805.00

ıent of the District of Columbia
Department of Health

NE AND OSTEOPATHY (MD/DO)
W LICENSE APPLICATION

All applic... plication and submit the original application and all required supporting documents. If more space is ... additional sheets with typed responses. False or misleading statements will be cause for disciplina... prosecution pursuant to *DC Code 22-2405*. **YOU MUST INITIAL EACH PAGE OF THE APPLICATION.**

If you have any questions, call HRLA Customer Service at (877) 672-2174, Monday through Friday, 8:30AM to 4:00PM EST.

SECTION 1: LICENSURE TYPE & FEES

Professional Designation:	Graduate Type:	Application Type:
☑ Medicine & Surgery (MD)	☑ U.S./Canada	☑ License by Examination ($805.00)
☐ Osteopathy & Surgery (DO)	☐ International	

SECTION 2: APPLICANT INFORMATION

First Name: Jessica	MI: L	Last Name: Rubino
Date of Birth: [redacted]		SSN: [redacted]

Gender: ☐ Male ☑ Female

Degree(s) Held: ☑ MD ☐ DO ☐ MBBS ☐ MBA ☐ MPH ☐ PHD ☐ Other:

Race & Ethnicity (Optional):

☐ American Indian/Alaskan Native ☐ Asian/South Asian
☐ Black/African American ☑ Caucasian/White
☐ Native Hawaiian or Other Pacific Islander ☐ Hispanic or Latino
☐ Choose Not to Disclose ☐ Other: _____

Language(s) Spoken (Other than English):

☑ Spanish ☐ Vietnamese ☐ French
☐ Tagalog ☐ Amharic ☐ Mandarin
☐ Cantonese ☐ Russian ☐ German
☐ Korean ☐ Other: _____

SECTION 3: OTHER NAME(S) USED

If your name has changed at any point since you have taken any exams or attended college or university, you must provide a copy of a legal name change document for each time that it has changed. Acceptable documents for individuals are marriage certificates, divorce decrees, court orders, copies of social security cards or a passport.

First Name:	MI:	Last Name:
First Name:	MI:	Last Name:
First Name:	MI:	Last Name:

SECTION 4: MAILING ADDRESS

Indicate your preferred mailing address by placing an "X" in the appropriate box. This will be the address to which all future licensing documents will be mailed.

☑ **HOME ADDRESS** ☐ **BUSINESS ADDRESS**

SECTION 5: HOME ADDRESS		
A P.O. Box may NOT be used for an address. Home address information will NOT be made available to the public.		
Current Home Address: [redacted]		
City: [redacted]	**State:** [redacted]	**Zip Code:** [redacted]
Phone Number: [redacted]	**Email Address:** [redacted]	

SECTION 6: BUSINESS ADDRESS(ES)		
A P.O. Box may NOT be used for an address. Business address information WILL be made available to the public.		
Current Business Address #1: 81 Langton St	**Phone Number:** 800-321-6879	
City: San Francisco	**State:** CA	**Zip Code:** 94103
Phone Number: 800-321-6879	**Email Address:**	
Current Business Address #2:	**Phone Number:**	
City:	**State:**	**Zip Code:**
Phone Number:	**Email Address:**	

IMPORTANT MESSAGE RE: UPDATING CONTACT INFORMATION

Physicians are required to update changes to their name, home address or business address within thirty (30) days of the change. Failure to do so may result in disciplinary action. It is imperative that you update your information in writing, either via mail or email, to the point of contact listed below:

Attn.: District of Columbia Board of Medicine
899 N. Capitol St. NE, 2nd Floor
Washington, DC 20002
E: dcbomed@dc.gov

SECTION 7: MEDICAL SCHOOL(S) ATTENDED		
List all medical schools attended, in reverse chronological order, beginning with the most recent at the top. Transcripts should be provided in a sealed envelope from the issuing institution for each school that you attended and listed below. Use additional sheets if necessary.		
School #1 Name: Southern Illinois University School Of Medicine	**Graduation Date:** 07/27/2012	**Degree/Certificate Awarded:** MD
City: Springfield	**State:** IL	**Country (If not the United States):**
School #2 Name:	**Graduation Date:**	**Degree/Certificate Awarded:**
City:	**State:**	**Country (If not the United States):**

SECTION 8: POST-GRADUATE MEDICAL TRAINING

List all post-graduate medical training you attended, regardless of whether you completed the program. Include both accredited and non-accredited internships, residencies and fellowships. Also include verification letters from your training programs. For "Type of Position", use the letter key code below. List experience in reverse chronological order, beginning with the most recent. Explain all gaps greater than three (3) months. Use additional sheets if necessary.

Position Key Code:

A. Fellowship | **B.** Internship | **C.** Residency | **D.** Other

Program #1 Name: Family Medicine	**Start Date:** 07/01/2014	**End Date:** 08/24/2016	**Type of Position:** A
City: Dallas	**State:** TX		**Country (If not the United States):**
Program #2 Name: Family Medicine	**Start Date:** 07/01/2013	**End Date:** 06/30/2014	**Type of Position:** B
City: Chicago	**State:** IL		**Country (if not the United States):**
Program #3 Name:	**Start Date:**	**End Date:**	**Type of Position:**
City:	**State:**		**Country (if not the United States):**
Program #4 Name:	**Start Date:**	**End Date:**	**Type of Position:**
City:	**State:**		**Country (if not the United States):**
Program #5 Name:	**Start Date:**	**End Date:**	**Type of Position:**
City:	**State:**		**Country (If not the United States):**
Program #6 Name:	**Start Date:**	**End Date:**	**Type of Position:**
City:	**State:**		**Country (if not the United States):**

SECTION 9: WORK EXPERIENCE

List ALL work experience covering the five (5) year period prior to the submission of the application. Explain all gaps greater than three (3) months. Use additional sheets if necessary.

Employer #1 Name: Nurx	**Start Date:** 08/23/2017	**End Date:** Present	**Reason for Leaving:** n/a
City: San Francisco	**State:** CA		**Country (if not the United States):**
Employer #2 Name: Whole Woman's Health Alliance and Whole Woman's Health, LLC	**Start Date:** 05/01/2017	**End Date:** Present	**Reason for Leaving:** n/a
City: San Antonio and Austin	**State:** TX		**Country (if not the United States):**
Employer #3 Name: Beacon Family Health Care	**Start Date:** 11/01/2016	**End Date:** Present	**Reason for Leaving:** n/a
City: Austin	**State:** TX		**Country (if not the United States):**
Employer #4 Name: Catapult Health	**Start Date:** 10/01/2012	**End Date:** 05/31/2013	**Reason for Leaving:** To attend postgraduate training
City: Austin	**State:** TX		**Country (if not the United States):**

SECTION 10: OTHER MEDICAL LICENSES

List all states and jurisdictions in which you have EVER held a medical license, regardless of status. Verifications should be provided from the issuing jurisdiction(s) for each license. For license type, indicate whether it was a full license, a temporary license, a training license, or any other type of license issued to you. Use additional sheets if necessary.

Jurisdiction #1: Texas	**License Type:** Full	**Issue Date:** 12/16/2016	**Exp. Date:** 02/28/2019	**License Number:** R1121
Jurisdiction #2: Michigan	**License Type:** Full	**Issue Date:** 10/14/2016	**Exp. Date:** 01/31/2018	**License Number:** 4301111191
Jurisdiction #3:	**License Type:**	**Issue Date:**	**Exp. Date:**	**License Number:**
Jurisdiction #4:	**License Type:**	**Issue Date:**	**Exp. Date:**	**License Number:**

SECTION 11: PRACTICE SPECIALTIES & BOARD CERTIFICATIONS

If you practice in a specialty area, indicate your specialty in the boxes below. Use the specialty codes listed if applicable. If a specialty code is not listed, please write the full specialty in the boxes provided.

- AC Academic Medicine
- ADM Administrative Medicine
- AI Allergy & Immunology
- AN Anesthesiology
- DE Dermatology
- EM Emergency Medicine
- FM Family Medicine
- GE Geriatrics
- HOS Hospitalist
- IN Internal Medicine (General)
- IN Internal Medicine
  - IN/CA Cardiology
  - IN/EN Endocrinology
  - IN/GI Gastroenterology
  - IN/HEM Hematology
  - IN/ID Infectious Disease
  - IN/NEP Nephrology
  - IN/NEU Neurology
  - IN/ONC Oncology
  - IN/PCC Pulmon. Critical Care
  - IN/PUD Pulmon. Disease
  - IN/RH Rheumatology
- MG Medicine Genetics
- NU Nuclear Medicine
- OB Obstetrics & Gynecology
- OC Occupational Health
- OP Ophthalmology
- OMT Osteopathic Manipulative Treatment
- ENT Otolaryngology
- PA Pathology
- PED Pediatrics (General)
- PED Pediatrics
  - PED/AD Adolescent Medicine
  - PED/CA Cardiology
  - PED/EN Endocrinology
  - PED/GI Gastroenterology
  - PED/HEM Hematology
  - PED/NEO Neonatology
  - PED/NEP Nephrology
  - PED/NEU Neurology
  - PED/ONC Oncology
  - PED/PCC Pulmon. Critical Care
  - PED/PUD Pulmon. Disease
  - PED/RH Rheumatology
- PMR Physical Medicine & Rehabilitation
- PR Preventive Medicine/Public Health
- PSY Psychiatry
- RA Radiology
- REM Research Medicine
- SU Surgery (General)
- SU Surgery
  - SU/BT Burn/Trauma
  - SU/CS Cardiac Surgery
  - SU/CO Colon & Rectal Surgery
  - SU/GE General Surgery
  - SU/NE Neurological Surgery
  - SU/OR Orthopedic Surgery
  - SU/PL Plastic Surgery
  - SU/TH Thoracic Surgery
  - SU/TP Transplant
  - SU/UR Urology
  - SU/VA Vascular

Specialty #1: FM	
Specialty #2:	
Specialty #3:	
Specialty #4:	

If you are Board Certified in a specialty, please list the specialty and the related certifying agency below.

Certifying Board #1: Family Medicine; American Board of Family Medicine	**Certifying Agency:**
Certifying Board #2:	**Certifying Agency:**
Certifying Board #3:	**Certifying Agency:**
Certifying Board #4:	**Certifying Agency:**

SECTION 12: REQUIRED SCREENING QUESTIONS

Please answer questions 1 through 15 by placing an "X" in the appropriate boxes. If you answer "Yes" to any question, you must provide full information and complete details on a separate sheet of paper, as well as attach copies of all relevant documents such as final court orders. Failure to provide relevant information will delay the application processing time.

