Uniform Application for Licensure

Application ID: 307252
FID: 300443934

License Requested: MD
License Type: Permanent Medical License
Submitted to: Kansas State Board of Healing Arts
Submission Date: 8/28/2020 12:07 PM

Practitioner Name

Shah, Mansi Rajendra

Contact Information

Address

Public Access	Board Contact	Type	Address
No	Yes	Home	CONFIDENTIAL
Yes	No	Business	751 S. Bascom ave San Jose San Jose, CA 95128 UNITED STATES

Phone

Public Access	Board Contact	Type	Phone Number	Phone Extension
Yes	No	Business	(408) 885-0000	
No	Yes	Mobile	CONFIDENTIAL	

Email

Public Access	Board Contact	Email
No	Yes	CONFIDENTIAL
Yes	No	mansi.shah@duke.edu

Identification

USMLE Number	SSN	Birth Date	Birth Place	Gender	NPI	Practitioner Type	US Citizen
53100194	CONFIDENTIAL		Los Gatos, CA UNITED STATES	F		MD	Yes

Medical School

Medical School Name	Address	Start Date	End Date	Graduation Date	Degree Code
Case Western Reserve University School of Medicine	Office of the Registrar, T-408 10900 Euclid Avenue Cleveland, OH 441064968 UNITED STATES	07/01/2012	05/15/2016	05/15/2016	MD

Fifth Pathway

None Reported

ECFMG

Certificate Number	Issue Date
None Reported	

Postgraduate Training

Hospital Name:	**Duke University Hospital Program** Durham, NC UNITED STATES	**Program Code:**	ACGME 1203621222
		Attendance Dates:	
Institution:	Duke University Hospital	**Start Date:**	06/24/2016
Training Specialty:	Family Medicine	**End Date:**	07/14/2019
		Program Type:	Internship/Residency
Training Status:	Completed		
Clinical %:	100	**Administrative %:**	0

Hospital Name:	**Santa Clara Valley Medical Center** San Jose, CA UNITED STATES	**Program Code:**	
		Attendance Dates:	
Institution:	Stanford University	**Start Date:**	08/01/2019
Training Specialty:	Family Practice Obstetrics	**End Date:**	07/31/2020
		Program Type:	Fellowship
Training Status:	Completed		
Clinical %:	100	**Administrative %:**	0

Examination History

Exam	State	Last Attempt	Pass/Fail	Number Of Attempts
USMLE Step 1 Examination		07/03/2014	Pass	1
USMLE Step 2 CK Examination		08/14/2015	Pass	1
USMLE Step 2 CS Examination		10/19/2015	Pass	1
USMLE Step 3 Examination		04/27/2017	Pass	1

State Licensure History

MD, DO, PA License History

License Entity	Licensing State	License Number	Issue Date	Expiration Date	License Type	License Status
North Carolina Medical Board	NC		05/06/2016	07/14/2019		Inactive
Medical Board of California	CA	A-161849	04/10/2019	04/30/2021	Full	Active
Washington Medical Commission	WA	MD61067297			Full	Pending

Physician Reported License History

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

Chronology of Activity Type

Practice/Emp/ Desc:	**Case Western Reserve University School of Medicine**		**Chronology Type:**	Medical Education	
	Address:	Cleveland, OH US	**Attendance Dates:**		
	Position/Dept:		**From:**	07/01/2012	to 05/15/2016
	Clinical %:				
	Admin %:				
	Employment:	**Staff Privileges:**	**Affiliation:**		

Practice/Emp/ Desc:	**Duke University Hospital Program**		**Chronology Type:**	Accredited Training	
	Address:	Durham, NC US	**Attendance Dates:**		
	Position/Dept:		**From:**	06/24/2016	to 07/14/2019
	Clinical %:	100			
	Admin %:	0			
	Employment:	**Staff Privileges:**	**Affiliation:**		

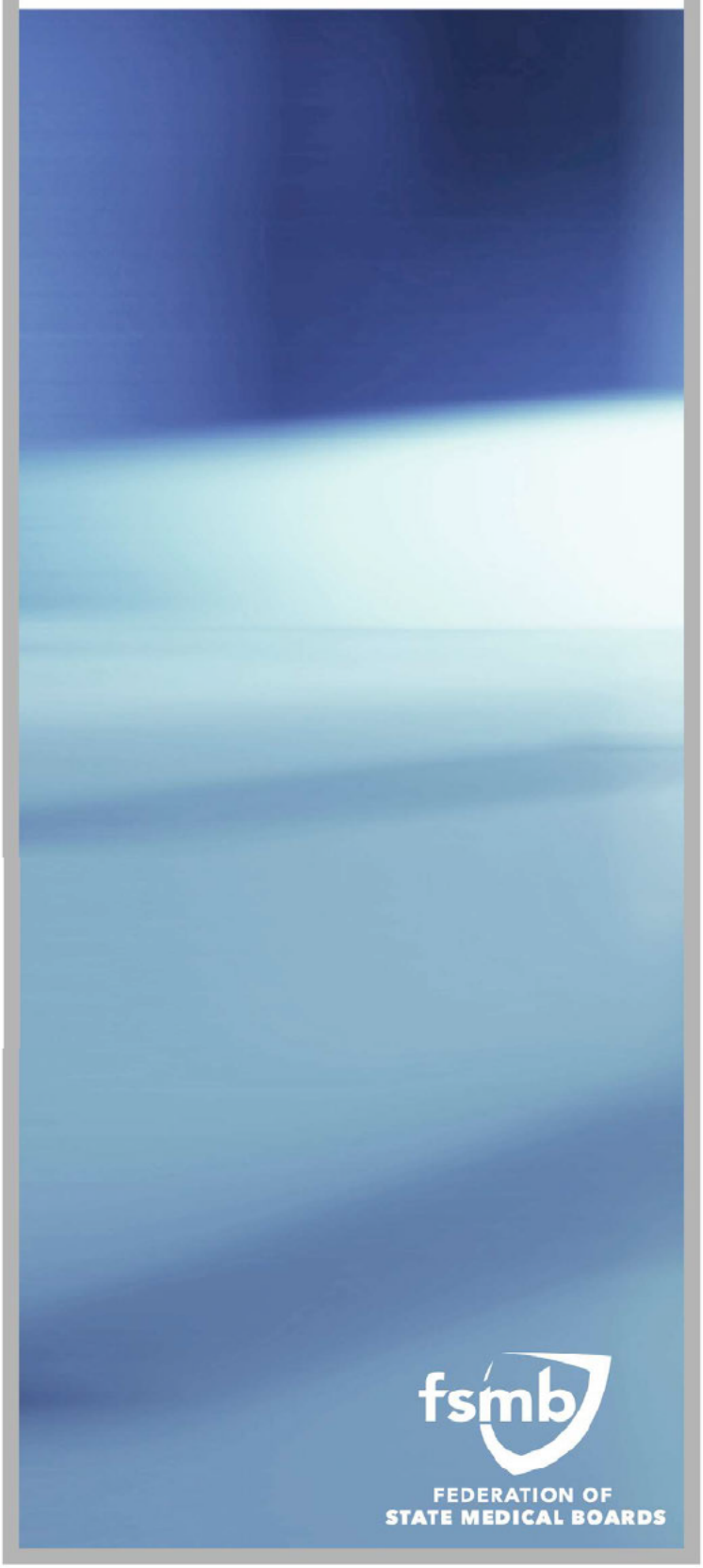
Practice/Emp/ Desc:	**Santa Clara Valley Medical Center**		**Chronology Type:**	Other Training	
	Address:	San Jose, CA US	**Attendance Dates:**		
	Position/Dept:		**From:**	08/01/2019	to 07/31/2020
	Clinical %:	100			
	Admin %:	0			
	Employment:	**Staff Privileges:**	**Affiliation:**		

