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. 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 KS and will be reported to all appropriate state/federal/military agencies in other jurisdictions.*** Yes ☐ No ☑ If yes:

   Intended Kansas Residence Address:_____

   Expected Date of Commencing Residence:_____

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

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

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

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

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

RECEIVED
JUL 11 2022
KSBHA

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

Kansas

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

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

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

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

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

RECEIVED
JUL 11 2022
KSBHA

Uniform Application for Licensure

Application ID: 355416
FID: 217282169

License Requested: MD
License Type: Permanent Medical License
Submitted to: Kansas State Board of Healing Arts
Submission Date: 7/6/2022 12:31 PM

Practitioner Name

Oni-Orisan, Adeola

Alternate Name(s): Oni-Orisan, Adeola Oladayo

Oni-Orisan, Adeola Oladayo Olawunmi

Contact Information

Address

Public Access	Board Contact	Type	Address
No	Yes	Home	CONFIDENTIAL
Yes	No	Business	5107 E Kellogg Dr Wichita, KS 67218 UNITED STATES

Phone

Public Access	Board Contact	Type	Phone Number	Phone Extension
Yes	No	Business	(316) 260-6934	
No	Yes	Mobile	CONFIDENTIAL	

Email

Public Access	Board Contact	Email
No	Yes	CONFIDENTIAL
Yes	No	bfhsscollaboratory@gmail.com

Identification

USMLE Number	SSN	Birth Date	Birth Place	Gender	NPI	Practitioner Type	US Citizen
	CONFIDENTIAL		Ann Arbor, Michigan UNITED STATES	F	1124523774	MD	Yes

Medical School

Medical School Name	Address	Start Date	End Date	Graduation Date	Degree Code
Harvard Medical School	25 Shattuck Street Boston, MA 02115 UNITED STATES	08/17/2009	05/24/2018	05/24/2018	MD

Fifth Pathway

None Reported

ECFMG

Certificate Number	Issue Date
None Reported	

Postgraduate Training

Hospital Name: **University of California (San Francisco) Program**
San Francisco, CA UNITED STATES

Program Code: ACGME 1200511059

Attendance Dates:

Institution: University of California (San Francisco) School of Medicine

Start Date: 06/17/2018

Training Specialty: Family Medicine

End Date: 06/30/2021

Program Type: Residency

Training Status: Completed

Clinical %: 95

Administrative %: 5

Examination History

Exam	State	Last Attempt	Pass/Fail	Number Of Attempts
USMLE Step 1 Examination		04/08/2011	Pass	1
USMLE Step 2 CK Examination		05/23/2012	Pass	1
USMLE Step 2 CS Examination		09/17/2012	Pass	1
USMLE Step 3 Examination		03/01/2019	Pass	1

State Licensure History

MD, DO, PA License History

License Entity	Licensing State	License Number	Issue Date	Expiration Date	License Type	License Status
Georgia Composite Medical Board	GA	90329	09/30/2021	10/31/2022	Full	Active
Medical Board of California	CA	A-167053	12/13/2019	12/31/2023	Full	Active

Physician Reported License History

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

Chronology of Activity Type

Practice/Emp/ Desc: **Harvard Medical School**

Chronology Type: Medical Education

Address: Boston, MA US

Attendance Dates:

Position/Dept:

From: 08/17/2009 to 05/24/2018

Clinical %:

Admin %:

Employment: **Staff Privileges:** **Affiliation:**

Practice/Emp/ Desc: **University of California, San Francisco**

Chronology Type: PGT/Education

Address: 3333 California St
San Francisco, CA 94118
US

Attendance Dates:

Position/Dept: PhD student - Medical Anthropology

From: 08/16/2012 to 09/11/2018

Clinical %: 0

Admin %: 100

Employment: ○ **Staff Privileges:** ○ **Affiliation:** ○

Practice/Emp/ Desc: **University of California (San Francisco) Program**

Chronology Type: Accredited Training

Address: San Francisco, CA
US

Attendance Dates:

Position/Dept:

From: 06/17/2018 to 06/30/2021

Clinical %: 95

Admin %: 5

Employment: **Staff Privileges:** **Affiliation:**

Practice/Emp/ Desc: **San Francisco Free Clinic**

Chronology Type: Work

Address: 4900 California St
San Francisco, CA 94118
US

Attendance Dates:

Position/Dept: contract physician - primary care

From: 07/01/2021 to In Progress

Clinical %: 100

Admin %: 0

Employment: • **Staff Privileges:** • **Affiliation:** ○

Practice/Emp/ Desc: **Planned Parenthood Southeast**

Chronology Type: Work

Address: 440 Moreland Avenue SE
Atlanta, GA 30316
US

Attendance Dates:

