Alison Case, MD

Licensed Physician #MD2019-0938

Issue Date	Expiration Date
10/21/2019	07/01/2020

Signature of Holder

The bearer is prohibited by law from using this identification card to give the impression that they are in any way connected with a governmental agency.

New Mexico Medical Board

Triennial Renewal Certificate

This is to certify that

Alison Case, MD

License Number: MD2019-0938

Having complied with the provisions of the Medical Practice Act is hereby granted a license to practice in the State of New Mexico as a Physician.

Issue Date: 10/21/2019 Date Expires: 07/01/2020*

A New Mexico medical license that has not been renewed by July 1 of the renewal year will remain temporarily active with respect to medical practice until September 30 of the renewal year at which time, the status will be changed to lapsed. A lapsed license is not valid for practice in New Mexico.

This License Must Be Conspicuously Posted In Each Practice Location

RH 1193710

HSC

The New Mexico Physician and Practitioner Credentials Application ©

Physician (MD) Application

THE NEW MEXICO MEDICAL SOCIETY

Date of Application: 6/5/2019 Application Fee: $400.00

PayPal Confirmation: [redacted] TOTAL: $400.00

Name: Alison Case

Maiden or Other Names Used

Will you be applying by endorsement? ☐ Yes ☑ No Applying using: ☑ NMMB ☐ HSC ☐ FCVS

What are your NM practice plans? UNM Maternal and Child Health Fellow

Gender: Female Citizenship: United States Place of Birth:

Social Security Number: [redacted] Date of Birth: [redacted]1988

State Tax ID#: IN ☐ Pending Fed. Tax ID#: ☐ Pending

Medicare#: ☐ Pending Medicaid #: ☐ Pending

Unique Physician Identification Number (UPIN): ☐ Pending

National Provider Identifier Number (NPI): ☐ Pending

Home Address

Street Address: [redacted]

City, State/Province and Zipcode: Fort Wayne, IN, 46814

Country: United States

Telephone Number: [redacted] Pager Number:

Cell Phone Number: Spouse's Name (Optional): Alison Case

Credentials Correspondence Address

Department:

Street Address: [redacted]

City, State/Province and Zipcode: Fort Wayne, IN, 46814

Country: United States Email [redacted]@gmail.com

Telephone Number: [redacted] Facsimile Number:

Military Service

Branch: Type of Discharge:

Dates: From: To: ☐ Current Rank:

Immigration

Status: Certification Number:

ECFMG (Educational Commission for Foreign Medical Graduates)

Number (if applicable): Date Issued: (Please attach a copy of your ECFMG certificate)

Languages

Foreign Languages (spoken fluently by practitioner):

Certifications

ACLS CERTIFICATION	ATLS CERTIFICATION	PALS CERTIFICATION
Certified? ☐ Yes ☑ No	Certified? ☐ Yes ☑ No	Certified? ☐ Yes ☑ No
Expires:	Expires:	Expires:

HOSPITAL AND HEALTHCARE AFFILIATIONS

☑ Are you a PCP? ☑ Do you deliver babies? ☑ Are you an MD, DO, or DPM?

If you answered yes to any question above, you must:
(a) Have admitting privileges at a hospital (list below) OR
(b) Provide a written explanation as to the arrangements you have made with a physician to admit your patients, along with a signed letter from that physician confirming the arrangements, and the name of the facility where your patients will be admitted.

☑ Do you have courtesy or consulting privileges at this facility.
☑ If yes, do these courtesy or consulting privileges allow you to admit patients.

If no, provide a written explanation as to the arrangements you have made with a physician to admit your patients, along with a signed letter from that physician confirming the arrangements, and the name of the facility where your patients will be admitted.

I am currently a family practice resident

Please list all hospital staff membership and/or healthcare organization affiliations in the past fifteen (15) years, and your status (active, courtesy, consulting, etc.) If an institution is no longer in existence, please provide an alternative source of verification. Attach a separate page if necessary.

No affiliation information provided

Facility Name: ☐ Is this your primary admitting facility
Department:
Street Address:
City: State/Province: Zip Code:
Country:
Phone Number: Facsimile:
Appointment Dates From: To: ☐ Present
Type of Appointment: Privileges Assigned:

WORK HISTORY

Please list all previous experience for the past fifteen (15) years, including months and years, listing the most recent first. Attach a separate page if necessary. Please attach a current CV or resume.

Organization: Greater Lawrence Family Health Center From: 06/2016 To: 02/2017 ☐ Present
Department:
Street Address: 34 Haverhill St
City: Lawrence State/Province: MA Zip Code: 01841
Country: United States Phone Number:
Contact: Fax Number:
Type of Practice: Inactive

PGT

Please provide written explanation for any gaps in work history of six (6) months or more.

Organization: Fort Wayne Medical Education Program From: 02/2017 To: ☑ Present
Department: Attn: Darlene
Street Address: 2448 Lake Ave
City: Ft Wayne State/Province: IN Zip Code: 46805
Country: United States Phone Number: 260-422-6573
Contact: Fax Number: 260-399-4242
Type of Practice: Resident/Fellow

Please provide written explanation for any gaps in work history of six (6) months or more.

Work history gap explanations follow:

PRACTICE LOCATIONS

Group Name: Fort Wayne Medical Education Program Effective Date: 2/2017
Department:
Street Address: 750 S Broadway
City: Fort Wayne State/Province: IN Zip Code: 46802
Country: United States
Phone Number: 260-423-2675 Facsimile Number:
Email Address: Answering Service Number:
Foreign Languages (spoken fluently at practice):
Office Manager or Contact Person: Phone:

Billing Address

Contact Person: Tax ID #:
Department:
Street Address:
City: State/Province: Zip Code:
Country: United States
Phone Number: Facsimile Number:
Practice Associates (if applicable): Call Coverage (if applicable):

/
/
/

What are the office hours for your Practice or Group Practice? (Provide days/hours):
What provisions have been made for after hours?:

CONTINUING EDUCATION

1. If you are applying for privileges at a hospital or clinic, please attach documentation of all continuing education hours you have obtained in the last two(2) years or complete the attached statement of continuing medical education.

2. If you are applying for privileges at a hospital or clinic, please complete the enclosed privilege request form and ensure that you include any additional privileges that you are requesting. This will ensure your application is considered based upon the most accurate information available.

PROFESSIONAL REFERENCES

Please list five (5) professional peers with the same type of license, or a higher level of licensure, who are familiar with your professional performance in the past three (3) years.

