87049

State Medical Board of Ohio

30 E. Broad St., 3rd Floor • Columbus, OH 43215-6127 • (614) 466-3934 • Website: www.med.ohio.gov

Ohio Addendum to Application

Ohio Training Program

Are you or will you be in an accredited training program in Ohio? If yes, identify name of training program and location:	☐ Yes ☒ No
Name of Hospital/Training Program _____ City	Start Date: ___/___ month/year

Specialty Boards

Name of Specialty Board (If none, enter "N/A")	Year Certified	Country
N/A		

TOEFL iBT

(International Medical School Graduates only)

THE TOEFL, TWE and ECFMG'S ENGLISH EXAM (PRIOR TO 7/1/98), ETC., ARE NOT EQUIVALENT AND CANNOT BE SUBSTITUTED FOR THE TOEFL iBT

Graduates of medical schools located outside the United States and Canada must achieve a score of at least 26 in Speaking and 26 in Listening with a total score of 90 on the TOEFL iBT, regardless of citizenship or country of birth. Prior to July 2006 the Test of Spoken English was required with a minimum score of 40 (between 7/95-7/06) or 230 (prior to 7/95). The following are the only exceptions permitted under Ohio law:

N/A

	YES	NO
Have you completed two years of undergraduate college work in the United States?	☐	☐
During the five years immediately preceding the date of your application, have you: (Please note you must be able to answer "YES" to both parts of this question) Held a current medical license (i.e., unrestricted, training certificate, educational permit) in the United States? **AND** Have you been actively practicing medicine (graduate medical education is included) in the United States?	☐	☐
Have you completed a Fifth Pathway program?	☐	☐
Have you passed the Clinical Skills Assessment examination given by ECFMG on or after July 1, 1998?	☐	☐

If you answered **NO** to all of the above questions, you **must** take the TOEFL iBT. Refer to the application instructions for contacting the Educational Testing Service. The Board cannot waive this requirement.

Applicant Name: Michael James Subit Date: 1/2/2010

OK 1/21/10 KAR

Ohio Addendum to Application

Preliminary Education Form

TO BE COMPLETED BY ALL APPLICANTS

Full Name	Last (Surname)	First	Middle	Suffix (Jr., II)
	Subit	Michael	James	

High School or Equivalent

School Name: Wheeling Park High School
City: Wheeling | State: WV | Country: USA
Dates Attended From: MO/YR 08 / 91 To: MO/YR 06 / 94

Undergraduate College or Equivalent

School Name: West Virginia University
City: Morgantown | State: WV | Country: USA
Dates Attended From: MO/YR 08 / 94 To: MO/YR 06 / 98 | Degree Received: B.A. | Bachelor of Arts

School Name:
City: | State: | Country:
Dates Attended From: MO/YR / To: MO/YR / | Degree Received:

Medical or Osteopathic School of Graduation

School Name: West Virginia University School of Medicine
City: Morgantown | State: WV | Country: USA
Dates Attended From: MO/YR 08 / 01 To: MO/YR 05 / 06 | Degree Received: MD | Doctorate of Medicine

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FOR BOARD USE ONLY

CERTIFICATE OF PRELIMINARY EDUCATION

NO: 117748 DATE ISSUED: JAN 22 2010

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

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JAN - 6 2010

Ohio Addendum to Application
Additional Information
Medicine or Osteopathic Medicine

If you answer "YES" to any of the following questions, you are required to furnish complete details, including date, place, reason and disposition of the matter. All affirmative answers must be thoroughly explained on a separate sheet of paper. You must submit copies of all relevant documentation, such as court pleadings, court or agency orders, and institutional correspondence and orders. Please note that some questions require very specific and detailed information. Make sure all responses are complete.

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

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

JAN - 6 2010

		YES	NO
10.	Have you ever been requested to appear before any board, bureau, department, agency, or other body, including those in Ohio, concerning allegations against you?	☐	☑
11.	Have you ever entered into an agreement of any kind, whether oral or written, with respect to a professional license, in lieu of or in order to avoid formal disciplinary action, with any board, bureau, department, agency, or other body, including those in Ohio?	☐	☑
12.	Have you ever been notified of any investigation concerning you by any board, bureau, department, agency, or other body, including those in Ohio, with respect to a professional license?	☐	☑
13.	Have you ever been notified of any charges, allegations, or complaints filed against you with any board, bureau, department, agency, or other body, including those in Ohio, with respect to a professional license?	☐	☑
14.	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?	☐	☑
15.	Have you ever pled guilty to, been found guilty of a violation of any law, or been granted intervention or treatment in lieu of conviction regardless of the legal jurisdiction in which the act was committed, other than a minor traffic violation? If yes, submit copies of all relevant documentation, such as police reports, ***certified*** court records and any institutional correspondence and orders.	☐	☑
16	Have you ever forfeited collateral, bail, or bond for breach or violation of any law, police regulation, or ordinance other than for a minor traffic violation; been summoned into court as a defendant or had any lawsuit filed against you (other than a malpractice suit)? If yes, submit copies of all relevant documentation, such as police reports, ***certified*** court records and any institutional correspondence and orders.	☐	☑
17.	Have you been a defendant in a legal action involving professional liability (malpractice), or had a professional liability claim paid on your behalf, or paid such a claim yourself? In addition, ask your malpractice insurance carrier(s) to provide a complete claims history report for the last 10 years to the State Medical Board of Ohio. If your current carrier has provided coverage for less than 10 years, ask your previous carrier to submit a claims history report to the Board.	☐	☑
18.	Have you ever been denied professional liability insurance or coverage, or had such insurance or coverage canceled, limited, or restricted in any way?	☐	☑
19.	Have you ever been denied or relinquished participation in any third party reimbursement program, whether governmental or private, including Medicaid and Medicare; or had such participation limited, restricted, suspended, or revoked; or been warned, reprimanded, requested to appear before, or fined by the responsible body?	☐	☑
20.	Have you ever been denied privileges, or had privileges revoked, suspended, restricted, reduced, or terminated by the Department of Defense, the Veteran's Administration, or any of their respective components?	☐	☑

		YES	NO
21.	Have you ever been diagnosed as having, or have you been treated for, pedophilia, exhibitionism, or voyeurism?	☐	☑
22. a)	Within the last ten years, have you been diagnosed with or have you been treated for, bipolar disorder, schizophrenia, paranoia, or any other psychotic disorder?	☐	☑
b)	Have you, since attaining the age of eighteen or within the last ten years, whichever period is shorter, been admitted to a hospital or other facility for the treatment of bipolar disorder, schizophrenia, paranoia, or any other psychotic disorder?	☐	☑

If you answered "YES" to any part of this question, please provide details on a separate sheet, *including date(s) of diagnosis or treatment, and a description of your present condition. Include the* name, current mailing address, and telephone number of each person who treated you, as well as each facility where you received treatment, and the reason for treatment. Have each treating physician submit a letter detailing the dates of treatment, diagnosis and prognosis.

For purposes of questions 23 and 24 the following phrases or words have the following meaning:

"Ability to practice medicine" is to be construed to include all of the following:

1. The cognitive capacity to make appropriate clinical diagnoses and exercise reasoned medical judgments and to learn and keep abreast of medical developments; and
2. The ability to communicate those judgments and medical information to patients and other health care providers, with or without the use of aids or devices, such as voice amplifiers; and
3. The physical capability to perform medical tasks such as physical examination and surgical procedures, with or without the use of aids or devices, such as corrective lenses or hearing aids.

"Medical condition" includes physiological, mental, or psychological conditions or disorders, such as but not limited to orthopedic, visual, speech, and hearing impairments, cerebral palsy, epilepsy, muscular dystrophy, multiple sclerosis, cancer, heart disease, diabetes, mental retardation, emotional or mental illness, specific learning disabilities, HIV disease, tuberculosis, drug addiction, and alcoholism.

		YES	NO
23.	Do you have, or have you been diagnosed as having, a medical condition which in any way impairs or limits your ability to practice medicine with reasonable skill and safety? **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 chemical dependency or substance abuse, and you have successfully completed or are currently receiving treatment at a program approved by this board and have adhered to all statutory requirements as contained in Sections 4731.224 and 4731.25, O.R.C., and related provisions. Any questions concerning approval can be directed to the board offices.	☐	☑
a)	Are the limitations or impairment caused by your medical condition reduced or ameliorated because you receive ongoing treatment or received treatment in the past (with or without medication) or participate in a monitoring program?	☐	N/A ☐

If you receive such ongoing treatment or participate in such monitoring program the board will make an individualized assessment of the nature, severity, and duration of the risk associated with an ongoing medical condition so as to determine whether an unrestricted license should be issued, whether conditions should be imposed, or whether you are not eligible for licensure. Have each treating physician submit a letter detailing the dates of treatment, diagnosis and prognosis.

b)	Are the limitation or impairments caused by your medical condition reduced or ameliorated because of the field of practice, the setting, or the manner in which you have chosen to practice?	☐	N/A ☐

"Chemical substances" is to be construed to include alcohol, drugs, or medications including those taken pursuant to a valid prescription for legitimate medical purposes and in accordance with the prescribers direction, as well as those used illegally.

		YES	NO
24.	Do you use chemical substance(s) which in any way impair or limit your ability to practice medicine with reasonable skill and safety?	☐	☑
	a) Are the limitations or impairment caused by your use of chemical substances reduced or ameliorated because you receive ongoing treatment (with or without medication) or participate in a monitoring program?	☐	☐ N/A

If you receive such ongoing treatment or participate in such monitoring program the board will make an individualized assessment of the nature, severity, and duration of the risk associated with an ongoing medical condition so as to determine whether an unrestricted license should be issued, whether conditions should be imposed, or whether you are not eligible for licensure. Have each treating physician submit a letter detailing the dates of treatment, diagnosis and prognosis.

	b) Are the limitation or impairments caused by your use of chemical substances reduced or ameliorated because of the field of practice, the setting, or the manner in which you have chosen to practice?	☐	☐ N/A

For purposes of question 25 the following phrases or words have the following meaning:

"Currently" does not mean on the day of, or even in the weeks or months preceding the completion of this application. Rather it means recently enough so that the use of drugs may have an ongoing impact on one's functioning as a licensee, or within the past two years.

"Illegal use of controlled substances" means the use of controlled substances obtained illegally (e.g. heroin or cocaine) as well as the use of controlled substances which are not obtained pursuant to a valid prescription or not taken in accordance with the direction of a licensed healthcare practitioner.

		YES	NO
25.	Are you currently engaged in the illegal use of controlled substances?	☐	☑
	a) If "YES," are you currently participating in a supervised rehabilitation program or professional assistance program which monitors you in order to assure that you are not using illegal controlled substances.	☐	☐ N/A

JAN - 6 2010

State Medical Board of Ohio

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Ohio Addendum to Application
Certificate of Recommendation
Medicine or Osteopathic Medicine

This form is to be completed by a physician fully licensed in the STATE IN WHICH THE FORM IS NOTARIZED. The recommending physician must have known the applicant for at least **SIX months**. Relatives may not serve as recommending physicians. Recommending physicians are strongly urged to include additional comments. **The recommending physician must sign this form in front of a notary**. ALL questions must be answered. This form is not intended to standardize the recommendation or restrict it in any way. However, its form is designed to ensure that certain information is included. Please complete the form and return directly to the State Medical Board of Ohio at the above address.

DO NOT COMPLETE UNLESS A COLOR PHOTO OF APPLICANT IS ATTACHED TO THE BOTTOM OF THIS FORM
BLACK & WHITE PHOTOS ARE NOT ACCEPTABLE

I, DAVID J PATTON (recommending physician, print name *legibly*), a licensed and practicing physician in the state of WV (State of residence),

affirm that Michael James Subit (applicant, print name *legibly*) has been known to me personally for 4 years and that he/she is of good moral character. Further, the photograph affixed hereto is a genuine likeness of the applicant. I offer the following in support of his/her application for licensure:

- I rate his/her medical knowledge and technique as: excellent
- His/her relationship with patients is: excellent
- I rate his/her ~~ability to work well with peers and medical staff~~ as: excellent.
- His/her command of the English language is: excellent.
- Additional comments:

I hereby recommend the applicant for a license to practice medicine or osteopathic medicine in the State of Ohio.

Address of Recommending Physician	Number & Street: 1003 Oakhurst Dr.	Telephone Number (include area code)	(304)345 4525
	City: Charleston State: WV Zip Code: 25314		
Signature of Recommending ~~Physician (name stamps not acceptable)~~	[signature]	State of ~~Licensure &~~ License Number	WV 18950

[signature]
Signature of Applicant

Date Photo Taken: 12 / 2009
month/year

Subscribed and sworn to before me this 5th day of January, 2010

Jennifer R. Cooperrider
Notary Public Signature

Date Commission Expires: 11-5-17

OFFICIAL SEAL
NOTARY PUBLIC
STATE OF WEST VIRGINIA
JENNIFER R. COOPERRIDER
830 PENNSYLVANIA AVE., SUITE 304
CHARLESTON, WV 25302
My commission expires November 5, 2017

NOTARY SEAL

State Medical Board of Ohio

30 E. Broad St., 3rd Floor • Columbus, OH 43215-6127 • (614) 466-3934 • Website: www.med.ohio.gov/

Ohio Addendum to Application
Certificate of Recommendation
Medicine or Osteopathic Medicine

This form is to be completed by a physician fully licensed in the STATE IN WHICH THE FORM IS NOTARIZED. The recommending physician must have known the applicant for at least **SIX months**. Relatives may not serve as recommending physicians. Recommending physicians are strongly urged to include additional comments. **The recommending physician must sign this form in front of a notary**. ALL questions must be answered. This form is not intended to standardize the recommendation or restrict it in any way. However, its form is designed to ensure that certain information is included. Please complete the form and return directly to the State Medical Board of Ohio at the above address.