Malpractice

None Reported

FCVS

FEDERATION CREDENTIALS VERIFICATION SERVICE



Medical Professional Information Profile

This report provides credentialing information for:

Name: **Shah, Mansi Rajendra**

Social Security Number: CONFIDENTIAL

Date of Birth:

FID#: **300443934**

Recipient: **KS - Kansas State Board of Healing Arts**

Delivery Date: **09/03/2020**

ABOUT THIS PROFILE

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

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

FCVS FEDERATION CREDENTIALS VERIFICATION SERVICE

Affidavit and Release

fsmb

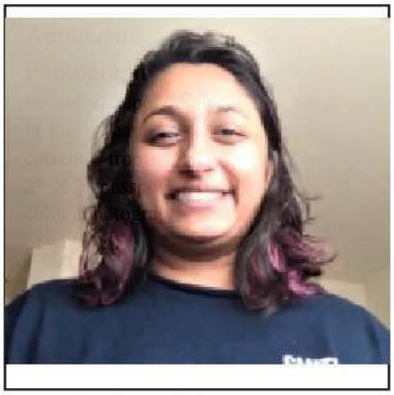
I, the undersigned, hereby certify under oath that I am the person named in this application, that all statements I have or shall make with respect thereto are true, that I am the original and lawful possessor and person named in the various forms and credentials furnished or to be furnished with respect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

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

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

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

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



Mansi Shah

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

Shah

Applicant's Printed Last Name

Mansi R.

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

07/27/2020

Date of Signature (must correspond to date of notarization)

MARIASOCORRO CHUA GARCIA
Electronic Notary Public
Commonwealth of Virginia
Registration No. 7616637
My Commission Expires Jun 30, 2024

State of Virginia, County of Fairfax,

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 27 day of July, 20 20.

Notary Public Signature:

My Notary Commission Expires: 06/30/2024

Notary Public for Fairfax County VA

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

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

FCVS ID Number

FID Number

FCVS FEDERATION CREDENTIALS VERIFICATION SERVICE

Identity

Biographic Information

Medical professional Name(s): **Shah, Mansi Rajendra**

Date of Birth: CONFIDENTIAL

Place of Birth: Los Gatos, California, UNITED STATES

Contact Information

Business Address: 751 S. Bascom ave
San Jose
San Jose, CA 95128
UNITED STATES

Home Address: CONFIDENTIAL

Mobile Phone:

Business Phone: (408) 885-0000

Email: CONFIDENTIAL

Email: mansi.shah@duke.edu

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: Shah (Last) Mansi (First) R (Middle)

FCVS ID Number: 300443934

Notary – Please complete the section below:

State of Virginia County of Fairfax

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

The statements on this document are subscribed and sworn to before me by the applicant on this (Day) 27, of (Month) July, (Year) 2020.

Notary Public Signature: _____

Commission Expiration Date* (Month) 06 / (Day) 30 / (Year) 2024

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

Notary Stamp Here

MARIASOCORRO CHUA GARCIA
Electronic Notary Public
Commonwealth of Virginia
Registration No. 7616637
My Commission Expires Jun 30, 2024

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

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

FCVS FEDERATION CREDENTIALS VERIFICATION SERVICE

Chronology of Activities

fsmb

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

Start Date	End Date	Activity Type	Location
07/01/2012	05/15/2016	Medical Education	Case Western Reserve University School of Medicine Cleveland Ohio UNITED STATES
06/24/2016	07/14/2019	Postgraduate Training	Duke University Hospital Program Durham North Carolina UNITED STATES
08/01/2019	07/31/2020	Postgraduate Training	Santa Clara Valley Medical Center San Jose California UNITED STATES

End of Chronology of Activities report for: Shah, Mansi Rajendra

FCVS FEDERATION CREDENTIALS VERIFICATION SERVICE

Medical Education

fsmb

Medical Education

Medical School: **Case Western Reserve University School of Medicine**

Location: Cleveland, OH

UNITED STATES

Credentials Analysis Information for Medical Education

There is no Omission/Discrepancy/Miscellaneous information identified.

FCVS FEDERATION CREDENTIALS VERIFICATION SERVICE

fsmb

Institution Name: Case Western Reserve University School of Medicine

City: Cleveland **State/Province:** Ohio **Country:** UNITED STATES

Premedical Education:

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

Credential/degree presented by the applicant for admission to your medical school: Bachelor's Degree

Enrollment and Participation:

Our records indicate that Shah, Mansi Rajendra

attended our medical school for a total of 180 weeks of medical education on the following dates: From MM/DD/YYYY: 07/11/2012 To MM/DD/YYYY: 05/15/2016

This individual was awarded the degree of Doctor of Medicine on 05/15/2016

DS KJ

Unusual circumstances

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

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

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

Other Explanation:

Medical School Code: 036010 FID:

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

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

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

Other Reason Explanation:

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

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

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

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

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

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

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

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

ELECTRONIC SEAL VERIFIED

Name: Kelsey Jorgensen

Title: Assistant Registrar

Signature: DocuSigned by: Kelsey Jorgensen 3703BFD49DAB489...

Date of Signature: 8/4/2020

Email: kjg23@case.edu

Medical School Code: 036010

FID:

CONFIDENTIAL

CONFIDENTIAL

CONFIDENTIAL

TRANSCRIPT KEY

ACCREDITATION

Case Western Reserve University is accredited at the institutional level by the Higher Learning Commission of the North Central Association of Colleges and Schools. In addition, many of its individual programs are accredited by nationally recognized professional associations. Additional information is available at http://bulletin.case.edu.

