RECEIVED
By Rebecca Berg at 2:53 pm, Apr 11, 2022

MAR 04 2022
KSBHA

Kansas

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 "<u>no</u>" 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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*** "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).

From:	Admin
To:	Berg, Rebecca [KSBHA]
Subject:	Re: Kansas State Board of Healing Arts - Licensure Needed Documentation
Date:	Monday, April 11, 2022 11:21:34 AM
Attachments:	20220411111619946.pdf 20220411111635676.pdf

EXTERNAL: This email originated from outside of the organization. Do not click any links or open any attachments unless you trust the sender and know the content is safe.

Hello Please see attached.

I have also ordered all transcripts please let me know if you have not received them.

Best,
Lizzie.

From: Berg, Rebecca [KSBHA] <Rebecca.Berg@ks.gov>
Sent: Monday, March 14, 2022 1:38 PM
To: Admin <admin@southwindwomenscenter.org>
Subject: Kansas State Board of Healing Arts - Licensure Needed Documentation

Hello Dr Jennifer Kerns,

To continue processing your licensure application please see the attached Missing Requirement Letter (MRL).

If you have any questions, please contact me.

Thank you,

Becky Berg
Licensing Analyst
Kansas State Board of Healing Arts
800 SW Jackson, LL – Suite A
Topeka, Kansas 66612
Email: rebecca.berg@ks.gov
Phone: 785.368.8206
Fax: 785.296.0852
http://www.kshba.org

MAR 04 2022

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, KSBHA
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: Kerns Suffix: ______

First name: Jennifer

Middle name: ______

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: ______

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

Street: ______

City: ______

State/Province: ______

Zip code: ______ Country: ______

Home phone: ______ Home fax: ______

Alternate phone: ______ Alternate fax: ______

Home email: ______

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

Date of birth: CONFIDENTIAL (mm/dd/yyyy) Gender: F Birth city: Sacramento

Birth state/province: California Birth country: United States

Social Security number*: CONFIDENTIAL (9 digits) NPI number**: 1518137116 (10 digits) U.S. Citizen? ☑ Yes ☐ No

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

**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/

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

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From:	Admin
To:	Berg, Rebecca [KSBHA]
Subject:	Re: Kansas State Board of Healing Arts - Licensure Needed Documentation
Date:	Monday, April 11, 2022 11:32:47 AM

EXTERNAL: This email originated from outside of the organization. Do not click any links or open any attachments unless you trust the sender and know the content is safe.

CONFIDENTIAL

From: Admin <admin@southwindwomenscenter.org>
Sent: Monday, April 11, 2022 11:20 AM
To: Berg, Rebecca [KSBHA] <Rebecca.Berg@ks.gov>
Subject: Re: Kansas State Board of Healing Arts - Licensure Needed Documentation

Hello Please see attached.

I have also ordered all transcripts please let me know if you have not received them.

Best,
Lizzie.

From: Berg, Rebecca [KSBHA] <Rebecca.Berg@ks.gov>
Sent: Monday, March 14, 2022 1:38 PM
To: Admin <admin@southwindwomenscenter.org>
Subject: Kansas State Board of Healing Arts - Licensure Needed Documentation

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To continue processing your licensure application please see the attached Missing Requirement Letter (MRL).

If you have any questions, please contact me.

Thank you,

Becky Berg
Licensing Analyst
Kansas State Board of Healing Arts
800 SW Jackson, LL – Suite A
Topeka, Kansas 66612
Email: rebecca.berg@ks.gov
Phone: 785.368.8206
Fax: 785.296.0852
http://www.kshba.org

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2022
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Applicant Name: Jennifer Kerns

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.

Medical School

1. Full Name of Medical School: University of California San Francisco

   Street: Box 0244 500 Pamassus Ave MU-200W

   City: San Francisco State/Province: CA Zip code: 94143

   Country: United States Attendance dates: From 06/1998 (mm/yyyy) to 05/2004 (mm/yyyy)

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

   Degree received (as stated on diploma): Medical Degree (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)

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.

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)

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.

ECFMG

☑ I do not have an ECFMG certificate.

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

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Applicant Name: Jennifer Kerns

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: Columbia University Department of Obstetrics and Gynecology
Street: 622 West 168th St.
City: New York State/Province: NY Zip code: 10032
Country: United States Department/Specialty: Obstetrics and Gynecology
Affiliated medical school name: ______
Attendance dates: From 07/2004 (mm/yyyy) to 06/2008 (mm/yyyy) Postgraduate year (e.g., 1, 2, 3, etc.): ______

- [ ] Chief Resident
- [ ] Fellowship
- [ ] Fellowship/Research
- [ ] House Officer
- [ ] Internship
- [ ] Internship/Residency
- [ ] Junior Registrar
- [ ] Preliminary
- [ ] Registrar
- [ ] Research
- [x] Residency
- [ ] Residency/Chief Residency
- [ ] Senior House Officer
- [ ] Senior Registrar
- [ ] Other: ______
- [ ] Transitional
- [ ] Unknown
- [ ] Unspecified

Successfully completed? [x] Yes [ ] No [ ] In progress; expected completion in ______ (mm/yyyy)

2. Full Name of Hospital: University of California San Francisco
Street: Box 0244 500 Pamassus Ave MU-200W
City: San Francisco State/Province: CA Zip code: 94143
Country: United States Department/Specialty: Obstetrics and Gynecology
Affiliated medical school name: University of California San Francisco
Attendance dates: From 07/2008 (mm/yyyy) to 06/2011 (mm/yyyy) Postgraduate year (e.g., 1, 2, 3, etc.): ______

- [ ] Chief Resident
- [x] Fellowship
- [ ] Fellowship/Research
- [ ] House Officer
- [ ] Internship
- [ ] Internship/Residency
- [ ] Junior Registrar
- [ ] Preliminary
- [ ] Registrar
- [ ] Research
- [ ] Residency
- [ ] Residency/Chief Residency
- [ ] Senior House Officer
- [ ] Senior Registrar
- [ ] Other: ______
- [ ] Transitional
- [ ] Unknown
- [ ] Unspecified

Successfully completed? [x] Yes [ ] No [ ] In progress; expected completion in ______ (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
- [ ] Fellowship
- [ ] Fellowship/Research
- [ ] House Officer
- [ ] Internship
- [ ] Internship/Residency
- [ ] Junior Registrar
- [ ] Preliminary
- [ ] Registrar
- [ ] Research
- [ ] Residency
- [ ] Residency/Chief Residency
- [ ] Senior House Officer
- [ ] Senior Registrar
- [ ] Other: ______
- [ ] Transitional
- [ ] Unknown
- [ ] Unspecified

Successfully completed? [ ] Yes [ ] No [ ] In progress; expected completion in ______ (mm/yyyy)

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KSBHA

Applicant Name: Jennifer Kems

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		☐ (P) ☐ (F) ☐ (U)	
USMLE Step II, CS		☐ (P) ☐ (F) ☐ (U)	
USMLE Step II, CK		☐ (P) ☐ (F) ☐ (U)	
USMLE Step III		☐ (P) ☐ (F) ☐ (U)	
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: California License number: A 104345 Issue date: 06/11/208

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

RECEIVED
By Rebecca Berg at 10:21 am, Jun 09, 2022

Applicant Name: Jennifer Kerns

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	05/2002	☑ (P) ☐ (F) ☐ (U)	1
USMLE Step II, CS		☑ (P) ☐ (F) ☐ (U)	
USMLE Step II, CK	02/2004	☑ (P) ☐ (F) ☐ (U)	1
USMLE Step III	08/2006	☑ (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: NY License number: 242369 Issue date: 11/14/2006

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

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By Rebecca Berg at 10:22 am, Jun 09, 2022

Applicant Name: Jennifer Kerns

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: Oklahoma License number: 38893 Issue date: 03/04/2022

License status: ☐ Active ■ Expired ☐ In Good Standing ☐ Inactive ☐ Limited ☐ Probationary ☐ Restricted ☐ Retired ☐ 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: Oklahoma License number: 38893 Issue date: 03/28/2022

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

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 ☐ Expired ☐ In Good Standing ☐ Inactive ☐ Limited ☐ Probationary ☐ Restricted ☐ Retired ☐ 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 ☐ Expired ☐ In Good Standing ☐ Inactive ☐ Limited ☐ Probationary ☐ Restricted ☐ Retired ☐ Revoked ☐ Suspended

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RECEIVED
By Rebecca Berg at 10:22 am, Jun 09, 2022

Applicant Name: Jennifer Kerns

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: 07/2004 (mm/yyyy) End date: 06/2008 (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*: NYPH, Columbia University

Street: 630 West 168th St

City: New York State/Province: NY Zip code: 10032

Country: USA Position: Resident

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

☒ Employment ☐ Staff Privileges ☐ Affiliation
☐ Other (describe your relationship with this institution):

2. Start date: 07/2008 (mm/yyyy) End date: 06/2011 (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 California San Francisco

Street: 505 Parnassus Ave.

City: San Francisco State/Province: CA Zip code: 94143

Country: USA Position: Fellowship

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

☒ Employment ☐ Staff Privileges ☐ Affiliation
☐ Other (describe your relationship with this institution):

3. Start date: 07/2008 (mm/yyyy) End date: 06/2008 (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 California San Francisco

Street: 505 Parnassus Ave.

City: San Francisco State/Province: CA Zip code: 94143

Country: USA Position: Fellowship

Department: School of Public Health Clinical**: 80 % Administrative***: 20 %

☐ Employment ☐ Staff Privileges ☐ Affiliation
☒ Other (describe your relationship with this institution): Training in clinical research

From: Lizeth Lucio
To: Berg, Rebecca [KSBHA]
Subject: Re: KS License Application
Date: Thursday, June 9, 2022 10:57:25 AM
Attachments: image001.png

EXTERNAL: This email originated from outside of the organization. Do not click any links or open any attachments unless you trust the sender and know the content is safe.

I am so sorry I was completely off end date 05/09

From: Berg, Rebecca [KSBHA] <Rebecca.Berg@ks.gov>
Sent: Thursday, June 9, 2022 10:45:52 AM
To: Lizeth Lucio <LLucio@itrustwomen.org>
Subject: RE: KS License Application

But it says start 7/08 end 6/08? Is it start 7/2007?