DO NOT COMPLETE UNLESS A COLOR PHOTO OF APPLICANT IS ATTACHED TO THE BOTTOM OF THIS FORM
BLACK & WHITE PHOTOS ARE NOT ACCEPTABLE

I, R.T. DePond MD, a licensed and practicing physician in the state of WV,
(recommending physician, print name *legibly*) (State of residence)

affirm that Michael James Subit has been known to me personally for 6 years
(applicant, print name *legibly*)

and that he/she is of good moral character. Further, the photograph affixed hereto is a genuine likeness of the applicant. I offer the following in support of his/her application for licensure:

- I rate his/her medical knowledge and technique as: Superior
- His/her relationship with patients is: Good
- ~~I rate his/her ability to work well with peers and medical staff as:~~ Good
- His/her command of the English language is: Excellent
- Additional comments: Good Physician

I hereby recommend the applicant for a license to practice medicine or osteopathic medicine in the State of Ohio.

Address of Recommending Physician	Number & Street: 830 Pennsylvania Ave #304 City: Charleston State: WV Zip Code: 25302	Telephone Number (include area code)	304 388-1515
Signature of Recommending ~~Physician (name stamps not acceptable)~~		State of ~~Licensure &~~ License Number	WV 16935

Signature of Applicant

Date Photo Taken: 12 / 2009
month/year

Subscribed and sworn to before me this 5th day of January, 2010.

Jennifer R. Cooperrider
Notary Public Signature

11-5-17
Date Commission Expires

OFFICIAL SEAL
NOTARY PUBLIC
STATE OF WEST VIRGINIA
JENNIFER R. COOPERRIDER
830 PENNSYLVANIA AVE., SUITE 304
CHARLESTON, WV 25302
My commission expires November 5, 2017
NOTARY SEAL

8704

Affidavit and Authorization for Release of Information: 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 this Board.

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 made or shall make with respect thereto are true, that I am the original and lawful possessor of 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 Physician 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 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 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 license or permit to practice medicine.

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

Subit
Applicant's Printed Last Name

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

1/5/2010
Date of Signature

NOTARY

Dated 1-5-10 Signed Jennifer R. Cooperrider

State of West Virginia County of Kanawha

SUBSCRIBED AND SWORN TO before me this 5th day of, January 2010.

My commission expires: 11-5-17 (NOTARY PUBLIC SIGNATURE & SEAL)

OFFICIAL SEAL
NOTARY PUBLIC
STATE OF WEST VIRGINIA
JENNIFER R. COOPERRIDER
830 PENNSYLVANIA AVE., SUITE 304
CHARLESTON, WV 25302
My commission expires November 5, 2017

Applicant Name: Subit, Michael James Date: 1/5/2010

January 2, 2010

To Whom It May Concern:

This statement is being submitted in response to question #4 of page 4 of the Ohio Addendum Application. I was placed on an academic probation during my training at West Virginia University School of Medicine. I took off one academic year from 7/2003 to 7/2004 to prepare for my USMLE Step 1 board exam. After one unsuccessful attempt at the exam, I was placed on academic probation. During my year off, I attended a board review course in preparation for my repeat attempt. I successfully passed my USMLE Step 1 exam on the second attempt. I was taken off of academic probation and returned to my medical school training. I completed my final two years of medical school with no further academic problems.

Sincerely,

Michael James Subit, MD

JAN – 6 2010

5/2006

gned
5/2006

VERIFICATION OF MEDICAL EDUCATION

Unusual Circumstances: The following questions apply to unusual circumstances that occurred during any part of the individual's medical education. Please check the appropriate response and provide dates and requested information. "Yes" responses to any of these questions require a copy of explanatory records or a written explanation (attach additional pages as necessary).

1. Do this individual's official records reflect (an) interruption(s) or extension(s) in his/her medical education?
   Response YES ☒ NO ☐

   If YES, please select the reason(s) for, indicate the dates of the interruption(s) or extension(s) and check whether the interruption/extension was approved or unapproved.

	From Mo/Yr	To Mo/Yr	Approved	Unapproved
Personal/Family			☐	☐
Academic remediation	9/17/2003	7/5/2004	☒	☐
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			☐	☐

   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? Response YES ☒ NO ☐

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

	From Mo/Yr	To Mo/Yr
Academic Probation	5/23/2002	6/27/2005
Probation for unprofessional conduct/behavioral		
Probation for other reason		

   Please specify 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? Response YES ☐ 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? Response YES ☐ 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? Response YES ☐ NO ☒

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

   _____

   _____

Grad Diploma

Medical Education

School	049030 - West Virginia University School of Medicine		
Address	Box 9000		
	Morgantown, WV 26506-9000		
	USA		
Phone	304-293-2408		
Dates	07/2001 - 05/2006	**Grad Date**	05/14/2006
Degree	MD - Doctor of Medicine		
Program 6+ years:	N		

PROVIDED BY APPLICANT

Completed clinical clerkship in a country other than where my medical school was located: N

Clinical Training

Unusual Circumstances

Leaves/Extensions	Y	Took one year off between my 2nd and 3rd years of medical training for board preparation and review course for USMLE Step 1 due to problems with examination.
Probation	Y	I was on academic probation due to problems with USMLE Step 1 exam during my 2nd year of training. After passing the exam and successfully completing my 3rd year clerkships, I was taken off of probation.
Disciplined	N	
Negative Reports	N	
Limitations	N	

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

USMLE™ United States Medical Licensing Examination™

This document was prepared by the
Federation of State Medical Boards of the United States, Inc.
Federation Place, PO Box 619850, Dallas, TX 75261-9850 Telephone (817) 868-4041

Date: 02/01/2010

Recipient:
Federation Credentials Verification Service
ATTN: FCVS

Packet ID: 112433

Examinee: Subin, Michael James
Alt Name(s):

Examinee ID#: 5-120-243-0
Date of Birth: 08/30/1976

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. Where numeric scores are reported, there are two scales used and the recommended minimum passing score ("MP") on each scale is shown in parentheses.

USMLE STEP 1

Test Date	Pass/Fail	Three-Digit Score Total	Three-Digit Score MP	Two-Digit Score Total	Two-Digit Score MP	Comments
04/02/2004	Pass	206	182	84	75	
08/21/2003	Fail	168	182	69	75	

USMLE STEP 2

Clinical Knowledge (CK)

Test Date	Pass/Fail	Three-Digit Score Total	Three-Digit Score MP	Two-Digit Score Total	Two-Digit Score MP	Comments
09/30/2005	Pass	196	182	80	75	

Clinical Skills (CS)*

Test Date	Pass/Fail	Three-Digit Score Total	Three-Digit Score MP	Two-Digit Score Total	Two-Digit Score MP	Comments
07/30/2005	Pass					

USMLE STEP 3

Test Date	Pass/Fail	Three-Digit Score Total	Three-Digit Score MP	Two-Digit Score Total	Two-Digit Score MP	Comments
WEST VIRGINIA 12/20/2006	Pass	201	184	82	75	

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

SEE REVERSE SIDE FOR EXPLANATION OF INFORMATION REPORTED ABOVE

Uniform Application for Physician Licensure

UA Username michaelsubit **Date Submitted** 1/1/2010
FCVS Status Applicant has an FCVS Packet

1. Name: Indicate your full legal name. If your name has changed at any time during your life and you are not using FCVS, you must submit a copy of the legal document (marriage certificate, divorce decree, etc.) supporting your name change.

1. Full Name (use no initials)

Last Name Subit
First Name Michael James
Middle Name
Suffix
Maiden Name
M.D. [X] **D.O.** [ ]

All other names used

First	Middle	Last	Suffix

2. Address/Phone: Please complete all sections and indicate which address you wish to be used for public access and which is to be used for mailings from the medical board. Each state's law determines whether each address or phone number is a public record in the state in which you are applying. You may wish to contact the licensing authority for that state for further information. Many boards publish the "Public Access" address on their website, therefore you should consider what your preferred address is for these purposes.

Business
[ ] **Public Access**
[X] **Mailing**

Street 707 Chesapeake Street
City Charleston **State/Province** WV **Zip Code** 25309
Telephone 304-972-6296
Fax
Email michaelsubit@yahoo.com
Alternate Phone

Home
[X] **Public Access**
[ ] **Mailing**

Street 707 Chesapeake Street
City Charleston **State/Province** WV **Zip Code** 25309
Telephone 304-972-6296
Fax
Email michaelsubit@yahoo.com
Alternate Phone

3. Identification: If you are not using FCVS, you must submit either a notarized copy of your birth certificate or a notarized copy of your current, valid passport.

3. Identification

08/30/1976	Wheeling	West Virginia	USA
Date of Birth (mm/dd/yyyy)	Birth City	Birth State/Province	Birth Country

M	Redacted	1619196037		
Gender	Social Security Number	NPID	Are you a U.S. Citizen?	[X] Yes [ ] No

Your social security number is required to facilitate reporting to the federal Healthcare Integrity & Protection Data Bank (42 U.S.C. Sections 1320a-7e(b), 5 U.S.C. Section 552a, and 45 C.F.R. pt. 61) and for accurate identification under the federal and state child support enforcement law (42 U.S.C. Section 666 and applicable state law). It may also be used for reporting to the National Practitioner Data Bank (42 U.S.C. Section 11101 and 45 C.F.R. pt. 60) and for other investigative/enforcement purposes in compliance with state laws governing physician discipline or as otherwise required by state or federal law.

4. Medical School: List all medical schools you have attended, even those from which you did not graduate, in chronological order. Attach an additional sheet if necessary. If you are not using FCVS, you must complete the attached "Medical Education Verification" form and send it to all medical schools you have attended. You must include a copy of your diploma to which the medical school must attach their seal prior to forwarding it to this Board. Additionally, the medical school must provide this Board with an official copy of your transcripts. The medical school must forward all documentation directly to this Board.

4. Medical School

1 **School Name** West Virginia University School of Medicine
Address Box 9000
Robert C. Byrd Health Sciences Center
City Morgantown
State/Province WV
ZIP Code 26506-9000
Country USA
Attendance Dates **From (mm/yyyy)** 07/2001 **To (mm/yyyy)** 05/2006
Graduation Date 5/14/2006
Degree MD

5. Fifth Pathway: If you attended a Fifth Pathway program and are not using FCVS, you must complete the attached "Fifth Pathway Verification" form and send it to your medical school and to the institution where you completed your rotations. You must include a copy of your diploma. The medical school and institution must forward all documentation directly to this Board.

5. Fifth Pathway (if applicable)

Medical School Name			
Address			
City			
State/Province			
ZIP Code			
Country			
Attendance Dates	**From (mm/yyyy)**	**To (mm/yyyy)**	**In Progress**
Graduation Date			
Degree			
Institution name where rotations performed			
Address			
City			
State/Province			
ZIP Code			
Country			
Attendance Dates	**From (mm/yyyy)**	**To (mm/yyyy)**	**In Progress**
Certification Date			

6. Postgraduate Training: List **all** postgraduate programs you have attended, even those you did not complete. Attach an additional sheet if necessary. If you are not using FCVS, you must complete the attached "Postgraduate Training Verification" form and send it to **all** postgraduate training programs you have attended. You must submit a copy of your certificate of program completion to this Board. Additionally, the postgraduate program must provide this Board with the Program Director's recommendation letter. The postgraduate program must forward all documentation directly to this Board.

6. Postgraduate Training

1 **Hospital Name**
Hospital Address

City
State/Province
ZIP Code
Country

PGY: (e.g., 1, 2, 3, etc.) ☐ **Internship** ☐ **Residency** ☐ **Fellowship** ☐ **Research** ☐ **Other**

Department/Specialty

From: / **To:** / **Successfully Completed?** ☐ **Yes** ☐ **No** **In Progress** ☐

Month Year Month Year

7. Examination History: If you are not using FCVS, you are responsible for contacting the appropriate examination entity and having a certified transcript of your scores sent directly to this Board.

7. Examination History

List each licensure examination, U.S. or international, you have taken (USMLE, NBME, NBOME, LMCC, Etc.).If additional space is necessary, please enclose a separate sheet with your application and include all the information below

Examination	State	Most Recent Date taken(Month/Year)	Passed (P) or Failed (F)		Number of attempts
USMLE Step 1		04/2004	[X] P	[ ] F	2
USMLE Step 2		09/2005	[X] P	[ ] F	1
USMLE Step2 CS		08/2005	[X] P	[ ] F	1
USMLE Step 3		12/2006	[X] P	[ ] F	1

8. ECFMG: If ECFMG is applicable and you are not using FCVS, you are responsible for contacting ECFMG and having a certified "Status Report" forwarded directly to this Board. There is a separate fee for this report. Reports can be obtained through the ECFMG web site at www.ecfmg.org.

8. ECFMG (if applicable)		
Certificate Number	Issue Date	Valid Through Date

9. State or Professional Licensure: List all state and Canadian provinces where you currently hold or have ever held any type of medical/osteopathic license. You must also complete the attached "Licensure Verification" form (Form #1) and forward it to all states in which you have held any health care license or certification. The verifying entity must forward all documentation directly to this Board. Some state boards charge a fee for this information. Contact the state board where you hold or held a license to determine their requirements.

9. State Licensure - MD or DO only - attach additional pages if necessary

	State/Province	**Type (MD, DO, etc)**	**License Number**	**Status**	**Issue Date**
1					

10. Chronology of Activities: List ALL activities (medical and non-medical) in chronological order beginning with medical school graduation to the PRESENT date, using **MONTH** and **YEAR**. *For any non-working time, you MUST state on the form 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. **DO NOT SUBSTITUE ANY OTHER RESUME FOR THIS FORM**. Be sure to indicate the percentage of working time spent in clinical administrative duties.