1.	Have you ever been arrested, charged, convicted, pled guilty to, or pled no contest to the violation of any federal, state or other statute or ordinance constituting a felony or misdemeanor, including driving under the influence or while impaired, but excluding minor traffic violations?	☐ Yes ☑ No
2.	Have you been a defendant or respondent to a claim for damages or a malpractice action? If you answer "Yes", please complete the Malpractice Claims Form and submit it along with all relevant court documents (e.g., Complaint, Answer, and Final Order/Decision). A separate Malpractice Claims Form MUST be completed for each malpractice case.	☐ Yes ☑ No
3.	Have you ever voluntarily surrendered a license or registration certificate, or allowed it to lapse, after formal charges had been brought against you or while you were under investigation?	☐ Yes ☑ No
4.	Have you ever surrendered your clinical privileges, voluntarily or involuntarily, or had your clinical privileges denied, revoked, or suspended at any hospital or health care facility?	☐ Yes ☑ No
5.	Have you ever been terminated or resigned, voluntarily or involuntarily, from a clinical or professional training program for any reason?	☐ Yes ☑ No
6.	Has any licensing authority, in any healthcare field, taken adverse action against your license or privileges or informed you of any pending charges?	☐ Yes ☑ No
7.	Has any licensing authority, health facility, or peer review board, in any healthcare field, informed you of any pending charge(s) or investigation(s) against you?	☐ Yes ☑ No
8.	Are you presently now, or have you ever been, under a corrective action plan imposed by an employer, medical facility or educational program?	☑ Yes ☐ No
9.	Do you have a medical condition or have you become aware of any medical condition that impairs or limits your ability to practice your profession?	☐ Yes ☑ No
10.	Have you ever engaged in any conduct that either indicated an impairment, or actually impaired, your ability to practice your profession?	☐ Yes ☑ No
11.	Have you ever entered into a monitoring program for purposes of monitoring your abuse of alcohol, drugs, or other controlled substances?	☐ Yes ☑ No
12.	Have you ever entered into a monitoring program for purposes of monitoring your professional behavior including recordkeeping, billing, boundaries, quality of care or any other matter related to the practice of your profession?	☐ Yes ☑ No
13.	Within the last ten (10) years have you voluntarily resigned, been asked to resign, terminated, or disciplined by any employer?	☐ Yes ☑ No
14.	Have you ever withdrawn a license application or have you been denied a license or denied the privilege of taking a license examination by any professional licensing board or agency?	☐ Yes ☑ No
15.	Have you ever been excluded from any federal or state run insurance program, including Medicare and/or Medicaid?	☐ Yes ☑ No

SECTION 14: DOCUMENT CHECKLIST

Please indicate the supporting documents you have included with this package or requested to be sent to the DC Board of Medicine. Please keep a photocopy of any submitted documents for your records, as they will not be returned.

☑ **Authorization to Release Information Form**

The Board cannot discuss the status or details of your application with a third party, without a signed release from you authorizing the Board and its staff to communicate said matters.

☑ **Two (2) recent and identical passport type photos of the applicant's face (approx. 2" x 2") with the applicant's name printed on the back**

The photo must be original photos and cannot be computer-generated copies, or paper copies.

☑ **One (1) photocopy of a current government issued photo ID**

☑ **Criminal Background Check (CBC)**

To access the CBC form and instructions, go to www.doh.dc.gov/service/criminal-background-check or contact the CBC unit at (877) 783-4187.

☑ **Three (3) Character Reference Forms**

Must be completed by an MD or DO in good standing in a jurisdiction of the United States who has knowledge of the applicants abilities and qualifications to practice medicine. If you have completed your postgraduate training within three years of the date of this application, at least one (1) reference letter needs to come from the director of your post-graduate clinical training program and one (1) from a supervising physician of your post-graduate clinical training program.

☑ **AMA/AOA Profile**

The profile should be submitted from the issuing institution.

☑ **Verification(s) of Licensure**

Verifications should be provided from the issuing jurisdiction(s) for each license identified in Section 10 of the application.

☑ **Medical School Transcripts**

Transcripts should be provided in a sealed envelope from the issuing institution for each school listed in Section 7.

☑ **Verification of Post-Graduate Training**

Verifications should be provided in a sealed envelope from the post-graduate institution for each program identified in Section 8 of the application. Each verification should be signed by the training program director or someone with authority to verify the applicant's participation in the identified post-graduate training program.

☑ **Examination Scores**

Examination scores must be received from the examining body.

☐ **ECFMG Certificate (for foreign-trained applicants only)**

☐ **Malpractice Claims Form (if responded "Yes" to screening question #2)**

Must submit all relevant court documentation (e.g., Complaint, Answer, and Final Order/Decision).

☑ **National Practitioner Databank (NPDB) Self Query Report**

The Self-Query Report must be requested from the NBPD (https://www.npdb.hrsa.gov/ext/selfquery/SQHome.jsp) no more than thirty (30) days prior to submission of the application.

SECTION 15: PAYMENT AND MAILING INFORMATION

Make your check or money order payable to "**DC Treasurer**". A charge of sixty-five dollars ($65.00) will be imposed for dishonored checks (Public Law 89-208). **ALL FEES ARE NON-REFUNDABLE.**	Mail your completed application and check to: **Board of Medicine – MD/DO New Application** **HRLA 1** **PO Box 37801** **Washington, DC 20013**

SECTION 16: APPLICANT'S AFFIDAVIT

I hereby attest that the information given in this application, including all writings and exhibits attached hereto, is true and complete to the best of my knowledge. I understand that the making of a false statement on this application, including all writings and exhibits attached hereto, is punishable by criminal penalties.

SIGNATURE OF APPLICANT: Jason R Reed	**DATE:** 12/13/17

REPORT FRAUD, WASTE, AND ABUSE: To report fraud, waste, or abuse within the District government, contact the DC Office of the Inspector General's hotline by phone at 1-800-521-1639 (toll free) or 202-724-TIPS (8477), by email at hotline.oig@dc.gov, or by TTY at 711. For additional information, visit the Office of the Inspector General's website at https://oig.dc.gov.

SECTION 13: CLEAN HANDS

Clean Hands Before Receiving a License or Permit Act of 1996 Certification Requirement

Please read the information below carefully before responding to this yes or no question, as any false information provided requires that the Department of Health proceed to revoke your license or permit for which you are now applying, and fine you one thousand dollars ($1,000.00), pursuant to D.C. Official Code § 47-2864 (2001).

IF YOU ANSWER "YES" TO THIS QUESTION, PLEASE SUBMIT PROOF OF THE ARRANGEMENTS YOU HAVE MADE TO PAY THE OUTSTANDING DEBT. IF YOU DO NOT HAVE AN APPROVED PAYMENT SCHEDULE TO PAY THE AMOUNT YOU OWE OR IF NO APPEAL IS PENDING, THE LAW REQUIRES THAT YOUR NEW LICENSE APPLICATION BE DENIED.

As of this date, do any of the below statements apply to you:

- I owe more than $100 in fines, penalties, or interest assessed pursuant to D.C. Official Code Title 2, Chapter 18 (Civil Infractions Act of 1985);
- I owe more than $100 in fines, penalties, or interest assessed pursuant to D.C. Official Code Title 8, Chapter 8 (Litter Control Administrative Act of 1985);
- I owe more than $100 in fines, penalties, or interest assessed pursuant to D.C. Official Code Title 8, Chapter 9 (Illegal Dumping Enforcement Act of 1994);
- I owe more than $100 in fines, penalties, or interest assessed pursuant to D.C. Official Code Title 31, Chapter 24 (The Compulsory/No-Fault Motor Vehicle Insurance Act of 1982);
- I owe more than $100 in fines, penalties, or interest assessed pursuant to D.C. Official Code Title 50, Chapter 3 (Department of For-Hire Vehicles Establishment Act of 1985);
- I owe more than $100 in fines, penalties, or interest assessed pursuant to D.C. Official Code Title 50, Chapter 15 (Registration of Motor Vehicles);
- I owe more than $100 in fines, penalties, or interest assessed pursuant to D.C. Official Code Title 50, Chapter 23 (Traffic Adjudication Act of 1978);
- I owe more than $100 in fines, penalties, or interest assessed by another jurisdiction; provided, that a reciprocity agreement is in effect between the jurisdiction and the District;
- I owe more than $100 in past due taxes;
- I owe more than $100 in any outstanding fines, penalties, or interest due to the District of Columbia;
- I owe any amount of past due District of Columbia Water and Sewer Authority service fees;
- I owe any amount of a vehicle conveyance fee pursuant to D.C. Official Code Title 50, Chapter 23;
- I owe any amount of past due fines, penalties, or past due restitution on behalf of an employee due to a violation of D.C. Official Code Title 32, Chapters 1A, 10, 13 or Title 2, Subchapter X-A; or
- I have failed to file required District tax returns.

☐ Yes ☑ No

The information presented above is in compliance with the requirement to submit with your application for licensure or permit under the *Clean Hands Before Receiving a License Permit Act of 1996*, effective May 11, 1996 (D.C. Law 11-118, D.C. Code §47-2861, et seq.).

2228 West Great Neck Road, Suite 205
Virginia Beach, VA 23451

Phone: 844.MYMODIO (696.6346)

Fax: 844.MY1VIEW (691-8439)

credentials@modiohealth.com

PROVIDER RELEASE OF INFORMATION AND AUTHORIZATION FORM

In order to determine my educational background, professional qualifications and suitability for appointment, I acknowledge and agree that Modio Health, Inc. ("Modio") has a valid interest in obtaining and verifying information concerning my professional competence. Therefore; in connection with any application I have made or will make:

1. I authorize Modio and any persons acting on its behalf to consult with hospital administrators, providers, malpractice insurance carriers and other persons and entities to obtain and verify information concerning my professional competence, character, and moral and ethical qualifications. I consent to and authorize Modio and all persons acting on its behalf to review relevant information in the medical records I have completed to ensure compliance with Modio quality assurance.

2. I consent to and authorize the release by any person or entity to Modio of all information and documentation that may be relevant to an evaluation of my professional competence, character, morality or ethical qualification, including any information and documents relating to any disciplinary action, clinical proceeding, professional incompetence, suspension or curtailment of medical or surgical privileges (including malpractice claims and/or coverage and chemical or alcohol dependency).

3. I understand that I have the burden and legal responsibility of providing adequate information to Modio to demonstrate my professional competence, character, moral and ethical qualifications.

4. I authorize Modio to disclose to such persons, employers, institutions, boards or agencies identifying and other information about me sufficient to enable Modio to make such inquiries.

5. I hereby release any such person or entity providing such information from any and all liability for doing so. I release Modio and its employees, managers, agents and consulting committees from any and all liability for their acts performed in good faith and without malice in obtaining, verifying and evaluation such information.

6. I may revoke this release of information and authorization by providing Modio five (5) working days prior written notice of revocation.

7. If any material changes occur affecting my professional and/or malpractice insurance status I agree to notify Modio writing within thirty (30) days of such change.