Position/Dept: Interim Medical Director - Abortion Services

From: 10/01/2021 to 04/30/2022

Clinical %: 80

Admin %: 20

Employment: • **Staff Privileges:** • **Affiliation:** ○

Practice/Emp/ Desc: **San Francisco Department of Public Health**

Chronology Type: Work

Address: 101 Grove St
94102, CA
US

Attendance Dates:

Position/Dept: Physician, part-time, per diem - Whole Person Integrated Care/Street Medicine

From: 10/15/2021 to In Progress

Clinical %: 100

Admin %: 0

Employment: • **Staff Privileges:** • **Affiliation:** ○

Malpractice

None Reported

FCVS | FEDERATION CREDENTIALS VERIFICATION SERVICE

Medical Professional Information Profile

This report provides credentialing information for:

Name:	**Oni-Orisan, Adeola Oladayo**
Social Security Number:	CONFIDENTIAL
Date of Birth:	
FID#:	**217282169**
Recipient:	**KS - Kansas State Board of Healing Arts**
Delivery Date:	**07/06/2022**

ABOUT THIS PROFILE

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

NOTICE: All documents bearing an original Official FCVS seal are certified to be an exact reproduction of the original. Where required, original documents are provided according to the agreements with the Institution issuing such document. FCVS maintains all original documents (excluding third-party examination transcripts) in the physician's source file.

FCVS FEDERATION CREDENTIALS VERIFICATION SERVICE

Affidavit and Release

fsmb

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

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

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

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

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

Adeola Oni-Orisan

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

Oni-Orisan

Applicant's Printed Last Name

Adeola O

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

08/24/2021

Date of Signature (must correspond to date of notarization)

CARISSA ASHLEN WILLIAMS
ELECTRONIC NOTARY PUBLIC
REG # 7808937
EXPIRES 8/31/2022
COMMONWEALTH OF VIRGINIA

State of Virginia, County of James City

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 24 day of August, 2021.

Notary Public Signature: Carissa Ashlen Williams

My Notary Commission Expires: August 31, 2022

Completed via Remote Online Notarization using 2way Audio/Video technology

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

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

FCVS ID Number

FID Number

FCVS FEDERATION CREDENTIALS VERIFICATION SERVICE

Identity

Biographic Information

Medical professional Name(s): **Oni-Orisan, Adeola Oladayo**

Oni-Orisan, Adeola Oladayo Olawunmi

Date of Birth: CONFIDENTIAL

Place of Birth: Ann Arbor, Michigan, UNITED STATES

Contact Information

Business Address: 5107 E Kellogg Dr
Wichita, KS 67218
UNITED STATES

Home Address: CONFIDENTIAL

Business Phone: (316) 260-6934

Mobile Phone: CONFIDENTIAL

Email:

Email: bfhsscollaboratory@gmail.com

Credentials Analysis Information for Identity

There is no Omission/Discrepancy/Miscellaneous information identified.

CERTIFICATION OF IDENTIFICATION

Certification by Notary Public Is Required

Applicant Full Legal Name: Oni-Orisan (Last) Adeola (First) Oladayo (Middle)

FCVS ID Number: 217282169

Notary – Please complete the section below:

State of Virginia County of James City

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

The statements on this document are subscribed and sworn to before me by the applicant on this (Day) 24, of (Month) August, (Year) 2021.

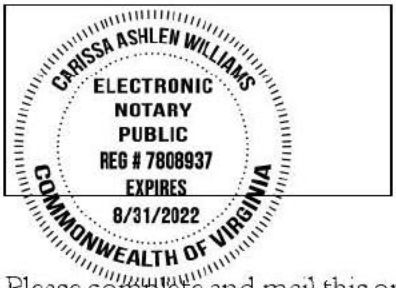
Notary Public Signature: Carissa Ashlen Williams

Commission Expiration Date* (Month) August /(Day) 31 /(Year) 2022

Completed via Remote Online Notarization using 2way Audio/Video Technology

*** The notary's commission expiration date must be current and legible. If no expiration date, such as 'lifetime', an explanation must be provided.**

Notary Stamp Here



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

Federation of State Medical Boards
ATTN: FCVS
400 Fuller Wiser Rd., Suite 300
Euless, TX 76039-3856

We the People

Of the United States,
in Order to form a more perfect Union,
establish Justice, insure domestic Tranquility,
provide for the common defence,
promote the general Welfare, and secure
the Blessings of Liberty to ourselves and
our Posterity, do ordain and establish this
Constitution for the United States of America.