10. Chronology of Activities

Dates: From/To	Practice/Employment
1 From: Month: 07 Year: 2006 To: Month: Year:	**Practice/Employment Name** Women and Children's Hospital Charleston Area Medical Center (or list non-working time as indicated above) **Practice/Employment Address** 830 Pennsylvania Avenue Suite 304 **City** Charleston **State/Province** West Virginia **ZIP Code** 25302 **Country** USA **Position and Department** Resident PGY-4-Obestetric and G **% Clinical** 100% **Administrative** **Employment** [X] **Staff Privileges** [ ] **Affiliation** [ ] **Other**

11. Malpractice: List of all claims or suits for medical malpractice made against you. A claim is any formal or informal demand for payment to any person or organization. If you do not have any such claims or suits, this section will be blank. Please have your information available before reviewing this section and contact the state board or FCVS to make changes.

11. Malpractice Liability Claims Information

Name of patient involved:

In which state did the action take place? **Case number (if applicable)**

Which court?
(If private compromise or settled before initiation of civil action, state here)

Current status of claim:

☐ Open (pending) ☐ Closed (settled) ☐ Dismissed (no money paid out) ☐ Other

Amount of judgement or settlement $ **Amount paid on your behalf $**

Month and year of event precipitating claim:

Month and year of lawsuit:

Insurance carrier at time:

What is/or was your status? ☐ **Primary defendant** ☐ **Co-defendant** ☐ **Other**

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

The Federation of State Medical Boards of the United States, Inc.
Federation Credentials Verification Service
P.O. Box 619850
Dallas, Texas 75261-9850
Telephone: (817) 868-4000
Fax: (817) 868-4099

Physician Information Profile

This report is compiled exclusively for:

Name:	**Michael James Subit**
SSN:	Redacted
DOB:	**08/30/1976**
Packet ID:	**112433**
Recipient:	**State Medical Board of Ohio**

NOTICE:

The Federation Credentials Verification Service (FCVS) was retained by the above referenced physician 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. All documents bearing the official FCVS seal are ceritified to be an exact reproduction 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.

Physician Information Profile is compiled and published by the Federation of State Medical Boards of the United States, Inc. as a reference source for its member boards and other authorized entities. Physician Information Profile may not be republished, sold, resold or duplicated, in whole or in part, for commercial or any other purposes, or for purposes of compiling lists or files without the express written consent of the Federation's Executive Vice President as authorized by its Board Of Directors. The use of this Physician Information Profile to establish independent data files or compendiums or information is strictly prohibited.

Table of Contents

Section I

FCVS Reports

FEDERATION CREDENTIALS VERIFICATION SERVICE

Physician Information Report

Identity:

Name:	**Michael James Subit**	
Other Name Used:	**N/A**	
Gender:	**Male**	
Date of Birth:	**08/30/1976**	
Place of Birth:	**Wheeling, WV USA**	
SSN:	Redacted	
Current Address:	**707 Chesapeake Street** **Charleston, WV 25309**	
Permanent Address:	**Same**	
Telephone Numbers:	Bus:	**304-989-1267**
	Fax:	**N/A**
	Home:	**304-972-6296**
	Other:	**N/A**
Physical Description:	Height:	**6' 03"**
	Weight:	**250 lbs**
	Eye Color:	**Brown**
	Hair Color:	**Brown**
Physical Marks:	Description:	**N/A**
	Location:	**N/A**

Premedical Education (Reported by physician. Not verified by FCVS):

Institution:	**West Virginia University, Morgantown, WV 26506-6009**
Dates of Attendance:	**07/1994 - 07/1998**
Degree Conferred/Issued:	**Bachelor of Arts**

Medical Education:

Medical School:	**West Virginia University School of Medicine** **PO Box 6009** **Morgantown, WV 26506-6009**
Dates of Attendance:	**08/20/2001 - 05/14/2006**
Date Degree Conferred/Issued:	**05/14/2006**
Degree Conferred/Issued:	**Doctor of Medicine**
Unusual Circumstance:	**Leave** **Probation** **See Form**

Graduate Medical Education:

Institution:	**West Virginia University (Charleston Division)** **Department of Obstetrics and Gynecology** **830 Pennsylvania Avenue # 304** **Charleston, WV 25302**
Training Level:	**1**
Program Type:	**Internship**
Specialty/Subspecialty:	**Obstetrics and Gynecology**
Dates of Attendance:	**07/01/2006 - 06/30/2007**
Completion:	**Yes**
Accreditation:	**ACGME**
Training Level:	**2-3**
Program Type:	**Residency**
Specialty/Subspecialty:	**Obstetrics and Gynecology**
Dates of Attendance:	**07/01/2007 - 06/30/2009**
Completion:	**Yes**
Accreditation:	**ACGME**
Training Level:	**4**
Program Type:	**Chief Resident**
Specialty/Subspecialty:	**Obstetrics and Gynecology**
Dates of Attendance:	**07/01/2009 - 06/30/2010**
Completion:	**To Be Completed On 06/30/2010**
Accreditation:	**ACGME**
Unusual Circumstance:	**None**

Fifth Pathway:

N/A

Examination History:

Licensure Examinations:	**USMLE Step 1** **USMLE Step 2** **USMLE Step 3**

Board Action:

A Report of the results from a search of the Board Action Data Bank is enclosed.

Credentials Analysis Report

The Credentials Analysis Report is a comparative report of a physician's credentials as reported to FCVS by the physician applicant and the primary source (Medical School, PGT program, etc.). It will also list particular missing documentation, if any, as outlined in the FCVS Policies and Procedures.

Physician Identification:

Name:	Michael James Subit
DOB:	08/30/1976
SSN:	Redacted
Packet ID:	112433
Request ID:	21699962

OMISSIONS

There are none identified.

DISCREPANCIES

Discrepancy 1:

Section of Profile:	**Examination History**
Discrepancy:	The applicant reports sitting for USMLE Step2 CS in 08/2005. The USMLE transcript reports the examination date was 07/30/2005.
Follow-Up:	Left to Recipient`s discretion.

MISCELLANEOUS INFORMATION

Miscellaneous 1:

Section of Profile:	**Medical Education**
Issue:	The applicant and West Virginia U Sch Med report Leave and Prob in the Unusual Circumstances sections of the application and the verification form, respectively during attendance at this institution.
Follow-Up:	See comments on Verification of Medical Education Form. A copy of the FCVS Medical Education application page completed by the applicant is included.

Miscellaneous 2:

Section of Profile:	**Post-Graduate Education**
Issue:	The applicant and West Virginia University (Charleston Division) do not report the same program types for PGY 1.

Follow-Up:	FCVS does not follow up on program type based on the definition of a resident per ACGME (A physician at any level of GME in a program accredited by the ACGME is considered a resident.).

End of report for Michael James Subit

Packet Id: 112433 Request Id: 21699962 Report Created By: DDS

The Federation of State Medical Boards
of the United States, Inc
PO Box 619850
Dallas, Texas 75261-9850
Telephone: (817)868-4000
FAX (817)868-4099

BOARD ACTION CLEARANCE REPORT

March 12, 2010

FCVS
400 Fuller Wiser Rd., #209
Euless, TX 76039

Re: Board Action Query Dated: March 12, 2010
Your Reference Number: FCVS-DDS
FSMB Batch Number: BQ1732628

The following is a final report of the search results from the Board Action Data Bank as of March 12, 2010 for practitioners su above-referenced batch for which NO board actions were identified.

Practitioners Cleared with No Actions as of March 12, 2010

Item	Name	DOB	School	Yr/Grad
14	Subit, Michael James	08/30/1976	049030	2006

LICENSE HISTORY
State Board
No License Information Available

PLEASE NOTE: The licensure history information contained in these reports is not considered licensure verification but rather an indicator of known states of historical licensure for these individuals. Use of this information should be limited to cross-reference purposes.

AMERICAN BOARD OF MEDICAL SPECIALTIES
VERIFICATION OF CERTIFICATION

As of: 3/12/2010

State Queried For: State Medical Board of Ohio

Physician Name: Michael James Subit

Date of Birth:

Year of Graduation:

Social Security Number:

ABMSU ID:

The data provided to FCVS by the ABMS does not include Specialty Certification information on file for this physician. This does not mean that the physician is not certified by one or more of the Member Boards of the American Board of Medical Specialties, as the data provided by ABMS does not include some physicians for which they have incomplete data.

All information on the ABMS report is based on a search of data shared with the FSMB by the American Board of Medical Specialties. For some physicians the biographic data in the ABMS database is incomplete and is not included in the shared data. FCVS is unable to verify specialty certification on these physicians. FCVS does not follow up with the applicant or ABMS on any missing or discrepant information.

Section II

Identity

Federation of STATE MEDICAL BOARDS

Affidavit and Release and Authorization for Release of Information, Documents and Records

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 "Instructions for Completing the FCVS Application" 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 waive confidentiality, 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 (FCVS) any such information, including documents, records regarding charges or complaints filed against me, formal or informal, pending or closed, my examination grades, or any other pertinent data and to permit FCVS or any of its agents or representatives to inspect and make copies of such documents, records, and other information in connection with this application that can subsequently be provided to professional licensing boards, hospitals and other entities when I apply for licensure, staff membership, employment or other privileges.

I hereby release, discharge and exonerate FCVS, 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 FCVS.

I will immediately notify FCVS in writing of any changes to the answers to any questions contained in this application if such a change occurs at any time prior to my FCVS Physician Information Profile being mailed.

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

Subit
Applicant's Printed Last Name

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

1/5/2010
Date of Signature

08/30/1976
Date of Birth

Redacted
Applicant SSN

NOTARY

Your seal or stamp must be partly upon the photograph.

State of West Virginia County of Kanawha

SUBSCRIBED AND SWORN TO before me this 5th day of January, 2010

My commission expires: 11-5-17

(NOTARY PUBLIC SIGNATURE & SEAL)

Notary Public signature: Jennifer R. Cooperrider

OFFICIAL SEAL
NOTARY PUBLIC
STATE OF WEST VIRGINIA
JENNIFER R. COOPERRIDER
830 PENNSYLVANIA AVE., SUITE 304
CHARLESTON, WV 25302
My commission expires November 5, 2017

I certify that on the date set forth above the individual named above did appear personally before me and that I did identify his appearance 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.

112433

WEST VIRGINIA STATE DEPARTMENT OF HEALTH—DIVISION OF VITAL STATISTICS

CERTIFICATE OF LIVE BIRTH

BIRTH NO. 1477 6 018937

Type, or print, in permanent ink. Dist. No. 350 Serial No. 1441

For instructions refer to the hospital handbook.

CHILD

1. CHILD—NAME (First, Middle, Last): Michael James SUBIT
2a. DATE OF BIRTH (Month, Day, Year): August 30, 1976
2b. HOUR: 4:35a M.
3. SEX: Male
4a. THIS BIRTH (Single, twin, triplet, etc.) (Specify): Single
4b. IF NOT SINGLE BIRTH (Born first, second, etc.) (Specify):
5a. COUNTY OF BIRTH: Ohio
5b. CITY, TOWN, OR LOCATION OF BIRTH: Wheeling
5c. INSIDE CITY LIMITS (specify yes or no): Yes
5d. HOSPITAL—name (If not in hospital, give street and number): Wheeling Hospital, Inc.

FATHER

6a. FATHER—Name (First, Middle, Last): Roger Brian Subit
6b. AGE (at time of this birth): 26
6c. STATE OF BIRTH (If not in U.S.A., name of country): West Virginia

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MOTHER

7a. MOTHER—Maiden name (First, Middle, Last): Edit Ilona Fulop
7b. AGE (at time of this birth): 23
7c. STATE OF BIRTH (If not in U.S.A., name of country): Hungary
7d. RESIDENCE: State: West V.
7e. County: Ohio
7f. City, town or location: Wheeling
7g. INSIDE CITY LIMITS (Specify yes or no): Yes
7h. Street and number: 27 Thrush Av.
8. MOTHER'S MAILING ADDRESS: P.B.Box 6523
9a. INFORMANT: Edit Subit
9b. RELATION TO CHILD: Mother

Multiple births (Enter numbers for twins)

Live birth(s)

10a. I certify that the above named child was born alive at the place and time and on the date stated above. Signature: H Rubin M D
10b. DATE SIGNED: 9-15-76
10c. ATTENDANT M.D., D.O., Midwife, Other (Specify): MD
10d. CERTIFIER—Name (Type or print): H. Rubin, M.D.
10e. Mailing address (Street or R.F.D. No., City or town, State, Zip): Medical Park, Wheeling, W.V 26003

Fetal death(s)

11a. REGISTRAR—Signature: Betty Gast
11b. Date Received by local registrar (Month, Day, Year): Sept. 17, 1976
12. Date on which given name added (Registrar):

Death under one year of age (Enter number of death certificate for this child.)

SEAL VERIFIED

SEAL VERIFIED

Section III

Medical Education

ERATION CREDENTIALS VERIFICATION SERV FCVS)

VERIFICATION OF MEDICAL EDUCATION

(This form must be completed by the medical school)

INSTRUCTIONS TO THE DEAN

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 complete this form and forward it to FCVS in the enclosed postage-paid, self-addressed envelope.**

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).**

VERIFICATION OF MEDICAL EDUCATION

Name of Institution: West Virginia University School of Medicine

Complete Address: P.O. BOX 9111

Street Address: 1146 HEALTH SCIENCES CENTER

City: MORGANTOWN **State:** WV **ZIP Code (Postal Code):** 26506-9111

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

Premedical Education:

Years of education required for admission to your medical school: four

Credential/degree presented by the applicant for admission to your medical school: B.A.