Thank you,

Becky Berg
Licensing Analyst
Kansas State Board of Healing Arts
800 SW Jackson, LL – Suite A
Topeka, Kansas 66612
Email: rebecca.berg@ks.gov
Phone: 785.368.8206
Fax: 785.296.0852
http://www.ksbha.org

From: Lizeth Lucio <LLucio@itrustwomen.org>
Sent: Thursday, June 9, 2022 10:44 AM
To: Berg, Rebecca [KSBHA] <Rebecca.Berg@ks.gov>
Subject: Re: KS License Application

EXTERNAL: This email originated from outside of the organization. Do not click any links or open any attachments unless you trust the sender and know the content is safe.

No typo, this was just a one year training program

From: Berg, Rebecca [KSBHA] <Rebecca.Berg@ks.gov>
Sent: Thursday, June 9, 2022 10:31:52 AM
To: Lizeth Lucio <LLucio@itrustwomen.org>
Subject: RE: KS License Application

Please see below. I think this was a typo on the end date. If you can email the correct date I can just add a note to the page. I'm just trying to prevent it getting sent back.

3. Start date: 07/2008 (mm/yyyy) End date: 06/2008 (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 California San Francisco

Street: 505 Parnassus Ave.

City: San Francisco State/Province: CA Zip code: 94143

Country: USA Position: Fellowship

Department: School of Public Health Clinical**: 80 % Administrative***: 20 %

- ☐ Employment
- ☐ Staff Privileges
- ☐ Affiliation
- ☒ Other (describe your relationship with this institution): Training in clinical research

Thank you,

Becky Berg

Licensing Analyst
Kansas State Board of Healing Arts
800 SW Jackson, LL – Suite A
Topeka, Kansas 66612
Email: rebecca.berg@ks.gov
Phone: 785.368.8206
Fax: 785.296.0852
http://www.ksbha.org

From: Lizeth Lucio <LLucio@itrustwomen.org>
Sent: Thursday, June 9, 2022 9:41 AM
To: Berg, Rebecca [KSBHA] <Rebecca.Berg@ks.gov>
Subject: RE: KS License Application

EXTERNAL: This email originated from outside of the organization. Do not click any links or open any attachments unless you trust the sender and know the content is safe.

Here is the updated app

From: Berg, Rebecca [KSBHA] <Rebecca.Berg@ks.gov>
Sent: Wednesday, June 8, 2022 9:59 AM
To: Lizeth Lucio <LLucio@itrustwomen.org>
Subject: RE: KS License Application

Hello,

Thank you for sending this. I saw that you hadn't listed the OK license information, just the NY. Can you please add it and send it back to me? I'll get it processed ASAP and let the specialist know it's ready.

Thank you,

Becky Berg

Licensing Analyst
Kansas State Board of Healing Arts

RECEIVED
By Rebecca Berg at 10:22 am, Jun 09, 2022

Applicant Name: Jennifer Kerns

Copy and attach additional pages as necessary.

4. Start date: 08/2005 (mm/yyyy) End date: 02/2008 (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*: Columbia University

Street: 630 W 168th

City: New York State/Province: NY Zip code: 10032

Country: USA Position: Admission Officer

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

- ☒ Employment
- ☐ Staff Privileges
- ☐ Affiliation
- ☐ Other (describe your relationship with this institution): ______

5. Start date: 06/2009 (mm/yyyy) End date: 05/2014 (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*: UCB-UCSF Joint Medical Program

Street: 2121 Berkeley Way, Room 5302

City: Berkeley State/Province: CA Zip code: 94720

Country: USA Position: Admissions Officer

Department: School of Public Health Clinical**: 80 % Administrative***: 20 %

- ☒ 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.

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From:	Lizeth Lucio
To:	Berg, Rebecca [KSBHA]
Subject:	RE: KS License Application
Date:	Thursday, June 9, 2022 9:41:44 AM
Attachments:	md_do_app part 4.pdf

EXTERNAL: This email originated from outside of the organization. Do not click any links or open any attachments unless you trust the sender and know the content is safe.

Here is the updated app

From: Berg, Rebecca [KSBHA] <Rebecca.Berg@ks.gov>
Sent: Wednesday, June 8, 2022 9:59 AM
To: Lizeth Lucio <LLucio@itrustwomen.org>
Subject: RE: KS License Application

Hello,

Thank you for sending this. I saw that you hadn't listed the OK license information, just the NY. Can you please add it and send it back to me? I'll get it processed ASAP and let the specialist know it's ready.

Thank you,

Becky Berg
Licensing Analyst
Kansas State Board of Healing Arts
800 SW Jackson, LL – Suite A
Topeka, Kansas 66612
Email: rebecca.berg@ks.gov
Phone: 785.368.8206
Fax: 785.296.0852
http://www.ksbha.org

From: Lizeth Lucio <LLucio@itrustwomen.org>
Sent: Wednesday, June 8, 2022 8:17 AM
To: Berg, Rebecca [KSBHA] <Rebecca.Berg@ks.gov>; Kerns, Jennifer <Jennifer.Kerns@ucsf.edu>
Subject: RE: KS License Application

EXTERNAL: This email originated from outside of the organization. Do not click any links or open any attachments unless you trust the sender and know the content is safe.

Hello Rebecca,

I hope you are well. Please see attached. With the New York license it is actually no longer registered so we are unable to verify it. It was only issued for training but I included it on the license piece.

Thank you.

From: Berg, Rebecca [KSBHA] <Rebecca.Berg@ks.gov>
Sent: Tuesday, June 7, 2022 11:32 AM
To: Kerns, Jennifer <Jennifer.Kerns@ucsf.edu>
Cc: Lizeth Lucio <LLucio@itrustwomen.org>
Subject: RE: KS License Application

Hello,

I just checked with the specialist who is assigned to review your application and she said yes, if the needed documentation gets returned as soon as possible she'll complete the review by the end of this week.

Thank you,

Becky Berg
Licensing Analyst
Kansas State Board of Healing Arts
800 SW Jackson, LL – Suite A
Topeka, Kansas 66612
Email: rebecca.berg@ks.gov
Phone: 785.368.8206
Fax: 785.296.0852
http://www.ksbha.org

From: Kerns, Jennifer <Jennifer.Kerns@ucsf.edu>
Sent: Monday, June 6, 2022 5:19 PM
To: Berg, Rebecca [KSBHA] <Rebecca.Berg@ks.gov>
Cc: Lizeth Lucio <LLucio@itrustwomen.org>
Subject: Re: KS License Application

EXTERNAL: This email originated from outside of the organization. Do not click any links or open any attachments unless you trust the sender and know the content is safe.

CONFIDENTIAL

Sent from my iPhone

On Jun 6, 2022, at 12:37 PM, Berg, Rebecca [KSBHA] <Rebecca.Berg@ks.gov> wrote:

This Message Is From an External Sender

This message came from outside your organization.

CONFIDENTIAL

Thank you,

Becky Berg

Licensing Analyst

Kansas State Board of Healing Arts

800 SW Jackson, LL – Suite A

Topeka, Kansas 66612

Email: rebecca.berg@ks.gov

Phone: 785.368.8206

Fax: 785.296.0852

http://www.ksbha.org

RECEIVED
MAR 04 2022
KSBHA

Applicant Name: Jennifer Kerns

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: 07/2020 (mm/yyyy) End date: Current (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 California San Francisco

Street: Box 0244 500 Pamassus Ave MU-200W

City: San Francisco State/Province: CA Zip code: 94143

Country: United States Position: Director

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

☒ Employment ☐ Staff Privileges ☐ Affiliation
☐ Other (describe your relationship with this institution):

2. Start date: 06/2018 (mm/yyyy) End date: 06/2020 (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 California San Francisco

Street: Box 0244 500 Pamassus Ave MU-200W

City: San Francisco State/Province: CA Zip code: 94143

Country: United States Position: Co-Director

Department: Fellowship in Family Planning Clinical**: 80 % Administrative***: 20 %

☒ Employment ☐ Staff Privileges ☐ Affiliation
☐ Other (describe your relationship with this institution):

3. Start date: 07/2011 (mm/yyyy) End date: Current (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 California, Zuckerberg San Francisco General

Street: Box 0244 500 Pamassus Ave MU-200W

City: San Francisco State/Province: CA Zip code: 94143

Country: United States Position: Associate Professor

Department: Obstetrics, Gynecology and Repro. Sciences Clinical**: 20 % Administrative***: 80 %

☒ Employment ☐ Staff Privileges ☐ Affiliation
☐ Other (describe your relationship with this institution):

RECEIVED
MAR 04 2022
KSBHA

Applicant Name: Jennifer Kerns

Copy and attach additional pages as necessary.

4. Start date: 06/2015 (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*: University of California San Francisco, Zuckerberg San Francisco General

Street: Box 0244 500 Pamassus Ave MU-200W

City: San Francisco State/Province: CA Zip code: 94143

Country: United States Position: Director of Research

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

☒ Employment ☐ Staff Privileges ☐ Affiliation
☐ Other (describe your relationship with this institution):

5. Start date: 07/2011 (mm/yyyy) End date: 07/2015 (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*: 5M Women's Clinic, San Francisco General Hospital

Street: 1001 Potrero Ave

City: San Francisco State/Province: CA Zip code: 94110

Country: United States Position: Assistant Medical Director

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

☒ Employment ☐ Staff Privileges ☐ Affiliation
☐ Other (describe your relationship with this institution):

6. Start date: 01/2010 (mm/yyyy) End date: 05/2011 (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*: Marin General Hospital

Street: 250 Bon Air Rd.

City: Greenbrae State/Province: CA Zip code: 94904

Country: United States Position: Hospitalist

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

☒ Employment ☐ Staff Privileges ☐ Affiliation
☐ Other (describe your relationship with this institution):

Please copy and attach additional pages as necessary.

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RECEIVED
MAR 04 2022
KSBHA

Applicant Name: Jennifer Kerns

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.

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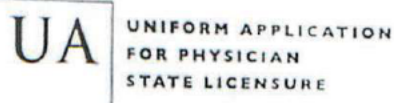
RECEIVED
By Rebecca Berg at 8:53 am, May 18, 2022



Medical School Verification (UA Form #2)

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: Kerns Suffix: ______

First name: Jennifer

Middle name: Lynne

Name if different when diploma awarded: ______

Name of medical school: University of California, San Francisco

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:** 5/11/2022

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 California, San Francisco

School name if different when the above applicant attended: ______

Medical school address (including city, state or province, zip code, and country as applicable):
513 Parnassus Avenue
San Francisco, CA 94143

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

Total weeks of education applicant attended your school: 153

Applicant's attendance dates: From 06/22/1998 to 06/13/2004

Graduation date: 06/13/2004 (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.