RELEASE OF INFORMATION

This educational record is subject to the Family Educational Rights and Privacy Act of 1974, as amended. It is released on the condition that the recipient will not permit any other party to have access to such information without the written consent of the student.

CALENDAR

The normal academic calendar is expressed in semester hours and consists of two semesters (Fall and Spring). There is also a summer term which may be either optional or required, depending on the student's academic program.

FIRST TIME FIRST YEAR UNDERGRADUATE STUDENTS

Effective Fall 1987, first time first year full-time undergraduate students are eligible during their first two semesters of enrollment to have courses with grades of F, NP or W suppressed from the transcript. Effective Fall 2006, only courses with a grade of W are eligible for transcript suppression.

ACADEMIC HONORS, ACADEMIC PROBATION, DISMISSAL/SEPARATION AND OTHER DESIGNATIONS

Each school within the University has specific academic policies for determining term honors, academic probation or academic dismissal/separation. Contact the University Registrar's office for further information.

TRANSCRIPT AUTHENTICITY

Official transcripts bear the printed University seal, the signature of the University Registrar, and are printed on blue security paper.

GRADING SYSTEM

Available grading options vary by school and/or program. For example, not all schools/programs offer the A+ grade. For more information about current and past grading for Case Western Reserve University schools, colleges and predecessors, please visit http://www.case.edu/registrar/grades/keys/.

As of Fall 2016, the following grading options are available subject to department/school policy:

Grade	Meaning	Quality Points
A+		4.333
A	Excellent	4.000
A-		3.666
B+		3.333
B	Good	3.000
B-		2.666
C+		2.333
C	Fair	2.000
C-		1.666
D+		1.333
D	Passing	1.000
D-		0.666
F	Failure	0.000
AD	Successful audit	n/a
AE	Achieves or exceeds competencies	n/a
AP	Advanced placement	n/a
AS	Advanced subsidiary	n/a
COM	Commendable	n/a
CR	Earns credit, credit/no credit course	n/a
H	Honors	n/a
I	Incomplete	n/a
IB	International baccalaureate	n/a
IP	In progress or extends > one term	n/a
M	Meets or exceeds expectations	n/a
NC	No credit, credit/no credit course	n/a
NG	Unsuccessful audit	n/a
NOG	Non-graded course	n/a
NP	No pass	n/a
P	Pass	n/a
PR	Proficiency	n/a
R	In progress or extends > one term	n/a
S	Satisfactory	n/a
SA	Special audit or alumni/senior audit	n/a
TR	Transfer	n/a
U	Unsatisfactory	n/a
W	Withdrawal from the class	n/a
WD	Withdrawal from all classes	n/a
WF	Withdrawn under Acad Regs 5 & 6	n/a

COURSE NUMBERING

100 – 199	Elementary Courses
200 – 299	Intermediate Courses
300 – 399	Advanced Undergraduate Courses
400 & up	Graduate Courses

The above numbering system does not apply to the School of Dental Medicine, School of Law, or Doctor of Medicine Program.

SCHOOL OF MEDICINE

GRADING SYSTEM

University Program: Core clerkships and clinical electives are graded H, COM, S, AE or U. Preclinical electives are graded P, NP, M or U though June 2009. Beginning July 2009 preclinical courses are graded AE or U.

College Program (Cleveland Clinic Lerner College of Medicine): All courses are graded M or U through June 2009. Beginning July 2009 all courses are graded AE or U. Competencies are used to assess performance and are described further at: http://www.case.edu/registrar/CCLCM_competencies.pdf

Physician Assistant Program: Non-clinical courses are letter graded. Clinical courses are graded H, COM, S or U.

Note: Cumulative Grade Point Average (GPA) is not applicable to the Doctor of Medicine Program.

COURSE NUMBERING (Doctor of Medicine Program only)

Series	Description
1000	1st year level courses
2000	2nd year level courses
3000	3rd year level courses
4000	4th year level courses
8000	Unlisted electives/Away elective
9000	Years 1 and 2 (preclinical, optional) electives
alpha suffix	Courses offered at area hospitals

QUESTIONS

Questions regarding transcripts may be directed to the University Registrar's Office, (216) 368-4310, registrar@case.edu. For more information, see http://www.case.edu/registrar.

SECURITY FEATURES:

Hologram	• Multi-dimensional foil seal fused to check stock. Cannot be photocopied.	**Microprinting**	• Small type in box surrounding this section appears as dotted line when copied.
Chemical Sensitive Paper	• Stains or discoloration on this document may indicate alteration attempt.	**True Watermark**	• Hold document to a light source to view. Cannot be copied.
Visible Fibers	• Visible fibers embedded in the paper.	**VOID Technology**	• When photocopied, the word "VOID" appears prominently across the face of the document.
Invisible Fibers	• Fibers in paper visible under ultraviolet light.		

The square on an origi transcript is printed thermochromic ink. Wh rubbed or breathed on will fade, then gradua return to normal.

DocuSign Envelope ID: A0354B8D-2FF5-4CDC-A6F4-4D04C45FC4A8

166A-E0E3-M4H5

This is a true certified copy of the original diploma issued to
Mansi Rajendra Shah
on May 15, 2016
Kelsey Jorgensen 3/25/2020
Kelsey Jorgensen, Assistant Registrar Date
CWRU School of Medicine
10900 Euclid Avenue
Cleveland, OH 44106-7507

Case Western Reserve University

On the recommendation of the Faculty of the

School of Medicine

The Trustees of the University have admitted

Mansi Rajendra Shah

to the Degree of

Doctor of Medicine

Given at Cleveland Ohio May fifteenth Two Thousand Sixteen

Barbara R Snyder
President

Pamela B. Davis
Dean

ELECTRONIC SEAL VERIFIED

DocuSign Envelope ID: A0354B8D-2FF5-4CDC-A6F4-4D04C45FC4A8

CeCredential TRUST™

CeDiploma: How it works

Independent Validation

To ensure the Degree information is still valid, we highly recommend you visit the School's official website to perform an additional validation.

Please visit **https://webapps.case.edu/registrar/cediploma/validate** to validate the CeDiploma.