Enrollment and Participation: Our records indicate that SUBIT, MICHAEL JAMES
(type/print individual's name: Last, First, Middle, Suffix)

attended our medical school for total of 152 weeks of medical education on the following dates (mm/dd/yy):

From 08 (Month) / 20 (Date) / 2001 (Year) **To** 05 (Month) / 14 (Date) / 2006 (Year)

This individual (check one):

Was awarded the degree of DOCTOR OF MEDICINE on 05 (Month) / 14 (Date) / 2006 (Year)

Was NOT awarded a degree because:
(please explain - attach additional pages if necessary)

Certification: By my signature, I, NORMAN D. FERRARI III, MD (type/print name), certify that the above information is an accurate account of the above named individual's official records maintained in this and is true and correct to my knowledge.

SEAL VERIFIED
Affix Institutional Seal Here.
If no seal is available, this form must be notarized.

Signature: Norman D Ferrari

Title: ASSOCIATE DEAN FOR STUDENT SERVICES

Date of Signature: FEBRUARY 1, 2010

Phone: (304) 293-2408 **Fax:** (304) 293-7814

Email:

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VERIFICATION OF MEDICAL EDUCATION

Unusual Circumstances: The following questions apply to unusual circumstances that occurred during any part of the individual's medical education. Please check the appropriate response and provide dates and requested information. "Yes" responses to any of these questions require a copy of explanatory records or a written explanation (attach additional pages as necessary).

1. Do this individual's official records reflect (an) interruption(s) or extension(s) in his/her medical education?
   Response YES ☒ NO ☐

   If YES, please select the reason(s) for, indicate the dates of the interruption(s) or extension(s) and check whether the interruption/extension was approved or unapproved.

	From Mo/Yr	To Mo/Yr	Approved	Unapproved
Personal/Family			☐	☐
Academic remediation	9/17/2003	7/5/2004	☒	☐
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			☐	☐

   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? Response YES ☒ NO ☐

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

	From Mo/Yr	To Mo/Yr
Academic Probation	5/23/2002	6/27/2005
Probation for unprofessional conduct/behavioral		
Probation for other reason		

   Please specify 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? Response YES ☐ 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? Response YES ☐ 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?
   Response YES ☐ NO ☒

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

Medical Education

School	049030 - West Virginia University School of Medicine		
Address	Box 9000 Morgantown, WV 26506-9000 USA		
Phone	304-293-2408		
Dates	07/2001 - 05/2006	**Grad Date**	05/14/2006
Degree	MD - Doctor of Medicine		
Program 6+ years:	N		

PROVIDED BY APPLICANT

Completed clinical clerkship in a country other than where my medical school was located: N

Clinical Training

Unusual Circumstances

Leaves/Extensions	Y	Took one year off between my 2nd and 3rd years of medical training for board preparation and review course for USMLE Step 1 due to problems with examination.
Probation	Y	I was on academic probabtion due to problems with USMLE Step 1 exam during my 2nd year of training. After passing the exam and successfully completing my 3rd year clerkships, I was taken off of probabtion.
Disciplined	N	
Negative Reports	N	
Limitations	N	

West Virginia University
School of Medicine
Charleston Division

MEDICAL STUDENT PERFORMANCE EVALUATION
For
MICHAEL JAMES SUBIT

November 1, 2005

IDENTIFYING INFORMATION

Michael James Subit is a fourth-year student at the West Virginia University School of Medicine, Charleston, WV. He is enrolled in the combined MD/MPH program.

ACADEMIC HISTORY

Date of Expected Graduation from Medical School: May 14, 2006
Date of Initial Matriculation in Medical School: August 20, 2001
Please explain any extensions, leave(s) of absence, gap(s), or break(s) in the student's educational program: Mr. Subit was placed on administrative leave after posting a failing score on his initial attempt at USMLE Step I. He resumed the curriculum after posting a passing score on his second attempt.

For transfer students: Not Applicable
Date of Initial Matriculation in Prior Medical School:
Date of Transfer from Prior Medical School:

Was this student required to repeat or otherwise remediate any coursework during his/her medical education? Yes ☒ No ☐

Please explain: Mr. Subit was required to remediate the Pharmacology course from the 2nd year of the curriculum.

Was this student the recipient of any adverse action(s) by the medical school or its parent institution? Yes ☒ No ☐

Please explain: Mr. Subit was placed on academic probation after obtaining an unsatisfactory evaluation in the pharmacology course during the second year of the curriculum. He was removed from probation after successfully remediating the course and completing the 3rd year of the curriculum.

ACADEMIC PROGRESS

Preclinical/Basic Science Curriculum:

Phone: 304-347 1319
877-985-2427
Fax: 304-347 1251
Studentservicesmed@hsc.wvu.edu

Office of Student Services

3110 MacCorkle Avenue SE
Charleston, WV 25304-1299

Michael James Subit completed the first two years of the curriculum in a satisfactory manner. He successfully passed Step 1 of the USMLE exam on the second attempt with a score of 206.

Core Clinical Clerkships and Elective Rotations:

Clerkship 1:Family Medicine:
Knowledge Base: Very solid exam scores. Very bright; asked the right questions. Appeared to be ahead of his peers early in the third year. Good formal oral presentation: DKA vs. Honk.
Clinical Skills: Good presentation of patient history and physical. Solid exam skills; history taking and oral verbal ability above expectations. Well organized.
Work Ethic: Michael was hardworking and genuinely interested in patients. Efficient – able to evaluate patients quickly without missing much. Participated well; very energetic and eager to learn. Showed initiative.
Professional Behavior: Interaction with both patients and staff were friendly and open while remaining professional. Mature; good doctor/patient relationship. Worked well as part of team.

Clerkship 2: Pediatrics:
Final score 354.4/406 total points. Core knowledge (10% of final grade) 34.2/40. Professional skills (15% of final grade) 55.3/60. Clinical skills inpatient (15% of final grade) 51.9/61. Clinical skills outpatient (15% of final grade) 59.7/65. Communication (15% of final grade) 54.3/60. Final exam score (30 % of final grade); raw score 82.5% (99/120).
Knowledge Base: Good fund of knowledge, always reading about patient topics. Read about each patient. Michael had a stronger knowledge base than most of his level and worked hard and read extensively it seemed. Read about patients.
Clinical Skills: He was actively involved in the diagnosis and workup of his patients. He showed interest in learning pediatric disease processes. He went the extra step and provided written suggestions for his patients. Good presentation skills, concise. Good history taking – very thorough, good leadership skills – oriented new student to clinic – process and procedures. Very thorough and appropriate history and physical. He presented a case of childhood obesity and guided the housestaff through a discussion of differential diagnosis/complications and treatment. Well done! Prepared and delivered a concise, informative and succinct presentation on Empyema and Pleural Effusion.
Work Ethic: Always available and willing to help out team.
Professional Behavior: Michael did a good job on the pediatric rotation. Highly motivated. Good attitude, wanted to learn and seek more knowledge. Very good job on floor. Followed patients closely and was actively involved with patients and a good team player with other residents. Well groomed, timely.

Clerkship 3: Obstetrics and Gynecology:
Knowledge Base: Practical Exam – 99%; MidTerm – 90%; Shelf Exam – 74 (66^{th} percentile); Group Presentation – Excellent; Journal Presentation – Excellent; Comments –Excellent knowledge base.

Clinical Skills: Compassionate, motivated. Well liked by patients, staff and residents. Respected his patients. Ideal medical student.
Work Ethic: Hard worker, responsible, dependable. Enjoyable to work with. Honest.
Professional Behavior: Professional, respectful, mature. Will make a great obstetrician and gynecologist – hope he chooses Charleston.
Clerkship 4: Internal Medicine:
Knowledge Base: Overall Score = 80.5. Shelf Board Score = 69 (30th percentile). Rated either above average or superior by all reviewers. Very enthusiastic and eager to learn with excellent fund of knowledge. Looked up facts and information independently without prompting.
Clinical Skills: Sought out and enjoyed procedural activities. Great potential to become a highly skilled physician. Michael formed close therapeutic relationships with his patients and thoroughly worked up their medical conditions. Almost at the intern level, just needs to work on development of treatment plans (which typically comes with 4th year sub-internship).
Work Ethic: Capable and enthusiastic. Energetic. Organized and interested.
Professional Behavior: Very mature in his dealings with patients and members of the medicine team. Exemplary behavior and professional demeanor. A leader among his peers.

Clerkship 5: Psychiatry:
Knowledge Base: Mr. Subit had a good working knowledge of psychiatry and had a good understanding of the theoretical base of psychiatry, and was able to apply this to clinical practice. He was very bright and read a lot. His patient presentations were good, and he obtained a perfect score on his formal case presentation to peers and a faculty preceptor. He scored at the 71st percentile nationally on the shelf examination in psychiatry. Overall, he did extremely well in demonstrating his facility with the material presented to him on this rotation.
Clinical Skills: He successfully met or exceeded all of the clinical skills requirements as measured by the demonstrable competence forms completed by faculty and residents. He was very psychologically minded, and residents noted that "he had very good observational skills, he can quickly interact and collect relevant clinical information and organize it; his clinical formulations are very good." Also noted: "Michael had good interviewing skills and an excellent bedside manner; he structures his questions well, has empathy and forms rapport with patients easily." Faculty noted that "he was bright, and comfortable doing psychiatric assessments and looking into psychosocial factors. He enjoyed challenging, complex cases. He makes good observations and presents cases well."
Work Ethic: Mr. Subit was a hard worker, very dedicated to his duties. He was prone to arrive early and stay late, and was always willing to pitch in clinically as needed for extra work. He clearly took his role very seriously, although he had a finely tuned sense of humor and got along well with the other staff. He was generally viewed as a diligent and astute observer.
Professional Behavior: He always dressed and groomed himself in a professional manner, and as noted had good emotional intelligence and social savvy. He had a very pleasant and outgoing personality and was well liked, but could be quite serious when

the situation called for it. It was the consensus opinion that this young man will make an excellent resident.

Clerkship 5: Neurology:
Knowledge Base: Michael had good working knowledge of Neurology, scoring a 68 on the Neurology Shelf Exam. He asked insightful questions during rounds, which reflected his reading. His presentations on rounds showed good command of Neuroanatomy, Neurophysiology, and Neuropharmacology.
Clinical Skills: Michael's clinical skills were outstanding. His consult write-ups were well-composed and logically laid out. He performed thorough Neurologic exams, and gave well-reasoned case presentations on rounds. He was able to apply his findings on the physical exam toward the differential diagnosis.
Work Ethic: He was a tireless worker, eagerly accepting all clinical work assigned to him. He was a valued member of the consult team.
Professional Behavior: In addition to being prompt and respectful, Michael's excellent sense of humor helped him to develop a warm rapport with patients and staff alike.

Clerkship 6: Surgery:
Knowledge Base: He had an excellent base of knowledge scoring 79 (87th percentile) on the shelf exam and 76 on the midterm.
Clinical Skills: Good history and physicals and his presentations were well organized.
Work Ethic: He was an important part of the team. He was dependable and prepared.
Professional Behavior: An excellent student physician.

SUMMARY:
Michael Subit has progressed through the medical degree curriculum in a satisfactory manner. His performance during the clinical rotations has been particularly noteworthy. He has an excellent bedside manner and a superior work ethic. He works well independently and as part of a team. He has been actively involved in research, with several publications resulting from his work. He demonstrates highly professional behavior. He is ranked in the 4th quartile of his class. He will make a fine house officer.

James P. Griffith, M.D.
Associate Dean for Student Services

West Virginia University School of Medicine
Charleston, West Virginia

Explanation of the Medical Student Performance Evaluation Appendices

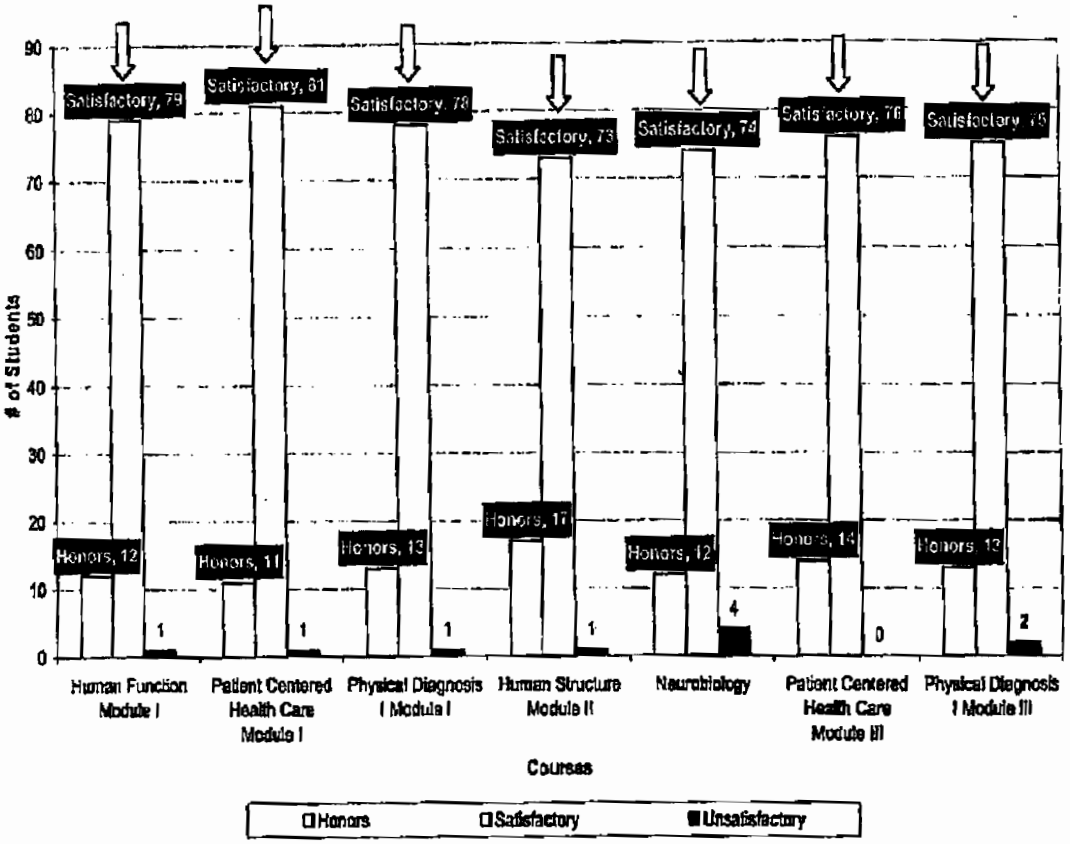
Attached to each Medical Student Performance Evaluation (MSPE) for a student from the West Virginia University School of Medicine you will find five appendices. These documents include graphical displays of student performance in course work during the first, second and third years of the curriculum, their final ranking into an academic quartile, and a narrative description of the school as requested with the MSPE format.

