medical school you have attended:

Name	City/State/Country	Dates (From – To)	Degree
SUNY Upstate Medical University	Syracuse, NY, USA	08/2010-05/2-014	MD

State or Professional Licensure:
List ALL states and Canadian provinces where you currently hold or have ever held ANY type of medical/osteopathic license. In addition, you must order verification of each license from each medical board. The verifying entity must forward all documentation directly to the Kentucky Board of Medical Licensure. Please note some state boards charge a fee for this information. Contact the state board where you currently hold or have held a license to determine their requirements.

Original (Full Unrestricted) Licensing State None Date License Issued _____
(This blank MUST BE FILLED IN: if there is no original full license, write "NONE")

State Licensed:	New York	License #	273866	License Type	Full
State Licensed:	Missouri	License #	2015015484	License Type	Full
State Licensed:	Indiana	License #	01078719A	License Type	Full
State Licensed:		License #		License Type	
State Licensed:		License #		License Type	
State Licensed:		License #		License Type	
State Licensed:		License #		License Type	
State Licensed:		License #		License Type	
State Licensed:		License #		License Type	
State Licensed:		License #		License Type	
State Licensed:		License #		License Type	
State Licensed:		License #		License Type	

COPY THIS PAGE TO LIST ADDITIONAL STATE LICENSES

Instructions: You must attach a recent (less than 6 months old) passport quality, color photograph of yourself to this form. Take the form to a notary public and sign the form in the presence of the notary public. The notarized form then must be sent directly to the Kentucky Board of Medical Licensure.

RECEIVED

JUN 17 2019

K.B.M.L.

Kentucky Board of Medical Licensure
Affidavit and Authorization for Release of Information

I, the undersigned, being duly sworn, hereby certify under oath 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.

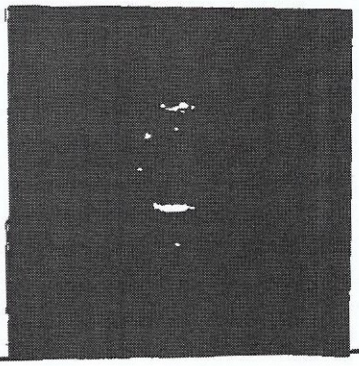
I acknowledge that I have read and understand the Application for Medical/Osteopathic Licensure and have answered all questions contained in the application truthfully and completely. I further acknowledge that failure on my part to answer questions truthfully and completely may lead to my being prosecuted 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 Kentucky Board of Medical Licensure, 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 a license to practice medicine 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 my licensure or permit to practice medicine.



Caitlin Bernard

Applicant's Signature (must be signed in the presence of a notary)

Caitlin Bernard

Applicant's Printed Name (Last, First MI, Suffix)

June 12, 2019

Date of Signature

NOTARY

Dated June 12, 2019 Signed Doug Jones

State of INDIANA County of MARION

Subscribed and Sworn to before me this 12th day of JUNE 2019.

My commission expires: May 24, 2026

(PLEASE AFFIX NOTARY SEAL HERE)

Kentucky Board of Medical Licensure
310 Whittington Parkway, Suite 1B
Louisville, Kentucky 40222

RECEIVED KBML
JUN 17 2019
KBML

Hospital, Clinic, Facility Affiliation List

Physician's Name Caitlin Bernard M.D. / D.O.

List all hospitals, clinics, etc., other than training (see below) where you have practiced medicine within the last five (5) years. This includes moonlighting, administrative, and all locum tenens assignments. **If you have been in training or are still in training, this form still needs to be completed. Please mark "in training" on the form and submit.** If there is a gap in time, please provide an explanation. No substitutions for this form will be accepted; it can be copied as needed. The only attachments accepted will be explanations of disciplinary actions and gaps in time.

Dates (From – To)	Hospital/Clinic/Facility Office Name & Address	Disciplinary Action Must Write "Yes" or "No" If "Yes," Provide Explanation	Indicate Locum Tenens, Moonlighting or Type of Privileges
07/2014 06/2015	Moi Teaching & Referral Hospital Eldoret, Kenya, 30100	no	Visiting Physician
09/2015-current	Eckonazi Hospital 720 Eskenazi Ave Indianapolis, IN 46202	No	Full Admitting
09/2015-current	Indiana University Health Academic Health Center 550 University Blvd Indianapolis, IN 46202	No	Full Admitting

I attest that the information contained here is true, accurate, and complete to the best of my knowledge.

Physician's Signature _____ Date 06/10/2019

Kentucky Board of Medical Licensure
310 Whittington Parkway, Suite 1B
Louisville, Kentucky 40222

MAIL FORM TO KBML

RECEIVED

JUN 17 2019

K.B.M.L.

CME Form

Name Caitlin Bernard
(Please Print or Type)

Record of Category I Continuing Medical Education Credits
(Last 3 years only)

DO NOT PROVIDE DOCUMENTATION

Please note: If you have been in training or are still in training this form still needs to be submitted. Please write "In training" on the form.

Dates:	Name of Activity/Course	# of Credit Hours
10/16/2017	North American Forum in Family Planning	15.5
06/03/2018	Fellowship in Family Planning Annual Meeting	23
11/16/2018	International Conference on Family Planning	22
9/2017-1/2019	Institutional Educational Activities	16.25

I attest that the above is valid.

Signature Caitlin Bernard

06/10/2019
Date

Michael L. Parson
Governor
State of Missouri

Kathleen (Katie) Steele Danner, Division Director
DIVISION OF PROFESSIONAL REGISTRATION

Department of Insurance
Financial Institutions
and Professional Registration
Chlora Lindley-Myers, Director

STATE BOARD OF REGISTRATION FOR THE HEALING ARTS
3605 Missouri Boulevard
P.O. Box 4
Jefferson City, MO 65102-0004
573-751-0098
866-289-5753 TOLL FREE
573-751-3166 FAX
800-735-2966 TTY
Website: http://pr.mo.gov/healingarts.asp

Connie Clarkston
Executive Director

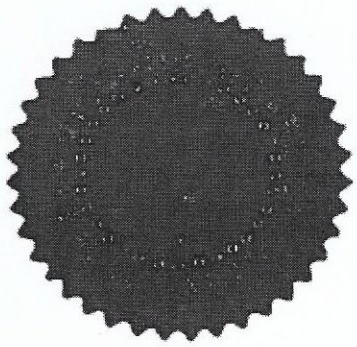
RECEIVED
JUN 24 2019
K.B.M.L.

To:

Kentucky Board of Medical Examiners
Hurstbourne Office Park 310 Whittington Pkwy, Suite 1B
Louisville, KY 40222-4916

This is to certify that the records of the Missouri Board of Healing Arts indicate the following information regarding Caitlin Bernard Bernard, M.D..

LICENSE TYPE:	Medical Physician & Surgeon
LICENSE NUMBER:	2015015484
DATE ISSUED:	5/20/2015
STATUS:	Lapsed
EXPIRATION DATE:	1/31/2018
DISCIPLINARY ACTION:	None



Morgan Colbert
Verifications Clerk

06/18/2019
Date

This is the only form that will be used by the Missouri State Board of Registration for the Healing Arts for the purpose of license verification.

STATE OF INDIANA

C

Eric J. Holcomb

Indiana Professional Licensing Agency
402 W. Washington St. Room W072
Indianapolis, IN 46204
Phone: (317) 232-2960
Fax: (317) 233-4236

Official Proof of Licensure
Digitally Certified Record

Personal Information	
Name:	Caitlin Bernard
Address:	[redacted]
Date of Birth:	[redacted]

License Information	
Number Issued:	01078719A
License Type:	Physician
Status:	Active
Issue date:	06/07/2017
Expiration Date:	10/31/2019
Obtained By:	Application

This licensee has met ALL requirements for licensure in the State of Indiana - including successfully passing all required exams.

For disciplinary action information, please visit our License Search & Verify service at www.in.gov/pla/3119.htm. Disciplinary action will either show under Previous Action or Violations. For additional information including questions regarding Disciplinary Action, contact the appropriate Board or Commission at http://www.in.gov/pla/boards.htm.

Digitally Certified on: Tue Jun 11 09:23:41 PM EST 2019

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, PARKS CAITLIN BERNARD was issued license/certificate number 273866 for the practice of MEDICINE on 02/24/2014.

RECEIVED
JUN 27 2019
K.B.M.L.