SIGNATURE OF BEARER / SIGNATURE DU TITULAIRE / FIRMA DEL TITULAR

3

PASSPORT
PASSEPORT
PASAPORTE

USA

UNITED STATES OF AMERICA

Type / Type / Tipo: P

Code / Code / Codigo: USA

Passport No. / No. du Passeport / No. de Pasaporte: CONFIDENTIAL

Surname / Nom / Apellidos
ONI-ORISAN

Given Names / Prénoms / Nombres
ADEOLA OLADAYO

Nationality / Nationalité / Nacionalidad
UNITED STATES OF AMERICA

Date of birth / Date de naissance / Fecha de nacimiento
CONFIDENTIAL

Place of birth / Lieu de naissance / Lugar de nacimiento
MICHIGAN, U.S.A.

Sex / Sexe / Sexo
F

Date of issue / Date de délivrance / Fecha de expedición
02 Dec 2016

Authority / Autorité / Autoridad
United States
Department of State

Date of expiration / Date d'expiration / Fecha de caducidad
01 Dec 2026

Endorsements / Mentions Spéciales / Anotaciones
SEE PAGE 27

USA

CONFIDENTIAL

CONFIDENTIAL

FCVS FEDERATION CREDENTIALS VERIFICATION SERVICE

Chronology of Activities

fsmb

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

Start Date	End Date	Activity Type	Location
08/17/2009	05/24/2018	Medical Education	Harvard Medical School Boston Massachusetts UNITED STATES
08/16/2012	09/11/2018	PGT/Education	University of California, San Francisco San Francisco California UNITED STATES
06/17/2018	06/30/2021	Postgraduate Training	University of California (San Francisco) Program San Francisco California UNITED STATES
07/01/2021		Work	San Francisco Free Clinic 4900 California St San Francisco, California UNITED STATES
10/01/2021	04/30/2022	Work	Planned Parenthood Southeast 440 Moreland Avenue SE Atlanta, Georgia UNITED STATES
10/15/2021		Work	San Francisco Department of Public Health 101 Grove St 94102, California UNITED STATES

End of Chronology of Activities report for: Oni-Orisan, Adeola Oladayo

FCVS FEDERATION CREDENTIALS VERIFICATION SERVICE

Medical Education

fsmb

Medical Education

Medical School: **Harvard Medical School**

Location: Boston, MA

UNITED STATES

Credentials Analysis Information for Medical Education

There is no Omission/Discrepancy/Miscellaneous information identified.

FCVS FEDERATION CREDENTIALS VERIFICATION SERVICE

fsmb

Institution Name: Harvard Medical School

City: Boston **State/Province:** Massachusetts **Country:** UNITED STATES

Premedical Education:

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

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

Enrollment and Participation:

Our records indicate that Oni-Orisan, Adeola Oladayo

attended our medical school for a total of 140 weeks of medical education on the following dates: From MM/DD/YYYY: 08/17/2009 To MM/DD/YYYY: 05/24/2018

This individual was awarded the degree of Doctor of Medicine on 05/24/2018

DS

Unusual circumstances

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

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

				From MM/DD/YYYY:	To MM/DD/YYYY:	
Personal/Family	Applicable	N/A	X	/ /	/ /	
Academic remediation	Applicable	N/A	X	/ /	/ /	
Health	Applicable	N/A	X	/ /	/ /	
Financial	Applicable	N/A	X	/ /	/ /	
Participation in joint degree program (e.g., MD/PhD)	Applicable	X N/A		07 / 01 / 2012	04 / 12 / 2017	Approved
Other	Applicable	N/A	X	/ /	/ /	

Other Explanation:

Medical School Code: 022020 FID: 217282169

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

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

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

Other Reason Explanation:

3. Do this individual's official records reflect that he/she was ever disciplined for unprofessional conduct/behavioral reasons by the medical school or parent university? **YES** **NO** X **N/A**

If YES, please provide detailed information about the circumstances and outcome(s):

4. Do this individual's official records reflect that he/she was ever the subject of negative reports for behavioral reasons or an investigation by the medical school or parent university? **YES** **NO** X **N/A**

If YES, please provide detailed information about the circumstances and outcome(s):

5. Do this individual's official records reflect that there were any limitations or special requirements imposed on the individual because of questions of academic incompetence, disciplinary problems, or any other reason? **YES** **NO** X **N/A**

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

6. Attach Transcript **7. Attach Diploma** **8. Do you have a Dean's Letter to Attach?** **YES** X **NO** **9. Would you like to upload an additional attachment?** **YES** X **NO**

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

ELECTRONIC SEAL VERIFIED	Name: Eugenia Trabucchi Title: Staff Assistant III Harvard Medical School Office of the Registrar Signature: DocuSigned by: Eugenia Trabucchi 476CC5EFAE6848F... Date of Signature: 9/3/2021 Email: registrar@hms.harvard.edu

Medical School Code: 022020 FID: 217282169

HARVARD MEDICAL SCHOOL

OFFICE OF THE REGISTRAR

25 SHATTUCK STREET
BOSTON, MASSACHUSETTS 02115-6092
Telephone (617) 432-1515

October 24, 2017

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

I, Terese Galuszka, Registrar, delegate Eugenia Trabucchi, Staff Assistant III, to be the signatory for all medical education verification forms.