Jessica Rubino
Name of Provider (please print)

[redacted]
Provider NPI #

Signature of Provider

12/5/17
Date

Texas

USA
TX

DRIVER LICENSE

4d DL 40657015 9 Class C
4a Iss 01/27/2016 4b Exp 06/29/2022
3 DOB [redacted]
1 RUBINO
2 JESSICA LOUISE
8 [redacted]
12 Restrictions AB 9a End NONE
16 Hgt 5-04 16 Sex F 18 Eyes BLU
5 [redacted]

[redacted]

☐ Directive to physician has been filed at tel #
☐ Emergency contact number
☐ Allergic reaction to drugs

RESTRICTIONS - A - With corrective lenses; B - LOFS 21 or over

TEXAS ROADSIDE ASSISTANCE [redacted]

ENDORSEMENTS:
NONE

[redacted]

REV. 08/01/2007


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
PASSPORT
PASSEPORT
PASAPORTE
USA
UNITED STATES OF AMERICA
Type / Type / Tipo
P
Code / Code / Código
USA
Passport
[redacted]
Surname / Nom / Apellidos
RUBINO
Given Names / Prénoms / Nombres
JESSICA LOUISE
Nationality / Nationalité / Nacionalidad
UNITED STATES OF AMERICA
Date of birth / Date de naissance / Fecha de nacimiento
[redacted]
Lugar de nacimiento
[redacted]
Sex / Sexe / Sexo
F
Date of issue / Date de délivrance / Fecha de expedición
15 Jun 2015
Authority / Autorité / Autoridad
United States
Department of State
Date of expiration / Date d'expiration / Fecha de caducidad
14 Jun 2025
Endorsements / Mentions Spéciales / Anotaciones
SEE PAGE 27
USA
P<USARUBINO<<JESSICA<LOUISE<<<<<<<<<<<<<<<<<<
[redacted]

Rev. 12/11 MEDICINE & OSTEOPATHY

DC Department of Health
Board of Medicine Character Reference Form

Board of Medicine
899 North Capitol St., NE 1st Flr.
Washington, DC 20002

(202)-724 4900

Please print/type name and location of setting completing this form (Should match setting listed on chronological page of application). Please note, this is not to be used as a substitute for a verification of your experience.

University of Texas Southwestern Medical Center

5323 Harry Hines Boulevard, Dallas, TX 75390

Jessica Rubino

Please clearly print/ type name of Applicant

The District of Columbia Board of Medicine, in its consideration of a candidate for licensure, depends on information by persons listed (references) regarding the candidate's character, employment and observed performance while providing care to patients and working with peers and staff. Please complete this form to the best of your ability and return it to the board so the information you provide can be given consideration in the processing of this candidate's application in a timely manner. I hereby authorize all my references to release to the D.C. Board of Medicine any information requested by the Board in connection with the processing of my application.

Signature of Applicant: Jessica Rubino

Item #1 must be completed, or form may be invalid

1. Date and type of service: This individual served with us as a Family Medicine Resident from 07/2014 (Month/Year) to 08/2016 (Month/Year). If you are responding for a training program, please provide the number of months of postgraduate training awarded 24.

2. Please evaluate: (Indicate with check mark)

	Poor	Fair	Good	Superior
Professional knowledge			✓	
Clinical judgment			✓	
Relationship with patients				✓
Ethical/professional conduct		✓		
Interest in work			✓	
Ability to communicate			✓	

3. To your knowledge, has the applicant been the subject of any disciplinary or legal proceeding convened by a state regulatory agency or board, employer hospital or health care facility? Yes ☑ *(if yes, please explain on a separate sheet)* No ☐

4. Recommendation: (please indicate with check mark)
   - Recommend highly and without reservation ☐; Recommend as qualified and competent ☑
   - Recommend with some reservation (explain) _____
   - Do not recommend (explain) _____

5. Of particular value to us in evaluating any candidate regarding any notable strengths and weaknesses (including personal demeanor). We would appreciate such comments from you.

6. The above report is based on: (please indicate with check mark)
   - Close personal observation ☑; General impression ☐; A composite of evaluations ☑;
   - Other: _____

7. Relationship to applicant
   - Program Director ☑; Immediate Supervisor ☐; Other: _____

Date (Required): 4/19/2018

Signed by: Syed Wasis Alam
Print or type name: ZUBAIR SYED, MD
Title: Program Director
Organization/Institution: UT Southwestern Family Medicine

PLEASE USE SPACE ON BACK TO PROVIDE ADDITIONAL INFORMATION AS DESIRED.

Rev. 12/11 MEDICINE & OSTEOPATHY

DC Department of Health
Board of Medicine Character Reference Form

Board of Medicine
899 North Capitol St., NE 1st Flr.
Washington, DC 20002
(202)-724 4900

Please print/type name and location of setting completing this form (Should match setting listed on chronological page of application). Please note, this is not to be used as a substitute for a verification of your experience.

Beacon Family Health Care

4208 Medical Pkwy, Austin, TX 78756

Jessica Rubino

Please clearly print/ type name of Applicant

The District of Columbia Board of Medicine, in its consideration of a candidate for licensure, depends on information by persons listed (references) regarding the candidate's character, employment and observed performance while providing care to patients and working with peers and staff. Please complete this form to the best of your ability and return it to the board so the information you provide can be given consideration in the processing of this candidate's application in a timely manner. I hereby authorize all my references to release to the D.C. Board of Medicine any information requested by the Board in connection with the processing of my application.

Signature of Applicant Jessica Rubino

Item #1 must be completed, or form may be invalid

1. Date and type of service: This individual served with us as AN EMPLOYED PHYSICIAN from JAN 2017 (Month/Year) to PRESENT (Month/Year). If you are responding for a training program, please provide the number of months of postgraduate training awarded _____.

2. Please evaluate: (Indicate with check mark)

		Poor	Fair	Good	Superior
Professional knowledge				✓	
Clinical judgment				✓	
Relationship with patients					✓
Ethical/professional conduct				✓	
Interest in work				✓	
Ability to communicate				✓	TO ✓

3. To your knowledge, has the applicant been the subject of any disciplinary or legal proceeding convened by a state regulatory agency or board, employer hospital or health care facility ? Yes☐; *(if yes, please explain on a separate sheet)* No☒ NOT WHILE UNDER MY EMPLOY

4. Recommendation: (please indicate with check mark)
   - Recommend highly and without reservation ☐; Recommend as qualified and competent ☒
   - Recommend with some reservation (explain) _____
   - Do not recommend (explain) _____

5. Of particular value to us in evaluating any candidate regarding any notable strengths and weaknesses (including personal demeanor). We would appreciate such comments from you.

6. The above report is based on: (please indicate with check mark)
   - Close personal observation ☒; General impression ☐; A composite of evaluations ☐;
   - Other: _____

7. Relationship to applicant
   - Program Director ☐; Immediate Supervisor ☐; Other: EMPLOYER, ALSO A F.P.

Date (Required): 12/17/17

Signed by: Erica Williams Sweeney MD
Print or type name: ERICA WILLIAMS SWEENEY MD
Title: OWNER / SELF
Organization/Institution: BEACON FAMILY HEALTH CARE

PLEASE USE SPACE ON BACK TO PROVIDE ADDITIONAL INFORMATION AS DESIRED.

DC | HEALTH
Health Regulation & Licensing Administration

GOVERNMENT OF THE DISTRICT OF COLUMBIA
MURIEL BOWSER, MAYOR

District of Columbia Board of Medicine
Character Reference Form

The District of Columbia Board of Medicine (Board), in its consideration of a candidate for licensure, depends on information by persons listed (i.e., references) regarding the candidate's character, employment and observed performance while providing care to patients and working with peers and staff. Please complete this form to the best of your ability and return it to the Board so the information you provide can be given consideration in the processing of this candidate's application.

APPLICANT INFORMATION		
First Name: Jessica	**MI:** L	**Last Name:** Rubino

CHARACTER REFERENCE

1. **Date and type of service:**

   The above named individual served with us as staff physician from 08/23/2017 to present.

   If you are responding for a training program, please provide the number of months of professional or postgraduate training awarded: _____.

2. **Please evaluate the following:**

	Poor	Fair	Good	Superior
Professionalism			X	
Clinical Judgment			X	
Relationship w/Patients			X	
Ethical/Professional Conduct				X
Interest in Work				X
Ability to Communicate			X	

3. **To your knowledge, has the applicant been the subject of any disciplinary or legal proceeding convened by a medical school, state regulatory agency or board, employer hospital, or health care facility? If yes, please explain on a separate sheet of paper.**

   To my knowledge, the applicant has not been subject to any such proceeding.

4. Recommendation (choose one):

- ☑ Recommend high and without reservation.
- ☐ Recommend as qualified and competent
- ☐ Recommend with some reservation (please explain):
- ☐ Do not recommend (please explain):

5. The above report is based on (choose all that apply):

- ☑ Close Personal Observation;
- ☐ General impression;
- ☐ A composite of evaluations;
- ☐ Other:

6. Relationship to applicant:

- ☐ Medical school professor;
- ☐ Program Director;
- ☐ Attending Physician;
- ☐ Other:
- ☑ Medical Director

ATTESTATION OF REFERENCE

I hereby attest that I am the individual who completed this form and provided the below responses, and that the responses given are true and accurate.

First Name: Jessica	MI: B	Last Name: Knox
SIGNATURE OF REFERENCE: JK		DATE: 07/12/2018

AMA Physician Profile

PREPARED FOR
District of Columbia Board of Medicine, Washington, DC

Name and Mailing Address

JESSICA LOUISE RUBINO
[redacted]

Birth date [redacted]

Primary Office Address

ST JOSEPH HOSPITAL
2900 N LAKE SHORE DR
CHICAGO, IL 60657-6274
Phone UNKNOWN

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 NPI information

National Provider Identifier (NPI)	Enumeration Date	Deactivation Date	Reactivation Date	Replacement Number	Last Reported Date
[redacted]	06/19/2013	NOT RPTD	NOT RPTD	NOT RPTD	01/15/2018

Current and/or historical medical school

SOUTHERN ILLINOIS UNIVERSITY SCHOOL OF MEDICINE

Degree Awarded: YES
Degree Year: 2012

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

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

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

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

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

Sponsoring Institution:	UNIVERSITY OF TEXAS SOUTHWESTERN MEDICAL SCHOOL
Sponsoring State:	TEXAS
Program name:	UNIVERSITY OF TEXAS SOUTHWESTERN MEDICAL SCHOOL PROGRAM
Specialty:	FAMILY MEDICINE
Training Type:	SPECIALTY
Dates:	7/2014 - 8/2016 (Verified)

Sponsoring Institution:	PRESENCE ST JOSEPH HOSPITAL (CHICAGO)
Sponsoring State:	ILLINOIS
Program name:	PRESENCE SAINT JOSEPH HOSPITAL (CHICAGO) PROGRAM
Specialty:	FAMILY MEDICINE
Training Type:	
Dates:	6/2013 - 6/2014* (Verified)

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

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

Specialty Board Certification

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

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

Certifying board: AMERICAN BOARD OF FAMILY MEDICINE
Certificate: FAMILY MEDICINE
Certificate type: GENERAL

Duration	Status	Effective Date	Expiration Date	Reverify Date	Occurrence	Last Reported	Participating in MOC
MOC+	Active	11/18/2016	n/a	02/15/2018	INITIAL	01/04/2018	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.

