

New License Application

Submission Date: 04/09/2018

License Type - Training Certificate (MD)

Personal Information

Provide the necessary personal information in the fields to the right. All fields with (*) are required and must be completed to continue the application process.

Title

First Name

Olivia

Middle Name

Louise

Last Name

Thornton

Maiden Name

Social Security Number

REDACTED

Date of Birth

6/25/1992

Email Address

olivia.thornton.lhs@gmail.com

Phone Number

(806) 577-8420

Other Phone Number

Additional Information

Provide the necessary additional information in the fields to the right. All fields with (*) are required and must be completed to continue the application process.

Do you have other aliases?

What is your gender?

Female

What is your ethnicity?

White

In which country were you born?

United States

In which state were you born (if United States)?

Texas

In which city were you born?

Lubbock

License Mailing Address

Select a license mailing address by clicking the appropriate checkbox to the right (this is the address used for all postal communications from the Board for this license). To add a new address, click Add Address, complete the required fields, and click Save.

7234 Sunny Day
San Antonio
TX
78240-2463
United States

License Public Address

Select a public license mailing address by clicking the appropriate checkbox to the right (this is the address that will be viewable by the public). To add a new address, click Add Address, complete the required fields, and click Save.

11100 Euclid Ave
Cleveland
OH
44106-1716
United States

Military Service

If you have served in the military, provide the information for the type of service and duration of the service. Also, provide proof of your service.

Have you served in the military?

No

Has your spouse served in the military?

Not Applicable

Country of Service

Service Branch

Are you still serving in the military (Active or Reserve)?

Were you honorably discharged from your service?

Service Start Date

Service End Date

Education History

List all undergraduate, graduate, and Medical Schools you have attended, including those from which you did not graduate. As you type, the name of your school should auto-populate. Once it does, click on it to select. If your school does not auto-populate, type and select Other. You will then enter your school's name and address in the fields that appear.

Educational Institution - University of Texas - HS Center at San Antonio

Degree Type - Doctoral

Degree - MD

Enrollment date - 7/28/2014

Graduation date - 5/20/2018

Educational Institution - University of Texas at Austin

Degree Type - Bachelor's

Degree - BS

Enrollment date - 8/1/2010

Graduation date - 5/20/2014

Educational Institution - University of Texas Health Science Center - Houston

Degree Type - Masters

Degree - MPH

Enrollment date - 6/1/2014

Graduation date - 12/18/2017

Employment History

List your employment history for the past five years including medical, non-medical, and post-graduate training. For any non-working time, you must indicate exactly what your activities were, such as vacation or seeking employment as well as your permanent address. If you worked for a physician staffing group or did locum tenens, you must list all facilities where you worked and include complete dates and addresses. Be sure to indicate the percentage of working time spent in clinical or other duties.

Employer / Non-Working Activity - Vacation

Job Title - N/A

Start Date - 5/21/2018

End Date - 6/18/2018

Street Address - 7234 Sunny Day

Employment City - San Antonio

Employment County - County

Employment State - Texas

Employment Zipcode - 78240

Employment Country - United States

License Verification

You must complete the License Verification component if you hold or have ever held a professional license or certification in a state or Canadian Province. You must request verification of all your applicable licenses and certifications from the issuing state or Canadian province to be sent to the State Medical Board of Ohio. Please include both active and inactive professional licenses or certifications.

Residency Component

List the post-graduate training program(s) you will attend or have attended, including those you did not complete. As you type, the name of your Hospital/Institution should auto-populate. Once it does, click on it to select. If your Hospital/Institution does not auto-populate, type and select Other. You will then enter your Hospital/Institution name in the fields that appear.

Residency Number - RES10107

Hospital Name - Case Western Reserve Univ/Univ Hospitals Case Medical Center

Address - 11100 Euclid Ave

City - Cleveland

State - OH

ZipCode - 44106

Country - United States

PG Years - 1

PG Type - Internship

Department/Specialty - Obstetrics and Gynecology

Start Date - 6/18/2018

End Date - 6/30/2019

Successfully Completed? - false

Questions

Answer the following questions by selecting the Yes/No option for each question. Once completed, click Save and Continue.

Question - Have you ever been denied staff membership at any hospital, nursing home, clinic, health maintenance organization, or similar institution?