Signature
Registrar
October 24, 2017

FCVS FEDERATION CREDENTIALS VERIFICATION SERVICE

Applicant Reported Unusual Circumstances

fsmb

Medical School

Medical Professional Name: Oni-Orisan, Adeola Oladayo

Harvard Medical School

Unusual Circumstances

Did you have any interruption(s) or extension(s) in your medical education?	**Yes**
Dates: 08/2012 To 05/2017	
Leave of absence to complete PhD at another institution (UCSF)	
Were you ever placed on probation?	**No**
Were you ever disciplined or placed under investigation?	**No**
Were any negative reports for behavioral reasons ever filed by instructors?	**No**
Were any limitations or special requirements imposed on you because of academic performance, incompetence, disciplinary problems or for any other reason?	**No**

End of Applicant Reported Unusual Circumstances report for: Oni-Orisan, Adeola Oladayo

Harvard Medical School

October 1, 2017

The enclosed Medical Student Performance Evaluation (MSPE) is a summary of this student's academic record written by senior members of our faculty. It is an objective distillation of the student's career and academic performance at Harvard Medical School. This letter is not intended to specify future career plans and therefore does not indicate the specialty to which the student is applying.

Principal Clinical Experience (PCE)
The Principal Clinical Experience (PCE) is the year-long program in which each student is assigned to a primary hospital teaching site for the core (required) clinical clerkships. The student then completes a required medicine or pediatrics subinternship, ordinarily at a different hospital, and clinical electives may be taken at any Harvard-affiliated hospital.

Evaluations Quoted in the Letter
All core clinical clerkship evaluations available in the student's file at the time that the MSPE is compiled are included, quoted in full and in chronological order. As a result of scheduling, some subinternship evaluations may not be available in time to be included.

Clinical Grading Policy
Beginning in May 2013, our clinical grading policy changed and we recalibrated our grading nomenclature. The current nomenclature is: U (Unsatisfactory), P (Pass), H (Honors) and HD (Honors with Distinction). The new grading nomenclature is also used in subinternships and in clinical electives.

Students who completed core clinical clerkships before 2013 were graded under the old grading nomenclature: U (Unsatisfactory), S (Satisfactory), H (Honors) and HH (High Honors). Therefore, the transcript and MSPE evaluations for students graduating in May 2017 who have spent six or more years at HMS (e.g., an MD-PhD student who took some clerkships before starting graduate school) may have a mix of both grading systems.

Histograms
For reference, we include histograms of the grade distributions for each core clerkship, using data from the year the student was in the PCE. No histogram is included for any student who completed the PCE before Academic Year 2012-2013 because of the different grading policy at that time.

Student Ranking
As has been our long-standing policy, we do not rank our students, nor do we use any code words in this evaluation. We also do not participate in AOA or any other national honor societies. Our letters are written by a senior faculty member designated for this purpose, and then edited for consistency across the class and co-signed by the Dean for Students.

Edward Hundert

Edward M. Hundert, M.D.
Dean for Medical Education

Fidencio Saldaña MD, MPH

Fidencio Saldaña, M.D., M.P.H.
Dean for Students

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CONFIDENTIAL

VNIVERSITAS HARVARDIANA

CANTABRIGIAE IN REPVBLICA MASSACHVSETTENSIVM

PRAESES et Socii Collegii Harvardiani consentientibus honorandis ac reverendis Inspectoribus in comitiis sollemnibus

ADEOLA OLAWUNMI ONI-ORISAN

ad gradum Medicinae Doctoris

cum laude et thesi propria

admiserunt eique dederunt et concesserunt omnia insignia et iura quae ad hunc gradum spectant.

In cuius rei testimonium litteris Academiae sigillo munitis die XXIIII Maiae anno Domini MMXVIII Collegiique Harvardiani CCCLXXXII auctoritate rite commissa nomina subscripserunt.

