Kansas

EXPEDITED LICENSURE QUESTIONNAIRE

To determine if you are eligible for expedited licensure pursuant to K.S.A. 48-3406[i], please answer the following questions. If it is determined that your responses were intentionally false or misleading, you will be subject to an administrative disciplinary action in Kansas and will be reported to all appropriate state/ federal/military/law enforcement agencies.

1. Are you a current member of any branch of the United States armed services, United States military reserves, national guard of any state, or a former member with an honorable discharge? Yes ☐ No ☑ If yes:

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

2. Are you the spouse of a current member of any branch of the United States armed services, United States military reserves, national guard of any state, or a former member with an honorable discharge? Yes☐ No☑ If yes:

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

3. Do you currently reside in Kansas? Yes☐ No☑ If yes:

   Current Kansas Residence Address:________________________________

4. Do you intend* to establish residency in Kansas within the next 6 months? ***If you answer "yes" to this question but do not establish Kansas residency within the next 6 months, your Kansas license will be cancelled. If it is determined that your answer to this question was intentionally false or misleading, you will be subject to an administrative disciplinary action in KS and will be reported to all appropriate state/federal/military agencies in other jurisdictions.*** Yes ☐ No ☑ If yes:

   Intended Kansas Residence Address:________________________________

   Expected Date of Commencing Residence:__________

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

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

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

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

Organization that issued private certification/registration:________________ Date Issued:__________

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9/9/2021 KSBHA

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

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

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

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

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

Uniform Application for Licensure

Application ID: 350717
FID: 213020910

License Requested: MD
License Type: Permanent Medical License
Submitted to: Kansas State Board of Healing Arts
Submission Date: 4/25/2022 1:41 PM

Practitioner Name

Steinauer, Jody Ellen

Contact Information

Address

Public Access	Board Contact	Type	Address
No	Yes	Home	CONFIDENTIAL
Yes	No	Business	Ward 6D-14 1001 Potrero Ave. San Francisco, CA 94110 UNITED STATES

Phone

Public Access	Board Contact	Type	Phone Number	Phone Extension
Yes	No	Business	(628) 206-8358	
No	Yes	Mobile	CONFIDENTIAL	

Email

Public Access	Board Contact	Email
Yes	Yes	jody.steinauer@ucsf.edu

Identification

USMLE Number	SSN	Birth Date	Birth Place	Gender	NPI	Practitioner Type	US Citizen
	CONFIDENTIAL		Omaha, Nebraska UNITED STATES	F	1700839636	MD	Yes

Medical School

Medical School Name	Address	Start Date	End Date	Graduation Date	Degree Code
University of California, San Francisco, School of Medicine	513 Parnassus Avenue Room S-224 San Francisco, CA 941430410 UNITED STATES	08/01/1992	06/08/1997	06/08/1997	MD

Fifth Pathway

None Reported

ECFMG

Certificate Number	Issue Date
None Reported	

Postgraduate Training

Hospital Name:	**University of California** San Francisco, CA UNITED STATES	**Program Code:**	
		Attendance Dates:	
Institution:		**Start Date:**	07/01/2001
Training Specialty:	Complex Family Planning	**End Date:**	06/30/2003
		Program Type:	Fellowship
Training Status:	Completed		
Clinical %:	100	**Administrative %:**	0

Hospital Name:	**University of California (San Francisco) Program** San Francisco, CA UNITED STATES	**Program Code:**	ACGME 2200521047
		Attendance Dates:	
Institution:	University of California (San Francisco) School of Medicine	**Start Date:**	06/09/1997
Training Specialty:	Obstetrics & Gynecology	**End Date:**	06/30/2001
		Program Type:	Internship/Residency
Training Status:	Completed		
Clinical %:	100	**Administrative %:**	0

Examination History

Exam	State	Last Attempt	Pass/Fail	Number Of Attempts
USMLE Step 1 Examination		06/08/1994	Pass	1
USMLE Step 2 CK Examination		03/04/1997	Pass	1
USMLE Step 3 Examination		05/12/1998	Pass	1

State Licensure History

MD, DO, PA License History

License Entity	Licensing State	License Number	Issue Date	Expiration Date	License Type	License Status
Oklahoma State Board of Medical Licensure & Supervision	OK	38815	12/27/2021	12/01/2022	Full	Active
Medical Board of California	CA	A-67843	03/19/1999	08/31/2022	Full	Active

Physician Reported License History

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

Chronology of Activity Type

Practice/Emp/ Desc: University of California, San Francisco, School of Medicine

Chronology Type: Medical Education

Address: San Francisco, CA
US

Attendance Dates:

Position/Dept:

From: 08/01/1992 to 06/08/1997

Clinical %:

Admin %:

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

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

Chronology Type: Accredited Training

Address: San Francisco, CA
US

Attendance Dates:

Position/Dept:

From: 06/09/1997 to 06/30/2001

Clinical %: 100

Admin %: 0

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

Practice/Emp/ Desc: University of California

Chronology Type: Other Training

Address: San Francisco, CA
US

Attendance Dates:

Position/Dept:

From: 07/01/2001 to 06/30/2003

Clinical %: 100

Admin %: 0

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

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

Chronology Type: Work

Address: Ward 6D-14
1001 Potrero Ave.
San Francsico, CA 94110
US

Attendance Dates:

Position/Dept: Proessor - Obstetrics, Gynecology & Reproductive Sciences

From: 07/01/2003 to In Progress

Clinical %: 50

Admin %: 50

Employment: • **Staff Privileges:** ◦ **Affiliation:** ◦

Malpractice

None Reported

UA | UNIFORM APPLICATION FOR PHYSICIAN STATE LICENSURE

Medical School Verification (UA Form #2)

Applicant: Complete this form as instructed in the left sidebar.
Dean or Designated Med School Official: Complete as instructed in the left sidebar.

Applicant:

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

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

Send this form and a copy of your medical school diploma to the current Dean of your medical school.

Copy this form for multiple schools.