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RECEIVED
By Rebecca Berg at 8:53 am, May 18, 2022

Applicant Name: Jennifer Kerns

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.

	Reason	From Month/Year	To Month/Year	Approved	Unapproved
☐	Personal/Family			☐	☐
☐	Academic remediation			☐	☐
☐	Health			☐	☐
☐	Financial			☐	☐
■	Participation in joint degree program (e.g., MD/PhD)	05/2001	05/2002	☑	☐
☐	Participation in non-research special study (e.g., fellowship, international experience)			☐	☐
■	Other: Research	06/2000	12/2000	☑	☐

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).

	Reason	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.)

Seal Verified KSBHA

Signature: [signature]
Print name: John Davis, PhD, MD
Title: Associate Dean for Curriculum
Date: 5/13/2022
Phone number: 415-502-1045 Fax number:
Email: Franchesca.Torres@ucsf.edu

From:	Torres, Franchesca
To:	Berg, Rebecca [KSBHA]
Cc:	Kerns, Jennifer
Subject:	Medical school verification
Date:	Monday, May 16, 2022 9:32:42 PM
Attachments:	image001.png Verification_Kerns_Jennifer.pdf

EXTERNAL: This email originated from outside of the organization. Do not click any links or open any attachments unless you trust the sender and know the content is safe.

Hi Rebecca,

Please find the attached completed verification form for Dr. Jennifer Kerns. We have also mailed the hard copy of this document to the Kansas medical board.

If you have questions regarding her enrollment, I can be reached either via email or by phone.

Best,
Franchesca

Franchesca Torres Janusko
Pronouns: she/her/hers
Records Data Analyst, TEE Data & Analytics
Medical Education, School of Medicine

University of California, San Francisco
513 Parnassus Ave, Suite 211 | San Francisco, CA 94143
tel: 415.502.1045 | fax: 415.476.0714
Franchesca.Torres@ucsf.edu

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University of California
San Francisco

TRANSCRIPT of STUDENT ACADEMIC RECORD

Enrolled prior to Fall Quarter 1978 – Photocopy of hard copy or microfiche

Enrolled Fall Quarter 1978 or thereafter – Computer-generated transcript

Each quarter or term contains the following columns in left-to-right order: department, course number, title, units, grades, and codes (course titles are included beginning with Fall Quarter 2001).

GRADES IN GRADUATE DIVISION AND SCHOOLS OF DENTISTRY, NURSING, AND PHARMACY		
Grade	*Points*	*Meaning*
A	4.0	**Excellent**
B	3.0	**Good**
C	2.0	**Fair**
D	1.0	**Barely Passing**
F	0.0	**Fail**
H	–	**Honors.** Awarded in third and fourth year. *(Dentistry)*
Y	–	**Provisional grade.** Denotes a provisional non-passing grade. May be raised to a **D** if requirements are met, or changed to grade **F.**
	0.0	*(Pharmacy)*
I	–	**Incomplete.** Assigned when work is of passing quality but incomplete for good cause. Students may replace this grade with a passing grade and receive unit credit, provided they satisfactorily complete the coursework as authorized by the instructor.
IP	–	**In Progress.** For courses extending beyond one quarter.
P/NP	–	**Passed** / **Not Passed** *(Dentistry and Pharmacy)*
S/U	–	**Satisfactory** / **Unsatisfactory** *(Graduate and Nursing)*
SP/UP	–	**Satisfactory** / **Unsatisfactory Progress** *(Dentistry)*
NR	–	**Not Recorded**
GRADES IN SCHOOL OF MEDICINE		
P	–	**Passed**
H	–	**Honors.** Awarded in summer term 1992 or later.
I	–	**Incomplete** *(See description above)*
IP	–	**In Progress** *(See description above)*
E	–	**Provisional grade.** A provisional non-passing grade.
F	–	**Fail.** Grade **F** is a permanent grade.
NR	–	**Not Recorded**

CODES	CODE DESCRIPTIONS
C	Correction
G	Grade assigned, sequence completed
N	Provisional grade removed
R	Repeated course *(Dentistry and Pharmacy)*
S	Used when student is required by the dean to repeat a year, a term, or specific courses. Suppresses grade and units from calculation.
T	Repeat. Suppresses units from calculation.
X	Credit by examination
2	Intercampus Exchange
5	UC Berkeley Extension
7	SF Consortium or Stanford Exchange
W	Withdrew from all courses in the term

ACADEMIC STANDARDS FOR STUDENTS

STANDARDS OF SCHOLARSHIP

Graduate Students. Only grades of **A, B, C,** or **S** are counted toward satisfaction of degree requirements. A maximum of 6 units in which **S/U** grading is elected may be counted toward the minimum unit requirement for a graduate degree. Graduate students must maintain a minimum grade point average (GPA) of 3.0 in all upper-division and graduate courses.

Dentistry and Pharmacy Students. Grades of **A, B, C, D,** and **P** are counted toward satisfaction of degree requirements. Dentistry and Pharmacy students must maintain a minimum 2.0 cumulative GPA.

COURSE NUMBERING SYSTEM

100 = Upper-division undergraduate and professional courses.
200 & 300 = Graduate academic courses.
400 = Post-doctoral and professional school clinical courses.

REPETITION OF COURSES

Unless authorized by the dean, and except for courses normally offered for repeat credit, students may repeat only courses in which they received a **D, F,** or **NP.** Except by dean's permission, students may not repeat a course more than once for which they originally received a grade of **D, F,** or **NP.** When a course is repeated, the units are credited toward the degree only once. A student's grade point average is computed quarterly and cumulatively on the total number of units attempted and completed (successfully or unsuccessfully).

FULL-TIME STUDENTS

Dentistry, Medicine, and Pharmacy students must be enrolled full time.

PART-TIME STUDENTS

Graduate Division and Nursing students who meet certain criteria may apply for part-time status.

WITHDRAWAL

A registered student who withdraws, is dismissed, or is absent without leave from the University before the end of the term may receive a grade of **F** or **NP** for each course in which he/she is enrolled.

ACCREDITATION

The University of California, San Francisco is accredited by the Western Association of Schools and Colleges.

PRIVACY NOTICE

This educational record is subject to the federal Family Educational Rights and Privacy Act (FERPA) of 1974 and subsequent amendments. This educational record is furnished for official use only and may not be released to or accessed by outside agencies or third parties without the written consent of the student identified on this record.

University of California, San Francisco
Office of the Registrar
500 Parnassus Avenue, MU-200W
Box 0244
San Francisco, CA 94143-0244
Tel. (415) 476-4356 • Fax (415) 476-9690
http://registrar.ucsf.edu

From:	registrar@ucsf.edu
To:	Berg, Rebecca [KSBHA]
Cc:	jennifer.kerns@ucsf.edu
Subject:	UCSF Transcript Available
Date:	Monday, May 9, 2022 2:47:48 PM

EXTERNAL: This email originated from outside of the organization. Do not click any links or open any attachments unless you trust the sender and know the content is safe.

Jennifer Lynne Kerns has requested that the UCSF Office of the Registrar send you a PDF transcript. You can download the transcript by clicking on this link:

https://saa.ucsf.edu/transcript-pickup?order=65772&accesscode=817093790

If you have questions, please contact us at 415-476-8280 or registrar@ucsf.edu.

Sincerely,
UCSF Office of the Registrar

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: Kerns Suffix: ________

First name: Jennifer

Middle name: ________________

Name if different when diploma awarded: ________________

Name of postgraduate training program: Columbia University Department of Obstetrics and Gynecology

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 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:** ________

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: New York Presbyterian - Columbia

Institution address: 622 W 168th Street New York, NY 10032

Institution city / state or province / zip code: ________________

Affiliated medical school name: Columbia University

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: OBGYN

Attendance dates: From 07/01/2004 to 06/30/2008

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

RECEIVED
APR 19 2022
KSBHA

Applicant Name: Jennifer Kerns

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.

AFFIX INSTITUTIONAL SEAL HERE

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

Seal Verified KSBHA

Signature: Rini Banerjee Ratan, MD
Print name: Rini Banerjee Ratan
Title: Program Director
Date: 4/7/2022
Phone number: 2123052376 Fax number:
Email: rr2172@columbia.edu

RECEIVED
APR 19 2022
KSBHA

RECEIVED
By Rebecca Berg at 6:27 am, May 05, 2022

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: Kerns Suffix: ______

First name: Jennifer

Middle name: ______

Name if different when diploma awarded: ______

Name of postgraduate training program: Fellowship in Family Planning

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 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

DocuSigned by:

Applicant signature: Jennifer Kerns **Date:** 5/4/22

90A9BB4669064C0...

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: UCSF at Zuckerberg San Francisco General

Institution address: 1001 Potrero Ave Ward 6D

Institution city / state or province / zip code: San Francisco, CA 94110

Affiliated medical school name: University of California San Francisco

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

Postgraduate year (e.g., 1, 2, 3, etc.): 5,6,7 ☐ Internship ☐ Residency ☒ Fellowship

☐ Research ☐ Chief Residency ☐ Other: ______

Specialty/Subspecialty: Fellowship in Family Planning

Attendance dates: From 07/01/2008 to 06/30/2011

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 Program became ACGME accredited in 2021

© July 2014 Federation of State Medical Boards

Applicant Name: Jennifer Kerns

RECEIVED
By Rebecca Berg at 6:27 am, May 05, 2022

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.

Signature: DocuSigned by: Jody Steinauer 393D9DC0EDD04FF...

Print name: Jody Steinauer

Title: Former Program Director

Date: 5/4/2022

Phone number: 415-378-0008 Fax number: 628-306-3112

Email: jody.steinauer@ucsf.edu

AFFIX INSTITUTIONAL SEAL HERE

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

SECURE: RE: Jennifer Kerns, MD

From: Kirsch, Molly
To: Berg, Rebecca [KSBHA]
Cc:
Sent: 5/4/2022 3:45:18 PM
Attachments: Kerns,_Jen_ver for Kansas_5-4-22 SIGNED.pdf

Hi Becky,

Attached is the fellowship verification for Dr. Jennifer Kerns. I am unable to get it sealed or notarized due to working remotely. Let me know if you have any questions.