PRAESES

DECANVS ORDINIS MEDICINAE

This is to certify that this is a true and accurate copy of the original diploma issued to Adeola Olawunmi Oni-Orisan by Harvard University, Harvard Medical School, on May 24, 2018.

Terese Galuszka
Registrar

ELECTRONIC SEAL VERIFIED

Translation of M.D. diploma

HARVARD UNIVERSITY IN CAMBRIDGE

The President and Fellows of Harvard College with the consent of the Honorable and the Reverend Board of Overseers, in solemn council assembled, have admitted

Adeola Olawunmi Oni-Orisan

to the rank of Doctor of Medicine cum laude in a special field and have given her and conferred upon her rights and privileges belonging to this rank.

In testimony whereof, to these letters, authenticated by the seal of the University, the President, and Dean, by the authority rightfully committed to them have subscribed their names on the 24th of May year 2018 Harvard College the three hundred and eighty-second.

Drew Gilpin Faust
President

George Q. Daley
Dean of the Faculty of Medicine

(Seal)

This is to certify that this is a true and accurate copy of the diploma translation of the diploma issued to Adeola Olawunmi Oni-Orisan, MD, by Harvard University, Harvard Medical School, on May 24, 2018.

Terese Galuszka
Registrar

ELECTRONIC SEAL VERIFIED

FCVS FEDERATION CREDENTIALS VERIFICATION SERVICE

Postgraduate Training

fsmb

Postgraduate Training

Accreditation ID: **1200511059**

Institution: **University of California (San Francisco) Program**

Location: San Francisco, CA
UNITED STATES

Credentials Analysis Information for Postgraduate Training

There is no Omission/Discrepancy/Miscellaneous information identified.

FCVS FEDERATION CREDENTIALS VERIFICATION SERVICE

fsmb

Verification of Postgraduate Medical Education

Accreditation Code: 1200511059

Institution Name: University of California (San Francisco) Program

Affiliated University: University of California (San Francisco) School of Medicine

City: San Francisco **State:** California **Country:** United States

Verification For: Adeola Oladayo Oni-Orisan **Date of Birth:** CONFIDENTIAL

Program Participation:

PGY: 1	Accredited By: ACGME	Status: Complete
Specialty: Family Medicine		
From: 06/17/2018	To: 06/16/2019	Program Type: Residency

PGY: 2	Accredited By: ACGME	Status: Complete
Specialty: Family Medicine		
From: 06/17/2019	To: 06/16/2020	Program Type: Residency

PGY: 3	Accredited By: ACGME	Status: Complete
Specialty: Family Medicine		
From: 06/17/2020	To: 06/16/2021	Program Type: Residency

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

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

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

FID: 217282169

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

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

Unusual Circumstances

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

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

ELECTRONIC SEAL VERIFIED	Name: Diana Coffa Title: Program Director Degree: MD Signature: DocuSigned by: Diana Coffa 520872E338A14C9... Date of Signature: 9/14/2021

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

FID: 217282169

FCVS FEDERATION CREDENTIALS VERIFICATION SERVICE

Applicant Reported Unusual Circumstances

fsmb

Graduate Medical Education

Medical Professional Name:	Oni-Orisan, Adeola Oladayo
Accreditation ID:	1200511059
Institution:	University of California (San Francisco) Program
Specialty:	Family Medicine

Unusual Circumstances

Training Period: 6/17/2018 - 6/30/2021 **Residency**

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

End of Applicant Reported Unusual Circumstances report for: Oni-Orisan, Adeola Oladayo

University of California, San Francisco
School of Medicine

IN AFFILIATION WITH

San Francisco General Hospital

HEREBY CERTIFIES THAT

Adeola Olawunmi Oni-Orisan, MD, PhD

HAS SUCCESSFULLY COMPLETED A RESIDENCY IN

FAMILY & COMMUNITY MEDICINE

JUNE 17, 2018 - JUNE 30, 2021

DIANA A. COFFA, M.D.
RESIDENCY DIRECTOR

GEORGE W. SABA, PH.D.
ASSOCIATE RESIDENCY DIRECTOR

LYDIA LEUNG, M.D.
ASSOCIATE RESIDENCY DIRECTOR

CLAUDIA DIAZ MOONEY, M.D.
ASSOCIATE RESIDENCY DIRECTOR

KEVIN GRUMBACH, M.D.
CHAIR, FAMILY & COMMUNITY MEDICINE

TERESA J. VILLELA, MD
CHIEF OF SERVICE, FAMILY & COMMUNITY MEDICINE

TALMADGE E. KING, JR., MD
DEAN, SCHOOL OF MEDICINE

Licensure / Examinations

Exam: USMLE

Credential Analysis Information for Licensure / Examinations

There is no Omission/Discrepancy/Miscellaneous information identified.