Our records also indicate the following information:
Date of birth: [redacted]
School attended: SUNY UPSTATE MED CTR
Date of graduation: 05/22/10
Degree earned: MD

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
04/11								0000P	OOSCT
12/09						0000P			
06/08			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: NO Last reg period ended: 01/31/16
Address: [redacted]

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

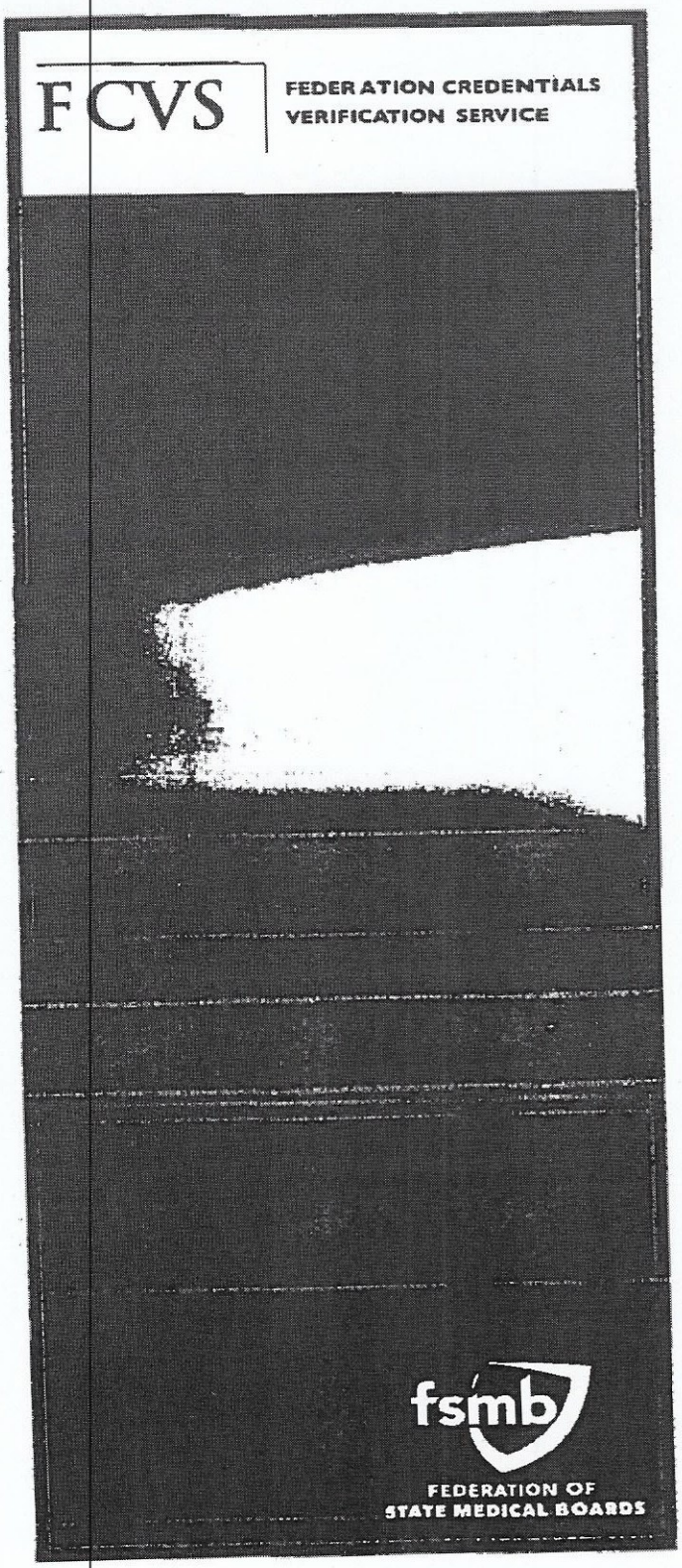
I, Audrey Bell, Education Program Assistant 1, Division of Professional Licensing Services of the New York State Education Department, do hereby state that as Education Program Assistant 1 of said Division, I have legal custody of the official records of the Division of Professional Licensing Services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

SEAL

Audrey Bell
06/21/19
Education Program Assistant 1

DN MO 104

FCVS | FEDERATION CREDENTIALS VERIFICATION SERVICE



fsmb
FEDERATION OF STATE MEDICAL BOARDS

Medical Professional Information Profile

This report provides credentialing information for:

Name:	**Bernard, Caitlin**
Social Security Number:	[redacted]
Date of Birth:	
FID#:	**215612037**
Recipient:	**KY - Kentucky Board of Medical Licensure**
Delivery Date:	**07/03/2019**

ABOUT THIS PROFILE

The Federation Credentials Verification Service (FCVS) was retained by the above referenced medical professional to verify his/her medical credentials for submission to your agency/organization. Unless noted otherwise, all documents contained in this report were received directly from the issuing institution per written request made by FCVS.

NOTICE: All documents bearing an original Official FCVS seal are certified to be an exact representation of the original. Where required, original documents are provided according to the agreements with the institution issuing such document. FCVS maintains all original documents (excluding third-party examination transcripts) in the physician's source file.

FCVS | FEDERATION CREDENTIALS VERIFICATION SERVICE

Affidavit and Release

fsmb

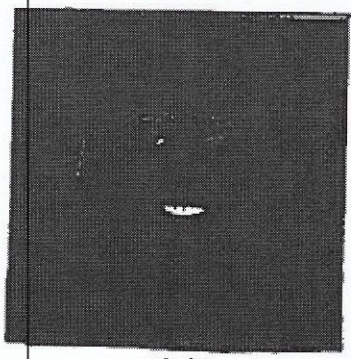
I, the undersigned, hereby certify under oath that I am the person named in this application, that all statements I have or shall make with respect thereto are true, that I am the original and lawful possessor and person named in the various forms and credentials furnished or to be furnished with respect 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 answered all questions contained in the application truthfully and completely. I further acknowledge that failure on my part to answer questions truthfully and completely may lead to me 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 Federation Credentials Verification Service 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 Federation Credentials Verification Service or any of its agents or representatives to inspect and make copies of such documents, records, and other information in connection with this application.

Notary:
Your seal (or stamp) must be partly upon the photo and partly upon the signature of the applicant.

I hereby release, discharge and exonerate the Federation Credentials Verification Service, its agents or representatives and any person furnishing information, of any and all liability of every nature and kind arising out of investigation made by the Federation Credentials Verification Service. I authorize the Federation Credentials Verification Service to release information, material, documents, orders or the like relating to me or this application to any entity at my request.



Applicant's Signature (must be signed in the presence of a notary)

Bernard
Applicant's Printed Last Name

Caitlin
Applicant's Printed First Name, Middle Initial and Suffix (e.g. Jr.)

June 12, 2019
Date of Signature (must correspond to date of notarization)

State of INDIANA, County of MARION

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. The statements on this document are subscribed and sworn to before me by the applicant on this 12th day of JUNE 2019.

Notary Public Signature

My Notary Commission Expires: May 24, 2026

Please complete and mail this original document to the Federation of State Medical Boards at

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

FCVS ID Number
FCVS

215 612 037

FID Number
215612037

FCVS FEDERATION CREDENTIALS VERIFICATION SERVICE

Identity

Biographic Information

Medical professional Name(s): **Bernard, Caitlin**

Parks, Caitlin Bernard

Date of Birth: [redacted]

Place of Birth:

Contact Information

Home Address: [redacted]

Mobile Phone:

Email:

Credentials Analysis Information for Identity

There is no Omission/Discrepancy/Miscellaneous information identified.

CERTIFICATION OF IDENTIFICATION

Certification by Notary Public Is Required

Applicant Full Legal Name: Bernard (Last) Caitlin (First) (Middle)

FCVS ID Number: FCVS FID # 215612037

Notary – Please complete the section below:

State of INDIANA County of MARION

I certify that on the date set forth below, the individual named above, did appear personally before me and presented one of the following forms of identification as proof of his/her identity (Birth Certificate or Valid Passport). I further certify that I did identify this applicant by comparing his/her physical appearance with the photograph on a Government issued photo identification presented by the applicant.

The statements on this document are subscribed and sworn to before me by the applicant on this (Day) 12th, of (Month) JUNE, (Year) 2019.

