

**The applications behind this page are:**

- Current residents who are upgrading their training licenses to full licenses; or
- Fellows coming into Oklahoma to continue their training with full licenses.

**Possible application deficiencies:**

- Form 2 reflecting successful completion of their program; or
- Evaluations completed by their program director (current OK residents only); or
- Questionnaire completed by the applicants (current OK training residents only); or
- USMLE step 3 examination scores; or
- Upgrade fee (from training license to full license)

These applications are being considered for Approval **PENDING COMPLETION** of their application.

All applications, once completed, will be reviewed by the Board Secretary.

Should any issues arise that are of concern, the applicant will be asked to appear before the Medical Board at the July or September Board meeting.

# Oklahoma State Board of Medical Licensure and Supervision

## Application Summary

<b>Type</b>	<b>Number</b>	<b>Name</b>
MD	41688	BRENT HICKMAN
MEDICAL DOCTOR		

**Incomplete Information (due to space limitations on this page, this may not be a complete list)**

OTHER DEFICIENCIES: NEED USMLE STEP 3 / EVALUATION  
 Exam verification date  
 PostGrad - Form 2 COLLEGE OF MEDICINE OKC  
 USMLE Exams Incomplete

**Last Medical School Attended:**

039-01 Univ Of Ok Coll Of Med, Oklahoma City Ok 73190

Number of Licenses Previously Granted to Graduates of this Medical School:7,358

Application for: Resident \_\_\_\_\_ Full License \_\_\_\_\_ Reinstatement \_\_\_\_\_

**The Secretary of the Board has reviewed this application and:**

- 1) AUTHORIZED CIRCULARIZATION TO OTHER BOARD MEMBERS \_\_\_\_\_
  
- 2) ALL FIVE CRITERIA HAVE BEEN MET [Fast Track] \_\_\_\_\_
  - Passed USMLE
  - No DUIs or Legal Issues
  - No Malpractice Issues
  - US Graduate
  - Graduated Medical School in 4 years or less
  
- 3) HAS ISSUED A TEMPORARY LICENSE THROUGH \_\_\_\_ / \_\_\_\_ / \_\_\_\_
  
- 4) HAS ISSUED A SPECIAL PGY-1 TRAINING LICENSE \_\_\_\_\_



# Oklahoma State Board of Medical Licensure and Supervision Application Summary

**Type**    **Number**    **Name**  
 MD       41688       BRENT HICKMAN  
 MEDICAL DOCTOR

**Practice Address:**  
 May 12, 2023

**Status:**

**Endorsed By:** USMLE

**Res:** TR

**Received:** 05/02/2023

**Entered:** 05/02/2023

**Temp Issued:**

**Temp Expires:**

**Train Issued:** 07/01/2023

**Train Expires:** 09/30/2024

**Fed Rec:** 05/14/2024

**AMA Rec:** 05/14/2024

**Board Action:**

**License #:** 41688

**Sex:** M

**Ethnic Origin:** 5

	<u>Test</u>	<u>Score</u>	<u>Date Taken</u>	<u>Date Verified</u>	<u>Attempts</u>
<b>Test 1:</b>	USMLE 1	PASS	06/10/21	6/12/23	1
<b>Test 2:</b>	USMLE 2	PASS	07/29/22	6/12/23	1
<b>Test 3:</b>	Note: <b>PASS</b> means higher than 75				
<b>Test AV:</b>					
<b>Total Possible:</b>					
<b>Okla Passing:</b>					
<b>Total Score:</b>					