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

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

Date: 07/06/2022

Federation Credentials Verification Service
ATTN: FCVS
FCVSID: 714944

Examinee: Oni-Orisan, Adeola Oladayo
Alt Name(s): Oni-Orisan, Adeola Oladayo Olawunmi

Examinee ID: 5-266-940-5
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
04/08/2011	Pass	CONFIDENTIAL		

USMLE STEP 2

Clinical Knowledge (CK)

Test Date	Pass/Fail	Comments
05/23/2012	Pass	

Clinical Skills (CS)

Test Date	Pass/Fail	Comments
09/17/2012	Pass	

USMLE STEP 3

Test Date	Pass/Fail	Comments
03/01/2019	Pass	

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: Oni-Orisan, Adeola Oladayo

Examinee ID: 5-266-940-5
Date of Birth: CONFIDENTIAL

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

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

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

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

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

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

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

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

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

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

03/2015

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

PDC PHYSICIAN DATA CENTER

fsmb

PRACTITIONER PROFILE

Prepared for:	FCVS SMB Profiles	As of Date:7/6/2022

PRACTITIONER INFORMATION

Name:	Oni-Orisan, Adeola Oladayo
Alternate Name(s):	Oni-Orisan, Adeola Oladayo Olawunmi
DOB:	CONFIDENTIAL
Medical School:	Harvard Medical School Boston, Massachusetts, UNITED STATES
Year of Grad:	2018
Degree Type:	MD
NPI:	1124523774

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
1124523774	Individual			10/19/2021

LICENSE HISTORY

Jurisdiction	License Number	Issue Date	Expiration Date	Last Updated
CALIFORNIA	A-167053	12/13/2019	12/31/2023	07/06/2022
		FSMB License Status: Active		
GEORGIA	90329	09/30/2021	10/31/2022	06/16/2022
		FSMB License Status: Active		

PDC PHYSICIAN DATA CENTER

fsmb

PRACTITIONER PROFILE

Prepared for:	FCVS SMB Profiles	As of Date:7/6/2022
Practitioner Name:	Oni-Orisan, Adeola Oladayo	

ACTIVE US DRUG ENFORCEMENT ADMINISTRATION (DEA)

DEA Number	Schedule	Address	Expiration Date	Last Reported
FO8989521	22N 33N 4 5	SAN FRANCISCO,CA 94110	12/31/2022	01/05/2022
FO1020851	22N 33N 4 5	ATLANTA,GA 30303	12/31/2024	01/05/2022

PDC PHYSICIAN DATA CENTER

fsmb

PRACTITIONER PROFILE

Prepared for:	FCVS SMB Profiles	As of Date:7/6/2022
Practitioner Name:	Oni-Orisan, Adeola Oladayo	

ABMS® CERTIFICATION HISTORY

Certifying Board:	American Board of Family Medicine
Certificate:	Family Medicine
Certification Type:	General
Certification Status:	Certified
Participating in MOC:	Yes

Status	Duration	Effective Date	Expiration Date	Reverification Date	Occurrence	Last Reported
Active	MOC	07/01/2021		02/15/2023	Initial	06/30/2022

The presence and display of ABMS certification data in no way constitutes any affiliation, association with or endorsement of any advertising, promotion or sponsorship by ABMS, its Member Boards and the Board Certified Physicians listed in this directory. ABMS disclaims any responsibility or affiliation for other data that is provided in the directory that is not ABMS sourced information.

AOA® CERTIFICATION HISTORY

No AOA Certifications found.

FCVS FEDERATION CREDENTIALS VERIFICATION SERVICE

NPDB Report

ONI-ORISAN, ADEOLA OLADAYO **DCN: 5500000192761521**

FOR AUTHORIZED USE BY: Kansas State Board of Healing Arts **Continuous Query ID: 300000013152920**

Process Date: 7/6/2022

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

ONI-ORISAN, ADEOLA OLADAYO - CONTINUOUS QUERY RESPONSE

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

Practitioner Name:	ONI-ORISAN, ADEOLA OLADAYO ONI-ORISAN, ADEOLA OLADAYO OLAWUNMI
Date of Birth:	CONFIDENTIAL
Gender:	FEMALE
Work Address:	5107 E KELLOGG DR WICHITA, KS 67218
Home Address:	CONFIDENTIAL
Social Security Numbers (SSN):	
National Provider Identifiers (NPI):	1124523774
Drug Enforcement Administration (DEA) Numbers:	FO1020851 FO8989521
License(s):	Physician (MD), 90329, GA Physician (MD), A-167053, CA
Professional School(s):	HARVARD MEDICAL SCHOOL (2018)
Subject ID:	217282169