Student performance is ranked into no more than four categories which includes honors, satisfactory and unsatisfactory. The total number of students receiving each summative performance indicator is noted on the y-axis and the name of the course is located on the x-axis. The quartile distribution is done on a percentage basis and not an absolute number. The category in which the individual student is located is designated by an arrow at the top of the appropriate bar in the graph.

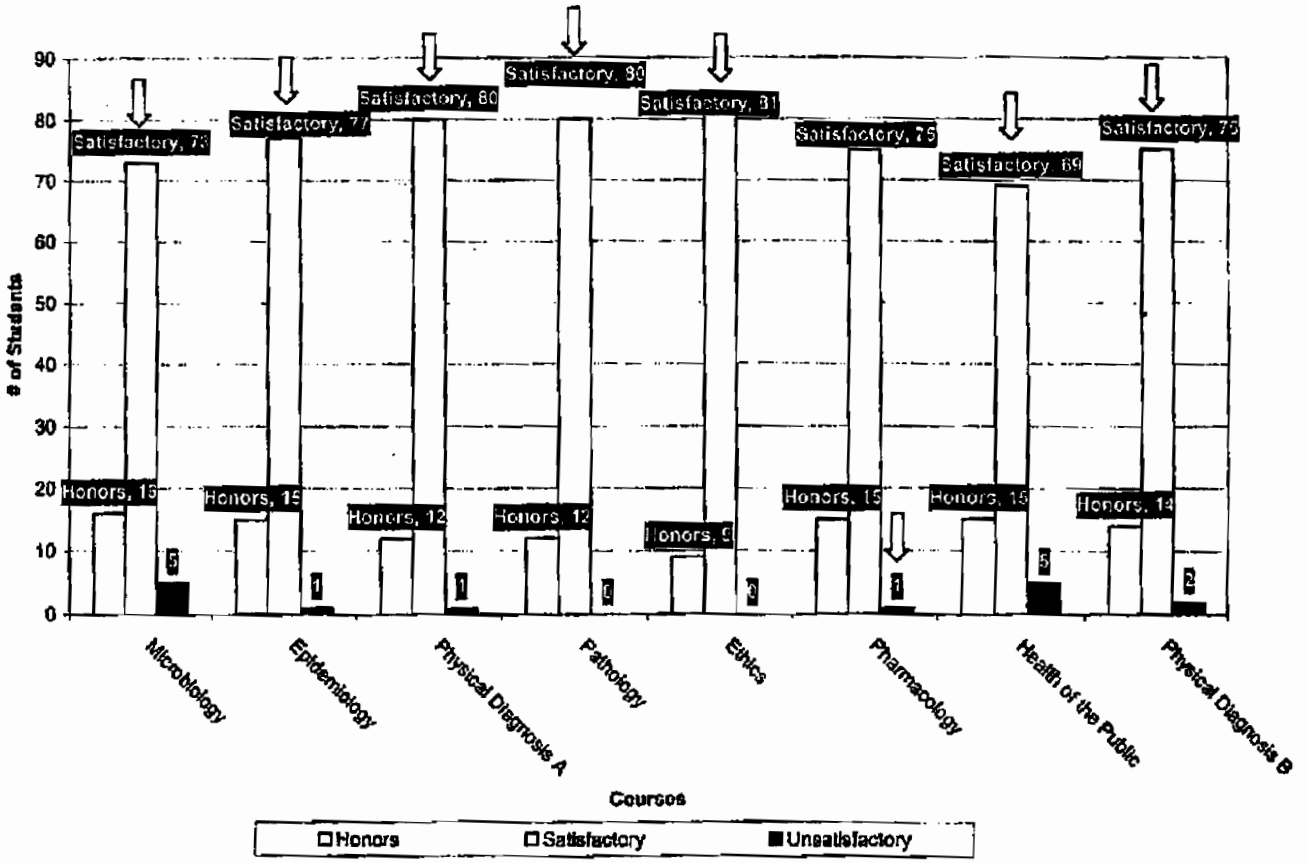
Questions should be addressed to the Associate Deans for Student Services, who are responsible for the preparation of this document.

Comparative Performance Data For: Michael James Subit

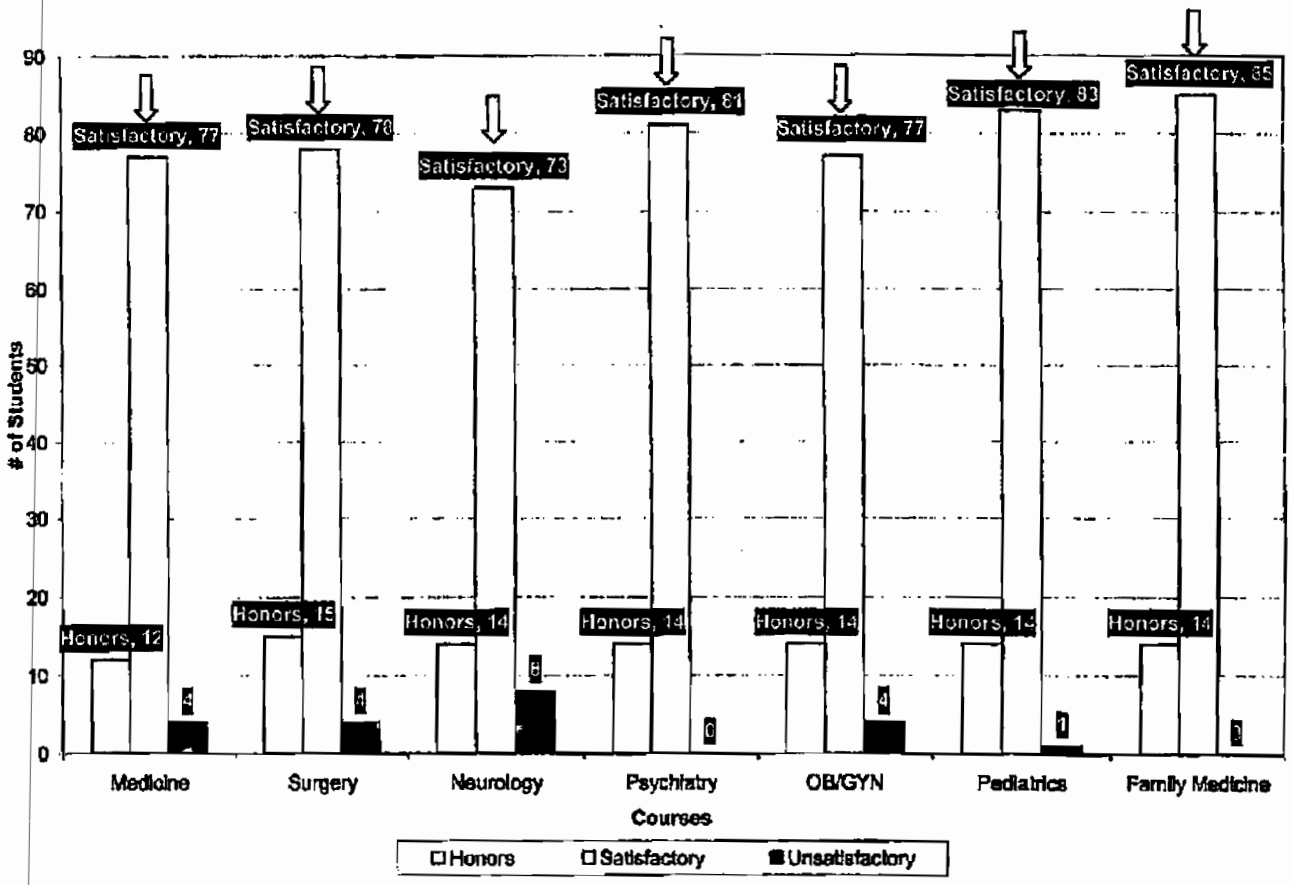
Appendix A: Comparative Performance in First-Year Courses



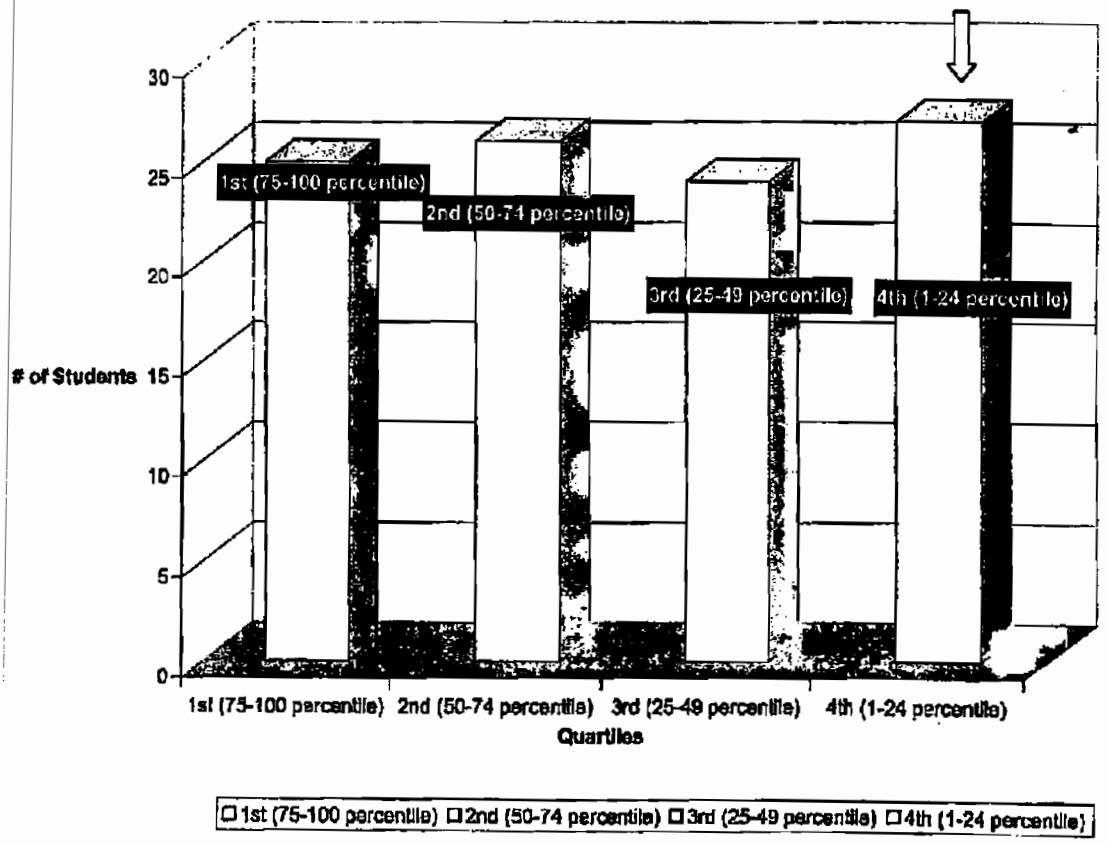
Appendix B: Comparative Performance in Second-Year Courses



Appendix C: Comparative Performance in Third-Year Courses



Appendix D: Overall Comparative Performance in Medical School



Appendix E: Medical School Information Page

West Virginia University School of Medicine
Charleston, West Virginia

The West Virginia University School of Medicine was established in 1902 as a two year, pre-clinical campus. In 1960 the curriculum was changed to a four-year program awarding the MD Degree. A clinical campus was established in 1972 in Charleston, West Virginia for completion of the clinical portion of the curriculum. In 2002, a third campus in Martinsburg, West Virginia was opened.

As a state supported school our mission is to educate natives of West Virginia to serve the health care needs of the citizens of the state. Our average length of enrollment is 4 years to complete the MD Degree. The Morgantown and Charleston campuses have a traditional third year curriculum with six, eight week blocks. The Eastern campus uses an integrated method where three clerkships are completed simultaneously over a six month period.

The evaluation system includes letter grade plus narrative evaluation for all coursework. Official grades include Honors, Satisfactory, Unsatisfactory, and Incomplete. The Honors designation is restricted to no more than the top 15% of a course.

USMLE Requirements:
Step 1: required for promotion to third year of curriculum, and for graduation
Step 2 (CS and CK): not required for promotion, but is required for graduation

Successful completion of a comprehensive Objective Structured Clinical Evaluation (OSCE) is required and occurs at the completion of the third year of the curriculum and prior to graduation.