### PRE-MED EDUCATION

**School Name:** TULSA COMMUNITY COLLEGE

**City:** TULSA

**Degree:**

**State:** OK **Country:** UNITED STATES

**From:** 1/2018 **To:** 5/ 2018 **Verified:**

**School Name:** COMMUNITY COLLEGE OF THE AIR FORCE

**City:** MAXWELL-GUNTER AFB

**Degree:** ASSOCIATE OF SCIENCE

**State:** AL **Country:** UNITED STATES

**From:** 2/2013 **To:** 3/ 2018 **Verified:**

**School Name:** UNIVERSITY OF OKLAHOMA

**City:** NORMAN

**Degree:**

**State:** OK **Country:** UNITED STATES

**From:** 8/2012 **To:** 5/ 2017 **Verified:**

**School Name:** UNION HIGH SCHOOL

**City:** TULSA

**Degree:** HS DIPLOMA

**State:** OK **Country:** UNITED STATES OF AMERICA

**From:** 1/2012 **To:** 5/ 2012 **Verified:**

## Oklahoma State Board of Medical Licensure and Supervision Application Summary

**Type**    **Number**    **Name**  
 MD        41688        BRENT HICKMAN  
 MEDICAL DOCTOR

MEDICAL SCHOOL EDUCATION			
<b>Name:</b> Univ Of Ok Coll Of Med, Oklahoma City Ok 73190			
<b>Foreign Name:</b>			
<b>City:</b> Oklahoma City	<b>State/Country:</b> United States of America		
<b>Degree:</b> MD	<b>From:</b> 8 / 2019	<b>To:</b> 5 / 2023	<b>Diploma Ver'd:</b> Y

POST GRADUATE EDUCATION			
<b>Facility:</b> COLLEGE OF MEDICINE OKC		<b>Specialty:</b> ANESTHESIOLOGY	
<b>Res. Fellowship:</b> Residency			
<b>City:</b> OKLAHOMA CITY		<b>State:</b> OK	<b>Country:</b> UNITED STATES OF AM
<b>Verified:</b>	<b>From:</b> 7 / 2023	<b>To:</b> /	
<b>ACGME Ver'd:</b>			
<b>Comments:</b>			

PRACTICE HISTORY			
<b>Employed:</b> OKLAHOMA HEART INSTITUTE		<b>Supervisor:</b>	
<b>City:</b> TULSA		<b>State:</b> OK	<b>Country:</b> UNITED STATES
<b>Specialty:</b> PATIENT CARE TECHNICIAN		<b>From:</b> 2 / 2018	<b>To:</b> 7 / 2019 <b>Verified:</b>
<b>Comments:</b>			
<b>Employed:</b> OKLAHOMA AIR NATIONAL GUARD		<b>Supervisor:</b>	
<b>City:</b> TULSA		<b>State:</b> OK	<b>Country:</b> UNITED STATES
<b>Specialty:</b> 219TH ENGINEERING INSTALLATIONS UNIT		<b>From:</b> 2 / 2013	<b>To:</b> 8 / 2019 <b>Verified:</b>
<b>Comments:</b>			

Other Licenses					
State	Lic Type and Number	Status	Issued	Exp	Verif

DEFICIENCIES
OTHER DEFICIENCIES: NEED USMLE STEP 3 / EVALUATION
Exam verification date
PostGrad - Form 2 COLLEGE OF MEDICINE OKC
USMLE Exams Incomplete

RETURN FORM TO:  
OKLAHOMA STATE BOARD OF MEDICAL LICENSURE AND SUPERVISION  
[oktraining@okmedicalboard.org](mailto:oktraining@okmedicalboard.org)

APR 28 2024

OKLAHOMA STATE BOARD OF  
MEDICAL LICENSURE  
AND SUPERVISION

**QUESTIONNAIRE**  
Please read and follow ALL instructions

**FORM INSTRUCTIONS:** Complete both pages of this form *only if* you are renewing or upgrading your training license. Attach the appropriate documentation and answer the confidential questions.

**PAYMENT INSTRUCTIONS:** If you **ARE FULLY LICENSED**, you **MUST** go online and renew your license – **DO NOT pay your renewal fee via these instructions (doing so will delay your renewal)** for those needing to pay online please see the instructions of ATTACHMENT 2.

**ATTESTATION STATEMENT:** By completing this document, I agree to pay the appropriate fee on **ONLINE BILL PAY**. If you are **UPGRADING** your training license to a full license, your fee will be \$250 & you will choose **MD TRAINING-TO-FULL**. If you are **RENEWING** your training license, your fee will be \$150 & you will choose **MD TRAINING LICENSE RENEWAL**.