Best,
Molly

Molly Kirsch, MPA *(she/her/hers)*
Medical Education Coordinator
Complex Family Planning Fellowship Coordinator
UCSF Dept of Ob/Gyn & R.S. at ZSFG
1001 Potrero Ave., Ward 6D23
San Francisco, CA 94110
Cell: (415) 710-9159

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From: Berg, Rebecca [KSBHA] <Rebecca.Berg@ks.gov>
Sent: Wednesday, May 4, 2022 11:55 AM
To: Kirsch, Molly <Molly.Kirsch@ucsf.edu>
Subject: RE: Jennifer Kerns, MD

This Message Is From an External Sender

This message came from outside your organization.

Here's the form you requested.

Thank you,
Becky Berg

Licensing Analyst
Kansas State Board of Healing Arts
800 SW Jackson, LL – Suite A
Topeka, Kansas 66612
Email: rebecca.berg@ks.gov
Phone: 785.368.8206
Fax: 785.296.0852
http://www.ksbha.org

From: Kirsch, Molly <Molly.Kirsch@ucsf.edu>
Sent: Wednesday, May 4, 2022 11:57 AM
To: Berg, Rebecca [KSBHA] <Rebecca.Berg@ks.gov>
Subject: FW: Jennifer Kerns, MD

EXTERNAL: This email originated from outside of the organization. Do not click any links or open any attachments unless you trust the sender and know the content is safe.

Hi Becky,

Are you able to send me the fellowship verification form you need completed for Dr. Kerns? I should be able to complet it and return it to you today.

Thank you,
Molly

Molly Kirsch, MPA *(she/her/hers)*
Medical Education Coordinator
Complex Family Planning Fellowship Coordinator
UCSF Dept of Ob/Gyn & R.S. at ZSFG
1001 Potrero Ave., Ward 6D23
San Francisco, CA 94110
Cell: (415) 710-9159

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From: Kerns, Jennifer <Jennifer.Kerns@ucsf.edu>
Sent: Wednesday, May 4, 2022 9:53 AM
To: Kirsch, Molly <Molly.Kirsch@ucsf.edu>
Subject: FW: Jennifer Kerns, MD

Hi
Can you do that same postgrad verification that I completed fellowship at UCSF?
I need to send to the Kansas licensing board.

Thank you!

From: Berg, Rebecca [KSBHA] <Rebecca.Berg@ks.gov>
Date: Tuesday, May 3, 2022 at 2:28 PM
To: Lizeth Lucio <LLucio@itrustwomen.org>
Cc: Kerns, Jennifer <Jennifer.Kerns@ucsf.edu>
Subject: RE: Jennifer Kerns, MD

This Message Is From an External Sender

This message came from outside your organization.

Hello,

I've looked through all the documents we've received and these are the items still outstanding:

- **Professional School Verification or Diploma with Transcripts with final degree awarded** - We have not received the pre-referenced items from University of California San Francisco. All items must come directly from the school to our office. They are welcome to email these documents to me. The seal or notary must be clearly visible to be accepted by email.
- **Postgraduate Verification** – We have not received verification from all of your postgraduate training programs. We received the verification from Columbia but not from University of California San Francis Please have the program send a completed verification form to me directly.
- **Proof of Malpractice Insurance –** Please submit one of the following: Certificate of Compliance from th KHCSF, Certificate of Insurance, or a letter of intent from the liability insurance company or the future employer. All new policies and policies that renew on or after January 1, 2022, KSA 40-3402 requires active license holders to maintain 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. ***Please note that a license may be pre-approved and granted if proof of malpractice coverage is more than 90 days out.***

I've sent the fingerprints off for the background check.

Please let me know if you have any questions.

Thank you,

Becky Berg
Licensing Analyst
Kansas State Board of Healing Arts
800 SW Jackson, LL – Suite A
Topeka, Kansas 66612
Email: rebecca.berg@ks.gov
Phone: 785.368.8206
Fax: 785.296.0852
http://www.ksbha.org

From: Lizeth Lucio <LLucio@itrustwomen.org>
Sent: Tuesday, May 3, 2022 2:10 PM
To: Berg, Rebecca [KSBHA] <Rebecca.Berg@ks.gov>
Cc: Kerns, Jennifer <Jennifer.Kerns@ucsf.edu>
Subject: Jennifer Kerns, MD

EXTERNAL: This email originated from outside of the organization. Do not click any links or open any attachments unless you trust th sender and know the content is safe.

Hello Becky,

I hope you are well. I wanted to follow up on this. We have provided a home address, we did not use FCVS so we have asked for transcripts and scores to be sent, I included the fee for the NPDB report to be ran through the KSBHA side, th questionnaire and third party release were sent in and the background check has gone in. I wanted to see if there is

All my best,

Lizzie Lucio
Trust Women
O: 316-425-3215
F: 316-425-3451
llucio@itrustwomen.org
www.trustwomen.org

NOTICE: This E-mail (including attachments) is covered by the Electronic Communications Privacy Act, 18 U.S.C. 2510-2521, is confidential and may be legally privileged. If you are not the intended recipient, you are hereby notified that any retention, dissemination, distribution or copying of this communication is strictly prohibited. Please reply to the sender that you have received the message in erro then delete it.

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

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

Recipient: KANSAS STATE BOARD OF HEALING ARTS

Date: 04/18/2022

Examinee: Kerns, Jennifer Lynne
Alt Name(s):

Examinee ID: 5-080-068-9
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
05/20/2002	Pass	CONFIDENTIAL		

USMLE STEP 2

Clinical Knowledge (CK)

Test Date	Pass/Fail	Score	Minimum Pass	Comments
02/26/2004	Pass	CONFIDENTIAL		

USMLE STEP 3

Test Date	Pass/Fail	Score	Minimum Pass	Comments
08/04/2006	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.

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: Kerns, Jennifer Lynne

Examinee ID: 5-080-068-9
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.

Oklahoma Board of Medical Licensure and Supervision

Search Results

Last Update: Monday, June 6, 2022 11:54 AM CDT

KERNS, JENNIFER

Practice Address:	UNIVERSITY OF SAN FRANCISCO 1001 POTRERO AVE. WARD 6D SAN FRANCISCO CA 94110 Address last updated on 11/5/2021
Phone #:	(628) 206-3157
Fax #:	
County:	NOT OKLAHOMA
License:	38893
Dated:	3/28/2022
Expires:	3/1/2023
Temp. Lic. Issued:	3/4/2022
Temp. Lic. Expires:	5/12/2022
License Type:	Medical Doctor
Specialty:	Obstetrics & Gynecology

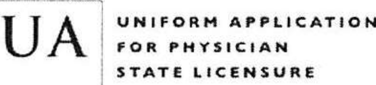
Status:	Active
Status Class:	Fully Licensed
Restricted to:	
Registered to Dispense:	NO
Medical School:	Univ Of CA, San Francisco, Sch Of Med, San Francisco CA 94143
Graduated:	6 / 2004
CME Year:	2025

Pending and/or Past Disciplinary Actions: No Disciplinary Action Taken.

All information below is entered by the licensee but not verified by the Oklahoma Medical Board.

Certifications:	AMERICAN BOARD OF OBSTETRICS AND GYNECOLOGY
New Patients:	Contact licensee
Medicaid:	Contact licensee
Medicare:	Contact licensee
HMO/PPO:	None listed
Hospital Privileges:	None listed

Locations:	**Hours:**	**Languages:**
UNIVERSITY OF SAN FRANCISCO 1001 POTRERO AVE. WARD 6D SAN FRANCISCO CA 94110 Phone #: (628) 206-3157 Fax #:		



UNIFORM APPLICATION FOR PHYSICIAN STATE LICENSURE

Affidavit and Authorization for Release of Information

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

KSBHA

Applicant:

This is a separate form from the FCVS affidavit and release.

If you are using FCVS, you must complete both FCVS and UA affidavits. Send the FCVS affidavit to FCVS.

Sign this form with attached photo in the presence of a notary public.

Send this notarized affidavit to:

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

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

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

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

I will immediately notify the Board in writing of any changes to the answers to any of the questions contained in this application if such a change occurs at any time prior to a license to practice medicine being granted to me by the Board.

I understand my failure to answer questions contained in this application truthfully and completely may lead to denial, revocation, or other disciplinary sanction of my license or permit to practice medicine.

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

Kerns
Applicant's printed last name

Jennifer
Applicant's printed first name, middle initial, and suffix (e.g., Jr.)

3/2/2022
Date of signature (must correspond to date of notarization)

Notary

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 2 day of March, 2022

Notary Public Signature:

My Notary Commission Expires: 01/08/2025

NOTARY PUBLIC - State of Kansas
My Appt. Expires
(NOTARY PUBLIC SEAL)

Seal Verified KSBHA

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ADDENDUM 1
KANSAS STATE BOARD OF HEALING ARTS

Select the discipline applying for and the license designation being requested.

☑ Medicine & Surgery ☐ Osteopathic Medicine & Surgery

☑ Active — A license issued to a person authorizing the practice of medicine and surgery, osteopathic medicine and surgery, chiropractic or podiatry. Applicants for active licensure must provide evidence of professional liability insurance (which will be in effect as of the date of licensure) in compliance with Kansas law before a license will be issued. Each active license may be renewed annually. Licensees must maintain and submit evidence of satisfactory completion of a program of continuing education. Licensees must maintain and submit evidence of professional liability insurance, and contribute to the Kansas Health Care Stabilization Fund (more information about this fund can be found here: https://hcsf.kansas.gov/).

☐ Federal Active — A license issued to only a person who meets all the requirements for a license to practice the healing arts in Kansas and who practiced that branch of the 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. Continuing education, expiration and renewal of a license shall be applicable to a federally active license. A person who practices under a federally active license shall not be deemed to be rendering professional service as a health care provider in this state and is not required to have policy of professional liability coverage in effect.

☐ Inactive — A license issued to a person who is not regularly engaged in the practice of the healing arts in Kansas and who does not hold oneself out to the public as being professionally engaged in such practice. An inactive license shall not entitle the holder to practice the healing arts in this state. Each inactive license may be renewed annually. The holder of an inactive license shall not be required to submit evidence of satisfactory completion of a program of continuing education and is not required to have basic coverage or self-insurance in effect solely because such person is no longer engaged in rendering professional service as a health care provider.

☐ Exempt — A license issued to a person who is not regularly engaged in the practice of the healing arts or podiatry in Kansas and who does not hold oneself out to the public as being professionally engaged in such practice. Each exempt license may be renewed annually. The holder of an exempt license is 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. Additionally, the holder of an exempt license may perform administrative functions. The holder of an exempt license shall not be required to submit evidence of satisfactory completion of a program of continuing education nor are they required to have basic coverage or self-insurance in effect.