Utilization of the clerkship narrative comments in the construction of the MSPE includes **complete and unabridged** narrative comments.

Utilization by this medical school of the AAMC "Guidelines for Medical Schools Regarding Academic Transcripts" is completely in compliance with the recommendations.

This MSPE is the responsibility of the Office of Student Services and is signed by the Associate Dean of the campus where the student completed his/her required clerkships.

Students are permitted to review but not edit their MSPE prior to its transmission.

WEST VIRGINIA UNIVERSITY
P. O. BOX 6009
MORGANTOWN, WV 26506-6009

OFFICE OF THE UNIVERSITY REGISTRAR
ACADEMIC TRANSCRIPT

Student No: 700109841 Date Issued: 19-FEB-2010 Official Transcript

Page: 1

Record of: Michael James Subit
Issued To: Federation Credentials
Verification Services
PO Box 619859
Dallas, TX 75261-9850

Course Level: Professional
High School: Wheeling Park High School 01-JUN-1994
Only Admit: Fall 2001

College: Medicine
Major: Medicine

Degree Awarded: Doctor of Medicine 14-MAY-2006
College: Medicine
Major: Medicine

SUBJ	NO.	COURSE TITLE	CRED	GRD	PTS	R

TRANSFER CREDIT ACCEPTED BY THE INSTITUTION:

Transient Univ of Vermont

PCOL	000	Medical Pharmacology	6.00	CR		
Ehrs: 6.00 GPA-Hrs: 0.00 QPts: 0.00 GPA: 0.00						

INSTITUTION CREDIT:

Fall 2001						
CCMD	730	Human Function	16.00	S		0.00
CCMD	740	Patient-Centered Health Care	5.00	S		0.00
CCMD	745	Introduction to the Patient	7.00	S		0.00
Ehrs: 28.00 GPA-Hrs: 0.00 QPts: 0.00 GPA: 0.00						
Spring 2002						
ANAT	703	Human Structure	17.00	S		0.00
CCMD	741	Patient Centered Health Care 2	2.00	PR		0.00
CCMD	746	Introduction to the Patient 2	3.00	PR		0.00
Ehrs: 17.00 GPA-Hrs: 0.00 QPts: 0.00 GPA: 0.00						
Summer I 2002						
CCMD	740	Patient-Centered Health Care	5.00	S		0.00
CCMD	745	Introduction to the Patient	7.00	S		0.00
CCMD	775	Neurobiology	6.00	S		0.00
Ehrs: 18.00 GPA-Hrs: 0.00 QPts: 0.00 GPA: 0.00						
Fall 2002						
CCMD	712	Epidemiology & Biostatistics	3.00	S		0.00
CCMD	721	Physcl Diagnos/Clncl Integratn	6.00	S		0.00
MBIM	701	Immunity/Infection and Disease	12.00	S		0.00
Ehrs: 21.00 GPA-Hrs: 0.00 QPts: 0.00 GPA: 0.00						
Spring 2003						
CCMD	713	Evidence Based Medicine 2	2.00	S		0.00
CCMD	722	Physcl Dignos/Clncl Integratn 2	4.00	S		0.00
PATH	751	Mechanisms of Human Disease	12.00	S		0.00
PCOL	761	Medical Pharmacology	7.00	U		0.00
Ehrs: 18.00 GPA-Hrs: 7.00 QPts: 0.00 GPA: 0.00						
Summer I 2003						
CCMD	791H	ADTP:Step 1-Board Preparation	2.00	PR		0.00
Ehrs: 0.00 GPA-Hrs: 0.00 QPts: 0.00 GPA: 0.00						
Summer II 2003						
CCMD	791H	ADTP:Step 1-Board Preparation	2.00	PR		0.00
Ehrs: 0.00 GPA-Hrs: 0.00 QPts: 0.00 GPA: 0.00						
Fall 2003						
BMP	741	Clinical Clerkship:Psychiatry	6.00	W		0.00
CCMD	791H	ADTP:Step 1-Board Preparation	1.00	PR		0.00
NEUR	741	Clinical Clerkship Neurology	2.00	W		0.00
OBST	741	Clin Clerk-Obstetrcs/Gynecolgy	8.00	W		0.00
Ehrs: 0.00 GPA-Hrs: 0.00 QPts: 0.00 GPA: 0.00						
Spring 2004						
CCMD	791H	ADTP:Step 1-Board Preparation	5.00	S		0.00
Ehrs: 5.00 GPA-Hrs: 0.00 QPts: 0.00 GPA: 0.00						
Summer I 2004						
CCMD	791G	ADTP:Professional Development	2.00	S		0.00
Ehrs: 2.00 GPA-Hrs: 0.00 QPts: 0.00 GPA: 0.00						
Summer II 2004						
CCMD	791H	ADTP:Step 1-Board Preparation	2.00	S		0.00
PMED	731	Clerkship	8.00	PR		0.00
Ehrs: 2.00 GPA-Hrs: 0.00 QPts: 0.00 GPA: 0.00						
Fall 2004						
PMED	731	Clerkship	8.00	S		0.00
OBST	741	Clin Clerk-Obstetrcs/Gynecolgy	8.00	S		0.00
PEDI	731	Clinical Clerkship-Pediatrics	8.00	S		0.00
Ehrs: 24.00 GPA-Hrs: 0.00 QPts: 0.00 GPA: 0.00						

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

SUBJ	NO.	COURSE TITLE	CRED	GRD	PTS	R

Institution Information continued:

Spring 2005						
BMP	741	Clinical Clerkship:Psychiatry	6.00	S		0.00
MED	731	Clerkship Med Yr Course	8.00	S		0.00
NEUR	741	Clinical Clerkship Neurology	2.00	S		0.00
SURG	741	Clin Clerk Surg Yr Cours	8.00	PR		0.00
Ehrs: 16.00 GPA-Hrs: 0.00 QPts: 0.00 GPA: 0.00						
Summer I 2005						
CCMD	791I	ADTP:Step 2- Board Preparation	2.00	PR		0.00
SURG	741	Clin Clerk Surg Yr Cours	8.00	S		0.00
Ehrs: 8.00 GPA-Hrs: 0.00 QPts: 0.00 GPA: 0.00						
Summer II 2005						
CCMD	788	Selective Experiences-Medicine	6.00	S		0.00
CCMD	791I	ADTP:Step 2- Board Preparation	2.00	PR		0.00
Ehrs: 6.00 GPA-Hrs: 0.00 QPts: 0.00 GPA: 0.00						
Fall 2005						
CCMD	788	Selective Experiences-Medicine	6.00	S		0.00
CCMD	791	ADTP:Surgical Care	4.00	PR		0.00
CCMD	791A	ADTP:Critical Care	1.00	PR		0.00
CCMD	791B	ADTP:Rural Health 1	4.00	PR		0.00
CCMD	791C	ADTP:Rural Health 2	4.00	PR		0.00
CCMD	791D	ADTP:Hospital Care	1.00	PR		0.00
CCMD	791I	ADTP:Step 2- Board Preparation	1.00	S		0.00
Ehrs: 7.00 GPA-Hrs: 0.00 QPts: 0.00 GPA: 0.00						
Spring 2006						
CCMD	788	Selective Experiences-Medicine	6.00	S		0.00
CCMD	791	ADTP:Surgical Care	4.00	S		0.00
CCMD	791A	ADTP:Critical Care	4.00	S		0.00
CCMD	791B	ADTP:Rural Health 1	4.00	S		0.00
CCMD	791C	ADTP:Rural Health 2	4.00	S		0.00
CCMD	791D	ADTP:Hospital Care	4.00	S		0.00
CCMD	791I	ADTP:Step 2- Board Preparation	1.00	S		0.00
Ehrs: 27.00 GPA-Hrs: 0.00 QPts: 0.00 GPA: 0.00						

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

	Earned Hrs	GPA Hrs	Points	GPA
TOTAL INSTITUTION	199.00	7.00	0.00	0.00
TOTAL TRANSFER	6.00	0.00	0.00	0.00
OVERALL	205.00	7.00	0.00	0.00

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

SEAL VERIFIED

In compliance with the Family Educational Rights and Privacy Act of 1974, this information is released on the condition that the recipient "will not permit any other party to have access to such information without the written consent of the student."

Transcript key printed on the back of the official transcript.

TO VERIFY THE AUTHENTICITY OF THIS TRANSCRIPT, RUB OR BREATHE ON THE AREA ABOVE. COLOR WILL DISAPPEAR & THEN REAPPEAR.

An official transcript is printed on a blue West Virginia University background with the school seal.

Steve Robinson, Ph.D.
University Registrar

WEST VIRGINIA UNIVERSITY
OFFICE OF THE UNIVERSITY REGISTRAR
P. O. BOX 6009
MORGANTOWN, WEST VIRGINIA 26506-6009

MARKING SYSTEM

A — Excellent
B — Good
C — Fair
D — Poor but passing
F — Failure
UF — Failure
IN — Failure (abolished Summer II 2001)
IF — Failure (established Fall 2001)
INC — Permanent Incomplete (Graduate Students only)
I — Incomplete
P — Pass
S — Satisfactory
U — Unsatisfactory
W — Withdrew
WU — Withdrew unsatisfactory (Established 6/17/68)
X — Audit

Medical School courses only:
H — Honors (Established Fall 1988)
PR — Progress (Established 9/14/56)

SPECIAL NOTES:

D/F Repeat Policy (Approved for students entering the University after May, 1979) Any entry marked with an I has been repeated by the student under a D/F Repeat Policy. An associated previous entry is marked with E to indicate the deletion of credit hours and points.

Individual courses may bear indicators denoting special circumstances or requirements met as outlined below.

H - Indicates Honors Course

W - Indicates Course satisfying the University's writing requirement

+ - Indicates Honors Course satisfying the University's writing requirement

* - Indicates Academic Forgiveness

COURSE NUMBERING SYSTEM FROM AUGUST 24, 1970

1-99 — Courses intended primarily for freshmen and sophomores.
100-199 — Courses intended primarily for juniors and seniors.
200-299 — Courses for advanced undergraduate students and selected graduate students.
300-399 — Courses for graduate students and selected, advanced undergraduates.
400-499 — Courses for graduate students only.
900 — Courses for Professional Development. (Courses do not count toward graduation/degree.)

COURSE NUMBERING SYSTEM EFFECTIVE AUGUST 2001

100-199 — Courses intended primarily for Freshman
200-299 — Courses intended primarily for Sophomores
300-399 — Courses intended primarily for Juniors
400-499 — Courses intended primarily for Seniors and selected Graduate students
500-599 — Courses intended for advanced Undergraduates and Graduate students.
600-699 — Courses intended primarily for Master's degree students.
700-799 — Courses intended for Doctoral and advanced Master's degree students.
900-999 — Courses for Professional Development (Courses do not count toward graduation/degree.)

West Virginia University follows a semester calendar. Grade points for all classes are awarded based on a 4.0 scale. Plus/minus grading is utilized, but does not affect the calculation of the grade point average (with the exception of the College of Law).

The College of Law at West Virginia University uses a weighted plus/minus grading scale. The values assigned to each grade are denoted below. Please note that the College of Law used two different weighting systems between 1989 and present. Both systems are denoted below along with applicable date ranges.

1989-2004	2005-Present
4.3 – A+	4.3 – A+
4.0 – A	4.0 – A
3.7 – A-	3.7 – A-
3.3 – B+	3.3 – B+
3.0 – B	3.0 – B
2.7 – B-	2.7 – B-
2.3 – C+	2.3 – C+
2.0 – C	2.0 – C
1.5 – C-	1.7 – C-
1.0 – D	1.3 – D+
.0 – F	1.0 – D
	.0 – F

AUTHENTICITY CONFIRMATION: To test for authenticity, apply liquid bleach to the blue print background sample below. If authentic, the color will turn to brown.

A black and white transcript is not an original. Alteration of the transcript may be a criminal offense. Border prints "ORIGINAL" when magnified.

Questions concerning this transcript can be directed to: Office of the University Registrar
West Virginia University, P.O. Box 6009, Morgantown, WV 26506-6009
Telephone (304) 293-2121. FAX # (304) 293-8991.

THIS IS A TRUE LIKENESS OF THE DIPLOMA THAT WAS AWARDED TO MICHAEL JAMES SUBIT ON MAY 14, 2006.

WEST VIRGINIA UNIVERSITY

SCHOOL OF MEDICINE

Know all persons by these presents
that the West Virginia University Board of Governors
upon the recommendation of the faculty
has conferred upon

MICHAEL JAMES SUBIT

The Degree of

DOCTOR OF MEDICINE

With all the rights, honors, and privileges thereunto appertaining. Witness the seal of the university and the signatures of its duly authorized officers hereunto affixed this fourteenth day of May, two thousand six.

SEAL
VERIFIED

President of the University

Chair, West Virginia University Board of Governors

Dean of the School

Vice President for Health Sciences

NORMAN D. FERRARI III, MD
ASSOCIATE DEAN FOR STUDENT SERVICES
FEBRUARY 1, 2010

STATE of WEST VIRGINIA, COUNTY OF KANAWHA:

I, Rachael Trout, a notary public in and for said state, do certify that on 5-30-06 I carefully compared the above copy of Diploma with the Original. It is complete, full, true and exact copy of the document it purports to reproduce.
My commission expires October 4, 2010.