Diploma Validation

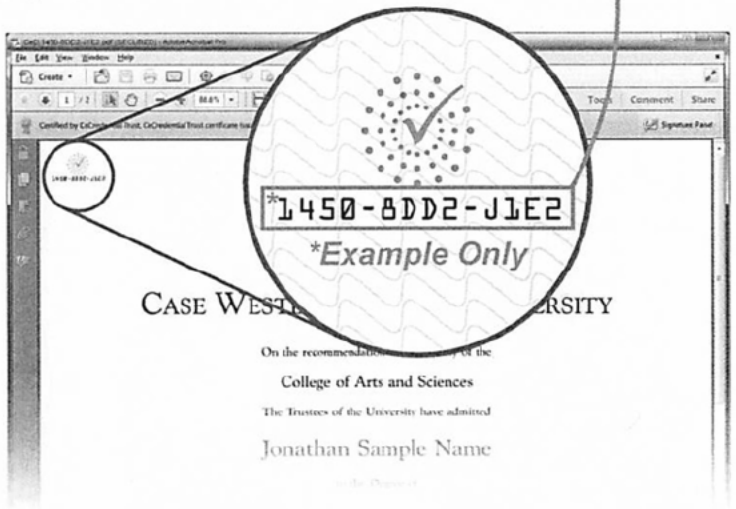
Please enter CeDiD (not case sensitive): *1450-8DD2-J1E2

Enter the first two letters of the name as it appears on the diploma: Jo

Submit

powered by CeCredential TRUST

The CeDiploma symbol and CeDiD are located on the upper left corner of the diploma.

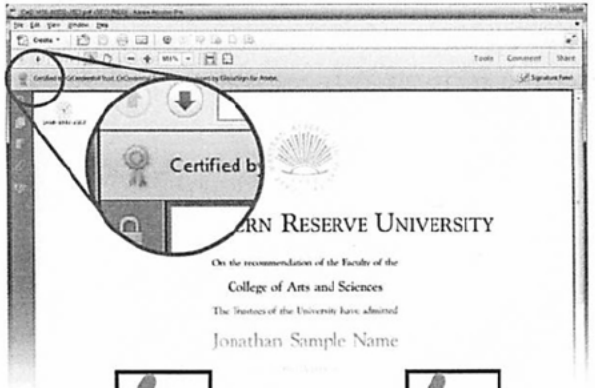


Digital Signature Explanation

Each CeDiploma will be certified by CeCredential Trust and should read as such.

A blue ribbon signifies that the document has not been tampered with.

Valid and certified!
Authenticity and Integrity are verified
TRUST



Error!
The author cannot be verified
DO NOT TRUST
CHECK INTERNET CONNECTIVITY

Error!
The document has been modified since it was signed
DO NOT TRUST

Note to Mac and Linux users: To view a CeDiploma, you must use Adobe Reader or Adobe Acrobat 7.0 or higher.

The digital signature may not display on Tablets or Mobile Phones and cannot be properly viewed with other PDF viewers.

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FCVS FEDERATION CREDENTIALS VERIFICATION SERVICE

Applicant Reported Unusual Circumstances

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Medical School

Medical Professional Name: Shah, Mansi Rajendra

Case Western Reserve 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: Shah, Mansi Rajendra

400 FULLER WISER ROAD | EULESS, TX 76039 | TEL (817) 868 - 5000 | FAX (817) 868 - 5099

Postgraduate Training

Accreditation ID: **1203621222**

Institution: **Duke University Hospital Program**

Location: Durham, NC
UNITED STATES

Accreditation ID: **None**

Institution: **Santa Clara Valley Medical Center**

Location: San Jose, CA
UNITED STATES

Credentials Analysis Information for Postgraduate Training

Issue:
The Verification of Post Graduate Training Form from Santa Clara Valley Medical Center dated 08/01/2019 to 07/31/2020 reported in the Chronology of Activities is not included in the Profile.

Solution:
FCVS does not obtain verification of non-accredited training programs.

Issue:
FCVS has identified a Post Graduate Training Discrepancy at Duke University Hospital Program, Department of Family Medicine.

Unusual Circumstances

Solution:
FCVS does not follow up with the Medical Professional or Institution with inconsistent information on Unusual Circumstance questions.

FCVS FEDERATION CREDENTIALS VERIFICATION SERVICE

fsmb

Verification of Postgraduate Medical Education

Accreditation Code: 1203621222

Institution Name: Duke University Hospital Program

Affiliated University: Duke University Hospital

City: Durham **State:** North Carolina **Country:** United States

Verification For: Mansi Rajendra Shah **Date of Birth:** CONFIDENTIAL

Program Participation:

PGY: 1	Accredited By: ACGME	Status: Complete
Specialty: Family Medicine		
From: 06/24/2016	To: 07/14/2017	Program Type: Internship/Residency

PGY: 2	Accredited By: ACGME	Status: Complete
Specialty: Family Medicine		
From: 07/15/2017	To: 07/14/2018	Program Type: Residency

PGY: 3	Accredited By: ACGME	Status: Complete
Specialty: Family Medicine		
From: 07/15/2018	To: 07/14/2019	Program Type: Residency

PGY: N/A	Accredited By: None of these	Status: Complete
Specialty: Family Medicine		
From:	To:	Program Type: Internship/Residency

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

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

FID:

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

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

Unusual Circumstances

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

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

ELECTRONIC SEAL VERIFIED	Name: Teri Pond Title: Program Coordinator Degree: None Signature: DocuSigned by: Teri Pond B2BDCEA8C57246A... Date of Signature: 7/28/2020

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

FID:

FCVS FEDERATION CREDENTIALS VERIFICATION SERVICE

Applicant Reported Unusual Circumstances

fsmb

Graduate Medical Education

Medical Professional Name:	Shah, Mansi Rajendra
Accreditation ID:	1203621222
Institution:	Duke University Hospital Program
Specialty:	Family Medicine

Unusual Circumstances

Training Period: 6/24/2016 - 7/14/2019 **Internship/Residency**

Did you have any interruption(s) or extension(s) in your medical education?	**Yes**
Dates: 05/2017 to 05/2017	
Medical leave for 2 weeks	
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: Shah, Mansi Rajendra

Duke University

Duke University Medical Center

This is to certify that

Mansi Rajendra Shah, M.D.

Has Completed Creditably Graduate Training
In the Duke University Medical Center
And Affiliate Hospitals

Department of Community and Family Medicine
Program of Family Medicine
6/24/2016 - 4/30/2017
5/15/2017 - 7/14/2019

Chancellor for Health Affairs

Chair of Department

DUKE UNIVERSITY MEDICAL CENTER

Director, Graduate Medical Education

Program Training Director

7/15/2019
Durham, North Carolina

Santa Clara Valley Medical Center

The County of Santa Clara, San Jose, California

Certifies That

Mansi Shah, M.D.