+The above certifying board has implemented standards which specify that the board certification is contingent upon meeting ongoing requirements of Maintenance of Certification (MOC). Only certificates issued by a MOC participating board will reflect a reverification date.

Current and/or historical medical licensure

Jurisdiction	MD / DO	Date Granted	Expiration Date	Status	License Type	Last Reported
Texas	MD	12/16/2016	02/28/2019	ACTIVE	UNLIMITED	01/03/2018
Michigan	MD	10/14/2016	01/31/2018	ACTIVE	UNLIMITED	01/03/2018
Texas	MD	07/01/2014	08/24/2016	UNKNOWN	RESIDENT	09/07/2016
Illinois	MD	06/11/2013	06/24/2016	INACTIVE	RESIDENT	12/12/2017

Action Notifications

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

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

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

U.S. Drug Enforcement Administration (DEA)

DEA number	Schedule	Expiration Date	Last Reported Date	Address
XXXXXX852	22N 33N 4 5	04/30/2019	03/01/2017	Beacon Family Health Care 4208 Medical Pkwy Austin, TX 78756-3310

Only the last three characters of active DEA numbers are displayed

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

ECFMG Certfication

Applicant Number:

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

Profile Information

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

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

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

Texas Medical Board

Mailing Address: P.O. Box 2018 • Austin, Tx 78768-2018
Phone (512) 305-7010

WASHINGTON DC DEPARTMENT OF HEALTH BOARD OF MEDICINE
899 NORTH CAPITOL STREET NE
WASHINGTON, DC 20002-0000

February 23, 2018

For: WASHINGTON DC DEPARTMENT OF HEALTH BOARD OF MEDICINE

In response to a recent request, we verify the following information:

****

Physician: JESSICA LOUISE RUBINO, MD
License: R1121
Date Issued: 12/16/2016
Licensed by:
Date of Birth: [redacted]
Medical School: SOUTHERN ILLINOIS UNIV SCH OF MED, SPRINGFIELD
Graduation Year: 2012
Permit Expires: 02/28/2019

Registration Status:

This is to certify that the above-named physician is licensed to practice medicine in Texas.

Disciplinary Status:

The board has not filed any formal complaints or statements of charges against this physician.

Investigation Status:

Not applicable.

****

If you have any further questions, please contact the Hearings division

Sincerely,

Customer Information Center
BOARD SEAL

PUBLIC VERIFICATION / PHYSICIAN PROFILE

PHYSICIAN IN TRAINING PERMIT

NAME: JESSICA LOUISE RUBINO MD **DATE:** 09/14/2018

THE INFORMATION IN THIS BOX HAS BEEN VERIFIED
BY THE TEXAS MEDICAL BOARD

Date of Birth: [redacted]
Permit Number: BP10051026
Permit Type: PHYSICIAN IN TRAINING PERMIT
Permit Status: PERMIT TERMINATED
Permit Status Date: 8/24/2016
Begin Date: 07/01/2014
Expiration Date: 08/24/2016
End Date: 08/24/2016
Terminated Date: 08/24/2016

Board Action (includes all actions regardless of license/permit type)
NONE

THE INFORMATION IN THIS BOX WAS REPORTED BY THE LICENSEE AND
HAS NOT BEEN VERIFIED BY THE TEXAS MEDICAL BOARD

Gender: FEMALE

Current Primary Practice Address:
[redacted]

Education

Graduation Year: 2012
Medical School: SOUTHERN ILLINOIS UNIV SCH OF MED, SPRINGFIELD

Program Type: RESIDENT
Training Institution: UNIV OF TX SOUTHWESTERN MED CTR (3 YR PROGRAM)
Program Specialty: FAMILY MEDICINE

Summary of all License/Permit Types

Issue Date:	Type:
07/01/2014	PHYSICIAN IN TRAINING PERMIT
12/16/2016	LICENSED PHYSICIAN

STATE OF MICHIGAN

RICK SNYDER
GOVERNOR

DEPARTMENT OF LICENSING AND REGULATORY AFFAIRS
LANSING

SHELLY EDGERTON
DIRECTOR

VERIFICATION OF LICENSURE

MICHIGAN BOARD OF MEDICINE

VERIFICATION OF LICENSURE AS OF February 21, 2018

NAME: Jessica Louise Rubino **BIRTHDATE:** [redacted]

ADDRESS: [redacted]

TYPE: Medical Doctor **ORIGINAL DATE:** 10/14/2016

LICENSE NUMBER: 4301111191 **STATUS:** Active **EXPIRATION DATE:** 01/31/2021

OBTAINED BY: Web By Examination

EXAM DATE	EXAM TYPE	EXAM SCORE OR RESULT

DISCIPLINARY ACTION NONE

OPEN FORMAL COMPLAINTS NONE

This verification was produced by VeriDoc on behalf of the State of Michigan with license information last updated on: 2/21/2018.

NATIONAL PRACTITIONER DATA BANK

NPDB

P.O. Box 10832
Chantilly, VA 20153-0832

https://www.npdb.hrsa.gov

5500000129996670
Process Date: 12/11/2017
Page: 1 of 1

To: RUBINO, JESSICA LOUISE

[redacted]

From: National Practitioner Data Bank
Re: Response to Your Self-Query

The enclosed information is released by the National Practitioner Data Bank (NPDB) for restricted use under the provisions of Title IV of Public Law 99-660, the Health Care Quality Improvement Act of 1986, as amended; Section 1921 of the Social Security Act; and Section 1128E of the Social Security Act.

Title IV established the NPDB as an information clearinghouse to collect and release certain information related to malpractice payment history and professional competence or conduct of physicians, dentists, and other licensed health care practitioners.

Section 1921 of the Social Security Act expanded the scope of the NPDB. Section 1921 was enacted to protect program beneficiaries from unfit health care practitioners, and to improve the anti-fraud provisions of federal and state health care programs. Section 1921 authorizes the NPDB to collect certain adverse actions taken by state licensing and certification authorities, peer review organizations, and private accreditation organizations, as well as final adverse actions taken by state law or fraud enforcement agencies (including, but not limited to, state law enforcement agencies, state Medicaid Fraud Control Units, and state agencies administering or supervising the administration of a state health care program), against health care practitioners, health care entities, providers and suppliers.

Section 1128E of the Social Security Act was added by Section 221(a) of Public Law 104-191, the Health Insurance Portability and Accountability Act of 1996. The statute established a national data collection program (formerly known as the Healthcare Integrity and Protection Data Bank) to combat fraud and abuse in health care delivery and to improve the quality of patient care. Section 1128E information is now collected and disclosed by the NPDB as a result of amendments made by Section 6403 of the Affordable Care Act of 2010, Public Law 111-148. Section 1128E information includes certain final adverse actions taken by federal agencies and health plans against health care practitioners, providers, and suppliers.

Regulations governing the NPDB are codified at 45 CFR part 60. Responsibility for operating the NPDB resides with the Secretary of the U.S. Department of Health and Human Services (HHS), and HRSA, Division of Practitioner Data Banks.

Reports from the NPDB contain limited summary information and should be used in conjunction with information from other sources in granting privileges, or in making employment, affiliation, contracting or licensure decisions. NPDB responses may contain more than one report on a particular incident, if two or more actions were taken as a result of a single incident (e.g., an exclusion from a federal or state health care program and an adverse licensure action). The NPDB is a flagging system, and a report may be included for a variety of reasons that do not necessarily reflect adversely on the professional competence or conduct of the subject named in the report.

All information received from the NPDB is considered confidential and must be used solely for the purpose for which it was disclosed. Further, ANY PERSON WHO VIOLATES THE CONFIDENTIALITY PROVISIONS AS SPECIFIED IN TITLE IV OF PUBLIC LAW 99-660, AS AMENDED, IS SUBJECT TO A CIVIL MONEY PENALTY OF UP TO $11,000 FOR EACH VIOLATION. Subjects of reports who obtain information about themselves from the NPDB are permitted to share that information with anyone they choose.

If you require additional assistance, visit the NPDB web site (https://www.npdb.hrsa.gov) or contact the NPDB Customer Service Center at 1-800-767-6732 (TDD: 1-703-802-9395). Information Specialists are available to speak with you weekdays from 8:30 a.m. to 6:00 p.m. (5:30 p.m. on Fridays) Eastern Time. The NPDB Customer Service Center is closed on all Federal holidays.

NATIONAL PRACTITIONER DATA BANK

NPDB

P.O. Box 10832
Chantilly, VA 20153-0832

https://www.npdb.hrsa.gov

5500000129996670
Process Date: 12/11/2017
Page: 1 of 1

RUBINO, JESSICA LOUISE - SELF-QUERY RESPONSE

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

Practitioner Name: RUBINO, JESSICA LOUISE
Date of Birth: [redacted] **Gender:** FEMALE
Delivery Address: [redacted]
Social Security Number: [redacted] **DEA:** [redacted]
NPI: [redacted]
License: PHYSICIAN (MD), R1121, TX, GENERAL PRACTICE/FAMILY PRACTICE
PHYSICIAN (MD), 4301111191, MI, GENERAL PRACTICE/FAMILY PRACTICE
Professional School(s): SOUTHERN ILLINOIS UNIVERSITY SCHOOL OF MEDICINE (2012)

B. PAYMENT INFORMATION

Credit Card Information: [redacted]
NPDB Charge: $4.00* **NPDB Bill Reference Number:** N55302432
* Each charge will appear separately on your credit card statement.
Transaction Date: 12/11/2017 **Additional Paper Copies Requested:** 0