**PLEASE PRINT ALL INFORMATION**

FIRST NAME	Brent	LAST NAME	Hickman
EMAIL ADDRESS	[REDACTED]		
LICENSE NUMBER	41688	CELL PHONE	[REDACTED]
HOME ADDRESS	[REDACTED]	CITY/STATE	[REDACTED]
PROGRAM ATTENDING	University of Oklahoma Health Science	SPECIALTY	Anesthesiology

**DOCUMENTATION TO ATTACH**

PAYMENT COMPLETED			
<input type="checkbox"/>	\$150 payment made on Billpay for <b>RENEWAL</b> of training license	<input checked="" type="checkbox"/>	\$250 payment made on Billpay for <b>UPGRADE</b> of training license

DOCUMENTATION REQUIRED			
<input type="checkbox"/>	Form 2 (must be received directly from program) <b>**ONLY FOR UPGRADE - ATTACHMENT 3</b>	<input type="checkbox"/>	Evaluation (must be received directly from program) - ATTACHMENT 4
<input type="checkbox"/>	USMLE Step 3 (must be received directly from USMLE)	<input type="checkbox"/>	Answer confidential questions (on back of this form)

FOREIGN TRAINED STUDENTS			
<input type="checkbox"/>	Current visa	<input type="checkbox"/>	Social Security Number <b>**if not provided at initial application</b>
<input type="checkbox"/>	Background Check <b>**if not done at initial application</b>		

**IF YOU ARE FULLY LICENSED – DO NOT COMPLETE THIS FORM. YOU MUST GO ONLINE AND RENEW AT <https://pay.apps.ok.gov/medlic/md/login.php> ENTER YOUR LICENSE NUMBER & PIN – COMPLETE YOUR RENEWAL AND PAY THE RENEWAL FEE.**

741688  
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APR 28 2024

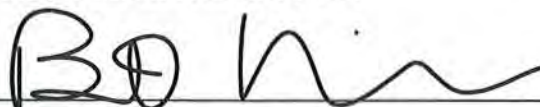
NAME Brent Hickman

OKLAHOMA STATE BOARD OF  
MEDICAL LICENSURE

PLEASE COMPLETE THE RENEWAL QUESTIONS BELOW, IF YOU HAVE ANY "YES" ANSWERS YOU MUST PROVIDE A NOTARIZED STATEMENT EXPLAINING YOUR ANSWER.

<i>SINCE RENEWAL OF YOUR TRAINING LICENSE OR INITIAL ISSUE OF YOUR TRAINING LICENSE (whichever is most recent)</i>		
QUESTIONS	YES	NO
Have you failed any part of the USMLE exam (not previously disclosed)?	<input type="checkbox"/>	<input checked="" type="checkbox"/>
Have you been the subject of investigation or disciplinary action (including probation) by a hospital or training program?	<input type="checkbox"/>	<input checked="" type="checkbox"/>
Have you had any adverse judgment or settlement against you rising from a professional liability claim?	<input type="checkbox"/>	<input checked="" type="checkbox"/>
Have you been reported to the National Practitioner Data Bank (NPDB)?	<input type="checkbox"/>	<input checked="" type="checkbox"/>
Have you ever been denied, had removed, or suspended hospital privileges?	<input type="checkbox"/>	<input checked="" type="checkbox"/>
Have you surrendered hospital privileges while under investigation or to avoid investigation?	<input type="checkbox"/>	<input checked="" type="checkbox"/>
Have you entered into an Agreement with a Federal, State, or Local jurisdictional body to avoid formal action?	<input type="checkbox"/>	<input checked="" type="checkbox"/>
Has your application for licensure ever been denied?	<input type="checkbox"/>	<input checked="" type="checkbox"/>
Have you surrendered a license or had any disciplinary action taken on any license?	<input type="checkbox"/>	<input checked="" type="checkbox"/>
Have you been investigated by or requested to appear before a licensing or disciplinary agency (other than the Oklahoma State Board of Medical Licensure and Supervision)?	<input type="checkbox"/>	<input checked="" type="checkbox"/>
Have you obtained an assessment or been treated for use of any drug or chemical substance including alcohol?	<input type="checkbox"/>	<input checked="" type="checkbox"/>
Have you been arrested for, charged with, or convicted of a felony or misdemeanor other than a traffic violation?	<input type="checkbox"/>	<input checked="" type="checkbox"/>
Have you been arrested for, charged with, or convicted of a traffic violation involving the use of any drug or chemical substance?	<input type="checkbox"/>	<input checked="" type="checkbox"/>
Have you been addicted to or abused any drug or chemical substance including alcohol?	<input type="checkbox"/>	<input checked="" type="checkbox"/>
Have you been denied provider participation, terminated, sanctioned or penalized by any third-party payor including TRICARE, MEDICARE, or MEDICAID?	<input type="checkbox"/>	<input checked="" type="checkbox"/>
Have you surrendered or had any adverse action taken against any narcotic permit (State or Federal)?	<input type="checkbox"/>	<input checked="" type="checkbox"/>