Has Faithfully Served as a Fellow in Obstetrics

August 1, 2019 through July 31, 2020

Having Discharged the Duties with Satisfaction and Credit to the Medical Center,
We do Hereby Grant this Certificate

Ingrid Bonz

Fellowship Director

Licensure / Examinations

Exam: USMLE

Credential Analysis Information for Licensure / Examinations

There is no Omission/Discrepancy/Miscellaneous information identified.

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

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

Date: 09/03/2020

Federation Credentials Verification Service
ATTN: FCVS

FCVSID: 562098

Examinee: Shah, Mansi Rajendra
Alt Name(s):

Examinee ID: 5-310-019-4
Date of Birth: CONFIDENTIAL

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

USMLE STEP 1

Test Date	Pass/Fail	Score	Minimum Pass	Comments
07/03/2014	Pass	CONFIDENTIAL		

USMLE STEP 2

Clinical Knowledge (CK)

Test Date	Pass/Fail	Comments
08/14/2015	Pass	

Clinical Skills (CS)

Test Date	Pass/Fail	Comments
10/19/2015	Pass	

USMLE STEP 3

Test Date	Pass/Fail	Comments
04/27/2017	Pass	

End of Exam History

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

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

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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

fsmb

PRACTITIONER PROFILE

Prepared for: FCVS As of Date:9/3/2020

PRACTITIONER INFORMATION

Name:	Shah, Mansi Rajendra
DOB:	CONFIDENTIAL
Medical School:	Case Western Reserve University School of Medicine Cleveland, Ohio, UNITED STATES
Year of Grad:	2016
Degree Type:	MD
NPI:	1831552306

BOARD ACTIONS

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

NATIONAL PROVIDER IDENTIFIER (NPI)

NPI	NPI Type	Deactivation Date	Reactivation Date	Last Reported
1831552306	Individual			06/04/2018

LICENSE HISTORY

Jurisdiction	License Number	Issue Date	Expiration Date	Last Updated
CALIFORNIA	A-161849	04/10/2019	04/30/2021	09/02/2020
NORTH CAROLINA		05/06/2016	07/14/2019	08/10/2020
WASHINGTON	MD61067297	08/24/2020	02/10/2021	08/31/2020

US DRUG ENFORCEMENT ADMINISTRATION (DEA)

DEA Number	Schedule	Address	Expiration Date	Last Reported
FS8745715	22N 33N 4 5	SAN JOSE,CA 95128	02/28/2022	06/12/2020

PDC PHYSICIAN DATA CENTER

fsmb

PRACTITIONER PROFILE

Prepared for:	FCVS	As of Date:9/3/2020
Practitioner Name:	Shah, Mansi Rajendra	

ABMS® CERTIFICATION HISTORY

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

Status	Duration	Effective Date	Expiration Date	Reverification Date	Occurrence	Last Reported
Active	MOC	07/15/2019		02/15/2021	Initial	08/27/2020

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

AOA® CERTIFICATION HISTORY

No AOA Certifications found.

FCVS FEDERATION CREDENTIALS VERIFICATION SERVICE

NPDB Report

SHAH, MANSI RAJENDRA **DCN: 5500000165252106**

FOR AUTHORIZED USE BY: Kansas State Board of Healing Arts **Continuous Query ID: 300000009588562**

Process Date: 9/3/2020

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

SHAH, MANSI RAJENDRA - CONTINUOUS QUERY RESPONSE

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

Practitioner Name:	SHAH, MANSI RAJENDRA
Date of Birth:	CONFIDENTIAL
Gender:	FEMALE
Work Address:	751 S. BASCOM AVE SAN JOSE, CA 95128
Home Address:	CONFIDENTIAL
Social Security Numbers (SSN):	
National Provider Identifiers (NPI):	1831552306
Drug Enforcement Administration (DEA) Numbers:	FS8745715
License(s):	Physician (MD), NO LICENSE, NC Physician (MD), A-161849, CA Physician (MD), MD61067297, WA
Professional School(s):	CASE WESTERN RESERVE UNIVERSITY SCHOOL OF MEDICINE (2016)
Subject ID:	300443934

B. CONTINUOUS QUERY ENROLLMENT INFORMATION

Enrollment Status:	Enrolled - 9/3/2020 - 9/30/2021* * Unless enrollment is canceled by the entity prior to this date
Statutes Queried:	Section 1921, Section 1128E, Title IV
Entity Name:	Kansas State Board of Healing Arts
Authorized Agent:	Federation of State Medical Boards, (817) 868 - 4000
Customer Use:	300443934

C. SUMMARY OF REPORTS ON FILE WITH THE DATA BANK AS OF 9/3/2020

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

CONFIDENTIAL DOCUMENT - FOR AUTHORIZED USE ONLY

SHAH, MANSI RAJENDRA **DCN: 5500000165252106**

FOR AUTHORIZED USE BY: Kansas State Board of Healing Arts **Continuous Query ID: 300000009588562**

Government Administrative Action(s):	No Reports	Judgment or Conviction Report(s):	No Reports
Clinical Privileges Action(s):	No Reports	Peer Review Organization Action(s):	No Reports

UA UNIFORM APPLICATION FOR PHYSICIAN STATE LICENSURE

Postgraduate Training Verification (UA Form #3)

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

Applicant:

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

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

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

Copy this form for multiple training programs.

Section 1: Applicant Information

Last name: Shah Suffix: _____

First name: Mansi

Middle name: Rajendra

Name if different when diploma awarded: _____

Name of postgraduate training program: Santa Clara Valley Medical Center

Date of birth: CONFIDENTIAL Social Security number*: CONFIDENTIAL

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

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

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

Applicant signature: Mansi Shah **Date:** 9/23/2020

Dean or Designated Official:

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

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

Make copies and attach additional pages if necessary.