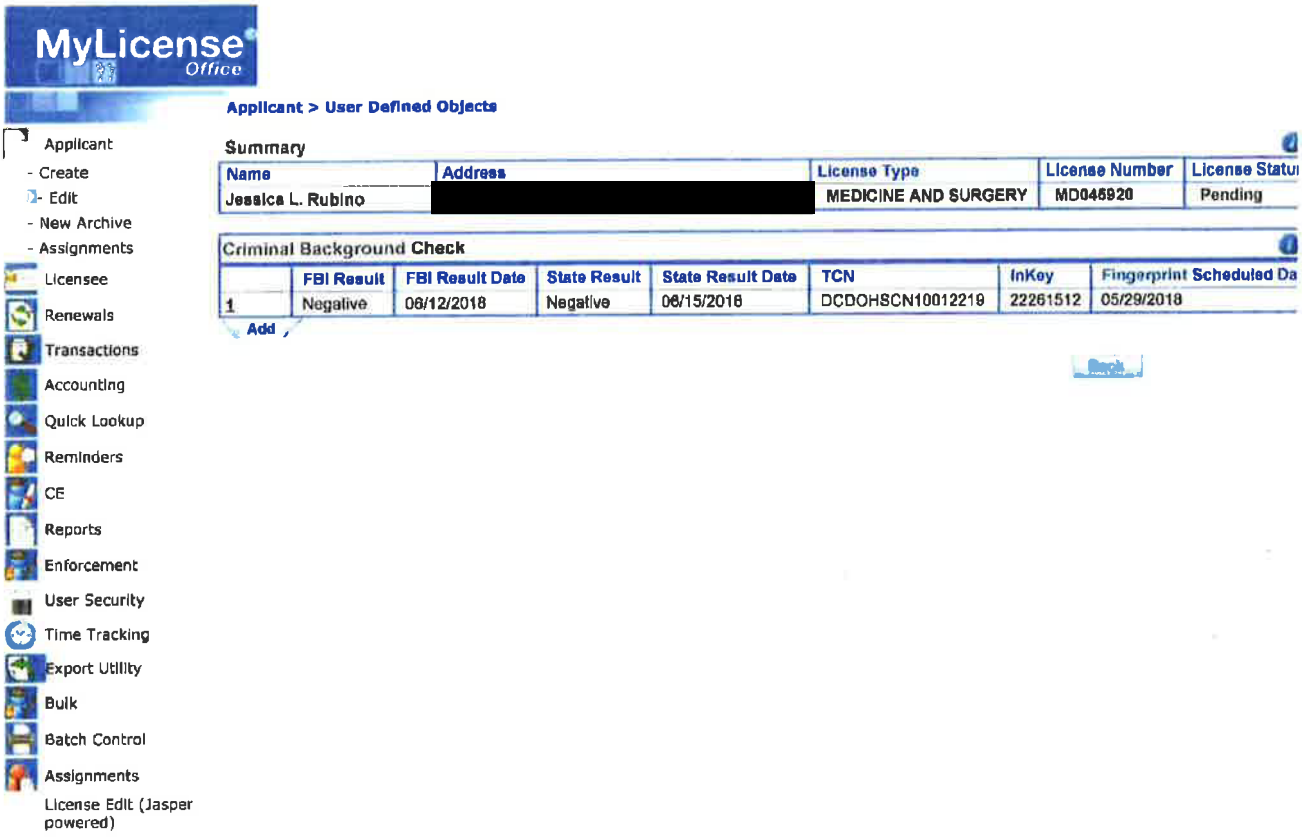
C. SUMMARY OF REPORTS ON FILE WITH THE DATA BANK AS OF 12/11/2017

The following report types have been searched:

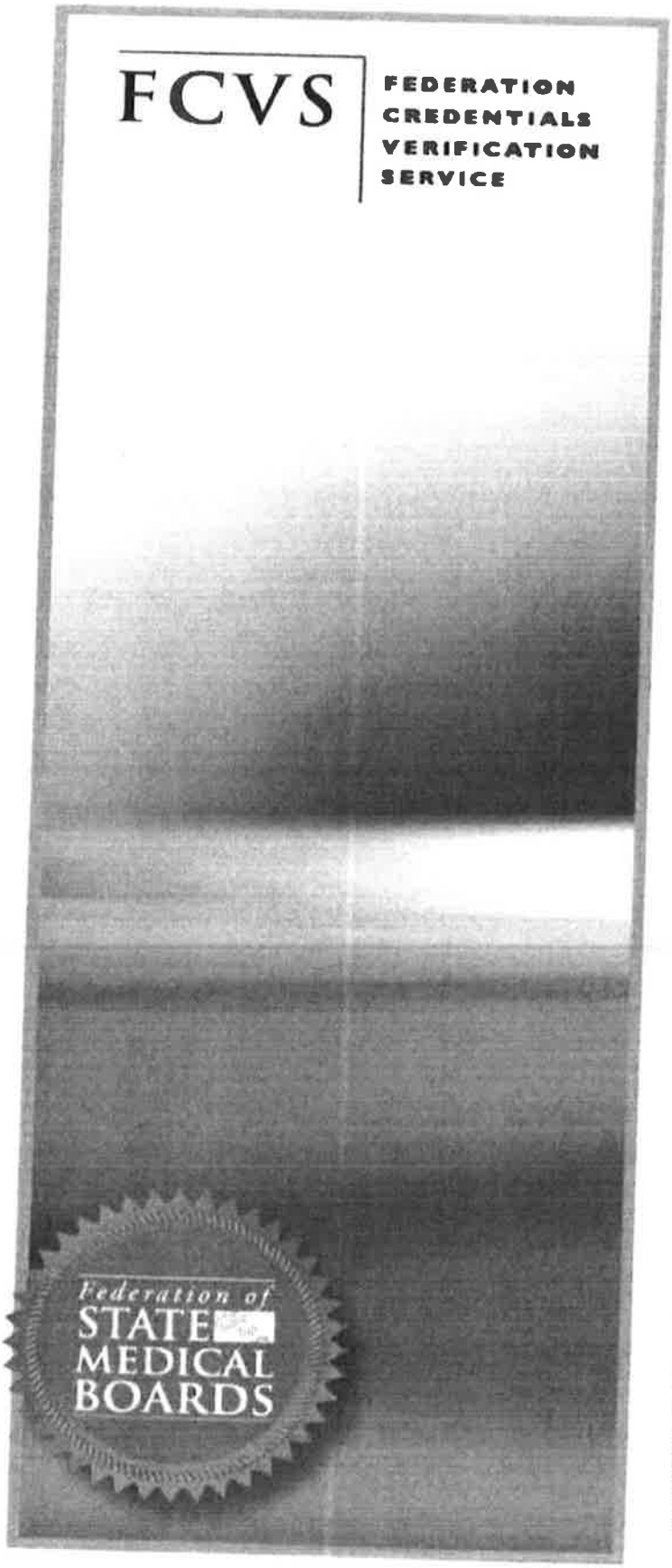
Medical Malpractice Payment Report(s):	No Reports	Health Plan Action(s):	No Reports
State Licensure Action(s):	No Reports	Professional Society Action(s):	No Reports
Exclusion or Debarment Action(s):	No Reports	DEA/Federal Licensure Action(s):	No Reports
Government Administrative Action(s):	No Reports	Judgment or Conviction Report(s):	No Reports
Clinical Privileges Action(s):	No Reports	Peer Review Organization Action(s):	No Reports

Copies of these reports are enclosed for restricted/limited use as prescribed by statutes listed on the preceeding cover page.

---------- No Reports Found Based on the Subject Information Submitted ----------



FCVS | FEDERATION CREDENTIALS VERIFICATION SERVICE



Medical Professional Information Profile

This report provides credentialing information for:

Name:	**Rubino, Jessica Louise**
Social Security Number:	[redacted]
Date of Birth:	
FID#:	**217877273**
Recipient:	**DC - District of Columbia Board of Medicine**
Delivery Date:	**02/13/2018**

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

Federation of STATE MEDICAL BOARDS

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.

CLINISHA BLAKE
NOTARY PUBLIC

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

Rubino
Applicant's Printed Last Name

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

12/18/17
Date of Signature (must correspond to date of notarization)

State of Texas, County of Travis

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 18th day of Dec., 2017.

Notary Public Signature: Clinisha Blake

My Notary Commission Expires: 9/3/19

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
FCVS

FID Number
217877273

217 877 273

FCVS | FEDERATION CREDENTIALS VERIFICATION SERVICE

Identity

Federation of STATE MEDICAL BOARDS

Biographic Information

Medical professional Name(s): **Rubino, Jessica Louise**

Date of Birth: [redacted]

Place of Birth:

Contact Information

Home Address: [redacted]

Mobile Phone:

Email:

Credentials Analysis Information for Identity

There is no Omission/Discrepancy/Miscellaneous information identified.

CERTIFICATION OF IDENTIFICATION

Certification by Notary Public Is Required

Applicant Full Legal Name: Rubino (Last) Jessica (First) Louise (Middle)

FCVS ID Number: FCVS

Notary – Please complete the section below:

State of Texas County of Travis

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

The statements on this document are subscribed and sworn to before me by the applicant on this (Day) 13th, of (Month) Dec., (Year) 2017.

Notary Public Signature: [signature]

Commission Expiration Date* (Month) 9 / (Day) 3 / (Year) 19

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

Notary Stamp Here

CLINISHA BLAKE
MY COMMISSION EXPIRES
SEPTEMBER 3, 2019

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

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

FCVS ID Number
FCVS

PP

FID Number
217877273

217 877273


We the People
Of the United States,
SIGNATURE OF BEARER / SIGNATURE DU TITULAIRE / FIRMA DEL TITULAR
PASSPORT
PASSEPORT
PASAPORTE
USA
UNITED STATES OF AMERICA
F
USA
[redacted]
RUBINO
JESSICA LOUISE
UNITED STATES OF AMERICA
[redacted]
[redacted]
F
15 Jun 2015
14 Jun 2025
United States
Department of State
SEE PAGE 27
USA
P<USARUBINO<<JESSICA<LOUISE<<<<<<<<<<<<<<<<<<<
[redacted]

217 877 273

FCVS FEDERATION CREDENTIALS VERIFICATION SERVICE

Chronology of Activities

Federation of STATE MEDICAL BOARDS

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
08/01/2007	07/27/2012	Medical Education	Southern Illinois University School Of Medicine Springfield Illinois UNITED STATES
08/01/2012	06/01/2013	Work	Catapult Health 8144 Walnut Hill Lane Suite 1100 Dallas, Texas UNITED STATES
07/01/2013	07/01/2014	Postgraduate Training	Presence Saint Joseph Hospital (Chicago) Program Chicago Illinois UNITED STATES
07/01/2014	08/24/2016	Postgraduate Training	University of Texas Southwestern Medical School Program Dallas Texas UNITED STATES

End of Chronology of Activities report for: Rubino, Jessica Louise

FCVS FEDERATION CREDENTIALS VERIFICATION SERVICE

Medical Education

Federation of STATE MEDICAL BOARDS

Medical Education

Medical School: **Southern Illinois University School Of Medicine**

Location: Springfield, IL

UNITED STATES

Credentials Analysis Information for Medical Education

Issue:
FCVS has identified a medical education Discrepancy at Southern Illinois University School Of Medicine.

Unusual Circumstances

Solution(s):
FCVS does not follow up with the Medical Professional or the institution with inconsistent information on Unusual Circumstances questions.

FCVS FEDERATION CREDENTIALS VERIFICATION SERVICE

Verification of Medical Education

Federation of STATE MEDICAL BOARDS

Instruction to the Dean

Please complete both pages of this form, sign date and seal on the front page then return to:

Federation Credentials Verification Service
400 Fuller Wiser Rd
Suite 300
Euless, TX 76039

The individual identified on the attached Authorization for Release of Information, Documents and Records form has authorized your medical school to provide to the Federation Credentials Verification Service (FCVS) any and all information pertaining to their education at your institution.

Please note: If your institution processes transcript requests through another office, FCVS has likely made such a request under separate cover.

If your office also processes transcript requests, please attach the individual's official transcript (which indicates courses taken, dates and hours of attendance, and scores, grades, or evaluation).