Notary Public Signature: Donita Jones

Commission Expiration Date* (Month) MAY / (Day) 24 / (Year) 2026

*** The notary's commission expiration date must be current and legible. If no expiration date, such as 'lifetime', an explanation must be provided. If you are in California, the notary may attach a California All-Purpose Acknowledgement form to this document.**

Notary Stamp Here

DONITA JONES
Notary Public - Seal
Marion County - State of Indiana
Commission Number NP0713779
My Commission Expires May 24, 2026

Please complete and mail this original document and a photocopy of the birth certificate or passport presented to the Notary to:

Federation of State Medical Boards
ATTN: FCVS
400 Fuller Wiser Rd
Euless, TX 76039-3856

FCVS ID Number
FCVS

FID Number
215612037

215612037 PF


We the People
Of the United States,
SIGNATURE OF BEARER / SIGNATURE DU TITULAIRE / FIRMA DEL TITULAR
PASSPORT
PASSEPORT
PASAPORTE
UNITED STATES OF AMERICA
USA
[redacted]
Surname / Nom / Apellidos
BERNARD
Given Name(s) / Prénom(s) / Nombres
CAITLIN
Nationality / Nationalité / Nacionalidad
UNITED STATES OF AMERICA
Date of birth / Date de naissance / Fecha de nacimiento
[redacted]
Place of birth / Lieu de naissance / Lugar de nacimiento
[redacted]
Sex / Sexe / Sexo
[redacted]
Date of issue / Date de délivrance / Fecha de expedición
14 JUN 2017
Authority / Autorité / Autoridad
United States
Department of State
Date of expiration / Date d'expiration / Fecha de caducidad
13 JUN 2027
SEE PAGE 27
USA
[redacted]

215 612 037

FILED
APR 14 2017
22ND JUDICIAL CIRCUIT
CIRCUIT CLERK'S OFFICE
DEPUTY

IN THE CIRCUIT COURT OF St. Louis City, MISSOURI
(County where court is located. City of St. Louis is considered a county.)

In re:

CAITLIN BERNARD PARIS
(First Name) (Middle Name) (Last Name) (Jr./Sr./III)
Petitioner *(Enter your full legal name above)*

Case No. 1122-F10078
(Use number on Petition)

Division No. 14A
(Use number on Petition)

Judgment for Change of Name of Adult Individual

1. Parties Appearing *(Check all that apply)*

   Petitioner CAITLIN BERNARD PARIS
   (First Name) (Middle Name) (Last Name) (Jr./Sr./III)

   You are the Petitioner in this case.

   ☒ appears in person.

   ☐ appears by Attorney.

2. The court finds that the change of name would be proper and would not be detrimental to the interests of any other person.

3. The name of Petitioner is changed as follows:

   From CAITLIN BERNARD PARIS
   (First Name) (Middle Name) (Last Name) (Jr./Sr./III)

   To CAITLIN BERNARD
   (First Name) (Middle Name) (Last Name) (Jr./Sr./III)

   Birth Date [redacted]
   (mm/dd/yyyy)

4. Change of Birth Records *(Check one of the two boxes)*

   ☐ It is further ordered that the Division of Health and Senior Services, Bureau of Vital Statistics for the State of Missouri alter the birth certificate of Petitioner to reflect this judgment. This judgment shall be mailed by the Petitioner to the Division of Health and Senior Services.

   ☐ It is further ordered that the State of _____ alter the birth certificate of Petitioner to reflect this judgment. This judgment shall be mailed by the Petitioner to the appropriate state of birth of Petitioner.

5. Notice *(Check one of the two boxes)*

☒ Notice of the change of name shall be published at least once each week for three consecutive weeks in the following newspaper of general circulation:
St Louis City Monitor

☐ No notice of change of name is to be published because the petitioner is the victim of a crime based upon domestic violence as defined in §455.010, RSMo; or the victim of child abuse as defined in §210.110, RSMo; or the victim of abuse by a family or household member as defined in §455.010, RSMo.

6. Court Costs *(Check one of the two boxes)*

☐ Court costs are waived.
☒ Court costs are to be paid from the court cost deposit(s) previously posted.

7. Waiver of Right to Rehearing *(If case is heard by a Commissioner pursuant to §487.010, RSMo, et seq.)*

We, the undersigned parties, do hereby acknowledge receipt of the findings and recommendations of the commissioner and waive the right to file a motion for rehearing in this case.

☐ Signature of Petitioner's Attorney _____
☒ Signature of Petitioner Caitlin Bernard / Caitlin Bernard

(If heard by a Family Court Judge)

_____
(Judge)

_____
(Date)

(If heard by a Family Court Commissioner)
Findings and Recommendations of Commissioner:

_____ 4-14-17
(Commissioner) *(Date)*

All orders and these findings and recommendations of the Commissioner are confirmed and adopted as the judgment of the court.

_____ 4/14/17
(Judge) *(Date)*

A certified copy of this judgment is to be mailed to the following person(s): *(Check all applicable boxes)*

☐ _____
(Print Name of Petitioner's Attorney)

_____
(Street)

_____
(City, State, Zip)

_____
(Telephone Number with Area Code)

☒ Caitlin Bernard
(Print Name of Petitioner)

[redacted]
(Street)

[redacted]
(City, State, Zip)

[redacted]
(Telephone Number with Area Code)

fsmb

No Supporting Document for Name

PROVIDED BY APPLICANT

Name: Caitlin Bernard Bernard

I cannot provide FCVS a legible/complete supporting document for the name above because the source of this name is:

- ☐ An abbreviation or complete spelling of my first, middle or last name
- ☐ My father or grandfather's name is included in my name
- ☐ A paternal and/or maternal last name(s) included in my name
- ☐ A nickname or spelling variation of my name
- ☐ An error or inaccurate spelling of my name
- ☑ I do not know the source of this variation of my name

OR

The source document for the name above has been lost or destroyed. The original source of my name was *(Select only one)*:

- ◯ Birth Certificate
- ◯ Marriage License
- ◯ Divorce Decree
- ◯ Passport
- ◯ Name Change document
- ◯ Naturalization Certificate
- ◯ Baptismal Certificate
- ◯ Refugee Travel Document

Signature

Date 6/10/19

Federation ID# 2156120 37

FCVS FEDERATION CREDENTIALS VERIFICATION SERVICE

Chronology of Activities

fsmb

The Chronology of Activities is a comprehensive report of a medical professional's activities as reported to FCVS in the medical professional application.

Start Date	End Date	Activity Type	Location
09/01/2006	05/22/2010	Medical Education	State University of New York Upstate Medical University Syracuse New York UNITED STATES
07/01/2010	06/30/2014	Postgraduate Training	SUNY Upstate Medical University Program Syracuse New York UNITED STATES
07/01/2014	06/01/2015	Work	Indiana University 550 University Blvd UH 2440 Indianapolis, Indiana UNITED STATES
07/01/2015	06/30/2017	Postgraduate Training	Washington University in St Louis St Louis Missouri UNITED STATES

End of Chronology of Activities report for: Bernard, Caitlin

FCVS FEDERATION CREDENTIALS VERIFICATION SERVICE

Medical Education

fsmb

Medical Education

Medical School: **State University of New York Upstate Medical University**

Location: Syracuse, NY
UNITED STATES

Credentials Analysis Information for Medical Education

There is no Omission/Discrepancy/Miscellaneous information identified.

FCVS FEDERATION CREDENTIALS VERIFICATION SERVICE

Verification of Medical Education

Federation of STATE MEDICAL BOARDS

Instruction to the Dean

Please complete both pages of this form, sign date and seal on the front page then return to:

Federation Credentials Verification Service
400 Fuller Wiser Road
Suite 300
Euless, TX 76039

The individual identified on the attached Authorization for Release of Information, Documents and Records form has authorized your medical school to provide to the Federation Credentials Verification Service (FCVS) any and all information pertaining to their education at your institution.

Please note: If your institution processes transcript requests through another office, FCVS has likely made such a request under separate cover.

If your office also processes transcript requests, please attach the individual's official transcript (which indicates courses taken, dates and hours of attendance, and scores, grades, or evaluation).

Institution Name: State University of New York Upstate Medical University

Address Line 1:

Address Line 2:

City: **State/Province:** **Zip Code (Postal Code):**

Country:

If name of institution was different when this individual attended, please note this name below:
N/A

Premedical Education:
Years of education required for admission to your medical school: 1
Credential/degree presented by the applicant for admission to your medical school: None

Enrollment and Participation: Our records indicate that Bernard, Caitlin
(type/print individual's name: Last, First, Middle, Suffix)
attended our medical school for total of 4 years of medical education on the following dates: From: 08/28/2006 (Month Day Year) To: 04/30/2010 (Month Day Year)

This individual
Was awarded the degree of Doctor of Medicine on 05/22/2010 (Month Day Year)
Was NOT awarded a degree because: (please explain - additional page if necessary)

Attestation

Affix Institutional Seal Here

If no seal is available, this form must be notarized.