Name and Title: Cameron Nelson MD — Specialty: Family Medicine
Department:
Street Address: 1100 Mercer Ave
City: Decatur — State/Province: IN — Zip Code: 46733
Country: United States — Email: cameron.nelson@adamshealthnetwork.org
Phone Number: 260-724-2145 — Facsimile Number:

Name and Title: Sarah Turner MD — Specialty: Family Medicine
Department:
Street Address: 750 S Broadway
City: Fort Wayne — State/Province: IN — Zip Code: 46802
Country: United States — Email: STurner3@lhn.net
Phone Number: 260-423-2675 — Facsimile Number:

Name and Title: Scott Smith MD — Specialty: Family Medicine
Department:
Street Address: 1100 Mercer Ave
City: Decatur — State/Province: IN — Zip Code: 46733
Country: United States — Email: scott.smith@adamshealthnetwork.org
Phone Number: 260-724-2145 — Facsimile Number:

Name and Title: Steve Schwieterman MD — Specialty: Family Medicine
Department:
Street Address: 750 S Broadway
City: Fort Wayne — State/Province: IN — Zip Code: 46802
Country: United States — Email: sschwieterman@fwmep.edu

Phone Number: 260-423-2675 Facsimile Number:

Name and Title: Zachry Waterson DO Specialty: Family Medicine
Department:
Street Address: 750 S Broadway
City: Fort Wayne State/Province: IN Zip Code: 46802
Country: United States Email: zwaterson@fwmep.edu
Phone Number: 260-423-2675 Facsimile Number:

LICENSURE REGISTRATION INFORMATION

List all licenses held in all jurisdictions. Attach a separate page if necessary.

State Professional License/Certification Number: 11019152A. ☐ Pending
State: Indiana Issue Date: Expiration Date: 10/31/2019

State Professional License/Certification Number: 267847 ☐ Pending
State: Massachusetts Issue Date: Expiration Date: 6/30/2017

LICENSING EXAM

Please check all that apply:

☐ State Board Exam (Prior to 1973) Which State? Date(s) passed?

☐ FLEX

Part/Step 1 Date Passed

☐ LMCC

Part/Step 1 Date Passed

☐ National Board (MBME)
Part/Step 1 Date Passed 5/1/2019 Part/Step 2 Date Passed Part/Step 3 Date Passed

☑ USMLE

Part/Step 1 Date Passed 6/12/2013 Part/Step 2 Date Passed 8/28/2014 Part/Step 3 Date Passed 3/1/2017

DRUG CERTIFICATION INFORMATION

Federal Drug Enforcement Administration (DEA) Registration: ☐ N/A
DEA Number: FC7135898 Expiration Date: 10/31/2019 ☐ Pending

State Controlled Substance Registration (CSR): ☐ N/A

CSR Number: 01079227B Expiration Date: 10/31/2019 State: Indiana ☐ Pending

EDUCATION

List all medical, osteopathic, dental or podiatric schools attended for graduate education and list all hospitals where you received training for post - graduate training. Attach a copy of your certificate. Disclose every residency program initiated, whether completed or not, and all completed programs. Attach a separate page if necessary.Check the type of education listed.

Degree Level: Residency

Institution: Greater Lawrence Family Health Center — Dates Attended:

Department: — From:

Street Address: 34 Haverhill St — To: 2/2017

City: Lawrence State/Province: MA Zip Code: 01841

Country: United States Graduation Date: 2017

Degree Earned: RES - Residency or Specialty: Family Practice

If teaching appointment: Department/Position

Degree Level: Graduate

Institution: Michigan State University College of Human Medicine — Dates Attended:

Department: Office of Student Affairs and Services A 234 Life — From:

Street Address: A 234 Life Sciences Building — To: 5/2015

City: East Lansing State/Province: MI Zip Code: 48824

Country: United States Graduation Date: 2015

Degree Earned: MD - Doctor of Medicine or Specialty: Medicine

If teaching appointment: Department/Position

Degree Level: Undergraduate

Institution: Depauw University — Dates Attended:

Department: — From:

Street Address: 313 S LOCUST ST — To: 5/2009

City: Greencastle State/Province: IN Zip Code: 46135-1736

Country: United States Graduation Date: 2009

Degree Earned: BA - Bachelor of Arts or Specialty: Biology

If teaching appointment: Department/Position

Degree Level: Residency

Institution: Fort Wayne Medical Education Program
Department: Attn: Darlene
Street Address: 2448 Lake Ave
City: Ft Wayne State/Province: IN Zip Code: 46805
Country: United States
Degree Earned: RES - Residency
If teaching appointment: Department/Position

Dates Attended:
From:
To: Present
Graduation Date:
or Specialty: Family Practice

SPECIALTY BOARD CERTIFICATIONS

If you are not Board certified by a Board recognized by the American Board of Medical Specialties, the American Osteopathic Association, the National Commission on Certification of Physician Assistants, the American Nurses' Credentialing Center, or the National Certification Commission, or accepted by examination in your specialty, please give a brief explanation on an attached sheet.Explain any gaps or delays in achieving Board certification by the recognized Board in your specialty area.

☐ Board or ☑ Specialty Specialty: Family Medicine
Certification Number: Accepted for Examination? ☑ Yes ☐ No
If not accepted, have you made application? ☐ Yes ☑ No ☐ N/A If no, provide an explanation: I have passed my board exam and v finish my residenc requirement 7/31/2019. After this I will be boar certified by the ABFM.

MEDICAL MALPRACTICE INSURANCE

Do you have current medical malpractice insurance? ☑ Yes ☐ No

Please list medical malpractice insurance carriers for the past five (5) years. Attach a separate page if necessary.

Carrier: The Medical Protective Company Limits: ,
Department:
Street Address: 5814 Reed Road ☐ Pending
City, State/Province and Zipcode: Fort Wayne, IN, 46835
Country: United States
Dates Insured: From: To: 07/31/2019 Policy Number: [redacted]

PROFESSIONAL PRACTICE QUESTIONS

Please answer the following Yes or No questions. Note that "N/A" is not an acceptable response except for question #16. If you answer YES to any question, you must give details including name, address, and telephone number of significant parties on a separate sheet of paper. You must respond to each question.

