EXPEDITED LICENSURE QUESTIONNAIRE

To determine if you are eligible for expedited licensure pursuant to K.S.A. 48-3406[i], please answer the following questions. If it is determined that your responses were intentionally false or misleading, you will be subject to an administrative disciplinary action in Kansas and will be reported to all appropriate state/federal/military/law enforcement agencies.

1. Are you a current member of any branch of the United States armed services, United States military reserves, national guard of any state, or a former member with an honorable discharge? Yes ☐ No ☑ If yes:

   Branch:_____ Dates of Service:_____ Military ID#:_____

2. Are you the spouse of a current member of any branch of the United States armed services, United States military reserves, national guard of any state, or a former member with an honorable discharge? Yes☐ No☑ If yes:

   Branch:_____ Dates of Service:_____ Military ID#:_____

3. Do you currently reside in Kansas? Yes☐ No☑ If yes:

   Current Kansas Residence Address:_____

4. If you do not currently reside in Kansas, do you intend* to establish residency in Kansas within the next 6 months? ***If you answer "yes" to this question but do not establish Kansas residency within the next 6 months, your Kansas license will be cancelled. If it is determined that your answer to this question was intentionally false or misleading, you will be subject to an administrative disciplinary action in Kansas and will be reported to all appropriate state/federal/military agencies in other jurisdictions.*** Yes ☐ No ☒ If yes:

   Intended Kansas Residence Address:_____

   Expected Date of Commencing Residence:_____

If you answered "no" to all questions #1 through #4, you do not need to answer questions #5 through #7.

5. Are you currently licensed, registered, or certified to practice (the profession for which you are seeking licensure in Kansas) by another state, district, or territory of the United States and have worked under that license for at least 1 year. ***This does not include certifications or registrations issued by private boards, professional societies, or any organization other than a government body of a state, district, or territory of the U.S.*** Yes☐ No☐ If no:

   a. Have you practiced the profession for which you are seeking licensure in Kansas for at least 3 years in a state that does not license/register/certify the profession? Yes ☐ No☐

   b. Have you practiced the profession for which you are seeking licensure in Kansas for at least 2 years in a state that does not license/register/certify the profession and you held a certification or registration issued by a private organization during those 2 years? Yes☐ No☐ If yes:

      Organization that issued private certification/registration: _____ Date Issued:

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KSBHA

Kansas State Board of Healing Arts
800 SW Jackson – Lower Level, Suite A., Topeka, KS 66612
Phone: (785) 296-7413; Fax: (785) 296-0852; Email: KSBHA_Licensing@ks.gov
www.ksbha.org

Kansas

*** "Active practice" does not include care provided while in a training program, residency, or fellowship; or employment that consisted solely of research activities or administrative duties. The Board generally considers active practice to be direct patient care that for either (1) at least one full day per week for 50 weeks during a year; or (2) 400 hours during a year.**

6. Have you actively practiced* the profession for which you are seeking licensure in Kansas during the last 2 years? Yes☐ No☐

If you answered "yes" to question #6, you do not need to answer question #7.

7. If you answered "No" to questions #6, please provide a detailed explanation regarding your active clinical practice and direct patient care during the 12 months immediately preceding the submission of your application. Please explain any gaps in active practice in the 12 months immediately preceding the submission for your application, including the amount of time and reason.

[i] An applicant who has not been in the active practice of their occupation during the two years preceding the application for which a license is sought, may be required to complete additional testing, training, monitoring or continuing education as the KSBHA deems necessary to establish present ability to practice in a manner that protects the health and safety of the public K.S.A. 48-3406(d).

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UA UNIFORM APPLICATION FOR PHYSICIAN STATE LICENSURE

Uniform Application – Core Application

Applicant: Follow the instructions given in the left sidebar of each page.
Send this application to the Kansas State Board of Healing Arts,
800 SW Jackson, Lower Level - Suite A, Topeka, KS 66612

Indicate your full legal name and any other names you have used in the past. 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 to the Board.

Full Name

Last name: Barker Suffix: _____

First name: Emily

Middle name: Sara

Maiden name (if applicable): _____

All other names used/identified as: _____

_____ Degree Type ☒ M.D. ☐ D.O.

Please complete all fields and indicate which address you want to use for public access and at which address you want to receive mailings from the Board. State laws vary on which address or phone number is or is not a matter of public record. Additionally, many state boards publish the Public Access address on their web sites. You may wish to contact the appropriate state licensing authority to determine which information will be a matter of public record.

Practice Address

☒ Public Access
☒ Mailings for Medical Board

Street: 5107 E. Kellogg Dr.

_____

City: Wichita

State/Province: KS

Zip code: 67218 Country: United States

Practice phone: 316-260-6934 Practice fax: 316-425-3451

Alternate phone: _____ Alternate fax: _____

Practice email: admin@southwindwomenscenter.org

Home Address

☐ Public Access
☐ Mailings for Medical Board

CONFIDENTIAL

If you are not using FCVS, you must submit one of the following to the Board: certified birth certificate, notarized copy of your birth certificate, original valid passport, or notarized copy of your current valid passport. Please check the state specific instructions for more information.

Identification

CONFIDENTIAL

Date of birth: ___ (mm/dd/yyyy) Gender: F Birth city: Portland

Birth state/province: Maine Birth country: United States

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Social Security number*: _____ (9 digits) NPI number**: 1194255075 (10 digits) U.S. Citizen? ☑ Yes ☐ No

Be sure to list your name at the top of each following page.

*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.

**The National Provider Identifier (NPI) is a Health Insurance Portability and Accountability Act (HIPAA) Administrative Simplification Standard. For more information on the NPI, visit http://www.cms.hhs.gov/NationalProvIdentStand/

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Applicant Name: Emily S. Barker

List all medical schools you have attended, even those from which you did not graduate, in chronological order. Please copy and attach additional pages if necessary.

If you are not using FCVS, you must complete the Medical Education Verification form and send it to all medical schools you have attended. Include a copy of your diploma to which the medical school must attach their seal prior to forwarding it to the Board.

Additionally, the medical school must provide the Board with an official copy of your transcripts. If transcripts are not in English, an original, certified, and official English translation is required.

If you attended a Fifth Pathway program and are not using FCVS, you must complete the 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 the Board.

If ECFMG is applicable and you are not using FCVS, contact ECFMG and have a certified status report forwarded from them to the Board. There is a separate fee for this report.

Medical School

1. Full Name of Medical School: University of Wisconsin Medical School

Street: 750 Higland Ave

City: Madison State/Province: WI Zip code: 53726

Country: United States Attendance dates: From 08/2013 (mm/yyyy) to 05/2017 (mm/yyyy)

Date degree conferred/issued (indicate if not applicable): 05/15/2017 (mm/dd/yyyy)

Degree received (as stated on diploma): Doctor of Medicine (indicate if not applicable)

2. Full Name of Medical School: _____

Street: _____

City: _____ State/Province: _____ Zip code: _____

Country: _____ Attendance dates: From _____ (mm/yyyy) to _____ (mm/yyyy)

Date degree conferred/issued (indicate if not applicable): _____ (mm/dd/yyyy)

Degree received (as stated on diploma): _____ (indicate if not applicable)

Fifth Pathway

☑ I did not participate in a Fifth Pathway program.

Affiliated medical school that awarded the Fifth Pathway Certification

Full Name of Medical School: _____

Street: _____

City: _____ State/Province: _____ Zip code: _____

Country: _____ Attendance dates: From _____ (mm/yyyy) to _____ (mm/yyyy)

Date degree conferred/issued: _____ (mm/dd/yyyy) Degree (as stated on diploma): _____

Hospital or clinic in which you performed the required rotations

Institution name: _____

Rotation dates: From _____ (mm/yyyy) to _____ (mm/yyyy) Certificate date: _____ (mm/dd/yyyy)

ECFMG

☒ I do not have an ECFMG certificate.

Certificate number: _____ Issue date: _____ (mm/dd/yyyy)

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Applicant Name: Emily S. Barker

List all postgraduate programs you have attended, even those you did not complete. Please copy and attach additional pages if necessary.

If you are not using FCVS, you must complete the 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 the Board. The postgraduate program must forward all documentation directly to the Board.

Postgraduate Training

1. Full Name of Hospital: Rush University Medical Center
Street: 600 S. Paulina St.
City: Chicago State/Province: IL Zip code: 60612
Country: United States Department/Specialty: Obstetrics and Gynecology
Affiliated medical school name: Rush University Medical Center
Attendance dates: From 07/2017 (mm/yyyy) to 06/2021 (mm/yyyy) Postgraduate year (e.g., 1, 2, 3, etc.): 4

☐ Chief Resident	☐ Internship/Residency	☒ Residency	☐ Transitional
☐ Fellowship	☐ Junior Registrar	☐ Residency/Chief Residency	
☐ Fellowship/Research	☐ Preliminary	☐ Senior House Officer	☐ Unknown
☐ House Officer	☐ Registrar	☐ Senior Registrar	☐ Unspecified
☐ Internship	☐ Research	☐ Other:	

Successfully completed? ☑ Yes ☐ No ☐ In progress; expected completion in _____ (mm/yyyy)

2. Full Name of Hospital: Washington University in St. Louis
Street: Post Address: MSC 8064-37-1005, 660 S. Euclid Ave.
City: St. Louis State/Province: MO Zip code: 63110
Country: United States Department/Specialty: Complex Family Planning
Affiliated medical school name: Washington University School of Medicine
Attendance dates: From 07/2021 (mm/yyyy) to _____ (mm/yyyy) Postgraduate year (e.g., 1, 2, 3, etc.): _____

☐ Chief Resident	☐ Internship/Residency	☐ Residency	☐ Transitional
☒ Fellowship	☐ Junior Registrar	☐ Residency/Chief Residency	
☐ Fellowship/Research	☐ Preliminary	☐ Senior House Officer	☐ Unknown
☐ House Officer	☐ Registrar	☐ Senior Registrar	☐ Unspecified
☐ Internship	☐ Research	☐ Other:	

Successfully completed? ☐ Yes ☑ No ☐ In progress; expected completion in 06/2023 (mm/yyyy)

3. Full Name of Hospital: _____
Street: _____
City: _____ State/Province: _____ Zip code: _____
Country: _____ Department/Specialty: _____
Affiliated medical school name: _____
Attendance dates: From _____ (mm/yyyy) to _____ (mm/yyyy) Postgraduate year (e.g., 1, 2, 3, etc.): _____

☐ Chief Resident	☐ Internship/Residency	☐ Residency	☐ Transitional
☐ Fellowship	☐ Junior Registrar	☐ Residency/Chief Residency	
☐ Fellowship/Research	☐ Preliminary	☐ Senior House Officer	☐ Unknown
☐ House Officer	☐ Registrar	☐ Senior Registrar	☐ Unspecified
☐ Internship	☐ Research	☐ Other:	

Successfully completed? ☐ Yes ☐ No ☐ In progress; expected completion in APR 2 1 2023 (mm/yyyy)

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Applicant Name: Emily S. Barker

List the information for each licensure exam you have taken, whether U.S. or international (USMLE, LLMCC, NBME, etc.).

If you are not using FCVS, you must contact the appropriate examination entity and have them send a certified transcript of your scores directly to the Board.

Examination History

Examination	Most recent date taken (mm/yyyy)	Passed/Failed/Unknown	Number of attempts
FLEX Pre-1985		☐ (P) ☐ (F) ☐ (U)	
FLEX Component 1		☐ (P) ☐ (F) ☐ (U)	
FLEX Component 2		☐ (P) ☐ (F) ☐ (U)	
LMCC – Single		☐ (P) ☐ (F) ☐ (U)	
LMCC – Part I		☐ (P) ☐ (F) ☐ (U)	
LMCC – Part II		☐ (P) ☐ (F) ☐ (U)	
NBME Part I		☐ (P) ☐ (F) ☐ (U)	
NBME Part II		☐ (P) ☐ (F) ☐ (U)	
NBME Part III		☐ (P) ☐ (F) ☐ (U)	
SPEX		☐ (P) ☐ (F) ☐ (U)	
NBOME Part I		☐ (P) ☐ (F) ☐ (U)	
NBOME Part II		☐ (P) ☐ (F) ☐ (U)	
NBOME Part III		☐ (P) ☐ (F) ☐ (U)	
COMLEX-USA Level 1		☐ (P) ☐ (F) ☐ (U)	
COMLEX-USA Level 2, CE		☐ (P) ☐ (F) ☐ (U)	
COMLEX-USA Level 2, PE		☐ (P) ☐ (F) ☐ (U)	
COMLEX-USA Level 3		☐ (P) ☐ (F) ☐ (U)	
COMVEX		☐ (P) ☐ (F) ☐ (U)	
USMLE Step I	06/2015	☑ (P) ☐ (F) ☐ (U)	1
USMLE Step II, CS	06/2016	☑ (P) ☐ (F) ☐ (U)	1
USMLE Step II, CK	07/2016	☑ (P) ☐ (F) ☐ (U)	1
USMLE Step III	11/2017	☑ (P) ☐ (F) ☐ (U)	1
State Board Exam			
State:		☐ (P) ☐ (F) ☐ (U)	
State:		☐ (P) ☐ (F) ☐ (U)	
State:		☐ (P) ☐ (F) ☐ (U)	
State:		☐ (P) ☐ (F) ☐ (U)	

List all state and Canadian provinces where you currently hold or have ever held any type of health care related license. Please copy and attach additional pages if necessary.