I swear under penalty of perjury, that I am the person completing this Questionnaire and understand that any medical license procured or obtained by fraud or misrepresentation will result in disciplinary action taken against the licensee pursuant to the provisions of 59 O.S. § 508.

Signature 

Date 4/28/2024

# Oklahoma State Board of Medical Licensure and Supervision

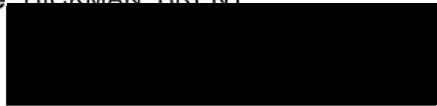
APPLICATION FOR OKLAHOMA MEDICAL DOCTOR LICENSE

PAGE 7 of 500

Received:05/02/2023

Applicant Name: HICKMAN, BRENT

MD 41688



Date Of Birth: [Redacted]

Place Of Birth (City, State): TULSA, OK

Sex: M

Race: Other

Education									
Type	Name	City	ST	Country	From	To	Degree	Comments	Veri
UG	TULSA COMMUNITY COLLEGE	TULSA	OK		1/2018	5/2018			
UG	COMMUNITY COLLEGE OF THE AIR FORCE	MAXWELL-GI	AL		2/2013	3/2018	ASSOCIATE OF SCIENCE		
UG	UNIVERSITY OF OKLAHOMA	NORMAN	OK		8/2012	5/2017			

Medical School Name	City	State	Country	Comments	From	To
Univ Of Ok Coll Of Med, Oklahoma City Ok 73190	Oklahoma City	OK	United States		8/2019	5/2023

Post-Graduate							
Facility	City	St	Country	Specialty	Comments	From	To
UNIVERSITY OF OKLAHOMA	OKLAHOMA CITY	OK	UNITED S			/	6/2027

Practice History								
Employer	Specialty	Supervisor	City	ST	Country	From	To	Verif
OKLAHOMA HEART INSTITUTE	PATIENT CARE TECHNICIAN		TULSA	OK		2/2018	7/2019	
OKLAHOMA AIR NATIONAL GUARD	219TH ENGINEERING INSTALLATIONS UNIT		TULSA	OK		2/2013	8/2019	

Other/ Out-Of-State Licenses					
State	License #	Profession	Status	Issue Date	Exp Date

MD Exam				
Exam	State	Score	Date Taken	#
USMLE				

\$250/-

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# Oklahoma State Board of Medical Licensure and Supervision