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

Section 2: Postgraduate Training Verification

Institution name: Santa Clara Valley Medical Center

Institution address: 751 S. Bascom Ave

Institution city / state or province / zip code: San Jose, CA 95129

Affiliated medical school name: Stanford School of Medicine

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

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

☐ Research ☐ Chief Residency ☐ Other: _____

Specialty/Subspecialty: Family Practice Obstetrics

Attendance dates: From 8/1/2019 to 7/31/2020

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

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

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

RECEIVED
By Colleen Krallman at 8:38 am, Sep 28, 2020

Applicant Name: Mansi R. Shah

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

Specialty/Subspecialty: _____

Attendance dates: From _____ to _____

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

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

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

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

Specialty/Subspecialty: _____

Attendance dates: From _____ to _____

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

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

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

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

Unusual Circumstances

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

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

Signature: [signature]
Print name: Ingrid Bossen
Title: MD OBGyn Fellowship Dir.
Date: 9/24/20
Phone number: 408-885-5550 Fax number: 408-885-3609
Email: ingrid.bossen@hhs.sccgov.org

AFFIX INSTITUTIONAL SEAL HERE

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

Seal Verified KSBHA

From: Bossen, Ingrid
To: Krallman, Colleen [KSBHA]
Subject: UNIFORM APPLICATION
Date: Thursday, September 24, 2020 2:14:04 PM
Attachments: UNIFORM APPLICATION.pdf
ATT00001.txt

UA UNIFORM APPLICATION FOR PHYSICIAN STATE LICENSURE

RECEIVED
SEP 14 2020
KSBHA

Affidavit and Authorization for Release of Information

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

Applicant:

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

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

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

Send this notarized affidavit to:

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

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

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

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

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

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

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

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

Shah
Applicant's printed last name

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

8/31/20
Date of signature (must correspond to date of notarization)

-fold up- -fold up-

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

(see next page) **Notary**

State of _____, County of _____,

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 _____ day of _____, 20____.

Notary Public Signature: _____

(NOTARY PUBLIC SEAL)

My Notary Commission Expires: _____

ACKNOWLEDGMENT

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

State of California
County of SANTA CLARA)

On 08/31/2020 before me, R. C. SINGH, NOTARY PUBLIC
(insert name and title of the officer)

personally appeared MANSI RAJENDRA SHAH,
who proved to me on the basis of satisfactory evidence to be the person(s) whose name(s) is/are subscribed to the within instrument and acknowledged to me that he/she/they executed the same in his/her/their authorized capacity(ies), and that by his/her/their signature(s) on the instrument the person(s), or the entity upon behalf of which the person(s) acted, executed the instrument.

I certify under PENALTY OF PERJURY under the laws of the State of California that the foregoing paragraph is true and correct.

WITNESS my hand and official seal.

Seal Verified KSBHA

R. C. SINGH
Notary Public - California
Santa Clara County
Commission # 2306779
My Comm. Expires Oct 21, 2023

Signature _____ (Seal)

ADDENDUM 1
KANSAS STATE BOARD OF HEALING ARTS

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

☒ Medicine & Surgery ☐ Osteopathic Medicine & Surgery

☒ Active

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

☐ Federal Active

A license issued to only a person who meets all the requirements for a license to practice the healing arts in Kansas and who practiced that branch of the healing arts solely in the course of employment or active duty in the United States government or any of its departments, bureaus or agencies or who, in addition to such employment or assignment, provides professional services as a charitable health care provider as defined under K.S.A. 75-6102. Continuing education, expiration and renewal of a license shall be applicable to a federally active license. A person who practices under a federally active license shall not be deemed to be rendering professional service as a health care provider in this state and is not required to have policy of professional liability coverage in effect.

☐ Inactive

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

☐ Exempt

A license issued to a person who is not regularly engaged in the practice of the healing arts or podiatry in Kansas and who does not hold oneself out to the public as being professionally engaged in such practice. Each exempt license may be renewed annually. The holder of an exempt license is entitled to all the privileges of their branch of the healing arts and (1) may serve as a coroner or as a paid employee of a local health department as defined by K.S.A. 65-241; or (2) practice as a charitable health care provider for an indigent health care clinic as defined by K.S.A. 75-6102. Additionally, the holder of an exempt license may perform administrative functions. The holder of an exempt license shall not be required to submit evidence of satisfactory completion of a program of continuing education nor are they required to have basic coverage or self-insurance in effect.

List intended professional activities: _____

Additional Information:

1. Have you ever been licensed to practice the Healing Arts in Kansas? ☐ Yes ☒ No
2. Give location of intended practice in Kansas Wichita, Overland Park
3. Primary Specialty Family Medicine

   American Board Certified X American Board Eligible _____

ADDENDUM 2
KANSAS STATE BOARD OF HEALING ARTS

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

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

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

2. Have you ever had any application for any professional license refused or denied by any licensing authority? Yes ☐ No ☒

3. Have you ever been refused or denied the privilege of taking an examination required for any professional licensure? Yes ☐ No ☒

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4. Have you ever been warned, censured, disciplined, had admissions monitored, had privileges limited, suspended, revoked or placed on probation, or have you ever involuntarily or voluntarily (to avoid disciplinary action or investigation) resigned or withdrawn from any licensed hospital, nursing home, clinic or other health care facility in which you have trained, including but not limited to residency or postgraduate training programs, or otherwise been a staff member, been a partner or held privileges?

5. Have you ever been denied staff membership with any licensed hospital, nursing home, clinic or other health care facility?

6. Have you ever been requested to resign, withdraw or otherwise terminate your position with a partnership, professional association, corporation or other practice organization, either public or private?

7. Have you ever voluntarily surrendered any professional license? Yes ☐ No ☒

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

9. Have you ever been notified or requested to appear before a licensing or disciplinary agency? Yes ☐ No ☒

10. To your knowledge, have any complaints (regardless of status) ever been filed against you with any licensing agency, professional association, hospital, nursing home, clinic or other health care facility? Yes ☐ No ☒

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

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

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

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

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

16. Have you ever been arrested? Do not include minor traffic or parking violations or citations except those related to a DUI, DWI or a similar charge. You must include all arrests including those that have been set aside, dismissed or expunged or where a stay of execution has been issued. Yes ☐ No ☒

17. Have you ever been charged with a crime, indicted, convicted of a crime, imprisoned, or placed on probation (a crime includes both Class A misdemeanors and felonies)? You must include all convictions including those that have been set aside, dismissed or expunged or where a stay of execution has been issued. Yes ☐ No ☒

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

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

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

21. Have you ever been terminated, sanctioned, penalized, or had to repay money to any State Medicaid or Federal Medicaid Programs or private insurance company? Yes ☐ No ☒

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

ADDENDUM 3

Kansas State Board of Healing Arts

800 SW Jackson, Lower Level, Suite A
Topeka, Kansas 66612

Recommendations from Two Reputable Physicians

The KSBHA requires two (2) recommendations from licensed physicians. Persons attesting to the good character of the applicant are attesting to the fact that they have known the applicant for at least one (1) year.

CONFIDENTIAL

Name of Applicant (Printed or Typed): Mansi Rajendra Shah **Date of Birth:**

Please mail this document to the Kansas State Board of Healing Arts at the address above. Thank you. DO NOT RETURN TO APPLICANT.

This is to certify that I have known Dr. Shah (type or print) for 13 years; that he/she is a capable physician and is not addicted to alcohol or drugs.

I further certify that to the best of my knowledge and belief Dr. Shah is a fit and proper person for endorsement for license by the Kansas State Board of Healing Arts.