Answer - No

Question - Have you ever been warned, censured, disciplined, had admissions monitored, had privileges limited, had privileges suspended or terminated, been put on probation, or been requested to withdraw from or resign privileges at any hospital, nursing home, clinic, health maintenance organization, or other similar institution in which you have trained, been a staff member, or held privileges, for reasons other than failure to maintain records on a timely basis, or failure to attend staff or section meetings?

Answer - No

Question - Have you ever resigned from, withdrawn from, or terminated, or have you ever been requested to resign from, withdraw from, or otherwise been terminated from, a position with a medical partnership, professional association, corporation, health maintenance organization, or other medical practice organization, either private or public?

Answer - No

Question - Have you ever resigned from, withdrawn from, or have you ever been warned by, censured by, disciplined by, been put on probation by, been requested to withdraw from, dismissed from, been refused renewal of a contract by, or expelled from, a medical school, clinical clerkship, externship, preceptorship, residency, or graduate medical education program?

Answer - No

Question - Have you ever transferred from one graduate medical education program to another?

Answer - No

Question - Have you ever, for any reason, lost specialty board certification in the U.S. or elsewhere, or been denied such certification, or denied examination for such certification?

Answer - No

Question - Has any board, bureau, department, agency or other body, including those in Ohio, in any way limited, restricted, suspended, or revoked any professional license, certificate or registration granted to you; placed you on probation; or imposed a fine, censure or reprimand against you?

Answer - No

Question - Have you ever voluntarily surrendered, resigned, or otherwise forfeited any professional license, certificate or registration issued to you by any board, bureau, department, agency, or other body; or have you ever withdrawn any application for licensure, relicensure, or examination, in any state (including Ohio), territory, province, or country?

Answer - No

Question - Have you ever, for any reason, been denied licensure or relicensure, application for licensure or relicensure, or the privilege of taking an examination, in any state (including Ohio), territory, province, or country?

Answer - No

Question - Have you ever been requested to appear before any board, bureau, department, agency, or other body, including those in Ohio, concerning allegations against you?

Answer - No

Question - Have you ever entered into an agreement of any kind, whether oral or written, with respect to a professional license, in lieu of or in order to avoid formal disciplinary action, with any board, bureau, department, agency, or other body, including those in Ohio?

Answer - No

Question - Have you ever been notified of any investigation concerning you by any board, bureau, department, agency, or other body, including those in Ohio, with respect to a professional license?

Answer - No

Question - Have you ever been notified of any charges, allegations, or complaints filed against you with, any board, bureau, department, agency, or other body, including those in Ohio, with respect to a professional license?

Answer - No

Question - Have you ever been denied, or have you ever surrendered, a state or federal controlled substance or drug registration; had it revoked, terminated, or restricted in any way; or been warned, reprimanded, or fined by, or been requested to appear before, the responsible agency?

Answer - No

Question - Have you ever pled guilty to, been found guilty of a violation of any law, or been granted intervention or treatment in lieu of conviction regardless of the legal jurisdiction in which the act was committed, other than a minor traffic violation? If yes, submit copies of all relevant documentation, such as police reports, certified court records and any institutional correspondence and orders.

Answer - No

Question - Have you ever been arrested, forfeited collateral, bail, or bond for breach or violation of any law, police regulation, or ordinance other than for a minor traffic violation; been summoned into court as a defendant or had any lawsuit filed against you (other than a malpractice suit)? If yes, submit copies of all relevant documentation, such as police reports, certified court records and any institutional correspondence and orders.

Answer - No

Question - Have you been a defendant in a legal action involving professional liability (malpractice), or had a professional liability claim paid on your behalf, or paid such a claim yourself? If yes, you must complete the enclosed malpractice claim information form. In addition, ask your malpractice insurance carrier(s) to provide a complete claims history report for the last 10 years to the State Medical Board of Ohio. If your current carrier has provided coverage for less than 10 years , ask your previous carrier to submit a claims history report to the Board.

Answer - No

Question - Have you ever been denied professional liability insurance or coverage, or had such insurance or coverage canceled, limited, or restricted in any way?

Answer - No

Question - Have you ever been denied or relinquished participation in any third party reimbursement program, whether governmental or private, including Medicaid and Medicare; or had such participation limited, restricted, suspended, or revoked; or been warned, reprimanded, requested to appear before, or fined by the responsible body?

Answer - No

Question - Have you ever been denied privileges, or had privileges revoked, suspended, restricted, reduced, or terminated by the Department of Defense, the Veteran's Administration, or any of their respective components?