List intended professional activities: ____________________

Additional Information:

1. Have you ever been licensed to practice the Healing Arts in Kansas? ☐ Yes ☑ No
2. Give location of intended practice in Kansas 5107 E. Kellogg Dr. Wichita, KS 67218
3. Primary Specialty Obstetrics and Gynecology

   American Board Certified Yes   American Board Eligible ____________

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.

Jennifer Kerns — Full Name of Applicant

02/07/202 — 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 prior to completing the training? Yes ☐ No ☑
2. Have you ever had any application for any professional license refused or denied by any licensing authority? Yes ☐ No ☑
3. Have you ever been refused or denied the privilege of taking an examination required for any professional licensure? Yes ☐ No ☑
4. Have you ever been warned, censured, disciplined, had admissions monitored, had privileges limited, suspended, revoked or placed on probation, or have you ever involuntarily or voluntarily (to avoid disciplinary action or investigation) resigned or withdrawn from any licensed hospital, nursing home, clinic or other health care facility in which you have trained, including but not limited to residency or postgraduate training programs, or otherwise been a staff member, been a partner or held privileges? CONFIDENTIAL
5. Have you ever been denied staff membership with any licensed hospital, nursing home, clinic or other health care facility?
6. 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?
7. Have you ever voluntarily surrendered any professional license? Yes ☐ No ☑
8. Has any licensing authority ever limited, restricted, suspended, revoked, censured or placed on probation or had any other disciplinary action taken against any professional license you have held? Yes ☐ No ☑
9. Have you ever been notified or requested to appear before a licensing or disciplinary agency? Yes ☐ No ☑
10. To your knowledge, have any complaints (regardless of status) ever been filed against you with any licensing agency, professional association, hospital, nursing home, clinic or other health care facility? Yes ☐ No ☑

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11. Has any professional association imposed any disciplinary action against you? Yes [ ] No [✓]

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

13. Have you ever been denied a Drug Enforcement Administration (DEA) or state bureau of narcotics or controlled substance registration certificate or been called before or warned by any such agency or other lawful authority concerned with controlled substances? Yes [ ] No [✓]

14. Have you ever surrendered your state or federal controlled substances registration, or had it revoked, suspended, or restricted in any way? Yes [ ] No [✓]

15. Have you ever been notified of any charges or complaints filed against you by any licensing or disciplinary agency? Yes [ ] No [✓]

16. Have you ever been arrested? Do not include minor traffic or parking violations or citations except those related to a DUI, DWI or a similar charge. You must include all arrests including those that have been set aside, dismissed or expunged 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 (a crime includes both Class A misdemeanors and felonies)? You must include all convictions including those that have been set aside, dismissed or expunged or where a stay of execution has been issued. Yes [ ] No [✓]

18. Have you ever been court martialed or discharged dishonorably 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 provider 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 Medicaid or Federal Medicaid 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.

PRACTITIONER PROFILE

Prepared for:	Kansas State Board of Healing Arts	As of Date:3/2/2022

PRACTITIONER INFORMATION

Name:	Kerns, Jennifer Lynne
DOB:	CONFIDENTIAL
Medical School:	University of California, San Francisco, School of Medicine San Francisco, California, UNITED STATES
Year of Grad:	2004
Degree Type:	MD
NPI:	1518137116

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
1518137116	Individual			06/04/2018

LICENSE HISTORY

Jurisdiction	License Number	Issue Date	Expiration Date	Last Updated
CALIFORNIA	A-104345	06/11/2008	03/31/2022	03/02/2022
		FSMB License Status: Active		
NEW YORK	242369	11/14/2006	10/31/2008	03/02/2022
		FSMB License Status: Inactive		

ACTIVE US DRUG ENFORCEMENT ADMINISTRATION (DEA)

DEA Number	Address	Last Reported
FK0911760	SAN FRANCISCO,CA 94110	01/05/2022

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PRACTITIONER PROFILE

Prepared for:	Kansas State Board of Healing Arts	As of Date:3/2/2022
Practitioner Name:	Kerns, Jennifer Lynne	

ABMS® CERTIFICATION HISTORY

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

Status	Duration	Effective Date	Expiration Date	Reverification Date	Occurrence	Last Reported
Active	Time Limited	12/31/2021	12/31/2022		Recertification	02/24/2022
Expired	Time Limited	12/31/2020	12/31/2021		Recertification	02/24/2022
Expired	Time Limited	12/31/2019	12/31/2020		Recertification	02/24/2022
Expired	Time Limited	12/31/2018	12/31/2019		Recertification	02/24/2022
Expired	Time Limited	12/31/2017	12/31/2018		Recertification	02/24/2022
Expired	Time Limited	12/31/2016	12/31/2017		Recertification	02/24/2022
Expired	Time Limited	12/31/2015	12/31/2016		Recertification	02/24/2022
Expired	Time Limited	12/31/2014	12/31/2015		Recertification	02/24/2022
Expired	Time Limited	12/31/2013	12/31/2016		Recertification	02/24/2022
Expired	Time Limited	12/16/2012	12/31/2016		Recertification	02/24/2022
Expired	Time Limited	12/31/2011	12/31/2016		Recertification	02/24/2022
Expired	Time Limited	11/05/2010	12/31/2016		Initial	02/24/2022

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AOA® CERTIFICATION HISTORY

No AOA Certifications found.

PLEASE NOTE: For more information regarding the above data, please contact the reporting board or reporting agency. The information contained in this report was supplied by the respective state medical boards and other reporting agencies. The Federation makes no representations or warranties, either express or implied, as to the accuracy, completeness or timeliness of such information and assumes no responsibility for any errors or omissions contained therein. Additionally, the information provided in this profile may not be distributed, modified or reproduced in whole or in part without the prior written consent of the Federation of State Medical Boards.

WAIVER AGREEMENT
AND
FBI PRIVACY ACT STATEMENT (Cont.)

Fingerprint-Based Record Checks for Noncriminal Justice Purposes

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 ☒ 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 the provisions of Title 21 Kansas Statutes Annotated, Section 5903.

The name, address, and date of birth provided below appear on a valid identification document as defined in Title 28 United States Code, section 1028.

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

[signature] — 4/18/2022

Signature — Date

Jennifer Kerns — CONFIDENTIAL

Printed Name — Date of Birth

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Residential Address — City — State — Zip

TO BE COMPLETED BY THE FINGERPRINTING AGENCY:

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

State/Branch: CA. DMV ID Number: CONFIDENTIAL

Agency Name: REDTOMATOES P3DIGITIX LIVE SCAN 2141 Broadway # 2 Oakland CA 94612 — Redtomatoes P3Digitix Livescan [illegible]

Address: 610 - 16th St #34 Oakland CA-94612

Telephone: 510-847-4828 Fax: 801-730-6228

Name of Individual Verifying Identity: Sunil Jawal CA-DOJ [illegible] FPL #504712

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

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AMA Physician Profile

PREPARED FOR

Kansas State Board of Healing Arts, Topeka, KS

Name and Mailing Address

JENNIFER LYNNE KERNS
CONFIDENTIAL

Birth date CONFIDENTIAL

Primary Office Address

769 SPRUCE ST
BERKELEY, CA 94707-2040

Phone UNKNOWN

Physician's major professional activity MEDICAL TEACHING

Self-designated practice specialty OBSTETRICS & 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
1518137116	03/10/2008	NOT RPTD	NOT RPTD	NOT RPTD	04/22/2022

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.

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*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 CALIFORNIA SAN FRANCISCO SCHOOL OF MEDICINE

Degree Awarded:	YES	**Degree Type:**	MD
Enrollment Date:	08/1998	**Degree Date:**	06/2004

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:	NEW YORK PRESBYTERIAN HOSPITAL
Sponsoring State:	NEW YORK
Specialty:	OBSTETRICS & GYNECOLOGY
Training Type:	
Dates:	07/2004 - 06/2008
Status:	COMPLETED

Specialty board certification

This section provides specialty board certification data specific to one or more of the 24 boards recognized by the American Board of Medical Specialties (ABMS) and the AMA (through the Liaison Committee on Specialty Boards) as reported by the ABMS.

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

Certifying board: AMERICAN BOARD OF OBSTETRICS AND GYNECOLOGY
Certificate: OBSTETRICS & GYNECOLOGY
Certificate type: GENERAL

Duration	Status	Effective Date	Expiration Date	Reverify Date	Occurrence	Last Reported	Participating in MOC
TIME LIMITED	Active	12/31/2021	12/31/2022		RE-CERT	04/26/2022	Y
TIME LIMITED	Expired	12/31/2020	12/31/2021		RE-CERT	04/26/2022	Y
TIME LIMITED	Expired	12/31/2019	12/31/2020		RE-CERT	04/26/2022	Y
TIME LIMITED	Expired	12/31/2018	12/31/2019		RE-CERT	04/26/2022	Y
TIME LIMITED	Expired	12/31/2017	12/31/2018		RE-CERT	04/26/2022	Y
TIME LIMITED	Expired	12/31/2016	12/31/2017		RE-CERT	04/26/2022	Y
TIME LIMITED	Expired	12/31/2015	12/31/2016		RE-CERT	04/26/2022	Y
TIME LIMITED	Expired	12/31/2013	12/31/2016		RE-CERT	04/26/2022	Y
TIME LIMITED	Expired	12/16/2012	12/31/2016		RE-CERT	04/26/2022	Y
TIME LIMITED	Expired	12/31/2011	12/31/2016		RE-CERT	04/26/2022	Y
TIME LIMITED	Expired	11/05/2010	12/31/2016		INITIAL	04/26/2022	Y
TIME LIMITED	Expired	12/31/2014	12/31/2015		RE-CERT	04/26/2022	Y

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

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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
104345	MD	CA	06/11/2008	03/31/2024		ACT	UNL	04/07/2022	JENNIFER KERNS
38893	MD	OK	03/28/2022	03/01/2023		ACT	UNL	04/06/2022	JENNIFER KERNS
60242369	MD	NY	11/14/2006	10/01/2008		INA	UNL	09/02/2009	NRT

Abbreviation key: ACT = Active, DEN = Denied, 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 intended to assist with credentialing. 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.

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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.

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RECEIVED
By KSBHA at 12:00 pm, May 10, 2022

KAMMCO

On Behalf of Kansas Health Care
Provider Insurance Availability Plan

LETTER OF INTENT

May 9, 2022

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

RE: Jennifer Kerns, 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 Jennifer Kerns, 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. Kerns 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. Kerns 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
Subject:	Jennifer Kerns, MD - letter of intent attached
Date:	Monday, May 9, 2022 11:10:00 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 Jennifer Kerns, MD - letter of intent.pdf

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EXTERNAL: This email originated from outside of the organization. Do not click any links or open any attachments unless you trust the sender and know the content is safe.

Good morning –

Please find attached the Plan's letter of intent on Dr. Jennifer Kerns, MD.

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

Thanks,

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

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RECEIVED
By Rebecca Berg at 3:04 pm, Apr 11, 2022

Kansas

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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, Jennifer Kerns, 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: Credentialing Specialist

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]
Signature of Applicant

04/10/2022
Date

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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: 689767

DATE: 03/04/2022

NAME:	LICENSE TYPE:	FEE:	LIC #:
JENNIFER KERNS	MD	APP $300 KBI $47 NPDB $3	3.4.2022

AMOUNT: 350.00

RECEIVED FROM:

JENNIFER KERNS
JENNIFER KERNS
JENNIFER KERNS

Wichita KS 67218
Wichita KS 67218
Wichita KS 67218

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, Interim Executive Director

Laura Kelly, Governor

March 14, 2022

Jennifer Kerns, MD
5107 E Kellogg Dr
Wichita KS 67218

Dear Jennifer Kerns:

CONFIDENTIAL

Sincerely,

Becky Berg

Rebecca Berg | *Licensing Analyst* | **Phone**: 785-368-8206 | **Email**: rebecca.berg@ks.gov

BOARD MEMBERS: TOM ESTEP, MD, PRESIDENT, Wichita • RONALD M. VARNER, DO, VICE PRESIDENT, Augusta • ABEBE ABEBE, MD, Shawnee
MARK BALDERSTON, DC, Shawnee • MOLLY BLACK, MD, Shawnee • RICHARD BRADBURY, DPM, Salina • R. JERRY DEGRADO, DC, Wichita
ROBIN D. DURRETT, DO, Great Bend • STEVEN J. GOULD, DC, Cheney • CAMILLE HEEB, MD, Topeka • STEVE KELLY, PUBLIC MEMBER, Newton
JENNIFER KOONTZ, MD, Newton • JOHN F. SETTICH, PH.D., PUBLIC MEMBER, Atchison • STEPHANIE SUBER, DO, Lawrence • SHERRI WATTENBARGER, PUBLIC MEMBER, Overland Park

From:	Berg, Rebecca [KSBHA]
To:	admin@southwindwomenscenter.org
Subject:	Kansas State Board of Healing Arts - Licensure Needed Documentation
Date:	Monday, March 14, 2022 1:38:00 PM
Attachments:	MRL-1.pdf Kerns_Jennifer -Ext Release.pdf Kerns_Jennifer -Ext ExpLic.pdf

Hello Dr Jennifer Kerns,

To continue processing your licensure application please see the attached Missing Requirement Letter (MRL).

If you have any questions, please contact me.

Thank you,

Becky Berg
Licensing Analyst
Kansas State Board of Healing Arts
800 SW Jackson, LL – Suite A
Topeka, Kansas 66612
Email: rebecca.berg@ks.gov
Phone: 785.368.8206
Fax: 785.296.0852
http://www.kshba.org

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PRESS FIRMLY TO SEAL

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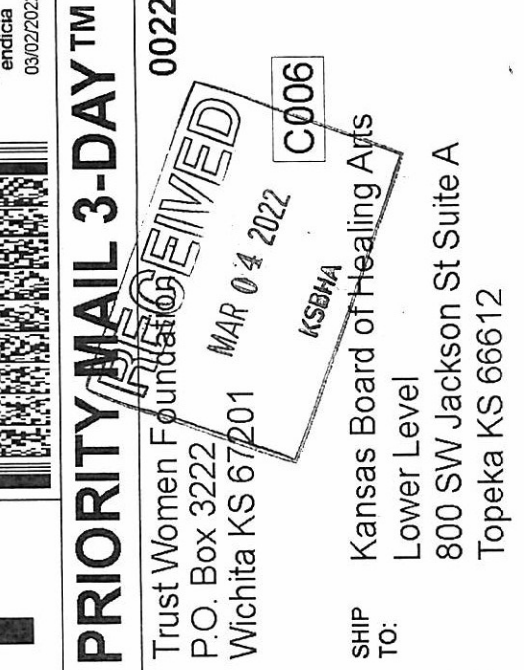

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Kansas Board of Healing Arts
Lower Level
800 SW Jackson St Suite A
Topeka KS 66612

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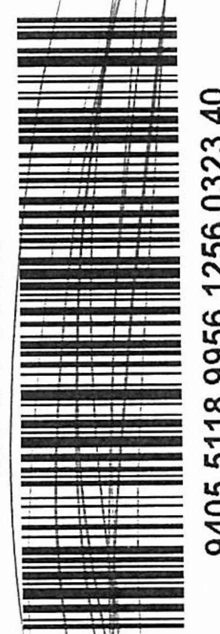

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WHEN USED INTERNATIONALLY, A CUSTOMS DECLARATION ...

WAIVER AGREEMENT
AND
FBI PRIVACY ACT STATEMENT (Cont.)

Fingerprint-Based Record Checks for Noncriminal Justice Purposes

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 USC 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:

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

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 Childcare Protection Act/Volunteers for Children Act (NCPA/VCA) explained in Public Law 103-209 and Public Law 105-251. Pursuant to K.S.A. 22-4701 et seq. and K.S.A. 22-5001, 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 to challenge 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 (USC) 552a(b); 28 USC 534(b); 42 USC 14616, Article IV(c); 28 CFR 20.21(c), 20.33(d), and 906.2(d).)

FBI PRIVACY ACT STATEMENT

Authority:
The FBI's acquisition, preservation, and exchange of 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 USC 552a), the requesting agency 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 asks 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 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).

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.

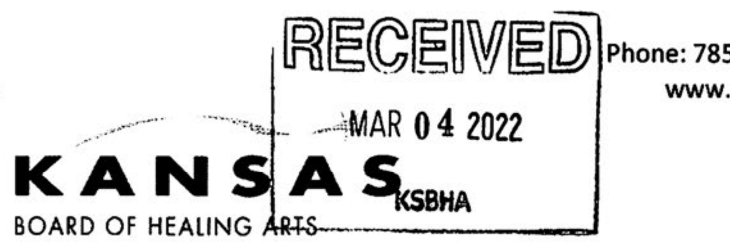
Mail the completed Waiver Agreement and fingerprint card to the Board. You may want to use a mailing service that allows for delivery confirmation.

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.

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

Phone: 785-296-7413
www.ksbha.org



KANSAS LICENSURE APPLICATION INSTRUCTIONS
MEDICINE & SURGERY (MD) and OSTEOPATHIC MEDICINE & SURGERY (DO)

Please visit www.ksbha.org for all statutes and regulations

Completing the Kansas Licensure Application

Review the following instructions carefully before completing the application. This information is vital to the successful completion of your application. Failure to submit all required information and documentation will result in processing delays. Please allow two (2) weeks after the submission of the application before contacting our office. **Do not make a commitment to any work dates prior to being licensed.**

Kansas does not have direct reciprocity with any state. All applicants are considered on an individual basis. You may be requested to submit information or documentation in addition to the requirements mentioned herein before the application will be deemed complete. **It is highly recommended you make and keep copies, for your records, of all items submitted for review. Do not send original forms or documentation to the Board.**

In completing the application, you will be asked to account for all time since medical school graduation and list all **Malpractice Liability Claims Information**. Having this information on hand before you begin your session will facilitate completing your application.

If you have any questions about the information provided to you in the application packet, please contact our office at 785/296-7413. Thank you for applying for licensure in the State of Kansas.

The Federation Credentials Verification Service (FCVS)

The Board accepts the use of FCVS as part of the licensure process. FCVS staff creates a permanent profile of primary source verified documents related to identity, medical education, postgraduate training, and more. The profile can be updated as needed and sent to boards and other entities without the need to verify each item again.

Applicants using FCVS to verify their credentials are still required to complete the Kansas State Board of Healing Arts Uniform Application (UA). If you do not use FCVS, you must provide your credentials to the Board for verification along with completing the UA.

For clarification, the Uniform Application (UA) is used to apply for state licensure. The FCVS application is used only to create or update a personalized profile of primary source verified credentials for use in the overall licensing process.

To use FCVS, visit http://www.fsmb.org/ and select "FCVS" in the Licensure or Sign In menu, then sign in and continue as directed. Users with existing FCVS profiles should complete a Subsequent FCVS Application to ensure the profile is up to date. New FCVS users should complete the Initial FCVS Application. All users must, during the application process, designate the Kansas State Board of Healing Arts to receive the FCVS profile. Self designations are not accepted.

More information about FCVS is available at http://www.fsmb.org/licensure/fcvs/. For assistance, use the messaging tool within FCVS or call 888-275-3287 with your FCVS ID number between 8am and 5pm CT on weekdays.

The Uniform Application for Physician State Licensure (UA)

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This packet contains a version of the UA that can be completed and mailed to the Board instead of completing the UA online. There is no fee for using the paper UA.

Please note the following:

- The Board requires that you submit your valid National Provider ID number in the space provided.
- Accepted examinations are National Boards (NBME, NBOME), FLEX, USMLE, State Examinations, LMCC, COMLEX, or a combination of FLEX, USMLE, and National Boards. Applicants who took the FLEX prior to June 1985 must have passed with a FLEX weighted average of 75 or higher, attained in one sitting. Applicants who took the USMLE must complete all steps within 10 years.
- List all professional licenses (nurse, EMT, physician assistant, etc.) you have held in the U.S. or Canada, regardless of status (active, inactive, etc.). If you hold licenses in countries outside the U.S. or Canada, please provide that information on a separate sheet of paper to the Board. Use the Licensure Verification form in this packet to request license verifications from each board.
- On the Chronology of Activities, for military or locum tenens assignments, list each location/assignment separately. Additionally, for military service, please provide a copy of your discharge or separation documents.
- For all locations where you have had admitting privileges, check the "Staff Privileges" box.
- For all malpractice, claims include a written statement from the insurance company or insurance / personal / institution attorney. Include date of occurrence, name of the insurance company involved on your behalf, name of claimant(s), other defendant(s) and/or institution involved, list of all attorneys involved, case number and location of filing, status of the matter, and summary of the occurrence; or you may provide court documents. Failure to provide complete information will result in delay of processing the application.