(Please type or print)

Name: Juhi Goswami

Profession: Please select one: MD ☑ DO ☐

CONFIDENTIAL

Street 1:

Street 2:

State/Zip:

Telephone:

Signature:

Date: 8/25/20

ADDENDUM 3

Kansas State Board of Healing Arts

800 SW Jackson, Lower Level, Suite A
Topeka, Kansas 66612

Recommendations from Two Reputable Physicians

The KSBHA requires two (2) recommendations from licensed physicians. Persons attesting to the good character of the applicant are attesting to the fact that they have known the applicant for at least one (1) year.

CONFIDENTIAL

Name of Applicant (Printed or Typed): Mansi Rajendra Shah **Date of Birth:** _____

Please mail this document to the Kansas State Board of Healing Arts at the address above. Thank you. DO NOT RETURN TO APPLICANT.

This is to certify that I have known Dr. Shah (type or print) for 17 years; that he/she is a capable physician and is not addicted to alcohol or drugs.

I further certify that to the best of my knowledge and belief Dr. Shah is a fit and proper person for endorsement for license by the Kansas State Board of Healing Arts.

(Please type or print)

Name: Aline Zorian

Profession: Please select one: MD [X] DO [ ]

CONFIDENTIAL

Street 1: _____

Street 2: _____

State/Zip: _____

Telephone: _____

Signature: _____

Date: 8/28/20

WAIVER AGREEMENT
AND
FBI PRIVACY ACT STATEMENT (Cont.)

Fingerprint-Based Record Checks for Noncriminal Justice Purposes

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

I have ☐ ***OR*** have not ☒ been convicted of a crime.

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

Under penalty of perjury, I hereby declare that I am the person described below and understand that any falsification of this statement constitutes a severity level 9, nonperson felony under the provisions of Title 21 Kansas Statutes Annotated, Section 5903.

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

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

Signature: [signature] Date: 8/31/20

Printed Name: Marsi R. Shah Date of Birth: CONFIDENTIAL

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Residential Address: City: State: Zip:

TO BE COMPLETED BY THE FINGERPRINTING AGENCY:

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

State/Branch: California ID Number: CONFIDENTIAL

Agency Name: The UPS Store #0180

Address: 1030 E El Camino Real, Sunnyvale, CA 94087

Telephone: 408-245-1600 Fax: 408-245-2135

Name of Individual Verifying Identity: Seung Eun Yu

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

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AMA Physician Profile

Name and Mailing Address

MANSI RAJENDRA SHAH
DUKE UNIV MED CTR
DEPT OF COMMUNITY & FAMILY MEDICINE
BOX 3886
DURHAM, NC 27710-0001

Primary Office Address

SAME AS MAILING ADDRESS

Phone (859) 323-5057

Birth date CONFIDENTIAL

Physician's major professional activity OFFICE BASED PRACTICE

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

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

AMA membership status NON MEMBER

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

Current and/or historical NPI information

National Provider Identifier (NPI)	Enumeration Date	Deactivation Date	Reactivation Date	Replacement Number	Last Reported Date
1831552306	04/01/2016	NOT RPTD	NOT RPTD	NOT RPTD	08/21/2020

Current and/or historical medical school

CASE WESTERN RESERVE UNIVERSITY SCHOOL OF MEDICINE

Degree Awarded: YES
Degree Year: 2016

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: DUKE UNIVERSITY HOSPITAL
Sponsoring State: NORTH CAROLINA
Program name: DUKE UNIVERSITY HOSPITAL PROGRAM
Specialty: FAMILY MEDICINE
Training Type: SPECIALTY
Dates: 6/2016 - 6/2019 (Verified)

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	07/15/2019	n/a	02/15/2021	INITIAL	03/19/2020	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

License No.	MD / DO	Jurisdiction	Date Granted	Expiration Date	Renewal Date	Status	License Type	Last Reported
A00161849	MD	CA	04/10/2019	04/30/2021		ACTIVE	UNLTD	08/05/2020

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
XXXXXX715	22N 33N 4 5	02/28/2022	08/14/2020	Santa Clara County 751 S Bascom Ave San Jose, CA 95128-2604

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.

From: Scott Maccio
To: KSBHA_Licensing
Subject: [Not Virus Scanned] AMA Profile Reports
Date: Monday, August 31, 2020 5:05:05 PM
Attachments: image001.png
image002.png
image003.png
image004.png
image005.png
image006.png
licenseBoardBatch 08-31-20 KS.pdf

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- Mansi Shah

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Scott Maccio
Credentialing Products Support Coordinator
scott.maccio@ama-assn.org

ACORD®

CERTIFICATE OF LIABILITY INSURANCE

DATE (MM/DD/YYYY)

THIS CERTIFICATE IS ISSUED AS A MATTER OF INFORMATION ONLY AND CONFERS NO RIGHTS UPON THE CERTIFICATE HOLDER. THIS CERTIFICATE DOES NOT AFFIRMATIVELY OR NEGATIVELY AMEND, EXTEND OR ALTER THE COVERAGE AFFORDED BY THE POLICIES BELOW. THIS CERTIFICATE OF INSURANCE DOES NOT CONSTITUTE A CONTRACT BETWEEN THE ISSUING INSURER(S), AUTHORIZED REPRESENTATIVE OR PRODUCER, AND THE CERTIFICATE HOLDER.

IMPORTANT: If the certificate holder is an ADDITIONAL INSURED, the policy(ies) must have ADDITIONAL INSURED provisions or be endorsed. If SUBROGATION IS WAIVED, subject to the terms and conditions of the policy, certain policies may require an endorsement. A statement on this certificate does not confer rights to the certificate holder in lieu of such endorsement(s).

PRODUCER	CONTACT NAME:	
Direct Placement by AFFILIATES INSURANCE RECIPROCAL, A RRG 30 MAIN STREET, SUITE 330 BURLINGTON, VT 05401	PHONE (A/C, No, Ext):	FAX (A/C, No):
	E-MAIL ADDRESS:	

INSURER(S) AFFORDING COVERAGE	NAIC #
INSURER A : AFFILIATES INSURANCE RECIPROCAL, A RISK RETENTION GROUP	13677
INSURER B :	
INSURER C :	
INSURER D :	
INSURER E :	
INSURER F :	

INSURED
PLANNED PARENTHOOD GREAT PLAINS
AN AFFILIATE OF PLANNED PARENTHOOD
FEDERATION OF AMERICA, INC.
4401 W 109TH STREET, #200
OVERLAND PARK, KANSAS 66211

COVERAGES **CERTIFICATE NUMBER:** **REVISION NUMBER:**

THIS IS TO CERTIFY THAT THE POLICIES OF INSURANCE LISTED BELOW HAVE BEEN ISSUED TO THE INSURED NAMED ABOVE FOR THE POLICY PERIOD INDICATED. NOTWITHSTANDING ANY REQUIREMENT, TERM OR CONDITION OF ANY CONTRACT OR OTHER DOCUMENT WITH RESPECT TO WHICH THIS CERTIFICATE MAY BE ISSUED OR MAY PERTAIN, THE INSURANCE AFFORDED BY THE POLICIES DESCRIBED HEREIN IS SUBJECT TO ALL THE TERMS, EXCLUSIONS AND CONDITIONS OF SUCH POLICIES. LIMITS SHOWN MAY HAVE BEEN REDUCED BY PAID CLAIMS.