You must also complete the Licensure Verification form and send it to all states in which you have held any health care license or certification. Some state boards charge a fee for this information. The verifying entity must forward all licensure documentation to the Board.

State/Province Professional Licensure ☐

1. Practitioner license type: ☑ Full license ☐ Temporary ☐ Training ☐ Limited

- ■ Doctor of Medicine
- ☐ Doctor of Osteopathic Medicine
- ☐ Doctor of Dental Surgery
- ☐ Doctor of Dental Medicine
- ☐ Doctor of Psychology
- ☐ Doctor of Podiatric Medicine
- ☐ Doctor of Chiropractic
- ☐ Nurse Practitioner
- ☐ Licensed Practical Nurse
- ☐ Registered Nurse
- ☐ Physician Assistant
- ☐ Emergency Medical Technician
- ☐ Other (please specify) _____

State/Province: Illinois License number: 036152693 Issue date: 04/23/2020

License status: ■ Active ☐ Inactive ☐ Restricted ☐ Expired ☐ Limited ☐ Retired ☐ In Good Standing ☐ Probationary ☐ Revoked ☐ Suspended

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Applicant Name: _____

Please copy and attach additional pages if necessary.

2. Practitioner license type: ☑ Full license ☐ Temporary ☐ Training ☐ Limited

- ■ Doctor of Medicine
- ☐ Doctor of Osteopathic Medicine
- ☐ Doctor of Dental Surgery
- ☐ Doctor of Dental Medicine
- ☐ Doctor of Psychology
- ☐ Doctor of Podiatric Medicine
- ☐ Doctor of Chiropractic
- ☐ Nurse Practitioner
- ☐ Licensed Practical Nurse
- ☐ Registered Nurse
- ☐ Physician Assistant
- ☐ Emergency Medical Technician
- ☐ Other (please specify) _____

State/Province: Missouri License number: 2021010438 Issue date: 03/22/2021

License status: ■ Active ☐ Inactive ☐ Restricted ☐ Expired ☐ Limited ☐ Retired ☐ In Good Standing ☐ Probationary ☐ Revoked ☐ Suspended

3. Practitioner license type: ☐ Full license ☐ Temporary ☑ Training ☐ Limited

- ■ Doctor of Medicine
- ☐ Doctor of Osteopathic Medicine
- ☐ Doctor of Dental Surgery
- ☐ Doctor of Dental Medicine
- ☐ Doctor of Psychology
- ☐ Doctor of Podiatric Medicine
- ☐ Doctor of Chiropractic
- ☐ Nurse Practitioner
- ☐ Licensed Practical Nurse
- ☐ Registered Nurse
- ☐ Physician Assistant
- ☐ Emergency Medical Technician
- ☐ Other (please specify) _____

State/Province: Illinois License number: 125069995 Issue date: 05/01/2017

License status: ~~■ Active~~ ■ ~~Inactive~~ ☐ Restricted ☐ Expired ☐ Limited ☐ Retired ☐ In Good Standing ☐ Probationary ☐ Revoked ☐ Suspended

Inactive

4. Practitioner license type: ☐ Full license ☐ Temporary ☐ Training ☐ Limited

- ☐ Doctor of Medicine
- ☐ Doctor of Osteopathic Medicine
- ☐ Doctor of Dental Surgery
- ☐ Doctor of Dental Medicine
- ☐ Doctor of Psychology
- ☐ Doctor of Podiatric Medicine
- ☐ Doctor of Chiropractic
- ☐ Nurse Practitioner
- ☐ Licensed Practical Nurse
- ☐ Registered Nurse
- ☐ Physician Assistant
- ☐ Emergency Medical Technician
- ☐ Other (please specify) _____

State/Province: _____ License number: _____ Issue date: _____

License status: ☐ Active ☐ Inactive ☐ Restricted ☐ Expired ☐ Limited ☐ Retired ☐ In Good Standing ☐ Probationary ☐ Revoked ☐ Suspended

5. Practitioner license type: ☐ Full license ☐ Temporary ☐ Training ☐ Limited

- ☐ Doctor of Medicine
- ☐ Doctor of Osteopathic Medicine
- ☐ Doctor of Dental Surgery
- ☐ Doctor of Dental Medicine
- ☐ Doctor of Psychology
- ☐ Doctor of Podiatric Medicine
- ☐ Doctor of Chiropractic
- ☐ Nurse Practitioner
- ☐ Licensed Practical Nurse
- ☐ Registered Nurse
- ☐ Physician Assistant
- ☐ Emergency Medical Technician
- ☐ Other (please specify) _____

State/Province: _____ License number: _____ Issue date: _____

License status: ☐ Active ☐ Inactive ☐ Restricted ☐ Expired ☐ Limited ☐ Retired ☐ In Good Standing ☐ Probationary ☐ Revoked ☐ Suspended

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Applicant Name: Emily S. Barker

List ALL activities (medical, non-medical, and postgraduate training) in chronological order beginning with medical school graduation to the PRESENT date, indicating month and year.

*Also list your permanent or home address for each non-working time.

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 SUBSTITUTE ANY OTHER RESUME FOR THIS SECTION.

Copy and attach additional pages as necessary.

** Clinical indicates the percentage of time spent with patients.

*** Administrative indicates the percentage of time spent on administrative tasks like paperwork, etc.

Chronology of Activities

1. Start date: 07/2021 (mm/yyyy) End date: Present (mm/yyyy)

Type of Activity: ☐ Health activity (non-working time due to health reasons) ☐ Military service ■ Postgraduate training/education ☐ Seeking employment ☐ Vacation ☐ Work

Practice/Employment Name or Description of non-working time*: Univeristy of Washington in St. Louis

Street: Post Address: MSC 8064-37-1005, 660 S. Euclid Ave.

City: St. Louis State/Province: MO Zip code: 63110

Country: United States Position: Fellow

Department: Complex Family Planning Clinical**: 80 % Administrative***: 20 %

■ Employment ☐ Staff Privileges ☐ Affiliation

☐ Other (describe your relationship with this institution): _____

2. Start date: 07/2017 (mm/yyyy) End date: 06/2021 (mm/yyyy)

Type of Activity: ☐ Health activity (non-working time due to health reasons) ☐ Military service ■ Postgraduate training/education ☐ Seeking employment ☐ Vacation ☐ Work

Practice/Employment Name or Description of non-working time*: Rush University Medical Center

Street: 600 S. Paulina St.

City: Chicago State/Province: IL Zip code: 60612

Country: United States Position: Resident

Department: Obstetrics and Gynecology Clinical**: 80 % Administrative***: 20 %

■ Employment ☐ Staff Privileges ☐ Affiliation

☐ Other (describe your relationship with this institution): _____

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3. Start date: 08/2013 (mm/yyyy) End date: 05/2017 (mm/yyyy)

Type of Activity: ☐ Health activity (non-working time due to health reasons) ☐ Military service ■ Postgraduate training/education ☐ Seeking employment ☐ Vacation ☐ Work

Practice/Employment Name or Description of non-working time*: University of Wisonsin-Madison

Street: 750 Highland Ave.

City: Madison State/Province: WI Zip code: 53726

Country: United States Position: Medical Student

Department: School of Medicine Clinical**: 0 % Administrative***: 0 %

☐ Employment ☐ Staff Privileges ☐ Affiliation

☒ Other (describe your relationship with this institution): Medical Student

Chronology of Activity Type

Practice/Emp/ Desc: University of Wisconsin Medical School
Chronology Type: Medical Education
Address: Madison, WI US
Attendance Dates:
Position/Dept:
From: 08/15/2013 to 05/15/2017
Clinical %:
Admin %:
Employment: **Staff Privileges:** **Affiliation:**

Practice/Emp/ Desc: Moved States to be able to continue my education.
Chronology Type: Vacation
Address: chicago, IL 60612 US
Attendance Dates:
Position/Dept:
From: 06/01/2017 to 07/01/2017
Clinical %: 0
Admin %: 0
Employment: **Staff Privileges:** **Affiliation:**

Practice/Emp/ Desc: Rush University Medical Center Program
Chronology Type: Accredited Training
Address: Chicago, IL US
Attendance Dates:
Position/Dept:
From: 07/01/2017 to 06/30/2021
Clinical %: 80
Admin %: 20
Employment: **Staff Privileges:** **Affiliation:**

Practice/Emp/ Desc: Washington University/B-JH/SLCH Consortium Program
Chronology Type: Accredited Training
Address: St. Louis, MO US
Attendance Dates:
Position/Dept:
From: 07/01/2021 to 06/30/2023
Clinical %: 80
Admin %: 20
Employment: **Staff Privileges:** **Affiliation:**

Practice/Emp/ Desc: University of Washington in. St. Louis
Chronology Type: PGT/Education
Address: Post Address: MSC 8064-37-1005, 660 S. Euclid Ave. St. Louis, MO 63110 US
Attendance Dates:
Position/Dept: Fellow - Complex Family Planning
From: 07/01/2021 to In Progress
Clinical %: 80
Admin %: 20
Employment: • **Staff Privileges:** • **Affiliation:**

Applicant Name: _____

Copy and attach additional pages as necessary.

4. Start date: _____ (mm/yyyy) End date: _____ (mm/yyyy)

Type of Activity: ☐ Health activity (non-working time due to health reasons) ☐ Military service ☐ Postgraduate training/education ☐ Seeking employment ☐ Vacation ☐ Work

Practice/Employment Name **or** Description of non-working time*: _____

Street: _____

City: _____ State/Province: _____ Zip code: _____

Country: _____ Position: _____

Department: _____ Clinical**: ____% Administrative***: ____%

☐ Employment ☐ Staff Privileges ☐ Affiliation

☐ Other (describe your relationship with this institution): _____

5. Start date: _____ (mm/yyyy) End date: _____ (mm/yyyy)

Type of Activity: ☐ Health activity (non-working time due to health reasons) ☐ Military service ☐ Postgraduate training/education ☐ Seeking employment ☐ Vacation ☐ Work

Practice/Employment Name **or** Description of non-working time*: _____

Street: _____

City: _____ State/Province: _____ Zip code: _____

Country: _____ Position: _____

Department: _____ Clinical**: ____% Administrative***: ____%

☐ Employment ☐ Staff Privileges ☐ Affiliation

☐ Other (describe your relationship with this institution): _____

6. Start date: _____ (mm/yyyy) End date: _____ (mm/yyyy)

Type of Activity: ☐ Health activity (non-working time due to health reasons) ☐ Military service ☐ Postgraduate training/education ☐ Seeking employment ☐ Vacation ☐ Work

Practice/Employment Name **or** Description of non-working time*: _____

Street: _____

City: _____ State/Province: _____ Zip code: _____

Country: _____ Position: _____

Department: _____ Clinical**: ____% Administrative***: ____%

☐ Employment ☐ Staff Privileges ☐ Affiliation

☐ Other (describe your relationship with this institution): _____

Please copy and attach additional pages as necessary.

Applicant Name: Emily S. Barker

You must complete this section to report 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 private compromise or settled before initiation of civil action, state on this line.

All fields are required to be answered. Please have your information available before starting this section.

Please copy and attach additional pages if necessary.

Malpractice Liability Claims Information

☑ I have not had any malpractice claims or suits made against me.

1. Name of patient involved: _____

In which state, territory, or province did the action take place? _____

Which court*? _____

Case number (if applicable) _____ Month and year of lawsuit: _____

Month and year of event precipitating claim: _____

Current claim status: ☐ Closed (settled) ☐ Dismissed (no money paid out) ☐ Open (pending) ☐ Other: _____

Amount of judgment or settlement: $_____ Amount paid on your behalf: $_____

What is/was your status? ☐ Primary Defendant ☐ Co-Defendant ☐ Other (specify): _____

Insurance carrier at the time: _____

Please provide specifics in reference to the adverse event, including the allegations and your role in the event, in the space below. Use another sheet of paper or the back of this form if necessary.

Complete the forms on the following pages as instructed.