1	Has your professional liability coverage ever been terminated by action of the insurance company (except as a result of the company ceasing to offer insurance coverage to physicians or other practitioners)?	☐ Yes	☑ No
2	Have you ever been denied professional liability insurance coverage?	☐ Yes	☑ No
3	Has your professional liability carrier ever excluded any specific procedures from your coverage?	☐ Yes	☑ No
4	Have you ever been denied membership or renewal thereof, or been subject to disciplinary action in any professional organization?	☐ Yes	☑ No
5	Have you ever been excluded from or sanctioned by Medicare and/or Medicaid?	☐ Yes	☑ No
6	Have you ever been arrested? If so explain the circumstance, regardless of the outcome (i.e. expunged, dismissed, sealed, vacated).	☐ Yes	☑ No
7	Have you ever been named as a defendant in any criminal proceedings?	☐ Yes	☑ No
8	Have you ever been subject to investigation by a governmental entity or Board that either could have resulted, or did result, in licensure sanctions or other adverse actions, irrespective of the outcome?	☐ Yes	☑ No
9	Have you ever been named in any formal requests for corrective actions filed by any healthcare entity where you have had an appointment (a request which could result in either formal or informal proceedings)?	☐ Yes	☑ No
10a	Have your privileges at any healthcare entity ever been voluntarily or involuntarily suspended, restricted, diminished, revoked, surrendered, or not renewed, for any reason, except for medical records delinquency unrelated to your professional competence or conduct?	☐ Yes	☑ No
10b	Have you ever agreed not to exercise your clinical privileges while under investigation?	☐ Yes	☑ No
10c	Have you ever been investigated and/or terminated by a healthcare entity for cause, or without cause, related to your clinical competence or conduct, which could impact patient safety/care, or allowed to resign in lieu of termination for such reason?	☐ Yes	☑ No
11	Have you ever resigned from a healthcare entity to avoid modification, suspension, or termination of privileges, or while under investigation?	☐ Yes	☑ No
12a	Has your application for licensure or license to practice in any jurisdiction ever been investigated, voluntarily or involuntarily limited, suspended, revoked, surrendered or denied?	☐ Yes	☑ No
12b	Are any currently held licenses pending investigation or being challenged?	☐ Yes	☑ No
13	Have you ever been notified to appear before any licensing agency for a hearing or complaint of any nature?	☐ Yes	☑ No
14	Has your federal or state narcotics registration certificate in any jurisdiction ever been investigated, or voluntarily or involuntarily limited, suspended, revoked, or restricted?	☐ Yes	☑ No
15	Have you ever been involved in a settlement, medical malpractice claim or suit, or have you ever received written notice of intent to file such a suit? If yes, please provide the following information for each claim or suit. Please list on a separate sheet of paper for each case: Name, age, sex of patient/claimant, Date(s) and type of treatment and/or surgery that led to the allegations against you, Nature of allegations in claims/suits. Specify whether a suit was ever filed, Names of other practitioners and hospital, if any, involved in claims or suit, Disposition or current status of claim or suit (be specific), Name of insurance carrier defending you.	☐ Yes	☑ No
16	Have you ever been reported to the National Practitioner Data Bank?	☐ Yes	☑ No
17a	Are you now, or were you in the past, addicted to, abusive of, or in treatment for abuse of any controlled substances, habit-forming drugs, illegal drugs, prescription medication or alcohol?	[redacted]	

17b	Are you being treated with opiates for chronic pain? If yes, please provide to the Board upon application a current evaluation from your treating pain provider (MD or DO)	[redacted]	
18	Do you have or have you been diagnosed with an illness or condition which impairs your judgement or affects your ongoing ability to practice medicine in a competent, ethical and professional manner? If yes, please have your treating physician send the NM Medical Board a letter regarding your diagnosis, treatment, and current status.	[redacted]	
19a	Have you ever, for any reason, resigned from a medical school or postgraduate training (PGT) program?	☐ Yes	☑ No
19b	Have you ever, for any reason, withdrawn from a medical school or postgraduate training (PGT) program?	☑ Yes	☐ No
19c	Have you ever, for any reason, been suspended, dismissed, or expelled from a medical school or postgraduate training (PGT) program?	☐ Yes	☑ No
19d	Have you ever, for any reason, been placed on probation or remediation, including academic probation or remediation, by a medical school or postgraduate training (PGT) program?	☐ Yes	☑ No
19e	Have you ever, for any reason, taken a leave of absence or break from, or had any interruptions or extensions in, a medical school or postgraduate training (PGT) program for any personal or professional reason (including illness or disability, pregnancy or maternity, any academic issues, etc)?	☑ Yes	☐ No
20	I attest that I will limit my practice to areas in which I am competent to practice.	☑ Yes	
21	Are you currently in arrears for payments of amounts required to be paid pursuant to an outstanding judgement and order for child support in New Mexico or in any other state?	☐ Yes	☑ No

Professional Practice Questions - Explanations

19b: During my first year of residency I switched from Greater Lawrence Medical Education Program to Fort Wayne Medical Education Program to be nearer to family in Indiana. I left in good standing.

19e: I worked as a legislative fellow for one year after medical school, before PGT. I took a one month break in my PGY-1 year after switching residency programs (see above).

New Mexico Medical Board
2055 S. Pacheco St. Bldg. 400
Santa Fe, NM 87505 (505) 476-7220

APPLICANT'S OATH

I, Alison Case, **hereby certify that I am the person pictured below and named in this application for a license to practice as a Physician in the State of New Mexico; that all statements I have made herein are true; that I am the original and lawful possessor and person named in the various forms and credentials furnished to the New Mexico Medical Board (Board) with my application.**

I acknowledge and state that I have read the Information and Instructions that accompanied this application and I have answered all questions truthfully. I understand that the fee I submitted is not refundable.

I authorize and request every person, hospital, clinic, community, governmental agency, court, association, institution or other organization having 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 their 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, and their agents or representatives, and any person furnishing information, from any and all liability of every nature and kind arising out of the furnishing or inspection of such documents, records, other information, or the investigation made by the Board. I authorize the Board to release information, material, documents, orders, or the like relating to me or to this application to any other agency of the State of New Mexico or the appropriate licensing agency of any other state or Territory of the United States or any agency of the United States government.

Applicant Signature — Date: 7/23/19

*Passport-quality color photograph taken within six months prior to filing the application, approximate size 2 x 2 inches, head and shoulders only, full face, front view, plain white or off-white background, standard photo stock paper, scanned or computer-generated photographs should have no visible pixels or dots.

Applicant Name ALISON CASE **Date** 7/23/19

Alison Anne Case

EDUCATION

Fort Wayne Medical Education Program – Fort Wayne, IN February 2017-Present
Greater Lawrence Family Medicine Residency Program – Lawrence, MA June -December 2015

Michigan State University College of Human Medicine – East Lansing, MI 2011-2015
M.D.
Rural Physician Program—Marquette, MI

DePauw University - Greencastle, IN 2006-2009
Bachelor of Arts in Biology
GPA: 3.5/4.0
Science Research Fellows Program of Distinction

HONORS AND AWARDS

Recipient of James A. Gordon Scholarship Spring 2013
Recipient of CHM Dean's Endowed Scholarship Fall 2011

WORK EXPERIENCE

Adams Memorial Hospital Emergency Department Moonlighting 2018-2019
Decatur, Indiana
Supervisor: Scott Smith, MD
Moonlighting during Family Medicine Residency 12 hour shifts in a rural emergency department.

Moonlight

AMSA Education and Advocacy Fellow 2015-2016
American Medical Student Association- Sterling, VA
Supervisor: Joshua Caulfield
Full time position providing educational programming and advocacy outreach including grassroots mobilization as well as federal level policy work. Assisted with AMSA programming including fall conferences, institutes, scholars programs, and convention. Highlights included developing curriculum for and leading an Advocacy Leadership Course, reaching out to chapters for advocacy trainings, both in person and virtual, in bird-dogging and meeting with elected officials, planning AMSA's National Lobby Day, and managing the poster sessions for AMSA's fall conferences and National Convention, among other involvement in many of AMSA's active campaigns and initiatives.

