Submission Date and Time: 7/1/2021 7:54 PM

New License Application

License Type - Doctor of Medicine (MD)

Application/License Number - APP-000486275

Personal Information

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

Title
No Response
First Name
Courtney
Middle Name
A
Last Name
Kerestes
Maiden Name
No Response
Social Security Number
*****[redacted]
Date of Birth
6/3/1989
Email Address
courtney.kerestes@gmail.com
Phone Number
(612) 801-7767
Other Phone Number
No Response
What is your U.S. Residency status related to your employment?
United States Citizen
Do you consider yourself Hispanic, Latino/a or of Spanish origin?
No
What do you consider your race?
White
List languages you personally use to communicate with patients excluding an interpreter or software
English
Other Language
No Response
Individual National Provider Identifier - if N/A enter all zeroes

1528447273
Enter home US zip-code. Enter NA if unavailable
43206

Additional Information

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

Do you have other aliases?
No Response
What is your gender?
Female
In which country were you born?
United States
In which state were you born (if United States)?
Minnesota
In which city were you born?
Hastings

Employment Status

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

What is your primary employment status
Not currently working - seeking position that requires this license
Which of the following best describes your five-year employment plan?
Maintain practice hours as is
Are you currently employed outside of USA?
No

License Mailing Address

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

395 W 12th Ave 5th Fl
Columbus
OH
43210-1267
United States

License Public Address

Select a public license mailing address by clicking the appropriate checkbox to the right (this is the address that will be viewable by the public). To add a new address, click Add Address, complete the required fields, and click Save.

395 W 12th Ave 5th Fl
Columbus
OH
43210-1267
United States

Military Service

If you have served in the military, provide the information for the type of service and duration of the service. Also, provide proof of your service.

Have you served in the military?
No
If you answered "Yes", are you currently serving in the military?
No Response
Has your spouse served in the military?
No
If you answered "Yes", are they currently serving in the military?
No Response
I declined to answer these questions

Secondary Email Recipient

You may define another email recipient for all automated emails you receive related to your license. You may change this recipient at any time from your dashboard.

Secondary Email Address:

Education History

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

Educational Institution - Gustavus Adolphus College
Degree Type - Bachelor's
Degree - BA
Enrollment date - 1/1/2008
Graduation date - 6/1/2011

Educational Institution - University of Iowa Carver College of Medicine
Degree Type - Doctoral
Degree - MD
Enrollment date - 8/15/2011
Graduation date - 5/15/2015

Educational Institution - University of Hawaii-Manoa
Degree Type - Masters
Degree - Master of Science in Quantitative Health and Clinical Research
Enrollment date - 8/22/2019
Graduation date - 5/15/2021

Employment History

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

Employer / Non-Working Activity - University of Iowa Hospitals and Clinics
Job Title - Resident Physician
Start Date - 7/1/2015
End Date - 6/30/2019
Average Hours/Week- 70
Street Address - 200 Hawkins Drive
Employment City - Iowa City
Employment County - Johnson
Employment State - Iowa
Employment Zipcode - 52242-1009
Employment Country - United States

Employer / Non-Working Activity - University of Hawaii John A. Burns School of Medicine
Job Title - Fellow Physician
Start Date - 7/1/2019
End Date - 6/30/2021
Street Address - 1319 Punahou St, Suite 824
Employment City - Honolulu
Employment County - Honolulu
Employment State - Hawaii
Employment Zipcode - 96826

Employment Country - United States

License Verification

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

R-10259
Doctor of Medicine (MD)
Iowa Board of Medicine
inactive
United States
Iowa

036.155138
Doctor of Medicine (MD)
State of Illinois Division of Professional Regulation
current
United States
Illinois

MD-20161
Doctor of Medicine (MD)
Hawaii Board of Medicine
current
United States
Hawaii

Examination Tracking

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

Examination - USMLE Step 1
Status - Passed
Exam date - 6/7/2013
Number of Attempts - 1

Examination - USMLE Step 2 CK
Status - Passed
Exam date - 6/27/2014

Number of Attempts - 1

Examination - USMLE Step 2 CS
Status - Passed
Exam date - 7/16/2014
Number of Attempts - 1

Examination - USMLE Step 3
Status - Passed
Exam date - 2/6/2017
Number of Attempts - 1

Specialty Tracking Component

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

Residency Component

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

Residency Number - RES46001
Hospital Name - University of Iowa Hospitals and Clinic
Address - 200 Hawkins Dr
City - Iowa City
State - IA
ZipCode - 52242-1009
Country - United States
PG Years - 4
PG Type - Residency
Department/Specialty - Obstetrics and Gynecology
Start Date - 7/1/2015
End Date - 6/30/2019
Successfully Completed? - true

Residency Number - RES46002
Hospital Name - University of Hawaii John A Burns School of Medicine
Address - 1319 Punahou St #824
City - Honolulu
State - HI
ZipCode - 96826
Country - United States
PG Years - 2

PG Type - Fellowship
Department/Specialty - Complex Family Planning
Start Date - 7/1/2019
End Date - 6/30/2021
Successfully Completed? - true

Current Employment Location(s)

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

Questions

Answer the following questions by selecting the Yes/No option for each question. Once completed, click Save and Continue. For any question that is answered in the affirmative you will later be required to upload a detailed explanation and supporting documents.