Institution Name: Southern Illinois University School Of Medicine

Address Line 1:

Address Line 2:

City:

State/Province:

Country:

Zip Code (Postal Code):

If name of institution was different when this individual attended, please note this name below:

Premedical Education:

Years of education required for admission to your medical school: 90 Sem hrs. min. Bachelors degree preferred

Credential/degree presented by the applicant for admission to your medical school: BS Biology/Chemistry ✓ Spanish Illinois College

Enrollment and Participation: Our records indicate that Rubino Jessica Louise
(type/print individual's name: Last, First, Middle, Suffix)

attended our medical school for total of 201 weeks of medical education on the following dates: **From:** 8/15/07 (Month Day Year) **To:** 7/27/12 (Month Day Year)

This individual

Was awarded the degree of Doctor of Medicine on 7/27/12 (Month Day Year)

Was NOT awarded a degree because: (please explain - additional page if necessary)

Attestation

After Institutional Seal Here

To search available, this form must be notarized.

BOARD OF TRUSTEES · SOUTHERN ILLINOIS UNIVERSITY · CHARTERED 1869 · STATE OF ILLINOIS

217877273

Watermark

For FCVS internal use only.

SEAL VERIFIED

Name: Karla Heneberg

Signature: Karla Heneberg

Title: Registrar

Date of Signature: 2/6/18 **Phone:** 217 545-2860

Fax: 217 545-5538 **Email:** kheneberg@siumed.edu

217 877 273 1421 217877273

FCVS FEDERATION CREDENTIALS VERIFICATION SERVICE

Verification of Medical Education

Federation of STATE MEDICAL BOARDS

* See Transcript

Unusual Circumstances

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

If Yes, please specify the reason(s) for, indicate the date of the interruptions(s) or extension(s) and check whether the interruption/extension was approved or unapproved:

Personal/Family	From (Mo/Yr) ___/___	To (Mo/Yr) ___/___	___ Approved	___ Unapproved
* Academic remediation ___V___	From (Mo/Yr) 7/08	To (Mo/Yr) 5/10	X Approved	___ Unapproved
Health	From (Mo/Yr) ___/___	To (Mo/Yr) ___/___	___ Approved	___ Unapproved
Financial	From (Mo/Yr) ___/___	To (Mo/Yr) ___/___	___ Approved	___ Unapproved
Participation in joint degree Program (e.g., MD/PhD)	From (Mo/Yr) ___/___	To (Mo/Yr) ___/___	___ Approved	___ Unapproved
Participation in non-research special study (e.g., fellowship, international experience)	From (Mo/Yr) ___/___	To (Mo/Yr) ___/___	___ Approved	___ Unapproved
Participation in non-degree research	From (Mo/Yr) ___/___	To (Mo/Yr) ___/___	___ Approved	___ Unapproved
Other	From (Mo/Yr) ___/___	To (Mo/Yr) ___/___	___ Approved	___ Unapproved

Please Specify:
Repeat / Remediation of Sophomore / Yr 2 Curriculum
Pediatrics Clerkship Remediation - Had to repeat the written exam.

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

If YES, please select the reason(s) for the probation, indicate the dates of placement on and removal from probation and attach additional documentation to this report:

* Academic Probation ___V___	From (Mo/Yr) 07/08	To (Mo/Yr) 5/10
Probation for unprofessional conduct/behavioral	From (Mo/Yr) ___/___	To (Mo/Yr) ___/___
Probation for other reason	From (Mo/Yr) ___/___	To (Mo/Yr) ___/___

Please specify a reason:
Was placed on academic probation due to being required to repeat Yr 2

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 X NO

If YES, please provide detailed documentation/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 X NO

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

X YES ___ NO

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?

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

* Remediation of Sophomore / Yr 2 Curriculum
* Pediatrics Clerkship Remediation - Had to repeat the written exam. * Was required to repeat Yr 2 on academic probation.

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FCVS | FEDERATION CREDENTIALS VERIFICATION SERVICE

Applicant Reported Unusual Circumstances

Federation of STATE MEDICAL BOARDS

Medical School

Medical Professional Name: Rubino, Jessica Louise

Southern Illinois University School Of Medicine

Unusual Circumstances

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

End of Applicant Reported Unusual Circumstances report for: Rubino, Jessica Louise

SOUTHERN ILLINOIS UNIVERSITY SCHOOL OF MEDICINE

Office of Student Affairs
P.O. Box 19624, Springfield, IL 62794-9624

Name: Rubino, Jessica Louise

Date of Birth: [redacted]

Date of Matriculation: 08/13/2007

Degree: DOCTOR OF MEDICINE

Date Conferred: 07/27/2012

Course Title	Dates	# of Weeks	Credits	Evaluation
FRESHMAN YEAR, CARBONDALE	08/13/2007 - 06/05/2008			S
Cardiovascular/Renal/Respirato		14.00		
Sensorimotor Systems & Behav		12.00		
Endocrine/Reproduction/Gastro		12.00		
Clinical & Research Experience		3.00		
SOPHOMORE YEAR, SPRINGFIELD	07/07/2008 - 06/29/2009			U
Orientation		1.00		
Doctoring		1.00		
Hematology/Immuno/Infection		7.00		
Cardiovascular/Resp/Renal		10.00		
Neuromuscular/Behavior		10.00		
Endocrine/Reproduction/GI		10.00		
SOPHOMORE YEAR, SPRINGFIELD	08/10/2009 - 05/23/2010			S*
Orientation		1.00		
Doctoring		1.00		
Hematology/Immunoy/Infection		7.00		
Cardiovascular/Resp/Renal		10.00		
Neuromuscular Behavior		10.00		
Endocrine/Reproduction/GI		10.00		
Junior/Senior Years, Springfield				
Clerkships				
Psychiatry Clerkship	09/27/2010 - 11/01/2010	6.00		S
Obstetrics/Gynecology Clkshp	11/08/2010 - 12/13/2010	6.00		S
Doctoring Year 3: Phys/Pt Rel.	01/03/2011 - 01/10/2011	2.00		S
Internal Medicine Clerkship	01/17/2011 - 03/21/2011	10.00		S
Surgery Clerkship	04/25/2011 - 06/27/2011	10.00		S
Fam/Comm Medicine Clerkship	07/05/2011 - 08/08/2011	6.00		S
Pediatrics Clerkship	11/07/2011 - 12/12/2011	6.00		S*
Neurology Clerkship	01/30/2012 - 02/20/2012	4.00		S
Doctoring Year 4: Society, Law	02/27/2012 - 03/05/2012	2.00		S
Electives				
Issues in Minority Health Care	09/06/2010 - 09/06/2010	1.00		S
Community Hlth Serv & Resource	09/13/2010 - 09/13/2010	1.00		S
Intro to Cutaneous Medicine	04/11/2011 - 04/18/2011	2.00		S
Basic Science Review, Step 1 Falcon Physician Review	08/15/2011 - 09/26/2011	7.00		S
Patient Education	01/23/2012 - 01/23/2012	1.00		S
Spanish for the Medical Prof	03/12/2012 - 05/14/2012	1.00		S
Nutrition in Pediatric Care	03/12/2012 - 03/12/2012	1.00		S
PT/OT/Speech&Language Therapy	03/19/2012 - 03/19/2012	1.00		S
Emergency Medicine-Springfield	04/09/2012 - 04/30/2012	4.00		S
Physical Activity Basics&Teach	05/07/2012 - 05/07/2012	1.00		S
Patient Education	05/14/2012 - 05/14/2012	1.00		S
Emerging Trends in Public Hlth	05/21/2012 - 05/21/2012	1.00		S
Midwifery Elective	05/28/2012 - 05/28/2012	1.00		S
Public Health Leadership	06/04/2012 - 06/04/2012	1.00		S

RAISED SEAL NOT REQUIRED
Printed on Sorry Based security paper

Registrar: Karla Hensley

Date Issued: 2/6/18

217 877 273

SEAL VERIFIED

Grading Key 1969-1992
H = Honors
S = Satisfactory
U = Unsatisfactory
I = Incomplete

Grading Key 1993-
H = Honors
S = Satisfactory
S* = Satisfactory After Remediation
U = Unsatisfactory
I = Incomplete

SOUTHERN ILLINOIS UNIVERSITY
SCHOOL OF MEDICINE
Office of Student Affairs
P.O. Box 19624, Springfield, IL 62794-9624

Name: Rubino, Jessica Louise

Course Title	Dates	# of Weeks	Evaluation
Junior/Senior Years, Springfield			
Electives		**Credits**	
History of Family Practice	06/18/2012 - 06/25/2012	2.00	S
Alternative Systems of Healing	07/02/2012 - 07/02/2012	1.00	S
Minority Healthcare	07/09/2012 - 07/16/2012	2.00	S
Alternative Systems of Healing	07/23/2012 - 07/23/2012	1.00	S

*** End of Transcript ***
Page 2 of 2

SOUTHERN ILLINOIS UNIVERSITY CHARTERED 1869

SEAL VERIFIED

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Registrar Kate Hemeberg

Date Issued 2/6/18

217 877 273

Grading Key 1988-1992
H = Honors
S = Satisfactory
U = Unsatisfactory
I = Incomplete

Grading Key 1993 -
H = Honors
S = Satisfactory
S* = Satisfactory After Remediation
U = Unsatisfactory
I = Incomplete

Southern Illinois University

Carbondale

School of Medicine

On recommendation of the Chancellor and Faculty,
the Board of Trustees, by virtue of the authority vested in it, has
conferred on

Jessica Louise Rubino

the degree of

Doctor of Medicine

and has granted this Diploma as evidence thereof
the twenty-seventh day of July, 2012

KARLA HENEBRY
Official Seal
Notary Public - State of Illinois
My Commission Expires May 21, 2020

KARLA H
Officia
Notary Public -
My Commission Exp
2020

Certified copy of original medical school diploma
Karla Henebry, Expires 5/21/20

SEAL
VERIFIED

Chancellor

Dean

President

Chairman of Board

FCVS FEDERATION CREDENTIALS VERIFICATION SERVICE

Postgraduate Training

Federation of STATE MEDICAL BOARDS

Postgraduate Training

Accreditation ID: **1201611103**

Institution: **Presence Saint Joseph Hospital (Chicago) Program**

Location: Chicago, IL
UNITED STATES

Accreditation ID: **1204821361**

Institution: **University of Texas Southwestern Medical School Program**

Location: Dallas, TX
UNITED STATES

Credentials Analysis Information for Postgraduate Training

Issue:
FCVS has identified a postgraduate training Discrepancy at University of Texas Southwestern Medical School Program.

Unusual Circumstances

Solution(s):
FCVS does not follow up with the Medical Professional or the institution with inconsistent information on Unusual Circumstances questions.