☐ UA Affidavit and Authorization for Release of Information
☐ UA Form #1: Licensure Verification Form
☐ All state-specific forms included with this core application

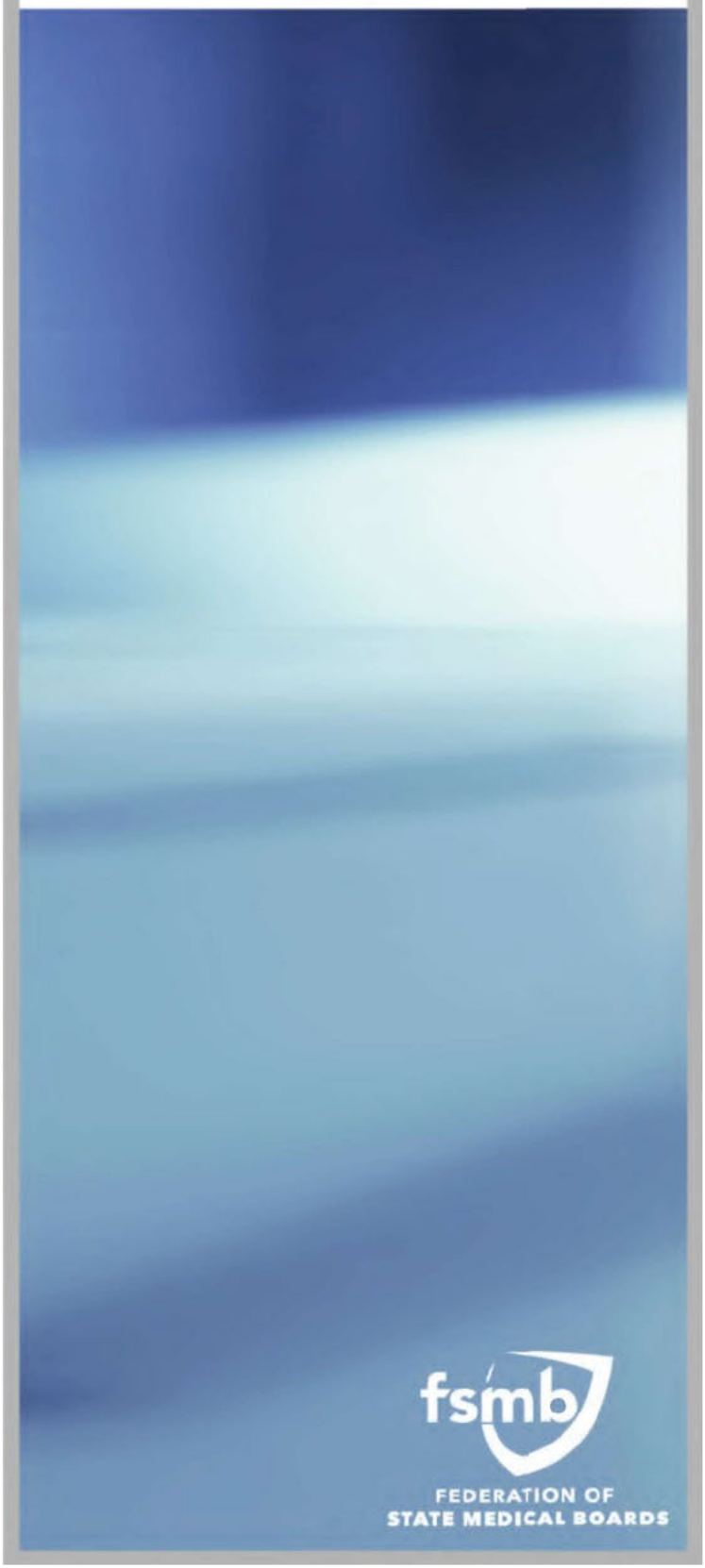
If you are using FCVS for credentials verification, you do not have to complete forms 2, 3, and 4.

☐ UA Form #2: Medical School Verification
☐ UA Form #3: Postgraduate Training Verification
☐ UA Form #4: Fifth Pathway Verification (if applicable)

Review & Submit

Please review all of your entries prior to submission. Be sure to include all forms, fees, and state addenda. You are strongly advised to keep a copy for your records.

FCVS | FEDERATION CREDENTIALS VERIFICATION SERVICE



Medical Professional Information Profile

This report provides credentialing information for:

Name:	**Barker, Emily**
Social Security Number:	CONFIDENTIAL
Date of Birth:	
FID#:	**300943735**
Recipient:	**KS - Kansas State Board of Healing Arts**
Delivery Date:	**04/18/2023**

ABOUT THIS PROFILE

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

NOTICE: All documents bearing an original Official FCVS seal are certified to be an exact 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.

FCVS FEDERATION CREDENTIALS VERIFICATION SERVICE

Affidavit and Release

fsmb

I, the undersigned, hereby certify under oath that I am the person named in this application, that all statements I have or shall make with respect thereto are true, that I am the original and lawful possessor and person named in the various forms and credentials furnished or to be furnished with respect to my application and that all documents, forms or copies thereof furnished or to be furnished with respect to my application are strictly true in every aspect.

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

I authorize and request every person, hospital, clinic, government agency (local, state, federal or foreign), court, association, institution or law enforcement agency having custody or control of any documents, records and other information pertaining to me to furnish to the Federation Credentials Verification Service any such information, including documents, records regarding charges or complaints filed against me, formal or informal, pending or closed, or any other pertinent data and to permit the Federation Credentials Verification Service or any of its agents or representatives to inspect and make copies of such documents, records, and other information in connection with this application.

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

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

Emon Christian Moore
REGISTRATION NUMBER
8033469
COMMISSION EXPIRES
September 30, 2026

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

Barker
Applicant's **Printed** Last Name

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

03/26/2023
Date of Signature (**must** correspond to date of notarization)

State of Virginia, County of Prince William,
I certify that on the date set forth below the individual named above did appear personally before me and that I did identify this applicant by: (a) comparing his/her physical appearance with the photograph on the identifying document presented by the applicant and with the photograph affixed hereto, and (b) comparing the applicant's signature made in my presence on this form with the signature on his/her identifying document.
The statements on this document are subscribed and sworn to before me by the applicant on this 26th day of March, 2023.

Notary Public Signature:

My Notary Commission Expires: 09/30/2026

Notarized online using audio-video communication

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FID Number
300943735

FCVS FEDERATION CREDENTIALS VERIFICATION SERVICE

Identity

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Biographic Information

Medical professional Name(s): **Barker, Emily**

Barker, Emily Sara

Date of Birth: CONFIDENTIAL

Place of Birth: Portland, Maine, UNITED STATES

Contact Information

Home Address: CONFIDENTIAL

Mobile Phone:

Email:

Credentials Analysis Information for Identity

There is no Omission/Discrepancy/Miscellaneous information identified.

CERTIFICATION OF IDENTIFICATION

Certification by Notary Public Is Required

Applicant Full Legal Name: ~~Barker~~ BARKER ~~Emily~~ EMILY Sara SARA

Last First Middle

Applicant:

1. **COMPLETE** this document in the presence of a Notary.
2. **SELECT** the identity document used:
   - ☐ Birth Certificate
   - ☑ Passport
3. **ATTACH** a photocopy of the identity document presented to the Notary.

Notary Public: Please complete the section below.

Notary Exception – A notary public or other officer completing this certificate verifies only the identity of the individual who signed the document to which this certificate is attached, and not the truthfulness, accuracy, or validity of that document.

State of Virginia County of Prince William

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

26th March 2023

Notary Public Signature: _____

Commission Expiration Date* (Month) 09 / (Day) 30 / (Year) 2026

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

Notary Stamp Here

COMMONWEALTH OF VIRGINIA · ELECTRONIC NOTARY PUBLIC ·

Emon Christian Moore

REGISTRATION NUMBER
8033469
COMMISSION EXPIRES
September 30, 2026

Notarized online using audio-video communication

FID Number

300943735

FCVS FEDERATION CREDENTIALS VERIFICATION SERVICE

Chronology of Activities

fsmb

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

Start Date	End Date	Activity Type	Location
08/15/2013	05/15/2017	Medical Education	University of Wisconsin Medical School Madison Wisconsin UNITED STATES
07/01/2017	06/30/2021	Postgraduate Training	Rush University Medical Center Program Chicago Illinois UNITED STATES
07/01/2021		PGT/Education	University of Washington in. St. Louis St. Louis Missouri UNITED STATES
07/01/2021	06/30/2023	Postgraduate Training	Washington University/B-JH/SLCH Consortium Program St. Louis Missouri UNITED STATES

Enc of Chronology of Activities report for: Barker, Emily

FCVS FEDERATION CREDENTIALS VERIFICATION SERVICE

Medical Education

fsmb

Medical Education

Medical School: **University of Wisconsin Medical School**

Location: Madison, WI

UNITED STATES

Credentials Analysis Information for Medical Education

There is no Omission/Discrepancy/Miscellaneous information identified.

FCVS FEDERATION CREDENTIALS VERIFICATION SERVICE

fsmb

Institution Name: University of Wisconsin Medical School

City: Madison **State/Province:** Wisconsin **Country:** UNITED STATES

Premedical Education:

Years of education required for admission to your medical school: 0

Credential/degree presented by the applicant for admission to your medical school: Baccalaureate

Enrollment and Participation:

Our records indicate that Barker, Emily

attended our medical school for a total of 156 weeks of medical education on the following dates: From MM/DD/YYYY: 08/19/2013 To MM/DD/YYYY: 05/13/2017

This individual was awarded the degree of Doctor of Medicine on 05/13/2017

DS

Unusual circumstances

1. Do this individual's official records reflect (an) interruption(s) in his/her medical education? **YES** **NO** X **N/A**

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 MM/DD/YYYY:	To MM/DD/YYYY:
Personal/Family	Applicable	N/A	/ /	/ /
Academic remediation	Applicable	N/A	/ /	/ /
Health	Applicable	N/A	/ /	/ /
Financial	Applicable	N/A	/ /	/ /
Participation in joint degree program (e.g., MD/PhD)	Applicable	N/A	/ /	/ /
Other	Applicable	N/A	/ /	/ /

Other Explanation:

Medical School Code: 050020

FID: 300943735

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

If YES, please select the reason(s) for the probation and indicate the date(s) of placement on and removal from probation.

			From MM/DD/YYYY:	To MM/DD/YYYY:
Academic Probation	Applicable	N/A	/ /	/ /
Probation for unprofessional conduct/behavior	Applicable	N/A	/ /	/ /
Probation for other reason	Applicable	N/A	/ /	/ /

Other Reason Explanation:

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? **YES** **NO** X **N/A**

If YES, please provide detailed 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? **YES** **NO** X **N/A**

If YES, please provide detailed 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? **YES** **NO** X **N/A**

If YES, please provide detailed information about the nature of the limitations or special requirements:

6. Attach Diploma

7. Would you like to upload an additional attachment? **YES** **NO** X

Attestation of Person completing Verification of Medical Education document: I hereby attest that the information contained herein accurately reflects the training records of the above-named physician.

ELECTRONIC SEAL VERIFIED

Name: Jack K. Fischer

Title: Certification Officer

Signature: DocuSigned by: Jack Fischer 30E095C1D1ED4AE...

Date of Signature: 3/29/2023

Email: studentservices@med.wisc.edu

Medical School Code: 050020

FID: 300943735

FCVS FEDERATION CREDENTIALS VERIFICATION SERVICE

Applicant Reported Unusual Circumstances

fsmb

Medical School

Medical Professional Name: Barker, Emily

University of Wisconsin Medical School

Unusual Circumstances

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

Enc of Applicant Reported Unusual Circumstances report for: Barker, Emily

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CONFIDENTIAL

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WISCONSIN
UNIVERSITY OF WISCONSIN-MADISON

University Of Wisconsin–Madison
Office of the Registrar
333 East Campus Mall Suite #11101, Madison WI 53715
Telephone: (608) 262-3811
Fax: (608) 265-8946
Email: registrar@em.wisc.edu
Website: registrar.wisc.edu

The University of Wisconsin–Madison transcript legend is available in the following link: go.wisc.edu/transcr ptkey.

Accreditation:

The University of Wisconsin–Madison is accredited by the Higher Learning Commission of the North Central Association of Colleges and Schools. In addition, various schools within UW-Madison hold accreditation from their professional accrediting associations.

Academic Calendar:

The academic calendar is based on the semester system, consisting of approximately 15 weeks of instruction (Fall and Spring Terms). Summer sessions vary in length. For more information, see: secfac.wisc.edu/academic-calendar.

To Confirm Authenticity:

Official transcripts bear the signature and seal of the Registrar.

Printed transcripts- The face of the document has a colored background. A black and white or color copy of this document is not an original and should not be accepted as an official institutional document. Additional tests are Isted in the text box below.

Electronic transcripts- PDF transcripts viewed electronically are recognized as official documents. A printed copy of a PDF Transcript will be considered unofficial and will display the words PRINTED COPY on all pages.

This document cannot be released to a third party without the written consent of the student. This is in accordance with the Family Educational Rights and Privacy Act of 1974. If you have any questions about this document, please contact our office. ALTERATION OF THIS DOCUMENT MAY BE A CRIMINAL OFFENSE.

PROVIDED BY APPLICANT

17F9-9031-E8R4

UNIVERSITY OF WISCONSIN-MADISON

The Board of Regents of the University of Wisconsin System,
on the nomination of the faculty, has conferred upon

EMILY SARA BARKER

The Degree of

DOCTOR OF MEDICINE

Together with all honors, rights, and privileges belonging to that degree.
In witness whereof, this diploma is granted.

Given at Madison, in the State of Wisconsin,
this thirteenth day of May, in the year two thousand and seventeen
and of the University the one hundred sixty-seventh.

President, University of Wisconsin System

Chancellor, University of Wisconsin–Madison

President of the Board of Regents

Postgraduate Training

Accreditation ID: **2201621090**

Institution: **Rush University Medical Center Program**

Location: Chicago, IL
UNITED STATES

Accreditation ID: **2362822001**

Institution: **Washington University/B-JH/SLCH Consortium Program**

Location: St. Louis, MO
UNITED STATES

Credentials Analysis Information for Postgraduate Training

There is no Omission/Discrepancy/Miscellaneous information identified.

FCVS FEDERATION CREDENTIALS VERIFICATION SERVICE

fsmb

Verification of Postgraduate Medical Education

Accreditation Code: 2201621090

Institution Name: Rush University Medical Center Program

Affiliated University: Rush University Medical Center

City: Chicago **State:** Illinois **Country:** United States

Verification For: Emily Barker **Date of Birth:** CONFIDENTIAL

Program Participation:

PGY: 1	Accredited By: ACGME	Status: Complete
Specialty: Obstetrics & Gynecology		
From: 07/01/2017	To: 06/30/2018	Program Type: Residency

PGY: 2	Accredited By: ACGME	Status: Complete
Specialty: Obstetrics & Gynecology		
From: 07/01/2018	To: 06/30/2019	Program Type: Residency

PGY: 3	Accredited By: ACGME	Status: Complete
Specialty: Obstetrics & Gynecology		
From: 07/01/2019	To: 06/30/2020	Program Type: Residency

PGY: 4	Accredited By: ACGME	Status: Complete
Specialty: Obstetrics & Gynecology		
From: 07/01/2020	To: 06/30/2021	Program Type: Residency

PGY:	Accredited By:	Status:
Specialty:		
From:	To:	Program Type:

PGY:	Accredited By:	Status:
Specialty:		
From:	To:	Program Type:

FID: 300943735

PGY:	Accredited By:	Status:
Specialty:		
From:	To:	Program Type:

To report additional training, include training as an attachment at the end of page 2.

Unusual Circumstances

1. Did this individual ever take a leave of absence from his/her training?	Yes	No x	Not Available
2. Was this individual ever placed on probation?	Yes	No x	Not Available
3. Was this individual ever disciplined or placed under investigation?	Yes	No x	Not Available
4. Were any negative reports for behavioral reasons ever filed by instructors?	Yes	No x	Not Available
5. Were any limitations or special requirements placed upon this individual because of academic incompetence, disciplinary problems, or any other reason?	Yes	No x	Not Available

Attestation of Person completing Verification of Postgraduate Training document (Program Director): I hereby attest that the information contained herein accurately reflects the training records of the above-named physician.

ELECTRONIC SEAL VERIFIED	Name: Sloane York Title: Program Director Degree: MD Signature: DocuSigned by: Sloane York 7EB55776329F4D9 Date of Signature: 3/29/2023

Would you like to upload an additional attachment(e.g. Rotation Schedule)? Yes No x
If reporting additional years in the attachment, include PGY year, specialty, start date, end date, status and program type.

FID: 300943735

FCVS FEDERATION CREDENTIALS VERIFICATION SERVICE

Applicant Reported Unusual Circumstances

fsmb

Graduate Medical Education

Medical Professional Name:	Barker, Emily
Accreditation ID:	2201621090
Institution:	Rush University Medical Center Program
Specialty:	Obstetrics & Gynecology

Unusual Circumstances

Training Period: 7/1/2017 - 6/30/2021 **Residency**

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

Enc of Applicant Reported Unusual Circumstances report for: Barker, Emily

Rush University Medical Center

Emily Barker, MD

has successfully completed a

Residency

in

Obstetrics & Gynecology

July 1, 2017 To June 30, 2021

COLLEGII MED. RUSH. SIGILLUM
MDCCCXXXVII
CHICAGO

Senior Associate Dean, Graduate Medical Education

Dean Rush Medical College

Chairperson of Department

Program Director

FCVS FEDERATION CREDENTIALS VERIFICATION SERVICE

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Verification of Postgraduate Medical Education

Accreditation Code: 2362822001

Institution Name: Washington University/B-JH/SLCH Consortium Program

Affiliated University: Washington University/B-JH/SLCH Consortium

City: St. Louis **State:** Missouri **Country:** United States

Verification For: Emily Barker **Date of Birth:** CONFIDENTIAL

Program Participation:

PGY: 5	Accredited By: ACGME	Status: Complete
Specialty: Obstetrics & Gynecology/Complex Family Planning		
From: 07/01/2021	To: 06/30/2022	Program Type: Fellowship

PGY: 6	Accredited By: ACGME	Status: In Progress
Specialty: Obstetrics & Gynecology/Complex Family Planning		
From: 07/01/2022	To: 06/30/2023	Program Type: Fellowship

PGY:	Accredited By:	Status:
Specialty:		
From:	To:	Program Type:

PGY:	Accredited By:	Status:
Specialty:		
From:	To:	Program Type:

PGY:	Accredited By:	Status:
Specialty:		
From:	To:	Program Type:

PGY:	Accredited By:	Status:
Specialty:		
From:	To:	Program Type:

FID: 300943735

PGY:	Accredited By:	Status:
Specialty:		
From:	To:	Program Type:

To report additional training, include training as an attachment at the end of page 2.

Unusual Circumstances

1. Did this individual ever take a leave of absence from his/her training?	Yes	No x	Not Available
2. Was this individual ever placed on probation?	Yes	No x	Not Available
3. Was this individual ever disciplined or placed under investigation?	Yes	No x	Not Available
4. Were any negative reports for behavioral reasons ever filed by instructors?	Yes	No x	Not Available
5. Were any limitations or special requirements placed upon this individual because of academic incompetence, disciplinary problems, or any other reason?	Yes	No x	Not Available

Attestation of Person completing Verification of Postgraduate Training document (Program Director): I hereby attest that the information contained herein accurately reflects the training records of the above-named physician.

ELECTRONIC SEAL VERIFIED	Name: David L Eisenberg Title: Program Director Degree: MD Signature: DocuSigned by: David L Eisenberg EC260034FD034AF Date of Signature: 4/17/2023

Would you like to upload an additional attachment(e.g. Rotation Schedule)? Yes No x
If reporting additional years in the attachment, include PGY year, specialty, start date, end date, status and program type.

FID: 300943735

FCVS FEDERATION CREDENTIALS VERIFICATION SERVICE

Applicant Reported Unusual Circumstances

fsmb

Graduate Medical Education

Medical Professional Name:	Barker, Emily
Accreditation ID:	2362822001
Institution:	Washington University/B-JH/SLCH Consortium Program
Specialty:	Obstetrics & Gynecology/Complex Family Planning

Unusual Circumstances

Training Period: 7/1/2021 - 6/30/2023 **Fellowship**

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

Enc of Applicant Reported Unusual Circumstances report for: Barker, Emily

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Licensure / Examinations

Exam: USMLE

Credential Analysis Information for Licensure / Examinations

There is no Omission/Discrepancy/Miscellaneous information identified.

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

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

Date: 04/18/2023

Federation Credentials Verification Service
ATTN: FCVS
FCVSID: 781349

Examinee: Barker, Emily
Alt Name(s): Barker, Emily Sara

Examinee ID: 5-345-514-3
Date of Birth: CONFIDENTIAL

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, two-digit scores will no longer be reported. Test results reported as passing represent an exam score of 75 or higher on a two-digit scale. Step 1 examinations taken on or after January 26, 2022 are reported as pass/fail, with no numeric score; Step 1 examinations taken before January 26, 2022 will continue to be reported with a 3-digit score.

USMLE STEP 1

Test Date	Pass/Fail	Score	Minimum Pass	Comments
06/17/2015	Pass	CONFIDENTIAL		

USMLE STEP 2

Clinical Knowledge (CK)

Test Date	Pass/Fail	Score	Minimum Pass	Comments
07/14/2016	Pass	CONFIDENTIAL		

Clinical Skills (CS)

Test Date	Pass/Fail	Comments
06/14/2016	Pass	

USMLE STEP 3

Test Date	Pass/Fail	Score	Minimum Pass	Comments
11/28/2017	Pass	CONFIDENTIAL		

End of Exam History

NOTE: The USMLE Step 2 CS examination was last administered March 16, 2020. Examinees with a failing outcome may not have had an opportunity to retest. The USMLE defines successful completion of its examination sequence as passing Step 1, Step 2 CK, and Step 3.

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

US·MLE
United States
Medical
Licensing
Examination

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

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

Examinee: Barker, Emily

Examinee ID: 5-345-514-3
Date of Birth: CONFIDENTIAL

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

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

STEP 1 AND STEP 2 CLINICAL SKILLS (CS)
Step 1 examinations taken on or after January 26, 2022 are reported as pass/fail, with no numeric score; Step 1 examinations taken before January 26, 2022 will continue to be reported with a 3-digit score. All Step 2 CS results are reported as pass or fail, with no numeric score. Test results reported as passing represent an exam score of 75 or higher on a two-digit scale.

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

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

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

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

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

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

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

03/2015

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

PDC PHYSICIAN DATA CENTER

fsmb

PRACTITIONER PROFILE

Prepared for: FCVS SMB Profiles As of Date:4/18/2023

PRACTITIONER INFORMATION

Name:	Barker, Emily
Alternate Name(s):	Barker, Emily Sara
DOB:	CONFIDENTIAL
Medical School:	University of Wisconsin Medical School Madison, Wisconsin, UNITED STATES
Year of Grad:	2017
Degree Type:	MD
NPI:	1194255075

BOARD ACTIONS

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

NATIONAL PROVIDER IDENTIFIER (NPI)

NPI	NPI Type	Deactivation Date	Reactivation Date	Last Reported
1194255075	Individual			10/19/2021

LICENSE HISTORY

Jurisdiction	License Number	Issue Date	Expiration Date	Last Updated
ILLINOIS	125069995	05/01/2017	06/30/2020	03/24/2023
	FSMB License Status: Canceled			
ILLINOIS	036152693	04/23/2020	07/31/2023	03/24/2023
	FSMB License Status: Active			
MISSOURI	2021010438	03/22/2021	01/31/2024	04/06/2023
	FSMB License Status: Active			

PDC PHYSICIAN DATA CENTER

fsmb

PRACTITIONER PROFILE

Prepared for:	FCVS SMB Profiles	As of Date:4/18/2023
Practitioner Name:	Barker, Emily	

ABMS® CERTIFICATION HISTORY

No ABMS Certifications found.

AOA® CERTIFICATION HISTORY

No AOA Certifications found.

FCVS FEDERATION CREDENTIALS VERIFICATION SERVICE

NPDB Report

BARKER, EMILY **DCN: 5500000207687586**

FOR AUTHORIZED USE BY: Kansas State Board of Healing Arts **Continuous Query ID: 300000015071957**

Process Date: 4/18/2023

The following is a render of data received by National Practitioner Data Bank (NPDB) as interpreted by FSMB

BARKER, EMILY - CONTINUOUS QUERY RESPONSE

A. SUBJECT IDENTIFICATION INFORMATION (Recipients should verify that subject identified is, in fact, the subject of interest.)

Practitioner Name:	BARKER, EMILY BARKER, EMILY SARA
Date of Birth:	CONFIDENTIAL
Gender:	FEMALE
Work Address:	5107 E. KELLOGG DR. WICHITA, KS 67218
Home Address:	CONFIDENTIAL
Social Security Numbers (SSN):	
National Provider Identifiers (NPI):	1194255075
Drug Enforcement Administration (DEA) Numbers:	FB0659562 FB0141832
License(s):	Physician (MD), 036152693, IL Physician (MD), 125069995, IL Physician (MD), 2021010438, MO
Professional School(s):	UNIVERSITY OF WISCONSIN MEDICAL SCHOOL (2017)
Subject ID:	300943735

B. CONTINUOUS QUERY ENROLLMENT INFORMATION

Enrollment Status:	Enrolled - 4/18/2023 - 4/30/2024* * Unless enrollment is canceled by the entity prior to this date
Statutes Queried:	Title IV, Section 1921, Section 1128E
Entity Name:	Kansas State Board of Healing Arts
Authorized Agent:	Federation of State Medical Boards, (817) 868 - 4000
Customer Use:	300943735

C. SUMMARY OF REPORTS ON FILE WITH THE DATA BANK AS OF 4/18/2023

The following report types have been searched:

Medical Malpractice Payment Report(s):	No Reports	Health Plan Action(s):	No Reports
State Licensure or Certification Action(s):	No Reports	Professional Society Action(s):	No Reports

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BARKER, EMILY **DCN: 5500000207687586**

FOR AUTHORIZED USE BY: Kansas State Board of Healing Arts **Continuous Query ID: 300000015071957**

Exclusion or Debarment Action(s):	No Reports	DEA/Federal Licensure Action(s):	No Reports
Government Administrative Action(s):	No Reports	Judgment or Conviction Report(s):	No Reports
Clinical Privileges Action(s):	No Reports	Peer Review Organization Action(s):	No Reports

AFFIDAVIT AND AUTHORIZATION FOR RELEASE OF INFORMATION

Applicant: In the presence of a notary public, sign and date this form with attached photo. Email completed form to KSBHA_Licensing@ks.gov or mail directly to the Kansas State Board of Healing Arts.

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 a change occurs 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 to practice medicine.

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

Emily Sara Barker
Applicant's printed first name middle initial, last name, and suffix (e.g., Jr.)

04/05/2023
Date of signature (must correspond to date of notarization)

NOTARY PUBLIC - State of Kansa
Stormi Herbison
My Appt. Expires 01/08/2025 **NOTARY**

Seal Verified KSBHA

State of Kansas, County of Sedgwick.

I certify that on the date set forth below, the individual named above did appear personally before me and that I did identify this applicant by: (a) comparing his/her physical appearance with the photograph on the identifying document presented by the applicant and with the photograph affixed hereto, and (b) comparing the applicant's signature made in my presence on this form with the signature on his/her identifying document.

The statements on this document are subscribed and sworn to before me by the applicant on this 05 day of 04, 20 23

Notary Public Signature _____ My Notary Commission Expires 01/08/2025

Kansas State Board of Healing Arts
800 SW Jackson – Lower Level, Suite A., Topeka, KS 66612
Phone: (785) 296-7413; Fax: (785) 296-0852; Email: KSBHA_Licensing@ks.gov
www.ksbha.org

Kansas

LICENSE DESIGNATION

Please note: If you have NOT practiced medicine and surgery in the last two-years and you wish to engage in the active practice, under K.A.R. 100-6-6, you must select the Reentry Active license designation and submit a proposed reentry plan. For all information regarding the Reentry Active license designation see K.A.R. 100-6-6 in the Healing Arts Practice Handbook.

LICENSE DESIGNATION

Read each description and select the appropriate designation.

☑ Active	Engaged in the practice of medicine and surgery. Required to complete continuing education, maintain professional liability insurance, and be compliant with the Kansas Health Care Stabilization Fund.
☐ Federal Active	Engaged in the practice of healing arts solely in the course of employment or active duty in the United States government or any of its departments, bureaus or agencies or who, in addition to such employment or assignment, provides professional services as a charitable health care provider as defined under K.S.A. 75-6102. Required to complete continuing education. **Not** required to have professional liability insurance or be compliant with the Kansas Health Care Stabilization Fund.
☐ Reentry Active	Under an approved reentry plan, reentering the active practice of medicine and surgery. Required to complete continuing education, maintain professional liability insurance, and be compliant with the Kansas Health Care Stabilization Fund.
☐ Exempt	Does **not** regularly engage in the practice of healing arts and does not hold oneself out to the public as being professionally engaged in such practice. Entitled to all the privileges of their branch of the healing arts and (1) may serve as a coroner or as a paid employee of a local health department as defined by K.S.A. 65-241; or (2) practice as a charitable health care provider for an indigent health care clinic as defined by K.S.A. 75-6102. May perform administrative functions. **Not** required to maintain continuing education, maintain professional liability insurance, or be compliant with the Kansas Health Care Stabilization Fund.
☐ Inactive	**Not** engaged in the practice of the healing arts and does not hold oneself out to the public as being professionally engaged in such practice. **Not** required to maintain continuing education, maintain professional liability insurance or be compliant with the Kansas Health Care Stabilization Fund.

PROFESSIONAL LIABILITY INSURANCE & FUND COMPLIANCE (Active License and Reentry Active License types only)

For all new policies and policies that renew on and after January 1, 2022, K.S.A. 40-3402 requires MD, DO, DC, DPM and PAs with an active or reentry active license in Kansas to maintain professional liability insurance of not less than $500,000 per claim, and not less than $1,500,000 annual aggregate for all claims made during the policy period. These professions are also required to maintain compliance with the Kansas Health Care Stabilization Fund (KHCSF). K.S.A. 40-3404; K.S.A. 65-2809(c); K.S.A. 65-2005(d); K.S.A. 65-28a03(b).

Submit one of the following as proof of coverage (proof must include the insurance company's information, applicants name, coverage amounts, and coverage dates):

- Certificate of Insurance
- Letter of intent from the liability insurance company or employer

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www.ksbha.org

When the license is ready for approval:

- If the professional liability insurance is effective upon licensure approval or has a past effective date the license will be issued that day.
- If the professional liability insurance has a future effective date the license will be approved but will not be issued or become effective until the date the professional liability insurance goes into effect. Furthermore, the license effective date cannot be more than 90 days from the date the license is ready for approval. If at the time the license is ready for approval the professional liability insurance effective date is more than 90 days out, the license will not be approved, and you will be contacted to provide a policy with an updated effective date.

I certify that I have read and understand the professional liability insurance and KHCSF requirements and will maintain compliance while holding an active or reentry active license in Kansas.	X

PROPOSED REENTRY PLAN (Reentry Active License Only)

Any physician who has not engaged in the practice of healing arts in the last two years must submit a proposed reentry plan for board review. Upon meeting all licensure requirements and approval of the reentry plan a Reentry Active license will be issued. While holding a reentry active license the physician shall not practice outside the scope of the approved reentry plan.

The reentry plan shall contain the following:

(1) Name of the supervising physician, who is approved by the board;
(2) An assessment of the physician's current strengths and weaknesses in the intended area or areas of practice. The assessment may include testing and evaluation by colleagues, educators, or others; and
(3) An education component that addresses the physician's area or areas of needed improvement, if any, and consists of a reentry period of monitored practice and education upon terms based on the factors listed in K.A.R. 100-6-6(c).

EXEMPT PROFESSIONAL ACTIVITIES (Exempt License Only)

Select all professional activities you intend to engage in.

☐ Administration	☐ Charitable Health Care Provider	☐ Consultant
☐ Coroner/Deputy Coroner	☐ Paid Employee of Local Health Department	☐ Paid Employee of an Indigent Health Care Clinic
☐ Treatment of Family and Friends with No Compensation		
☐ Other:		

PRIMARY SPECIALTY AND BOARD CERTIFICATION

Primary Specialty: Obstetrics and Gynecology	
Board Certified: ☐ Yes ☑ No	If no, are you Board eligible: ☑ Yes ☐ No
Board Certification:	Board Certification:

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ATTESTATION QUESTIONS

Please answer each of the following questions. **All "yes" answers MUST be thoroughly explained in detail on a separate signed page.** You are required to furnish complete details including date, place, reason, and disposition of the matter and attach all relevant documentation. All information received will be checked accordingly to verify the truth and veracity of your answers. **It is imperative you honestly and fully answer all questions, regardless of whether you believe the information requested is relevant.**

If you are unsure of your response to a question, check the "yes" box and submit the appropriate documentation. Your responses on your application are evaluated as evidence of your candor and honesty. An honest "yes" answer to a question on your application is not definitive as to the Boards' assessment of your present moral character and fitness, but a dishonest "no" answer is evidence of a lack of candor and honesty. Please be advised that a false response to any of these questions may be grounds for denial of licensure. If a question is not applicable, then check the "no" box.

Emily S. Barker
Full Name of Applicant

03/20/2023
Date

1. Have you ever been dropped, suspended, expelled, fined, placed on probation, allowed to resign, requested to leave temporarily or permanently, or otherwise had action taken against you by any professional training program, excluding academic probation in medical school, prior to completing the training? Yes ☐ No ☑

2. Have you ever had any application for any professional license, registration, or certificate denied by any licensing authority? Yes ☐ No ☑

3. Have you ever been denied the privilege of taking an examination required for any professional license, registration, or certificate? Yes ☐ No ☑

4. While working in a healthcare facility as a staff member (including postgraduate training) did you ever have your privileges censured, limited, suspended, revoked, or received other disciplinary action?

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5. While working in a healthcare facility as a staff member (including postgraduate training) did you ever voluntarily or involuntarily resign while under investigation?

6. Have you ever been denied privileges with any health care facility?

7. Have you ever been requested to resign, withdraw, or otherwise terminate your position with a partnership, professional association, corporation, or other practice organization, either public or private? Yes ☐ No ☑

8. Have you ever voluntarily surrendered any professional license registration, or certificate, in lieu of formal disciplinary proceedings? Yes ☐ No ☑

9. Has any licensing authority ever limited, suspended, revoked, censured or placed you on probation, or have you had any other disciplinary action taken against any professional license, registration, or certificate you have held? Yes ☐ No ☑

10. Have you ever been requested to appear before a licensing authority? Yes ☐ No ☑

11. To your knowledge, have any complaints or charges ever been filed against you, or are you currently under investigation, with any licensing agency, professional association, or health care facility? Yes ☐ No ☑

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www.ksbha.org

Revised 9/6/2022

Kansas

12. Has any professional association imposed any disciplinary action against you? Yes ☐ No ☑

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13. Do you currently have any physical or mental health condition (including alcohol or substance use) that impairs your ability to practice your profession in a competent, ethical, and professional manner?

14. Have you ever been denied a Drug Enforcement Administration (DEA) or state bureau of narcotics or controlled substance registration certificate? Yes ☐ No ☑

15. Have you ever had your Drug Enforcement Administration (DEA) or state bureau of narcotics or controlled substance registration revoked, suspended, or restricted in any way, or surrendered in lieu of formal proceedings? Yes ☐ No ☑

16. Have you ever been arrested? You must include all arrests including those that have been set aside, dismissed, expunged, pardoned, or where a stay of execution has been issued. Yes ☐ No ☑

17. Have you ever been charged with a crime, indicted, convicted of a crime, imprisoned, or placed on probation? You must include those that have been set aside, dismissed, pardoned, or expunged, or where a stay of execution has been issued. Yes ☐ No ☑

18. Have you ever been court martialed or dishonorably discharged from the armed services? Yes ☐ No ☑

19. Have you ever been a defendant in a legal action involving professional liability (malpractice), or had a professional liability claim paid in your behalf, or paid such claim yourself? Yes ☐ No ☑

20. Have you ever been denied participation in any State Medicaid or Federal Medicare Programs, or in a private insurance company? Yes ☐ No ☑

21. Have you ever been terminated, sanctioned, penalized, or had to repay money to any state or federal Medicaid or Medicare Programs, or private insurance company? Yes ☐ No ☑

It is your continued duty to update the Board on any changes once the application has been submitted.

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WAIVER AGREEMENT
AND
FBI PRIVACY ACT STATEMENT (Cont.)

FBI CJIS Division
Attn: Criminal History Analysis Team 1
1000 Custer Hollow Road
Clarksburg, West Virginia 26306

The FBI will forward your challenge to the appropriate contributing agency to verify or correct the entry. Upon receipt of an official communication directly from that agency, the FBI will make any necessary changes/corrections to your record in accordance with the information supplied by that agency (see 28 CFR 16.30 through 16.34). The Authorized Recipient must submit a new set of fingerprints and fee to receive the updated federal criminal history record.

I have ____ ***OR*** have not X been convicted of a crime.

If convicted, describe the crime(s), the date and location of the crime(s), and the name of the convicting court:

Under penalty of perjury, I hereby declare that I am the person described below, and understand that any falsification of this statement constitutes a severity level 9, nonperson felony under K.S.A. 21-5903.

I have been provided the Waiver Agreement, FBI Privacy Act Statement, and information about how to challenge my criminal records for accuracy and completeness.

Signature

3/31/2023
Date

Emily S. Barker
Printed Name

CONFIDENTIAL
Date of Birth

CONFIDENTIAL
Residential Address

City

State

Zip

TO BE COMPLETED BY THE FINGERPRINTING AGENCY:

Method of Verifying Identity: ☑ Driver's License ☐ State Issued ID Card ☐ Military ID Card ☐ Passport

State/Branch: Missouri

ID Number: CONFIDENTIAL

Agency Name: Midwest Fingerprinting & More LLC

Address: 7320 N. Florissant Rd St. Louis Mo 63121

Telephone: 1-888-533-4643 Fax: ____

Name of Individual Verifying Identity: Cetris Ivy Sr (C.E.O.)

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AUTHORIZED RECIPIENT: *1. Must maintain original or arrange for FBI to maintain.*
2. Must provide a copy to the applicant.

Revised 06/2022

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AMA Physician Profile

PREPARED FOR

Kansas State Board of Healing Arts, Topeka, KS

Name and Mailing Address

EMILY SARA BARKER
WASHINGTON UNIVERSITY SCHOOL OF MEDICINE
MAIL STOP: 8064-37-1005
660 S EUCLID AVE
SAINT LOUIS, MO 63110-1010

Primary Office Address

SAME AS MAILING ADDRESS

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Birth date

Phone UNKNOWN

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

Self-designated practice specialty

COMPLEX FAMILY PLANNING (OBSTETRICS AND GYNECOLOGY) (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 NON MEMBER

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

Current and/or historical National Provider Identifier (NPI) information

NPI Number	Enumeration Date	Deactivation Date	Reactivation Date	Replacement Number	Last Reported Date
1194255075	06/14/2017	NOT RPTD	NOT RPTD	NOT RPTD	04/21/2023

Current and/or historical medical school

US medical school information is verified directly from the school. In some instances, a medical school will designate the National Student Clearinghouse (NSC) as its verification agent. Instances of verification by NSC are indicated on an AMA Profile when applicable.

On the profile, ***enrollment date*** *is understood to mean the date a student begins a pre-matriculation program, attends orientation immediately preceding enrollment, or becomes enrolled in classes at a medical school.* ***Degree date*** *is understood to mean the date a physician is awarded his/her degree upon completion of the degree program. When provided by the primary source, a month is also included for these two dates. Date information provided by primary sources does vary. Enrollment date for international medical graduates is not reported to AMA.*

School: UNIVERSITY OF WISCONSIN SCHOOL OF MEDICINE & PUBLIC HEALTH

Degree Awarded:	YES	**Degree Type:**	MD
Enrollment Date:	08/2013	**Degree Date:**	05/2017

Current and/or historical ACGME-accredited graduate medical training programs

This section's data is sourced only from training programs accredited by the Accreditation Council for Graduate Medical Education (ACGME) as part of the National Graduate Medical Education Census. Program name is only reported for training received in 2010 and later. Training types are identified as specialty (residency) or subspecialty (fellowship) only for training received in 2016 and later.

The AMA Profile does not include non-ACGME accredited training programs, and the absence of such does not necessarily indicate a gap in training.

Training performed in Canada or at an accredited US osteopathic institution is updated only upon verification by the program. US licensing authorities accept GME from both entities as equivalent to training performed at an ACGME-accredited program.

Verification of training status may be indicated in one of four ways. ***Completed*** *indicates that the training has been completed in its entirety and verified with the program.* ***Training in Progress*** *indicates the training has a future completion date and is verified as in progress.* ***Verification of Completion in Progress*** *indicates the training has a past completion date and was verified as in progress but the program has not yet verified completion.* ***Partially Completed*** *indicates the training is verified as partially completed but the physician either changed programs or did not complete the training.*

Sponsoring Institution:	WASHINGTON UNIVERSITY/B-JH/SLCH CONSORTIUM
Sponsoring State:	MISSOURI
Program name:	WASHINGTON UNIVERSITY/B-JH/SLCH CONSORTIUM PROGRAM
Specialty:	COMPLEX FAMILY PLANNING (OBSTETRICS AND GYNECOLOGY)
Training Type:	SUB-SPECIALTY
Dates:	07/01/2021 - 06/30/2023
Status:	TRAINING IN PROGRESS

Sponsoring Institution:	RUSH UNIVERSITY MEDICAL CENTER
Sponsoring State:	ILLINOIS
Program name:	RUSH UNIVERSITY MEDICAL CENTER PROGRAM
Specialty:	OBSTETRICS & GYNECOLOGY

Training Type: SPECIALTY
Dates: 07/01/2017 - 06/30/2021
Status: COMPLETED

Specialty board certification

NO DATA REPORTED AT THIS TIME

Current and/or historical medical licensure

License Number	MD / DO	Locale	Date Granted	Expiration Date	Renewal Date	Status	License Type	Last Reported	Name on License
2021010438	MD	MO	03/22/2021	01/31/2024	11/08/2022	ACT	UNL	12/05/2022	Emily Sara Barker
125.069995	MD	IL	05/01/2017	06/30/2020		INA	RES	12/31/2021	EMILY BARKER

Abbreviation key: ACT = Active, INA = Inactive, LIM = Limited, NRT = Not reported, RES = Resident, TEM = Temporary, UNK = Unknown, UNL = Unlimited

Action notifications reported to the AMA

Medical Licensing Boards: NO ACTIONS REPORTED AT THIS TIME
Medicare/Medicaid Sanctions from DHHS: NO ACTIONS REPORTED AT THIS TIME
US DOJ Drug Enforcement Administration: NO ACTIONS REPORTED AT THIS TIME

U.S. Drug Enforcement Administration (DEA)

NO DATA REPORTED AT THIS TIME

ECFMG certification

NOT APPLICABLE

Profile information

The content of the AMA Physician Profile is for credentialing use only. The content cannot be used or assembled for an employment purpose as defined under the Fair Credit Reporting Act. An organization's appropriate use of the data contained in the AMA Physician Masterfile meets select 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 AMA Profiles Hub, go to the "Profile Manager" tab, find the clinician 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, the link in the "Profile Manager" tab will be updated for this clinician so that you can access the new information.

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

KAMMCO

On Behalf of Kansas Health Care
Provider Insurance Availability Plan

LETTER OF INTENT

May 4, 2023

Kansas State Board of Healing Arts
800 S.W. Jackson, Lower Level, Ste. A
Topeka, KS 66612

RE: Emily S. Barker, MD

TO WHOM IT MAY CONCERN:

Pending confirmation by the Kansas Health Care Provider Insurance Availability Plan (Plan) from the Kansas Board of Healing Arts (the Board) that Dr. Emily Barker, MD has been approved for an active Kansas license, the Plan will provide claims-made coverage effective as soon as possible, with limits of $500,000 per claim/$1,500,000 annual aggregate. This will also confirm that in addition to coverage with the Plan, Dr. Barker has selected $500,000 per claim/$1,500,000 annual aggregate limits with the Health Care Stabilization Fund.

Please note this Letter of Intent confers no conditions or obligations on the Plan to provide notice should Dr. Barker make the decision not to purchase Plan coverage. Additionally, this letter is not proof of coverage.

Please do not hesitate to contact the Underwriting Department with questions.

Sincerely,

Sara Patry
Underwriter

From: Sara Patry
To: KSBHA_Licensing
Cc: LaJeune Fitzpatrick
Subject: Emily S. Barker, MD - letter of intent attached
Date: Thursday, May 4, 2023 10:38:56 AM
Attachments: email_sig_logo_8c91e9ed-47b3-4b42-a947-0e2fe894c04e1111.png
fb_5760325c-6b93-4e4d-90ae-191c1cb85005111.png
in_d4fdf9ac-bf38-48bc-aca4-2218dc12af9d111.png
Emily S. Barker, MD - letter of intent.pdf

Good morning –

Please find attached the Plan's letter of intent on Dr. Emily S. Barker, MD.

If you have any questions, please feel free to contact me.

Thanks,

KAMMCO

Sara Patry
Underwriter
623 SW 10th Avenue Topeka, Kansas 66612
Office: 785.232.2224 | Fax: 785.232.4704
w: www.KAMMCO.com | e: SPatry@kammco.com

Kansas

THIRD PARTY RELEASE

If you would like the Kansas State Board of Healing Arts ("Board") staff to talk with third parties about your application complete this form. This form provides authorization for the Board to release information regarding your application to third parties. This information includes, but is not limited to: application information, license verification, status change, address changes, Kansas Health Care Stabilization Fund information, continuing education information, audit information, and past or current legal issues and documents. This authorization expires one year from the date of signature. You can revoke this authorization at any time by submitting a request in writing. Revoking this authorization will not affect any action taken prior to receipt of your written request. A reproduction of this authorization shall have the same effect as the original. Email to KSBHA_Licensing@ks.gov or mail it directly to the Board.

I, Emily S. Barker, authorize Board staff to release and discuss any and all information pertaining to my application, with the following individuals:

1. Name: Lizeth Lucio
   Phone: 316-425-3215
   Email: LLucio@itrustwomen.org
   Relationship: co-worker

2. Name: _____
   Phone: _____
   Email: _____
   Relationship: _____

I acknowledge by my signature, that although I am not required to authorize the Board to release information to third parties, I am giving my consent for Board staff to do so. Additionally, I understand that I may revoke this authorization in writing at any time, except for that information which has already been released with consent, prior to my revocation.

Signature of Applicant

4/11/2023
Date

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Kansas State Board of Healing Arts
800 SW Jackson – Lower Level, Suite A., Topeka, KS 66612
Phone: (785) 296-7413; Fax: (785) 296-0852; Email: KSBHA_Licensing@ks.gov
www.ksbha.org

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OFFICIAL RECEIPT
KANSAS BOARD OF HEALING ARTS
800 SW Jackson, Lower Level-Suite A
Topeka, KS 66612
(785) 296-7413

RECEIPT NUMBER: 737505 DATE: 04/21/2023
04/21/2023
04/21/2023

NAME: LICENSE TYPE: FEE: LIC #:
Barker_Emily

AMOUNT: 300.00
47.00
3.00 TYPE: Credit Card
Credit Card
Credit Card CH/CC #: 032026
032026
032026

RECEIVED FROM:

Schaunta James-Boyd
Schaunta James-Boyd
Schaunta James-Boyd

Wichita KS 67217
Wichita KS 67217
Wichita KS 67217

Kansas State Board of Healing Arts
800 SW Jackson, Lower Level-Suite A
Topeka, KS 66612

State Board of Healing Arts

PHONE: 785-296-7413
FAX: 785-368-7103
KSBHA_healingarts@ks.gov
www.ksbha.org

Susan B Gile, Executive Director

Laura Kelly, Governor

Emily Sara Barker, MD
5107 E. Kellogg Drive
Wichita KS 67218

April 28, 2023

Dear Emily Sara Barker:

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Sincerely,

Terrin Pittz | Licensing Analyst | Phone: 785-296-8824| Email: Terrin.Pittz@ks.gov

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Cc: "admin@southwindwomenscenter.org"
Subject: Kansas State Board of Healing Arts - Licensure Needed Documentation
Date: Friday, April 28, 2023 10:32:00 AM
Attachments: MRL.pdf
image002.png

Good Morning Dr. Barker,

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Email is the best way to communicate with me.

Thank you,

Terrin Pittz

Licensing Analyst
Kansas State Board of Healing Arts
800 SW Jackson, Lower Level, Suite A
Topeka, Kansas 66612
Email Terrin.Pittz@ks.gov
Phone 785.296.8824

WAIVER AGREEMENT
AND
FBI PRIVACY ACT STATEMENT (Cont.)

information to available records in order to identify other information that may be pertinent to the application. During the processing of this application, and for as long hereafter as may be relevant to the activity for which this application is being submitted, the FBI may disclose any potentially pertinent information to the requesting agency and/or to the agency conducting the investigation. The FBI may also retain the submitted information in the FBI's permanent collection of fingerprints and related information, where it will be subject to comparisons against other submissions received by the FBI. Depending on the nature of your application, the requesting agency and/or the agency conducting the application investigation may also retain the fingerprints and other submitted information for other authorized purposes of such agency(ies).

Routine Uses:
The fingerprints and information reported on this form may be disclosed pursuant to your consent, and may also be disclosed by the FBI without your consent as permitted by the Federal Privacy Act of 1974 (5 U.S.C. 552a(b)) and all applicable routine uses as may be published at any time in the Federal Register, including the routine uses for the FBI Fingerprint Identification Records System (Justice/FBI-009) and the FBI's Blanket Routine Uses (Justice/FBI-BRU). Routine uses include, but are not limited to, disclosures to: appropriate governmental authorities responsible for civil or criminal law enforcement, counterintelligence, national security or public safety matters to which the information may be relevant; to State and local governmental agencies and nongovernmental entities for application processing as authorized by Federal and State legislation, executive order, or regulation, including employment, security, licensing, and adoption checks; and as otherwise authorized by law, treaty, executive order, regulation, or other lawful authority. If other agencies are involved in processing this application, they may have additional routine uses.

Additional Information:
The requesting agency and/or the agency conducting the application-investigation will provide you additional information pertinent to the specific circumstances of this application, which may include identification of other authorities, purposes, uses, and consequences of not providing requested information. In addition, any such agency in the Federal Executive Branch has also published notice in the Federal Register describing any system(s) of records in which that agency may also maintain your records, including the authorities, purposes, and routine uses for the system(s).

RIGHT TO OBTAIN AND CHALLENGE ACCURACY OF CRIMINAL HISTORY RECORDS

You may request a copy of your state and/or national criminal history record from the Authorized Recipient for the purpose of challenging for accuracy and completeness.

Alternatively, you may obtain a copy of your **Kansas criminal history record information** (CHRI) to review for accuracy and completeness, by submitting a set of your fingerprints, a letter requesting your criminal history record, and payment of the appropriate fee to the KBI. For further details, including the current fee, visit the following Internet website: http://www.kansas.gov/kbi/info/info_brochures.shtml then find the brochure named "Record Checks for Non-Criminal Justice Purposes". Or, to provide official court documents to make a correction you may write to:

Kansas Bureau of Investigation
Attn: Criminal History Records
1620 SW Tyler
Topeka, Kansas 66612-1837

If a change is made to your Kansas criminal history record due to a challenge, a new copy of your Kansas criminal history record will be sent to the Authorized Recipient to make a final decision about your status as an employee, volunteer or contractor, or your eligibility for any pertinent license, certification or registration, or adoption.

To obtain a copy of your **national CHRI, also known as the Identity History Summary**, for review and challenge you must submit a set of your fingerprints and the appropriate fee to the FBI. Information regarding this process may be obtained at: https://www.fbi.gov/services/cjis/identity-history-summary-checks. Or, you may write to:

Kansas

FINGERPRINT AND BACKGROUND CHECK INSTRUCTIONS

A criminal background check is required prior to issuance of licensure. Be aware that fingerprint processing may delay your application. **Please make it a priority to complete the fingerprint process.**

Following is the Waiver Agreement and FBI Privacy Act Statement. Please complete, sign and date the top portion of this form. At the time fingerprints are collected the fingerprinting agency must complete the bottom portion. Mail the completed form and fingerprint card to the Board. Fingerprints will not be submitted for processing without a completed and signed Waiver Agreement.

Fingerprinting should be conducted by a person who is appropriately trained to collect fingerprints. It is not necessary that it be a law enforcement agency, however they must be authorized to do fingerprints. Please visit https://www.nbinformation.com/locations/locationMap.php for a listing of fingerprinting locations.

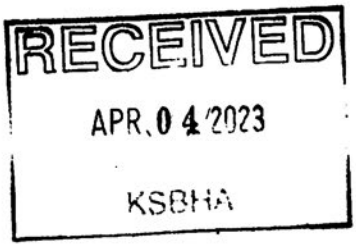
Fingerprints to be submitted for background checks must be recorded on the current version of the FBI's Applicant Fingerprint Card, FD Form 258. Some agencies offer electronic scanning (Livescan) please note the fingerprints must be printed on the fingerprint card and submitted to the Board. Please check with the fingerprinting agency to see if fingerprint cards are available or if a fee is required. To request a fingerprint card be mailed to you please email KSBHA_Licensing@ks.gov or call (785) 296-7413.

Complete the applicant section of the fingerprint card. Ensure the appropriate data fields are completed prior to submission. Include name, aliases, complete mailing address, social security number, citizenship, date of birth, and personal information (sex, race, height, weight, eyes, hair, place of birth). The spaces for OCA, FBI and MNU numbers can be left blank. Cards with missing or incomplete information will be rejected and must be resubmitted.

Mail the completed Waiver Agreement and fingerprint card to the Board. You may want to use a mailing service that allows for delivery confirmation.

Kansas State Board of Healing Arts
Attn: Licensing
800 SW Jackson, Lower Level – Suite A
Topeka, KS 66612
Phone: (785) 296-0934
Email: KSBHA_Licensing@ks.gov

Fingerprint results are valid for 6 months from the date received. Applications for licensure completed after the 6-month period will be required to submit a new Waiver Agreement, fingerprint card, and $47 fee.



WAIVER AGREEMENT
AND
FBI PRIVACY ACT STATEMENT

Fingerprint-Based Record Checks for Noncriminal Justice Purposes

I hereby authorize (*Name of Authorized Recipient*) **The Kansas State Board of Healing Arts** to submit a set of my fingerprints to the Kansas Bureau of Investigation (KBI) for the purpose of identifying me and accessing and reviewing Kansas and/or national criminal history records that may pertain to me. The fingerprints are authorized to be submitted under the authority of the National Child Protection Act/Volunteers for Children Act (NCPA/VCA) explained in Public Law (Pub. L.) 103-209 and Pub. L. 105-251. Pursuant to K.S.A. 22-4701 et seq., K.S.A. 22-5001, K.S.A 75-712i, and 2022 Kansas Laws Ch. 92, § 1 (Senate Sub. for H.B. 2495), the Authorized Recipient may obtain my criminal history record information for noncriminal justice purposes. By signing this waiver, it is my intent to authorize release to the above-referenced Authorized Recipient of any Kansas and/or national criminal history record that may pertain to me. I further understand that, if applicable, the Authorized Recipient may choose to deny me unsupervised access to children, the elderly, or individuals with disabilities until the criminal history background check is completed.

I understand that, upon my request, the Authorized Recipient will provide me a copy of the criminal history background report, received on me, for the purpose of challenging the accuracy and completeness of any information contained in any such report. I may be afforded a reasonable amount of time to correct or complete the criminal history record (or decline to do so) before the Authorized Recipient makes a final decision about my status as an employee, volunteer or contractor, or my eligibility for any pertinent license, certification or registration, or adoption. See 28 CFR 50.12(b).

I understand that officials receiving the results of the criminal history record check are to use those results only for authorized purposes and are prohibited from retaining or disseminating such results in violation of federal statute, regulation or executive order, or rule, procedure or standard established by the National Crime Prevention and Privacy Compact Council. See 5 United States Code (U.S.C.) 552a(b); 28 U.S.C. 534(b);34 U.S.C. 40316, Article IV(c); 28 CFR 20.21(c), 20.33(d), 906.2(d); and 2022Kansas Laws Ch. 92, § 1 (Senate Sub. for H.B. 2495).

I understand that my fingerprints will be retained by the KBI and/or the Federal Bureau of Investigation if the Authorized Recipient participates in the state or national Rap Back program for continued suitability for being an employee, volunteer or contractor, or eligibility for any license, certification, registration, or adoption. The Rap Back program will notify the Authorized Recipient when there are updates to my criminal history record. Once I am no longer employed, a volunteer contractor, licensed, certified, registered, or seeking adoption, the Authorized Recipient shall request my fingerprints be removed from the state and/or national Rap Back program.

FBI PRIVACY ACT STATEMENT

Authority:
The FBI's acquisition, preservation, and exchange of identification records and information requested by this form is generally authorized under 28 U.S.C. 534. Depending on the nature of your application, supplemental authorities include numerous federal statutes, hundreds of state statutes pursuant to Pub. L. 92-544, Presidential executive orders, regulations and/or orders of the Attorney General of the United States, or other authorized authorities. Examples include, but are not limited to: 5 U.S.C. 9101; Pub. L. 94-29; Pub. L. 101-604; and Executive Orders 10450 and 12968. Providing the requested information is voluntary; however, failure to furnish the information may affect timely completion or approval of your application.

Social Security Account Number (SSAN).
Your SSAN is needed to keep records accurate because other people may have the same name and birth date. Pursuant to the Federal Privacy Act of 1974 (5 U.S.C. 552a), the Authorized Recipient is responsible for informing you whether disclosure is mandatory or voluntary, by what statutory or other authority your SSAN is solicited, and what uses will be made of it. Executive Order 9397 also requires federal agencies to use this number to help identify individuals in agency records.

Principal Purpose:
Certain determinations, such as employment, security, licensing, and adoption, may be predicated on fingerprint-based checks. Your fingerprints and other information contained on (and along with) this form may be submitted to the requesting agency, the agency conducting the application investigation, and/or FBI for the purpose of comparing the submitted

Uniform Application for Licensure

Application ID: 376347
FID: 300943735

License Requested: MD
License Type: Permanent Medical License
Submitted to: Kansas State Board of Healing Arts
Submission Date: 4/14/2023 2:47 PM

Practitioner Name

Barker, Emily Sara

Alternate Name(s): Barker, Emily

Contact Information

Address

Public Access	Board Contact	Type	Address
Yes	Yes	Business	5107 E. Kellogg Dr. Wichita, KS 67218 UNITED STATES

CONFIDENTIAL

Phone

Public Access	Board Contact	Type	Phone Number	Phone Extension
Yes	Yes	Business	(316) 260-6934	

CONFIDENTIAL

Email

Public Access	Board Contact	Email

CONFIDENTIAL

Identification

USMLE Number	SSN	Birth Date	Birth Place	Gender	NPI	Practitioner Type	US Citizen
	CONFIDENTIAL	CONFIDENTIAL	Portland, Maine UNITED STATES	F	1194255075	MD	Yes

Medical School

Medical School Name	Address	Start Date	End Date	Graduation Date	Degree Code
University of Wisconsin Medical School	750 Highland Drive Room 2141G HLSC Madison, WI 53705 UNITED STATES	08/15/2013	05/15/2017	05/15/2017	MD

Fifth Pathway

None Reported

ECFMG

Certificate Number	Issue Date
None Reported	

Postgraduate Training

Hospital Name:	**Rush University Medical Center Program** Chicago, IL UNITED STATES	**Program Code:**	ACGME 2201621090
		Attendance Dates:	
Institution:	Rush University Medical Center	**Start Date:**	07/01/2017
Training Specialty:	Obstetrics & Gynecology	**End Date:**	06/30/2021
		Program Type:	Residency
Training Status:	Completed		
Clinical %:	80	**Administrative %:**	20

Hospital Name:	**Washington University/B-JH/SLCH Consortium Program** St. Louis, MO UNITED STATES	**Program Code:**	ACGME 2362822001
		Attendance Dates:	
Institution:	Washington University/B-JH/SLCH Consortium	**Start Date:**	07/01/2021
Training Specialty:	Obstetrics & Gynecology/Complex Family Planning	**End Date:**	06/30/2023
		Program Type:	Fellowship
Training Status:	Active		
Clinical %:	80	**Administrative %:**	20

Examination History

Exam	State	Last Attempt	Pass/Fail	Number Of Attempts
USMLE Step 1 Examination		06/17/2015	Pass	1
USMLE Step 2 CS Examination		06/14/2016	Pass	1
USMLE Step 2 CK Examination		07/14/2016	Pass	1
USMLE Step 3 Examination		11/28/2017	Pass	1

State Licensure History

MD, DO, PA License History

License Entity	Licensing State	License Number	Issue Date	Expiration Date	License Type	License Status
Illinois Department of Financial and Professional Regulation	IL	036152693	04/23/2020	07/31/2023	Full	Active
Illinois Department of Financial and Professional Regulation	IL	125069995	05/01/2017	06/30/2020	Temporary	Canceled
Missouri Board of Registration for the Healing Arts	MO	2021010438	03/22/2021	01/31/2024	Full	Active

Physician Reported License History

Practitioner License Type	Licensing State	License Number	Issue Date	Expiration Date	Type	License Status
None Reported						

Malpractice

None Reported

Medical School Verification (UA Form #2)

STATE LICENSURE

Applicant: Complete this form as instructed in the left sidebar.
Dean or Designated Med School Official: Complete as instructed in the left sidebar.

Applicant:

This form is not needed if you are using FCVS for credentials verification.

Complete Section 1 and fill in your name at the top of page 2. Type or print legibly.

Send this form and a copy of your medical school diploma to the current Dean of your medical school.

Copy this form for multiple schools.

Section 1: Applicant Information

Last name: Barker Suffix: _____

First name: Emily

Middle name: Sara

Name if different when diploma awarded: N/A

Name of medical school: University of Wisconsin School of Medicine

Date of birth: CONFIDENTIAL Social Security number*: CONFIDENTIAL

*The social security number is to be used for purposes of identification only and may not be used for any other reason.

Waiver for Release of Information: I authorize the medical school listed above to provide any and all information pertaining to my medical education at that institution to the Board listed below. I request that the Dean or a designated official complete Section 2 of this form and seal the copy of my diploma (attached), then return this form, the sealed diploma copy, and a copy of my official transcripts to the Board listed below at the given address.

Board name: Kansas State Board of Healing Arts
Mailing address: 800 SW Jackson, Lower Level – Suite A
City/State/Zip: Topeka, KS 66612

Applicant signature: [signature] **Date:** 4/14/2023

Dean or Designated Official:

Please complete Section 2 of this form and certify the enclosed copy of the above named applicant's diploma by placing your school seal on it.

Mail the sealed diploma copy and an official copy of the transcripts of the above named physician with this form and any attachments to the Kansas State Board of Healing Arts at the address listed in Section 1. Do not mail this form to FCVS/FSMB.

If transcripts are not in English, an original, certified, and official English translation is required.

Section 2: Medical School Verification

Medical school name: University of Wisconsin School of Medicine and Public Health

School name if different when the above applicant attended: _____

Medical school address (including city, state or province, zip code, and country as applicable):
750 Highland Ave, Madison, WI 53705

Hours of undergraduate education required for admission into your school: 0

Total weeks of education applicant attended your school: 156

Applicant's attendance dates: From 08/19/2013 to 05/13/2017

Graduation date: 05/13/2017 (indicate N/A if not applicable) Degree: MD (indicate N/A if not applicable)

The questions on the following page apply to unusual circumstances that occurred during any part of the individual's medical education. Please check the appropriate response(s) 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.

Applicant Name: Emily Sara Barker

1. Do the official records for this individual reflect (an) interruption(s) or extension(s) in his/her medical education? Yes ☐ No ☑

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

	From Month/Year	To Month/Year	Approved	Unapproved
☐ Personal/Family			☐	☐
☐ Academic remediation			☐	☐
☐ Health			☐	☐
☐ Financial			☐	☐
☐ Participation in joint degree program (e.g., MD/PhD)			☐	☐
☐ Participation in non-research special study (e.g., fellowship, international experience)			☐	☐
☐ Other:			☐	☐

2. Do the official records for this individual reflect that he/she was ever placed on academic or disciplinary probation during his/her medical education? 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 documentation/information of the circumstances and outcome(s).

	From Month/Year	To Month/Year
☐ Academic probation		
☐ Probation for unprofessional conduct/behavioral reasons		
☐ Probation for other reason(s) (please specify):		

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

If yes, please attach documentation/information of the circumstances and outcome(s).

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

If yes, please attach documentation/information of the circumstances and outcome(s).

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

If yes, please attach documentation/information of the nature of the limitations or special requirements.

I CERTIFY THAT to the best of my knowledge and belief, the foregoing is a true, accurate, and complete statement of the record of the individual named on this form.

AFFIX INSTITUTIONAL SEAL HERE
(If no seal is available, this form must be notarized.)

Signature: Jack K. Fischer
Print name: Jack K Fischer
Title: Certification Officer
Date: 04/26/2023
Phone number: 608-263-4912 Fax number: 608-263-1187
Email: Studentservices@med.wisc.edu

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University Of Wisconsin–Madison
Office of the Registrar
333 East Campus Mall Suite #11101, Madison WI 53715
Telephone: (608) 262-3811
Fax: (608) 265-8946
Email: registrar@em.wisc.edu
Website: registrar.wisc.edu

The University of Wisconsin–Madison transcript legend is available in the following link: go.wisc.edu/transcriptkey.

Accreditation:

The University of Wisconsin–Madison is accredited by the Higher Learning Commission of the North Central Association of Colleges and Schools. In addition, various schools within UW-Madison hold accreditation from their professional accrediting associations.