Watermark
For FCVS internal use only

ELECTRONIC SEAL VERIFIED

Name: Jennifer Martin Tse

Signature: *Jennifer Martin Tse*

Title: University Registrar
Date of Signature: 07/01/2019 **Phone:** (315) 464-4604
Fax: (315) 464-8822 **Email:** registrar@upstate.edu

215612037 1482 215612037

Unusual Circumstances

1. Do this individual's official records reflect (an) interruption(s) or extension(s) in his/her medical education? No

If Yes, please specify the reason(s) for, indicate the date of the interruptions(s) or extension(s) and check whether the interruption/extension was approved or unapproved:

	From Date:	To Date:
Personal/Family		
Academic remediation		
Health		
Financial		
Participation in joint degree Program (e.g., MD/PhD)		
Participation in non-research special study (e.g., fellowship, international experience)		
Participation in non-degree research		
Other:		
Other:		

Please Specify:

2. Do this individual's official records reflect that he/she was ever placed on academic or disciplinary probation during his/her medical education? No

If YES, please select the reason(s) for the probation, indicate the dates of placement on and removal from probation and attach additional documentation to this report:

	From Date:	To Date:
Academic Probation		
Probation for unprofessional conduct/behavioral		
Other:		

Please specify a reason:

3. Do this individual's official records reflect that he/she was ever disciplined for unprofessional conduct/behavioral reasons by the medical school or parent university? No

If YES, please provide detailed documentation/information about the circumstances and outcome(s):

4. Do this individual's official records reflect that he/she was ever the subject of negative reports for behavioral reasons or an investigation by the medical school or parent university? No

If YES, please provide detailed documentation/information about the circumstances and outcome(s):

5. Do this individual's official records reflect that there were any limitations or special requirements imposed on the individual because of questions of academic incompetence, disciplinary problems, or any other reason? No

If YES, please provide detailed documentation/information about the nature of the limitations or special requirement:

400 FULLER WISER ROAD | SUITE 300 | EULESS, TX 76039 TEL(817)868-5000 FAX(817)868-5099

FCVS FEDERATION CREDENTIALS VERIFICATION SERVICE

Applicant Reported Unusual Circumstances

fsmb

Medical School

Medical Professional Name: Bernard, Caitlin

State University of New York Upstate Medical University

Unusual Circumstances

Did you have any interruption(s) or extension(s) in your medical education?	**No**
Were you ever placed on probation?	**No**
Were you ever disciplined or placed under investigation?	**No**
Were any negative reports for behavioral reasons ever filed by instructors?	**No**
Were any limitations or special requirements imposed on you because of academic performance, incompetence, disciplinary problems or for any other reason?	**No**

End of Applicant Reported Unusual Circumstances report for: Bernard, Caitlin

400 FULLER WISER ROAD | EULESS, TX 76039 | TEL (817) 868 - 5000 | FAX (817) 868 - 5099

This will be considered an official document, when sent by The SUNY Upstate Medical University Registrar's Office, only in the following instances: 1) directly to an official third party through the third party's online document service. 2) to an authorized department within SUNY Upstate Medical University.

STATE UNIVERSITY OF NEW YORK
UPSTATE MEDICAL UNIVERSITY

OFFICE OF THE REGISTRAR
155 ELIZABETH BLACKWELL STREET
SYRACUSE, NY 13210

Student No: [redacted]

Date of Birth: [redacted]

Date Issued: 18-JUN-2019

Page: 1

Record of: Caitlin Bernard
Current Name: Caitlin Bernard
*** WARNING ***
--No Address--

Issued To: FCVS

Course Level: Professional

Current Program
Program : Medicine MD
College : College of Medicine
Major : Medicine

Degrees Awarded Doctor of Medicine 22-MAY-2010
Degree Program
Program : Medicine MD
College : College of Medicine
Major : Medicine

SUBJ	NO.	COURSE TITLE	CRED GRD	PTS R
INSTITUTION CREDIT:				
Fall 2006				
College of Medicine				
Medicine				
FAMP	1642	Literature and Medicine	1.00 P	0.00
*Pass/fail course				
MANA	107	Human Anatomy	9.00 H	0.00
MMFM	101	Molecular Fndtns Med	9.00 HP	0.00
MPOM	105	Practice of Medicine I	8.00 P	0.00
MPPH	101	Case Readings I	3.00 H	0.00
Ehrs: 30.00 GPA-Hrs: 21.00 QPts: 0.00 GPA: 0.00				
Spring 2007				
College of Medicine				
Medicine				
MANA	108	Microscopic Anatomy	4.00 HP	0.00
MBBH	101	Brain And Behavior	7.00 HP	0.00
MPHY	101	Physiology	6.00 HP	0.00
OBGY	3622	Miracle Continuity	2.00 H	0.00
PYCH	6828	Intro to Medical Spanish	3.00 H	0.00
PYCH	6899	Psychiatry	2.00 HP	0.00
Ehrs: 24.00 GPA-Hrs: 24.00 QPts: 0.00 GPA: 0.00				
Fall 2007				
College of Medicine				

********** CONTINUED ON NEXT COLUMN **********

Term Information continued:
Medicine

SUBJ	NO.	COURSE TITLE	CRED GRD	PTS R
MICI	201	Microbiology and Immunology	8.00 HP	0.00
MPHM	201	Pharmacology	7.00 H	0.00
MPOM	201	Practice of Medicine II	8.00 P	0.00
MPPH	202	MLC II: Pathophy Mechanisms	8.00 H	0.00
MPTH	201	Pathology	9.00 H	0.00
Ehrs: 40.00 GPA-Hrs: 32.00 QPts: 0.00 GPA: 0.00				
Spring 2008				
College of Medicine				
Medicine				
MBSC	201	Behavioral Science	3.00 H	0.00
OBGY	3622	Miracle Continuity	2.00 H	0.00
Ehrs: 5.00 GPA-Hrs: 5.00 QPts: 0.00 GPA: 0.00				
Commendation				
Fall 2008				
College of Medicine				
Medicine				
MDCN	2000	Medicine Clerkship	12.00 H	0.00
OBGY	3600	Ob/Gyn Clerkship	6.00 HP	0.00
PEDS	5600	Pediatric Clerkship	6.00 H	0.00
Ehrs: 24.00 GPA-Hrs: 24.00 QPts: 0.00 GPA: 0.00				
Spring 2009				
College of Medicine				
Medicine				
ANAT	0408	Anatomy in Depth: Prep/Resid	2.00 P	0.00
CBHX	2400	Bioethics At Bedside Clerkship	1.00 HP	0.00
CBHX	2406	Global Health Discussion Group	1.00 P	0.00
*Pass/fail course				
INTD	9427	Peer Tutoring in Basic Science	4.00 P	0.00
*Pass/fail course				
NEUR	3000	Neuroscience Clerkship	5.00 HP	0.00
OBGY	3619	Reproductive Health	4.00 H	0.00
OPTH	3000	Ophthalmology Clerkship	1.00 H	0.00
PEDS	5698	Pediatrics	2.00 P	0.00

********** CONTINUED ON PAGE 2 **********

This will be considered an official document, when sent by The SUNY Upstate Medical University Registrar's Office, only in the following instances: 1) directly to an official third party through the third party's online document service. 2) to an authorized department within SUNY Upstate Medical University.