Answer - No

Question - Have you ever been diagnosed as having, or have you been treated for, pedophilia, exhibitionism, or voyeurism?

Answer - No

Question - In the past five years, have you been diagnosed as having, or been hospitalized for a medical condition which in any way impairs or limits your ability to practice medicine with reasonable skill and safety? You may answer "NO" to this question if you hold a current training certificate to pursue training in Ohio and the only such medical condition is chemical dependency or substance abuse, and you have successfully completed or are currently receiving treatment at a program approved by this board and have adhered to all statutory requirements as contained in Section 4731.224 and 4731.25, O.R.C., and related provisions. Any questions concerning approval can be directed to the board offices.

Answer - No

Question - Do you use chemical substance(s) which in any way impair or limit your ability to practice medicine with reasonable skill and safety?

Answer - No

Question - Are you currently engaged in the illegal use of controlled substances?

Answer - No

Question - Are you an American/Canadian medical graduate?

Answer - Yes

Attachments

If applicable, upload the Attachments for your license application by clicking the Add Attachment button(s). If uploading an attachment as a submission, it is necessary that the name of the file attachment is less than 80 characters in length for it to be received successfully. The character limit does include the file attachment extension, such as (.doc) and (.pdf). The (.exe) and (.html) file extensions are not supported for submissions. For documentation that needs to be submitted directly to the Board or by hardcopy, please acknowledge by clicking the Attest button(s). If no attachment or attestation items appear, please click the Save and Continue button.

Title - Certification of Training Program

Description - I attest that I will complete the top portion of the Certification of Training form and forward it directly to the hospital training program director in Ohio where I will be training.

Attested - Attestation complete

Title - Verification of Medical Education (Form 1)

Description - I attest that I will complete the top portion of the Verification of Medical Education Form 1, forward it to my medical/osteopathic school of graduation, and ensure it is returned directly to the board. All schools must complete the form after graduation.

Attested - Attestation complete

Review + Submit

Once the review has been processed, the license application will be completed.

Application Review - Completed

Attestation

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

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

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

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

I will immediately notify the board in writing of any changes to the answers to any of the questions contained in this application if such a change occurs at any time prior to the credential for which I have applied being granted to me by the board.

I understand my failure to answer questions contained in this application truthfully and completely may lead to denial, revocation, or other disciplinary sanction of the credential for which I have applied.

Consent to Electronic Signature - **Consented**

Date/Time Stamp - 04/09/2018 18:39:36

Type your First Name and Last Name as they appear on the application to sign electronically.

Olivia Thornton

Submit your Application -After clicking the 'Submit' button below, you will no longer be able to change this application. **PLEASE DO NOT USE THE BROWSER'S BACK BUTTON AS THAT MAY OVERWRITE YOUR DATA.** If you want to return to your application, simply log out and log back in. If this application requires payment you will be prompted to begin the payment process. You must complete the payment process before the board will review your application. If this application does not require payment, you will be navigated back to the eLicense home page and the board will review your application.



TRAINING CERTIFICATE - Medicine or Osteopathic Medicine
Training Program Certification

Program: Complete this form and email directly to certificates@med.ohio.gov.

Applicant's Full Name: Thornton Olivia L
Last First Middle Suffix (Jr., II)

Name of Training Program: University Hospitals Cleveland Medical Center

Training Program Address: 11100 Euclid Ave
Street Address
Cleveland OH 44106
City State Zip Code

Type of Program (check only one): [] Intern [X] Resident [] Clinical Fellow

Specialty: OBGYN Resident

CERTIFICATION DATES - Indicate the month, day and year for both the beginning and ending dates in which the training certificate is to be issued. Date range cannot exceed three years. If the application is received prior to the date of the appointment, the appointment date will be used. If the application is received after the appointment date, a new form will be required.

Beginning Date: 6/24/2018 Ending Date: 6/23/2021
Month/Day/Year Month/Day/Year

I certify that the above information is an accurate account of the above-named individual's official records and is true and correct to my knowledge.