Section 1: Applicant Information

Last name: Steinauer Suffix: ______

First name: Jody

Middle name: Ellen

Name if different when diploma awarded: ______

Name of medical school: University of California, San Francisco

Date of birth: CONFIDENTIAL Social Security number*: CONFIDENTIAL

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

Waiver for Release of Information: I authorize the medical school listed above to provide any and all information pertaining to my medical education at that institution to the Board listed below. I request that the Dean or a designated official complete Section 2 of this form and seal the copy of my diploma (attached), then return this form, the sealed diploma copy, and a copy of my official transcripts to the Board listed below at the given address.

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

Applicant signature: Jody Steinauer **Date:** 04-25-2022

Dean or Designated Official:

Please complete Section 2 of this form and certify the enclosed copy of the above named applicant's diploma by placing your school seal on it.

Mail the sealed diploma copy and an official copy of the transcripts of the above named physician with this form and any attachments to the Kansas State Board of Healing Arts at the address listed in Section 1. Do not mail this form to FCVS/FSMB.

If transcripts are not in English, an original, certified, and official English translation is required.

Section 2: Medical School Verification

Medical school name: University of California, San Francisco

School name if different when the above applicant attended: ______

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

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

Total weeks of education applicant attended your school: 191

Applicant's attendance dates: From 09/07/1992 to 06/08/1997

Graduation date: 06/08/1997 (indicate N/A if not applicable) Degree: MD (indicate N/A if not applicable)

The questions on the following page apply to unusual circumstances that occurred during any part of the individual's medical education. Please check the appropriate response(s) and provide dates and requested information. "Yes" responses to any of these questions require a copy of explanatory records or a written explanation. Attach additional pages as necessary.

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Applicant Name: Jody Ellen Steinauer

1. Do the official records for this individual reflect (an) interruption(s) or extension(s) in his/her medical education? Yes ☒ No ☐

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

	From Month/Year	To Month/Year	Approved	Unapproved
☐ Personal/Family			☐	☐
☐ Academic remediation			☐	☐
☐ Health			☐	☐
☐ Financial			☐	☐
☐ Participation in joint degree program (e.g., MD/PhD)			☐	☐
☐ Participation in non-research special study (e.g., fellowship, international experience)			☐	☐
☒ Other: Research	12/1996	3/1997	☒	☐

2. Do the official records for this individual reflect that he/she was ever placed on academic or disciplinary probation during his/her medical education? Yes ☐ No ☒

If yes, please select the reason(s) for the probation, indicate the date(s) of placement on and removal from probation, and attach documentation/information of the circumstances and outcome(s).

	From Month/Year	To Month/Year
☐ Academic probation		
☐ Probation for unprofessional conduct/behavioral reasons		
☐ Probation for other reason(s) (please specify):		

3. Do the official records for this individual reflect that he/she was ever disciplined for unprofessional conduct/behavioral reasons by the medical school or parent university? Yes ☐ No ☒

If yes, please attach documentation/information of the circumstances and outcome(s).

4. Do the official records for this individual reflect that he/she was ever the subject of negative reports for behavioral reasons or an investigation by the medical school or parent university? Yes ☐ No ☒

If yes, please attach documentation/information of the circumstances and outcome(s).

5. Do the official records for this individual reflect that there were ever any limitations or special requirements imposed on the individual because of questions of academic incompetence, disciplinary problems, or any other reason? Yes ☐ No ☒

If yes, please attach documentation/information of the nature of the limitations or special requirements.

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

Signature: [signature]

Print name: John Davis, PhD, MD

Title: Associate Dean for Students

Date: 4/29/2022

Phone number: 415-502-1045 Fax number:

Email: Franchesca.Torres@ucsf.edu

AFFIX INSTITUTIONAL SEAL HERE

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

Seal Verified KSBHA

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UCSF
University of California
San Francisco

TRANSCRIPT of STUDENT ACADEMIC RECORD

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

Enrolled Fall Quarter 1978 or thereafter – Computer-generated transcript

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

GRADES IN GRADUATE DIVISION AND SCHOOLS OF DENTISTRY, NURSING, AND PHARMACY		
Grade	*Points*	*Meaning*
A	4.0	**Excellent**
B	3.0	**Good**
C	2.0	**Fair**
D	1.0	**Barely Passing**
F	0.0	**Fail**
H	–	**Honors.** Awarded in third and fourth year. *(Dentistry)*
Y	–	**Provisional grade.** Denotes a provisional non-passing grade. May be raised to a **D** if requirements are met, or changed to grade **F.**
	0.0	*(Pharmacy)*
I	–	**Incomplete.** Assigned when work is of passing quality but incomplete for good cause. Students may replace this grade with a passing grade and receive unit credit, provided they satisfactorily complete the coursework as authorized by the instructor.
IP	–	**In Progress.** For courses extending beyond one quarter.
P/NP	–	**Passed** / **Not Passed** *(Dentistry and Pharmacy)*
S/U	–	**Satisfactory** / **Unsatisfactory** *(Graduate and Nursing)*
SP/UP	–	**Satisfactory** / **Unsatisfactory Progress** *(Dentistry)*
NR	–	**Not Recorded**
GRADES IN SCHOOL OF MEDICINE		
P	–	**Passed**
H	–	**Honors.** Awarded in summer term 1992 or later.
I	–	**Incomplete** *(See description above)*
IP	–	**In Progress** *(See description above)*
E	–	**Provisional grade.** A provisional non-passing grade.
F	–	**Fail.** Grade **F** is a permanent grade.
NR	–	**Not Recorded**
CODES	**CODE DESCRIPTIONS**	
C	Correction	
G	Grade assigned, sequence completed	
N	Provisional grade removed	
R	Repeated course *(Dentistry and Pharmacy)*	
S	Used when student is required by the dean to repeat a year, a term, or specific courses. Suppresses grade and units from calculation.	
T	Repeat. Suppresses units from calculation.	
X	Credit by examination	
2	Intercampus Exchange	
5	UC Berkeley Extension	
7	SF Consortium or Stanford Exchange	
W	Withdrew from all courses in the term	