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

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

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

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

Question - Have you ever been investigated by, warned by, censured by, disciplined by, put on probation by, requested to resign or withdraw from, dismissed from, refused renewal of a contract by, or expelled from, a

medical or podiatry school, clinical clerkship, externship, preceptorship, residency, postdoctoral training program, or graduate medical education program?
Answer - No

Question - Have you ever, for any reason, lost specialty board certification in the U.S. or elsewhere, or been denied such certification, or denied examination for such certification?
Answer - No

Question - Has any board, bureau, department, agency or other body, including those in Ohio, in any way limited, restricted, suspended, or revoked any professional license, certificate or registration granted to you; placed you on probation; or imposed a fine, censure or reprimand against you?
Answer - No

Question - Have you ever voluntarily surrendered, resigned, or otherwise forfeited any professional license, certificate or registration issued to you by any board, bureau, department, agency, or other body; or have you ever withdrawn any application for licensure, relicensure, or examination, in any state (including Ohio), territory, province, or country? You may answer NO to this question if you voluntarily allowed a license, certificate, or registration to lapse or expire due to non-renewal.
Answer - No

Question - Have you ever, for any reason, been denied licensure or relicensure, application for licensure or relicensure, or the privilege of taking an examination, in any state (including Ohio), territory, province, or country?
Answer - No

Question - Are you one of the following: a medical director of an emergency medical service organization, a physician member of an advisory board of an emergency medical service organization, an employee of the State of Ohio, an employee of the Department of Corrections and have or have had contact with inmates and persons under supervision, or an employee of the Department of Youth Services? An affirmative answer to this question provides notice to the board that your residential and familial information is exempt from disclosure under Ohio's public records laws. Failure to self-identify may result in the board releasing such information in response to public records requests. In the event that your answer to this question changes before your next license renewal, you should immediately notify the board.
Answer - No

Question - Have you ever entered into an agreement of any kind, whether oral or written, with respect to a professional license, in lieu of or in order to avoid formal disciplinary action, with any board, bureau, department, agency, or other body, including those in Ohio?
Answer - No

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

Question - Have you ever been denied or have you ever surrendered a state or federal controlled substance or drug registration; had it revoked, terminated, or restricted in any way; or been warned, reprimanded, or fined by, or been requested to appear before, the responsible agency?
Answer - No

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

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

Question - Within the last ten years have you had a professional liability (malpractice) claim paid on your behalf, or paid such a claim yourself?
Answer - No

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

Question - Have you ever been denied or relinquished participation as a provider in any third party reimbursement program, whether governmental or private, including Medicaid and Medicare; or had such participation limited, restricted, suspended, or revoked; or been warned, reprimanded, requested to appear before, or fined by the responsible body?
Answer - No

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

Question - In the past five years, have you been diagnosed as having, or been hospitalized for a medical condition which in any way impairs or limits your ability to practice medicine with reasonable skill and safety? You may answer "NO" to this question if you hold a current training certificate to pursue training in Ohio and the only such medical condition is chemical dependency or substance abuse, and you have successfully completed or are currently receiving treatment at a program approved by this board and have adhered to all statutory requirements as contained in Section 4731.224 and 4731.25, O.R.C., and related provisions. Any questions concerning approval can be directed to the board offices.
Answer - No

Question - Do you use chemical substance(s) which in any way impair or limit your ability to practice medicine with reasonable skill and safety?

Answer - No

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

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

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

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

Attachments

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

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

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

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

Review + Submit

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

Application Review - Completed

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

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

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

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

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

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

Consent to Electronic Signature - **Consented**
Date/Time Stamp - 7/1/2021 7:54 PM
Type your First Name and Last Name as they appear on the application to sign electronically.

Courtney Kerestes
Submit your Application -After clicking the ‘Submit’ button below, you will no longer be able to change this application. **PLEASE DO NOT USE THE BROWSER'S BACK BUTTON AS THAT MAY OVERWRITE YOUR DATA.** If you want to return to your application, simply log out and log back in.
If this application requires payment you will be prompted to begin the payment process. You must complete the payment process before the board will review your application. If this application does not require payment, you will be navigated back to the eLicense home page and the board will review your application.

Submission Date and Time: 6/20/2023 2:53 PM

License Renewal Application

License Type - Doctor of Medicine (MD)

License Number - 35.143183

License Renewal Number - LR-004981933

Personal Information

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

Title
No Response
First Name
Courtney
Middle Name
A
Last Name
Kerestes
Maiden Name
No Response
Social Security Number
****Redacted
Date of Birth
6/3/1989
Email Address
courtney.kerestes@gmail.com
Phone Number
(612) 801-7767
Other Phone Number
No Response
What is your U.S. Residency status related to your employment?
United States Citizen
Do you consider yourself Hispanic, Latino/a or of Spanish origin?
No
What do you consider your race?
White
List languages you personally use to communicate with patients excluding an interpreter or software
English
Other Language

No Response
Individual National Provider Identifier - if N/A enter all zeroes
1528447273
Enter home US zip-code. Enter NA if unavailable
43206

Additional Information

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

Do you have other aliases?
No Response
What is your gender?
Female
In which country were you born?
United States
In which state were you born (if United States)?
Minnesota
In which city were you born?
Hastings

Employment Status

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

What is your primary employment status
Actively working in a position(s) that requires this license
Which of the following best describes your five-year employment plan?
Maintain practice hours as is
Are you currently employed outside of USA?
No

License Mailing Address

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

395 W 12th Ave 5th Fl
Columbus
OH
43210-1267
United States

License Public Address

Select a public license mailing address by clicking the appropriate checkbox to the right (this is the address that will be viewable by the public). To add a new address, click Add Address, complete the required fields, and click Save.

395 W 12th Ave 5th Fl
Columbus
OH
43210-1267
United States

Military Service

If you have served in the military, provide the information for the type of service and duration of the service. Also, provide proof of your service.

Have you served in the military?
No
If you answered "Yes", are you currently serving in the military?
No Response
Has your spouse served in the military?
No
If you answered "Yes", are they currently serving in the military?
No Response
I declined to answer these questions

Secondary Email Recipient

You may define another email recipient for all automated emails you receive related to your license. You may change this recipient at any time from your dashboard.

