




TRAINING CERTIFICATE - Medicine or Osteopathic Medicine and Podiatric Medicine Ohio Training Program Certification

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

Applicant's Full Name:	<u>McCarthy-Rowland</u>	<u>Noria</u>	<u>M</u>
	<small>Last</small>	<small>First</small>	<small>Middle</small>
			<small>Suffix (Jr., II)</small>
Name of Ohio Training Program:	<u>University Hospitals, Cleveland Medical Center</u>		
Training Program Address:	<u>11100 Euclid Avenue</u>		
	<small>Street Address</small>		
	<u>Cleveland</u>	<u>Ohio</u>	<u>44106</u>
	<small>City</small>	<small>State</small>	<small>Zip Code</small>
Type of Program (check only one):			
<input checked="" type="checkbox"/>	ACGME/AOA/CPME/APMA accredited internship or residency		
	Specialty: <u>OBGYN</u>		
<input type="checkbox"/>	A clinical fellowship program at an institution with ACGME/AOA/CPME/APMA accredited residency program in a clinical field the same as or related to the clinical field of the fellowship program		
	Clinical Field of Fellowship: _____		
	Related ACGME/AOA/CPME/APMA Accredited Residency Program: _____		
<input type="checkbox"/>	An elective clinical rotation that lasts not more than one year and is offered to interns, residents, or clinical fellows participating in programs that are located outside this state and meet the requirements of one of the above. Name of out-of-state accredited program: _____		
<p>CERTIFICATION DATES - Indicate the month, day and year for both the beginning and ending dates in which the training certificate is to be issued. 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.</p>			
Beginning Date:	<u>06/17/2019</u>	Ending Date:	<u>06/30/2022</u>
	<small>Month/Day/Year</small>		<small>Month/Day/Year</small>
<p>1) I certify that the training program will verify that the applicant has been issued a diploma, ECFMG certificate or a fifth pathway certificate, before permitting the applicant to begin participation in the training program.</p> <p>2) I certify that the training program will notify the Medical Board if a holder of a training certificate has not been issued a diploma, an ECFMG certificate, or a fifth pathway certificate, before the start date of the training program.</p> <p>3) I certify that the above information is true and correct to my knowledge.</p>			
	<u>Susan Nedorost, M.D.</u>	<u>DIO Graduate Medical Education</u>	
	<small>Name of Medical or Program Director</small>	<small>Title</small>	
		<u>04/17/2019</u>	
	<small>Signature</small>	<small>Date</small>	
	<u>216.844.7320</u>	<u>Susan.Nedorost@UHhospitals.org</u>	
	<small>Phone Number</small>	<small>Email</small>	

Submission Date and Time: 5/14/2019 1:55 PM

New License Application

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. 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.

Title

No Response

First Name

Noria

Middle Name

No Response

Last Name

McCarthy

Maiden Name

No Response

Social Security Number

REDACTED

Date of Birth

6/22/1992

Email Address

noria.mccarther@gmail.com

Phone Number

(816) 588-7299

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?

Black or African American

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

English

Other Language

No Response

Individual National Provider Identifier - if not applicable leave blank

1174187116

Enter home US zip-code. Enter NA if unavailable

66221

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?

Noria McCarther-Rowland

What is your gender?

Female

In which country were you born?

United States

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

Missouri

In which city were you born?

Kansas City

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?

Not currently working - student pursuing this license

Which of the following best describes your five-year employment plan?

Return to school or training program

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.

13905 Eby St

Overland Park

KS

66221-2112

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:

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. If you did not receive a degree, please select "Not Applicable" as the degree type and do not enter a graduation date.

Educational Institution - University of Missouri - Kansas City

Degree Type - Bachelor's

Degree - B.S. Biology

Enrollment date - 6/1/2012

Graduation date - 5/22/2015

Educational Institution - Trinity University

Degree Type - Not Applicable
Degree - Not applicable
Enrollment date - 8/15/2010
Graduation date - 5/15/2012

Educational Institution - University of Kansas School of Medicine
Degree Type - Doctoral
Degree - Doctor of Medicine
Enrollment date - 7/20/2015
Graduation date - 5/19/2019

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.

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 - RES23067
Hospital Name - University Hospitals of Cleveland
Address - 11100 Euclid Avenue
City - Cleveland
State - OH
ZipCode - 44106
Country - United States
PG Years - 1
PG Type - Internship

Department/Specialty - Obstetrics and Gynecology

Start Date - 6/24/2019

End Date - 6/24/2023

Successfully Completed? - false

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.

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 - Yes

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 - Yes

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

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 - Completion of Medical Education

Description - I attest that I will notify the Board if I have not been issued a diploma, ECFMG Certificate, or Fifth Pathway Certificate before the start date of the training program.

Attested - Attestation complete

Title - Supporting Documents

Description - 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...

REDACTED

Title - Supporting Documents

Description - 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...

REDACTED

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 - 5/14/2019 1:55 PM

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

Noria McCarther

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.

Submission Date and Time: 5/27/2022 4:07 PM

License Renewal Application

License Type - Training Certificate (MD)

License Number - 57.248434

License Renewal Number - LR-004599419

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

Noria

Middle Name

No Response

Last Name

McCarthy

Maiden Name

No Response

Social Security Number

REDACTED

Date of Birth

6/22/1992

Email Address

noria.mccarther@gmail.com

Phone Number

(816) 588-7299

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?

Black or African American

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

1174187116

Enter home US zip-code. Enter NA if unavailable

44114

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?