COMMUNITY ADVOCACY AND EXTRACURRICULAR ACTIVITIES

American Medical Association Resident Fellow Section Head of Resolutions July 20180-present
American Medical Association Committee on Legislative Affairs July 2017-2018
Advocate with T1 International Fall 2018-Present
Advocate with Planned Parenthood Indiana-Kentucky Fall 2018-Present

PUBLICATIONS

Vaglia, JL., White, Kurt, **Case, A.** "Evolving possibilities: postembryonic axial elongation in salamanders with biphasic (*Eurcyea cirrigera*, *Eurycea longicauda*, *Eurycea quadridigitata*) and paedomorphic life cycles (*Eurycea nana* and *Ambystoma mexicanum*)" Acta Zoologica Vol 91. Issue 4, October 2010.

PRESENTATIONS

Case, Alison; Kowaleski, Tim; Henricksen, Brian. "Northeast Indiana Addiction Study", Indiana Academy of Family Medicine Research Symposium, Carmel, IN, May 2019.

Case, Alison; Henricksen, Brian. "A Study of No Show Rates and Reasons Behind Them in a Family Medicine Clinic". Indiana Academy of Family Medicine Research Symposium, Carmel, IN, May 2019.

Case, Alison, Voigt, Brig, Finkbeiner, David. "Baseline Survey of Fruit and Vegetable Intake and Produce Prescription Program Feasibility in a sample bariatric clinic patients in Marquette, MI", CAAM Student Research Meeting, Marquette, MI, April 2014.

Case, Alison. "PBMC Potpurri Cytokine and Chemokine Responses to *P. falciparum* malaria", Malaria and Vector Biology Interest Group Seminar. Rockville, Maryland, National Institutes of Health-Laboratory of Malaria and Vector Research, June, 2011.

Case, Alison. "A comparison of vertebral morphology in three species of salamander across life stages", Evolution, Minneapolis, MN, June 2008; Science Research Fellows Symposium, Greencastle, IN, November 2007.

INTERESTS

Running, hiking, camping, choral music, science fiction literature and cinema, traveling, tropical medicine

AMA Physician Profile

PREPARED FOR

New Mexico Medical Board, Santa Fe, NM

Name and Mailing Address

ALISON CASE

[redacted]

Birth date [redacted]/1988

Primary Office Address

1100 MERCER AVE
DECATUR, IN 46733-2303

Phone UNKNOWN

Physician's major professional activity HOSPITAL BASED RESIDENTS - ALL YEARS

Self-designated practice specialty FAMILY MEDICINE (primary)
UNSPECIFIED (secondary)

Self-designated practice specialties (SDPS) listed on the AMA Physician Profile do not imply recognition or endorsement of any field of medical practice by the Association nor does it imply verification by a member board of the American Board of Medical Specialties (ABMS) or that the physician has been trained or has special competence to practice the SDPS.

AMA membership status MEMBER

All information from this point forward is provided by the primary source

Current and/or historical NPI information

National Provider Identifier (NPI)	Enumeration Date	Deactivation Date	Reactivation Date	Replacement Number	Last Reported Date
[redacted]	06/20/2016	NOT RPTD	NOT RPTD	NOT RPTD	05/15/2019

Current and/or historical medical school

MICHIGAN STATE UNIVERSITY COLLEGE OF HUMAN MEDICINE

Degree Awarded: YES
Degree Year: 2015

Current and/or historical post graduate medical training programs accredited by the Accreditation Council for Graduate Medical Education (ACGME)

Beginning with the 2010 cycle of the National GME Census, post-graduate training segments will include the name of the program attended in addition to the sponsoring institution. Program-level information prior to 2010 will not be available for reporting. Future training dates, as reported by the program, should be interpreted as "in progress" or "current" with the projected date of completion.

Beginning with the 2016/2017 cycle of the National GME Census post-graduate training segments will include a training type of specialty (residency) or subspecialty (fellowship). Training types for programs reported prior to 2016 will not include this designation.

Post-graduate training performed at accredited osteopathic institutions or in Canada are updated on the AMA Physician Masterfile only upon verification by the program. US licensing authorities accept graduate medical education from both entities as equivalent to training performed in a US program accredited by ACGME.

If a segment below is indicated as "being re-verified", it typically means that the physician is a current resident and the AMA is confirming with the residency program that the physician is still enrolled - this standard process occurs on an annual basis.

Sponsoring Institution:	FORT WAYNE MEDICAL EDUCATION PROGRAM
Sponsoring State:	INDIANA
Program name:	FORT WAYNE MEDICAL EDUCATION PROGRAM
Specialty:	FAMILY MEDICINE
Training Type:	SPECIALTY
Dates:	2/2017 - 7/2019 (Verified)

Sponsoring Institution:	GREATER LAWRENCE FAMILY HEALTH CENTER INC
Sponsoring State:	MASSACHUSETTS
Program name:	GREATER LAWRENCE FAMILY HEALTH CENTER PROGRAM
Specialty:	FAMILY MEDICINE
Training Type:	SPECIALTY
Dates:	6/2016 - 1/2017* (Verified)

***Program reports partial training completed at this institution. Please review final postgraduate training segment(s) to determine completion.*

NATIONAL BOARD OF MEDICAL EXAMINERS (NBME) CERTIFICATION YEAR: MD: 0

Specialty Board Certification

Specialty Board Certification(s) by one or more of the 24 boards recognized by the American Board of Medical Specialties (ABMS) and the American Medical Association (AMA) through the Liaison Committee on Specialty Boards, as reported by the ABMS:

The AMA Physician Profile has been designated by the ABMS as an Official ABMS Display Agent of Member Board Certification data. Therefore, the ABMS Board Certification information on the AMA Physician Profile is considered a designated equivalent source in regard to credentialing standards set forth by Joint Commission. The AMA is also an NCQA-approved source for verification of medical school, postgraduate medical training, ABMS Board certification, and Federal DEA registration.

Certifying board: TO DATE, THERE HAVE BEEN NO BOARD CERTIFICATIONS REPORTED.
Certificate:
Certificate type:

Duration	Status	Effective Date	Expiration Date	Reverify Date	Occurrence	Last Reported	Participating in MOC

For certification dates, a default value of "01" appears in the day or month field if data were not provided to AMA. Please contact the appropriate specialty board directly for this information.

Current and/or historical medical licensure

License No.	MD / DO	Jurisdiction	Date Granted	Expiration Date	Renewal Date	Status	License Type	Last Reported
01079227A	MD	IN	09/18/2017	10/31/2019		ACTIVE	UNLTD	06/03/2019
R29706	MD	MN	10/21/2018	11/03/2018		INACTIVE	RES	06/03/2019
11019152A	MD	IN	02/20/2017	06/30/2018		INACTIVE	RES	11/02/2017
267847	MD	MA	05/05/2016	06/30/2017		INACTIVE	LTD	06/26/2017

Action Notifications

To date, there have been no actions reported to the AMA by any US state licensing agency. ✓

To date, there have been no Medicare/Medicaid sanctions reported to the AMA by the Department of Health and Human Services.

To date, there have been no federal sanctions reported to the AMA by any branch of the US military, the Veteran's Administration or the US Department of Justice. ✓

U.S. Drug Enforcement Administration (DEA)

DEA number	Schedule	Expiration Date	Last Reported Date	Address

None Reported

Only the last three characters of active DEA numbers are displayed

Many states require their own controlled substances registration/license. Please check with your state licensing authority for requirement information as the AMA does not maintain this information.

ECFMG Certfication

Applicant Number:

The Educational Commission for Foreign Medical Graduates (ECFMG) applicant identification number does not imply current ECFMG certification status. To verify ECFMG status, contact the ECFMG Certification Verification Service online at https://cvsonline2.ecfmg.org/

Profile Information

The content of the AMA Physician Profile is intended to assist with credentialing. An organization's appropriate use of the data contained in the AMA Physician Masterfile meets selected primary source verification requirements of the Joint Commission, the Accreditation Association for Ambulatory Health Care (AAAHC) and the American Accreditation Health Care Commission(AAHCC)/Utilization Review Accreditation Commission (URAC). The AMA Physician Masterfile is also an NCQA-approved source for verification of medical school, post-graduate medical training, ABMS Board Certification and federal DEA registration.

If any of the data in this Profile is believed to be incorrect, please log in to your account on our profiles website, go to the profile manager tab, find the provider for whom you think we have inaccurate information and click on the "Report" button in the "Report a Discrepancy" column. Enter any of the information that you feel needs to be researched. The AMA will contact the primary source of the data to determine which data is correct. We will notify you of the outcome of our research. If any changes are made to the profile we will update the link in profile manager for this provider so that you can access the new, updated information.

If you have any questions or need additional information about the AMA Physician Profile Service, please call (800) 665-2882.

PDC PHYSICIAN DATA CENTER

fsmb

PRACTITIONER PROFILE

Prepared for: New Mexico Medical Board As of Date:6/12/2019

PRACTITIONER INFORMATION

Name:	Case, Alison Anne
Alternate Name(s):	Case, Alison A
	Case, Alison
DOB:	[redacted]1988
Medical School:	Michigan State University College of Human Medicine East Lansing, Michigan, UNITED STATES
Year of Grad:	2015
Degree Type:	MD
NPI:	[redacted]

BOARD ACTIONS

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

LICENSE HISTORY

Jurisdiction	License Number	Issue Date	Expiration Date	Last Updated
INDIANA	01079227A	09/18/2017	10/31/2019	06/04/2019
MASSACHUSETTS	267847	05/05/2016	06/30/2017	06/27/2017

PDC PHYSICIAN DATA CENTER

fsmb

PRACTITIONER PROFILE

Prepared for:	New Mexico Medical Board	As of Date:6/12/2019
Practitioner Name:	Case, Alison Anne	

ABMS® CERTIFICATION HISTORY

No ABMS Certifications found.

AOA® CERTIFICATION HISTORY

No AOA Certifications found.

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

Commonwealth of Massachusetts
Board of Registration in Medicine
200 Harvard Mill Square, Suite 330
Wakefield, Massachusetts 01880
(781) 876-8200
www.mass.gov/massmedboard
Enforcement Division Fax: (781) 876-8381
Legal Division Fax: (781) 876-8380
Licensing Division Fax: (781) 876-8383

CHARLES D. BAKER
Governor
KARYN E. POLITO
Lieutenant Governor
MARYLOU SUDDERS
Secretary
Health and Human Services
MONICA BHAREL, MD, MPH
Commissioner
Department of Public Health

CANDACE LAPIDUS SLOANE, MD
Chair, Physician Member
GEORGE ABRAHAM, MD
Vice Chair, Physician Member
ROBIN S. RICHMAN, MD
Secretary, Physician Member
WOODY GIESSMANN, LADC-I, CADAC, CIP, CAI
Public Member
JULIAN N. ROBINSON, MD
Physician Member
MICHAEL D. MEDLOCK, MD
Physician Member
PAUL G. GITLIN, ESQ
Public Member
GEORGE ZACHOS, ESQ.
Executive Director

Verification of Limited License

August 8, 2019

To Whom It May Concern:

This is to certify that Dr. Alison A. Case has been granted limited license number 267847 to serve as an Intern in Family Medicine and authority to practice medicine only at Greater Lawrence Family Health Center. Service at the hospital began on June 13, 2016 and expired on June 30, 2017.

Our files contain no derogatory information on this physician.

Staff Member, Board of Registration in Medicine
Tammi McManus

Seal

Please be advised that the above information is based entirely on examination of our open and closed complaint files, as well as post-1986 disciplinary actions. It is not based on a review of the application for licensure, renewal of licensure or any reports that the Board is required to receive by statute (from courts, insurers, hospitals, etc...).
e/share/verifications/Limited-No]

State of Indiana

DEMOGRAPHIC INFORMATION

Name: Alison Anne Case

ADDRESS INFORMATION

City/State/Zip: Fort Wayne IN 46814
County: Allen

LICENSE INFORMATION

Lic #:	01079227A	Profession:	Medical Licensing Board	Type:	Physician	Secondary:	
Status:	Active	Issued:	9/18/2017	Expiration:	10/31/2021		
Method:	Application						

DISCIPLINE INFORMATION

RELATED LICENSES

Lic #:	**01079227B**	Name:	Case, Alison Anne		
License Type:	CSR-Physician	License Status:	Active	Relationship:	Same Licensee

SPECIALTY INFORMATION

No Specialty Information

DOCUMENTS

No Public Documents Available

State of Indiana

DEMOGRAPHIC INFORMATION

Name: Alison Anne Case

ADDRESS INFORMATION

City/State/Zip: Fort Wayne IN 46814
County: Allen

LICENSE INFORMATION

Lic #:	11019152A	Profession:	Medical Licensing Board	Type:	Postgraduate Training Permit	Secondary:	
Status:	Superseded	Issued:	2/20/2017	Expiration:	6/30/2018		
Method:	Application						

DISCIPLINE INFORMATION

RELATED LICENSES

No Related Licenses

DOCUMENTS

No Public Documents Available

MINNESOTA BOARD OF MEDICAL PRACTICE

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

July 10, 2019

New Mexico Medical Board
2055 S. Pacheco, Bldg. 400
Santa Fe, NM 87505

This is to certify that a standard search of the available records of the Minnesota Board of Medical Practice indicates the following:

Physician:	Alison Anne Case
Date of birth:	[redacted]/1988
	RP29706 -Residency Permit
On:	October 21, 2018
Expiration date is:	November 03, 2018
Status:	Residency Permit - Cancelled/Expired
Issued on the basis of:	Not Applicable
Corrective action:	
Disciplinary action:	None

This license information was last updated on: 7/10/2019 10:11:43AM

The above format is the standard format prepared for all physicians regulated by this board.

Please be advised that the Board does not release information as to whether there has been a complaint filed or an investigation conducted on individual verifications. All physicians are considered in good standing unless noted otherwise.

Further public records including disciplinary and corrective actions may be available from the Board's website at www.bmp.state.mn.us under professional profile. If other information is needed, please contact the Minnesota Board of Medical Practice at 612-617-2130.