Secondary Email Address:

Specialty Tracking Component

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

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

Medical SubSpeciality - null

Current Employment Location(s)

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

Name of Practice Site - Ohio State University Wexner Medical Center
Practice Settings - Hospital - Inpatient
Street Address - 395 W 12th Ave, 5th floor
City - Columbus
State - OH
Zip Code - 43210
Major Area of Focus or Specialty - Obstetrics and Gynecology (ABMS)
Total Hours Worked at this practice site, per Week - 25

Percent of time spent per week in each of the following at this practice site:
Direct Patient Care - 60
Teaching/Academic - 20
Research - 20
Professional Services - 0
Administrative Activities - 0
Other - 0
Total Hours- 100

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

Name of Practice Site - OSU Outpatient Care Upper Arlington
Practice Settings - Office/Clinic - Multi Specialty Group
Street Address - 1800 Zollinger Road, 4th floor
City - Columbus
State - OH
Zip Code - 43221
Major Area of Focus or Specialty - Obstetrics and Gynecology (ABMS)
Total Hours Worked at this practice site, per Week - 14

Percent of time spent per week in each of the following at this practice site:
Direct Patient Care - 100
Teaching/Academic - 0

Research - 0
Professional Services - 0
Administrative Activities - 0
Other - 0
Total Hours- 100

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

Name of Practice Site - Planned Parenthood East Columbus
Practice Settings - Office/Clinic - Single Specialty Group
Street Address - 3255 E Main St
City - Columbus
State - OH
Zip Code - 43213
Major Area of Focus or Specialty - Obstetrics and Gynecology (ABMS)
Total Hours Worked at this practice site, per Week - 8

Percent of time spent per week in each of the following at this practice site:
Direct Patient Care - 80
Teaching/Academic - 20
Research - 0
Professional Services - 0
Administrative Activities - 0
Other - 0
Total Hours- 100

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

Questions

Answer the following questions by selecting the Yes/No option for each question. Once completed, click Save and Continue. For any question that is answered in the affirmative you will later be required to upload a detailed explanation and supporting documents.

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

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

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

Question - At any time since submission of your last application for renewal have you been addicted to or dependent upon alcohol or any chemical substance; or been treated for, or been diagnosed as suffering from, an alcohol or other substance use disorder? You may answer NO to this question if you have been found to be eligible for the One-Bite Program and are in compliance with a monitoring agreement with the One-Bite monitoring organization. You must answer YES if you have relapsed at any time since submission of your last application for renewal.
Answer - No

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

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

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

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

Question -

Are you one of the following: a medical director of an emergency medical service organization, a physician member of an advisory board of an emergency medical service organization, an employee of a community mental health service provider, an employee of a local alcohol, drug addiction, and mental health services

board, an employee of ODMHAS, are involved in court-ordered patient commitments in some capacity, an employee of the State of Ohio, an employee of the Department of Corrections and have or have had contact with inmates and persons under supervision, or an employee of the Department of Youth Services?

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

Answer - No

Question - Do you prescribe controlled substances?
Answer - Yes

Question - Primary DEA Number
Answer - FK814 7969

Question - At any time since signing your last application for renewal of your certificate have you been investigated, warned, censured, put on probation, terminated, or disciplined by any employer, hospital, group practice, nursing home, clinic, health maintenance organization, or other similar institution, for any reason?
Answer - No

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

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

Question - At any time since signing your last application for renewal of your certificate, have you engaged in conduct prohibited by the Medical Board’s rules regarding sexual misconduct and impropriety (chapter 4731-26 of the Administrative Code)?
Answer - No

Attachments

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

Review + Submit

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

Application Review - Completed

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

Consent to Electronic Signature - **Consented**
Date/Time Stamp - 6/20/2023 2:53 PM
Type your First Name and Last Name as they appear on the application to sign electronically.
Courtney Kerestes
Submit your Application -After clicking the ‘Submit’ button below, you will no longer be able to change this application. **PLEASE DO NOT USE THE BROWSER'S BACK BUTTON AS THAT MAY OVERWRITE YOUR DATA.** If you want to return to your application, simply log out and log back in.
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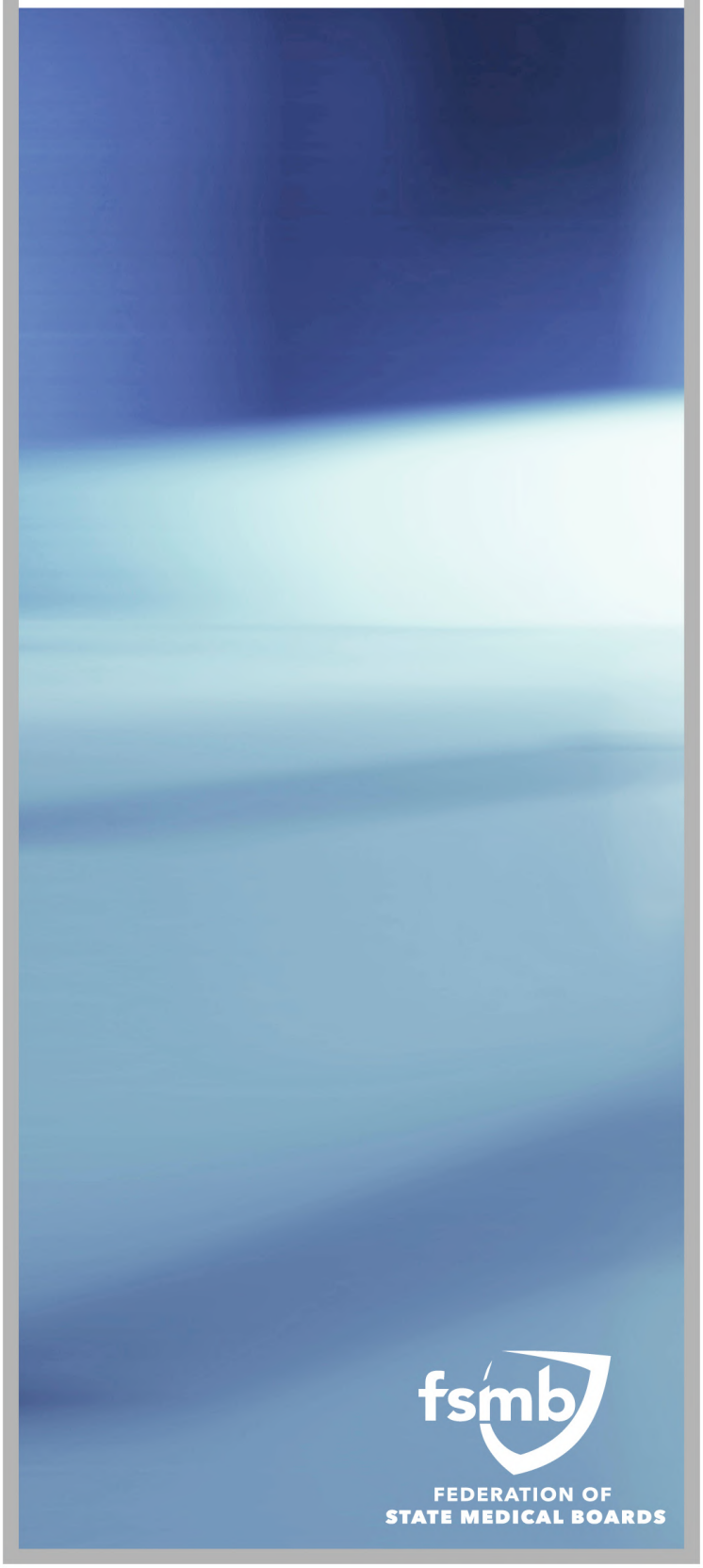
FCVS