Noria McCarther-Rowland

What is your gender?

Female

In which country were you born?

United States

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

Missouri

In which city were you born?

Kansas City

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.

2320 Superior Ave E Apt 308

Cleveland

OH

44114-4277

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 - University Hospitals Cleveland Medical Center
Practice Settings - Hospital - Inpatient
Street Address - 11100 Euclid Ave
City - Cleveland
State - OH
Zip Code - 44106
Major Area of Focus or Specialty - Obstetrics and Gynecology (ABMS)
Total Hours Worked at this practice site, per Week - 80

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

Direct Patient Care - 70
Teaching/Academic - 10
Research - 10
Professional Services - 5
Administrative Activities - 5
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 - No
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 a community mental health service provider, an employee of a local alcohol, drug addiction, and mental health services board, an employee of ODMHAS, are involved in court-ordered patient commitments in some capacity, 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, an alcohol or other substance use disorder? You may answer NO to this question if you have been found to be eligible for the One-Bite Program and are in compliance with a monitoring agreement with the One-Bite monitoring organization. You must answer YES if you have relapsed at any time since submission of your last application for renewal.

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 - 5/27/2022 4:07 PM

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

Noria McCarther

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.

- [Close Window](#)
- [Print This Page](#)
- [Expand All](#) | [Collapse All](#)

SR-745417

Board	Medical Board	Marked for Deletion	<input type="checkbox"/>
Type (Deprecated)	Verification to Another Entity	Record Type	Verification to Another Entity Service Request
Applicant	Noria McCarther	Status	Complete
Submitted Date	6/15/2023	License	57.248434
Completion Date	6/16/2023	Reason for Submitting Service Request	Electronic verification of Ohio training license for Kansas state medical licensing.
Account Primary Contact Email		Active Service Request	<input type="checkbox"/>
Face to Face Clinical Hours		Endorsement	

Verification Request - Mail To:

Board Name	Kansas State Board of Healing Arts	Street Address	800 SW Jackson, Lower Level - Suite A
Verification Recipient Name		City	Topeka
Verification Recipient email address	ksbha_licensing@ks.gov	State/Province	Kansas
Verification Email sent	<input type="checkbox"/>	Country	United States
Complete Email Sent?	<input checked="" type="checkbox"/>	Zip/Postal Code	66612

Financials

System Information

Action Items

[Link Attachment](#)

Submissions

Fees

10172817

Type	Verification Fee
Total	\$50.00
Paid in Full	<input checked="" type="checkbox"/>
Fee Paid Date	6/15/2023
Paid By (Deprecated)	
OAKS Revenue Code	426121
Receipt Number	R-6698280
View Cart	N/A

Payments

PY-6653315



Verification of Licensure

This verification of licensure shows that as of **6/16/2023**, this licensee has the below listed license status and formal action. **As with all licensees, this could change upon future Board disciplinary action, which can be found at license.ohio.gov/oh_verifylicense.**

Full Name:	Noria McCarther
Date of Birth:	06/22/1992
Type of License:	Training Certificate (MD)
License Number:	57.248434
Original Licensure Date:	05/30/2019
Effective Date:	5/27/2022
Expiration Date:	06/16/2025
Status:	Active
Sub-status:	
Board Action:	No
Board Action Summary:	



If you need additional information or to receive certified copies of a public record, please send an email request to Med-PublicRecordRequests@med.ohio.gov. All communications to the Board must include the name and license number of the licensee. For general license verification questions, send an email to license@med.ohio.gov.

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SR-791442

Board	Medical Board	Marked for Deletion	<input type="checkbox"/>
Type (Deprecated)	Verification to Another Entity	Record Type	Verification to Another Entity Service Request
Applicant	Noria McCarther	Status	Complete
Submitted Date	9/14/2023	License	57.248434
Completion Date	9/18/2023	Reason for Submitting Service Request	Missouri Medical License Application
Account Primary Contact Email		Active Service Request	<input type="checkbox"/>
Face to Face Clinical Hours		Endorsement	

Verification Request - Mail To:

Board Name	Missouri Board of Registration for the Healing Arts	Street Address	P.O. Box 4
Verification Recipient Name	Missouri Board of Registration for the Healing Arts	City	Jefferson City
Verification Recipient email address	licensure@pr.mo.gov	State/Province	Missouri
Verification Email sent	<input checked="" type="checkbox"/>	Country	United States
Complete Email Sent?	<input checked="" type="checkbox"/>	Zip/Postal Code	65102

Financials

Total Fees	\$50.00	Total Payments	\$50.00
		Total Balance	\$0.00

System Information

Created By	Noria McCarther, 9/14/2023, 3:26 PM	Last Modified By	System Administrator, 9/18/2023, 2:28 PM
Owner	e-License Record Owner e-License Record Owner	Number	SR-791442

Action Items

[Link Attachment](#)

Submissions



Verification of Licensure

This verification of licensure shows that as of **9/18/2023**, this licensee has the below listed license status and formal action. **As with all licensees, this could change upon future Board disciplinary action, which can be found at license.ohio.gov/oh_verifylicense.**

Full Name:	Noria McCarther
Date of Birth:	06/22/1992
Type of License:	Training Certificate (MD)
License Number:	57.248434
Original Licensure Date:	05/30/2019
Effective Date:	5/27/2022
Expiration Date:	06/16/2025
Status:	Active
Sub-status:	
Board Action:	No
Board Action Summary:	



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