ACADEMIC STANDARDS FOR STUDENTS

STANDARDS OF SCHOLARSHIP

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

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

COURSE NUMBERING SYSTEM

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

REPETITION OF COURSES

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

FULL-TIME STUDENTS

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

PART-TIME STUDENTS

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

WITHDRAWAL

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

ACCREDITATION

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

PRIVACY NOTICE

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

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

From: registrar@ucsf.edu
To: Berg, Rebecca [KSBHA]
Cc: jodysteinauer@gmail.com
Subject: UCSF Transcript Available
Date: Tuesday, June 14, 2022 6:53:35 PM

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

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

CONFIDENTIAL

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

Sincerely,
UCSF Office of the Registrar

RECEIVED
By KSBHA at 11:53 am, Apr 29, 2022

UA UNIFORM APPLICATION FOR PHYSICIAN STATE LICENSURE

Postgraduate Training Verification Form

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: Steinauer Suffix: ______

First name: Jody

Middle name: Ellen

Name if different when diploma awarded: ______

Name of postgraduate training program: Obstetrics and Gynecology residency

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: Jody Steinauer **Date:** 04-25-2022

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: University of California (San Francisco)

Institution address: 490 Illinois Street, Floor 10, Box 0132

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

Affiliated medical school name: UCSF Medical Center

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: Obstetrics and Gynecology

Attendance dates: From 6/24/2000 to 6/24/2001

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

Applicant Name: ____________________

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

☐ Research ☐ Chief Residency ☐ Other: ____________________

Specialty/Subspecialty: Obstetrics & Gynecology

Attendance dates: From 07/01/1998 to 06/23/2000

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.): 1 ☒ Internship ☐ Residency ☐ Fellowship

☐ Research ☐ Chief Residency ☐ Other: Obstetrics & Gynecology

Specialty/Subspecialty: ____________________

Attendance dates: From 06/21/1997 to 06/21/1998

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: ____________________

Print name: Sara Whetstone, MD

Title: Program Director

Date: 04/29/2022

Phone number: 415-885-7788 Fax number: 415-353-9509

Email: sara.whetstone@ucsf.edu

AFFIX INSTITUTIONAL SEAL HERE

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

Seal Verified KSBHA

UA UNIFORM APPLICATION FOR PHYSICIAN STATE LICENSURE

Postgraduate Training Verification (UA Form #3)

RECEIVED
By KSBHA at 11:53 am, Apr 29, 2022

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: Steinauer Suffix: _____

First name: Jody

Middle name: Ellen

Name if different when diploma awarded: _____

Name of postgraduate training program: Family Planning Fellowship

Date of birt 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: Jody Steinauer Date: 04-25-2022

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: University of California San Francisco at San Francisco General

Institution address: 1001 Potrero Ave. Ward 6D

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

Affiliated medical school name: University of California San Francisco

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

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

☐ Research ☐ Chief Residency ☐ Other: _____

Specialty/Subspecialty: Family Planning

Attendance dates: From 07/01/2001 to 06/30/2003

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 Fellowship became accredited in 2021

Applicant Name: Jody Steinauer

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: ____________

Print name: Jennifer Kerns

Title: Program Director

Date: 4/29/22

Phone number: 628-206-3157 Fax number: 628-206-3112

Email: Jennifer.Kerns@ucsf.edu

AFFIX INSTITUTIONAL SEAL HERE

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

Seal Verified KSBHA

From: Canio, Patrick
To: KSBHA_Licensing
Subject: Secure: Training Verification for Dr. Jody Steinauer
Date: Friday, April 29, 2022 11:45:09 AM
Attachments: logo.png
SecureMessageAtt.html

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

UCSF

This is a secure message.

Click here by 2022-05-06 09:43 PDT to read your message.
After that, open the attachment.

More Info

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

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

Recipient: KANSAS STATE BOARD OF HEALING ARTS

Date: 05/03/2022

Examinee: Steinauer, Jody Ellen
Alt Name(s):

Examinee ID: 4-046-022-2
Date of Birth: CONFIDENTIAL

Results for Steps taken by this examinee (and for which results have been reported to date) are shown below. For Steps that span more than one day, the test date reflects the day on which the examination began. Pass/fail outcomes are based upon the minimum passing level in place at the time of test administration and are not altered by subsequent revisions to the minimum passing level. Effective April 1, 2013, two-digit scores will no longer be reported. Test results reported as passing represent an exam score of 75 or higher on a two-digit scale. Step 1 examinations taken on or after January 26, 2022 are reported as pass/fail, with no numeric score; Step 1 examinations taken before January 26, 2022 will continue to be reported with a 3-digit score.

USMLE STEP 1

Test Date	Pass/Fail	Score	Minimum Pass	Comments
06/08/1994	Pass	CONFIDENTIAL		

USMLE STEP 2

Clinical Knowledge (CK)

Test Date	Pass/Fail	Comments
03/04/1997	Pass	

USMLE STEP 3

Test Date	Pass/Fail	Comments
05/12/1998	Pass	

End of Exam History

NOTE: The USMLE Step 2 CS examination was last administered March 16, 2020. Examinees with a failing outcome may not have had an opportunity to retest. The USMLE defines successful completion of its examination sequence as passing Step 1, Step 2 CK, and Step 3.

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

Rev 2018

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

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

Examinee: Steinauer, Jody Ellen

Examinee ID: 4-046-022-2
Date of Birth: CONFIDENTIAL

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

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

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

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

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

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

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

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

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

PHYSICIAN DATA CENTER INFORMATION APPEARING AS"NOTE"
The Physician Data Center of the Federation of State Medical Boards (FSMB) contains actions reported to the FSMB by U.S. licensing and disciplinary boards, the U.S. Department of Health and Human Services, government regulatory entities and international licensing authorities. To be included in the Physician Data Center, an action must be a matter of public record or be legally releasable to state medical boards or other entities with recognized authority to review physician credentials. Certain actions reported to and released by the Physician Data Center are not disciplinary or otherwise prejudicial in nature. Such actions are reported to ensure that records are complete and to assist in preventing misrepresentation or the use of lost or stolen credentials by unauthorized persons. Once reported to the FSMB, an action becomes part of the permanent record of the individual physician, and the existence of such an action may be indicated on the USMLE transcript by a Note.
03/2015

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

UA **UNIFORM APPLICATION FOR PHYSICIAN STATE LICENSURE**

Affidavit and Authorization for Release of Information

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

Applicant:

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

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

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

Send this notarized affidavit to:

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

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

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

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

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

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

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

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

Steinauer
Applicant's printed last name

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

April 28, 2022
Date of signature (must correspond to date of notarization)

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MAY 06 2022
KSBHA

-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.

Notary

State of California, County of ALAMEDA,

Seal Verified KSBHA

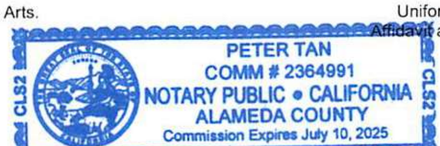
I certify that on the date set forth below, the individual named above did appear personally before me and that I did identify this applicant by: (a) comparing his/her physical appearance with the photograph on the identifying document presented by the applicant and with the photograph affixed hereto, and (b) comparing the applicant's signature made in my presence on this form with the signature on his/her identifying document.

The statements on this document are subscribed and sworn to before me by the applicant on this 28TH day of APRIL, 20 22.

Notary Public Signature: P Tan

My Notary Commission Expires: JULY 10, 2025

(NOTARY PUBLIC SEAL)



ADDENDUM 1
KANSAS STATE BOARD OF HEALING ARTS

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

☑ Medicine & Surgery ☐ Osteopathic Medicine & Surgery

☑ Active

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

☐ Federal Active

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

☐ Inactive

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

☐ Exempt

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

List intended professional activities: Gynecological care

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 Trust Women, 5107 E Kellogg Dr., Wichita
3. Primary Specialty Obstetrics and Gynecology

American Board Certified yes, ABOG American Board Eligible ____________

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Applicant Name Joey Steinauer

Kansas

ADDENDUM 2
ATTESTATION QUESTIONS

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

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

Jody Steinauer — Full Name of Applicant

April 25, 2022 — Date

1. Have you ever been dropped, suspended, expelled, fined, placed on probation, allowed to resign, requested to leave temporarily or permanently, or otherwise had action taken against you by any professional training program prior to completing the training? Yes ☐ No ☑
2. Have you ever had any application for any professional license refused or denied by any licensing authority? Yes ☐ No ☑
3. Have you ever been refused or denied the privilege of taking an examination required for any professional licensure? Yes ☐ No ☑

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4. Have you ever been warned, censured, disciplined, had admissions monitored, had privileges limited, suspended, revoked or placed on probation, or have you ever involuntarily or voluntarily (to avoid disciplinary action or investigation) resigned or withdrawn from any licensed hospital, nursing home, clinic or other health care facility in which you have trained, including but not limited to residency or postgraduate training programs, or otherwise been a staff member, been a partner or held privileges?
5. Have you ever been denied staff membership with any licensed hospital, nursing home, clinic or other health care facility?
6. Have you ever been requested to resign, withdraw or otherwise terminate your position with a partnership, professional association, corporation or other practice organization, either public or private?
7. Have you ever voluntarily surrendered any professional license? Yes ☐ No ☑
8. Has any licensing authority ever limited, restricted, suspended, revoked, censured or placed on probation or had any other disciplinary action taken against any professional license you have held? Yes ☐ No ☑
9. Have you ever been notified or requested to appear before a licensing or disciplinary agency? Yes ☐ No ☑
10. To your knowledge, have any complaints (regardless of status) ever been filed against you with any licensing agency, professional association, hospital, nursing home, clinic or other health care facility? Yes ☐ No ☑

Kansas

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

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

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

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

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

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

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

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

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

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

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

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

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PDC PHYSICIAN DATA CENTER

fsmb

PRACTITIONER PROFILE

Prepared for:	Kansas State Board of Healing Arts	As of Date:5/4/2022

PRACTITIONER INFORMATION

Name:	Steinauer, Jody Ellen
DOB:	CONFIDENTIAL
Medical School:	University of California, San Francisco, School of Medicine San Francisco, California, UNITED STATES
Year of Grad:	1997
Degree Type:	MD
NPI:	1700839636

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
1700839636	Individual			01/03/2022

LICENSE HISTORY

Jurisdiction	License Number	Issue Date	Expiration Date	Last Updated
CALIFORNIA	A-67843	03/19/1999	08/31/2022	04/27/2022
	FSMB License Status: Active			
OKLAHOMA	38815	12/27/2021	12/01/2022	04/29/2022
	FSMB License Status: Active			

ACTIVE US DRUG ENFORCEMENT ADMINISTRATION (DEA)

DEA Number	Schedule	Address	Expiration Date	Last Reported
BS6308022	22N 33N 4 5	SAN FRANCISCO,CA 94110	02/28/2023	01/05/2022

PRACTITIONER PROFILE

Prepared for:	Kansas State Board of Healing Arts	As of Date:5/4/2022
Practitioner Name:	Steinauer, Jody Ellen	

ABMS® CERTIFICATION HISTORY

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

Status	Duration	Effective Date	Expiration Date	Reverification Date	Occurrence	Last Reported
Active	Time Limited	12/31/2021	12/31/2022		Recertification	04/28/2022
Expired	Time Limited	12/31/2020	12/31/2021		Recertification	04/28/2022
Expired	Time Limited	12/31/2019	12/31/2020		Recertification	04/28/2022
Expired	Time Limited	12/31/2018	12/31/2019		Recertification	04/28/2022
Expired	Time Limited	12/31/2017	12/31/2018		Recertification	04/28/2022
Expired	Time Limited	12/31/2016	12/31/2017		Recertification	04/28/2022
Expired	Time Limited	12/31/2015	12/31/2016		Recertification	04/28/2022
Expired	Time Limited	12/31/2014	12/31/2015		Recertification	04/28/2022
Expired	Time Limited	12/31/2013	12/31/2014		Recertification	04/28/2022
Expired	Time Limited	12/16/2012	12/31/2013		Recertification	04/28/2022
Expired	Time Limited	12/31/2011	12/31/2012		Recertification	04/28/2022
Expired	Time Limited	12/31/2010	12/31/2011		Recertification	04/28/2022
Expired	Time Limited	12/31/2009	12/31/2010		Recertification	04/28/2022
Expired	Time Limited	01/09/2004	12/31/2009		Initial	04/28/2022

AOA® CERTIFICATION HISTORY

No AOA Certifications found.

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 X 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.

Jody Steinauer — 04-24-2022

Signature — Date

Jody Steinauer — CONFIDENTIAL

Printed Name — Date of Birth

CONFIDENTIAL

Residential Address — City — State — Zip

TO BE COMPLETED BY THE FINGERPRINTING AGENCY:

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

State/Branch: CALIFORNIA ID Number: CONFIDENTIAL

Agency Name: Cal Live Scan

Address: 2855 Telegraph Ave, Suite 303 Berkeley, CA 94705

Telephone: Cal Live Scan $97 (510)848-2989 Fax:

Name of Individual Verifying Identity: PETER T. FPC 501593 FPC 501593

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

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Revised 02/2020

CONFIDENTIAL

AMA Physician Profile

Name and Mailing Address

JODY ELLEN STEINAUER
CONFIDENTIAL

Birth date CONFIDENTIAL

Primary Office Address

SAME AS MAILING ADDRESS

Phone CONFIDENTIAL

Physician's major professional activity OFFICE BASED PRACTICE

Self-designated practice specialty OBSTETRICS & GYNECOLOGY (primary)
UNSPECIFIED (secondary)

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

AMA membership status NON MEMBER

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

Current and/or historical National Provider Identifier (NPI) information

NPI Number	Enumeration Date	Deactivation Date	Reactivation Date	Replacement Number	Last Reported Date
1700839636	05/19/2006	NOT RPTD	NOT RPTD	NOT RPTD	04/22/2022

Current and/or historical medical school

US medical school information is verified directly from the school. In some instances, a medical school will designate the National Student Clearinghouse (NSC) as its verification agent. Instances of verification by NSC are indicated on an AMA Profile when applicable.

*On the profile, **enrollment date** is understood to mean the date a student begins a pre-matriculation program, attends orientation immediately preceding enrollment, or becomes enrolled in classes at a medical school. **Degree date** is understood to mean the date a physician is awarded his/her degree upon completion of the degree program. When provided by the primary source, a month is also included for these two dates. Date information provided by primary sources does vary. Enrollment date for international medical graduates is not reported to AMA.*

School: UNIVERSITY OF CALIFORNIA SAN FRANCISCO SCHOOL OF MEDICINE

Degree Awarded:	YES	**Degree Type:**	MD
Enrollment Date:	NOT REPORTED	**Degree Date:**	06/1997

Current and/or historical ACGME-accredited graduate medical training programs

This section's data is sourced only from training programs accredited by the Accreditation Council for Graduate Medical Education (ACGME) as part of the National Graduate Medical Education Census. Program name is only reported for training received in 2010 and later. Training types are identified as specialty (residency) or subspecialty (fellowship) only for training received in 2016 and later.

The AMA Profile does not include non-ACGME accredited training programs, and the absence of such does not necessarily indicate a gap in training.

Training performed in Canada or at an accredited US osteopathic institution is updated only upon verification by the program. US licensing authorities accept GME from both entities as equivalent to training performed at an ACGME-accredited program.

*Verification of training status may be indicated in one of four ways. **Completed** indicates that the training has been completed in its entirety and verified with the program. **Training in Progress** indicates the training has a future completion date and is verified as in progress. **Verification of Completion in Progress** indicates the training has a past completion date and was verified as in progress but the program has not yet verified completion. **Partially Completed** indicates the training is verified as partially completed but the physician either changed programs or did not complete the training.*

Sponsoring Institution:	UNIVERSITY OF CALIFORNIA (SAN FRANCISCO) SCHOOL OF MEDICINE
Sponsoring State:	CALIFORNIA
Specialty:	OBSTETRICS & GYNECOLOGY
Training Type:	
Dates:	06/1997 - 06/2001
Status:	COMPLETED

Specialty board certification

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

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

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

Duration	Status	Effective Date	Expiration Date	Reverify Date	Occurrence	Last Reported	Participating in MOC
TIME LIMITED	Active	12/31/2021	12/31/2022		RE-CERT	04/26/2022	Y
TIME LIMITED	Expired	12/31/2020	12/31/2021		RE-CERT	04/26/2022	Y
TIME LIMITED	Expired	12/31/2019	12/31/2020		RE-CERT	04/26/2022	Y
TIME LIMITED	Expired	12/31/2018	12/31/2019		RE-CERT	04/26/2022	Y
TIME LIMITED	Expired	12/31/2017	12/31/2018		RE-CERT	04/26/2022	Y
TIME LIMITED	Expired	12/31/2016	12/31/2017		RE-CERT	04/26/2022	Y
TIME LIMITED	Expired	12/31/2015	12/31/2016		RE-CERT	04/26/2022	Y
TIME LIMITED	Expired	12/31/2014	12/31/2015		RE-CERT	04/26/2022	Y
TIME LIMITED	Expired	12/31/2013	12/31/2014		RE-CERT	04/26/2022	Y
TIME LIMITED	Expired	12/16/2012	12/31/2013		RE-CERT	04/26/2022	Y
TIME LIMITED	Expired	12/31/2011	12/31/2012		RE-CERT	04/26/2022	Y
TIME LIMITED	Expired	12/31/2010	12/31/2011		RE-CERT	04/26/2022	Y
TIME LIMITED	Expired	12/31/2009	12/31/2010		RE-CERT	04/26/2022	Y
TIME LIMITED	Expired	01/09/2004	12/31/2009		INITIAL	04/26/2022	Y

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

Current and/or historical medical licensure

License Number	MD / DO	Locale	Date Granted	Expiration Date	Renewal Date	Status	License Type	Last Reported	Name on License
38815	MD	OK	12/27/2021	12/01/2022		ACT	UNL	02/02/2022	JODY ELLEN STEINAUER
67843	MD	CA	03/19/1999	08/31/2022		ACT	UNL	02/03/2022	JODY ELLEN STEINAUER

Abbreviation key: ACT = Active, DEN = Denied, INA = Inactive, LIM = Limited, NRT = Not reported, RES = Resident, TEM = Temporary, UNK = Unknown, UNL = Unlimited

Action notifications reported to the AMA

Medical Licensing Boards: NO ACTIONS REPORTED AT THIS TIME
Medicare/Medicaid Sanctions from DHHS: NO ACTIONS REPORTED AT THIS TIME
US DOJ Drug Enforcement Administration: NO ACTIONS REPORTED AT THIS TIME

U.S. Drug Enforcement Administration (DEA)

DEA Number*	Business Activity†	Drug Schedule	Activity	Expiration Date	Payment Indicator	Last Reported	Address
------022	C-0	22N 33N 4 5	Active	02/28/2023	Paid	04/27/2022	Zsfg Sfgh-Ward 6D-14 1001 Potrero Ave San Francisco, CA 94110-3518

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

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

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

ECFMG certification

NOT APPLICABLE

Profile information

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

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

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

From:	Scott Maccio (he/him/his)
To:	KSBHA_Licensing
Subject:	AMA Profile Reports
Date:	Wednesday, May 4, 2022 2:43:36 PM
Attachments:	image001.png image002.png image003.png image004.png image005.png image006.png licenseBoardBatch 05-04-22 KS.pdf

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

- Jody Steinauer

CONFIDENTIAL

AMA 175 YEARS

Scott Maccio
Credentialing Products Support Coordinator

Renew your AMA membership, or join today!

RECEIVED
By Rebecca Berg at 8:25 am, Jul 11, 2022

No: 169794621

This Certificate is provided to:
Trust Women Foundation
P.O. Box 3222
Wichita KS 67201

Return Address

Zuckerberg San Francisco General Hospital
1001 Potrero Avenue, Building 20, Room 2103
San Francisco, CA 94110

UNIVERSITY OF CALIFORNIA
EVIDENCE OF SELF-INSURANCE
PROFESSIONAL LIABILITY & HOSPITAL LIABILITY

Type of Coverage	Self-Insured Limits
I. PROFESSIONAL MEDICAL AND HOSPITAL LIABILITY:	5,000,000 Each Occurrence 10,000,000 Aggregate

II. SPECIAL TERMS & CONDITIONS:

1. This certificate is issued in connection with work performed by:
   Jody Steinauer, MD at Trust Women Clinic - 5107 E. Kellogg Drive, Wichita, KS 67218

   This certificate is only valid for work performed within the course and scope of his/her employment within:
   Department of Obstetrics, Gynecology & Reproductive Sciences at Zuckerberg San Francisco General Hospital

   University employees are provided a University funded defense and indemnification for alleged negligence acts or omissions rising out of the course and scope of the University employment except where they act or fail to act because of actual fraud, corruption, or actual malice. (California Tort Claims Act. Government Code Section 810).

2. The self-insurance evidenced herein follows the provisions of the Bylaws and Standing Orders of the Regents of the University of California and self-insurance programs as administered by the University of California, Office of the President, Office of Risk Services, which do not permit any assumption of liability which does not result from and is not caused by the negligent acts or omissions of its officers, agents, or employees. Any indemnification or hold harmless clause with broader provisions than required under such Bylaws and Standing Orders shall invalidate this certificate.

3. This certificate is in effect until the expiration date indicated below or termination of applicable contract, affiliation agreement or termination of University employment, whichever comes first.

Should any of the above described program of self-insurance be materially modified or cancelled before the expiration date shown below, The Regents of the University of California will give 30 days written notice to the certificate holder.

Marcella Gigena

Effective Date: 07/01/2022

Marcella Gigena
UCSF Office of Risk Management - ZSFGH
1001 Potrero, Building 20, Room 2103
San Francisco CA 94110

Expiration Date: 07/01/2023

Approval Date: 6/24/2022

This Certificate is issued as a matter of information only and confers no rights upon the certificate holder. The Certificate does not amend, extend or alter the coverage described above. This certificate does not constitute a contract between the holder and the University of California.

Form: PL Individual 0914

From: Steinauer, Jody
To: Berg, Rebecca [KSBHA]
Subject: Certificate
Date: Friday, July 8, 2022 6:21:46 PM
Attachments: Trust-Women-Foundat_Zuckerberg-San-_-ZSFGH-2223-PL_6-24-2022_169794621_1.pdf

---

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Hi Becky,

CONFIDENTIAL

Jody Steinauer

CONFIDENTIAL

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

RECEIPT NUMBER: 698364 DATE: 06/02/2022

NAME:	LICENSE TYPE:	FEE:	LIC #:
Jody Steinauer		300.00	
		47.00	
		3.00	

AMOUNT:
TYPE: Credit Card
CH/CC #: 042027

RECEIVED FROM:

Jody Steinauer

CONFIDENTIAL

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

Kansas
State Board of Healing Arts

PHONE: 785-296-7413
FAX: 785-368-7103
KSBHA_healingarts@ks.gov
www.ksbha.org

Susan B Gile, Acting Executive Director

Laura Kelly, Governor

June 13, 2022

Jody Ellen Steinauer, MD

CONFIDENTIAL

Sincerely,

Becky Berg

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

From: Berg, Rebecca [KSBHA]
To: Steinauer, Jody
Subject: Kansas State Board of Healing Arts - Licensure Needed Documentation
Date: Monday, June 13, 2022 10:14:00 AM
Attachments: MRL-1.pdf

Hello Dr. Jody Steinauer ,

CONFIDENTIAL

Thank you,

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

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

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

KANSAS
BOARD OF HEALING ARTS

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

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

Completing the Kansas Licensure Addendum

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

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

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

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

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

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

Complete, sign and date the top portion of Waiver Agreement and FBI Privacy Act Statement. At the time fingerprints are collected the fingerprinting agency must complete the bottom portion. Mail the completed form and fingerprint card to the Board. Fingerprints will not be submitted for processing without completed and signed Waiver Agreement. Submit completed background check waiver, Fingerprint card, and $47 fee.

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

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

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

UNIFORM APPLICATION FOR PHYSICIAN STATE LICENSURE CHECKLIST

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

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

PDC PHYSICIAN DATA CENTER

fsmb

PRACTITIONER PROFILE

Prepared for:	Uniform Application for Physician State Licensure	As of Date:4/25/2022

PRACTITIONER INFORMATION

Name:	Steinauer, Jody Ellen
DOB:	CONFIDENTIAL
Medical School:	University of California, San Francisco, School of Medicine San Francisco, California, UNITED STATES
Year of Grad:	1997
Degree Type:	MD
NPI:	1700839636

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
1700839636	Individual			01/03/2022

LICENSE HISTORY

Jurisdiction	License Number	Issue Date	Expiration Date	Last Updated
CALIFORNIA	A-67843	03/19/1999	08/31/2022	04/20/2022
		FSMB License Status: Active		
OKLAHOMA	38815	12/27/2021	12/01/2022	04/22/2022
		FSMB License Status: Active		

ACTIVE US DRUG ENFORCEMENT ADMINISTRATION (DEA)

DEA Number	Schedule	Address	Expiration Date	Last Reported
BS6308022	22N 33N 4 5	SAN FRANCISCO,CA 94110	02/28/2023	01/05/2022

PDC PHYSICIAN DATA CENTER

fsmb

PRACTITIONER PROFILE

Prepared for:	Uniform Application for Physician State Licensure	As of Date:4/25/2022
Practitioner Name:	Steinauer. Jody Ellen	

ABMS® CERTIFICATION HISTORY

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

Status	Duration	Effective Date	Expiration Date	Reverification Date	Occurrence	Last Reported
Active	Time Limited	12/31/2021	12/31/2022		Recertification	03/31/2022
Expired	Time Limited	12/31/2020	12/31/2021		Recertification	03/31/2022
Expired	Time Limited	12/31/2019	12/31/2020		Recertification	03/31/2022
Expired	Time Limited	12/31/2018	12/31/2019		Recertification	03/31/2022
Expired	Time Limited	12/31/2017	12/31/2018		Recertification	03/31/2022
Expired	Time Limited	12/31/2016	12/31/2017		Recertification	03/31/2022
Expired	Time Limited	12/31/2015	12/31/2016		Recertification	03/31/2022
Expired	Time Limited	12/31/2014	12/31/2015		Recertification	03/31/2022
Expired	Time Limited	12/31/2013	12/31/2014		Recertification	03/31/2022
Expired	Time Limited	12/16/2012	12/31/2013		Recertification	03/31/2022
Expired	Time Limited	12/31/2011	12/31/2012		Recertification	03/31/2022
Expired	Time Limited	12/31/2010	12/31/2011		Recertification	03/31/2022
Expired	Time Limited	12/31/2009	12/31/2010		Recertification	03/31/2022
Expired	Time Limited	01/09/2004	12/31/2009		Initial	03/31/2022

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

AOA® CERTIFICATION HISTORY

No AOA Certifications found.

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

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ECFMG Status Report (if applicable) sent to the Board.	N/A ☐	Completed via FCVS

RECEIVED
MAY 06 2022
KSBHA

Steinauer, Jody

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

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

KANSAS
BOARD OF HEALING ARTS

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

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Kansas

AD ASTRA PER ASPERA

EXPEDITED LICENSURE QUESTIONNAIRE

To determine if you are eligible for expedited licensure pursuant to K.S.A. 48-3406[i], please answer the following questions. If it is determined that your responses were intentionally false or misleading, you will be subject to an administrative disciplinary action in Kansas and will be reported to all appropriate state/ federal/military/law enforcement agencies.

1. Are you a current member of any branch of the United States armed services, United States military reserves, national guard of any state, or a former member with an honorable discharge? Yes ☐ No ☑ If yes:

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

2. Are you the spouse of a current member of any branch of the United States armed services, United States military reserves, national guard of any state, or a former member with an honorable discharge? Yes☐ No☑ If yes:

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

3. Do you currently reside in Kansas? Yes☐ No☑ If yes:

   Current Kansas Residence Address:__________

4. Do you intend* to establish residency in Kansas within the next 6 months? ***If you answer "yes" to this question but do not establish Kansas residency within the next 6 months, your Kansas license will be cancelled. If it is determined that your answer to this question was intentionally false or misleading, you will be subject to an administrative disciplinary action in KS and will be reported to all appropriate state/federal/military agencies in other jurisdictions.*** Yes ☐ No ☑ If yes:

   Intended Kansas Residence Address:__________

   Expected Date of Commencing Residence:__________

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

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

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

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

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

From:	Steinauer, Jody
To:	KSBHA_Licensing
Subject:	Kansas license application
Date:	Tuesday, May 3, 2022 6:41:42 PM
Attachments:	image001.png Steinauer application.pdf Steinauer KS license fee.pdf

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

Dear Kansas Board of Healing Arts,

CONFIDENTIAL

Jody

Jody Steinauer, MD,
Philip D. Darney Distinguished Professor of Family Planning & Reproductive Health
Director, Bixby Center for Global Reproductive Health
Dept. of Obstetrics, Gynecology & Reproductive Sciences
Zuckerberg San Francisco General Hospital
University of California, San Francisco

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

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

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

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

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

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: Gynecological care

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 Trust Women, 5107 E Kellogg Dr., Wichita
3. Primary Specialty Obstetrics and Gynecology

   American Board Certified yes, ABOG   American Board Eligible ______

Kansas

ADDENDUM 2
ATTESTATION QUESTIONS

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

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

Jody Steinauer — Full Name of Applicant

April 25, 2022 — Date

1. Have you ever been dropped, suspended, expelled, fined, placed on probation, allowed to resign, requested to leave temporarily or permanently, or otherwise had action taken against you by any professional training program prior to completing the training? Yes ☐ No ☑
2. Have you ever had any application for any professional license refused or denied by any licensing authority? Yes ☐ No ☑
3. Have you ever been refused or denied the privilege of taking an examination required for any professional licensure? Yes ☐ No ☑

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4. Have you ever been warned, censured, disciplined, had admissions monitored, had privileges limited, suspended, revoked or placed on probation, or have you ever involuntarily or voluntarily (to avoid disciplinary action or investigation) resigned or withdrawn from any licensed hospital, nursing home, clinic or other health care facility in which you have trained, including but not limited to residency or postgraduate training programs, or otherwise been a staff member, been a partner or held privileges?
5. Have you ever been denied staff membership with any licensed hospital, nursing home, clinic or other health care facility?
6. Have you ever been requested to resign, withdraw or otherwise terminate your position with a partnership, professional association, corporation or other practice organization, either public or private?
7. Have you ever voluntarily surrendered any professional license? Yes ☐ No ☑
8. Has any licensing authority ever limited, restricted, suspended, revoked, censured or placed on probation or had any other disciplinary action taken against any professional license you have held? Yes ☐ No ☑
9. Have you ever been notified or requested to appear before a licensing or disciplinary agency? Yes ☐ No ☑
10. To your knowledge, have any complaints (regardless of status) ever been filed against you with any licensing agency, professional association, hospital, nursing home, clinic or other health care facility? Yes ☐ No ☑

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

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

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

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

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

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

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

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

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

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

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

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

RECEIVED
By Rebecca Berg at 10:31 am, Jul 07, 2022

No: 1730385856

Return Address

This Certificate is provided to:
Trust Women Foundation
P.O. Box 3222
Wichita KS 67201

Zuckerberg San Francisco General Hospital
1001 Potrero Avenue, Building 20, Room 2103
San Francisco, CA 94110

UNIVERSITY OF CALIFORNIA
EVIDENCE OF SELF-INSURANCE
PROFESSIONAL LIABILITY & HOSPITAL LIABILITY

Type of Coverage	Self-Insured Limits
I. PROFESSIONAL MEDICAL AND HOSPITAL LIABILITY:	5,000,000 Each Occurrence 10,000,000 Aggregate

II. SPECIAL TERMS & CONDITIONS:

1. This certificate is issued in connection with work performed by:
   Jody Steinauer, MD at Trust Women Wichita Clinic, 5107 E. Kellogg Drive, Wichita, KS 67218.

   This certificate is only valid for work performed within the course and scope of his/her employment within:
   Department of Obstetrics, Gynecology and Reproductive Sciences at ZSFG Hospital
   Effective: 02/01/2022 - 07/01/2022

   University employees are provided a University funded defense and indemnification for alleged negligence acts or omissions rising out of the course and scope of the University employment except where they act or fail to act because of actual fraud, corruption, or actual malice. (California Tort Claims Act. Government Code Section 810).

2. The self-insurance evidenced herein follows the provisions of the Bylaws and Standing Orders of the Regents of the University of California and self-insurance programs as administered by the University of California, Office of the President, Office of Risk Services, which do not permit any assumption of liability which does not result from and is not caused by the negligent acts or omissions of its officers, agents, or employees. Any indemnification or hold harmless clause with broader provisions than required under such Bylaws and Standing Orders shall invalidate this certificate.

3. This certificate is in effect until the expiration date indicated below or termination of applicable contract, affiliation agreement or termination of University employment, whichever comes first.

Should any of the above described program of self-insurance be materially modified or cancelled before the expiration date shown below, The Regents of the University of California will give 30 days written notice to the certificate holder.

Marcella Gigena

Effective Date: 07/01/2021

Marcella Gigena
UCSF Office of Risk Management - ZSFGH
1001 Potrero, Building 20, Room 2103
San Francisco CA 94110

Expiration Date: 07/01/2022

Approval Date: 2/17/2022

This Certificate is issued as a matter of information only and confers no rights upon the certificate holder. The Certificate does not amend, extend or alter the coverage described above. This certificate does not constitute a contract between the holder and the University of California.

Form: PL Individual 0914

From:	Steinauer, Jody
To:	Berg, Rebecca [KSBHA]
Subject:	Re: Kansas State Board of Healing Arts - Licensure Needed Documentation
Date:	Thursday, July 7, 2022 10:16:08 AM
Attachments:	TWF - J Steinauer TWC Wichita.pdf

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

Hi Beckv.

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Jody

From: "Berg, Rebecca [KSBHA]" <Rebecca.Berg@ks.gov>
Date: Thursday, July 7, 2022 at 7:03 AM
To: "Steinauer, Jody" <jody.steinauer@ucsf.edu>
Subject: RE: Kansas State Board of Healing Arts - Licensure Needed Documentation

This Message Is From an External Sender

This message came from outside your organization.

Good Morning,

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Thanks!

Thank you,

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

ATTENTION Doctor of Osteopathic Medicine & Surgery: If you have applied or are applying for your initial license, please note the Board requires all licensed professionals to renew their license annually.

Applicants licensed __before__ August 1, 2022 will be required to renew in September of 2022, those licensed __on or after__ August 1, 2022 will be required to renew in September of 2023.

To request the license be issued on or after August 1st the applicant must submit an email prior to final review of the application, requesting the license be issued on or after August 1st. Submitting a request does not guarantee the license will be issued on August 1st, time of issuance will vary.

From: Steinauer, Jody <jody.steinauer@ucsf.edu>
Sent: Tuesday, July 5, 2022 7:08 PM
To: Berg, Rebecca [KSBHA] <Rebecca.Berg@ks.gov>
Subject: Re: Kansas State Board of Healing Arts - Licensure Needed Documentation

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

Hi Becky,

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Jody

From: "Berg, Rebecca [KSBHA]" <Rebecca.Berg@ks.gov>
Date: Monday, June 13, 2022 at 8:17 AM
To: "Steinauer, Jody" <jody.steinauer@ucsf.edu>
Subject: Kansas State Board of Healing Arts - Licensure Needed Documentation

This Message Is From an External Sender
This message came from outside your organization.

Hello Dr. Jody Steinauer ,

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Thank you,
Becky Berg
Licensing Analyst
Kansas State Board of Healing Arts

800 SW Jackson, LL – Suite A
Topeka, Kansas 66612
Email: rebecca.berg@ks.gov
Phone: 785.368.8206
Fax: 785.296.0852
http://www.kshba.org