Student No: [redacted]

Record of: Caitlin Bernard

STATE UNIVERSITY OF NEW YORK
UPSTATE MEDICAL UNIVERSITY

Date of Birth: [redacted]

OFFICE OF THE REGISTRAR
155 ELIZABETH BLACKWELL STREET
SYRACUSE, NY 13210

Date Issued: 18-JUN-2019

SUBJ	NO.	COURSE TITLE	CRED	GRD	PTS	R
Institution Information continued:						
SURG	8200	Surgery Clerkship	8.00	H	0.00	
		Ehrs: 28.00 GPA-Hrs: 19.00 QPts:	0.00	GPA:	0.00	
Commendation						
Fall 2009						
College of Medicine						
Medicine						
FAMP	1600	Family Medicine Clerkship	4.00	P	0.00	
OBGY	3605	General OB/GYN A.I.	4.00	H	0.00	
OBGY	3608	Reproductive Endoc & Infer	4.00	H	0.00	
OBGY	3699	Ob/Gyn	4.00	H	0.00	
		Ehrs: 16.00 GPA-Hrs: 12.00 QPts:	0.00	GPA:	0.00	
Spring 2010						
College of Medicine						
Medicine						
INTD	9600	MLC III-Current Biomedical Res	4.00	H	0.00	
PYCH	6800	Psychiatry Clerkship	6.00	P	0.00	
UROL	8400	Urology Clerkship	2.00	HP	0.00	
		Ehrs: 12.00 GPA-Hrs: 6.00 QPts:	0.00	GPA:	0.00	

********** TRANSCRIPT TOTALS **********

	Earned Hrs	GPA Hrs	Points	GPA
TOTAL INSTITUTION	179.00	143.00	0.00	0.00
TOTAL TRANSFER	0.00	0.00	0.00	0.00
OVERALL	179.00	143.00	0.00	0.00

********** END OF TRANSCRIPT **********

STATE UNIVERSITY OF NEW YORK

UPSTATE MEDICAL UNIVERSITY

ON THE RECOMMENDATION OF THE FACULTY AND BY
VIRTUE OF THE AUTHORITY VESTED IN THEM THE TRUSTEES OF THE UNIVERSITY
HAVE CONFERRED ON

CAITLIN BERNARD

THE DEGREE OF

DOCTOR OF MEDICINE

AND HAVE GRANTED THIS DIPLOMA AS EVIDENCE THEREOF
GIVEN IN THE CITY OF SYRACUSE IN THE STATE OF NEW YORK IN THE
UNITED STATES OF AMERICA ON THE TWENTY-SECOND DAY OF MAY
TWO THOUSAND AND TEN

Chairman, SUNY Board of Trustees

Chairman, College Council

Chancellor of the State University of New York

President, Upstate Medical University

ELECTRONIC
SEAL
VERIFIED

FCVS FEDERATION CREDENTIALS VERIFICATION SERVICE

Postgraduate Training

fsmb

Postgraduate Training

Accreditation ID: 2203521215
Institution: SUNY Upstate Medical University Program
Location: Syracuse, NY
UNITED STATES

Accreditation ID: None
Institution: Washington University in St Louis
Location: St Louis, MO
UNITED STATES

Credentials Analysis Information for Postgraduate Training

Issue:
The Verification of Post Graduate Training Form from Washington University in St Louis dated 07/01/2015 to 06/30/2017 reported in the Chronology of Activities is not included in the Profile.

Solution:
FCVS does not obtain verification of non-accredited training programs.

fsmb

Federation Credentials Verification Service (FCVS)
400 Fuller Wiser Rd, Euless, TX 76039
Tel: (817) 868-5099 Fax: (817) 868-5099 Email: fcvsgme@fsmb.org

RECEIVED
JUL 02 2019
By

Verification of Postgraduate Medical Education

Institution: SUNY Upstate Medical University Program
Specialty: Obstetrics & Gynecology
Address: Syracuse, NY

Attention: Program Director
Attested University:

Verification For:

Name: Caitlin Bernard
DOB: [redacted]
Individual's Name on Record (if different from above):

Program Participation:

Important:
Report incomplete postgraduate years (PGY) separate from those that were successfully completed.

If the postgraduate year is currently in progress report the expected completion date in the "To" field.

Report Internships, Residencies and Fellowships separately.

Use one section per Department/Specialty. If the Department/Specialty is rotating or transitional, please provide a schedule of rotations.

PGY: 1
☐ Internship ☒ Residency ☐ Chief Residency ☐ Fellowship ☐ Research
Specialty/Subspecialty: OB/Gyn
From: 7/1/10 To: 6/30/11
Successfully Completed?: ☑ Yes ☐ No ☐ In Progress
Accredited by: ☒ ACGME ☐ AOA ☐ LCGME ☐ RSC ☐ CFPC ☐ RCPSC ☐ APPAP ☐ None of these

PGY: 2
☐ Internship ☒ Residency ☐ Chief Residency ☐ Fellowship ☐ Research
Specialty/Subspecialty: OB/Gyn
From: 7/1/11 To: 6/30/12
Successfully Completed?: ☑ Yes ☐ No ☐ In Progress
Accredited by: ☒ ACGME ☐ AOA ☐ LCGME ☐ RSC ☐ CFPC ☐ RCPSC ☐ APPAP ☐ None of these

PGY: 3
☐ Internship ☒ Residency ☐ Chief Residency ☐ Fellowship ☐ Research
Specialty/Subspecialty: OB/Gyn
From: 7/1/12 To: 6/30/13
Successfully Completed?: ☒ Yes ☐ No ☐ In Progress
Accredited by: ☒ ACGME ☐ AOA ☐ LCGME ☐ RSC ☐ CFPC ☐ RCPSC ☐ APPAP ☐ None of these

Unusual Circumstances:

Check the correct response. Omitted responses require written explanation.

If necessary, you may continue your explanation on a separate sheet of paper.

SEAL VERIFIED

1. Did this individual ever take a leave of absence or break from his/her training? ☐ Yes ☒ No
2. Was this individual ever placed on probation? ☐ Yes ☒ No
3. Was this individual ever disciplined or placed under investigation? ☐ Yes ☒ No
4. Were any negative reports for behavioral reasons ever filed by instructors? ☐ Yes ☒ No
5. Were any limitations or special requirements placed upon this individual because of questions of academic incompetence, disciplinary problems or any other reason? ☐ Yes ☒ No

Please explain any "Yes" response from above:

Certification:

Affix your institutional seal in this space. If no seal is available, you must have this form notarized.

Completion of the following is certification that the information above is an accurate account of this individual's records and is true and correct. The signature line must contain the original signature, or the electronic typed signature, of the program director (M.D./D.O. only).

Name: Danielle A Kate, MD Signature:
Title: Associate Dean, GME Date of Signature: 6/21/19
Tel: 315-464-8948 Fax: 315-464-7619 E-Mail: KateD@upstate.edu

Rev 10/02/2018 FID: 215612037 ACGME ID: 2203521215 GME CODE:

Federation Credentials Verification Service (FCVS)
400 Fuller Wiser Rd, Euless, TX 76039
Tel: (817) 868-5099 Fax: (817) 868-5099 Email: fcvsgme@fsmb.org

RECEIVED
JUL 02 2019
By

Verification of Postgraduate Medical Education

Institution: SUNY Upstate Medical University Program
Specialty: Obstetrics & Gynecology
Address: Syracuse, NY

Attention: Program Director
Affiliated University:

Verification For:

Name: Caitlin Bernard
DOB: [redacted]
Individual's Name on Record (if different from above):

Program Participation:

Important:
Report incomplete postgraduate years (PGY) separate from those that were successfully completed.

If the postgraduate year is currently in progress report the expected completion date in the "To" field.

Report Internships, Residencies and Fellowships separately.

Use one section per Department/Specialty. If the Department/Specialty is rotating or transitional, please provide a schedule of rotations.

PGY: 4
☐ Internship ☐ Residency ☒ Chief Residency ☐ Fellowship ☐ Research
Specialty/Subspecialty: OB/Gyn
From: 7/1/13 To: 6/30/14
Successfully Completed?: ☒ Yes ☐ No ☐ In Progress
Accredited by: ☒ ACGME ☐ AOA ☐ LCGME ☐ RSC ☐ CFPC ☐ RCPSC ☐ APPAP ☐ None of these

PGY:
☐ Internship ☐ Residency ☐ Chief Residency ☐ Fellowship ☐ Research
Specialty/Subspecialty:
From: To:
Successfully Completed?: ☐ Yes ☐ No ☐ In Progress
Accredited by: ☐ ACGME ☐ AOA ☐ LCGME ☐ RSC ☐ CFPC ☐ RCPSC ☐ APPAP ☐ None of these

PGY:
☐ Internship ☐ Residency ☐ Chief Residency ☐ Fellowship ☐ Research
Specialty/Subspecialty:
From: To:
Successfully Completed?: ☐ Yes ☐ No ☐ In Progress
Accredited by: ☐ ACGME ☐ AOA ☐ LCGME ☐ RSC ☐ CFPC ☐ RCPSC ☐ APPAP ☐ None of these

Unusual Circumstances:

Check the correct response. Omitted responses require written explanation.

If necessary, you may continue your explanation on a separate sheet of paper.

SEAL VERIFIED

1. Did this individual ever take a leave of absence or break from his/her training? ☐ Yes ☒ No
2. Was this individual ever placed on probation? ☐ Yes ☒ No
3. Was this individual ever disciplined or placed under investigation? ☐ Yes ☒ No
4. Were any negative reports for behavioral reasons ever filed by instructors? ☐ Yes ☒ No
5. Were any limitations or special requirements placed upon this individual because of questions of academic incompetence, disciplinary problems or any other reason? ☐ Yes ☒ No

Please explain any "Yes" response from above:

Certification:

Affix your institutional seal in this space. If no seal is available, you must have this form notarized.

Completion of the following is certification that the information above is an accurate account of this individual's records and is true and correct. The signature line must contain the original signature, or the electronic typed signature, of the program director (M.D./D.O. only).

Name: Danielle A. Katz, MD
Signature:
Title: Associate Dean, GME
Date of Signature: 6/12/19
Tel: 315-464-8948 Fax: 315-464-7619 E-Mail: KatzD@upstate.edu

Rev. 10/02/2018

FID: 215612037
ACGME ID: 2203521215
GME CODE:

Graduate Medical Education

UPSTATE MEDICAL UNIVERSITY

August 31, 2017

Federation of State Medical Boards
400 Fuller Wiser Road, Suite 300
Euless, TX 76039

To Whom It May Concern:

Please be advised that Danielle Katz, MD is the sole authorized signatory for postgraduate training verifications at SUNY Upstate Medical University. Dr. Katz serves as the Associate Dean for Graduate Medical Education and the ACGME Designated Institutional Official. As such she holds ultimate oversight of all our residency and fellowship programs. Be advised that Dr. William Grant retired on July 31, 2017.

Sincerely,

Suzanne Henderson-Kendrick
Director, Graduate Medical Education

750 East Adams Street - Room 1816 | Syracuse, NY 13210 | Ph: 315.464.8948 | Fax. 315.464.7619 | www.upstate.edu | State University of New York

13-0299

FCVS FEDERATION CREDENTIALS VERIFICATION SERVICE

Applicant Reported Unusual Circumstances

fsmb

Graduate Medical Education

Medical Professional Name:	Bernard, Caitlin
Accreditation ID:	2203521215
Institution:	SUNY Upstate Medical University Program
Specialty:	Obstetrics & Gynecology

Unusual Circumstances

Training Period: 7/1/2010 - 6/30/2014 **Residency**

Did you have any interruption(s) or extension(s) in your medical education?	**No**
Were you ever placed on probation?	**No**
Were you ever disciplined or placed under investigation?	**No**
Were any negative reports for behavioral reasons ever filed by instructors?	**No**
Were any limitations or special requirements imposed on you because of academic performance, incompetence, disciplinary problems or for any other reason?	**No**

End of Applicant Reported Unusual Circumstances report for: Bernard, Caitlin

400 FULLER WISER ROAD | EULESS, TX 76039 | TEL (817) 868 - 5000 | FAX (817) 868 - 5099

FCVS FEDERATION CREDENTIALS VERIFICATION SERVICE

Licensure / Examinations

fsmb

Licensure / Examinations

Exam: USMLE

Credential Analysis Information for Licensure / Examinations

There is no Omission/Discrepancy/Miscellaneous information identified.

Date
July 03, 2019

Bernard, Caitlin

FID
215612037

United States Medical Licensing Examination® (USMLE®)
Certified Transcript of Scores

This document was prepared by
Federation of State Medical Boards of the United States, Inc. (FSMB)
400 Fuller Wiser Road, Euless, TX 76039-3856 · Telephone (817) 868-4000

Date: 07/03/2019

Federation Credentials Verification Service
ATTN: FCVS

FCVSID: 463378

Examinee: Bernard, Caitlin
Alt Name(s): Parks, Caitlin Bernard

Examinee ID: 5-213-732-0
Date of Birth: [redacted]

Results for Steps taken by this examinee (and for which results have been reported to date) are shown below. For Steps that span more than one day, the test date reflects the day on which the examination began. Pass/fail outcomes are based upon the minimum passing level in place at the time of test administration and are not altered by subsequent revisions to the minimum passing level. Effective April 1, 2013, test results are reported on a three-digit scale only; two-digit scores reported for prior administrations will no longer be reported. Test results reported as passing represent an exam score of 75 or higher on a two-digit scoring scale.

USMLE STEP 1

Test Date	Pass/Fail	Score	Minimum Pass	Comments
06/16/2008	Pass	243	(185)	

USMLE STEP 2

Clinical Knowledge (CK)

Test Date	Pass/Fail	Score	Minimum Pass	Comments
12/30/2009	Pass	256	(184)	

Clinical Skills (CS)

Test Date	Pass/Fail	Comments
11/10/2009	Pass	

USMLE STEP 3

Test Date	Pass/Fail	Score	Minimum Pass	Comments
04/12/2011	Pass	236	(187)	

End of Exam History

NOTE: A search of the Physician Data Center of the Federation of State Medical Boards (FSMB) reveals no reported information on this examinee.

United States Medical Licensing Examination® (USMLE®)
Certified Transcript of Scores

This document was prepared by
Federation of State Medical Boards of the United States, Inc. (FSMB)
400 Fuller Wiser Road, Euless, TX 76039-3856 - Telephone (817) 868-4000

Examinee: Bernard, Caitlin

Examinee ID: 5-213-732-0
Date of Birth: [redacted]

INTERPRETATION OF RESULTS

USMLE transcripts include a complete examination history. On those Step examinations for which numeric scores are reported, a three-digit scale is used. Most scores fall between 140 and 260 on this scale. The recommended minimum passing score is shown on the front of the transcript next to the examinee's score for each administration along with a pass/fail outcome. Test results reported as passing represent an exam score of 75 or higher on a two-digit scoring scale. The level of proficiency required to meet the recommended minimum passing level for each USMLE Step is reviewed periodically and is subject to change. Such changes do not alter pass/fail outcomes from prior test administrations.

For examinations with reported scores, the Standard Error of Measurement (SEM) provides an index of the variation that would be expected to occur if an examinee were tested repeatedly using different sets of items covering similar content. The SEM is usually in the range of 4 to 8 points.

STEP 2 CLINICAL SKILLS (CS)

Step 2 CS results are reported as pass or fail, with no numeric score. Had the two-digit reporting scale been used, examinees would have had to achieve a score of 75 or higher in order to pass.

ANNOTATIONS APPEARING UNDER "COMMENTS"

Circumstances in connection with an administration shown on this transcript may result in one or more annotations listed next to the score. A description of each Comment is provided below:

Indeterminate - Results are at or above the passing level but cannot be certified as representing a valid measure of the examinee's knowledge or competence as sampled by the examination. No score is reported. Information regarding the nature of the indeterminate score is available. If such information is not enclosed with this transcript, it may be obtained by contacting the organization from which you received the transcript or the USMLE Secretariat, 3750 Market Street, Philadelphia, PA 19104, telephone (215) 590-9700.

Incomplete - The examinee sat for some, but not all, of the scheduled examination. No score is reported.

Irregular Behavior - The Committee for Individualized Review determined that the examinee engaged in irregular behavior. Examples of irregular behavior are described in the current edition of the USMLE Bulletin of Information. Information regarding the nature of the irregular behavior and the determination of the Committee is available. If such information is not enclosed with this transcript, it may be obtained by contacting the organization from which you received the transcript or the USMLE Secretariat, 3750 Market Street, Philadelphia, PA 19104, telephone (215) 590-9700.

Score Not Available - The score is not available. Further review and/or analysis may be pending, or it may have been determined that the score cannot be reported.

ANNOTATIONS APPEARING AS "NOTE"

Circumstances not in connection with an administration shown on this transcript may result in one or more annotations and an explanation or instructions to contact the appropriate individual or organization. The Note will appear at the end of the document.

PHYSICIAN DATA CENTER INFORMATION APPEARING AS "NOTE"

The Physician Data Center of the Federation of State Medical Boards (FSMB) contains actions reported to the FSMB by U.S. licensing and disciplinary boards, the U.S. Department of Health and Human Services, government regulatory entities and international licensing authorities. To be included in the Physician Data Center, an action must be a matter of public record or be legally releasable to state medical boards or other entities with recognized authority to review physician credentials. Certain actions reported to and released by the Physician Data Center are not disciplinary or otherwise prejudicial in nature. Such actions are reported to ensure that records are complete and to assist in preventing misrepresentation or the use of lost or stolen credentials by unauthorized persons. Once reported to the FSMB, an action becomes part of the permanent record of the individual physician, and the existence of such an action may be indicated on the USMLE transcript by a Note.

03/2015

This document was printed from a secure website and accurately reflects score information maintained by the FSMB.

PDC PHYSICIAN DATA CENTER

fsmb

PRACTITIONER PROFILE

Prepared for: FCVS As of Date:7/3/2019

PRACTITIONER INFORMATION

Name:	Bernard, Caitlin
Alternate Name(s):	Parks, Caitlin Bernard
DOB:	[redacted]
Medical School:	State University of New York Upstate Medical University Syracuse, New York, UNITED STATES
Year of Grad:	2010
Degree Type:	MD
NPI:	1477871929

BOARD ACTIONS

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

LICENSE HISTORY

Jurisdiction	License Number	Issue Date	Expiration Date	Last Updated
INDIANA	01078719A	06/07/2017	10/31/2019	07/02/2019
MISSOURI	2015015484	05/20/2015	01/31/2018	01/10/2018
NEW YORK	273866	02/24/2014	01/31/2016	06/26/2019

PDC PHYSICIAN DATA CENTER

fsmb

PRACTITIONER PROFILE

Prepared for: FCVS As of Date:7/3/2019

Practitioner Name: Bernard, Caitlin

ABMS® CERTIFICATION HISTORY

Certifying Board: American Board of Obstetrics and Gynecology
Certificate: Obstetrics and Gynecology
Certification Type: General
Certification Status: Certified
Participating in MOC: Yes

Status	Duration	Effective Date	Expiration Date	Reverification Date	Occurrence	Last Reported
Expired	Time Limited	01/16/2018	12/31/2018		Initial	06/27/2019
Active	Time Limited	12/31/2018	12/31/2019		Recertification	06/27/2019

The presence and display of ABMS certification data in no way constitutes any affiliation, association with or endorsement of any advertising, promotion or sponsorship by ABMS, its Member Boards and the Board Certified Physicians listed in this directory. ABMS disclaims any responsibility or affiliation for other data that is provided in the directory that is not ABMS sourced information.

AOA® CERTIFICATION HISTORY

No AOA Certifications found.

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

Kentucky Board of Medical Licensure
310 Whittington Parkway, Suite 1B
Louisville, Kentucky 40222

2021 Application for Renewal of Kentucky Medical/Osteopathic License -
Renewal Fee: $150.00

Application Renewed On: 01/19/21 3:59 PM
Caitlin Bernard M.D. KY License #: 53568

Note: Intentional false answers or misrepresentation in applying for or procuring a license, registration or reactivation in Kentucky are grounds for disciplinary action, including denial or revocation of license, and are reported to the National Practitioner Data Bank and/or appropriate national professional credentialing organization. You must answer 'yes' to any question if the event(s) described in that question has actually occurred. You must answer, 'yes' in such circumstances even if you have been advised by an attorney or other person that you may answer 'no'. You must also answer 'yes' in such circumstance even if the record of the event has been sealed or expunged by Court order, or has been designated 'confidential' by the body involved. After answering 'yes' to the appropriate question(s), you may advise the Board of any additional relevant information pertaining to your answer (i.e., record has been sealed or expunged, record is designated 'confidential,' attorney has advised that you properly answer 'no'). The Board will consider this additional information, along with your answer(s), in determining the appropriate action. If you have any question about whether or not you should answer 'yes' to a question, you should err in favor of answering 'yes', providing an explanation, because any non-disclosure violation will likely result in denial of your application or disciplinary action against your license.

Failure to truthfully and completely answer any question on this application (electronic or manual), including intentional and inadvertent non-disclosure, will result in a minimum fine of $1,000.00.

1. Mailing Address: [redacted]

2. Practice Address: 842 South 7th Street

Louisville, KY 40203

3. Phone: (317) 880-3944

4. Email: caitlinb@iu.edu

5. Are you retired? No

6. Are you currently practicing in Kentucky? Yes

2021 Application for Renewal of Kentucky Medical/Osteopathic License

Application Renewed On: 01/19/21 3:59 PM
Caitlin Bernard M.D. KY License #: 53568

7. Please provide KY County and number of hours worked weekly in this county:

a) county Jefferson
b) Hours 4
842 South 7th Street
Louisville, KY 40203

If you have additional practice counties in Kentucky, please indicate so below:

a) county Hours 0

b) county Hours 0

8. Do you currently have hospital staff privileges in Kentucky? No

9. Do you currently have a collaborative agreement with an Advanced Practice Registered Nurse (APRN)? No

If so, please list their names.

10. Do you have plans to practice medicine in Kentucky during the year? Yes

11. Type of Practice? Faculty

12. Specialty? Obstetrics/Gynecology

13. Do you work in or own a pain/bariatric clinic? No

14. Do you dispense/administer controlled substances to patients from your private office setting (i.e. outside of a hospital, long-term care facility)? No

15. Do you have an active DEA license? yes

DEA Number(s): [redacted]

16. State law requires Kentucky licensed physicians who are authorized to prescribe or dispense controlled substances in the Commonwealth to register for an account with the KASPER system. Have you registered for an account with the Kentucky All Schedule Prescription Electronic Reporting (KASPER) system? Yes

17. Gender [redacted]

18. Race [redacted]

2021 Application for Renewal of Kentucky Medical/Osteopathic License

Application Renewed On: 01/19/21 3:59 PM
Caitlin Bernard M.D. KY License #: 53568

1. Since you last registered, have you had any license, certificate, registration or other privilege to practice as a health care professional denied, revoked, suspended, probated, restricted, reprimanded, limited, or subjected to any other disciplinary action, by a state medical/osteopathic licensing board, or Federal, or International authority with the exception of the Kentucky Medical Board?
No

2. Since you last registered, have you surrendered such credential, or placed it into an inactive status, to avoid disciplinary action or in connection with or in anticipation of a disciplinary investigation/action by the licensing authority of such jurisdiction with the exception of the Kentucky Medical Board?
No

3. Since you last registered, have you been or are you currently under investigation by any State medical/osteopathic licensing board, Federal or International licensure authority or any drug licensure/enforcement authority with the exception of the Kentucky Medical Board?
No

4. Since you last registered, has the Drug Enforcement Administration (DEA), or any state or International drug licensure/enforcement authority denied, revoked, suspended, restricted, limited, or otherwise disciplined a controlled substance registration certificate issued to you?
No

5. Since you last registered, have you voluntarily or involuntarily surrendered a medical or osteopathic license with the exception of your Kentucky license, or controlled substance registration certificate issued to you?
No

6. Since you last registered, has any hospital or hospital medical staff removed, suspended, restricted, limited, probated, reprimanded or failed to renew your privileges for cause, or taken any other disciplinary action against your privileges?
No

7. Since you last registered, have you resigned your privileges at any hospital under pressure or investigation or while you were the subject of disciplinary proceedings?
No

2021 Application for Renewal of Kentucky Medical/Osteopathic License

Application Renewed On: 01/19/21 3:59 PM
Caitlin Bernard M.D. KY License #: 53568

8. Since you last registered, are any legal proceedings regarding licensure presently pending against you by any State, Federal or International licensure authority or any drug licensure/enforcement authority with the exception of the Kentucky Medical Board?
No

9. Since you last registered, have you been removed, suspended, expelled or disciplined by any professional medical association or society?
No

10. Since you last registered, have you entered a guilty plea, nolo contendere plea or 'Alford' plea, or been convicted, of any felony offense, any misdemeanor offense, or alcohol related offense in any court?
No

11. Since you last registered, have you had to pay a settlement or judgement greater than $250,000 in a malpractice or other civil action against your medical license?
No

12. Since you last registered, to your knowledge, have you become the subject of any criminal investigation or are any criminal charges pending against you?
No

X I hereby state that the information I have provided in this application is true, accurate and complete to the best of my knowledge and belief. I understand that any false information on my application may subject my license to disciplinary action pursuant to the Medical Practice Act. Checking this box serves as my electronic signature. By submitting this application online and checking this box, I waive any claim that my electronic signature is not my actual signature in any disciplinary proceeding based upon an allegation that specific answers in this application are not true. If I refuse to provide this waiver by checking the checkbox, I understand that I must file a paper application which includes my actual signature.

Electronic Signature: Caitlin Bernard
Date: 01/19/21

2021 Application for Renewal of Kentucky Medical/Osteopathic License

Application Renewed On: 01/19/21 3:59 PM

Caitlin Bernard M.D. KY License #: 53568

The answer to this question is exempt from public disclosure under KRS 61.878(1) (a) and KRS311.619 and shall be subject to inspection only upon order of a court of competent jurisdiction, except that no court shall authorize the inspection by any party of any materials pertaining to civil litigation beyond that which is provided by the Kentucky Rules of Civil Procedure governing pretrial discovery. The answer to the question may be considered by the Board and may be disclosed in any contested case proceeding, including a Show Cause proceeding, or appeal of a licensing decision based upon them.

(1.) Since you last registered, have you suffered from any condition for which you are not being appropriately treated that impairs your judgment or that would otherwise adversely affect your ability to practice medicine in a competent, ethical and professional manner?

[redacted]

X I hereby state that the information I have provided in this application is true, accurate and complete to the best of my knowledge and belief. I understand that any false information on my application may subject my license to disciplinary action pursuant to the Medical Practice Act. Checking this box serves as my electronic signature. By submitting this application online and checking this box, I waive any claim that my electronic signature is not my actual signature in any disciplinary proceeding based upon an allegation that specific answers in this application are not true. If I refuse to provide this waiver by checking the checkbox, I understand that I must file a paper application which includes my actual signature.

Electronic Signature: Caitlin Bernard
Date: 01/19/21

2021 Application for Renewal of Kentucky Medical/Osteopathic License

Application Renewed On: 01/19/21 3:59 PM
Caitlin Bernard M.D. KY License #: 53568

Continuing Medical Education Requirements

Continuing Medical Education (CME) regulation 201 KAR 9:310 requires all medical and osteopathic physicians maintaining an active Kentucky medical license to obtain 60 hours of CME every three years. Thirty hours must be in Category 1 accredited by the Accreditation Council on Continuing Medical Education or the American Osteopathic Association and thirty hours may consist of non-supervised personal activities.

According to 201 KAR 9:310, each physician licensed to practice medicine or osteopathy within Kentucky who is authorized to prescribe or dispense controlled substances within the Commonwealth shall complete at least 4.5 hours of approved Category I Credit continuing medical education hours relating to the use of KASPER, pain management, addiction disorders or a combination of two or more of those subjects. A licensee may satisfy this requirement by completing a single approved program of 4.5 hours or longer or by completing multiple approved programs for a total of 4.5 hours or longer for this cycle. Information on approved courses can be found on the Board's website.

A physician who obtained a new license during the CME cycle should refer to the information below for calculating CME hours due.

According to the Continuing Medical Education (CME) regulation 201 KAR 9:310, for each (3) year CME cycle, a licensee shall complete:

(a) A total of sixty (60) hours of CME, if his/her license has been renewed for each year of a CME cycle;
(b) If his/her license has not been renewed for each year of a CME cycle, licensee shall complete twenty (20) hours of CME for each year for which his/her license has been renewed.
(c) A licensee whose initial licensure was granted the first year of the CME cycle for which verification is submitted: completion of sixty (60) hours of CME before the end of the cycle;
(d) A licensee whose initial licensure was granted the second year of the CME cycle for which a verification is submitted: completion of forty (40) hours of CME before the end of the cycle;
(e) A licensee whose initial licensure was granted the third year of the CME cycle for which verification is submitted; completion of twenty (20) hours of CME before the end of the cycle.

2021 Application for Renewal of Kentucky Medical/Osteopathic License

Application Renewed On: 01/19/21 3:59 PM
Caitlin Bernard M.D. KY License #: 53568

Continuing Medical Education Requirements

You are required to report that you have completed the CME requirements for the years that you have maintained an active medical license in Kentucky during the cycle.

1. Have you completed your CME requirements for the CME cycle January 1, 2018 to December 31,2020?
Yes

If you have not satisfied the CME requirements, you may request an extension of time. If you request an extension, the Board will assess a $100.00 fee. According to 201 KAR 9:310. section 4, 'The Board may grant an extension of time to a physician who for sufficient cause has not yet received continuing medical education requirements for the cycle.' In order to request an extension, please provide explanation below. You will receive correspondence from the Board after April 1, 2021 accepting your extension request with instructions for submitting required CME hours. Your extension acceptance letter will be mailed separate from your wallet card.
Please grant an extension to complete the Continuing Medical Education hours required for the CME cycle January 1, 2018 - December 31, 2020. I did not complete the required hours because:

I hereby state that the information I have provided in this application is true, accurate and complete to the best of my knowledge and belief. I understand that any false information on my application may subject my license to disciplinary action pursuant to the Medical Practice Act. Checking this box serves as my electronic signature. By submitting this application online and checking this box, I waive any claim that my electronic signature is not my actual signature in any disciplinary proceeding based upon an allegation that specific answers in this application are not true. If I refuse to provide this waiver by checking the checkbox, I understand that I must file a paper application which includes my actual signature.

Electronic Signature: Caitlin Bernard
Date: 01/19/21

Kentucky Board of Medical Licensure
310 Whittington Parkway, Suite 1B
Louisville, Kentucky 40222

2022 Application for Renewal of Kentucky Medical/Osteopathic License -
Renewal Fee: $150.00

Application Renewed On: 01/11/22 9:58 AM
Caitlin Bernard M.D. KY License #: 53568

Note: Intentional false answers or misrepresentation in applying for or procuring a license, registration or reactivation in Kentucky are grounds for disciplinary action, including denial or revocation of license, and are reported to the National Practitioner Data Bank and/or appropriate national professional credentialing organization. You must answer 'yes' to any question if the event(s) described in that question has actually occurred. You must answer, 'yes' in such circumstances even if you have been advised by an attorney or other person that you may answer 'no'. You must also answer 'yes' in such circumstance even if the record of the event has been sealed or expunged by Court order, or has been designated 'confidential' by the body involved. After answering 'yes' to the appropriate question(s), you may advise the Board of any additional relevant information pertaining to your answer (i.e., record has been sealed or expunged, record is designated 'confidential,' attorney has advised that you properly answer 'no'). The Board will consider this additional information, along with your answer(s), in determining the appropriate action. If you have any question about whether or not you should answer 'yes' to a question, you should err in favor of answering 'yes', providing an explanation, because any non-disclosure violation will likely result in denial of your application or disciplinary action against your license.

Failure to truthfully and completely answer any question on this application (electronic or manual), including intentional and inadvertent non-disclosure, will result in a minimum fine of $1,000.00.

1. Mailing Address: [redacted]

2. Practice Address: 842 South 7th Street
Louisville, KY 40203

3. Phone: (317) 205-8088

4. Email: caitlinb@iu.edu

5. Are you retired? No

6. Are you currently practicing in Kentucky? Yes

2022 Application for Renewal of Kentucky Medical/Osteopathic License

Application Renewed On: 01/11/22 9:58 AM
Caitlin Bernard M.D. KY License #: 53568

7. Please provide KY County and number of hours worked weekly in this county:

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Louisville, KY 40203

If you have additional practice counties in Kentucky, please indicate so below:

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8. Do you currently have hospital staff privileges in Kentucky? No

9. Do you currently have a collaborative agreement with an Advanced Practice Registered Nurse (APRN)? No

If so, please list their names.

10. Do you have plans to practice medicine in Kentucky during the year? Yes

11. Type of Practice? Faculty

12. Specialty? Obstetrics/Gynecology

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14. Do you dispense/administer controlled substances to patients from your private office setting (i.e. outside of a hospital, long-term care facility)? No

15. Do you have an active DEA license? yes

DEA Number(s): [redacted]

16. State law requires Kentucky licensed physicians who are authorized to prescribe or dispense controlled substances in the Commonwealth to register for an account with the KASPER system. Have you registered for an account with the Kentucky All Schedule Prescription Electronic Reporting (KASPER) system? Yes

17. Gender [redacted]

18. Race [redacted]

2022 Application for Renewal of Kentucky Medical/Osteopathic License

Application Renewed On: 01/11/22 9:58 AM
Caitlin Bernard M.D. KY License #: 53568

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No

2. Since you last registered, have you surrendered such credential, or placed it into an inactive status, to avoid disciplinary action or in connection with or in anticipation of a disciplinary investigation/action by the licensing authority of such jurisdiction with the exception of the Kentucky Medical Board?
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2022 Application for Renewal of Kentucky Medical/Osteopathic License

Application Renewed On: 01/11/22 9:58 AM
Caitlin Bernard M.D. KY License #: 53568

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12. Since you last registered, to your knowledge, have you become the subject of any criminal investigation or are any criminal charges pending against you?
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Electronic Signature: Caitlin Bernard
Date: 01/11/22

2022 Application for Renewal of Kentucky Medical/Osteopathic License

Application Renewed On: 01/11/22 9:58 AM

Caitlin Bernard M.D. KY License #: 53568

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(1.) Since you last registered, have you suffered from any condition for which you are not being appropriately treated that impairs your judgment or that would otherwise adversely affect your ability to practice medicine in a competent, ethical and professional manner?

[redacted]

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