In addition to completing the core UA, all applicants must:

- Complete the state addendum.
- Submit a notarized UA Affidavit and Authorization for Release of Information form to the Board. This is a separate form from the FCVS Affidavit and must be sent to the Kansas State Board of Healing Arts. Attach a recent (less than 6 months old) two inch by two inch (2" x 2") passport-type color photograph of yourself in the space provided. Proof photos, negatives, and digital photos are not acceptable.

  Please note that by signing the Affidavit and Authorization for Release of Information form, you agree to the following:

  I have carefully read the questions in the foregoing application and have answered them completely, without reservations of any kind, and I declare under penalty of perjury that my answers and all statements made by me herein are true and correct. Should I furnish any false information in this application, I hereby agree that such act shall constitute cause for the denial, suspension or revocation of my license to practice medicine and surgery, osteopathic medicine and surgery, chiropractic or podiatry in the state of Kansas and may subject me to a fine not exceeding $10,000 and term of imprisonment not exceeding 5 years for each violation. (K.S.A. 21-3805)

- KSBHA will verify each of your medical board licenses except for any board that does not provide free, current verifications and disciplinary actions on their official website. For those boards, use the licensure verification resource at http://www.fsmb.org/licensure/uniform-application/ to determine the fees and preferred verification method of each board. Use the Licensure Verification form in this packet for boards requiring a written request. You may use VeriDoc or another preferred method if applicable.

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If you are using FCVS for credentials verification,

- Do not complete the UA Medical Education, Postgraduate Training, or Fifth Pathway Verification forms, or send identity documents, transcripts, certificates, or examination scores to the Board. FCVS obtains this information and sends it to the Board as part of your FCVS profile of verified credentials.

If you are not using FCVS for credentials verification,

- Send to the Board a certified copy of a legal name change document (marriage certificate, divorce decree, court order) if your name is not the same on all of your submitted documents.

- Complete the UA Medical Education Verification, Postgraduate Training Verification, and Fifth Pathway Verification (if applicable) forms as directed on each form.

- Submit a notarized copy of your medical school diploma(s). The diploma(s) must be notarized as a true and accurate copy of the original. Note: Diplomas in languages other than English must be translated and the translation certified as accurate. Documents without such certification will not be accepted.

- Contact each appropriate examination entity to have a certified transcript of your scores sent directly from the exam entity to the Board. If you have taken any component of the NBME in conjunction with another exam (USMLE/FLEX), request your transcript of scores from the NBME. For exam entity contact information, see the UA FAQ at http://www.fsmb.org/licensure/uniform-application/faq.

- International Medical Graduates: Submit a notarized copy of your ECFMG Certificate to the Board. It must be notarized as a true and accurate copy of the original. Also request that a "Status Report of ECFMG Certification" be sent directly to the board. If you attended a Fifth Pathway Program, request that the Fifth Pathway Program Certificate be sent to the Board. See the UA FAQ link above for contact information.

Additional Licensure Information / Requirements

- **Application Fee.** The Kansas application fee is $300.00. It must be submitted with the application and is **NOT** refundable. You may pay by check, debit card, Visa, MasterCard, Discover, American Express or money order. Make checks payable to KSBHA. Checks returned for any reason by the payer's financial institution must be replaced by a money order, certified check, debit card or credit card.

- **AMA and AOIA Reports.** MDs must request the AMA report from the American Medical Association at https://profiles.ama-assn.org/amaprofiles/ or call 800-665-2882. DOs must request the AOIA report from the American Osteopathic Information Association at https://www.doprofiles.org or call 800-621-1773 x8145.

- **Criminal Background Report.** Effective January 1, 2009, applicants to practice the healing arts will be required to submit their fingerprints for state and national criminal history background checks. Addendum 4 explains in detail how to obtain and submit your fingerprints to the Board. **Be aware that fingerprint processing may delay your application. Please make it a PRIORITY to complete the fingerprint process. Complete, sign and return the *Waiver Agreement and Statement* form directly to the Board. Applicants will be required to submit the completed waiver and $47.00 fee.**

- **National Practitioner Data Bank Report.** Effective September 1, 1990, the Federal government opened the National Practitioner Data Bank (NPDB). This data bank, mandated by Congress, tracks regulatory board disciplinary actions, certain actions resulting from peer review and malpractice payments. **The Kansas State Board of Healing Arts will obtain a NPDB report for all applicants. Applicants will be required to submit the report fee of $3.00 to the Board.**

- **License Renewals.** MD licenses expire on July 31 and are renewed annually. License renewal will be required of all MD applicants receiving permanent licenses prior to May 1. DO licenses expire on October 31 and are renewed annually. License renewal will be required of all DO applicants receiving permanent licenses prior to August 1.

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UNIFORM APPLICATION FOR PHYSICIAN STATE LICENSURE CHECKLIST

After completing the Uniform Application, you are responsible for submitting certain documents. There are two checklists below; one to use if you are using the Federation Credentials Verification Service (FCVS) and one to use if you are not using FCVS. Please use the checklist that applies to you.

	NOT using FCVS to verify credentials	Using FCVS to verify credentials
Completed Uniform Application (UA).	☐	☐
Completed state addenda and fees (Application - **$300**, National Practitioner Data Bank Report **$3**, KBI Fee **$47**) sent to the Board.	☐	☐
Notarized UA Affidavit and Authorization for Release of Information form sent to the Board.	☐	☐
Request verification of other licenses permits or certifications, if applicable. The Board will verify your credentials for any state or jurisdiction that provides free and current verifications on their official state website. If the Board is unable to verify your credentials, complete the Verification Form and forward to all licensing agencies.	☐	☐
American Medical Association or American Osteopathic Information Association report sent to the Board from the AMA or AOIA.	☐	☐
Completed Background Check Waiver, Fingerprint card, **$47** Fee.	☐	☐
Supporting documentation of any legal name change sent to the Board.	☐	Completed via FCVS
Medical Education Verification form sent to the Board from all medical schools attended.	☐	Completed via FCVS
Medical School Transcripts sent to the Board by your medical school(s).	☐	Completed via FCVS
Medical School Diploma sent to the Board by your medical school(s).	☐	Completed via FCVS
Postgraduate Training Verification form sent to the Board from all programs you attended, even from those you have not completed.	☐	Completed via FCVS
Fifth Pathway form (if applicable) sent to the Board from the medical school and institution - include a copy of your diploma (must be sealed by your school).	☐	Completed via FCVS
Examination Transcripts sent to the Board.	☐	Completed via FCVS
ECFMG Status Report (if applicable) sent to the Board.	☐	Completed via FCVS

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

Phone: 785-296-7413
www.ksbha.org

KANSAS LICENSURE APPLICATION ADDENDUM INSTRUCTIONS MEDICINE & SURGERY (MD) and OSTEOPATHIC MEDICINE & SURGERY(DO)

Please visit www.ksbha.org for all statutes and regulations

Completing the Kansas Licensure Addendum

Complete each addendum as instructed. Please type or print your responses. Return the completed addenda along with any and all supporting documentation to the Kansas State Board of Healing Arts at the address above.

☐ **Addendum 1** These questions must be completed by the applicant.

☐ **Addendum 2** Each question must be completed by the applicant. Documentation must be provided for any "yes" answer(s). **It is imperative that you honestly and fully answer all questions, regardless of whether you believe the information requested is relevant.**

☐ **Addendum 3** This form must be completed by the applicant. All applicants for licensure in the State of Kansas must request a disciplinary inquiry report from the Federation of State Medical Boards (FSMB). Once this form has been completed, you may email it to the FSMB at boardinquiry@fsmb.org.

If you are using FCVS, do not complete this form. They will obtain your disciplinary report and send it to the Board.

☐ **Addendum 4** Effective January 1, 2009, applicants to practice the healing arts will be required to submit their fingerprints for state and national criminal history background checks. Addendum 4 explains in detail how to obtain and submit fingerprints to the Board.

Complete, sign and date the top portion of Waiver Agreement and FBI Privacy Act Statement. 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 completed and signed Waiver Agreement. Submit completed background check waiver, Fingerprint card, and $47 fee.

Be aware that fingerprint processing may delay your application. Please make it a priority to complete the fingerprint process.

☐ **Credit Card Payment Authorization Form** To pay by debit or credit card, complete the Credit Card/Debit Card Authorization Form.

Application fees must be submitted with the application. These *fees are* ***non-refundable*** and will be processed upon receipt. The Kansas Medicine and Surgery application fee is $300. Also, a background check fee of $47 and a National Practitioner Data Bank ("NPDB") report fee of $3 must accompany the application. **This totals $350.**

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ADDENDUM 4
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.

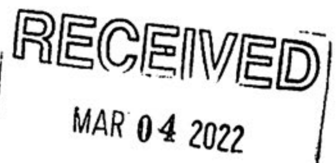
Complete the applicant section of the fingerprint card. Ensure the appropriate data fields are completed prior to submission. Include name, aliases, complete mailing address, social security number, citizenship, date of birth, and personal information (sex, race, height, weight, eyes, hair, place of 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 Childcare Protection Act/Volunteers for Children Act (NCPA/VCA) explained in Public Law 103-209 and Public Law 105-251. Pursuant to K.S.A. 22-4701 et seq. and K.S.A. 22-5001, 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.

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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 (USC) 552a(b); 28 USC 534(b); 42 USC 14616, Article IV(c); 28 CFR 20.21(c), 20.33(d), and 906.2(d).)

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Authority:
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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 USC 552a), the requesting agency 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 asks 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 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).

WAIVER AGREEMENT
AND
FBI PRIVACY ACT STATEMENT (Cont.)

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Fingerprint-Based Record Checks for Noncriminal Justice Purposes

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 USC 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:

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

MEDICAL BOARD
OF CALIFORNIA
Protecting consumers by advocating high quality, safe medical care.