Ruth M. Martinez
Executive Director

New Mexico Medical Board
2055 S. Pacheco St.
Building 400
Santa Fe, NM 87505
(505) 476-7220

RECEIVED
SEP 30 2019
NM MEDICAL BOARD

WORK EXPERIENCE VERIFICATION

I am applying for a medical license in the State of New Mexico. The New Mexico Medical Board requires this form to be completed by the Chief of Staff or facility's administrative staff. I hereby authorize release of all information in your files, favorable or otherwise, DIRECTLY to the NMMB, **2055 S. Pacheco St., Bldg. 400, Santa Fe, NM 87505.**

Alison Case
Applicant Name
[redacted]
City/State/Zip

Applicant Signature
12/2018 – present
*Dates of Privilege/Employment - mm/yy (must be provided)
[redacted]

The section below should be completed by the chief of staff or facility's administrative staff.
Letters of Recommendation are ***NOT*** accepted in lieu of this form.

Tammy Velasquez
Type or Print Name of person completing this form
Medical Staff Coordinator
Title
Adams Memorial Hospital
Name of Institution
1100 Mercer Ave.
Address
Decatur IN 46733
City / State / Zip

1. This evaluation is based on: ___Observation of applicant X Review of personnel file
2. In your estimation, is there any reason why this applicant should not be licensed to practice? ___Yes X No
3. To your knowledge, is there any mental or physical reason why this applicant should not be licensed? ___Yes X No
4. To your knowledge, is there any derogatory/disciplinary information regarding this applicant? ___Yes X No
5. Are the dates of privilege/employment provided by the applicant on this form accurate?* ___Yes ✓ No

***If not, please provide correct dates**: Beginning 08/2018 (Month/Year) Ending Present (Month/Year)

If you answered "YES" to questions 2, 3, and/or 4, please provide a written explanation and/or any supporting documentation that may be relevant.

Please affix hospital or notary seal here

Tammy Velasquez — Tammy Velasquez — 9/26/19
Printed name of person completing this form — Signature — Date

Tammy Velasquez — 9/26/19
Signature of Notary (if applicable) — Date

My commission expires: September 29, 2021

Please note on this form if there is no hospital or notary seal available.
Please return this form directly to the address above
Thank you for your cooperation.

Revised 10/04

New Mexico Medical Board
2055 S. Pacheco St.
Building 400
Santa Fe, NM 87505
(505) 476-7220

MEDICAL EDUCATION VERIFICATION

APPLICANT INSTRUCTIONS: Please complete the waiver for release of information and forward this form to your university/medical school(s) or university of graduation for verification.

Waiver for Release of Information

I authorize the medical school/university listed below to provide any and all information pertaining to my medical education at your institution.

Applicant's Signature: [signature] Date of Birth [redacted] 1/1988

Print or Type Name: ALISON A CASE Soc Sec # [redacted]

Other Name(s) _____

Name of Medical School: Michigan State University College of Human Medicine

Address: 15 Michigan St NE City Grand Rapids State MI Country USA

DEAN OR DESIGNATED OFFICIAL OF MEDICAL SCHOOL INSTRUCTIONS:

Please complete this form and forward it DIRECTLY to NMMB, 2055 S. Pacheco St., Bldg. 400, Santa Fe, NM 87505. Please include dean's letter (if available) and a **COPY OF THE OFFICIAL TRANSCRIPT** (which indicates courses taken, dates and hours of attendance, and scores, grades, or evaluations).

APPLICANT'S EDUCATIONAL DEGREE AND DATE AWARDED HISTORY
If name of institution was different from the above named institution when applicant attended, please enter name below:

_____

Enrollment and Participation: Our records indicate that

Case, Alison A
(type or print the applicant's name): (Last Name) (First Name) (MI)

attended our medical school on the following dates (indicate the month, day and year in the section below):

ATTENDANCE DATES:	FROM	TO	FROM	TO
	8/29/2011	5/8/2015	___/___/___	___/___/___
	___/___/___	___/___/___	___/___/___	___/___/___
	___/___/___	___/___/___	___/___/___	___/___/___

The applicant attended 146 total weeks of continuing on-campus education, not less than 32 weeks in each academic year and:

Check One

X Was awarded a degree in MD on 5/8/2015 (mm/dd/yr)

____ Was NOT awarded degree. Please explain reasons(s): ____

_____

_____

Unusual Circumstances: The following questions apply to unusual circumstances that occurred during any part of the applicant's medical education. ***All questions must be answered. If you answer "YES" to any of the questions below, please enclose an explanation.***

1. Did the applicant take any leaves of absence or breaks from his/her medical education? ___Yes __X__No
2. Was the applicant ever placed on probation? ___Yes __X__No
3. Was the applicant ever disciplined or under investigation? ___Yes __X__No
4. Were any negative reports ever filed by instructors regarding the applicant? ___Yes __X__No

COMMENTS:_____

AFF[illegible]L HERE

Intern[illegible] attach a copy of the [illegible] transcript or provide[illegible]

Signature: _____

Print Name: Angela Jenks

Title: Asst. College Records officer

Date: 7/17/19

This form *will not be accepted* unless it is stamped with the institutional seal.
Thank you for helping us process this application for licensure.

MICHIGAN STATE UNIVERSITY

OFFICIAL ACADEMIC TRANSCRIPT

CASE, ALISON ANNE STUDENT ID: [redacted]

PREVIOUS/TRANSFER INSTITUTIONS

DEPAUW UNIVERSITY
GREENCASTLE IN
BACHELOR OF ARTS GRANTED : 2009

HUMAN MEDICINE CREDIT

COURSE INFORMATION

COURSE	TITLE	CRS	GRADE	S R H
FALL SEMESTER 2011 08/29/11 - 12/16/11				
ANTR 551	MEDICAL GROSS ANATOMY	6	P	
BMB 514	MEDICAL BIOCHEMISTRY	3	P	
BMB 526	GENETICS	2	P	
HM 531	CLINICAL SKILLS I	2	P	
HM 571	INTEGRATIVE CLIN CORREL I	2	P	
HM 581	MENTOR PROGRAM	1	P	
PSL 534	CELL BIOLOGY AND PHYSIOLOGY I	3	P	
FALL SEMESTER 2011 09/14/11 - 12/07/11				
HM 590	SPECIAL TOPICS IN MEDICINE	1	P	
CUM CREDITS : 20.0	CUM GPA : N/A			
SPRING SEMESTER 2012 01/09/12 - 03/23/12				
PSL 535	CELL BIOLOGY AND PHYSIOLOGY II	4	P	
SPRING SEMESTER 2012 01/09/12 - 05/04/12				
HM 532	CLINICAL SKILLS II	2	P	
HM 572	INTEGRATIVE CLIN CORREL II	1	P	
MMG 522	MEDICAL MICROBIO & IMMUNOLOGY	5	P	
NOP 552	MEDICAL NEUROSCIENCE	4	P	
SPRING SEMESTER 2012 01/10/12 - 03/01/12				
EPI 546	IM/EPI BIOSTAT	1	P	
SPRING SEMESTER 2012 01/20/12 - 04/27/12				
HM 590	SPECIAL TOPICS IN MEDICINE	1	P	
SPRING SEMESTER 2012 03/28/12 - 05/04/12				
HM 561	BASIC PRINCIPLES OF PATHOLOGY	2	P	
CUM CREDITS : 40.0	CUM GPA : N/A			
SUMMER SEMESTER 2012 05/14/12 - 08/16/12				
HM 533	CLINICAL SKILLS III	2	P	
SUMMER SEMESTER 2012 05/16/12 - 06/15/12				
RAD 553	INTRODUCTION TO RADIOLOGY	1	P	
SUMMER SEMESTER 2012 05/18/12 - 06/29/12				
PHM 563	MEDICAL PHARMACOLOGY	3	P	
CUM CREDITS : 46.0	CUM GPA : N/A			