Federation of STATE MEDICAL BOARDS

Federation Credentials Verification Service (FCVS)

400 Fuller Wiser Rd, Euless, TX 76039
Tel: (817) 868-5000 Fax: (817) 868-5099 Email: fcvsgme@fsmb.org

Verification of Postgraduate Medical Education

Institution: Presence Saint Joseph Hospital (Chicago) Program
Specialty: Family Medicine
Address: Chicago, IL

Attention: **Program Director**
Affiliated University:

Verification For:

Name: Jessica Louise Rubino
DOB: 06/29/1985
Individual's Name on Record (if different from above):

Program Participation:

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

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

Report Internships, Residencies and Fellowships separately

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

PGY: 1
☒ Internship ☐ Residency ☐ Chief Residency ☐ Fellowship ☐ Research
Specialty/Subspecialty: FAMILY MEDICINE
From: 6/25/13 To: 6/24/14
Successfully Completed?: ☒ Yes ☐ No ☐ In Progress
Accredited by: ☒ ACGME ☐ AOA ☐ LCGME ☐ RSC ☐ CFPC ☐ RCPSC ☐ APPAP ☐ None of these

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

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

Unusual Circumstances:

Check the correct response. Omitted responses require written explanation

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

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

Please explain any "Yes" response from above:

Certification:

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

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

Name: LUIS T. GARCIA, MD Signature: Luis T. Garcia
Title: PROGRAM DIRECTOR Date of Signature: 2/1/18
Tel: 773-665-3300 Fax: E-Mail: lugarcia@presencehealth.org

Rev 01/21/2016 FID 217877273 ACGME ID: 1201611103 GME CODE:

FCVS FEDERATION CREDENTIALS VERIFICATION SERVICE

Applicant Reported Unusual Circumstances

Federation of STATE MEDICAL BOARDS

Graduate Medical Education

Medical Professional Name:	Rubino, Jessica Louise
Accreditation ID:	1201611103
Institution:	Presence Saint Joseph Hospital (Chicago) Program
Specialty:	Family Medicine

Unusual Circumstances

Training Period: 7/1/2013 - 7/1/2014 **Internship**

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: Rubino, Jessica Louise

FCVS | FEDERATION CREDENTIALS VERIFICATION SERVICE

Verification of Graduate Medical Education

Federation of STATE MEDICAL BOARDS

Institution: University of Texas Southwestern Medical School Program **Affiliated University:** University of Texas Southwestern Medical School
Address Line 1:
Address Line 2:

Country: US **City:** Dallas **State/Prov.:** TX **Zip Code:**

If name of institution was different when this individual attended, please note this name:

Verification For: Rubino, Jessica Louise **Date of Birth:** [redacted]

Individual's Name on Record (If different from above):

Program Participation:

Important:

Report Incomplete Training Levels (year) separate from those that were successfully completed.

If the training level (years) is currently in progress, report the expected completion date in the "To" field.

Report Internships, Residencies and Fellowships separately.

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

Program Type	Training Level	From	To	Successfully Completed?	Specialty/Subspecialty	Accredited by	Rotation Information
R	2-2	07/01/2014	08/24/2015	Yes	Family Medicine	ACGME	Not Available
R	3-3	08/25/2015	08/24/2016	Yes	Family Medicine	ACGME	

Unusual Circumstances

Check the correct response.

Omitted responses require written explanation.

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

1. Did this individual ever take a leave of absence or extension from his/her training? If "Yes" provide start and end dates: From: 12/24/2014 To: 02/18/2015	Yes
2. Was this individual ever placed on probation?	Yes
3. Was this individual ever disciplined or placed under investigation?	Yes
4. Were any negative reports for behavioral reason ever filed by instructors?	No
5. Were any limitations or special requirements placed upon this individual because of questions of academic incompetence, disciplinary problems or any other reason?	No

Please explain any "Yes" response from above:

1.Please refer to attached document. 2.Please refer to attached document. 3.Please refer to attached document.

Attestation

Affix Institutional Seal Here.

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

Watermark

For FCVS internal use only.

Completion attests the information above is an accurate account of this individual's records and is true and correct. Signature line must contain original signature or electronic typed signature of program director

Print Name: ZubairSyed **MD/DO:** Yes

Signature: *Zubair Syed*

Title: Program Director **Date:** 01/29/2018

Tel: (214) 648-8219 **Fax:** (214) 353-0604 **Email:** Zubair.Syed@UTSouthwestern.edu

217877273 115396 217877273

FCVS FEDERATION CREDENTIALS VERIFICATION SERVICE

Applicant Reported Unusual Circumstances

Federation of STATE MEDICAL BOARDS

Graduate Medical Education

Medical Professional Name:	Rubino, Jessica Louise
Accreditation ID:	1204821361
Institution:	University of Texas Southwestern Medical School Program
Specialty:	Family Medicine

Unusual Circumstances

Training Period: 7/1/2014 - 8/24/2016 **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: Rubino, Jessica Louise

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FCVS FEDERATION CREDENTIALS VERIFICATION SERVICE

Licensure / Examinations

Federation of STATE MEDICAL BOARDS

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 the
Federation of State Medical Boards of the United States, Inc.
Federation Place, 400 Fuller Wiser Road, Suite 300, Euless, TX 76039-3855 –Telephone (817)868-4000

Date: 02/13/2018

Federation Credentials Verification Service
ATTN: FCVS

FCVSID: 349452

Examinee: Rubino, Jessica Louise **Examinee ID:** 52218237

Alt Name(s): **Date of Birth:** [redacted]

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. Where numeric scores are reported, the recommended minimum passing score ("MP") is shown in parentheses. Pass/fail outcomes are based upon the minimum passing level in place at the time of test administration and are not altered by subsequent revisions to the minimum passing level. Effective April 1, 2013, test results are reported on a three-digit scale only; two-digit scores reported for prior administrations will no longer be reported. Test results reported as passing represent an exam score of 75 or higher on a two-digit scoring scale.

USMLE STEP 1

Test Date	Pass/Fail	Total	MP	Comments
1/23/2012	Pass	[redacted]		
10/27/2011	Fail			
8/23/2010	Fail			

USMLE STEP 2

Clinical Knowledge (CK)

Test Date	Pass/Fail	Total	MP	Comments
6/30/2012	Pass	[redacted]		

Clinical Skills (CS)*

Test Date	Pass/Fail	Total	MP	Comments
2/4/2012	Pass			

USMLE STEP 3

Test Date	Pass/Fail	Total	MP	Comments
9/22/2014	Pass	[redacted]		

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 the
Federation of State Medical Boards of the United States, Inc.
Federation Place, 400 Fuller Wiser Road, Suite 300, Euless, TX 76039-3855 --Telephone (817)868-4000

Examinee: Rubino, Jessica Louise

Examinee ID: 52218237

Date of Birth: [redacted]

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

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

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

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

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

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

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

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

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

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

03/2015

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

PDC PHYSICIAN DATA CENTER

Federation of STATE MEDICAL BOARDS

PRACTITIONER PROFILE

Prepared for: FCVS As of Date:2/13/2018

PRACTITIONER INFORMATION

Name:	Rubino, Jessica Louise
DOB:	6/29/1985
Medical School:	Southern Illinois University School Of Medicine Springfield, Illinois, UNITED STATES
Year of Grad:	2012
Degree Type:	MD
NPI:	[redacted]

BOARD ACTIONS

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

LICENSE HISTORY

Jurisdiction	License Number	Issue Date	Expiration Date	Last Updated
DC	MD045920			1/29/2018
MICHIGAN	4301111191	10/14/2016	1/31/2018	10/17/2017
TEXAS	BP10051026	7/1/2014	8/24/2016	2/2/2018
TEXAS	R1121	12/16/2016	2/28/2019	2/2/2018

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PDC PHYSICIAN DATA CENTER

Federation of STATE MEDICAL BOARDS

PRACTITIONER PROFILE

Prepared for: FCVS As of Date:2/13/2018

Practitioner Name: Rubino, Jessica Louise

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	11/18/2016		02/15/2018	Initial	1/25/2018

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12/13/17

DC MD New License Application

In response to section 12, question 8

To Whom It May Concern,

As a 3rd year resident at University of Texas Southwestern in 2016, I was placed on probation for several weeks after a page sent to my pager failed to go through and I failed to respond. No patient harm was done due to this error. I was taken off probation after completing the requirements, which included answering all pages and completing all outstanding patient charts. No further action was taken.

Jessica L Rubino, MD

DC | HEALTH
Health Regulation & Licensing Administration

GOVERNMENT OF THE DISTRICT OF COLUMBIA
MURIEL BOWSER, MAYOR

October 1, 2018

Open Records
Texas Medical Board
P.O. Box 2018
Austin, TX 78768
E: openrecords@tmb.state.tx.us

Re: Rubino, Jessica

To Whom It May Concern:

The District of Columbia Board of Medicine (Board) is currently reviewing the licensure application of a Dr. Jessica Rubino. It has come to our attention that Dr. Rubino was previously under investigation by the Texas Medical Board. Please accept this letter as a formal request for any and all documents related to any investigation(s) performed by the Texas Medical Board of Dr. Jessica Rubino (R1121). Please forward these documents to the following address:

Attn.: Frank B. Meyers
District of Columbia Board of Medicine
899 N. Capitol St. NE, 2nd Floor
Washington, DC 20002
P: (202) 724-8755
E: frank.meyers@dc.gov

If any further information is required, please do not hesitate to contact me. Thank you.

Sincerely,

Frank B. Meyers, JD
Executive Director
DC Board of Medicine

UT Southwestern
Medical Center

Department of Family and Community Medicine

January 29, 2018

To Whom It May Concern

As pertaining to Q#s 1,2 and 3 in the "Unusual Circumstances" section:

Jessica Rubino, MD tested preliminarily as "non-negative" in her urine screen for cannabinoids on December 23, 2014, which result subsequently was confirmed on the final test results. Her employer, Parkland Health and Hospital System, referred her to its Committee on Physician Peer Review and Assistance (COPPRA), and reported to the training program that she would be urine drug tested weekly, and was not to report to the training program until she was cleared by the COPPRA to resume her training. Dr. Rubino was absent from the training program from 12/24/2014 to 02/18/2015

Dr. Rubino was placed on probation from 5/24/2016 until 7/22/2016 for issues related to Patient care and Professionalism. She successfully fulfilled all requirements of her probation.

During her training, Dr. Rubino was under administrative investigation by the Texas Medical Board(TMB). The Residency program does not have any official notification from the TMB regarding the final status of the investigation.

Dr. Rubino's privileges and other professional activities have never been limited, restricted or denied in any way during her training, and she has never exhibited any impairment affecting skills or judgment. Dr. Rubino has always displayed good moral and ethical character.

Zubair Syed, MD
Program Director

FCVS Enclosure

5920 Forest Park Rd, Suite 651 /Dallas, Texas 75390-9165 / (214) 648-1399 fax (214) 353-0604

UT Southwestern
Medical Center

Department of Family and Community Medicine

April 19, 2018

DC Department of Health
Board of Medicine
899 North Capitol Street, NE, 1st Floor
Washington, DC 20002

RE: Jessica Rubino, MD

To Whom It May Concern:

Dr. Rubino was placed on probation from 5/24/2016 until 7/22/2016 for issues related to Patient Care and Professionalism. She successfully fulfilled all requirements of her probation.