Dr Susan Nedorost

Director of Graduate Medical Education

Name of Medical or Program Director

Title

Handwritten signature of Susan Nedorost

04/10/2018

Signature

Date

216-844-7320

Susan.Nedorost@uhhospitals.org

Phone Number

Email

0538885



State Medical Board of Ohio

State Medical Board of Ohio
30 East Broad Street, 3rd Floor
Columbus, OH 43215
(614) 466-3934 med.ohio.gov

TRAINING CERTIFICATE APPLICATION

Medical Education Verification

Do not complete this form prior to graduation

Schools: Email completed forms directly to certificates@med.ohio.gov.

THIS SECTION TO BE COMPLETED BY APPLICANT

Form section for applicant completion. Includes fields for Full Name (Thornton Olivia Louise), Name of MD, DO or DPM School (UT Health San Antonio), Location (San Antonio, Texas), Signature of Applicant, and Date (05/21/2018).

THIS SECTION TO BE COMPLETED BY MEDICAL, OSTEOPATHIC or PODIATRIC SCHOOL

Form section for school completion. Includes fields for Our records indicate that (Thornton Olivia), Attended medical/osteopathic/podiatric school from (7/2014 to 5/2018), This individual (check one) (Doctor of Medicine), I certify that the above information is an accurate account of the above-named individual's official records and is true and correct to my knowledge, and contact information for Blanca E. Guerra PhD, University Registrar.



5/25/2018

Dear Olivia Thornton:

This is to notify you that you are now licensed to practice in the State of Ohio. The Board approved your request and your license number **57.246345** was issued on 05/25/2018 and will expire on 06/23/2021.

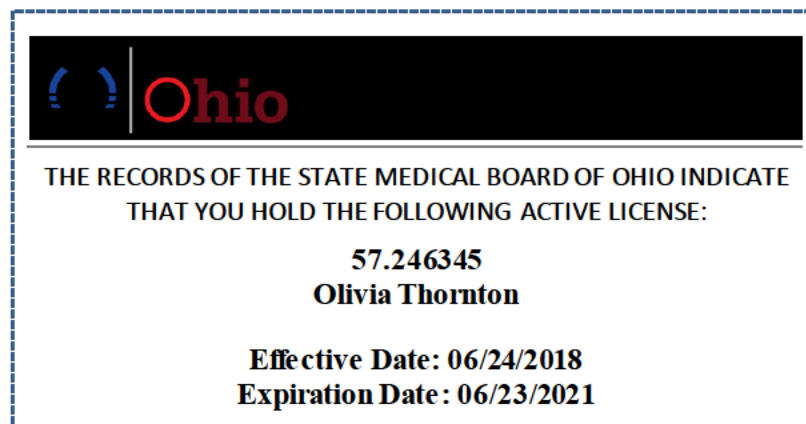
Below is a printable wallet card for your convenience. A wall certificate will be mailed to you within the next five business days. The wall certificate, by law, must be displayed in your office or the place where a major portion of your practice is conducted.

Please be advised that verification of your Ohio license must be obtained directly from the Board's website at <http://med.ohio.gov> or by going to <https://elicense.ohio.gov>. These websites are updated immediately to reflect license status.

Questions concerning licensure or renewal can be sent to med.license@med.ohio.gov or med.renewal@med.ohio.gov.

Sincerely,

State Medical Board of Ohio
Licensure & Renewal Department



Submission Date and Time: 3/8/2021 7:28 PM

License Renewal Application

License Type - Training Certificate (MD)

License Number - 57.246345

License Renewal Number - LR-004032629

Personal Information

Provide the necessary personal information in the fields to the right. All fields with (*) are required and must be completed to continue the application process. Demographic and workforce data collected for some licensed healthcare professions is used to enhance the state's capacity for healthcare workforce forecasting, policy development, and research. This data is used to analyze the supply and demand of the healthcare workforce serving Ohio. If you do not have an Individual Provider Identifier (NPI) number please enter nine zeroes.

Title

No Response

First Name

Olivia

Middle Name

Louise

Last Name

Thornton

Maiden Name

No Response

Social Security Number

REDACTED

Date of Birth

6/25/1992

Email Address

olivia.thornton.lhs@gmail.com

Phone Number

(806) 577-8420

Other Phone Number

No Response

What is your U.S. Residency status related to your employment?

United States Citizen

Do you consider yourself Hispanic, Latino/a or of Spanish origin?

No

What do you consider your race?

White

List languages you personally use to communicate with patients excluding an interpreter or software

English

Other Language

No Response
Individual National Provider Identifier - if N/A enter all zeroes
No Response
Enter home US zip-code. Enter NA if unavailable
44120

Additional Information

Provide the necessary additional information in the fields to the right. All fields with (*) are required and must be completed to continue the application process.