END OF COLUMN

COURSE	TITLE	CRS	GRADE	S R H
FALL SEMESTER 2012 08/27/12 - 09/17/12				
HM 513	NEUROLOGICAL DOMAIN	3	P	
FALL SEMESTER 2012 08/27/12 - 10/26/12				
HM 546	SOC CONTEXT CLIN DECIS	1	P	
FALL SEMESTER 2012 08/27/12 - 12/14/12				
HM 534	CLINICAL SKILLS IV	2	P	
HM 582	MENTOR PROGRAM YEAR II	1	P	
FALL SEMESTER 2012 08/29/12 - 12/14/12				
IM 618	CLINICAL TROPICAL MEDICINE	2	P	
FALL SEMESTER 2012 09/18/12 - 10/08/12				
HM 511	INFECTIOUS DISEASE & IMMUNOLGY	3	P	
FALL SEMESTER 2012 10/09/12 - 10/22/12				
HM 517	MUSCULOSKELETAL DOMAIN	2	P	
FALL SEMESTER 2012 10/15/12 - 12/07/12				
EPI 547	IM/EPIBIOSTAT II	1	P	
FALL SEMESTER 2012 10/23/12 - 11/19/12				
HM 539	HEM/NEO DOMAIN	4	P	
FALL SEMESTER 2012 11/20/12 - 12/14/12				
HM 516	THOUGHT EMOTION BEHAVE DOMAIN	4	P	
CUM CREDITS : 69.0	CUM GPA : N/A			
SPRING SEMESTER 2013 01/07/13 - 01/28/13				
HM 526	URINARY TRACT DOMAIN	3	P	
SPRING SEMESTER 2013 01/07/13 - 04/05/13				
HM 547	SOC CON CLIN DECISIONS II	2	P	
SPRING SEMESTER 2013 01/07/13 - 05/03/13				
HM 535	CLINICAL SKILLS V	2	P	
SPRING SEMESTER 2013 01/29/13 - 02/18/13				
HM 525	PULMONARY DOMAIN	3	P	
SPRING SEMESTER 2013 02/19/13 - 03/25/13				
HM 515	CARDIOVASCULAR DOMAIN	4	P	
SPRING SEMESTER 2013 03/26/13 - 04/15/13				
HM 528	MET & ENDO & REPROD DOMAIN	3	P	
SPRING SEMESTER 2013 04/08/13 - 05/03/13				
HM 548	MEDICAL HUMANITIES SEMINAR	2	P	
SPRING SEMESTER 2013 04/16/13 - 05/06/13				
HM 527	DIGESTIVE DOMAIN	3	P	
CUM CREDITS : 91.0	CUM GPA : N/A			
SUMMER SEMESTER 2013 05/13/13 - 08/15/13				
HM 635	CORE COMPETENCIES I	2	P	
HM 640	SERVICE LEARNING IN COMMUNITY	1	P	
SUMMER SEMESTER 2013 07/08/13 - 08/30/13				
MED 608	INTERNAL MEDICINE CLERKSHIP	12	P	
CUM CREDITS : 106.0	CUM GPA : N/A			

CONTINUED ON PAGE 02

PROVIDED SOLELY FOR: (1)
NEW MEXICO MEDICAL BOARD
NICOLE VALDEZ
BLDG. 400
2055 S PACHECO ST
SANTA FE NM 87505

Steven J. Shablin
University Registrar

THE FACE OF THIS TRANSCRIPT IS PRINTED WITH BLACK INK ON PAPER WITH GREEN BACKGROUND.

MICHIGAN STATE UNIVERSITY

OFFICIAL ACADEMIC TRANSCRIPT

CASE, ALISON ANNE

STUDENT ID: [redacted]

COURSE	TITLE	CRS	GRADE	S R	H
HUMAN MEDICINE CREDIT					
FALL SEMESTER 2013	08/28/13 - 12/13/13				
HM 636	CORE COMPETENCIES II	2	P		
FALL SEMESTER 2013	09/03/13 - 09/27/13				
FM 608	FAMILY PRACTICE CLERKSHIP	6	P		
FALL SEMESTER 2013	09/30/13 - 10/25/13				
PSC 608	PSYCHIATRY & BEHAV SCI CLKSHP	6	P		
FALL SEMESTER 2013	10/28/13 - 12/20/13				
PHD 600	PEDIATRIC SPECIALTY CLERKSHIP	12	P		
CUM CREDITS : 132.0	CUM GPA : N/A				
SPRING SEMESTER 2014	01/06/14 - 02/28/14				
OGR 608	OBSTETRICS & GYNECOLOGY CLKSHP	12	P		
SPRING SEMESTER 2014	01/06/14 - 05/02/14				
HM 637	CORE COMPETENCIES III	2	P		
SPRING SEMESTER 2014	03/03/14 - 04/25/14				
SUR 608	JUNIOR SURGERY CLERKSHIP	12	P		
CUM CREDITS : 158.0	CUM GPA : N/A				
SUMMER SEMESTER 2014	05/05/14 - 06/27/14				
FM 608	FAMILY PRACTICE CLERKSHIP	12	P		
SUMMER SEMESTER 2014	07/07/14 - 08/01/14				
SUR 620	SENIOR SURGERY CLERKSHIP	6	P		
CUM CREDITS : 176.0	CUM GPA : N/A				
FALL SEMESTER 2014	09/02/14 - 09/26/14				
MED 623	ADVANCED MEDICINE	6	P		
FALL SEMESTER 2014	09/29/14 - 10/24/14				
OGR 614	ADVANCED OBSTETRICS CLERKSHIP	6	P		
CUM CREDITS : 188.0	CUM GPA : N/A				
SPRING SEMESTER 2015	01/06/15 - 02/14/15				
IM 621	CLIN TROPICAL MEDICINE CLKSHP	9	P		
	BLANTYRE MALAWI				
SPRING SEMESTER 2015	02/02/15 - 02/27/15				
HM 691	RESEARCH CLERKSHIP	6	P		
SPRING SEMESTER 2015	03/02/15 - 03/27/15				
FM 610	ELECT CLKSHP IN FAMILY PRAC	6	P		
CUM CREDITS : 209.0	CUM GPA : N/A				

DOCTOR OF MEDICINE GRANTED: 05/08/15

MAJOR: HUMAN MEDICINE

COLLEGE: HUMAN MEDICINE

MEDICAL CLERKSHIP HONORS

MED 623 ADVANCED MEDICINE FALL 2014

----------NO ENTRIES BELOW THIS LINE----------

PROVIDED SOLELY FOR: (1)
NEW MEXICO MEDICAL BOARD
NICOLE VALDEZ
BLDG. 400
2055 S PACHECO ST
SANTA FE NM 87505

Steven J. Shablin
University Registrar

THE FACE OF THIS TRANSCRIPT IS PRINTED WITH BLACK INK ON PAPER WITH GREEN BACKGROUND.