INSR LTR	TYPE OF INSURANCE	ADDL INSD	SUBR WVD	POLICY NUMBER	POLICY EFF (MM/DD/YYYY)	POLICY EXP (MM/DD/YYYY)	LIMITS	
	COMMERCIAL GENERAL LIABILITY						EACH OCCURRENCE	$
	☐ CLAIMS-MADE ☐ OCCUR						DAMAGE TO RENTED PREMISES (Ea occurrence)	$
							MED EXP (Any one person)	$
							PERSONAL & ADV INJURY	$
	GEN'L AGGREGATE LIMIT APPLIES PER:						GENERAL AGGREGATE	$
	☐ POLICY ☐ PRO-JECT ☐ LOC						PRODUCTS - COMP/OP AGG	$
	☐ OTHER:							$
	AUTOMOBILE LIABILITY						COMBINED SINGLE LIMIT (Ea accident)	$
	☐ ANY AUTO						BODILY INJURY (Per person)	$
	☐ OWNED AUTOS ONLY ☐ SCHEDULED AUTOS						BODILY INJURY (Per accident)	$
	☐ HIRED AUTOS ONLY ☐ NON-OWNED AUTOS ONLY						PROPERTY DAMAGE (Per accident)	$
								$
	☐ UMBRELLA LIAB ☐ OCCUR						EACH OCCURRENCE	$
	☐ EXCESS LIAB ☐ CLAIMS-MADE						AGGREGATE	$
	☐ DED ☐ RETENTION $							$
	WORKERS COMPENSATION AND EMPLOYERS' LIABILITY Y / N ANY PROPRIETOR/PARTNER/EXECUTIVE OFFICER/MEMBER EXCLUDED? ☐ (Mandatory in NH) If yes, describe under DESCRIPTION OF OPERATIONS below	N / A					☐ PER STATUTE ☐ OTH-ER	
							E.L. EACH ACCIDENT	$
							E.L. DISEASE - EA EMPLOYEE	$
							E.L. DISEASE - POLICY LIMIT	$
	HEALTHCARE PROFESSIONAL LIABILITY CLAIMS-MADE COVERAGE			CONFIDENTIAL 'PROGRAM RETRO DATE PER INSURED'	5/1/2020	1/1/2021	PER CLAIM AGGREGATE	$1,000,000 $3,000,000

DESCRIPTION OF OPERATIONS / LOCATIONS / VEHICLES

MANSI SHAH IS AN INSURED UNDER THE ABOVE REFERNECED POLICY.

NOTICE : This policy is issued by your risk retention group. Your risk retention group may not be subject to all of the insurance laws and regulations of your state. State insurance insolvency guaranty funds are not available for your risk retention group.

CERTIFICATE HOLDER

MANSI SHAH
C/O PLANNED PARENTHOOD
GREAT PLAINS
4401 W 109TH STREET, #100
OVERLAND PARK, KANSAS 66211

CANCELLATION

SHOULD ANY OF THE ABOVE DESCRIBED POLICIES BE CANCELLED BEFORE THE EXPIRATION DATE THEREOF, NOTICE WILL BE DELIVERED IN ACCORDANCE WITH THE POLICY PROVISIONS.

AUTHORIZED REPRESENTATIVE David a. White.

From: Maida, Tabatha
To: Krallman, Colleen [KSBHA]
Subject: RE: Shah - Letter of Intent
Date: Monday, October 19, 2020 9:16:52 AM
Attachments: Mansi Shah.pdf

Hi Colleen,

Here is the cert of insurance for Dr. Shah.

Thanks,
Tabatha Maida (she/hers)
Health Services Coordinator
Planned Parenthood Great Plains (PPGP)
P: 501-500-8807
C: 845-699-8718
E: tabatha.maida@ppgreatplains.org

From: Krallman, Colleen [KSBHA] <Colleen.Krallman@ks.gov>
Sent: Tuesday, October 6, 2020 8:53 AM
To: Maida, Tabatha <Tabatha.Maida@ppgreatplains.org>
Subject: RE: Shah - Letter of Intent

That is fine. Just send it over to me when you are able and I will let them know it has been updated.

Sorry for the inconvenience.

Thank you,
Colleen Krallman
Licensing Analyst

KAMMCO

On Behalf of Kansas Health Care
Provider Insurance Availability Plan

LETTER OF INTENT

October 19, 2020

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

RE: Mansi R. Shah, MD

TO WHOM IT MAY CONCERN:

Pending confirmation by the Kansas Health Care Provider Insurance Availability Plan (Plan) from the Kansas Board of Healing Arts (the Board) that Dr. Shah has been approved for an active Kansas license, the Plan will provide claims-made coverage effective as soon as possible, with limits of $200,000 per claim/$600,000 annual aggregate. This will also confirm that in addition to coverage with the Plan, Dr. Shah has selected $800,000 per claim/$2,400,000 annual aggregate limits with the Health Care Stabilization Fund.

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

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

Sincerely,

Sara Patry
Underwriter

From: Sara Patry
To: KSBHA_Licensing
Subject: Mansi R. Shah, MD - letter of intent attached
Date: Monday, October 19, 2020 11:56:50 AM
Attachments: email_sig_logo_d4c91e27-d020-445b-89c5-d4940b79eb4911.png
Mansi R. Shah, MD - letter of intent.pdf

Good afternoon –

Please find attached the Plan's letter of intent on Dr. Mansi R. Shah, MD.

If you have any questions, please let me know.

Thanks,

KAMMCO

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

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

RECEIPT NUMBER: 638015 DATE: 09/14/2020

NAME:	LICENSE TYPE:	FEE:	LIC #:
MANSI SHAH	MD	APP $300 KBI $47	9.14.2020

AMOUNT: 347.00 TYPE: Check CH/CC #: 577

RECEIVED FROM:

Mansi Rajendra Shah

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