B. CONTINUOUS QUERY ENROLLMENT INFORMATION

Enrollment Status:	Enrolled - 7/6/2022 - 7/31/2023* * Unless enrollment is canceled by the entity prior to this date
Statutes Queried:	Title IV, Section 1921, Section 1128E
Entity Name:	Kansas State Board of Healing Arts
Authorized Agent:	Federation of State Medical Boards, (817) 868 - 4000
Customer Use:	217282169

C. SUMMARY OF REPORTS ON FILE WITH THE DATA BANK AS OF 7/6/2022

The following report types have been searched:

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

CONFIDENTIAL DOCUMENT - FOR AUTHORIZED USE ONLY

ONI-ORISAN, ADEOLA OLADAYO **DCN: 5500000192761521**

FOR AUTHORIZED USE BY: Kansas State Board of Healing Arts **Continuous Query ID: 300000013152920**

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

UA 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

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.

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

Oni-Orisan
Applicant's printed last name

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

07/07/22
Date of signature (must correspond to date of notarization)

RECEIVED
JUL 11 2022
KSBHA

fold up — After folding the bottom portion upward, bring the new bottom edge to the top edge and fold to fit in a standard envelope. — fold up

Notary

SURINDER KUMAR
NOTARY PUBLIC - CALIFORNIA
COMMISSION # 2257423
SAN FRANCISCO COUNTY
My Comm. Exp. October 2, 2022

State of CALIFORNIA, County of SAN FRANCISCO

Seal Verified KSBHA

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 7th day of JULY, 2022.

Notary Public Signature: Surinder Kumar

My Notary Commission Expires: OCT. 2, 2022

SURINDER KUMAR
NOTARY PUBLIC - CALIFORNIA
COMMISSION # 2257423
SAN FRANCISCO COUNTY
My Comm. Exp. October 2, 2022
(NOTARY PUBLIC SEAL)

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 Drive, Wichita, KS, 67218
3. Primary Specialty Family Medicine

   American Board Certified ABFM 07/2022 American Board Eligible _____

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Kansas

ADDENDUM 2
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.

Adeola Oni-Orisan
Full Name of Applicant

07/06/2022
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 ☑

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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?

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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KSBHA 8/9/2021

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

Kansas

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

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? Yes ☐ No ☑

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.

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JUL 11 2022
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Kansas State Board of Healing Arts
800 SW Jackson – Lower Level, Suite A., Topeka, KS 66612
Phone: (785) 296-7413; Fax: (785) 296-0852; Email: KSBHA_Licensing@ks.gov
www.ksbha.org

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.

Adeola Oni-Orisan — 07/06/2022

Signature — Date

Adeola Oni-Orisan — CONFIDENTIAL

Printed Name — Date of Birth

CONFIDENTIAL

Residential Address — City — State — Zip

TO BE COMPLETED BY THE FINGERPRINTING AGENCY:

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

State/Branch: CA — ID Number: CONFIDENTIAL

Agency Name: BACKGROUND CHECK U.S.A

Address: 1909 Mission St. S.F CA. 94103

Telephone: 415-780-9700 — Fax: _____

Name of Individual Verifying Identity: Sammy

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

CONFIDENTIAL

AMA Physician Profile

PREPARED FOR

Kansas State Board of Healing Arts, Topeka, KS

Name and Mailing Address

ADEOLA OLAWUNMI ONI-ORISAN
SAN FRANCISCO GENERAL HOSP
BLDG 80-83
1001 POTRERO AVE
SAN FRANCISCO, CA 94110-3594

Primary Office Address

SAME AS MAILING ADDRESS

Phone UNKNOWN

Birth date CONFIDENTIAL

Physician's major professional activity OFFICE BASED PRACTICE

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

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

AMA membership status 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
1124523774	03/27/2018	NOT RPTD	NOT RPTD	NOT RPTD	07/15/2022

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.