APPLICATION FOR OKLAHOMA MEDICAL DOCTOR LICENSE

PAGE 8 of 500

Received:05/02/2023

<b>Questions Answered 05/01/2023</b>	<b>Response</b>
A. Have you ever been denied provider participation, terminated, sanctioned, or penalized by any third party payor, to include TRICARE, MEDICARE, MEDICAID?	<b>N</b>
B. Have you ever surrendered or had any adverse action taken against any narcotic permit (state or federal)?	<b>N</b>
C. Have you ever been denied membership or had disciplinary action taken by a national, state or county professional organization?	<b>N</b>
D. Have you ever been denied or had removed or suspended hospital staff privileges?	<b>N</b>
E. Have you ever surrendered hospital staff privileges while under investigation or to avoid investigation?	<b>N</b>
F. Have you ever entered into an agreement with a federal, state or local jurisdictional body to avoid formal action?	<b>N</b>
G. Have you ever been the subject of an investigation, probation or disciplinary action by a hospital, clinic, practice group, training program or professional school?	<b>N</b>
H. Have you had any adverse judgment, settlement, or award against you arising from a professional liability claim?	<b>N</b>
I. Have you ever had professional liability coverage declined, canceled, issued on special terms, or renewal refused?	<b>N</b>
J. Have you ever been reported to the National Practitioners Data Bank (NPDB) or to the Healthcare Integrity and Protection Data Bank (HIPDB)? (If yes, enclose a copy of the report.)	<b>N</b>
K. Has your application for examination or a professional license ever been denied?	<b>N</b>
L. Have you ever failed any part of a licensure/certification/registration examination?	<b>N</b>
M. Have you ever surrendered a license or had a license revoked?	<b>N</b>
N. Has any disciplinary action been taken on any license?	<b>N</b>
O. Have you ever been subject of a review by professional licensing/regulatory agency based on a complaint filed against you?	<b>N</b>
P. Have you ever been arrested, charged with, or convicted of a felony or misdemeanor, other than traffic violations?	<b>N</b>
Q. Have you ever been arrested, charged with, or convicted of a traffic violation involving the use of any drug or chemical substance, including alcohol?	<b>N</b>
R. Are you now or have you within the past two years been addicted to or used in excess any drug or chemical substance, including alcohol?	<b>N</b>
S. Have you obtained an assessment or been treated for the use of any drug or chemical substance, including alcohol?	<b>N</b>
T. Do you currently have or have you had within the past two years any mental or physical disorder or condition which, if untreated, could affect your ability to practice competently?	<b>N</b>
U. Are you or your spouse currently on Active Duty in the U.S. Armed Forces?	<b>N</b>
V. Are you or your spouse currently Deployed on Active Duty in the U.S. Armed Forces?	<b>N</b>



Oklahoma State Board of Medical Licensure and Supervision

APPLICATION FOR OKLAHOMA MEDICAL DOCTOR LICENSE

PAGE 9 of 500

Received:05/02/2023

If licensed, where do you intend to locate?

OK

Why do you seek Licensure in the state of Oklahoma?

Post-Graduate Training

In what manner will you be communicating with your Oklahoma patients (telephone, email, internet, video-conference, etc)?

Describe how you will examine each patient in person prior to diagnosis, treating, correcting, or prescribing for a patient in Oklahoma from the state, province, or country you are located:

Describe the manner in which you intend to practice medicine across state lines in Oklahoma:

Have you executed or been offered a contract in connection with practice in the state of Oklahoma?

No

If 'Yes', Name of practice:

If so, Please identify with which category:

Name of Previous Carrier and Policy Holder

N/A

Name of Current Carrier and policy Holder

UNIVERSITY OF OKLAHOMA

Will your professional liability insurance policy cover your practice in Oklahoma

Yes

If NO, when do you expect to obtain liability insurance that will cover practice in Oklahoma

I attest that all the above information is accurate as of May 01, 2023: \_\_\_\_\_ (Signed Online)



**Applicant:** In the presence of a notary public, sign this form with attached photo.

**Send this form to:**

Oklahoma State Board of Medical Licensure and Supervision  
101 NE 51<sup>st</sup> Street  
Oklahoma City, OK 73105

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

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

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

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

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

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

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JUN 12 2023

OKLAHOMA STATE BOARD OF  
MEDICAL LICENSURE  
AND SUPERVISION



Brent Hickman

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

Hickman, Brent, W

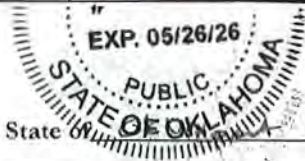
Applicants printed last name, first name, middle initial, and suffix (e.g., Jr.)

6/9/23

Date of signature (must correspond to the date of notarization)

[Please note: The Notary Public seal should overlap the bottom of the photo to the left]

NOTARY



State of OKLAHOMA, County of OKMONT

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

The statements on this document are subscribed and sworn to before me by the applicant on this 9 day of June, 2023

Notary Public Signature Keri Davis My Notary Commission Expires 5/26/26

T 41688  
WB



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

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

**Recipient:** OKLAHOMA STATE BOARD OF  
MEDICAL LICENSURE & SUPERVISION

**Date:** 06/09/2023

**Examinee:** Hickman, Brent Wesley  
**Alt Name(s):**

**Examinee ID:** 5-476-263-8  
**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. Pass/fail outcomes are based upon the minimum passing level in place at the time of test administration and are not altered by subsequent revisions to the minimum passing level. Effective April 1, 2013, two-digit scores will no longer be reported. Test results reported as passing represent an exam score of 75 or higher on a two-digit scale. Step 1 examinations taken on or after January 26, 2022 are reported as pass/fail, with no numeric score; Step 1 examinations taken before January 26, 2022 will continue to be reported with a 3-digit score.

USMLE STEP 1				
Test Date	Pass/Fail	Score	Minimum Pass	Comments
06/10/2021	Pass	217	(194)	

USMLE STEP 2				
<i>Clinical Knowledge (CK)</i>				
Test Date	Pass/Fail	Score	Minimum Pass	Comments
07/29/2022	Pass	256	(214)	

**End of Exam History**

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

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

RECEIVED  
'JUN 12 2023  
OKLAHOMA STATE BOARD OF  
MEDICAL LICENSURE  
AND SUPERVISION

T41688  
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## United States Medical Licensing Examination® (USMLE®) Certified Transcript of Scores

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

**Examinee:** Hickman, Brent Wesley

**Examinee ID:** 5-476-263-8

**Date of Birth:** [REDACTED]

### INTERPRETATION OF RESULTS

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

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

### STEP 1 AND STEP 2 CLINICAL SKILLS (CS)

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

### ANNOTATIONS APPEARING UNDER "COMMENTS"

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

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

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

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

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

### ANNOTATIONS APPEARING AS "NOTE"

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

### PHYSICIAN DATA CENTER INFORMATION APPEARING AS "NOTE"

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

03/2015

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

Oklahoma State Board of Medical Licensure and Supervision
101 NE 51st Street
Oklahoma City, OK 73105

This form must be completed by the institution and mailed directly from the institution.

Applicant's Name Brent Hickman

Institution: University of Oklahoma College of Medicine City/State Oklahoma City, OK

Our records indicate that the above named applicant attended our medical school on the following dates:

From 8 / 19 / 2019 To 5 / 20 / 2023 and was awarded the degree Doctor of Medicine

- 1. Does this individual's official record reflect (an) interruption(s) or extension(s) in his/her medical education? If yes, please explain.
2. Does this individual's official record reflect that he/she was ever placed on academic or disciplinary probation during his/her medical education? If yes, please explain.
3. Does this individual's official record reflect that he/she was ever the subject of negative reports for behavioral reasons or an investigation by the medical school or parent university? If yes, please explain below.
4. Does this individual's official record reflect that he/she was ever disciplined for unprofessional conduct/behavioral reasons by the medical school or parent university? If yes, please explain below
5. Does this individual's official record reflect that there were any limitations or special requirements imposed on the individual because of questions of academic incompetence, disciplinary problems, or any other reason? If yes, please explain below

Please explain any "YES" response from above:

Completion of the following is certification that the information above is an accurate account of this individual's records and is true and correct.

Name: Teresa Scordino, M.D. Signature [Handwritten Signature]

Title of Signatory: Associate Dean for Student Affairs Date of Signature 5/31/23

Tel: 405-271-2316 Fax: 405-271-2287 E-Mail: Teresa-Scordino@ouhsc.edu

If no seal is available, this form must be notarized

School Seal

Notary Public

Commission #

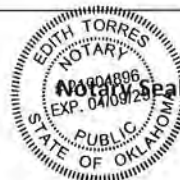
My commission expires:

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JUN 08 2023

OKLAHOMA STATE BOARD OF MEDICAL LICENSURE AND SUPERVISION

MARY TORRES



Handwritten blue ink mark: 41688 SJ



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Official Transcript

University of Oklahoma Health Sciences Center  
P. O. Box 26901  
Oklahoma City, OK 731260901  
United States

Name : Brent Hickman  
Student ID: 1796811  
Birthdate : [REDACTED]

OKLAHOMA STATE BOARD OF  
MEDICAL LICENSURE  
AND SUPERVISION

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T

Spring 2020

----- Degrees Awarded -----  
Degree : Doctor of Medicine  
Confer Date : 2023-05-20  
Plan : Medicine

PRIMARY SOURCE

Course	Description	Attempted	Earned	Grade	Points
INDT 8132	IMI	68.00	68.00	S	
INDT 8140	Gastrointestinal & Hepatobil	85.00	85.00	S	
INDT 8148	Endo, Metab & Nutri Biochem	85.00	85.00	S	
INDT 8156	Blood, Hematopoiesis & Lymph	77.00	77.00	S	

----- External Degrees -----

University of Oklahoma  
2017-05-12 Bachelor of Science  
Field of Study : Microbiology

TERM GPA :	0.000	GPH:	0.00	TOTALS :	315.00	315.00	0.000
OUHSC GPA :	0.000	GPH:	0.00	TOTALS :	834.50	834.50	0.000

----- Academic Program History -----

Program : Medicine MD  
2019-07-01 : Active in Program  
2019-07-01 : Medicine - MD Major  
2023-05-20 : Completed Program

Fall 2020

Course	Description	Attempted	Earned	Grade	Points
INDT 8264	Cardiovasc, Resp, Renal	164.00	164.00	S	
INDT 8266	PPS II: Clinical Ethics	35.00	35.00	S	
INDT 8272	Neurosciences	166.00	166.00	S	
INDT 8275	Clinical Medicine II	99.00	99.00	S	
INDT 8301	Enrichment Program: Humanities	16.00	16.00	S	

Course Topic(s): Medical Readers' Theater

----- Beginning of Medicine Record -----

Fall 2019

Course	Description	Attempted	Earned	Grade	Points		
INDT 8110	Design/Analysis Clin Res	16.00	16.00	S			
INDT 8122	Clinical Medicine I	111.50	111.50	S			
INDT 8124	The Human Structure	130.00	130.00	S			
INDT 8125	Foundations of Medicine	151.00	151.00	S			
INDT 8244	PPSI	87.00	87.00	S			
INDT 8555	Req Orientation Documents I			0.00 CE			
INDT 9100	Prologue	24.00	24.00	S			
TERM GPA :	0.000	GPH:	0.00	TOTALS :	519.50	519.50	0.000
OUHSC GPA :	0.000	GPH:	0.00	TOTALS :	519.50	519.50	0.000

Spring 2021

Course	Description	Attempted	Earned	Grade	Points
INDT 8280	Reproduction	98.00	98.00	S	
INDT 9200	MS2 Capstone	70.00	70.00	S	
INDT 9201	Joint, Skin, and Bone	40.00	40.00	S	

TERM GPA :	0.000	GPH:	0.00	TOTALS :	208.00	208.00	0.000
OUHSC GPA :	0.000	GPH:	0.00	TOTALS :	1522.50	1522.50	0.000

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*Low Klein*

REGISTRAR, OUHSC

THE UNIVERSITY OF OKLAHOMA HEALTH SCIENCES CENTER

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P. O. Box 26901  
Oklahoma City, OK 731260901  
United States

JUN 08 2023

Name : Brent Hickman  
Student ID: 1796811  
Birthdate : [REDACTED]

OKLAHOMA STATE BOARD OF  
MEDICAL LICENSURE  
AND SUPERVISION

PRIMARY  
SOURCE

Summer II 2021

Summer II 2022

Course	Description	Attempted	Earned	Grade	Points
INDT 9301	Clinical Transitions	40.00	40.00	S	
PSBS 9520	Psychiatry Clerkshp	240.00	240.00	A	960.000
TERM GPA :	4.000	GPH: 240.00	TOTALS : 280.00	280.00	960.000
OUHSC GPA :	4.000	GPH: 240.00	TOTALS : 1802.50	1802.50	960.000

Fall 2021

Course	Description	Attempted	Earned	Grade	Points
NEUR 9370	Neurology Clerkship	160.00	160.00	C	320.000
FM 9540	Fam Med Clerkship	160.00	160.00	A	640.000
PEDI 9650	Pediatric Clerkship	240.00	240.00	B	720.000
ANES 9110	Anesthesiology Selective	80.00	80.00	S	
UROL 9101	Urology Selective	80.00	80.00	S	
TERM GPA :	3.000	GPH: 560.00	TOTALS : 720.00	720.00	1680.000
OUHSC GPA :	3.300	GPH: 800.00	TOTALS : 2522.50	2522.50	2640.000