Rachael Trout, Notary Public

OFFICIAL SEAL
NOTARY PUBLIC
STATE OF WEST VIRGINIA
RACHAEL TROUT
33 STUART CIRCLE
HURRICANE, WV 25526
My Commission Expires October 4, 2010

112433

Section IV

Graduate Medical Education Training

Federation of STATE MEDICAL BOARDS

Federation Credentials Verification Service (FCVS)

Federation Place, P.O. Box 619850, Dallas, TX 75261-9850
Tel: (817) 868-5000 Fax: (817) 868-5099

Verification of Postgraduate Medical Education

Institution: **West Virginia University (Charleston Division)**

Address: **Department of Obstetrics and Gynecology**
Charleston, WV 25302-3390

Attention: **Program Director**

Affiliated University: ____

Verification For:

Name: **Subit, Michael James**

DOB: **08/30/1976**

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: 07/01/2006 To: 06/30/2007
Successfully Completed?: ☒ Yes ☐ No ☐ In Progress
Accredited by: ☒ ACGME ☐ AOA ☐ LCGME ☐ RSC ☐ CFPC ☐ RCPSC ☐ APPAP ☐ None of these

PGY: 2-3
☐ Internship ☒ Residency ☐ Chief Residency ☐ Fellowship ☐ Research
Specialty/Subspecialty: Ob/Gyn
From: 07/01/2007 To: 06/30/2009
Successfully Completed?: ☒ Yes ☐ No ☐ In Progress
Accredited by: ☒ ACGME ☐ AOA ☐ LCGME ☐ RSC ☐ CFPC ☐ RCPSC ☐ APPAP ☐ None of these

PGY: 4
☐ Internship ☐ Residency ☒ Chief Residency ☐ Fellowship ☐ Research
Specialty/Subspecialty: Ob/Gyn
From: 07/01/2009 To: 06/30/2010
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.

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
6. 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:

____
____

ELECTRONICALLY SEAL VERIFIED

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: S. Greg Heywood, M.D. Signature: *S. Greg Heywood, M.D.*

Title: Residency Program Director Date of Signature: January 22,

Tel: 304-388-1515 Fax: 304-388-1586 E-Mail: sheywood@hsc.wvu.edu

Federation of STATE MEDICAL BOARDS

PROVIDED BY APPLICANT

Full Name: Michael James Subit

Packet ID: 112433

20. Postgraduate Medical Education

List all of the postgraduate medical education programs you attended in chronological order. **Use one page per institution.**

IMPORTANT:

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

If your postgraduate year is currently in progress, indicate the EXPECTED completion date in the "To" field.

Report internships, residencies, fellowships and research programs separately.

Use one section per department.

(PGY) – Postgraduate years is also known as postgraduate training level.

If a break of six (6) months or more occurred between any of your postgraduate training activities, please provide a written explanation outlining your activities during this period on the "Explanation of Other Activities" form.

Charleston Area Medical Center
Complete name of hospital where training was conducted (Do not abbreviate).
West Virginia University School of Medicine
Complete name of affiliated university or college (Do not abbreviate).
501 Morris Street
Address line 1
PO Box 1547
Address line 2
Charleston — City
WV — State/Province
United States of America — Country
25326 - ____ — ZIP/Postal Code

PGY: 4
☐ Internship ☒ Residency ☐ Chief Residency ☐ Fellowship ☐ Research
Obstetrics and Gynecology — Specialty/Subspecialty
From: 7 /2009 To: 7 /2010
Successfully Completed? ☐ Yes ☐ No ☒ In Progress

PGY: 3
☐ Internship ☒ Residency ☐ Chief Residency ☐ Fellowship ☐ Research
Obstetrics and Gynecology — Specialty/Subspecialty
From: 7 /2008 To: 7 /2009
Successfully Completed? ☒ Yes ☐ No ☐ In Progress

PGY: 2
☐ Internship ☒ Residency ☐ Chief Residency ☐ Fellowship ☐ Research
Obstetrics and Gynecology — Specialty/Subspecialty
From: 7 /2007 To: 7 /2008
Successfully Completed? ☒ Yes ☐ No ☐ In Progress

PGY: 1
☐ Internship ☒ Residency ☐ Chief Residency ☐ Fellowship ☐ Research
Obstetrics and Gynecology — Specialty/Subspecialty
From: 7 /2006 To: 7 /2007
Successfully Completed? ☒ Yes ☐ No ☐ In Progress

Unusual Circumstances (check yes or no):

Did you ever take a leave(s) of absence or break(s) from your medical education?	☐ Yes ☒ No
Were you ever placed on probation?	☐ Yes ☒ No
Were you ever disciplined or placed under investigation?	☐ Yes ☒ No
Were any negative reports for behavioral reasons ever filed against you?	☐ Yes ☒ No
Were any limitations or special requirements imposed on you because of academic, incompetence, disciplinary problems or for any other reason?	☐ Yes ☒ No

---

Please explain any "YES" response from above:

____

Signature: *Michael James Subit, MD* Date: January 28, 2010

By typing my name above, I certify that I am the individual referenced in the FCVS application and that I agree to the terms and conditions set forth therein. Furthermore, I acknowledge that I have answered all questions and reported all information on this application page truthfully and completely.

Section V

Examination History/Score Transcripts

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

USMLE United States Medical Licensing Examination™

This document was prepared by the
Federation of State Medical Boards of the United States, Inc.
Federation Place, PO Box 619850, Dallas, TX 75261-9850 Telephone (817) 868-4041

Date: 02/01/2010

Recipient:
Federation Credentials Verification Service
ATTN: FCVS

Packet ID: 112433

Examinee: Subit, Michael James
Alt Name(s):

Examinee ID#: 5-121-243-0
Date of Birth: 08/30/1976

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. Where numeric scores are reported, there are two scales used and the recommended minimum passing score ("MP") on each scale is shown in parentheses.

USMLE STEP 1

Test Date	Pass/Fail	Three-Digit Score Total	Three-Digit Score MP	Two-Digit Score Total	Two-Digit Score MP	Comments
04/02/2004	Pass	206	182	84	75	
08/21/2003	Fail	168	182	69	75	

USMLE STEP 2

Clinical Knowledge (CK)

Test Date	Pass/Fail	Three-Digit Score Total	Three-Digit Score MP	Two-Digit Score Total	Two-Digit Score MP	Comments
09/30/2005	Pass	196	182	80	75	

Clinical Skills (CS)*

Test Date	Pass/Fail	Three-Digit Score Total	Three-Digit Score MP	Two-Digit Score Total	Two-Digit Score MP	Comments
07/10/2005	Pass					

USMLE STEP 3

Test Date	Pass/Fail	Three-Digit Score Total	Three-Digit Score MP	Two-Digit Score Total	Two-Digit Score MP	Comments
WEST VIRGINIA 12/20/2006	Pass	201	184	82	75	

NOTE: A search of the Board Action Data Bank of the Federation of State Medical Boards (FSMB) reveals unreported information on this examinee.

State Medical Board of Ohio

30 E. Broad St., 3rd Floor • Columbus, OH 43215-6127 • (614) 466-3934 • Website: http://med.ohio.gov/

1/28/2010

Michael James Subit, MD
707 Chesapeake St.
Charleston WV 25309

Your application for Ohio licensure has been reviewed. As of this date, the following has not been completed/received:

We have not received your core credentials packet from the Federation Credentials Verification Service (FCVS). To inquire about the status of your core credentials packet contact FCVS at (888) 275-3287.

ALL RESPONSES MUST BE IN WRITING. NO INFORMATION WILL BE TAKEN BY PHONE.

Inquiries about the status of your application must be requested in writing or by emailing the Board at med.license@med.state.oh.us.

The application processing time is ordinarily 10 to 12 weeks after receipt of an application by the Board. An incomplete application or any unusual circumstances may delay processing time.

Be sure to notify the Board, in writing, of any address change.

Sincerely,

Licensure Department

State Medical Board of Ohio

30 E. Broad St., 3rd Floor • Columbus, OH 43215-6127 • (614) 466-3934 • Website: http://med.ohio.gov/

4/23/2010

Michael James Subit, MD
707 Chesapeake St.
Charleston WV 25309

This is to notify you that you are now licensed to practice medicine or osteopathic medicine and surgery in the State of Ohio. The Board approved your request and your license number **095198** was issued on **04/23/2010** and will expire on **01/01/2012**.

Enclosed is your wallet card and wall certificate. The wall certificate, by law, must be displayed in your office or the place where a major portion of your practice is conducted.

Please be advised that verification of your Ohio license must be obtained directly from the Board's website at http://med.ohio.gov in the "Licensee Profile and Status section. The website is updated immediately to reflect newly issued licenses.

The Ohio Medical Board operates a "staggered renewal" system based upon the first letter of your last name at the time of licensure. Enclosed is a chart and information outlining the staggered medical license renewal system and continuing medical education (CME) hours required. Renewal applications are mailed approximately six months prior to the date of expiration. CME information may also be obtained from the Board's website.

SECTION 4731.281, OHIO REVISED CODE REQUIRES WRITTEN NOTICE TO THE BOARD OF ANY CHANGE OF PRINCIPAL PRACTICE ADDRESS OR RESIDENCE ADDRESS WITHIN THIRTY DAYS OF THE CHANGE. *A CHANGE OF ADDRESS FORM IS AVAILABLE ON THE BOARD'S WEBSITE.*

This notice authorizes you to make application for a U.S. Drug Enforcement Administration certificate of registration (controlled substance permit). To make such application, contact:

Drug Enforcement Administration (DEA)
431 Howard St.
Detroit, Michigan 48226
(800) 230-6844
www.deadiversion.usdoj.gov/

Any questions regarding the DEA registration must be directed to the DEA office.

Sincerely,

Kay L. Rieve
Administrative Officer

Date Posted: 12/20/2011 9:18:15 AM

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

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

Address Information

CREDENTIAL MAIL ADDRESS	5888 Cleveland Avenue Columbus, OH 43231 Franklin County United States of America (614) 882-4343 michaelsubit@gmail.com
MAIN	5888 Cleveland Avenue Columbus, OH 43231 Franklin County United States of America (614) 882-4343 michaelsubit@gmail.com

License Information

License Number	35.095198
License Name	Michael Subit

Fees

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

Medical Board Correspondence Email

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

. . . . . YES

Specialty Codes

1. Please select one specialty from the field below

. . . . . OBSTETRICS & GYNECOLOGY

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

. . . . . *{not Answered}*

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

. . . . . *{not Answered}*

CME-Physicians

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

. . . . . YES

Discipline

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

. . . . . NO

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

. . . . . NO

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

. . . . . NO

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

. . . . . NO

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

. . . . . NO

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

. . . . . NO

Social Security Number

1.

. . . . . Redacted

Nurse Collaboration Info

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

. . . . . NO

2. List the name/names and type of licensure for each nurse with whom you are

collaborating. **For example: Jane Doe, CNP; Mary Smith, CNS.**

. . . . . *{not Answered}*

Ohio Employment

1. Do you practice in Ohio?

. . . . . YES

Ohio Workforce Questions

1. "Clinical" - direct patient care

. 45-49

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

. 10-14

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

. 5-9

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

. 10-14

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

. 1-4

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

. 5-9

Clinical - Practice setting

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

. 20-24

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

. 20-24

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

. 0

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

. 0

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

. 20-24

Workforce Counties

1. Enter the first zip code:

. 43231

2. Enter the first county:

. . . . . Franklin

3. Enter the second zip code:

. 43213

4. Enter the second county:

. . . . . *{not Answered}*

5. Enter the third zip code:

. . . . . *{not Answered}*

6. Enter the third county:

. . . . . *{not Answered}*

Practice Arrangement (size)

1. Solo practitioner

. . . . . NO

2. Single-specialty Group

. 2-5

3. Multi-specialty Group

. . . . . N/A

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

. . . . . NO

Workforce Language Question

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

. . . . . YES

Languages

1. Select a language from the drop down list.

. . . . . Spanish

2. Select a language from the drop down list.

. . . . . Russian

3. Select a language from the drop down list.

. . . . . Hindi

ABMS Certified

1. Are you certified by an ABMS Board?

. . . . . NO

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

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

Date Posted: 12/9/2013 5:02:03 PM

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

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

Address Information

CREDENTIAL MAIL ADDRESS	500 South Trimble Rd Mansfield, OH 44906 Richland County United States of America (419) 756-6000 michaelsubit@gmail.com
MAIN	500 South Trimble Rd Mansfield, OH 44906 Richland County United States of America (419) 756-6000 michaelsubit@gmail.com

License Information

License Number	35.095198
License Name	Michael Subit

Fees

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

Medical Board Correspondence Email

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

. . . . . YES

Specialty Codes

1. Please select one specialty from the field below

. . . . . OBSTETRICS & GYNECOLOGY

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

. . . . . *{not Answered}*

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

. . . . . *{not Answered}*

CME-Physicians

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

. . . . . YES

Discipline

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

. . . . . NO

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

. . . . . NO

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

. . . . . NO

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

. . . . . NO

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

. . . . . NO

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

. . . . . NO

Social Security Number

1.

. . . . . Redacted

Nurse Collaboration Info

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

. . . . . YES

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

. . . . . Natalie Gailey, CNP; Shannon Malikowski, CNP

Ohio Employment

1. Do you practice in Ohio?

. . . . . YES

Ohio Workforce Questions

1. "Clinical" - direct patient care

. 55-59

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

. 0

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

. 10-14

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

. 1-4

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

. 1-4

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

. 5-9

Clinical - Practice setting

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

. 50-54

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

. 10-14

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

. 0

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

. 0

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

. 5-9

Workforce Counties

1. Enter the first zip code:

. 44906

2. Enter the first county:

. . . . . Richland

3. Enter the second zip code:

. . . . . *{not Answered}*

4. Enter the second county:

. . . . . *{not Answered}*

5. Enter the third zip code:

. . . . . *{not Answered}*

6. Enter the third county:

. . . . . *{not Answered}*

7. Do you have more than one practice location?

. . . . . NO

Practice Arrangement (size)

1. Solo practitioner

. . . . . NO

2. Single-specialty Group

. 5-10

3. Multi-specialty Group

. . . . . N/A

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

. . . . . NO

Workforce Language Question

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

. . . . . NO

ABMS Certified

1. Are you certified by an ABMS Board?

. . . . . NO

NPI number

1. Please enter your current NPI number

. 1619196037

DEA number

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

. . . . . fs1879305

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

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

Date Posted: 12/28/2015 8:54:44 AM

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

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

Address Information

CREDENTIAL MAIL ADDRESS	500 S. Trimble Mansfield, OH 44906 Richland County United States of America 419-756-6000 michaelsubit@gmail.com
MAIN	500 S. Trimble Mansfield, OH 44906 Richland County United States of America 419-756-6000 michaelsubit@gmail.com

License Information

License Number	35.095198
License Name	Michael Subit

Fees

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

Medical Board Correspondence Email

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

. . . . . YES

Specialty Codes

1. Please select one specialty from the field below

. . . . . OBSTETRICS & GYNECOLOGY

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

. . . . . *{not Answered}*

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

. . . . . *{not Answered}*

CME-Physicians

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

. . . . . YES

Discipline

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

. . . . . NO

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

. . . . . NO

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

. . . . . NO

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

. . . . . NO

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

. . . . . NO

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

. . . . . NO

Social Security Number

1.

. . . . . Redacted

Nurse Collaboration Info

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

. . . . . YES

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

. . . . . Shannon L. Malikowski CNP, Natalie Gailey CNP

Ohio Employment

1. Do you practice in Ohio?

. . . . . YES

Ohio Workforce Questions

1. "Clinical" - direct patient care

. 60-64

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

. 1-4

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

. 1-4

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

. 5-9

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

. 0

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

. 0

Clinical - Practice setting

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

. 40-44

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

. 10-14

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

. 0

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

. 0

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

. 0

Workforce Counties

1. Enter the first zip code:

. 44906

2. Enter the first county:

. . . . . Richland

3. Enter the second zip code:

. . . . . *{not Answered}*

4. Enter the second county:

. . . . . *{not Answered}*

5. Enter the third zip code:

. . . . . *{not Answered}*

6. Enter the third county:

. . . . . *{not Answered}*

7. Do you have more than one practice location?

. . . . . NO

Practice Arrangement (size)

1. Solo practitioner

. . . . . NO

2. Single-specialty Group

. 2-5

3. Multi-specialty Group

. . . . . N/A

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

. . . . . NO

Workforce Language Question

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

. . . . . YES

Languages

1. Select a language from the drop down list.

. . . . . Sign Language

2. Select a language from the drop down list.

. . . . . *{not Answered}*

3. Select a language from the drop down list.

. . . . . *{not Answered}*

ABMS Certified

1. Are you certified by an ABMS Board?

. . . . . YES

ABMS Specialty

1. Choose specialty from the dropdown list.

. . . . . Obstetrics and Gynecology

2. Choose specialty from the dropdown list.

. . . . . *{not Answered}*

3. Choose specialty from the dropdown list.

. . . . . *{not Answered}*

NPI number

1. Please enter your current NPI number

. 1619196037

DEA number

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

. . . . . FS1879305

OARRS Registration

1. Since signing your last renewal have you prescribed or personally furnished opioid analgesics or benzondiazepines while practicing in Ohio?

. . . . . NO

2. Are you registered with the Ohio Automated Rx Reporting System (OARRS)?

. . . . . YES

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

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

License Renewal Application

Submission Date: 12/13/2017

License Type - Doctor of Medicine (MD)

Personal Information

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

Title
Dr.
First Name
Michael
Middle Name
James
Last Name
Subit
Maiden Name
Social Security Number
Redacted
Date of Birth
8/30/1976
Email Address
michaelsubit@gmail.com
Phone Number
4197566000
Other Phone Number
4197566000

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?
What is your gender?
Male
What is your ethnicity?

In which country were you born?
United States
In which state were you born (if United States)?
West Virginia
In which city were you born?

Wheeling

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.

500 S. Trimble
Mansfield
OH
44906
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.

500 S. Trimble
Mansfield
OH
44906
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
Has your spouse served in the military?
No
Country of Service

Service Branch

Are you still serving in the military (Active or Reserve)?

Were you honorably discharged from your service?

Service Start Date

Service End Date

Specialty Tracking Component

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

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

Questions

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

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

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

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

Question - At any time since signing your last application for renewal of your certificate have you been addicted to or dependent upon alcohol or any chemical substance; or been treated for, or been diagnosed as suffering from, drug or alcohol dependency or abuse?
Answer - No

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

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

Question - Are you currently in a collaboration agreement with any Clinical Nurse Specialists, Certified Nurse-Midwives or Certified Nurse Practitioners?
Answer - Yes

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

Question - Primary NPI Number
Answer - 1619196037

Question - Primary DEA Number
Answer - FS1879305

Question - What is your current employment status?
Answer - Actively working in a position that requires the license I am renewing

Question - Do you currently possess an active license other than that for which you are renewing?
Answer - No

Question - On average, how many hours per week do you work under the license for which you are currently applying or renewing?
Answer - 50

Question - How many locations are you currently working in that require the license you are renewing?
Answer - 2

Question - Please provide the following information for up to 3 locations in which you use the license you are renewing, beginning with the locations you spend the most time: Facility Name, Address, City, State, Zip Code, Health Care Facility Type
Answer - Women's Care Inc., 500 S. Trimble Rd, Mansfield, Ohio 44906, Ohio Health Mansfield, 335 Glesserner Ave., Mansfield, Ohio 44903

Question - Do you have hospital privileges?
Answer - Yes

Question - Which of the following best describes your five-year employment plan?
Answer - Maintain practice hours as is

Question - Please select a language, other than English that you personally use to communicate with patients. Do not include a language that you use with the help of an interpreter or language software.
Answer - Not Applicable

Question - What is your U.S. residency status related to your employment?
Answer - U.S. Citizen

Question - Do you consider yourself Hispanic, Latino/a or of Spanish origin?
Answer - No

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

Attachments

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

Review + Submit

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

Application Review - Completed

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

Consent to Electronic Signature - **Consented**
Date/Time Stamp - 12/13/2017 10:46:15
Type your First Name and Last Name as they appear on the application to sign electronically.
Michael Subit

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.

Submission Date and Time: 12/9/2019 7:32 PM

License Renewal Application

License Type - Doctor of Medicine (MD)

Personal Information

Provide the necessary personal information in the fields to the right. All fields with (*) are required and must be completed to continue the application process. Demographic and workforce data collected for some licensed healthcare professions is used to enhance the state's capacity for healthcare workforce forecasting, policy development, and research. This data is used to analyze the supply and demand of the healthcare workforce serving Ohio. If you do not have an Individual Provider Identifier (NPI) number please enter nine zeroes.

Title
Dr.
First Name
Michael
Middle Name
James
Last Name
Subit
Maiden Name
No Response
Social Security Number
Redacted
Date of Birth
8/30/1976
Email Address
michaelsubit@gmail.com
Phone Number
4197566000
Other Phone Number
4197566000
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
1619196037
Enter home US zip-code. Enter NA if unavailable
44904

Additional Information

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

Do you have other aliases?
No
What is your gender?
Male
In which country were you born?
United States
In which state were you born (if United States)?
West Virginia
In which city were you born?
Wheeling

Employment Status

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

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

License Mailing Address

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

500 S. Trimble
Mansfield
OH
44906
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.

500 S. Trimble
Mansfield
OH
44906
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:
lyoha@wcareinc.com

Specialty Tracking Component

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

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

Current Employment Location(s)

Please provide the following information for all practice sites where you use this license, beginning with the locations in which you spend most of your time. If you are not actively working or volunteering in a position that requires this license (e.g. student or recent graduate) employment location information is optional. Employment location information helps improve the accuracy and efficiency of Health Professional Shortage Area Designations and enables Ohio to identify healthcare workforce distribution.

Name of Practice Site - Womens care inc
Practice Settings - Office/Clinic - Single Specialty Group
Street Address - 500 S Trimble Rd
City - Mansfield
State - OH
Zip Code - 44906
Major Area of Focus or Specialty - Obstetrics and Gynecology (ABMS)
Total Hours Worked at this practice site, per Week - 80

Percent of time spent per week in each of the following at this practice site:
Direct Patient Care - 80
Teaching/Academic - 10
Research - 0
Professional Services - 0
Administrative Activities - 10
Other - 0
Total Hours- 100

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

Questions

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

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

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

Question - At any time since signing your last application for renewal of your certificate have you been investigated, warned, censured, put on probation, disciplined, or have had any charges, allegations or complaints filed against you, by any board, bureau, department, agency, or any other body, including those in Ohio?
Answer - No

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

Question - At any time since signing your last application for renewal of your certificate have you had admissions monitored, had clinical privileges or other similar institutional authority limited, restricted, suspended, revoked, terminated, or placed on probation for any reason, or have resigned privileges at any institution?
Answer - No

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

Question - Are you currently in a collaboration agreement with any Clinical Nurse Specialists, Certified Nurse-Midwives or Certified Nurse Practitioners?
Answer - Yes

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

Question - Do you prescribe controlled substances?
Answer - Yes

Question - Primary DEA Number
Answer - fs1879305

Question - At any time since signing your last application for renewal of your certificate have you 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 - Since signing your last renewal have you prescribed opioid analgesics or benzondiazepines while practicing in Ohio?
Answer - Yes

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

Question - At any time since signing your last application for renewal of your certificate, 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). 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 - Duty to Report
Description - I acknowledge my duty to report to the board a belief that a violation of chapters 4730., 4731. 4759., 4760., 4761., 4762., 4774., or 4778. of the Revised Code, or any rule of the board has occurred, by myself or another individual.
Attested - Attestation complete

Review + Submit

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

Application Review - Completed

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

Consent to Electronic Signature - **Consented**
Date/Time Stamp - 12/9/2019 7:32 PM
Type your First Name and Last Name as they appear on the application to sign electronically.
Michael Subit
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.

Submission Date and Time: 11/2/2021 10:00 AM

License Renewal Application

License Type - Doctor of Medicine (MD)

License Number - 35.095198

License Renewal Number - LR-004432205

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
Michael
Middle Name
James
Last Name
Subit
Maiden Name
No Response
Social Security Number
Redacted
Date of Birth
8/30/1976
Email Address
michaelsubit@gmail.com
Phone Number
4197566000
Other Phone Number
4197566000
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
1619196037
Enter home US zip-code. Enter NA if unavailable
44904

Additional Information

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

Do you have other aliases?
No
What is your gender?
Male
In which country were you born?
United States
In which state were you born (if United States)?
West Virginia
In which city were you born?
Wheeling

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?
Increase practice hours
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.

500 S. Trimble
Mansfield
OH
44906
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.

500 S. Trimble
Mansfield
OH
44906
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:
rlweber@wcareinc.com

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.

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 - Women's Care Inc
Practice Settings - Office/Clinic - Partnership
Street Address - 500 S Trimble Rd
City - Mansfield
State - OH
Zip Code - 44905
Major Area of Focus or Specialty - Obstetrics & Gynecologic Surgery
Total Hours Worked at this practice site, per Week - 80

Percent of time spent per week in each of the following at this practice site:
Direct Patient Care - 80
Teaching/Academic - 10
Research - 0
Professional Services - 0
Administrative Activities - 10
Other - 0
Total Hours- 100

Hospital Admitting Privileges for Patients - Yes
Current Employment Arrangement - Self-Employed
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 - At any time since signing your last application for renewal of your certificate have you been found guilty of, or pled guilty or no contest to, or received treatment or intervention in lieu of conviction of, a misdemeanor or felony?
Answer - No

Question - At any time since signing your last application for renewal of your certificate have you surrendered, consented to limitation of, or to suspension, reprimand or probation concerning, a license to

practice any healthcare profession or state or federal privileges to prescribe controlled substances in any jurisdiction other than Ohio?
Answer - No

Question - At any time since signing your last application for renewal of your certificate have you been investigated, warned, censured, put on probation, disciplined, or have had any charges, allegations or complaints filed against you, by any board, bureau, department, agency, or any other body, including those in Ohio?
Answer - Yes

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

Question - At any time since signing your last application for renewal of your certificate have you had admissions monitored, had clinical privileges or other similar institutional authority limited, restricted, suspended, revoked, terminated, or placed on probation for any reason, or have resigned privileges at any institution?
Answer - No

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

Question - Are you currently in a collaboration agreement with any Clinical Nurse Specialists, Certified Nurse-Midwives or Certified Nurse Practitioners?
Answer - No

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

Question -

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 - Do you prescribe controlled substances?
Answer - Yes

Question - Primary DEA Number
Answer - FS1879305

Question - At any time since signing your last application for renewal of your certificate have you 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 - Since signing your last renewal have you prescribed opioid analgesics or benzondiazepines while practicing in Ohio?
Answer - Yes

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

Question - At any time since signing your last application for renewal of your certificate, 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 - Supporting Documents
Description - At any time since signing your last application for renewal of your certificate have you been investigated, warned, censured, put on probation, disciplined, or have had any charges, allegations or complaints filed against you, by any board, bureau, depart

Attached file - image.jpg

Review + Submit

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

Application Review - Completed

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

Consent to Electronic Signature - **Consented**
Date/Time Stamp - 11/2/2021 10:00 AM
Type your First Name and Last Name as they appear on the application to sign electronically.
Michael Subit
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