FEDERATION CREDENTIALS VERIFICATION SERVICE



Medical Professional Information Profile

This report provides credentialing information for:

Name:	**Kerestes, Courtney Anne**
Social Security Number:	**XXX-XX-**[redacted]
Date of Birth:	**June 03, 1989**
FID#:	**218540920**
Recipient:	**OH - State Medical Board of Ohio**
Delivery Date:	**06/21/2021**

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.

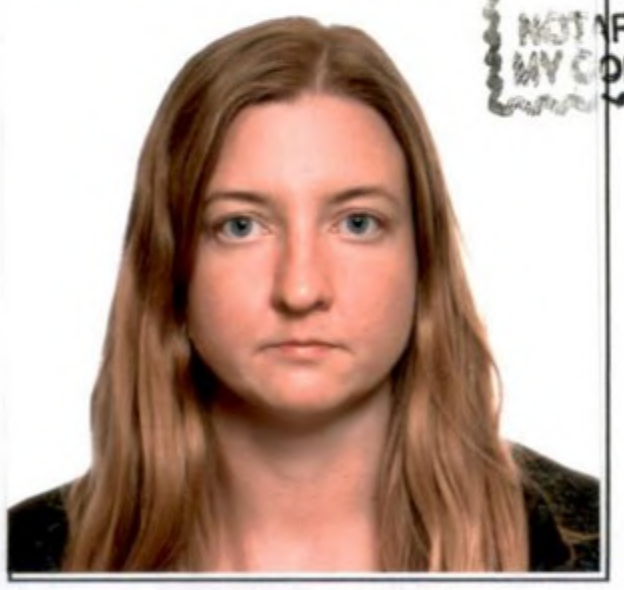
"OFFICIAL SEAL"
S SHAH
NOTARY PUBLIC, STATE OF ILLINOIS
MY COMMISSION EXPIRES 11/16/2023

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

Kerestes
Applicant's **Printed** Last Name

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

5/19/21
Date of Signature (**must** correspond to date of notarization)



State of ILLINOIS, County of COOK,
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 19 day of MAY, 2021.

Notary Public Signature:

My Notary Commission Expires: 11-16-2023

"OFFICIAL SEAL"
S SHAH
NOTARY PUBLIC, STATE OF ILLINOIS
MY COMMISSION EXPIRES 11/16/2023

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

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

FCVS ID Number
218 540 920

FID Number

FCVS FEDERATION CREDENTIALS VERIFICATION SERVICE

Identity

fsmb

Biographic Information

Medical professional Name(s): **Kerestes, Courtney Anne**

Date of Birth: June 03, 1989

Place of Birth: Hastings, Minnesota, UNITED STATES

Contact Information

Business Address: 395 W 12th Ave
5th floor
Columbus, OH 43210
UNITED STATES

Home Address: 801 S King St.
Apt 3906
Honolulu
Honolulu, HI 96813
UNITED STATES

Mobile Phone: (612) 801-7767

Email: courtney.kerestes@gmail.com

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: Kerestes (Last) Courtney (First) Anne (Middle)

FCVS ID Number: 218540920

Notary – Please complete the section below:

State of ILLINOIS County of COOK

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

The statements on this document are subscribed and sworn to before me by the applicant on this

(Day) 19, of (Month) MAY, (Year) 2021.