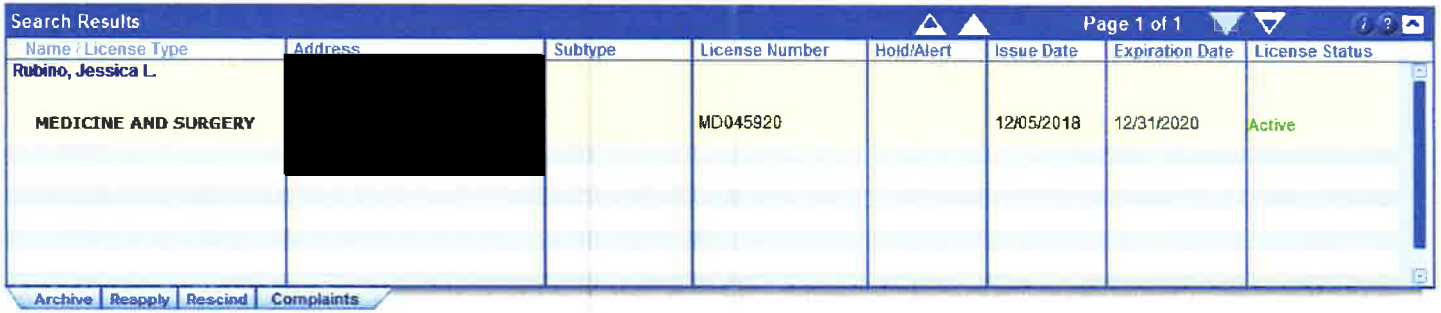
During her training, Dr. Rubino was under administrative investigation by the Texas Medical Board. The Residency program does not have any official notification from the TMB regarding the final status of the investigation.

Dr. Rubino's privileges and other professional activities have never been limited, restricted, or denied in any way during her training, and she has never exhibited any impairment affecting skills or judgement. Dr. Rubino has always displayed good moral and ethical character.

Sincerely,

Zubair Syed, MD
Program Director
UT Southwestern Family Medicine Residency Program

5920 Forest Park Rd., Suite 651 /Dallas, Texas 75390-9165 / (214) 648-1397 / fax (214) 353-0604

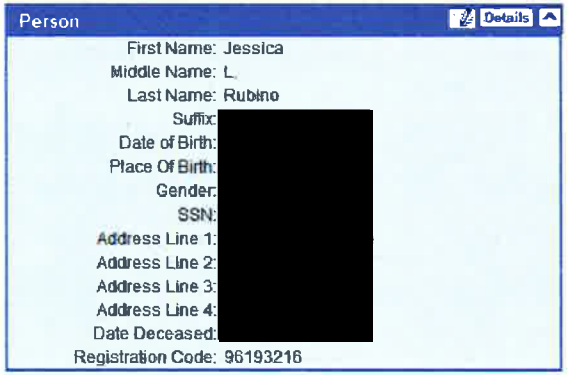


Search Results

Page 1 of 1

Name / License Type	Address	Subtype	License Number	Hold/Alert	Issue Date	Expiration Date	License Status
Rubino, Jessica L. MEDICINE AND SURGERY	[redacted]		MD045920		12/05/2018	12/31/2020	Active

Archive | Reapply | Rescind | Complaints



Person

Details

First Name: Jessica
Middle Name: L.
Last Name: Rubino
Suffix: [redacted]
Date of Birth:
Place Of Birth:
Gender:
SSN:
Address Line 1:
Address Line 2:
Address Line 3:
Address Line 4:
Date Deceased:
Registration Code: 96193216

License

Details

License Number: MD045920
License Type: MEDICINE AND SURGERY
Renewal Id:
Profession: MEDICINE
Sub Type:
Date This Status: 12/05/2018
Status: Active
Effective Date: 12/05/2018
Reason Changed: License Issuance
Expiration Date: 12/31/2020
Issue Date: 12/05/2018
from Country:
State/Prov:
Application Recd Date: 01/12/2018
Obtained By: Waiver of Examination
Reinstatment App Recd Date:
Date Last Renewal:
Disciplinary Limit Flag: N
Last Reprint Date:
Applicant Number: 326673

Facility

Details

Full Name: Jessica L. Rubino
PersonId: 282245
Owner/Manager:
Address Line1: [redacted]
Address Line2:
Address Line3:
Address Line4:

Practice Information

Details

In Active Practice Now?:
Practice in DC:
Active Practice in DC:
Hours per week?:

Alias

Details

Last Name	Date Changed	Alias Type Label
No Data		

Employers for License

Details

No Data

License Bond

Details

No Data

Specialties

Details

Authority Code Label	Is Primary	Issue Date	Expiration Date
Family Medicine - Board Certified	Y		

Employment

Details

No Data

Education

Details

School Name	School Type	Date Graduated	Degree Certificate
Southern Illinois University	College / University	07/27/2012	Doctorate

Requirements

Name	Status	Date
No Data		

CE Credits By Cycle

Current cycle		0.00	Not checked

Prerequisites

Details

Name	License Type	License Number	Status
No Data			

Schedules

Details

No Data

Inspection

No Data

CBC Override

Details

Date to Override:	Comments:
No Data	

Exam

Details

Exam Date	Exam State	Exam Type Label	Exam Score
No Data			

Inital/Renewal Question Answers

Details

Group Name	Group Response
No Data	

Person Photo ID

Criminal Background Check

Details

FBI Result	FBI Result Date	State Result	State Result Date
Negative	06/12/2018	Negative	06/15/2018

Person Or Facility Document

Details

Date Uploaded	Description	Category	Amendments
01/24/2018		Person	N
02/22/2018	FCVS	Person	N

ES-18-09-13 AA, CR, TS2	**JESSICA RUBINO, MD** **Specialties/Certifications:** Board Certified in Family Medicine. **Board Action:** To determine whether to license in view of answering "yes" to screening question #8. **Background:** Dr. Rubino answered "yes" to screening question #8, which asks: 1. **Question #8** – "Are you presently now, or have you ever been, under a corrective action plan imposed by an employer, medical facility or educational program?" Dr. Rubino reported that during her 3rd year of residency training at University of Texas Southwestern (UT Southwestern) in 2016, she was placed on probation for several weeks for failing to respond to a pager. The letter enclosed in the FCVS profile from UT Southwestern reported that Dr. Rubino's urine tested positive for cannabinoids. Dr. Rubino's employer Parkland Health and Hospital System referred Dr. Rubino to its Committee on Physician Peer Review and Assistance (COPPRA). The committee reported to Dr. Rubino's training program that she would be tested weekly and was not to report to the training program until she was cleared by COPPRA to resume training. Dr. Rubino was absent from the training program from 12/24/2014 to 02/18/2015. UT Southwestern reported that Dr. Rubino was under administrative investigation by the Texas Medical Board (TMB), and that the residency program did not receive any official notification from the TMB regarding the status of the investigation. Also, UT Southwestern reported that Dr. Rubino was on probation from 5/24/2016 to 7/22/2016 for issues related to patient care and professionalism. Dr. Rubino successfully fulfilled all requirements of her probation and completed the program on 8/24/16. Of note, information was requested from Dr. Rubino regarding the Texas Medical Board investigation, however she refused to provide	MH

	any such records. **CBC Report:** Federal – Negative State – Negative **Licensure Status:** Dr. Rubino currently holds unrestricted active medical licenses in Michigan and Texas. Dr. Rubino previously held a training license in Illinois; however, staff has only been able to informally verify licensure via Illinois' website, as the formal verification of licensure has not been received. **Motion:** Motion made by Mr. Smith to table the case until the information is obtained. Seconded by Dr. Iyengar. Dr. Wessel, Dr. Fripp, Dr. Wind, Dr. Strudwick, Mr. Smith, Dr. Iyengar, Dr. Smith, Mr. Dawson, Mr. Straub and Dr. Anderson voted in favor of the motion. The motion passed unanimously.	

MEETING MINUTES – OCTOBER 2018		
ES-18-10-24 ALL	**JESSICA RUBINO, MD** **Specialties/Certifications:** Board Certified in Family Medicine. **Board Action:** To determine whether to license in view of answering "yes" to screening question #8. The Board reviewed Dr. Rubino's application at the September 26, 2018 board meeting. As part of Dr. Rubino's application, she disclosed information regarding an investigation performed by the Texas Medical Board. When staff asked Dr. Rubino for clarification, she refused to provide such information. Following review at the September Board meeting, the matter was tabled and staff was directed to again request information from the applicant as well as follow up with the Texas Medical Board regarding the corrective action plan. The applicant has submitted a detailed explanation of the events	MH

leading to corrective action. The Texas Medical Board will not release any information regarding the matter.

Background:
Dr. Rubino answered "yes" to screening question #8, which asks:

1. **Question #8** – "Are you presently now, or have you ever been, under a corrective action plan imposed by an employer, medical facility or educational program?"

Dr. Rubino reported that during her 3rd year of residency training at University of Texas Southwestern (UT Southwestern) in 2016, she was placed on probation for several weeks for failing to respond to a pager.

The letter enclosed in the FCVS profile from UT Southwestern reported that Dr. Rubino's urine tested positive for cannabinoids. Dr. Rubino's employer Parkland Health and Hospital System referred Dr. Rubino to its Committee on Physician Peer Review and Assistance (COPPRA). The committee reported to Dr. Rubino's training program that she would be tested weekly and was not to report to the training program until she was cleared by COPPRA to resume training. Dr. Rubino was absent from the training program from 12/24/2014 to 02/18/2015.

UT Southwestern reported that Dr. Rubino was under administrative investigation by the Texas Medical Board (TMB), and that the residency program did not receive any official notification from the TMB regarding the status of the investigation. Also, UT Southwestern reported that Dr. Rubino was on probation from 5/24/2016 to 7/22/2016 for issues related to patient care and professionalism. Dr. Rubino successfully fulfilled all requirements of her probation and completed the program on 8/24/16.

Of note, information was requested from Dr. Rubino regarding the Texas Medical Board investigation, however she refused to provide any such records.

CBC Report:
Federal – Negative
State – Negative

Licensure Status:
Dr. Rubino currently holds unrestricted active medical licenses in

	Michigan and Texas. Dr. Rubino previously held a training license in Illinois; however, staff has only been able to informally verify licensure via Illinois' website, as the formal verification of licensure has not been received. **Motion:** Motion made by Dr. Wind to grant licensure with LOC re: need for transparency with licensing boards. Seconded by Dr. Wessel, Dr. Wind, Mr. Smith, Dr. Iyengar, Mr. Rich, Mr. Straub and Dr. Anderson voted in favor of the motion. Dr. Raczynski and Dr. Strudwick was absent. The motion passed.	