Licensing Program
2005 Evergreen Street, Suite 1200
Sacramento, CA 95815-5401
Phone: (916) 263-2382
Fax: (916) 263-2487
www.mbc.ca.gov

Gavin Newsom, Governor, State of California | Business, Consumer Services and Housing Agency | Department of Consumer Affairs

March 10, 2022

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

To Whom It May Concern:

This is to certify that as of March 9, 2022, the records of the Medical Board of California (Board) indicate the following information:

Physician:	JENNIFER KERNS
License Number:	A104345
Issued Date:	June 11, 2008
Exam Type:	A Written Examination
Expiration Date:	March 31, 2024
License Status:	Current
Board Discipline and/or Administrative Action:	No

If Board Discipline and/or Administrative Action is indicated, public records may be available at http://www.mbc.ca.gov; or you may contact the Board's Enforcement Program, Central File Room by email at central.fileroom@mbc.ca.gov, by fax at (916) 263-2420 or by mail at 2005 Evergreen Street, Suite 1200, Sacramento, CA 95815, to obtain information concerning the action.

Marina O'Connor
Chief of Licensing

Board of Medical Licensure & Supervision
State of Oklahoma

101 N.E. 51st Street
Oklahoma City, OK 73105

P.O. Box 18256
Oklahoma City, OK 73154-0256

Letter of Verification

March 10, 2022

This is to certify that the records of this Board indicate on the date of this letter the following information regarding:

Name:	JENNIFER KERNS
Address Date:	November 05, 2021
Address 1:	UNIVERSITY OF SAN FRANCISCO
Address 2:	1001 POTRERO AVE. WARD 6D
Address 3:	
City, State, ZIP:	SAN FRANCISCO, CA 94110

Profession:	MEDICAL DOCTOR
Profession Type:	MD
License Number:	38893
License Date:	03/04/2022
Status:	Active
Status Class:	
Expiration Date:	05/12/2022
Endorsed By:	USMLE
Restricted To:	

Disciplinary Actions:

Date	Description
	No Disciplinary Actions Taken

Previous Licenses:

Type	Issued	Expired
Temporary	03/04/2022	05/12/2022

Details of Disciplinary Action, if applicable, will be made available by photocopy from the public file upon written request only.

To expedite the verification of licensure/certification process, the above is the standard format for all professions regulated by this board

The Oklahoma State Board of Medical Licensure and Supervision certifies that the verification data displayed here is accurate according to the information stored in our database as of 03/10/2022.

Lisa Cullen
Director of Licensing
(405) 962-1400 ext 153

From:	support@veridoc.org
To:	KSBHA Licensing
Subject:	License Verification Statement - KERNS, JENNIFER
Date:	Thursday, March 10, 2022 12:42:26 PM
Attachments:	v978067AA.pdf v978067BA.pdf

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Verification of Licensure Status

The attached verification reports have been sent to you by the VeriDoc.org website. This email can be verified coming from this site by clicking on the link below.

Validate Verifications

Physician: KERNS, JENNIFER

Transaction ID: 978067

Confirmation Number: CONFIDENTIAL

This email contains 2 PDF attachments. If any are missing please contact support@veridoc.org.

Information from the attached verifications can be refreshed for up to 6 months. To view an updated copy, click on a link below.
California, Medical Board of
Oklahoma Board of Medical Licensure & Supervision

RECEIVED
MAR 04 2022
KSBHA

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, Jennifer Kerns, 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: Credentialing Specialist

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

______________________ Date

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MAR 04 2022
KSBHA

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 "<u>no</u>" 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: ______

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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* **"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).

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

RECEIVED
By Rebecca Berg at 10:51 am, May 18, 2022

TRUST WOMEN

May 12, 2022

Rebecca Berg
Kansas State Board of Healing Arts
800 SW Jackson, Lower Level, Ste A
Topeka, KS 66612

Dear Rebecca,

I am writing to you today to ask that you review Dr. Jennifer Kerns application for Medical Licensure through the Kansas Board of Healing Arts.

The Kansas Health Care Provider Insurance Availability Plan sent in a letter of intent for Malpractice on May 10, 2022.

Dr. Kerns is scheduled to provide coverage for Trust Women beginning June 16, 2022. We are terribly concerned, if Dr. Kerns is not licensed by June 16th, it will unduly hurt the patients we serve, leaving a multitude of women without care.

Please consider my request for the temporary emergency licensure for Dr. Kerns. Our patients will be grateful to have a physician to care for them. I look forward to hearing from you soon and thank you in advance.

Sincerely,

Schaunta James Boyd
Co-Executive Director
Trust Women
South Wind Women's Center

From:	Lizeth Lucio
To:	Berg, Rebecca [KSBHA]
Subject:	Dr. Kerns
Date:	Tuesday, May 17, 2022 10:09:16 AM
Attachments:	20220512101546845.pdf

EXTERNAL: This email originated from outside of the organization. Do not click any links or open any attachments unless you trust the sender and know the content is safe.

Hello Rebecca,

I hope you are well. Just wanted to pass along our letter of need for Dr. Kerns.

All my best,

Lizzie Lucio

Trust Women

O: 316-425-3215

F: 316-425-3451

llucio@itrustwomen.org

www.trustwomen.org

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MAR 04 2022
KSBHA

Applicant Name: Jennifer Kerns

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: ____________ License number: ____________ Issue date: ____________

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: ____________ License number: ____________ Issue date: ____________

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

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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RECEIVED
By Rebecca Berg at 12:36 pm, Jun 08, 2022

Applicant Name: Jennifer Kerns

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	05/2002	☑ (P) ☐ (F) ☐ (U)	1
USMLE Step II, CS		☑ (P) ☐ (F) ☐ (U)	
USMLE Step II, CK	02/2004	☑ (P) ☐ (F) ☐ (U)	1
USMLE Step III	08/2006	☑ (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: NY License number: 242369 Issue date: 11/14/2006

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

RECEIVED
By Rebecca Berg at 12:36 pm, Jun 08, 2022

Applicant Name: Jennifer Kerns

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: Oklahoma License number: 38893 Issue date: 03/04/2022

License status: ☐ Active ■ Expired ☐ In Good Standing ☐ Inactive ☐ Limited ☐ Probationary ☐ Restricted ☐ Retired ☐ 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: Oklahoma License number: 38893 Issue date: 03/28/2022

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

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 ☐ Expired ☐ In Good Standing ☐ Inactive ☐ Limited ☐ Probationary ☐ Restricted ☐ Retired ☐ 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 ☐ Expired ☐ In Good Standing ☐ Inactive ☐ Limited ☐ Probationary ☐ Restricted ☐ Retired ☐ Revoked ☐ Suspended

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From:	Lizeth Lucio
To:	Berg, Rebecca [KSBHA]
Subject:	RE: KS License Application
Date:	Wednesday, June 8, 2022 12:30:39 PM
Attachments:	md_do_app part 3.pdf

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Hello Rebecca,

Sorry about that here you go.

Thank you.

From: Berg, Rebecca [KSBHA] <Rebecca.Berg@ks.gov>
Sent: Wednesday, June 8, 2022 9:59 AM
To: Lizeth Lucio <LLucio@itrustwomen.org>
Subject: RE: KS License Application

Hello,

Thank you for sending this. I saw that you hadn't listed the OK license information, just the NY. Can you please add it and send it back to me? I'll get it processed ASAP and let the specialist know it's ready.

Thank you,

Becky Berg
Licensing Analyst
Kansas State Board of Healing Arts
800 SW Jackson, LL – Suite A
Topeka, Kansas 66612
Email: rebecca.berg@ks.gov
Phone: 785.368.8206
Fax: 785.296.0852
http://www.ksbha.org

From: Lizeth Lucio <LLucio@itrustwomen.org>
Sent: Wednesday, June 8, 2022 8:17 AM
To: Berg, Rebecca [KSBHA] <Rebecca.Berg@ks.gov>; Kerns, Jennifer <Jennifer.Kerns@ucsf.edu>
Subject: RE: KS License Application

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Hello Rebecca,

I hope you are well. Please see attached. With the New York license it is actually no longer registered so we are unable to verify it. It was only issued for training but I included it on the license piece.

Thank you.

From: Berg, Rebecca [KSBHA] <Rebecca.Berg@ks.gov>
Sent: Tuesday, June 7, 2022 11:32 AM
To: Kerns, Jennifer <Jennifer.Kerns@ucsf.edu>
Cc: Lizeth Lucio <LLucio@itrustwomen.org>
Subject: RE: KS License Application

Hello,

I just checked with the specialist who is assigned to review your application and she said yes, if the needed documentation gets returned as soon as possible she'll complete the review by the end of this week.

Thank you,

Becky Berg
Licensing Analyst
Kansas State Board of Healing Arts
800 SW Jackson, LL – Suite A
Topeka, Kansas 66612
Email: rebecca.berg@ks.gov
Phone: 785.368.8206
Fax: 785.296.0852
http://www.ksbha.org

From: Kerns, Jennifer <Jennifer.Kerns@ucsf.edu>
Sent: Monday, June 6, 2022 5:19 PM
To: Berg, Rebecca [KSBHA] <Rebecca.Berg@ks.gov>
Cc: Lizeth Lucio <LLucio@itrustwomen.org>
Subject: Re: KS License Application

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Sent from my iPhone

On Jun 6, 2022, at 12:37 PM, Berg, Rebecca [KSBHA] <Rebecca.Berg@ks.gov> wrote:

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Thank you,

Becky Berg
Licensing Analyst
Kansas State Board of Healing Arts
800 SW Jackson, LL – Suite A
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Applicant Name: Jennifer Kerns

RECEIVED
By Rebecca Berg at 12:36 pm, Jun 08, 2022

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: 07/2004 (mm/yyyy) End date: 06/2008 (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*: NYPH, Columbia University

Street: 630 West 168th St

City: New York State/Province: NY Zip code: 10032

Country: USA Position: Resident

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

☒ Employment ☐ Staff Privileges ☐ Affiliation

☐ Other (describe your relationship with this institution):

2. Start date: 08/2005 (mm/yyyy) End date: 02/2008 (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*: Columbia University

Street: 630 W 168th

City: New York State/Province: NY Zip code: 10032

Country: USA Position: Admissions officer

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

☒ Employment ☐ Staff Privileges ☐ Affiliation

☐ Other (describe your relationship with this institution):

3. 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*: UCB-UCSF Joint Medical Program

Street: 2121 Berkeley Way, Room 5302

City: Berkeley State/Province: CA Zip code: 94720

Country: USA Position: Admissions Officer

Department: School of Public Health Clinical**: 80 % Administrative***: 20 %

☒ Employment ☐ Staff Privileges ☐ Affiliation

☐ Other (describe your relationship with this institution):

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