Do you have other aliases?
No Response
What is your gender?
Female
In which country were you born?
United States
In which state were you born (if United States)?
Texas
In which city were you born?
Lubbock

Employment Status

Demographic and workforce data collected for some licensed healthcare professions is used to enhance the state's capacity for healthcare workforce forecasting, policy development, and research. This data is used to analyze the supply and demand of the healthcare workforce serving Ohio.

What is your primary employment status?
Actively working in a position(s) that requires this license
Which of the following best describes your five-year employment plan?
Move to a practice location out of Ohio
Are you currently employed outside of USA?
No

License Mailing Address

Select a license mailing address by clicking the appropriate checkbox to the right (this is the address used for all postal communications from the Board for this license). To add a new address, click Add Address, complete the required fields, and click Save.

3143 Ludlow Rd
Shaker Heights
OH
44120-2832
United States

License Public Address

Select a public license mailing address by clicking the appropriate checkbox to the right (this is the address that will be viewable by the public). To add a new address, click Add Address, complete the required fields, and click Save.

11100 Euclid Ave
Cleveland
OH
44106-1716
United States

Military Service

If you have served in the military, provide the information for the type of service and duration of the service. Also, provide proof of your service.

Have you served in the military?

No

If you answered "Yes", are you currently serving in the military?

No Response

Has your spouse served in the military?

Not Applicable

If you answered "Yes", are they currently serving in the military?

No Response

I declined to answer these questions



Secondary Email Recipient

You may define another email recipient for all automated emails you receive related to your license. You may change this recipient at any time from your dashboard.

Secondary Email Address:

Current Employment Location(s)

Please provide the following information for all practice sites where you use this license, beginning with the locations in which you spend most of your time. If you are not actively working or volunteering in a position that requires this license (e.g. student or recent graduate) employment location information is optional. Employment location information helps improve the accuracy and efficiency of Health Professional Shortage Area Designations and enables Ohio to identify healthcare workforce distribution.

Name of Practice Site - Rainbow Center for Women and Children
Practice Settings - Office/Clinic - Multi Specialty Group
Street Address - 5805 Euclid Ave
City - Cleveland
State - OH
Zip Code - 44103
Major Area of Focus or Specialty - Obstetrics & Gynecology (AOA)
Total Hours Worked at this practice site, per Week - 10

Percent of time spent per week in each of the following at this practice site:

Direct Patient Care - 100
Teaching/Academic - 0
Research - 0
Professional Services - 0
Administrative Activities - 0
Other - 0
Total Hours- 100

Hospital Admitting Privileges for Patients - No
Current Employment Arrangement - Salaried
Other Employment Arrangement - null
Intern/Resident Position - Yes
Employed as Federal Employee - Yes
Accepting New Patients - Yes

Name of Practice Site - University Hospitals Cleveland Medical Center
Practice Settings - Hospital - Inpatient
Street Address - 11100
City - Cleveland
State - OH
Zip Code - 44106
Major Area of Focus or Specialty - Obstetrics & Gynecology (AOA)
Total Hours Worked at this practice site, per Week - 70

Percent of time spent per week in each of the following at this practice site:

Direct Patient Care - 50
Teaching/Academic - 25
Research - 0
Professional Services - 0
Administrative Activities - 25
Other - 0
Total Hours- 100

Hospital Admitting Privileges for Patients - Yes
Current Employment Arrangement - Salaried
Other Employment Arrangement - null
Intern/Resident Position - Yes
Employed as Federal Employee - Yes
Accepting New Patients - Yes

Questions

Answer the following questions by selecting the Yes/No option for each question. Once completed, click Save and Continue. For any question that is answered in the affirmative you will later be required to upload a detailed explanation and supporting documents.

Question - At any time since signing your last application for renewal of your certificate have any malpractice awards been paid by you or on your behalf for acts occurring in any state other than Ohio?

Answer - No

Question - Are you one of the following: a medical director of an emergency medical service organization, a physician member of an advisory board of an emergency medical service organization, an employee of the State of Ohio, an employee of the Department of Corrections and have or have had contact with inmates and persons under supervision, or an employee of the Department of Youth Services? An affirmative answer to this question provides notice to the board that your residential and familial information is exempt from disclosure under Ohio's public records laws. Failure to self-identify may result in the board releasing such information in response to public records requests. In the event that your answer to this question changes before your next license renewal, you should immediately notify the board.