New Mexico Medical Board
2055 S. Pacheco St.
Building 400
Santa Fe, NM 87505
(505) 476-7220

POSTGRADUATE TRAINING VERIFICATION

I am applying for a license to practice medicine in New Mexico and the Medical Board requires this form to be completed by each hospital where I participated in an approved postgraduate training program in the United States or Canada. This is your authorization to release any information in your files of record, favorable or otherwise, DIRECTLY to the NMMB, 2055 S. Pacheco St., Bldg. 400, Santa Fe, NM 87505. Your prompt response will be appreciated.

Name: Alison A Case M.D.

Signature [signature] Date (Month/Day/Year) 7/10/19

(DO NOT DETACH)

This section to be completed by the office of the Administrator of the institution or program wherein the applicant satisfactorily completed (or will complete) an approved postgraduate training program in the United States or Canada.

This is to certify that Alison Case, M.D. undertook and satisfactorily completed a full term approved program of 7 (number) months in the Lawrence FMR - 34 Haverhill Street (Full name and complete address of facility) in the field of Family Medicine from 06/13/2016 (Date: Mo/Day/Yr) to 01/13/2017 (Date/Anticipated Date Mo/Day/Yr).

1. Was this program approved for postgraduate training during that period by the Accreditation Council for Graduate Medical Education, or the Royal College of Physicians and Surgeons of Canada? ✓ Yes ___ No
2. Was applicant ever placed on probation, restricted, or limited? ___ Yes ✓ No If yes, please attach written explanation.
3. Was there any reason not to continue applicant in the training program? ___ Yes ✓ No If yes, please attach written explanation.
4. Did the applicant have any medical condition, which in any way impaired or limited his/her ability to safely practice any field of medicine? ___ Yes ✓ No If yes, please attach written explanation.

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

   The cognitive capacity to make appropriate clinical diagnoses and exercise reasoned medical judgments and to learn and keep abreast of medical developments; and

   The ability to communicate those judgments and medical information to patients and health care providers, with or without the use of aids or devices, such as voice amplifiers; and

   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 addition and alcoholism.
5. Was the applicant ever diagnosed with or treated for bipolar disorder, schizophrenia, paranoia, or any psychotic disorder? ___ Yes ✓ No If yes, please attach written explanation.
6. Were applicant's final evaluations in every category rated satisfactory? ✓ Yes ___ No If no, please attach written explanation.

Please affix hospital or notary seal here

Michelle Olivieri
Printed name of person completing this form

[signature]
Signature

7/22/19
Date

Signature of Notary (if applicable) Date

My commission expires:

If there is no hospital or notary seal, this form is unacceptable.
Please return this form directly to the address above
Thank you for your cooperation.

New Mexico Medical Board
2055 S. Pacheco St.
Building 400
Santa Fe, NM 87505
(505) 476-7220

POSTGRADUATE TRAINING VERIFICATION

I am applying for a license to practice medicine in New Mexico and the Medical Board requires this form to be completed by each hospital where I participated in an approved postgraduate training program in the United States or Canada. This is your authorization to release any information in your files of record, favorable or otherwise, DIRECTLY to the NMMB, 2055 S. Pacheco St., Bldg. 400, Santa Fe, NM 87505. Your prompt response will be appreciated.

Name: Alison Case M.D.

Signature 06/13/19 Date (Month/Day/Year)

(DO NOT DETACH)

This section to be completed by the office of the Administrator of the institution or program wherein the applicant satisfactorily completed (or will complete) an approved postgraduate training program in the United States or Canada.

This is to certify that Alison Case, MD, M.D. undertook and satisfactorily completed a full term approved program of 36 (number) months in the FWMEP Family Medicine Residency (Full name and complete address of facility) in the field of Family Medicine from 2/13/2017 (Date: Mo/Day/Yr) to 7/31/2019 (Date/Anticipated Date).

1. Was this program approved for postgraduate training during that period by the Accreditation Council for Graduate Medical Education, or the Royal College of Physicians and Surgeons of Canada? ✓ **Yes** ___ **No**
2. Was applicant ever placed on probation, restricted, or limited? ___ **Yes** ✓ **No** If ***yes***, please attach written explanation.
3. Was there any reason not to continue applicant in the training program? ___ **Yes** ✓ **No** If ***yes***, please attach written explanation.
4. Did the applicant have any medical condition, which in any way impaired or limited his/her ability to safely practice any field of medicine? ___ **Yes** ✓ **No** If ***yes***, please attach written explanation.

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

   The cognitive capacity to make appropriate clinical diagnoses and exercise reasoned medical judgments and to learn and keep abreast of medical developments; and

   The ability to communicate those judgments and medical information to patients and health care providers, with or without the use of aids or devices, such as voice amplifiers; and

   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 addition and alcoholism.

5. Was the applicant ever diagnosed with or treated for bipolar disorder, schizophrenia, paranoia, or any psychotic disorder? ___ **Yes** ✓ **No** If ***yes***, please attach written explanation.
6. Were applicant's final evaluations in every category rated satisfactory? ✓ **Yes** ___ **No** If ***no***, please attach written explanation.

Zachry L. Waterson, DO, FAAFP — Printed name of person completing this form; Signature; 6/10/19 Date

Please affix hospital or notary seal

Alexis Colchin — Signature of Notary (if applicable); 6/10/19 Date

ALEXIS COLCHIN
Notary Public, State of Indiana
Adams County My commission expires: October 29, 2026
Commission Number NP0716574
My Commission Expires
October 29, 2026

If there is no hospital or notary seal, this form is unacceptable.
Please return this form directly to the address above
Thank you for your cooperation.

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

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

Recipient: NEW MEXICO MEDICAL BOARD **Date:** 06/03/2019

Examinee: Case, Alison Anne
Alt Name(s): Case, Alison A
Case, Alison

Examinee ID: 5-302-776-9
Date of Birth: [redacted]1988

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

USMLE STEP 1

Test Date	Pass/Fail	Score	Minimum Pass	Comments
06/12/2013	Pass	210	(188)	

USMLE STEP 2

Clinical Knowledge (CK)

Test Date	Pass/Fail	Score	Minimum Pass	Comments
08/28/2014	Pass	217	(209)	

Clinical Skills (CS)

Test Date	Pass/Fail	Comments
07/02/2014	Pass	

USMLE STEP 3

Test Date	Pass/Fail	Score	Minimum Pass	Comments
03/01/2017	Pass	202	(196)	

End of Exam History

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