Academic Calendar:

The academic calendar is based on the semester system, consisting of approximately 15 weeks of instruction (Fall and Spring Terms). Summer sessions vary in length. For more information, see: secfac.wisc.edu/academic-calendar.

To Confirm Authenticity:

Official transcripts bear the signature and seal of the Registrar.

Printed transcripts- The face of the document has a colored background. A black and white or color copy of this document is not an original and should not be accepted as an official institutional document. Additional tests are listed in the text box below.

Electronic transcripts- PDF transcripts viewed electronically are recognized as official documents. A printed copy of a PDF Transcript will be considered unofficial and will display the words PRINTED COPY on all pages.

This document cannot be released to a third party without the written consent of the student. This is in accordance with the Family Educational Rights and Privacy Act of 1974. If you have any questions about this document, please contact our office. ALTERATION OF THIS DOCUMENT MAY BE A CRIMINAL OFFENSE.

From: Jack Fischer
To: KSBHA_Licensing
Subject: Barker MD Verification & Transcripts
Date: Wednesday, April 26, 2023 2:00:44 PM
Attachments: Barker_Emily_MD17_UA.pdf
Barker_Emily_MD17_Transcripts.pdf

Please see the attached MD Verification Form and Transcripts.

If you have any questions or concerns, please do not hesitate to contact me.

Sincerely,
-Jack

Jack K. Fischer
Student Records and Curricular Specialist
University of Wisconsin-Madison
School of Medicine and Public Health
Health Sciences Learning Center
750 Highland Ave
Madison, WI 53705

From: Jack Fischer
To: KSBHA_Licensing
Subject: Barker MD Verification & Transcripts
Date: Wednesday, April 26, 2023 2:00:44 PM
Attachments: Barker_Emily_MD17_UA.pdf
Barker_Emily_MD17_Transcripts.pdf

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Sincerely,
-Jack

Jack K. Fischer
Student Records and Curricular Specialist
University of Wisconsin-Madison
School of Medicine and Public Health
Health Sciences Learning Center
750 Highland Ave
Madison, WI 53705

Illinois Department of Financial and Professional Regulation

Division of Professional Regulation

JB Pritzker
Governor

Mario Treto, Jr.
Acting Secretary

Cecilia Abundis
Director
Division of
Professional
Regulation

CERTIFICATION OF LICENSURE

Barnes Jewish Medical Group at
Shiloh
1414 Cross St

Licensee:	EMILY SARA BARKER MD
Number:	036.152693
Profession:	LICENSED PHYSICIAN AND SURGEON
Date of Issuance:	04/23/2020
Expiration Date:	07/31/2026
License Status:	ACTIVE
License Method:	ACCEPT EXAM
Disciplinary History:	Has not been disciplined

This document is a certified copy of the records maintained and kept by this department in the regular course of business as of 04/25/2023

Cecilia Abundis
Director
Division of Professional Regulation

04/25/2023
Date

Refer to the Department's Web Site at IDFPR.Illinois.gov to verify professional licenses via License Look-Up.

From: IL Department of Financial/Professional Regulation
To: EMILY SARA BARKER MD; KSBHA_Licensing
Subject: IDFPR Official Certification of Licensure
Date: Tuesday, April 25, 2023 9:10:47 AM
Attachments: License Certificate Print - 036.152693.pdf

To whom it may concern,

Attached to this email is the Illinois Department of Financial and Professional Regulation's Official ***Certification of Licensure*** for:

Board: Illinois Medical Board

Profession: LICENSED PHYSICIAN AND SURGEON

Licensee Name: EMILY SARA BARKER MD

License Number: 036.152693

As of: 04/25/2023

Thank you and please contact the Department if any questions may arise.

Illinois Department of Financial and Professional Regulation

Phone: 1 (800) 560-6420

https://idfpr.illinois.gov/

UA UNIFORM APPLICATION FOR PHYSICIAN STATE LICENSURE

Postgraduate Training Verification (UA Form #3)

Applicant: Complete this form as instructed in the left sidebar.
Program Director or Designated Official: Complete as instructed in the left sidebar.

Applicant:

This form is not needed if you are using FCVS for credentials verification.

Complete Section 1 and fill in your name at the top of page 2. Type or print legibly.

Send this form to the current Program Director of your postgraduate training program.

Copy this form for multiple training programs.

Section 1: Applicant Information

Last name: Barker Suffix: _____

First name: Emily

Middle name: Sara

Name if different when diploma awarded: _____

Name of postgraduate training program: Rush University Medical Center

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Date of birth _____ Social Security number*: _____

*The social security number is to be used for purposes of identification only and may not be used for any other reason.

Waiver for Release of Information: I authorize the postgraduate training program listed above to provide any and all information pertaining to my medical education at that institution to the Board listed below. I request that the Program Director or a designated official complete Section 2 of this form and send it to the Board listed below at the given address.

Board name: Kansas State Board of Healing Arts
Mailing address: 800 SW Jackson, Lower Level – Suite A
City/State/Zip: Topeka, KS 66612

Applicant signature: [signature] Date: 04/12/2023

Dean or Designated Official:

Please complete Section 2. Report incomplete years separately from those that were completed successfully. Report each Internship, Residency, and Fellowship separately.

Use one section per specialty/subspecialty. Provide a schedule of rotations if the specialty/ subspecialty is rotating/transitional.

Make copies and attach additional pages if necessary.

Send this form to the Kansas State Board of Healing Arts at the address listed in Section 1 with any added documentation, if applicable.

Section 2: Postgraduate Training Verification

Institution name: Rush University Medical Center

Institution address: 1620 W Harrison St

Institution city / state or province / zip code: Chicago, IL 60612

Affiliated medical school name: _____

Institution / school name if different when the applicant attended: _____

Postgraduate year (e.g., 1, 2, 3, etc.): 1-4 ☐ Internship ☑ Residency ☐ Fellowship

☐ Research ☐ Chief Residency ☐ Other: _____

Specialty/Subspecialty: Obstetrics and Gynecology

Attendance dates: From 07/01/2017 to 06/30/2021

Successfully completed*? ☑ Yes ☐ No ☐ In progress with expected completion date of _____

In each year of training, did the applicant demonstrate sufficient academic and clinical ability to qualify for advancement without conditional or probationary status to the next year and next progressive level of responsibility in a designated specialty program?

Accredited by: ☑ ACGME ☐ RCPSC ☐ AOA ☐ APPAP ☐ LCGME ☐ None of these ☐ RSC ☐ CFPC

RECEIVED
APR 18 2023
KSBHA

Applicant Name: Emily Sara Barker

Postgraduate year (e.g., 1, 2, 3, etc.): _____ ☐ Internship ☐ Residency ☐ Fellowship
☐ Research ☐ Chief Residency ☐ Other: _____

Specialty/Subspecialty: _____

Attendance dates: From _____ to _____

Successfully completed*? ☐ Yes ☐ No ☐ In progress with expected completion date of _____

*In each year of training, did the applicant demonstrate sufficient academic and clinical ability to qualify for advancement without conditional or probationary status to the next year and next progressive level of responsibility in a designated specialty program?

Accredited by: ☐ ACGME ☐ AOA ☐ LCGME ☐ RSC ☐ CFPC ☐ RCPSC ☐ APPAP ☐ None of these

Postgraduate year (e.g., 1, 2, 3, etc.): _____ ☐ Internship ☐ Residency ☐ Fellowship
☐ Research ☐ Chief Residency ☐ Other: _____

Specialty/Subspecialty: _____

Attendance dates: From _____ to _____

Successfully completed*? ☐ Yes ☐ No ☐ In progress with expected completion date of _____

*In each year of training, did the applicant demonstrate sufficient academic and clinical ability to qualify for advancement without conditional or probationary status to the next year and next progressive level of responsibility in a designated specialty program?

Accredited by: ☐ ACGME ☐ AOA ☐ LCGME ☐ RSC ☐ CFPC ☐ RCPSC ☐ APPAP ☐ None of these

Please explain any "Yes" response on an additional page or in the blank sidebar area above.

Unusual Circumstances

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

I CERTIFY THAT to the best of my knowledge and belief, **the foregoing is a true, accurate, and complete statement of the record of the individual named on this form.**

AFF
(If be notarized.)

Signature: _____
Print name: Sloane York, MD, MPH
Title: Program Director
Date: 04/12/2023
Phone number: 312 942 6610 Fax number: _____
Email: obgyn_residency@rush.edu

UA UNIFORM APPLICATION FOR PHYSICIAN STATE LICENSURE

Postgraduate Training Verification (UA Form #3)

Applicant: Complete this form as instructed in the left sidebar.
Program Director or Designated Official: Complete as instructed in the left sidebar.

Applicant:

This form is not needed if you are using FCVS for credentials verification.

Complete Section 1 and fill in your name at the top of page 2. Type or print legibly.

Send this form to the current Program Director of your postgraduate training program.

Copy this form for multiple training programs.

Section 1: Applicant Information

Last name: Barker Suffix: _____

First name: Emily

Middle name: S

Name if different when diploma awarded: _____

Name of postgraduate training program: Univeristy of Washington in St. Louis Complex Family Planning Fellowship

CONFIDENTIAL CONFIDENTIAL

Date of birth ____ Social Security number*: _____

**The social security number is to be used for purposes of identification only and may not be used for any other reason.*

Waiver for Release of Information: I authorize the postgraduate training program listed above to provide any and all information pertaining to my medical education at that institution to the Board listed below. I request that the Program Director or a designated official complete Section 2 of this form and send it to the Board listed below at the given address.

Board name: Kansas State Board of Healing Arts
Mailing address: 800 SW Jackson, Lower Level – Suite A
City/State/Zip: Topeka, KS 66612

Applicant signature: Emily Barker Date: 4/11/2023

Dean or Designated Official:

Please complete Section 2. Report incomplete years separately from those that were completed successfully. Report each Internship, Residency, and Fellowship separately.

Use one section per specialty/subspecialty. Provide a schedule of rotations if the specialty/ subspecialty is rotating/transitional.

Make copies and attach additional pages if necessary.

Send this form to the Kansas State Board of Healing Arts at the address listed in Section 1 with any added documentation, if applicable.

Section 2: Postgraduate Training Verification

Institution name: Washington University in St. Louis

Institution address: MSC 8064-37-1005, 600 S Euclid Ave

Institution city / state or province / zip code: St. Louis, MO 63108

Affiliated medical school name: Washington University School of Medicine

Institution / school name if different when the applicant attended: _____

Postgraduate year (e.g., 1, 2, 3, etc.): 6 ☐ Internship ☐ Residency ☒ Fellowship

☐ Research ☐ Chief Residency ☐ Other: _____

Specialty/Subspecialty: Complex Family Planning

Attendance dates: From 07/01/2021 to 06/30/2023

Successfully completed*? ☐ Yes ☐ No ☒ In progress with expected completion date of 06/30/2023

**In each year of training, did the applicant demonstrate sufficient academic and clinical ability to qualify for advancement without conditional or probationary status to the next year and next progressive level of responsibility in a designated specialty program?*

Accredited by: ☒ ACGME ☐ RCPSC ☐ AOA ☐ APPAP ☐ LCGME ☐ None of these ☐ RSC ☐ CFPC

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Applicant Name: Emily S. Barker

Postgraduate year (e.g., 1, 2, 3, etc.): _____ ☐ Internship ☐ Residency ☐ Fellowship
☐ Research ☐ Chief Residency ☐ Other: _____

Specialty/Subspecialty: _____

Attendance dates: From _____ to _____

Successfully completed*? ☐ Yes ☐ No ☐ In progress with expected completion date of _____

**In each year of training, did the applicant demonstrate sufficient academic and clinical ability to qualify for advancement without conditional or probationary status to the next year and next progressive level of responsibility in a designated specialty program?*

Accredited by: ☐ ACGME ☐ AOA ☐ LCGME ☐ RSC ☐ CFPC ☐ RCPSC ☐ APPAP ☐ None of these

Postgraduate year (e.g., 1, 2, 3, etc.): _____ ☐ Internship ☐ Residency ☐ Fellowship
☐ Research ☐ Chief Residency ☐ Other: _____

Specialty/Subspecialty: _____

Attendance dates: From _____ to _____

Successfully completed*? ☐ Yes ☐ No ☐ In progress with expected completion date of _____

**In each year of training, did the applicant demonstrate sufficient academic and clinical ability to qualify for advancement without conditional or probationary status to the next year and next progressive level of responsibility in a designated specialty program?*

Accredited by: ☐ ACGME ☐ AOA ☐ LCGME ☐ RSC ☐ CFPC ☐ RCPSC ☐ APPAP ☐ None of these

Please explain any "Yes" response on an additional page or in the blank sidebar area above.

Unusual Circumstances

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

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I CERTIFY THAT to the best of my knowledge and belief, the foregoing is a true, accurate, and complete statement of the record of the individual named on this form.

AFFIX [illegible] (If no [illegible] notarized.)

Signature: _____
Print name: D. Eisenberg
Title: Professor, Program Director
Date: 4-17-2023
Phone number: 314-747-6576 Fax number: 314-747-6722
Email: eisenbergd@wustl.edu

Program Director or Designated Official:
Send this form to the Kansas State Board of Healing Arts.

DO NOT SEND THIS FORM TO FCVS/FSMB.