Notary Public Signature: S Shah

Commission Expiration Date* (Month) 11 / (Day) 16 / (Year) 2023

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

Notary Stamp Here S Shah

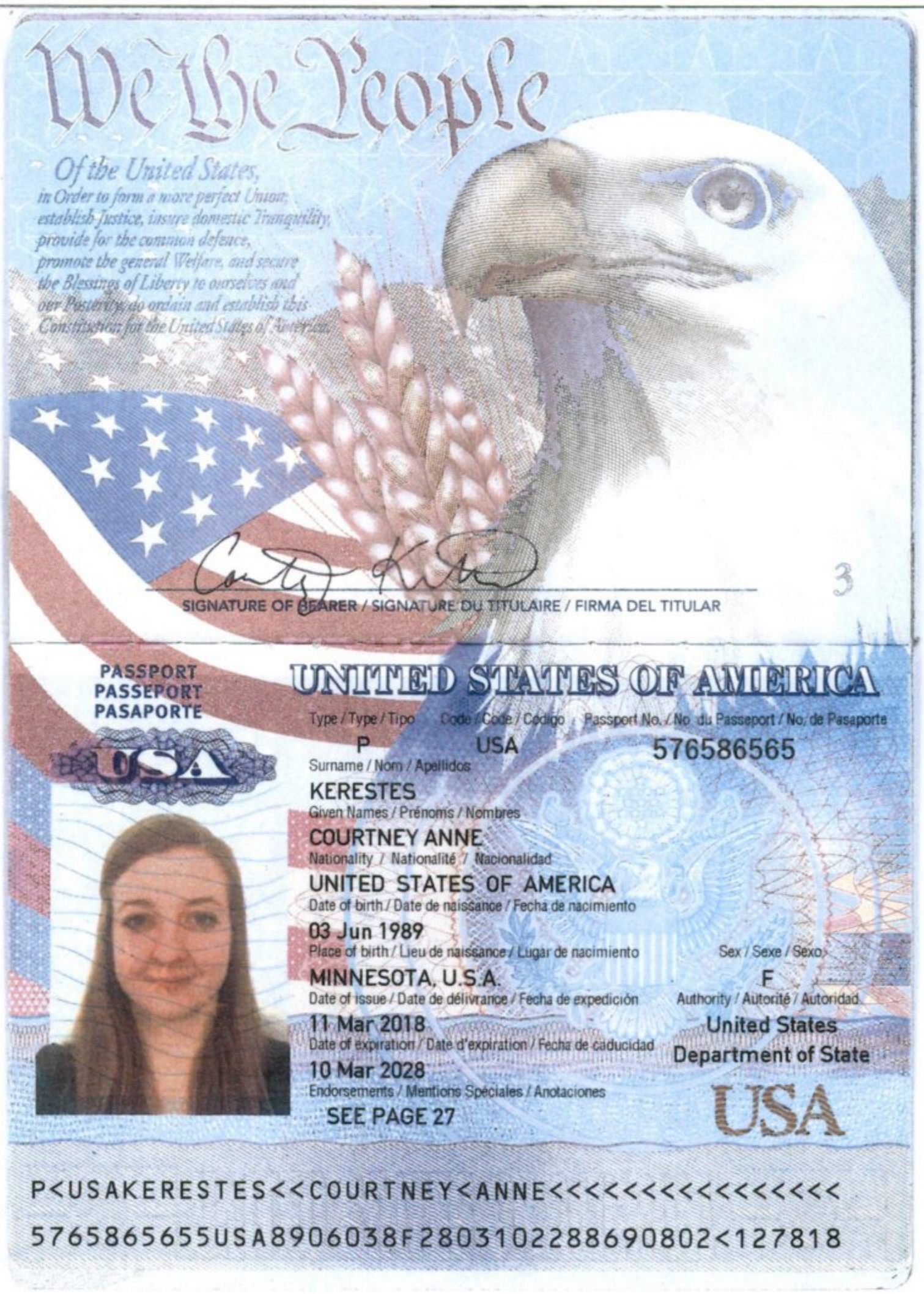
"OFFICIAL SEAL"
S SHAH
NOTARY PUBLIC, STATE OF ILLINOIS
MY COMMISSION EXPIRES 11/16/2023

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

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

FCVS ID Number PP FID Number

218 540 920


We the People
Of the United States,
in Order to form a more perfect Union,
establish Justice, insure domestic Tranquility,
provide for the common defence,
promote the general Welfare, and secure
the Blessings of Liberty to ourselves and
our Posterity, do ordain and establish this
Constitution for the United States of America.
SIGNATURE OF BEARER / SIGNATURE DU TITULAIRE / FIRMA DEL TITULAR
3
PASSPORT
PASSEPORT
PASAPORTE
USA
UNITED STATES OF AMERICA
Type / Type / Tipo
P
Code / Code / Código
USA
Passport No. / No. du Passeport / No. de Pasaporte
576586565
Surname / Nom / Apellidos
KERESTES
Given Names / Prénoms / Nombres
COURTNEY ANNE
Nationality / Nationalité / Nacionalidad
UNITED STATES OF AMERICA
Date of birth / Date de naissance / Fecha de nacimiento
03 Jun 1989
Place of birth / Lieu de naissance / Lugar de nacimiento
MINNESOTA, U.S.A.
Sex / Sexe / Sexo
F
Date of issue / Date de délivrance / Fecha de expedición
11 Mar 2018
Authority / Autorité / Autoridad
United States
Department of State
Date of expiration / Date d'expiration / Fecha de caducidad
10 Mar 2028
Endorsements / Mentions Spéciales / Anotaciones
SEE PAGE 27
USA
P<USAKERESTES<<COURTNEY<ANNE<<<<<<<<<<<<<<<<<<
5765865655USA8906038F2803102288690802<127818

218 540 920

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
08/12/2011	05/15/2015	Medical Education	University of Iowa Carver College of Medicine Iowa City Iowa UNITED STATES
06/22/2015	06/30/2019	Postgraduate Training	University of Iowa Hospitals and Clinics Program Iowa City Iowa UNITED STATES
07/01/2019	06/30/2021	Postgraduate Training	University of Hawaii Program Honolulu Hawaii UNITED STATES

End of Chronology of Activities report for: Kerestes, Courtney Anne

FCVS FEDERATION CREDENTIALS VERIFICATION SERVICE

Medical Education

Medical Education

Medical School: **University of Iowa Carver College of Medicine**

Location: Iowa City, IA

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 Iowa Carver College of Medicine

City: Iowa City **State/Province:** Iowa **Country:** UNITED STATES

Premedical Education:

Years of education required for admission to your medical school: 4

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

Enrollment and Participation:

Our records indicate that Kerestes, Courtney Anne

attended our medical school for a total of 158 weeks of medical education on the following dates: From MM/DD/YYYY: 08/22/2011 To MM/DD/YYYY: 05/15/2015

This individual was awarded the degree of Doctor of Medicine on 05/15/2015

DS SJ

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: 016010 FID: 218540920

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: Joan Smothers Title: Registrar Services Specialist Signature: DocuSigned by: Smothers, Joan E04232D8A2FB46B... Date of Signature: 5/25/2021 Email: ccom-registrar@uiowa.edu

Medical School Code: 016010 FID: 218540920

UNIVERSITY OF IOWA
CARVER COLLEGE
OF MEDICINE
University of Iowa Health Care

Office of Student Affairs and Curriculum

Roy J. and Lucille A.
Carver College of Medicine
Student Programs and Records
1216 Medical Education and Research Facility
Iowa City, Iowa 52242-2600
319-335-6823 ***Tel***
319-335-8643 ***Fax***
www.uihealthcare.com

November 6, 2019

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

To whom this may concern:

Due to staffing changes, please add Joan Smothers, Registrar Services Specialist, as an individual responsible for completion and certification of all medical education verification documents. These are the designated individual(s) available in the office of student affairs:

Matthew Edwards, CCOM Registrar
Annette Griffin, Registrar Services Specialist
Joan Smothers, Registrar Services Specialist

Sincerely,

Matthew Edwards, M.Ed.
Registrar

ME/alg

Courtney Anne Kerestes

the degree

Doctor of Medicine

With all the Honors, Rights and Privileges belonging to this Degr
in consideration of the satisfactory completion of the Program of Study pres

Roy J. and Lucille A. Carver College of M

Awarded at Iowa City in the state of Iowa
This fifteenth day of May, two thousand and fifteen.

PRESIDENT OF THE STATE BOARD OF REGENTS

THE UNIVERSITY OF IOWA
ORGANIZED FEB. 25 1847

PRES

FCVS FEDERATION CREDENTIALS VERIFICATION SERVICE

Applicant Reported Unusual Circumstances

fsmb

Medical School

Medical Professional Name: Kerestes, Courtney Anne

University of Iowa Carver College of Medicine

Unusual Circumstances

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

End of Applicant Reported Unusual Circumstances report for: Kerestes, Courtney Anne

THE UNIVERSITY OF IOWA

Office of the Registrar Official Transcript

Name:	Courtney Anne Kerestes
University ID:	00741172
Month/Date of Birth:	06/03
Date Generated:	05/26/21 08:58 AM

University of Iowa Degree(s):
Doctor of Medicine Conferred May 15, 2015
(Service Distinction Track)

Degree(s) from other institution(s):
BA Gustavus Adolphus College, Saint Peter, MN 2011

Previous/Transfer institution(s):
Gustavus Adolphus College, Saint Peter, MN 2007-2011

*******************START ACADEMIC RECORD*******************

Course Number		Course Title	Sem Hrs	Grade
Fall 2011 / Roy J. & Lucille A. Carver College of Medicine				
050	120	MED CELL BIOLOGY	2.0	H
050	162	FDTN CLIN PRAC I	5.0	H
060	103	MED GROSS HUM ANAT	6.0	H
099	163	MED BIOCHEMISTRY	4.0	H
050	195	HEALTH OUTREACH I	1.0	P
050	281	GLOBAL HEALTH I	1.0	P
070	110	MEDICAL GENETICS	2.0	P

	Graded Hrs Att	GPA	Graded Hrs Earned	Hrs Earned
UI Term:	0.0	0.00	0.0	21.0
UI Cum:	0.0	0.00	0.0	21.0

Spring 2012 / Roy J. & Lucille A. Carver College of Medicine				
050	163	FDTN CLIN PRAC II	5.0	H-
050	240	HUMAN ORGAN SYSTEMS	8.0	H-
060	234	MED NEUROSCIENCE	4.0	H-
148	251	PRIN MED IMMUNOLOGY	2.0	H-
050	196	HEALTH OUTREACH II	1.0	P
050	285	GLOBAL HEALTH II	1.0	P
414	198	UIHC COMPLIANC TRNG	0.0	R

	Graded Hrs Att	GPA	Graded Hrs Earned	Hrs Earned
UI Term:	0.0	0.00	0.0	21.0
UI Cum:	0.0	0.00	0.0	42.0

Summer 2012 / Roy J. & Lucille A. Carver College of Medicine				
050	005	MED RSRCH FELLOWSHP	0.0	R

	Graded Hrs Att	GPA	Graded Hrs Earned	Hrs Earned
UI Term:	0.0	0.00	0.0	0.0
UI Cum:	0.0	0.00	0.0	42.0

Fall 2012 / Roy J. & Lucille A. Carver College of Medicine				
071	105	Pharmacology for Health Sciences Medical	5.0	H
050	164	Foundations of Clinical Practice III	5.0	H-
061	103	Principles of Infectious Diseases	5.0	H-
069	205	Medical Pathology I	5.0	P

	Graded Hrs Att	GPA	Graded Hrs Earned	Hrs Earned
UI Term:	0.0	0.00	0.0	20.0
UI Cum:	0.0	0.00	0.0	62.0

Spring 2013 / Roy J. & Lucille A. Carver College of Medicine				
050	165	Foundations of Clinical Practice IV ICD	13.0	H
050	197	Community Health Outreach	2.0	P
050	183	Healthcare Ethics Law and Policy	2.0	P
069	206	Medical Pathology II	5.0	P

	Graded Hrs Att	GPA	Graded Hrs Earned	Hrs Earned
UI Term:	0.0	0.00	0.0	22.0
UI Cum:	0.0	0.00	0.0	84.0

Summer 2013 / Roy J. & Lucille A. Carver College of Medicine				
050	170	Clinical Beginnings	1.0	P
050	003	Clinical Clerkships	6.0	R

	Graded Hrs Att	GPA	Graded Hrs Earned	Hrs Earned
UI Term:	0.0	0.00	0.0	1.0
UI Cum:	0.0	0.00	0.0	85.0

Fall 2013 / Roy J. & Lucille A. Carver College of Medicine

1st Half Clinical Year 1 2013-2014				
064	011	Clinical Neurology	2.0	H
070	002	Clinical Pediatrics	6.0	H-
116	006	Clinical Anesthesia	2.0	P
078	101	Inpatient Internal Medicine	6.0	P
068	003	Clinical Otolaryngology	2.0	P
073	005	Clinical Psychiatry	4.0	P
079	104	Clinical Urology	2.0	P

	Graded Hrs Att	GPA	Graded Hrs Earned	Hrs Earned
UI Term:	0.0	0.00	0.0	24.0
UI Cum:	0.0	0.00	0.0	109.0

Spring 2014 / Roy J. & Lucille A. Carver College of Medicine

2nd Half Clinical Year 1 2013-2014				
066	004	Clinical Obstetrics and Gynecology	6.0	H
075	005	Clinical Surgery	6.0	H-
115	300	Preceptorship in Family Medicine	4.0	P
078	102	Outpatient Internal Medicine	4.0	P
050	180	Community-Based Primary Care	4.0	P

	Graded Hrs Att	GPA	Graded Hrs Earned	Hrs Earned
UI Term:	0.0	0.00	0.0	24.0
UI Cum:	0.0	0.00	0.0	133.0

Summer 2014 / Roy J. & Lucille A. Carver College of Medicine				
050	003	Clinical Clerkships	6.0	R

	Graded Hrs Att	GPA	Graded Hrs Earned	Hrs Earned
UI Term:	0.0	0.00	0.0	0.0
UI Cum:	0.0	0.00	0.0	133.0

http://registrar.uiowa.edu/legends-and-keys

ELECTRONIC SEAL VERIFIED

Laurence J. Lakewood

THE UNIVERSITY OF IOWA

Office of the Registrar Official Transcript

Fall 2014 / Roy J. & Lucille A. Carver College of Medicine

1st Half Clinical Year 2 2014-2015

DERM	8301	Clinical Dermatology	2.0	H
IM	8303	Electrocardiography	1.0	H
MED	8480	Global Cross-Cultural Clerkship	4.0	H
OBG	8402	Gynecologic Oncology Subinternship	4.0	H
OBG	8403	Reproductive Endocrinology Senior Elect	4.0	H-
PATH	8301	Laboratory Medicine in Clinical Practice	1.0	P

	Graded Hrs Att	GPA	Graded Hrs Earned	Hrs Earned
UI Term:	0.0	0.00	0.0	16.0
UI Cum:	0.0	0.00	0.0	149.0

Spring 2015 / Roy J. & Lucille A. Carver College of Medicine

2nd Half Clinical Year 2 2014-2015

MED	8480	Global Cross-Cultural Clerkship	4.0	H
OBG	8408	Non-Interventional Birth Elective	2.0	H
ANES	8402	Surgical and Neurosciences Intensive Car	4.0	H-
IM	8437	Multidisciplinary Cancer Care	2.0	P
ORTH	8301	Clinical Orthopaedics	2.0	P
RAD	8301	Clinical Radiology	2.0	P

	Graded Hrs Att	GPA	Graded Hrs Earned	Hrs Earned
UI Term:	0.0	0.00	0.0	16.0
UI Cum:	0.0	0.00	0.0	165.0

********************END ACADEMIC RECORD********************

Laurence J. Lakewood

Postgraduate Training

Accreditation ID: **2201821102**

Institution: **University of Iowa Hospitals and Clinics Program**

Location: Iowa City, IA
UNITED STATES

Accreditation ID: **2361422001**

Institution: **University of Hawaii Program**

Location: Honolulu, HI
UNITED STATES

Credentials Analysis Information for Postgraduate Training

Program Code: 2361422001

Issue:
The Medical Professional reported training from 07/01/2019 to 06/30/2020 as accredited. The institution confirmed the training as non-accredited.

Solution:
FCVS no longer obtains or reviews verification of non-accredited training programs; if received, it is included in the profile as is.

Federation Credentials Verification Service (FCVS)
400 Fuller Wiser Rd, Euless, TX 76039
Tel: (817) 868-5000 Email: fcvsgme@fsmb.org

Verification of Postgraduate Medical Education

Institution: University of Iowa Hospitals and Clinics Program
Specialty: Obstetrics & Gynecology
Address: Iowa City, IA

Attention: **Program Director**
Affiliated University:

Verification For:

Name: Courtney Anne Kerestes
DOB: 06/03/1989
Individual's Name on Record (If different from above):

Program Participation:

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

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

Report Internships, Residencies and Fellowships separately.

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

PGY: R1
☐ Internship ☑ Residency ☐ Chief Residency ☐ Fellowship ☐ Research
Specialty/Subspecialty: Obstetrics and Gynecology
From: 06/24/2015 To: 06/30/2016
Successfully Completed?: ☑ Yes ☐ No ☐ In Progress
Accredited by: ☑ ACGME ☐ AOA ☐ LCGME ☐ RSC ☐ CFPC ☐ RCPSC ☐ APPAP ☐ None of these

PGY: R2
☐ Internship ☑ Residency ☐ Chief Residency ☐ Fellowship ☐ Research
Specialty/Subspecialty: Obstetrics and Gynecology
From: 07/01/2016 To: 06/30/2017
Successfully Completed?: ☑ Yes ☐ No ☐ In Progress
Accredited by: ☑ ACGME ☐ AOA ☐ LCGME ☐ RSC ☐ CFPC ☐ RCPSC ☐ APPAP ☐ None of these

PGY: R3, R4
☐ Internship ☑ Residency ☐ Chief Residency ☐ Fellowship ☐ Research
Specialty/Subspecialty: Obstetrics and Gynecology
From: 07/01/2017 To: 06/30/2019
Successfully Completed?: ☑ Yes ☐ No ☐ In Progress
Accredited by: ☑ ACGME ☐ AOA ☐ LCGME ☐ RSC ☐ CFPC ☐ RCPSC ☐ APPAP ☐ None of these

Unusual Circumstances:

Check the correct response. Omitted responses require written explanation.

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

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

Please explain any "Yes" response from above:

ELECTRONIC SEAL VERIFIED

Certification:

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

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

Name: Colleen K. Stockdale, MD, MS Signature: Colleen K. Stockdale, MD, MS
Title: Residency Program Director Date of Signature: 05/26/2021
Tel: 319-353-6095 Fax: 319-384-8620 E-Mail: colleen-stockdale@uiowa.edu

FID: 218540920 ACGME ID: 2201821102 GME CODE:

FCVS FEDERATION CREDENTIALS VERIFICATION SERVICE

Applicant Reported Unusual Circumstances

fsmb

Graduate Medical Education

Medical Professional Name:	Kerestes, Courtney Anne
Accreditation ID:	2201821102
Institution:	University of Iowa Hospitals and Clinics Program
Specialty:	Obstetrics & Gynecology

Unusual Circumstances

Training Period: 6/22/2015 - 6/30/2019 **Residency**

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

End of Applicant Reported Unusual Circumstances report for: Kerestes, Courtney Anne

The University of Iowa

University of Iowa Hospitals and Clinics
and
Roy J. and Lucille A. Carver College of Medicine

CERTIFY

Courtney A. Kerestes, M.D.

SUCCESSFULLY COMPLETED TRAINING AS A

Resident in Obstetrics and Gynecology

IN THE DEPARTMENT OF

Obstetrics and Gynecology

June 24, 2015 - June 30, 2019

TO THE SATISFACTION OF THE
OFFICERS AND STAFF OF THE UNIVERSITY OF IOWA HOSPITALS AND CLINICS
IN WITNESS WHEREOF, THIS CERTIFICATE IS AWARDED AT IOWA CITY IN THE STATE OF IOWA

ASSOCIATE VICE PRESIDENT AND CEO,
UNIVERSITY OF IOWA HOSPITALS AND CLINICS

J. Brooks Jackson
VICE PRESIDENT FOR MEDICAL AFFAIRS
DEAN, CARVER COLLEGE OF MEDICINE

UNIVERSITY OF IOWA HEALTH CARE
Graduate Medical Education

Mark C. Wilson
ASSOCIATE DEAN AND DIRECTOR, GRADUATE MEDICAL EDUCATION

Kimberly K. Leslie MD
HEAD OF THE DEPARTMENT

DIRECTOR, TRAINING PROGRAM

The training program indicated on this certificate is accredited by the Accreditation Council for Graduate Medical Education
Duplicate/Original certificate issued 6/30/19

NPI# 1528447273

Federation Credentials Verification Service (FCVS)
400 Fuller Wiser Rd, Euless, TX 76039
Tel: (817) 868-5000 Email: fcvsgme@fsmb.org

Verification of Postgraduate Medical Education

Institution: University of Hawaii Program
Specialty: Obstetrics & Gynecology/Complex Family Planning
Address: Honolulu, HI

Attention: **Program Director**
Affiliated University:

Verification For:

Name: Courtney Anne Kerestes
DOB: 06/03/1989
Individual's Name on Record (If different from above):

Program Participation:

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

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

Report Internships, Residencies and Fellowships separately.

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

PGY: 6
☐ Internship ☐ Residency ☐ Chief Residency ☑ Fellowship ☐ Research
Specialty/Subspecialty: Complex Family Planning
From: 07/01/2020 To: 6/30/2021
Successfully Completed?: ☐ Yes ☐ No ☐ In Progress
Accredited by: ☐ ACGME ☐ AOA ☐ LCGME ☐ RSC ☐ CFPC ☐ RCPSC ☐ APPAP ☐ None of these

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

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

Unusual Circumstances:

Check the correct response. Omitted responses require written explanation.

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

ELECTRONIC SEAL VERIFIED

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

Please explain any "Yes" response from above:

Certification:

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

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

Name: Signature:
Title: Date of Signature:
Tel: Fax: E-Mail:

FID: ACGME ID: GME CODE:

FCVS FEDERATION CREDENTIALS VERIFICATION SERVICE

Applicant Reported Unusual Circumstances

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Graduate Medical Education

Medical Professional Name:	Kerestes, Courtney Anne
Accreditation ID:	2361422001
Institution:	University of Hawaii Program
Specialty:	Obstetrics & Gynecology/Complex Family Planning

Unusual Circumstances

Training Period: 7/1/2019 - 6/30/2021 **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**

End of Applicant Reported Unusual Circumstances report for: Kerestes, Courtney Anne

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: 06/21/2021

Federation Credentials Verification Service
ATTN: FCVS

FCVSID: 572523

Examinee: Kerestes, Courtney Anne
Alt Name(s):

Examinee ID: 5-299-377-1
Date of Birth: 06/03/1989

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

USMLE STEP 1

Test Date	Pass/Fail	Score	Minimum Pass	Comments
06/07/2013	Pass	245	(188)	

USMLE STEP 2

Clinical Knowledge (CK)

Test Date	Pass/Fail	Score	Minimum Pass	Comments
06/27/2014	Pass	256	(203)	

Clinical Skills (CS)

Test Date	Pass/Fail	Comments
07/16/2014	Pass	

USMLE STEP 3

Test Date	Pass/Fail	Score	Minimum Pass	Comments
02/06/2017	Pass	241	(196)	

End of Exam History

NOTE: The USMLE Step 2 CS examination has been suspended since March 16, 2020.

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

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Examinee: Kerestes, Courtney Anne

Examinee ID: 5-299-377-1
Date of Birth: 06/03/1989

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

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

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

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

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

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

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

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

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

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

03/2015

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

PDC PHYSICIAN DATA CENTER

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PRACTITIONER PROFILE

Prepared for:	FCVS	As of Date:6/21/2021

PRACTITIONER INFORMATION

Name:	Kerestes, Courtney Anne
DOB:	6/3/1989
Medical School:	University of Iowa Carver College of Medicine Iowa City, Iowa, UNITED STATES
Year of Grad:	2015
Degree Type:	MD
NPI:	1528447273

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
1528447273	Individual			11/17/2020

LICENSE HISTORY

Jurisdiction	License Number	Issue Date	Expiration Date	Last Updated
HAWAII	MD-20161	12/26/2018	01/31/2022	04/29/2021
ILLINOIS	036155138	12/28/2020	07/31/2023	04/29/2021
IOWA	R-10259	05/26/2015	06/30/2019	06/15/2021

ACTIVE US DRUG ENFORCEMENT ADMINISTRATION (DEA)

DEA Number	Schedule	Address	Expiration Date	Last Reported
FK8147969	22N 33N 4 5	HONOLULU,HI 96826	12/31/2021	06/10/2021

PDC PHYSICIAN DATA CENTER

fsmb

PRACTITIONER PROFILE

Prepared for:	FCVS	As of Date:6/21/2021
Practitioner Name:	Kerestes, Courtney Anne	

ABMS® CERTIFICATION HISTORY

No ABMS Certifications found.

AOA® CERTIFICATION HISTORY

No AOA Certifications found.

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