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: HARVARD MEDICAL SCHOOL

Degree Awarded:	YES	**Degree Type:**	MD
Enrollment Date:	08/2009	**Degree Date:**	05/2018

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:	UNIVERSITY OF CALIFORNIA (SAN FRANCISCO) SCHOOL OF MEDICINE
Sponsoring State:	CALIFORNIA
Program name:	UNIVERSITY OF CALIFORNIA (SAN FRANCISCO) PROGRAM
Specialty:	FAMILY MEDICINE
Training Type:	SPECIALTY
Dates:	06/2018 - 06/2021
Status:	COMPLETED

Specialty board certification

NO DATA REPORTED AT THIS TIME

Current and/or historical medical licensure

License Number	MD / DO	Locale	Date Granted	Expiration Date	Renewal Date	Status	License Type	Last Reported	Name on License
A-167053	MD	CA	12/13/2019	12/31/2023		ACT	UNL	06/14/2022	ADEOLA ONI-ORISAN

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)

DEA Number*	Business Activity†	Drug Schedule	Activity	Expiration Date	Payment Indicator	Last Reported	Address
------521	C-4	22N 33N 4 5	Active	12/31/2022	Exempt	08/04/2022	Bl 80, Wd 83 995 Potrero Ave San Francisco, CA 94110-2859

** Only the last three characters of DEA numbers are displayed*

† The Business Activity code and subcode provide additional detail about the physician. For instance, Business Activity code-subcode combinations C-1, C-4, C-5, C-6, C-9, C-A, C-B, C-C, and C-D indicate the physician holds a DEA DATA waiver. Learn more about Business Activity code-subcode combinations.

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

ECFMG 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.

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

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

KAMMCO

On Behalf of Kansas Health Care
Provider Insurance Availability Plan

LETTER OF INTENT

August 18, 2022

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

RE: Adeola Oni-Orisan, 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 Adeola Oni-Orisan, 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. Oni-Orisan 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. Oni-Orisan 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: Adeola Oni-Orisan, MD - letter of intent attached
Date: Thursday, August 18, 2022 10:06:35 AM
Attachments: Adeola Oni-Orisan, MD - letter of intent.pdf

Good morning –

Please find attached the Plan's letter of intent on Dr. Adeola Oni-Orisan, MD.

If you have any questions on the attached, please let me know.

Thanks,

CONFIDENTIAL

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

RECEIPT NUMBER: 705900 DATE: 07/20/2022

NAME:	LICENSE TYPE:	FEE:	LIC #:
Adeola Oni-Orisan		300.00	
		47.00	
		3.00	

AMOUNT:
TYPE: Check
CH/CC #: 133

RECEIVED FROM:

Adeola Oni-Orisan

CONFIDENTIAL

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, Acting Executive Director

Laura Kelly, Governor

Adeola Oni-Orisan, MD
32 Lundys Ln., Apt #6
San Francisco CA 94110

August 9, 2022

Dear Adeola Oni-Orisan:

CONFIDENTIAL

Sincerely,

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

From: Pittz, Terrin [KSBHA]
To: CONFIDENTIAL
Subject: Kansas State Board of Healing Arts - Licensure Needed Documentation
Date: Tuesday, August 9, 2022 1:52:00 PM
Attachments: MRL.pdf
image001.png

Good Afternoon Dr. Oni-Orisan,

CONFIDENTIAL

Email is the best way to communicate with me.

Thank you,

Terrin Pittz

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

* "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 36 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 why you are in active practice in the 12 months immediately preceding the submission for your application, including the amount of time and reason.

---

* 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. 65-3406(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:

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www.ksbha.org

KANSAS
BOARD OF HEALING ARTS

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.**

N/A **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.

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

Check Enclosed

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.**

RECEIVED
JUL 11 2022
KSBHA

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

Phone: 785-296-7413

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

Please visit [illegible] for all statutes and regulations

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

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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 [illegible] and will be processed upon receipt. The Kansas Medicine and Surgery application fee is [illegible]. Also, a background check fee of [illegible] and a National Practitioner Data Bank ("NPDB") report fee of $[illegible] must accompany the application. [illegible]

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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. Such active license may be renewed annually. Licensees must maintain said salaries or oldover 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: http://khcsf.ks.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 this 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 chiropractic health care provider as defined under K.S.A. 75-1702. Continuing education, renewal 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 chartitable health care provider to 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 _____
3. Primary Specialty _____

American Board Certified _____ American Board Eligible _____

CONFIDENTIAL

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EXPEDITED LICENSURE QUESTIONNAIRE

To determine if you are eligible for expedited licensure pursuant to K.S.A. 48-3406, 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 _x_ 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 _x_ If yes:

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

3. Do you currently reside in Kansas? Yes __ No _x_ If yes:

Current Kansas Residence Address:_____

4. 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 KS and will be reported to all appropriate state/federal/military agencies in other jurisdictions. Yes __ No __ If yes:

Intended Kansas Residence Address:_____

Expected Date of Commencing Residence:_____

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

5. Are you currently licensed, registered, or certified to practice (the profession for which you are seeking licensure in Kansas) by another state, district, or territory of the United States and have worked under that license for at least 1 year. This does not include certificates or registrations issued by private boards, professional societies, or any organization other than a governmental 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: