

Regular Mailing Address

State Board of Medicine

P.O. Box 2649

Harrisburg, PA 17105-2649

Phone: 717-783-1400 or 717-787-2381

Email: st-medicine@state.pa.us**Courier Delivery Address**

State Board of Medicine

2601 North Third Street

Harrisburg, PA 17110

HOSPITAL USE ONLYTO BE COMPLETED FOR BULK CHECK
USAGEHospital Name: TSUHHS # 000240Receipt # 5702852**APPLICATION FOR A GRADUATE LICENSE FOR GRADUATES OF
ACCREDITED MEDICAL SCHOOLS (SCHOOLS IN THE U.S. AND CANADA)**

Application Fee: \$30.00 not refundable. Make check payable to the "Commonwealth of Pennsylvania." Note: A processing fee of \$20.00 will be charged for any check or money order returned unpaid by your bank, regardless of the reason for non-payment.

TO BE COMPLETED BY APPLICANT: (Please Print or Type)

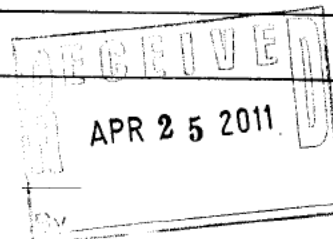
256339

NAME: ADELIYI THERESA B
Last First MiddleADDRESS: [REDACTED]TOLEDO OH 43614
City State Zip CodeSOCIAL SECURITY # [REDACTED] DATE OF BIRTH: [REDACTED]
MM/DD/YYYY

If your medical/licensure records are listed under another name or names, please list below:

Are you applying using credentials verification from FCVS? ☐ YES ☐ NO**NAME & ADDRESS OF MEDICAL SCHOOL**Univ. of Toledo COM
3000 Arlington Avenue
Toledo OH 43614**DATES OF ATTENDANCE**8/06 - 6/11**DATE OF GRADUATION**6/3/2011**NAME & ADDRESS OF HOSPITAL(S)****DATES OF PREVIOUS TRAINING****SPECIALTY****TO BE COMPLETED BY HOSPITAL LOCATED IN PENNSYLVANIA:**NAME OF HOSPITAL: Thomas Jefferson University Hospital HS- 000240-LADDRESS OF HOSPITAL: 111 South 11th Street, Suite 2170, Philadelphia, PA 19107YEAR IN TRAINING: 1 ACGME SPECIALTY: Obstetrics & Gynecology LEVEL IN TRAINING (PGY) 1DATES OF TRAINING REQUESTED: June 20, 2011 TO June 19, 2012
BEGINNING DATE-(MM/DD/YYYY) ENDING DATE-(MM/DD/YYYY)

I VERIFY THAT I AM THE PROGRAM DIRECTOR FOR THE HOSPITAL PROGRAM LISTED ABOVE
AND THAT THIS IS AN ACGME ACCREDITED PROGRAM AT THIS HOSPITAL.

NAME OF PROGRAM DIRECTOR: Debra A. Cifelli, Director of Medical Staff & House Staff AffairsSIGNATURE OF PROGRAM DIRECTOR: Debra A. Cifelli

Answer the following questions. If "YES" is answered to Questions #2 through #9, provide complete details on a separate sheet as well as certified copies of relevant documents. Sign and date below.

	Yes	No
1) Do you hold or have you ever held an unrestricted license, certification, or registration (active or inactive, current or expired) to practice medicine and/or surgery in another jurisdiction? <u>If yes, list the jurisdiction(s) here:</u>		✓
2) Have you withdrawn an application for a license, certificate or registration, had an application for a license denied or refused, or for any disciplinary reason agreed not to reapply for a license, certificate or registration in any profession in any state or jurisdiction?		✓
3) Have you had disciplinary action taken against your license, certificate or registration issued to you in any profession in any other state or jurisdiction?		✓
4) Have you been convicted, found guilty or pleaded nolo contendere, or received probation without verdict or accelerated rehabilitative disposition (ARD) as to any felony or misdemeanor, including any drug law violations, or do you have any criminal charges pending and unresolved in any state or jurisdiction? You are not required to disclose any ARD or other criminal matter that has been expunged by order of a court.		✓
5) Since May 19, 2002, have you been arrested for criminal homicide, aggravated assault, sexual offenses or drug offenses in any state, territory or country?		✓
6) Have you had practice privileges denied, revoked or restricted in a hospital or other health care facility, or have you been charged by a hospital, university, or research facility with violating research protocols, falsifying research, or engaging in other research misconduct?		✓
7) Have you had your DEA registration denied, revoked or restricted or have you had your provider privileges terminated by any medical assistance agency for cause?		✓
8) Are you, or have you ever been, addicted to the imtemperate use of alcohol or to the habitual use of narcotics or other habit-forming drugs? Note: You may answer "NO" if you are currently a participant in or have successfully completed the requirements of the Board's Professional Health Monitoring Program.)		
9) Since May 19, 2002, have any malpractice complaints been filed against you? If yes, the Board requires that you submit a copy of the <u>entire Civil Complaint</u> which must include the <u>docket number</u> , <u>filing date</u> , and the <u>date you were served</u> .		✓

SIGNED STATEMENT

Note that disclosing your social security number on this application is mandatory in order for the State Board of Medicine to comply with the requirements of the Federal Social Security Act pertaining to child support enforcement, as implemented in the Commonwealth of Pennsylvania at 23 Pa. C.S. 4304.1(a). In order to enforce domestic child support orders, the Commonwealth's licensing boards must provide to the Department of Public Welfare information prescribed by DPW about the licensee, including the social security number. Additionally, disclosing the number is mandatory in order for this board to comply with the reporting requirements of the Federal National Practitioner Data Bank and the Healthcare Integrity and Protection Data Bank. Reports to the NPDB/HIPDB must include the licensee's social security number.

I verify that the statements in this application are true and correct to the best of my knowledge, information and belief. I understand that false statements are made subject to the penalties of 18 Pa. C.S. Section 4904 relating to unsworn falsification to authorities and may result in the suspension or revocation of my license. I hereby authorize all hospitals, institutions or organizations, my references, personal physicians, employers (past and present), and all governmental agencies and instrumentalities (local, state, federal or foreign) to release to the Pennsylvania State Board of Medicine any information, files or records requested by the Board.

SIGNATURE OF APPLICANT

DATE

4/7/11

APR 25 2011

RECEIVED DIRECT

VERIFICATION OF MEDICAL EDUCATION
For Graduates of Accredited Medical Schools

SECTION 1: To be completed by applicant:

Name: ADELIYI THERESA BOSEDE
Last First Middle

Name of medical school: Univ. of Toledo College of Medicine

Location: Toledo, OH 43614

SUBMIT THE VERIFICATION OF MEDICAL EDUCATION FORM TO YOUR MEDICAL SCHOOL AND REQUEST YOUR SCHOOL TO RETURN THE COMPLETED FORM DIRECTLY TO THE BOARD IN AN OFFICIAL SCHOOL ENVELOPE.

SECTION 2: To be completed by Dean or Registrar of medical school:

Name of medical student: Theresa B. Adeliyi

Date student began to attend this medical school: 8/21/2006
MM/DD/YYYY

~~expected to~~
Date of graduation: 6/3/2011
MM/DD/YYYY

I certify that all of the above information is correct.

[Seal of School]

Signature of Dean or Registrar:

Sherri Armstrong

Date: 4/13/2011

This form may be completed ONLY three months prior to graduation. Upon completion, school must return this completed form directly to the Pennsylvania State Board of Medicine in an official school envelope. ***If graduation DOES NOT take place, notify the Board immediately***

DO NOT RETURN TO APPLICANT

Regular Mailing Address
State Board of Medicine
P.O. Box 2649
Harrisburg, PA 17105-2649

Courier Delivery Address
State Board of Medicine
2601 North Third Street
Harrisburg, PA 17110

**The Federation of State Medical Boards
of the United States, Inc**
PO Box 619850
Dallas, Texas 75261-9850
Telephone: (817)868-4000
FAX (817)868-4099

BOARD ACTION CLEARANCE REPORT

May 24, 2011

Attn: Tammy Dougherty
Pennsylvania State Board of Medicine
Tammy Dougherty
PO Box 2649
Harrisburg, PA 17105

Re: Board Action Query Dated: May 24, 2011
Your Reference Number: TSH
FSMB Batch Number: BQ1913627

The following is a report of the search results from the Board Action Data Bank as of May 24, 2011, for practitioners submitted as part of the above-referenced batch for which NO board actions were identified.

Practitioners Cleared with No Actions as of May 24, 2011

Item	Name	DOB	School	Yr/Grad	Request ID
4	ADELIYI, THERESA B		036030	2011	23778679

LICENSE HISTORY

State Board

No License Information Available

PLEASE NOTE: The licensure history information contained in these reports is not considered licensure verification but rather an indicator of known states of historical licensure for these individuals. Use of this information should be limited to cross-reference purposes.

6633233

COMMONWEALTH OF PENNSYLVANIA
DEPARTMENT OF STATE
BUREAU OF PROFESSIONAL AND OCCUPATIONAL AFFAIRS
STATE BOARD OF MEDICINE

MT199872
BURCHER

RENEWAL APPLICATION

THERESA ADELIYI BURCHER 9849
THOMAS JEFFERSON UNIVERSITY
HOUSE STAFF OFFICE
111 SOUTH 11TH STREET
SUITE 2170
PHILADELPHIA PA 19107-5096

State Board of Medicine
PO Box 2649
Harrisburg, PA 17105-2649

☐ I will not be participating in graduate training in Pennsylvania after the expiration date indicated below and request inactive status. **No fee is required. YOU MUST SIGN, DATE AND RETURN THIS FORM.**

THE FOLLOWING QUESTIONS MUST BE ANSWERED

YES	NO	If YES to 2-8 - provide details AND attach certified copies of legal document(s).
	✓	1. Do you hold or have you ever held a license, certification, or registration (active or inactive, current or expired) to practice this profession in any other state or jurisdiction? List:
	✓	2. Since your initial application or your last renewal, whichever is later, have you ever had disciplinary action taken against your license, certification, or registration issued to you in any profession in any other state or jurisdiction?
	✓	3. Since your initial application or your last renewal, whichever is later, have you withdrawn an application for a license, certification, or registration, had an application denied or refused, or for disciplinary reasons agreed not to reapply for a license, certificate or registration in any profession in any state or jurisdiction?
	✓	4. Since your initial application or your last renewal, whichever is later, have you been convicted, found guilty or pleaded nolo contendere, or received probation without verdict or accelerated rehabilitative disposition (ARD) as to any felony or misdemeanor, including any drug law violations, or do you have any criminal charges pending and unresolved in any state or jurisdiction? You are not required to disclose any ARD or other criminal matter that has been expunged by order of a court.
	✓	5. Since May 19, 2002, have you been arrested for criminal homicide, aggravated assault, sexual offenses, or drug offenses in any state, territory, or country?
	✓	6. Since your initial application or your last renewal, whichever is later, have you had practice privileges denied, revoked or restricted in a hospital or other health care facility?
	✓	7. Since your initial application or your last renewal, whichever is later, have you had your DEA registration denied, revoked or restricted or have you had your provider privileges terminated by any medical assistance agency for cause?
	✓	8. Since May 19, 2002, have any malpractice complaints been filed against you? If yes, the Board requires that you submit a copy of the <u>entire Civil Complaint</u> , which must include the <u>filing date</u> and the <u>date you were served</u> . If the Civil Complaint was previously submitted, provide a statement, which lists the docket number.

Please review and update, as necessary, the following information regarding your license:

	Beginning Date	Ending Date	Level	Specialty	Hospital #	Hospital Name
Current	06/20/2012	06/19/2013	Level 2	Obstetrics and Gynecology	HS000240L	THOMAS JEFFERSON UNIVERSITY
Renewal	6/20/2013	6/19/2014	Level 3	OB / Gyn	HS000240L	Thomas Jefferson Univ.

Signature of Licensee (Mandatory):

Date: 4/4/13

Medical School Graduation Date:

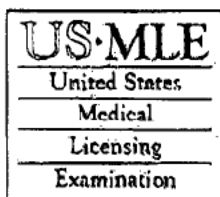
6/2/2011

SSN:

ATTACHMENTS FOR RENEWING:

- **FEE** – \$15.00 check payable to "COMMONWEALTH OF PENNSYLVANIA". Write your license number on your payment. A \$20.00 fee will be assessed for a returned payment.
- **LATE FEE** – \$5.00 per month, or part of a month. Late renewal fee will be assessed if postmarked after the expiration date.
- **NAME CHANGE DOCUMENT** – Submit a photocopy of a legal document verifying name change (i.e., marriage certificate, divorce decree, etc.)
- **PGY 2 LEVEL** – Copy of your USMLE Step 1 and 2 scores OR FLEX I scores OR National Board Part 1 and 2 scores OR an acceptable combination as indicated in the regulations.
- **PGY 3 LEVEL or above** – Copy of your USMLE Step 3 scores OR FLEX I and II scores OR National Board Parts 1-3 scores OR an acceptable combination as indicated in the regulations OR a copy of your unrestricted license WHICH SHOWS THE CURRENT EXPIRATION DATE.

MAY 2 2013



UNITED STATES MEDICAL LICENSING EXAMINATION®

STEP 3 SCORE REPORT

This score report is provided for the use of the examinee.

Third-party users of USMLE information are advised to rely solely on official USMLE transcripts.

Burcher, Theresa Adeliyi

USMLE ID: 5-209-941-3


Test Date: June 5, 2012

The USMLE is a single examination program for all applicants for medical licensure in the United States; it replaced the Federation Licensing Examination (FLEX) and the certifying examinations of the National Board of Medical Examiners (NBME Parts I, II and III). The program consists of three Steps designed to assess an examinee's understanding of and ability to apply concepts and principles that are important in health and disease and that constitute the basis of safe and effective patient care. Step 3 is designed to assess whether an examinee possesses the medical knowledge and understanding of clinical science considered essential for the unsupervised practice of medicine, with an emphasis on patient management in ambulatory-care settings. Results of the examination are reported to medical licensing authorities in the United States and its territories for use in granting an initial license to practice medicine. These scores represent your results for the administration of Step 3 on the test date shown above.

PASS	This result is based on the minimum passing score recommended by USMLE for Step 3. Individual licensing authorities may accept the USMLE-recommended pass/fail result or may establish a different passing score for their own jurisdictions.
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190	This score is determined by your overall performance on Step 3. For recent administrations, the mean and standard deviation for first-time examinees from U.S. and Canadian medical schools are approximately 219 and 17, respectively, with most scores falling between 140 and 260. A score of 190 is recommended by USMLE to pass Step 3. The standard error of measurement (SEM)† for this scale is approximately seven points.
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75	This score is also determined by your overall performance on the examination. A score of 75 on this scale, which is equivalent to a score of 190 on the scale described above, is recommended by USMLE to pass Step 3. The SEM† for this scale is approximately two points.
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Please confirm receipt @ 

†Your score is influenced both by your general understanding of clinical medicine and by the specific set of items selected for this Step 3 examination. The Standard Error of Measurement (SEM) provides an index of the variation in scores that would be expected to occur if an examinee were tested repeatedly using different sets of items covering similar content.

MAY 2 2013

COMMONWEALTH OF PENNSYLVANIA
DEPARTMENT OF STATE
BUREAU OF PROFESSIONAL AND OCCUPATIONAL AFFAIRS
STATE BOARD OF MEDICINE

MT199872
BURCHER

RENEWAL APPLICATION

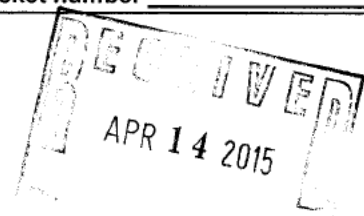
THERESA ADELIYI BURCHER 9849
THOMAS JEFFERSON UNIVERSITY
HOUSE STAFF OFFICE
111 SOUTH 11TH STREET
SUITE 2170
PHILADELPHIA PA 19107-5096

State Board of Medicine
PO Box 2649
Harrisburg, PA 17105-2649

☒ I will not be participating in graduate training in Pennsylvania after the expiration date indicated below and request inactive status. **No fee is required. YOU MUST SIGN, DATE AND RETURN THIS FORM.**

THE FOLLOWING QUESTIONS MUST BE ANSWERED

YES	NO	If YES to 2-13 - provide details AND attach certified copies of legal document(s).
	<input checked="" type="checkbox"/>	1. Do you hold or have you ever held a license, certificate, permit, registration or other authorization to practice a profession or occupation in any state or jurisdiction? If you answered yes, provide the profession and state or jurisdiction. List:
	<input checked="" type="checkbox"/>	2. Since your initial application or your last renewal, whichever is later, have you had disciplinary action taken against a professional or occupational license, certificate, permit, registration or other authorization to practice a profession or occupation issued to you in any state or jurisdiction or have you agreed to voluntary surrender in lieu of discipline?
	<input checked="" type="checkbox"/>	3. Do you currently have any disciplinary charges pending against your professional or occupational license, certificate, permit or registration in any state or jurisdiction?
	<input checked="" type="checkbox"/>	4. Since your initial application or last renewal, whichever is later, have you withdrawn an application for a professional or occupational license, certificate, permit or registration, had an application denied or refused, or for disciplinary reasons agreed not to apply or reapply for a professional or occupational license, certificate, permit or registration in any state or jurisdiction?
	<input checked="" type="checkbox"/>	5. Since your initial application or last renewal, whichever is later, have you been convicted (found guilty, pled guilty or pled nolo contendere), received probation without verdict or accelerated rehabilitative disposition (ARD), as to any criminal charges, felony or misdemeanor, including any drug law violations? Note: You are not required to disclose any ARD or other criminal matter that has been expunged by order of a court.
	<input checked="" type="checkbox"/>	6. Do you currently have any criminal charges pending and unresolved in any state or jurisdiction?
	<input checked="" type="checkbox"/>	7. Since your initial application or your last renewal, whichever is later, have you had your DEA registration denied, revoked or restricted?
	<input checked="" type="checkbox"/>	8. Since your initial application or your last renewal, whichever is later, have you had provider privileges denied, revoked, suspended or restricted by a Medical Assistance agency, Medicare, third party payor or another authority?
	<input checked="" type="checkbox"/>	9. Since your initial application or your last renewal, whichever is later, have you ever had practice privileges denied, revoked, suspended, or restricted by a hospital or any health care facility?
	<input checked="" type="checkbox"/>	10. Since your initial application or your last renewal, whichever is later, have you been charged by a hospital, university, or research facility with violating research protocols, falsifying research, or engaging in other research misconduct?
		11. Since your initial application or last renewal, whichever is later, have you engaged in the intemperate or habitual use or abuse of alcohol or narcotics, hallucinogenics or other drugs or substances that may impair judgment or coordination?
		12. If you answered "Yes" to question 11, are you currently participating in the Pennsylvania Professional Health Monitoring Program?
	<input checked="" type="checkbox"/>	13. Since your initial application or last renewal, whichever is later, have you been the subject of a civil malpractice lawsuit? If yes, please submit a copy of the entire Civil Complaint, which must include the filing date and the date you were served. Submit a statement which includes complete details of the complaints that have been filed against you. **If you previously reported the complaint to the Board, provide the docket number _____



Please review and update, as necessary, the following information regarding your license:

	Beginning Date	Ending Date	Level	Specialty	Hospital #	Hospital Name
Current	6/20/2014	6/19/2015	Level 4	Obstetrics and Gynecology	HS000240L	THOMAS JEFFERSON UNIVERSITY
Renewal						

Signature of Licensee (Mandatory):

[Redacted Signature]

Date: 3/25/15

Medical School Graduation Date:

6/3/2011

SSN:

[Redacted SSN]

CONTINUING MEDICAL EDUCATION

SPECIAL NOTICE TO ALL HEALTH-RELATED LICENSEES AND FUNERAL DIRECTORS

ACT 31 OF 2014 – INITIAL TRAINING AND CONTINUING EDUCATION IN CHILD ABUSE RECOGNITION AND REPORTING REQUIREMENTS

The Bureau of Professional and Occupational Affairs (BPOA), in conjunction with the Department of Human Services, is providing advance notice to all health-related licensees and funeral directors that are considered "mandatory reporters" under section 6311 of the Child Protective Services Law (CPSL) (23 P.S. § 6311), as amended, that EFFECTIVE JANUARY 1, 2015, all persons applying for issuance of an initial license shall be required to complete 3 hours of DPW-approved training in child abuse recognition and reporting requirements as a condition of licensure.

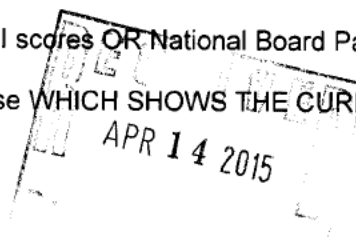
Additionally, EFFECTIVE WITH THE FIRST LICENSE RENEWAL AFTER JANUARY 1, 2015, all health-related licensees and funeral directors applying for the renewal of a license issued by the Board shall be required to complete at least 2 hours of Board-approved continuing education in child abuse recognition and reporting requirements as a condition of renewal.

Please note that Act 31 applies to all health-related licensees, regardless of whether they are subject to the continuing education requirements of the applicable board.

Details can be found at www.dos.state.pa.us/med. For a list of Board-approved providers, click the "Child Abuse CE Providers" link. Once you have completed a course, the approved provider will electronically submit your name, date of attendance, etc., to the Board.

ATTACHMENTS FOR RENEWING:

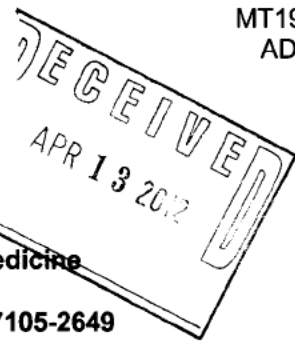
- **FEE** – \$15.00 check payable to "COMMONWEALTH OF PENNSYLVANIA". Write your license number on your payment. A \$20.00 fee will be assessed for a returned payment.
- **LATE FEE** - \$5.00 per month, or part of a month. Late renewal fee will be assessed if postmarked after the expiration date.
- **NAME CHANGE DOCUMENT** – Submit a photocopy of a legal document verifying name change (i.e., marriage certificate, divorce decree, etc.)
- **PGY 2 LEVEL** – Copy of your USMLE Step 1 and 2 scores OR FLEX I scores OR National Board Part 1 and 2 scores OR an acceptable combination as indicated in the regulations.
- **PGY 3 LEVEL or above** – Copy of your USMLE Step 3 scores OR FLEX I and II scores OR National Board Parts 1-3 scores OR an acceptable combination as indicated in the regulations OR a copy of your unrestricted license WHICH SHOWS THE CURRENT EXPIRATION DATE.



COMMONWEALTH OF PENNSYLVANIA
BUREAU OF PROFESSIONAL STANDARDS
RENEWAL

R 6074768

MT199872
ADELIYI



THERESA B ADELIYI 9849
THOMAS JEFFERSON UNIVERSITY
HOUSE STAFF OFFICE
111 SOUTH 11TH STREET
SUITE 2170
PHILADELPHIA PA 19107-5096

State Board of Medicine
PO Box 2649
Harrisburg, PA 17105-2649

The new middle name
registered as "Adeliya";
but "Adeliyi" appears
in the documents

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THE FOLLOWING QUESTIONS MUST BE ANSWERED

YES	NO	If YES to 2-8 - provide details AND attach certified copies of legal document(s).
	X	1. Do you hold or have you ever held a license, certification, or registration (active or inactive, current or expired) to practice this profession in any other state or jurisdiction? List:
	X	2. Since your initial application or your last renewal, whichever is later, have you ever had disciplinary action taken against your license, certification, or registration issued to you in any profession in any other state or jurisdiction?
	X	3. Since your initial application or your last renewal, whichever is later, have you withdrawn an application for a license, certification, or registration, had an application denied or refused, or for disciplinary reasons agreed not to reapply for a license, certificate or registration in any profession in any state or jurisdiction?
	X	4. Since your initial application or your last renewal, whichever is later, have you been convicted, found guilty or pleaded nolo contendere, or received probation without verdict or accelerated rehabilitative disposition (ARD) as to any felony or misdemeanor, including any drug law violations, or do you have any criminal charges pending and unresolved in any state or jurisdiction? You are not required to disclose any ARD or other criminal matter that has been expunged by order of a court.
	X	5. Since May 19, 2002, have you been arrested for criminal homicide, aggravated assault, sexual offenses, or drug offenses in any state, territory, or country?
	X	6. Since your initial application or your last renewal, whichever is later, have you had practice privileges denied, revoked or restricted in a hospital or other health care facility?
	X	7. Since your initial application or your last renewal, whichever is later, have you had your DEA registration denied, revoked or restricted or have you had your provider privileges terminated by any medical assistance agency for cause?
	X	8. Since May 19, 2002, have any malpractice complaints been filed against you? If yes, the Board requires that you submit a copy of the entire Civil Complaint, which must include the filing date and the date you were served. If the Civil Complaint was previously submitted, provide a statement, which lists the docket number.

Please review and update, as necessary, the following information regarding your license:

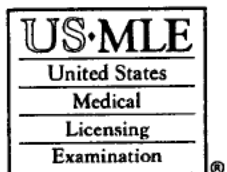
	Beginning Date	Ending Date	Level	Specialty	Hospital #	Hospital Name
Current	6/20/2011	6/19/2012	Level 1	Obstetrics and Gynecology	HS000240L	THOMAS JEFFERSON UNIVERSITY
Renewal	6/20/12	6/19/13	2	"	"	"

Signature of Licensee (Mandatory): _____ Date: 3/28/12
Medical School Graduation Date: 6/3/2011 SSN: _____

ATTACHMENTS FOR RENEWING:

- **FEE** - \$15.00 check payable to "COMMONWEALTH OF PENNSYLVANIA". Write your license number on your payment. A \$20.00 fee will be assessed for a returned payment.
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- **PGY 2 LEVEL** - Copy of your USMLE Step 1 and 2 scores OR FLEX I scores OR National Board Part 1 and 2 scores OR an acceptable combination as indicated in the regulations.
- **PGY 3 LEVEL or above** - Copy of your USMLE Step 3 scores OR FLEX I and II scores OR National Board Parts 1-3 scores OR an acceptable combination as indicated in the regulations OR a copy of your unrestricted license WHICH SHOWS THE CURRENT EXPIRATION DATE.

Name change to: Theresa Adeliyi Burcher

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

This document was prepared by
National Board of Medical Examiners® (NBME®)
3750 Market Street Philadelphia, PA 19104-3190 - Telephone (215) 590-9700

Date: 10/01/2010**Examinee ID:** 5-209-941-3**Date of Birth:** [REDACTED]**Examinee:** Adeliyi, Theresa

Results for all Steps taken by this examinee (and for which results have been reported to date) are shown below. For Steps that span more than one day, the test date reflects the day on which the examination began. Where numeric scores are reported, there are two scales used and the recommended minimum passing score ("MP") on each scale is shown in parentheses.

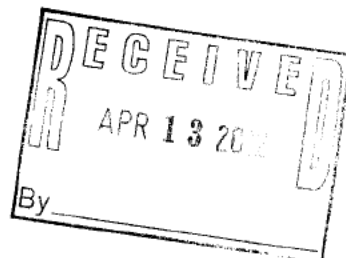
USMLE Step 1

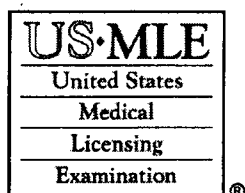
Test Date	Pass/Fail	Three-Digit Score		Two-Digit Score		Comments
		Total	MP	Total	MP	
06/22/2009	Pass	223	(185)	93	(75)	

USMLE Step 2*Clinical Knowledge (CK)*

Test Date	Pass/Fail	Three-Digit Score		Two-Digit Score		Comments
		Total	MP	Total	MP	
08/26/2010	Pass	224	(189)	97	(75)	

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





UNITED STATES MEDICAL LICENSING EXAMINATION®

STEP 2 CLINICAL SKILLS (CS) SCORE REPORT

This score report is provided for the use of the examinee.

Third-party users of USMLE information are advised to rely solely on official USMLE transcripts.

Adeliyi, Theresa

USMLE ID: 5-209-941-3

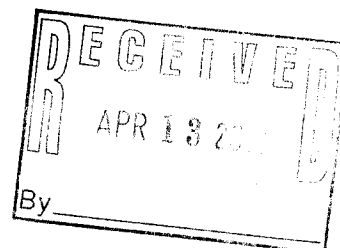
Test Date: October 5, 2010

The USMLE is a single examination program consisting of three Steps designed to assess an examinee's understanding of and ability to apply concepts and principles that are important in health and disease and that constitute the basis of safe and effective patient care. Step 2 is designed to assess whether an examinee can apply medical knowledge, skills, and understanding of clinical science essential for the provision of patient care under supervision, including emphasis on health promotion and disease prevention. The inclusion of Step 2 in the USMLE sequence is intended to ensure that due attention is devoted to principles of clinical sciences and basic patient-centered skills that provide the foundation for the safe and competent practice of medicine. There are two components to Step 2: a Clinical Knowledge (CK) examination and a Clinical Skills (CS) examination. This report represents results for the Step 2 CS examination only. Results of the examination are reported to medical licensing authorities in the United States and its territories for use in granting an initial license to practice medicine. The overall Pass/Fail outcome provided below represents your result for the administration of the Step 2 CS on the test date shown above.

<i>Overall Pass/Fail Outcome</i>
PASS

The overall outcome for Step 2 CS, reported above, is based upon the minimum passing levels set by USMLE for the three Step 2 CS subcomponents. The three subcomponents are Integrated Clinical Encounter (ICE), Communication and Interpersonal Skills (CIS), and Spoken English Proficiency (SEP). It is necessary to pass all three subcomponents in order to obtain an overall passing outcome on the Step 2 CS. Results for the three Step 2 CS subcomponents are reported below.

<i>ICE</i>	<i>CIS</i>	<i>SEP</i>
PASS	PASS	PASS

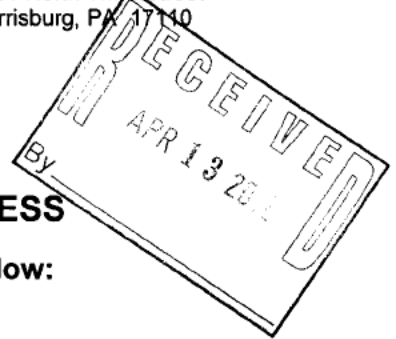


STATE BOARD OF MEDICINE

Mailing Address
P O Box 2649
Harrisburg, PA 17105-2649

Telephone: 717-783-1400
Fax: 717-787-7769
E-mail: st-medicine@state.pa.us
Website: www.dos.state.pa.us/med

Courier Mail
2601 North Third Street
Harrisburg, PA 17110



REQUEST FOR CHANGE OF NAME AND/OR ADDRESS

Complete the following information and check the appropriate block below:

Current Information

Last Name: Adeliya

First Name: Theresa Middle Initial:

License Number: MTT199872

Social Security Number: [REDACTED]

☐ Change of Name

You must submit a copy of a legal document verifying the name as it is currently listed in the Board's records and also the new name. The following are acceptable name change verification documents:

- (1) marriage certificate;
- (2) divorce decree which indicates the retaking of your maiden name;
- (3) other legal document indicating the retaking of a maiden name;
- (4) notarized copy of a passport;
- (5) notarized copy of a social security card;
- (6) for a legal name change, a copy of the court document must be provided.

New Name:

Last: Burcher First: Theresa Middle: Adeliya

☐ Change of Address

Old Address:

Street Address: _____

City: _____ State: _____ Zip Code: _____

New Address:

Street Address: _____

City: _____ State: _____ Zip Code: _____

Email Address: _____

FEE: To obtain a duplicate license reflecting the change of name and/or address, you must return this application and a \$5.00 fee, check or money order, payable to "Commonwealth of PA". Without the \$5.00 fee, the change(s) will be made but no duplicate will be issued. **A processing fee of \$20.00 will be charged for any check or money order returned unpaid by your bank, regardless of the reason for non-payment.**

MARRIAGE LICENSE BUREAU

**IN THE COURT OF COMMON PLEAS OF LEHIGH COUNTY PENNSYLVANIA
ORPHANS' COURT DIVISION**

STATE OF PENNSYLVANIA)
) ss:
COUNTY OF LEHIGH)

CERTIFICATE OF THE MARRIAGE OF



[REDACTED]

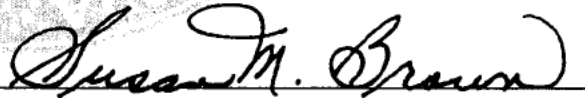
and

THERESA BOSEDE ADELIYI

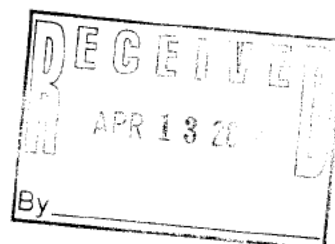
I, Susan M. Brown, Assistant Clerk of Orphans' Court Division of the Court of Common Pleas of Lehigh County, Pennsylvania, hereby certify that the following information appears in the official marriage license records maintained by the Office of Clerk of the Orphans' Court Division:

That [REDACTED] born [REDACTED] and Theresa Bosede Adeliyi, born [REDACTED] were united in Marriage, on March 25, 2002, at Bethlehem, Northampton County, Pennsylvania, by District Justice Joseph K. Barner, in accordance with Marriage License Number 2002-0220 duly issued by the Clerk of the Orphans' Court Division, Court of Common Pleas, Lehigh County, Pennsylvania.

IN WITNESS WHEREOF, I have hereto set my hand and affixed the seal of the Orphans' Court Division, Lehigh County, Pennsylvania, on this the 8th day of May, 2006.



Susan M. Brown
Assistant Clerk of Orphans' Court Division



COMMONWEALTH OF PENNSYLVANIA
DEPARTMENT OF STATE
BUREAU OF PROFESSIONAL AND OCCUPATIONAL AFFAIRS
STATE BOARD OF MEDICINE

Receipt #
6951204
MT199872
BURCHER

RENEWAL APPLICATION

THERESA ADELIYI BURCHER 9849
THOMAS JEFFERSON UNIVERSITY
HOUSE STAFF OFFICE
111 SOUTH 11TH STREET
SUITE 2170
PHILADELPHIA PA 19107-5096

State Board of Medicine
PO Box 2649
Harrisburg, PA 17105-2649

☐ I will not be participating in graduate training in Pennsylvania after the expiration date indicated below and request inactive status. **No fee is required. YOU MUST SIGN, DATE AND RETURN THIS FORM.**

THE FOLLOWING QUESTIONS MUST BE ANSWERED

YES	NO	If YES to 2-8 - provide details AND attach certified copies of legal document(s).
	✓	1. Do you hold or have you ever held a license, certification, or registration (active or inactive, current or expired) to practice this profession in any other state or jurisdiction? List:
	✓	2. Since your initial application or your last renewal, whichever is later, have you ever had disciplinary action taken against your license, certification, or registration issued to you in any profession in any other state or jurisdiction?
	✓	3. Since your initial application or your last renewal, whichever is later, have you withdrawn an application for a license, certification, or registration, had an application denied or refused, or for disciplinary reasons agreed not to reapply for a license, certificate or registration in any profession in any state or jurisdiction?
	✓	4. Since your initial application or your last renewal, whichever is later, have you been convicted, found guilty or pleaded nolo contendere, or received probation without verdict or accelerated rehabilitative disposition (ARD) as to any felony or misdemeanor, including any drug law violations, or do you have any criminal charges pending and unresolved in any state or jurisdiction? You are not required to disclose any ARD or other criminal matter that has been expunged by order of a court.
	✓	5. Since May 19, 2002, have you been arrested for criminal homicide, aggravated assault, sexual offenses, or drug offenses in any state, territory, or country?
	✓	6. Since your initial application or your last renewal, whichever is later, have you had practice privileges denied, revoked or restricted in a hospital or other health care facility?
	✓	7. Since your initial application or your last renewal, whichever is later, have you had your DEA registration denied, revoked or restricted or have you had your provider privileges terminated by any medical assistance agency for cause?
	✓	8. Since May 19, 2002, have any malpractice complaints been filed against you? If yes, the Board requires that you submit a copy of the entire Civil Complaint, which must include the filing date and the date you were served. If the Civil Complaint was previously submitted, provide a statement, which lists the docket number.

Please review and update, as necessary, the following information regarding your license:

	Beginning Date	Ending Date	Level	Specialty	Hospital #	Hospital Name
Current	06/20/2013	06/19/2014	Level 3	Obstetrics and Gynecology	HS000240L	THOMAS JEFFERSON UNIVERSITY
Renewal	6/20/2014	6/19/2015	4	" "	" "	" "

Signature of Licensee (Mandatory):

Date: 4/3/14

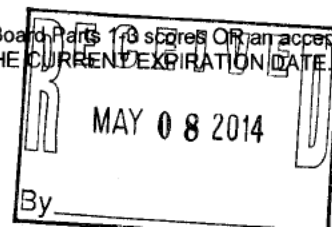
Medical School Graduation Date:

June 2015 (2011)

SSN:

ATTACHMENTS FOR RENEWING:

- **FEE** - \$15.00 check payable to "COMMONWEALTH OF PENNSYLVANIA". Write your license number on your payment. A \$20.00 fee will be assessed for a returned payment.
- **LATE FEE** - \$5.00 per month, or part of a month. Late renewal fee will be assessed if postmarked after the expiration date.
- **NAME CHANGE DOCUMENT** - Submit a photocopy of a legal document verifying name change (i.e., marriage certificate, divorce decree, etc.)
- **PGY 2 LEVEL** - Copy of your USMLE Step 1 and 2 scores OR FLEX I scores OR National Board Part 1 and 2 scores OR an acceptable combination as indicated in the regulations.
- **PGY 3 LEVEL or above** - Copy of your USMLE Step 3 scores OR FLEX I and II scores OR National Board Part 1 and 2 scores OR an acceptable combination as indicated in the regulations OR a copy of your unrestricted license WHICH SHOWS THE CURRENT EXPIRATION DATE.



Person Info

Name: Theresa Burcher

Address Info

Street Address:

Phone

Fax

City Ardmore

State PA

Zipcode 19003

Country 82

County Montgomery

Email:

7689
8/9/81

Are your medical/licensure records listed under another name or names?	Y
If you selected "Yes", please insert in the text box the other name or names. If yes, submit a copy of the legal document evidencing the name change (i.e., marriage license, divorce decree, naturalization, etc.)	Theresa Adeliyi
Indicate the Licensing Examination(s) passed. If you have taken an examination, you must contact the appropriate agency and request scores be sent directly to the Board .	USMLE
Please provide the dates for Part1/Step1:	06/22/2009
Please provide the dates for Part2/Step2:	08/26/2010
Please provide the dates for Part3/Step3:	06/05/2012
Have you completed ACGME accredited post graduate training in the United States or Canada?	N
PGY 1 Training Hospital Name:	Thomas Jefferson University Hospital
PGY 1 Training Dates Completed From:	06/20/2011
PGY 1 Training Dates Completed To:	06/18/2012
PGY 2 Training Hospital Name:	Thomas Jefferson University Hospital
PGY 2 Training Dates Completed From:	06/19/2012
PGY 2 Training Dates Completed To:	06/20/2013
Are you are a graduate of an unaccredited medical school (International Medical School)?	N
Did you complete PGY 3 training?	Y
PGY 3 Training Hospital Name:	Thomas Jefferson University Hospital
PGY 3 Training Dates Completed From:	06/21/2013
PGY 3 Training Dates Completed To:	06/19/2014
Do you hold a current and valid ECFMG Certification?	N
Have you previously held a Pennsylvania Graduate Training License?	Y
If you selected "Yes", insert your graduate training license number in the text box:	MT199872
Do you hold, or have you ever held, a license, certificate, permit, registration or other authorization to practice a profession or occupation in any state or jurisdiction?	Y
If you answered yes to the above question, please provide the profession and state or jurisdiction. Please do not abbreviate the profession.	Graduate Medical Trainee, PA
Have you had disciplinary action taken against a professional or occupational license, certificate, permit, registration or other authorization to practice a profession or occupation issued to you in any state or jurisdiction or have you agreed to voluntary surrender in lieu of discipline?	N
Do you currently have any disciplinary charges pending against your professional or occupational license, certificate, permit or registration in any state or jurisdiction?	N
Have you withdrawn an application for a professional or occupational license, certificate, permit or registration, had an application denied or refused, or for disciplinary reasons agreed not to apply or reapply for a professional or occupational license, certificate, permit or registration in any state or jurisdiction?	N
Have you been convicted (found guilty, pled guilty or pled nolo contendere), received probation without verdict or accelerated rehabilitative disposition (ARD), as to any criminal charges, felony or misdemeanor, including any drug law violations? Note: You are not required to disclose any ARD or other criminal matter that has been expunged by order of a court.	N
Do you currently have any criminal charges pending and unresolved in any state or jurisdiction?	N
Have you ever had your DEA registration denied, revoked or restricted?	N
Have you ever had provider privileges denied, revoked, suspended or restricted by a Medical Assistance agency, Medicare, third party payor or another authority?	N
Have you ever had practice privileges denied, revoked, suspended or restricted by a hospital or any health care facility?	N
Have you ever been charged by a hospital, university, or research facility with violating research protocols, falsifying research, or engaging in other research misconduct?	N
Do you currently engage in or have you ever engaged in the intemperate or habitual use or abuse of alcohol or narcotics, hallucinogenics or other drugs or substances that may impair judgment or coordination?	

If yes, are you currently participating in the Pennsylvania Professional Health Monitoring Program?

Since May 19, 2002, have any malpractice complaints been filed against you? If yes, the Board requires that you submit a copy of the entire Civil Complaint which must include the docket number, filing date, and the date you were served. Submit a statement which includes complete details of the complaints that have been filed against you.

N

Date Submitted: Thursday, March 12,
2015

Education Info

Profession: Medicine School: University of Toledo, College of Medicine. Toledo

From: 8/21/2006 To: 6/3/2011

Employment Information

No employment records

PENNSYLVANIA STATE BOARD OF MEDICINE

VERIFICATION OF MEDICAL EDUCATION **(For Graduates of American/Canadian Medical Schools)**

SECTION 1 - TO BE COMPLETED BY APPLICANT

NAME:	Last BURCHER	First THERESA	Middle ADELIYI
NAME OF MEDICAL SCHOOL:	UNIVERSITY OF TOLEDO COLLEGE OF MEDICINE		
LOCATION:	TOLEDO, OH		

Submit the verification of medical education form to your medical school and request the school return the completed form directly to the Board in an official school envelope.

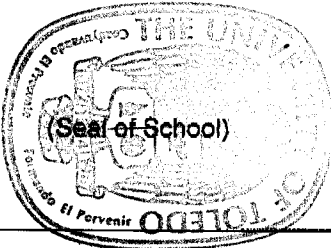
SECTION 2 - TO BE COMPLETED BY DEAN OR REGISTRAR OF MEDICAL SCHOOL

NAME OF MEDICAL SCHOOL:	University of Toledo - College of Medicine		
NAME OF MEDICAL STUDENT:	Last Adeliyi	First Theresa	Middle B.
DATE STUDENT BEGAN TO ATTEND THIS MEDICAL SCHOOL:	Month August	Day 25	Year 2008
DATE OF GRADUATION:	Month June	Day 03	Year 2011

I CERTIFY THAT ALL OF THE INFORMATION LISTED ABOVE IS CORRECT

SIGNATURE OF DEAN/REGISTRAR: 

DATE: Month **9** Day **3** Year **2015**



Upon completion, school must return this completed form directly to the Pennsylvania State Board of Medicine in an official school envelope.

**DO NOT RETURN THIS FORM
TO THE APPLICANT**

Regular Mailing Address
STATE BOARD OF MEDICINE
P.O. BOX 2649
HARRISBURG, PA 17105-2649
717-783-1400/717-787-2381

Courier Delivery Address
STATE BOARD OF MEDICINE
2601 NORTH THIRD STREET
HARRISBURG, PA 17110

RECEIVED DIRECT

APR 09 2015



ind

ab

Department of
Obstetrics and Gynecology
833 Chestnut Street, Concourse
Philadelphia, PA 19107
T 215-955-5000
F 215-923-1089

March 30, 2015

Pennsylvania State Board of Medicine
P.O. 2649
Harrisburg, PA 17105-2649

RE: Theresa Burcher, MD, #3327420

TO WHOM IT MAY CONCERN:

I am happy to support the application of Theresa Burcher, MD for medical licensure in the Commonwealth of Pennsylvania. I have known Dr. Burcher since the beginning of her residency in Obstetrics and Gynecology almost 4 years ago. I have worked with her as a teacher on a daily basis and I have had the opportunity to observe her performance in a variety of clinical situations, some of them stressful. I feel that I know her character and abilities quite well.

Dr. Burcher is a very intelligent, hard-working and compassionate physician. She has an excellent fund of knowledge and clearly keeps up with current developments in our field. She has well-developed surgical abilities and admirable clinical judgment. Dr. Burcher is widely respected by her colleagues and her teachers, and she has earned the confidence of her patients. Her integrity and professionalism have never been called into question. As far as I am aware, she is in excellent health, without evidence of any form of illness or substance dependency.

In summary, I have no hesitation in endorsing Dr. Burcher as being eminently qualified for medical licensure. Should you need additional information, I can be reached at [REDACTED], or [REDACTED].

Sincerely,
[REDACTED]

Thomas A. Klein, MD
PA License # MD 049180L
Professor and Vice Chair
Department of Obstetrics and Gynecology

APR 6 2015

PENNSYLVANIA STATE BOARD OF MEDICINE

VERIFICATION OF MEDICAL EDUCATION **(For Graduates of American/Canadian Medical Schools)**

SECTION 1 – TO BE COMPLETED BY APPLICANT


NAME:	Last BURCHER	First THERESA	Middle ADELIYI
NAME OF MEDICAL SCHOOL:	UNIV. OF TOLEDO, COLLEGE OF MEDICINE		
LOCATION:	TOLEDO, OH		

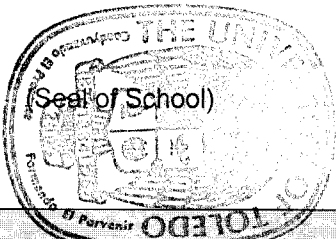
Submit the verification of medical education form to your medical school and request the school return the completed form directly to the Board in an official school envelope.

SECTION 2 – TO BE COMPLETED BY DEAN OR REGISTRAR OF MEDICAL SCHOOL

NAME OF MEDICAL SCHOOL:	The University of Toledo, College of Medicine and Life Sciences		
NAME OF MEDICAL STUDENT:	Last Burcher	First Theresa	Middle Adeliyi
DATE STUDENT BEGAN TO ATTEND THIS MEDICAL SCHOOL:	Month August	Day 01	Year 2008
DATE OF GRADUATION:	Month June	Day 03	Year 2011

I CERTIFY THAT ALL OF THE INFORMATION LISTED ABOVE IS CORRECT

SIGNATURE OF DEAN/REGISTRAR:	
DATE: Month 03 Day 20 Year 2015	Upon completion, school must return this completed form directly to the Pennsylvania State Board of Medicine in an official school envelope. <p style="text-align: center;">DO NOT RETURN THIS FORM TO THE APPLICANT</p>



Regular Mailing Address
STATE BOARD OF MEDICINE
P.O. BOX 2649
HARRISBURG, PA 17105-2649
717-783-1400/717-787-2381

Courier Delivery Address
STATE BOARD OF MEDICINE
2601 NORTH THIRD STREET
HARRISBURG, PA 17110

MAR 26 2015

RECEIVED DIRECT

md *6/20/15*

VERIFICATION OF ACGME APPROVED GRADUATE MEDICAL TRAINING

(Graduates of American/Canadian Medical Schools)

SECTION 1 – TO BE COMPLETED BY APPLICANT

NAME:	Last BURCHER	First THERESA	Middle ADELYN
1.	If training began before July 1, 1987, one year of approved training at a first (PGY 1) or second (PGY 2) year level must be verified. If the training began on or after July 1, 1987, two (2) years of approved training are required, one at first (PGY 1) year level and one at second (PGY 2) year level.		
2.	Training at a first (PGY 1) year must be ACGME approved entry level (training which requires no previous training). Training at a second (PGY 2) year must be ACGME approved and can be any specialty.		
3.	If training was completed at more than one hospital, duplicate this form and submit to each hospital.		

SECTION 2 – TO BE COMPLETED BY PROGRAM DIRECTOR WHERE THE GRADUATE TRAINING OCCURRED

If training was in Pennsylvania, information must coincide with data on graduate license. For applicants still in the second year of training, this form may be completed and signed by the program director thirty (30) days prior to the completion of the approved training. Forms postmarked or signed prior to the thirty days will not be accepted.

HOSPITAL WHERE TRAINING WAS COMPLETED:	Thomas Jefferson University Hospital
NAME OF SPONSORING INSTITUTION:	

LOCATED IN:	CITY Philadelphia	STATE PA	ACGME ACCREDITED
PGY LEVEL	FROM (MM/DD/YYYY)	TO (MM/DD/YYYY)	SPECIALTY
1	6/20/11	6/19/12	OB/GYN
PGY LEVEL	FROM (MM/DD/YYYY)	TO (MM/DD/YYYY)	SPECIALTY
2, 3, 4	6/20/12	3/9/15	OB/GYN
			Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>

"I certify that the above named applicant successfully completed/will successfully complete this graduate medical training and that there was/is no disciplinary action outstanding against this applicant. If this applicant does not complete this training, the Board will be notified." If there has been disciplinary or administrative action regarding this applicant, please provide a separate statement outlining the details.

If the hospital has no seal or stamp to affix to this document, I will have the form notarized to verify that it was completed by this hospital.

 Signature of Program Director	3/9/15 Date
-----------------------------------	-----------------------

(Seal)	<table style="width: 100%;"> <tr> <td style="width: 60%; text-align: center;"> Notary Signature </td> <td style="width: 40%; text-align: center;"> Notary Commission Expiration Date: July 2, 2017 </td> </tr> </table>	 Notary Signature	Notary Commission Expiration Date: July 2, 2017
 Notary Signature	Notary Commission Expiration Date: July 2, 2017		

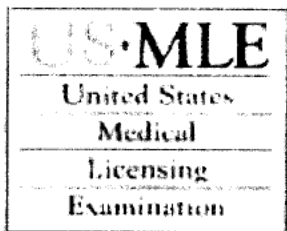
Regular Mailing Address
 STATE BOARD OF MEDICINE
 P.O. BOX 2649
 HARRISBURG, PA 17105-2649
 717-783-1400/717-787-2381

Courier Delivery Address
 STATE BOARD OF MEDICINE
 2601 NORTH THIRD STREET
 HARRISBURG, PA 17110

RETURN COMPLETED FORM DIRECTLY TO THE BOARD IN OFFICIAL HOSPITAL ENVELOPE

RECEIVED DIRECTOR

MAR 16 2015



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

This document was prepared by the
Federation of State Medical Boards of the United States, Inc.
Federation Place, 400 Fuller Wiser Road, Suite 300, Euless, TX 76039-3856 -- Telephone (817) 868-4000

Date : 03/16/2015

Recipient:

Pennsylvania State Board of Medicine
ATTN: Michael Coates
2601 N Third Street
Harrisburg, PA 17110

Examinee: Burcher, Theresa Adeliyi
Alt Name(s): Adeliyi, Theresa Bosede

Examinee ID#: 5-209-941-3
Date of Birth: [REDACTED]

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

USMLE STEP 1

Test Date	Pass/Fail	Total	MP	Comments
06/22/2009	Pass	223	(185)	

USMLE STEP 2

Clinical Knowledge (CK)

Test Date	Pass/Fail	Total	MP	Comments
08/26/2010	Pass	224	(189)	

Clinical Skills (CS)*

Test Date	Pass/Fail	Total	MP	Comments
10/05/2010	Pass			

USMLE STEP 3

	Test Date	Pass/Fail	Total	MP	Comments
PENNSYLVANIA	06/05/2012	Pass	199	(190)	

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

RECEIVED DIRECT

MAR 17 2015

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

BURCHER, THERESA ADELIYI - SELF-QUERY RESPONSE

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

Practitioner Name: BURCHER, THERESA ADELIYI
 Date of Birth: [REDACTED] Gender: FEMALE
 Other Name(s) Used: ADELIYI, THERESA BOSEDE
 Work Address: [REDACTED] ARDMORE, PA 19003-3124
 Social Security Number: [REDACTED] NPI: 1528358710
 License: PHYSICIAN RESIDENT (MD), MT199872, PA, OBSTETRICS & GYNECOLOGY
 Professional School(s): MEDICAL UNIVERSITY OF OHIO (2011)

B. PAYMENT INFORMATION

Credit Card Information: [REDACTED] (03/2019)
 NPDB Charge: \$10.00* NPDB Bill Reference Number: N36469468
 * Each charge will appear separately on your credit card statement.
 Transaction Date: 03/12/2015 Additional Paper Copies Requested: 1

C. SUMMARY OF REPORTS ON FILE WITH THE DATA BANK AS OF 03/12/2015

The following report types have been searched:

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

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

----- No Reports Found -----



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

<http://www.npdb.hrsa.gov>

To: BURCHER, THERESA ADELIYI

ARDMORE, PA 19003-3124

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

MAR 27 2015

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

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

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

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

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

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

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

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

md ab

Theresa Adeliyi Burcher

Thomas Jefferson University Hospital • Department of Obstetrics and Gynecology

[REDACTED] • Mezzanine Level • Philadelphia, PA 19107

Phone: [REDACTED]

email: [REDACTED]

RESIDENCY

Thomas Jefferson University Hospital, Philadelphia, PA
Department of Obstetrics and Gynecology
Residency Training, PGY-4

June, 2011 - Present

EDUCATION

University of Toledo College of Medicine, Toledo, OH

M.D., M.P.H – Public Health Administration

June, 2011

**University of Medicine and Dentistry of New Jersey Graduate
School of Biomedical Sciences, Newark, NJ**

M.S. in Biomedical Sciences

May, 2005

Lehigh University, Bethlehem, PA

B.A in Biology

December, 2003

B.A in Economics

HONORS, AWARDS AND SCHOLARSHIPS

Apple Teaching Awards, Thomas Jefferson University Hospital

2012 – 2014

- Prize awarded to resident judged, by medical students, to be best teacher on rotation.

Roland A. Gandy Medical Staff Scholarship, University of Toledo College of Medicine

2009 – 2011

- Awarded to minority medical student with academic and community achievement

Academic Excellence Scholarship, University of Toledo College of Medicine

2008 - 2009

African American Scholarship, University of Toledo College of Medicine

2008 – 2009

- Awarded to minority medical student with academic excellence.

Clara Elizabeth Jackson Carter Foundation Scholarship, National Medical Fellowship

2007 – 2008

The Lincoln Fund Scholarship, National Medical Fellowship

2006 – 2007

PRESENTATIONS

Gynecology Morbidity and Mortality. Thomas Jefferson University Hospital

10/2014

Grand Rounds Speaker

Obstetrics Morbidity and Mortality. Thomas Jefferson University Hospital

11/2014

Adeliyi, T.A., Kleshinski, J., Gore, S. Recruitment at UTCOM: Lessons Learned.

2009

Council of Graduate Student Affairs (CGSA) Conference, Chicago, IL

TEACHING EXPERIENCE

Thomas Jefferson University Hospital, Philadelphia PA

Induction of labor Lecture

Labor and delivery lecture

Endometrial Cancer lecture.

8/2014

9/2014

2/2015

University of Toledo College of Medicine, Toledo OH

USMLE Step 1 Workshop Facilitator

Anatomy and Neuroscience.

Spring 2010

2007-2010

MAR 27 2015

LEADERSHIP EXPERIENCE

University of Toledo College of Medicine, Toledo OH

Student National Medical Association (SNMA)

2006 – 2011

President (2008-2009)

Vice President (2007-2008)

Recruitment Initiative Coordinator (2006-2007)

Obstetrics and Gynecology Student Organization

2007 – 2011

President (2008-2009)

Vice president (2007-2008)

VOLUNTEER OR COMMUNITY SERVICE

JeffHOPE

7/2011 – Present

Student-run Free Medical clinic at 5 area homeless shelters.

Outreach Program to Students at Scott High School, Toledo, OH

Educated and supported student interests in careers in the health care field.

2007 – 2009

Toledo Black Nurses Association Health Screening Drive, Toledo OH.

Fall 2008

Provided community members with basic health screening tests

Gave referrals for appropriate healthcare provider for result follow up

Community Care Clinic – Mildred Bayer Clinic for the homeless

Toledo OH

8/2006 – 5/2009

COMMITTEE MEMBERSHIP

Thomas Jefferson University Hospital, Philadelphia PA

2013 – Present

JMC Counsel on Diversity

University of Toledo College of Medicine, Toledo OH

President's Committee for African American Recruitment and Scholarship Support

2008 – 2009

Participated in discussions and development of programs to increase student population of minority students

College of Medicine Admissions Committee

2008 – 2009

A voting member of admission panel for medical school admission.

PROFESSIONAL AFFILIATIONS

American Congress of Obstetricians and Gynecologist (ACOG): Member

American Medical Association (AMA): Member

National Medical Association (NMA): Member

Doctors for America (DFA): Member

MAR 27 2015

Certificate of Completion

Recognizing and Reporting Child Abuse: Mandated and Permissive Reporting in Pennsylvania

Meets ACT 31 of 2014 training requirements

3 continuing education hours

Presenter:

University of Pittsburgh School of Social Work, PA Child Welfare Resource Center
403 East Winding Hill Road, Mechanicsburg, PA 17055

Presented to:

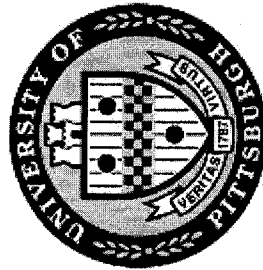
Burcher, Theresa

on the date:

Wednesday, March 25, 2015

Provider Number:
CACE000004

CE Course Number:
PCW000001



Mary Rose McCarthy, Director
PA Child Welfare Resource Center

Tracy Sosla, Director of Continuing Education
School of Social Work

PRINT

EXIT

MAR 27

PRACTITIONER PROFILE

Prepared for:

Pennsylvania State Board of Medicine

As of Date:3/26/2015

PRACTITIONER INFORMATION

Name: Theresa Adeliyi Burcher
Alternate Name(s): Theresa Bosede Adeliyi
DOB: [REDACTED]
Medical School: University of Toledo College of Medicine
Toledo, Ohio, UNITED STATES
Year of Grad: 2011
Degree Type: MD

BOARD ACTIONS

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

LICENSE HISTORY

Jurisdiction	License Number	Issue Date	Expiration Date	Last Updated
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PRACTITIONER PROFILE

Prepared for:	Pennsylvania State Board of Medicine	As of Date:3/26/2015
Practitioner Name:	Theresa Adeliyi Burcher	

ABMS® CERTIFICATION HISTORY

No ABMS 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.



COMMONWEALTH OF PENNSYLVANIA
STATE BOARD OF MEDICINE
P. O. BOX 2649
HARRISBURG, PENNSYLVANIA 17105
st-medicine@pa.gov
www.dos.state.pa.us/med
March 26, 2015

Telephone: 717-783-1400/787-2381
Fax: 717-787-7769

THERESA BURCHER 9849
[REDACTED]
ARDMORE PA 19003

RE: DISCREPANCY NOTICE – Unrestricted (American)

Dear Doctor:

The Board has received your application for an unrestricted medical license. The items listed below are needed to complete your application. A license cannot be issued until all items are received, approved and the application is complete. **You may not practice in the Commonwealth of Pennsylvania as a Physician and Surgeon until a license has been issued by the Board.**

- Curriculum Vitae listing **ALL** periods of employment or unemployment (i.e., child rearing, research, etc.) from graduation from medical school to present. The list must be in chronological order, include the month and year, and indicate the state/territory in which the employment occurred.
- A self query disclosure report from the **National Practitioner Data Bank (NPDB)** is required.
- Per Act 31 of 2014, three (3) hours of Board-approved continuing education in child abuse recognition and reporting requirements must be completed prior to your license being issued. Verification of completion must be sent electronically and directly from the course provider. Please note that it may take up to 7 days for the provider to submit the records to our office. Details can be found at www.dos.pa.gov. For a list of Board-approved providers, click the "Mandated Child Abuse Reporter Training Under Act 31" link.

PLEASE NOTE: Act 31 of 2014 applies to all health-related licensees, regardless of whether they are subject to any other continuing education requirements of the Board

**APPLICATIONS NOT COMPLETED WITHIN SIX MONTHS
WILL REQUIRE UPDATES OF CERTAIN DOCUMENTS.**

You may check the status of your application online at www.mylicense.state.pa.us. Click on the link duplicate licenses/address changes/application status. First time users will be required to register and create a user ID and password. Your registration code to register is: 33327420

Sincerely,

Pennsylvania State Board of Medicine

Person Info

Name: Theresa Burcher

Address Info

Street Address:

Email:

Phone

Fax

City Ardmore

State PA

Zipcode 19003

Country 82

County Montgomery

Survey Response Summary

Are your medical/licensure records listed under another name or names?

Y

If you selected "Yes", please insert in the text box the other name or names. If yes, Submit a copy of the legal document evidencing the name change (i.e., marriage license, divorce decree, naturalization, etc.)

Theresa Adeliyi

Indicate the Licensing Examination(s) passed. If you have taken an examination, you must contact the appropriate agency and request scores be sent **directly to the Board**.

USMLE

Please provide the dates for Part1/Step1:

06/22/2009

Please provide the dates for Part2/Step2:

08/26/2010

Please provide the dates for Part3/Step3:

06/05/2012

Have you completed ACGME accredited post graduate training in the United States or Canada?

N

PGY 1 Training Hospital Name:

Thomas Jefferson University Hospital

PGY 1 Training Dates Completed From:

06/20/2011

PGY 1 Training Dates Completed To:

06/18/2012

PGY 2 Training Hospital Name:

Thomas Jefferson University Hospital

PGY 2 Training Dates Completed From:

06/19/2012

PGY 2 Training Dates Completed To:

06/20/2013

Are you a graduate of an unaccredited medical school (International Medical School)?

N

Did you complete PGY 3 training?

Y

PGY 3 Training Hospital Name:

Thomas Jefferson University Hospital

PGY 3 Training Dates Completed From:

06/21/2013

PGY 3 Training Dates Completed To:

06/19/2014

Do you hold a current and valid ECFMG Certification?

N

Have you previously held a Pennsylvania Graduate Training License?

Y

If you selected "Yes", insert your graduate training license number in the text box:

MT199872

Question Response Summary

Do you hold, or have you ever held, a license, certificate, permit, registration or other authorization to practice a profession or occupation in any state or jurisdiction?

Y

If you answered yes to the above question, please provide the profession and state or jurisdiction. Please do not abbreviate the profession.

Graduate Medical Trainee. PA

Have you had disciplinary action taken against a professional or occupational license, certificate, permit, registration or other authorization to practice a profession or occupation issued to you in any state or jurisdiction or have you agreed to voluntary surrender in lieu of discipline?

N

Do you currently have any disciplinary charges pending against your professional or occupational license, certificate, permit or registration in any state or jurisdiction?

N

Have you withdrawn an application for a professional or occupational license, certificate, permit or registration, had an application denied or refused, or for disciplinary reasons agreed not to apply or reapply for a professional or occupational license, certificate, permit or registration in any state or jurisdiction?

N

Have you been convicted (found guilty, pled guilty or pled nolo contendere), received probation without verdict or accelerated rehabilitative disposition (ARD), as to any criminal charges, felony or misdemeanor, including any drug law violations? Note: You are not required to disclose any ARD or other criminal matter that has been expunged by order of a court.

N

Do you currently have any criminal charges pending and unresolved in any state or jurisdiction?

N

Have you ever had your DEA registration denied, revoked or restricted?

N

Have you ever had provider privileges denied, revoked, suspended or restricted by a Medical Assistance agency, Medicare, third party payor or another authority?

N

Have you ever had practice privileges denied, revoked, suspended or restricted by a hospital or any health care facility?

N

Have you ever been charged by a hospital, university, or research facility with violating research protocols, falsifying research, or engaging in other research misconduct?

N

Do you currently engage in or have you ever engaged in the intemperate or habitual use or abuse of alcohol or narcotics, hallucinogenics or other drugs or substances that may impair judgment or coordination?

If yes, are you currently participating in the Pennsylvania Professional Health Monitoring Program?

Since May 19, 2002, have any malpractice complaints been filed against you? If yes, the Board requires that you submit a copy of the **entire Civil Complaint** which must include the **docket number**, **filing date**, and the **date you were served**. Submit a statement which includes complete details of the complaints that have been filed against you.

N

Date Submitted: Thursday, March 12, 2015

Education Info

Profession: Medicine School: University of Toledo, College of Medicine. Toledo
From: 8/21/2006 To: 6/3/2011

Employment Information

No employment records

Person Info

Name:Theresa Burcher

Address Info

Street Address

Phone

Fax

CityArdmore

StatePA

Zipcode19003

Country82

CountyMontgomery

Email

Survey Response Summary

Question Response Summary

Are you submitting a name change with this renewal?

N

Have you completed your current CE requirements?

Y

Do you hold, or have you ever held, a license, certificate, permit, registration or other authorization to practice any health-related profession in any state or jurisdiction?

Y

If you answered yes to the above question, please provide the profession and state or jurisdiction.

Delaware

Since your initial application or last renewal, whichever is later, have you had disciplinary action taken against a professional or occupational license, certificate, permit, registration or other authorization to practice a profession or occupation issued to you in any state or jurisdiction or have you agreed to voluntary surrender in lieu of discipline?

N

Do you currently have any disciplinary charges pending against your professional or occupational license, certificate, permit or registration in any state or jurisdiction?

N

Since your initial application or last renewal, whichever is later, have you withdrawn an application for a professional or occupational license, certificate, permit or registration, had an application denied or refused, or for disciplinary reasons agreed not to apply or reapply for a professional or occupational license, certificate, permit or registration in any state or jurisdiction?

N

Since your initial application or last renewal, whichever is later, have you been convicted (found guilty, pled guilty or pled nolo contendere), received probation without verdict or accelerated rehabilitative disposition (ARD), as to any criminal charges, felony or misdemeanor, including any drug law violations? Note: You are not required to disclose any ARD or other criminal matter that has been expunged by order of a court.

N

Do you currently have any criminal charges pending and unresolved in any state or jurisdiction?

N

Since your initial application or last renewal, whichever is later, have you had your DEA registration denied, revoked or restricted?

N

Since your initial application or your last renewal, whichever is later, have you had provider privileges denied, revoked, suspended or restricted by a Medical Assistance agency, Medicare, third party payor or another authority?

N

Since your initial application or your last renewal, whichever is later, have you ever had practice privileges denied, revoked, suspended, or restricted by a hospital or any health care facility?

N

Since your initial application or your last renewal, whichever is later, have you been charged by a hospital, university, or research facility with violating research protocols, falsifying research, or engaging in other research misconduct?

N

Since your initial application or last renewal, whichever is later, have you engaged in the intemperate or habitual use or abuse of alcohol or narcotics, hallucinogenics or other drugs or substances that may impair judgment or coordination?

Since your initial application or your last renewal, whichever is later, have you been the subject of a civil malpractice lawsuit?

N

If yes, please submit a copy of the entire Civil Complaint, which must include the filing date and the date you were served. PLEASE NOTE: If you previously reported the complaint to the Board you will only need to provide the docket number here:

Have you completed 2 hours of Board-approved continuing education in child abuse recognition and reporting?

Y

Do you maintain current medical professional liability insurance in the Commonwealth of Pennsylvania?

Y

If you answer "No", please provide an explanation or reason for an exemption request.

Please provide the zip code of your primary employer/practice location. This data is being collected for the purpose of identifying healthcare professionals during state emergencies and may be provided to the Pennsylvania Emergency Management Agency for official use only.

19013

Date Submitted:

Sunday, November 20, 2016

Education Info

No education records

Employment Information

No employment records

Medicine- Medical Physician and Surgeon-
Accredited School Graduate



AA0001036339

BUREAU OF PROFESSIONAL AND OCCUPATIONAL AFFAIRS

P. O. Box 2649

Harrisburg, PA 17105-2649

APPLICANT INFORMATION

PERSONAL INFORMATION							
Last Name	BURCHER			First Name	THERESA		
Middle Name				Suffix			
Full Name	THERESA BURCHER						
SSN		Date Of Birth		Age		Gender	FEMALE
ADDRESS DETAILS							
Street Address							
City/State/Zip	ARDMORE PA 19003						
County	Montgomery				Country	United States	
CONTACT DETAILS							
Phone number				Mobile Phone number			
Primary Email Address				Secondary Email Address			
CHECKLIST ITEMS							
Checklist name	Status			Submitted Date	Expiration Date		
Application	Pending Review			12/17/2018			
Application Fee	Completed			12/17/2018			
Child Abuse CE	Completed			12/17/2018			
LEGAL QUESTIONS							
Questions	Answer			Document Uploaded	File Name		
1	Are you submitting a name change with this renewal?			N	No		
2	First Name				No		
3	Middle Name				No		
4	Last Name				No		
5	<p>You must submit a copy of a legal document verifying the name (s). The following are acceptable name change verification documents:</p> <p>(1) Marriage Certificate:</p> <p>(2) Divorce decree which indicates the retaking of your maiden name:</p> <p>(3) Other "legal" document indicating the retaking of a maiden name:</p> <p>(4) For a "legal" name change, a copy of the court document must be provided.</p>				No		
6	With the exception of the one you are currently renewing, do you hold, or have you ever held, a license, certificate, permit, registration or other authorization to practice a profession or occupation in any state or jurisdiction?			Y	No		

7	Please provide the profession and state or jurisdiction.	Medicine-Delaware	No	
8	Since your initial application or last renewal, whichever is later, have you had disciplinary action taken against a professional or occupational license, certificate, permit, registration or other authorization to practice a profession or occupation issued to you in any state or jurisdiction or have you agreed to voluntary surrender in lieu of discipline?	N	No	
9	Do you currently have any disciplinary charges pending against your professional or occupational license, certificate, permit or registration in any state or jurisdiction?	N	No	
10	Since your initial application or last renewal, whichever is later, have you withdrawn an application for a professional or occupational license, certificate, permit or registration, had an application denied or refused, or for disciplinary reasons agreed not to apply or reapply for a professional or occupational license, certificate, permit or registration in any state or jurisdiction?	N	No	
11	Since your initial application or last renewal, whichever is later, have you been convicted (found guilty, pled guilty or pled nolo contendere), received probation without verdict or accelerated rehabilitative disposition (ARD), as to any criminal charges, felony or misdemeanor, including any drug law violations? Note: You are not required to disclose any ARD or other criminal matter that has been expunged by order of a court.	N	No	
12	Do you currently have any criminal charges pending and unresolved in any state or jurisdiction?	N	No	
13	Since your initial application or your last renewal, whichever is later, have you had your DEA registration denied, revoked or restricted?	N	No	
14	Since your initial application or your last renewal, whichever is later, have you had provider privileges denied, revoked, suspended or restricted by a Medical Assistance agency, Medicare, third party payor or another authority?	N	No	
15	Since your initial application or your last renewal, whichever is later, have you had practice privileges denied, revoked, suspended, or restricted by a hospital or any health care facility?	N	No	
16	Since your initial application or your last renewal, whichever is later, have you been charged by a hospital, university, or research facility with violating research protocols, falsifying research, or engaging in other research misconduct?	N	No	
17	Since your initial application or last renewal, whichever is later, have you engaged in the intemperate or habitual use or abuse of alcohol or narcotics, hallucinogenics or other drugs or substances that may impair judgment or coordination?			
18	Since your initial application or your last renewal, whichever is later, have you been the subject of a civil malpractice lawsuit?	N	No	
19	Have you previously reported the complaint to the Board?		No	
20	Provide the docket number:		No	
21	Upload a copy of the entire Civil Complaint, which must include the filing date and the date you were served.		No	
22	Have you completed at least 2 hours of Board approved continuing education in pain management, identification of addiction or the practices of prescribing or dispensing of opioids?	Y	No	
23	Do you hold a DEA number or use the registration number of another person or entity to prescribe controlled substances?		No	
24	Have you registered with the Pennsylvania Prescription Drug Monitoring Program?	Y	No	

25	I will be retiring from practice but desire to place my license on active-retired status which will allow me to treat immediate family members. I am exempt from the CME requirements, except for completion of the 2 hours of Board-approved continuing education in child abuse recognition and reporting and 2 hours of Board approved continuing education in pain management, identification of addiction or the practices of prescribing or dispensing of opioids. Renewal must be completed and fee required.	N	No	
26	Do you maintain current medical professional liability insurance in the Commonwealth of Pennsylvania?	Y	No	
27	Upload an explanation or reason for an exemption request.		No	
28	Have you met your continuing education requirements? Please review the continuing education requirements posted on the Board's website at www.dos.pa.gov/med . Click on General Board Information. If you qualify for an exemption of the continuing education requirements, answer yes to the question. You are required to retain your official continuing education certificates of completion earned for this license renewal period until December 31, 2020.	Y	No	

Licenses/Certificates/Permits/Registrations in Any State/Jurisdiction

Profession	State/Jurisdiction
Medicine	Delaware

CONFIRMATION

<input checked="" type="checkbox"/>	All fees are non-refundable. Please check to continue with your transaction. (12/17/2018 12:03:14)
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BUREAU OF PROFESSIONAL AND OCCUPATIONAL AFFAIRS

P. O. Box 2649

Harrisburg, PA 17105-2649

APPLICANT INFORMATION

PERSONAL INFORMATION							
Last Name	ADELIYI			First Name	THERESA		
Middle Name	B			Suffix			
Full Name	THERESA B ADELIYI						
SSN		Date Of Birth		Age		Gender	FEMALE
ADDRESS DETAILS							
Street Address	WYNNEWOOD, PA 19096						
City/State/Zip	WYNNEWOOD PA 19096						
County	Montgomery				Country	United States	
CONTACT DETAILS							
Phone number				Mobile Phone number			
Primary Email Address				Secondary Email Address			
CHECKLIST ITEMS							
Checklist name	Status			Submitted Date	Expiration Date		
Application	Pending Review			12/07/2022			
Application Fee	Completed			12/07/2022			
Child Abuse CE	Not Received			12/07/2022			
LEGAL QUESTIONS							
Questions	Answer			Document Uploaded	File Name		
1	Are you submitting a name change with this renewal?			N	No		
2	First Name				No		
3	Middle Name				No		
4	Last Name				No		
5	You must submit a copy of a legal document verifying the name (s). The following are acceptable name change verification documents: (1) A birth certificate. (2) A marriage certificate (not a marriage license). (3) Divorce decree. (4) An official name change document issued by a court. (5) A passport. (6) A social security card. (7) A Pennsylvania driver's license or non-driver ID card. (8) A driver's license or official non-driver ID card issued by another state that complies with the federal REAL ID Act requirements (signified with a star on the front)				No		

6	With the exception of the one you are currently renewing, do you hold, or have you ever held, a license, certificate, permit, registration or other authorization to practice a profession or occupation in any state or jurisdiction?	Y	No	
7	Please provide the profession and state or jurisdiction.	Medicine- New Jersey	No	
8	Since your initial application or last renewal, whichever is later, have you had disciplinary action taken against a professional or occupational license, certificate, permit, registration or other authorization to practice a profession or occupation issued to you in any state or jurisdiction or have you agreed to voluntary surrender in lieu of discipline?	N	No	
9	Do you currently have any disciplinary charges pending against your professional or occupational license, certificate, permit or registration in any state or jurisdiction?	N	No	
10	Since your initial application or last renewal, whichever is later, have you withdrawn an application for a professional or occupational license, certificate, permit or registration, had an application denied or refused, or for disciplinary reasons agreed not to apply or reapply for a professional or occupational license, certificate, permit or registration in any state or jurisdiction?	N	No	
11	Since your initial application or your last renewal, whichever is later, have you had your DEA registration denied, revoked or restricted?	N	No	
12	Since your initial application or your last renewal, whichever is later, have you had provider privileges denied, revoked, suspended or restricted by a Medical Assistance agency, Medicare, third party payor or another authority?	N	No	
13	Since your initial application or your last renewal, whichever is later, have you had practice privileges denied, revoked, suspended, or restricted by a hospital or any health care facility?	N	No	
14	Since your initial application or your last renewal, whichever is later, have you been charged by a hospital, university, or research facility with violating research protocols, falsifying research, or engaging in other research misconduct?	N	No	
15	Since your initial application or last renewal, whichever is later, have you engaged in the intemperate or habitual use or abuse of alcohol or narcotics, hallucinogenics or other drugs or substances that may impair judgment or coordination?			
16	Since your initial application or your last renewal, whichever is later, have you been the subject of a civil malpractice lawsuit?	N	No	
17	Have you previously reported the complaint to the Board?		No	
18	Provide the state:		No	
19	Provide the county:		No	
20	Provide the docket number:		No	
21	Upload a copy of the entire Civil Complaint, which must include the filing date and the date you were served.		No	
22	Have you completed at least 2 hours of Board approved continuing education in pain management, identification of addiction or the practices of prescribing or dispensing of opioids?	Y	No	
23	Do you hold a DEA number or use the registration number of another person or entity to prescribe controlled substances?		No	
24	Have you registered with the Pennsylvania Prescription Drug Monitoring Program?	Y	No	

25	I will be retiring from practice but desire to place my license on active-retired status which will allow me to treat immediate family members. I am exempt from the CME requirements, except for completion of the 2 hours of Board-approved continuing education in child abuse recognition and reporting and 2 hours of Board approved continuing education in pain management, identification of addiction or the practices of prescribing or dispensing of opioids. Renewal must be completed and fee required.	N	No	
26	Do you maintain current medical professional liability insurance in the Commonwealth of Pennsylvania?	Y	No	
27	Upload an explanation or reason for an exemption request.		No	
28	Have you met your continuing education requirements? Please review the continuing education requirements posted on the Board's website at www.dos.pa.gov/med . Click on General Board Information. If you qualify for an exemption of the continuing education requirements, answer yes to the question. You are required to retain your official continuing education certificates of completion earned for this license renewal period until the end of the next renewal period.	Y	No	

Licenses/Certificates/Permits/Registrations in Any State/Jurisdiction

Profession	State/Jurisdiction
Medicine	New Jersey

PA VETERANS REGISTRY

Questions	Answer
1 Have you served in the U.S. Armed Forces?	N
2 Thank you for your service. Would you like to register with the PA Veterans Registry? The PA Veterans Registry provides veterans with information about federal, state and local benefits, programs and services that are available to Pennsylvania veterans and links veterans with resources that can provide assistance. Registration is quick and easy, and provides the Department of Military and Veterans Affairs (DMVA) with a way to contact you regarding the benefits and services you may be eligible for. If you check "Yes," you will receive an email with instructions to assist you in registering.	

ACKNOWLEDGEMENT OF DUTY TO SELF-REPORT DISCIPLINARY CONDUCT AND CERTAIN CRIMINAL ACTIVITY

<input checked="" type="checkbox"/>	<p>I hereby acknowledge that in addition to any existing reporting requirement required by a specific board or commission, I am REQUIRED pursuant to Act 6 of 2018 to NOTIFY the Bureau of Professional and Occupational Affairs WITHIN 30 DAYS of the occurrence of any of the following:</p> <p>(1) A disciplinary action taken against me by a licensing board or agency in another jurisdiction;</p> <p>(2) A finding or verdict of guilt, an admission of guilt, a plea of nolo contendere, probation without verdict, a disposition in lieu of trial or an Accelerated Rehabilitative Disposition (ARD) of any felony or misdemeanor offense in a criminal proceeding. I further acknowledge that failure to comply with these mandatory reporting requirements may subject me to disciplinary action by the Board. I acknowledge my understanding that to self-report a disciplinary action or criminal matter as set forth above, I may log in to the Pennsylvania Licensing System (PALS) at www.pals.pa.gov and select "Mandatory Reporting by Licensee" under the heading "Your Licenses."</p> <p>(12/07/2022 19:15:09)</p>
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CONFIRMATION

<input checked="" type="checkbox"/>	Any fees paid are non refundable. (12/07/2022 19:15:09)
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THE COURT OF COMMON PLEAS OF MONTGOMERY COUNTY,
PENNSYLVANIA

CIVIL ACTION – DIVORCE

THERESA BOSEDE ADELIYI BURCHER : NO. 2015-23081

VS.

DIVORCE DECREE

AND NOW, this 21st day of December, 2015, IT IS
DECREED that THERESA BOSEDE ADELIYI BURCHER and [REDACTED]
[REDACTED] are hereby DIVORCED FROM THE BONDS OF MATRIMONY.

☒ IT IS FURTHER ORDERED that the property settlement agreement between the parties,
dated December 5, 2015 and filed of record in this matter is hereby incorporated by reference as
fully as though the same were set forth herein at length. Said agreement shall not merge with,
but shall survive this Decree.

☐ No other relief granted.

BY THE COURT:


GAIL WEILHEIMER, J.



2015-23081-0012 12/22/2015 10:08 AM # 10605798
Divorce Decree

Rept=72607336 Fee:\$0.00
Mark Levy - MontCo Prothonotary

CERTIFIED FROM THE RECORDS OF THE
PROTHONOTARY, COURT OF COMMON PLEAS,
MONTGOMERY COUNTY, PA.

NOAH MARLIER, PROTHONOTARY

DATE:

1/22/20

CLERK

PROT0001
R: 01/02/2015

Pennsylvania
visitPA.com USA

DRIVER'S LICENSE

NOT FOR REAL ID PURPOSES

DUPS: 01

4d DLN: [REDACTED]
TAR1

3 DOB: [REDACTED]

4b EXP: 08/10/2023

4a ISS: 08/20/2020

1 ADELIYI

2 THERESA BOSEDE

8 [REDACTED]

WYNNEWOOD, PA 19096

15 SEX: F 18 EYES: BRO

16 HGT: 5'-06"

9 CLASS: C

9a END: NONE

12 RESTR: 1

5 DD: 2023301004701
TAR1 000000032070



ORGAN DONOR



CERTIFICATE OF BIRTH

NAME OF CHILD

THERESA BOSEDE ADELIYI

DATE OF BIRTH

TIME

SEX

12:16 AM**FEMALE**

MAIDEN NAME OF MOTHER

NAME OF FATHER

PLACE OF BIRTH

PATERSON CITY

COUNTY OF BIRTH

PASSAIC

DATE ISSUED:

JULY 26, 2006

FILE NUMBER

19810058142DATE FILED WITH REGISTRAR: **08/19/1981**

ISSUED BY:

6001189191

**State Department of Health and Senior Services
Bureau of Vital Statistics**

This is to certify that the above is correctly
copied from a record on file in my office.

*Certified copy not valid unless the raised
Great Seal of the State of New Jersey
or the seal of the issuing municipality
or county, is affixed hereon.*

Joseph A. Komosinski
Joseph A. Komosinski, State Registrar
Bureau of Vital Statistics

REG-42A
JULY 04



BUREAU OF PROFESSIONAL AND OCCUPATIONAL AFFAIRS

P. O. Box 2649

Harrisburg, PA 17105-2649

APPLICANT INFORMATION

PERSONAL INFORMATION							
Last Name	BURCHER			First Name	THERESA		
Middle Name				Suffix			
Full Name	THERESA BURCHER						
SSN		Date Of Birth		Age		Gender	FEMALE
ADDRESS DETAILS							
Street Address	ARDMORE, PA 19003						
City/State/Zip	Ardmore PA 19003						
County	Montgomery				Country	United States	
CONTACT DETAILS							
Phone number				Mobile Phone number			
Primary Email Address				Secondary Email Address			
CHECKLIST ITEMS							
Checklist name	Status			Submitted Date	Expiration Date		
Application	Pending Review			10/31/2020			
Application Fee	Completed			10/31/2020			
Child Abuse CE	Not Received			10/31/2020			
LEGAL QUESTIONS							
Questions	Answer			Document Uploaded	File Name		
1	Are you submitting a name change with this renewal?			Y	No		
2	First Name			Theresa	No		
3	Middle Name			B	No		
4	Last Name			Adeliyi	No		
5	You must submit a copy of a legal document verifying the name (s). The following are acceptable name change verification documents: (1) Marriage Certificate: (2) Divorce decree which indicates the retaking of your maiden name: (3) Other "legal" document indicating the retaking of a maiden name: (4) For a "legal" name change, a copy of the court document must be provided.				Yes	Birth certificate .pdf	

6	You must submit a copy of a legal document verifying the name (s). The following are acceptable name change verification documents: (1) Marriage Certificate: (2) Divorce decree which indicates the retaking of your maiden name: (3) Other "legal" document indicating the retaking of a maiden name: (4) For a "legal" name change, a copy of the court document must be provided.		Yes	Divorce paper.pdf
7	You must submit a copy of a legal document verifying the name (s). The following are acceptable name change verification documents: (1) Marriage Certificate: (2) Divorce decree which indicates the retaking of your maiden name: (3) Other "legal" document indicating the retaking of a maiden name: (4) For a "legal" name change, a copy of the court document must be provided.		Yes	License 2.pdf
8	With the exception of the one you are currently renewing, do you hold, or have you ever held, a license, certificate, permit, registration or other authorization to practice a profession or occupation in any state or jurisdiction?	Y	No	
9	Please provide the profession and state or jurisdiction.	Physician-Delaware	No	
10	Since your initial application or last renewal, whichever is later, have you had disciplinary action taken against a professional or occupational license, certificate, permit, registration or other authorization to practice a profession or occupation issued to you in any state or jurisdiction or have you agreed to voluntary surrender in lieu of discipline?	N	No	
11	Do you currently have any disciplinary charges pending against your professional or occupational license, certificate, permit or registration in any state or jurisdiction?	N	No	
12	Since your initial application or last renewal, whichever is later, have you withdrawn an application for a professional or occupational license, certificate, permit or registration, had an application denied or refused, or for disciplinary reasons agreed not to apply or reapply for a professional or occupational license, certificate, permit or registration in any state or jurisdiction?	N	No	
13	Since your initial application or your last renewal, whichever is later, have you had your DEA registration denied, revoked or restricted?	N	No	
14	Since your initial application or your last renewal, whichever is later, have you had provider privileges denied, revoked, suspended or restricted by a Medical Assistance agency, Medicare, third party payor or another authority?	N	No	
15	Since your initial application or your last renewal, whichever is later, have you had practice privileges denied, revoked, suspended, or restricted by a hospital or any health care facility?	N	No	
16	Since your initial application or your last renewal, whichever is later, have you been charged by a hospital, university, or research facility with violating research protocols, falsifying research, or engaging in other research misconduct?	N	No	
17	Since your initial application or last renewal, whichever is later, have you engaged in the intemperate or habitual use or abuse of alcohol or narcotics, hallucinogenics or other drugs or substances that may impair judgment or coordination?			

18	Since your initial application or your last renewal, whichever is later, have you been the subject of a civil malpractice lawsuit?	N	No	
19	Have you previously reported the complaint to the Board?		No	
20	Provide the state:		No	
21	Provide the county:		No	
22	Provide the docket number:		No	
23	Upload a copy of the entire Civil Complaint, which must include the filing date and the date you were served.		No	
24	Have you completed at least 2 hours of Board approved continuing education in pain management, identification of addiction or the practices of prescribing or dispensing of opioids?	N	No	
25	Do you hold a DEA number or use the registration number of another person or entity to prescribe controlled substances?	N	No	
26	Have you registered with the Pennsylvania Prescription Drug Monitoring Program?	N	No	
27	I will be retiring from practice but desire to place my license on active-retired status which will allow me to treat immediate family members. I am exempt from the CME requirements, except for completion of the 2 hours of Board-approved continuing education in child abuse recognition and reporting and 2 hours of Board approved continuing education in pain management, identification of addiction or the practices of prescribing or dispensing of opioids. Renewal must be completed and fee required.	N	No	
28	Do you maintain current medical professional liability insurance in the Commonwealth of Pennsylvania?	Y	No	
29	Upload an explanation or reason for an exemption request.		No	
30	Have you met your continuing education requirements? Please review the continuing education requirements posted on the Board's website at www.dos.pa.gov/med . Click on General Board Information. If you qualify for an exemption of the continuing education requirements, answer yes to the question. You are required to retain your official continuing education certificates of completion earned for this license renewal period until the end of the next renewal period.	Y	No	

Licenses/Certificates/Permits/Registrations in Any State/Jurisdiction

Profession	State/Jurisdiction
Physician	Delaware

PA VETERANS REGISTRY

Questions	Answer
1 Have you served in the U.S. Armed Forces?	N
2 Thank you for your service. Would you like to register with the PA Veterans Registry? The PA Veterans Registry provides veterans with information about federal, state and local benefits, programs and services that are available to Pennsylvania veterans and links veterans with resources that can provide assistance. Registration is quick and easy, and provides the Department of Military and Veterans Affairs (DMVA) with a way to contact you regarding the benefits and services you may be eligible for. If you check "Yes," you will receive an email with instructions to assist you in registering.	

CONFIRMATION

<input checked="" type="checkbox"/>	Any fees paid are non refundable. (10/31/2020 09:52:15)
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