Answer - No

Question - At any time since signing your last application for renewal of your certificate have you been found guilty of, or pled guilty or no contest to, or received treatment or intervention in lieu of conviction of, a misdemeanor or felony?

Answer - No

Question - At any time since signing your last application for renewal of your certificate have you surrendered, consented to limitation of, or to suspension, reprimand or probation concerning, a license to practice any healthcare profession or state or federal privileges to prescribe controlled substances in any jurisdiction other than Ohio?

Answer - No

Question - At any time since signing your last application for renewal of your certificate have you been investigated, warned, censured, put on probation, disciplined, or have had any charges, allegations or complaints filed against you, by any board, bureau, department, agency, or any other body, including those in Ohio?

Answer - No

Question - At any time since signing your last application for renewal of your certificate have you had admissions monitored, had clinical privileges or other similar institutional authority limited, restricted, suspended, revoked, terminated, or placed on probation for any reason, or have resigned privileges at any institution?

Answer - No

Question - At any time since submission of your last application for renewal have you been addicted to or dependent upon alcohol or any chemical substance; or been treated for, or been diagnosed as suffering from, drug or alcohol dependency or abuse? You may answer NO to this question if you have successfully completed treatment at, or are currently enrolled in, a program approved by this Board and have adhered to all statutory requirements during and subsequent to treatment. You must answer YES if you have ever relapsed.

Answer - No

Question - Since initial issuance of your training certificate, have you changed, or are you planning to change, the internship, residency, clinical fellowship, or elective clinical rotation that you have been appointed to in this State? If yes, please ensure that your program submits a Training Program Change Form, which is available on the Board's website.

Answer - No

Question - At any time since signing your last application for renewal of your certificate, have you engaged in conduct prohibited by the Medical Board's rules regarding sexual misconduct and impropriety (chapter 4731-26 of the Administrative Code)?

Answer - No

Question - At any time since signing your last application for renewal of your certificate have you been investigated, warned, censured, put on probation, terminated, or disciplined by any employer, hospital, group practice, nursing home, clinic, health maintenance organization, or other similar institution, for any reason?

Answer - No

Attachments

If applicable, upload the Attachments for your license application by clicking the Add Attachment button(s). Attachments related to affirmative answers must include a detailed explanation and supporting documentation. If uploading an attachment as a submission, it is necessary that the name of the file attachment is less than 80 characters in length for it to be received successfully. The character limit does include the file attachment extension, such as (.doc) and (.pdf). The (.exe) and (.html) file extensions are not supported for submissions. For documentation that needs to be submitted directly to the Board or by hardcopy, please acknowledge by clicking the Attest button(s). If no attachment or attestation items appear, please click the Save and Continue button.

Review + Submit

Once the review has been processed, the license application will be completed.

Application Review - Completed

Attestation

I understand that submitting a false, fraudulent, or forged statement or document or omitting a material fact in obtaining licensure may be grounds for disciplinary action against my license. Under penalty of law, I hereby swear or affirm that the information I have provided in the application is complete and correct, and that I have complied with all criteria for applying.

Consent to Electronic Signature - **Consented**

Date/Time Stamp - 3/8/2021 7:28 PM

Type your First Name and Last Name as they appear on the application to sign electronically.

Olivia Thornton

Submit your Application -After clicking the 'Submit' button below, you will no longer be able to change this application. **PLEASE DO NOT USE THE BROWSER'S BACK BUTTON AS THAT MAY**

OVERWRITE YOUR DATA. If you want to return to your application, simply log out and log back in.

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License Look Up

12/12/2025 12:47 PM

Olivia Louise Thornton	
License Number	57.246345
Status	Inactive
Sub-Status	Expired
Board	Medical Board
License Type	Training Certificate (MD)
Compact/Multi-State Eligible	
License Issue Date	5/25/18
License Expiration Date	6/23/24
License Effective Date	3/8/21
City	Cleveland
State	OH
Country	United States
Board Action	No

Board Action Details

Current date & time: **12/12/2025 12:47 PM**

Disclaimer: The Joint Commission and NCQA consider on-line status information as fulfilling the primary source verification requirement for verification of licensure in compliance with their respective credentialing standards.