Spring 2022

Course	Description	Attempted	Earned	Grade	Points
SURG 9760	Surgery Clerkship	320.00	320.00	B	960.000
MED 9250	Medicine Clerkship	320.00	320.00	B	960.000
RADI 9101	RADI Selective	80.00	80.00	S	
OBGY 9210	Obstet & Gyn Clerkship	240.00	240.00	B	720.000
TERM GPA :	3.000	GPH: 880.00	TOTALS : 960.00	960.00	2640.000
OUHSC GPA :	3.143	GPH: 1680.00	TOTALS : 3482.50	3482.50	5280.000

Course	Description	Attempted	Earned	Grade	Points
INDT 9300	Capstone	160.00	160.00	S	
INDT 9403	Subinternship Elective	160.00	160.00	A	640.000
Course Topic(s) : ANES Subinternship Elective					
TERM GPA :	4.000	GPH: 160.00	TOTALS : 320.00	320.00	640.000
OUHSC GPA :	3.217	GPH: 1840.00	TOTALS : 3802.50	3802.50	5920.000

Fall 2022

Course	Description	Attempted	Earned	Grade	Points
INDT 9403	Subinternship Elective	160.00	160.00	A	640.000
Course Topic(s) : FM Subinternship Elective					
INDT 9407	Fourth Year Selective	160.00	160.00	S	
Course Topic(s) : Pharmacology Readings Pharmacology Readings					

Course	Description	Attempted	Earned	Grade	Points
INDT 9407	Fourth Year Selective	80.00	80.00	S	
Course Topic(s) : Directed Readings in PHARM Directed Readings in PHARM					
INDT 9406	Special Studies Elective	80.00	80.00	S	
Course Topic(s) : ANES Special Studies Elective					
TERM GPA :	4.000	GPH: 160.00	TOTALS : 480.00	480.00	640.000
OUHSC GPA :	3.280	GPH: 2000.00	TOTALS : 4282.50	4282.50	6560.000

Spring 2023

Course	Description	Attempted	Earned	Grade	Points
INDT 9403	Subinternship Elective	160.00	160.00	A	640.000
Course Topic(s) : ANES Subinternship Elective					
INDT 9406	Special Studies Elective	160.00	160.00	S	
Course Topic(s) : ANES Special Studies Elective					

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*Lou Klein*

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Spring 2023 (cont.)

Course	Description	Attempted	Earned	Grade	Points
INDT 9406	Special Studies Elective	80.00	80.00	S	
Course Topic(s): INDT Special Studies Elective					
FM 9569	CH I	80.00	80.00	S	
FM 9572	CH II	80.00	80.00	S	
TERM GPA :	4.000	GPH: 160.00	TOTALS : 560.00	560.00	640.000
OUHSC GPA :	3.333	GPH: 2160.00	TOTALS : 4842.50	4842.50	7200.000
Medicine Career Totals					
OUHSC GPA :	3.333	GPH: 2160.00	TOTALS : 4842.50	4842.50	7200.000
Post-Baccalaureate Career Totals					
OUHSC GPA :	3.333	GPH: 135.00	TOTALS : 302.65	302.65	450.000
----- End Of Career (1 of 1) -----					
----- End Of Transcript -----					

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**EXPLANATION OF RECORD**  
**THE UNIVERSITY OF OKLAHOMA HEALTH SCIENCES CENTER**  
**OUHSC FICE CODE 5889**

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# AMA Physician Profile

PREPARED FOR

Oklahoma State Board of Licensure & Supervision, Oklahoma City, OK

**Name and Mailing Address**

BRENT WESLEY HICKMAN



**Primary Office Address**

Phone UNKNOWN

**Birth date**



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MAY 14 2024

OKLAHOMA STATE BOARD OF MEDICAL LICENSURE AND SUPERVISION

**Physician's major professional activity**

HOSPITAL BASED RESIDENTS - ALL YEARS

PRIMARY SOURCE

**AMA membership status**

MEMBER

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

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

NO DATA REPORTED AT THIS TIME

**Current and/or historical medical school**

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

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

**School:** UNIVERSITY OF OKLAHOMA COLLEGE OF MEDICINE

**Degree Awarded:** YES  
**Enrollment Date:** 08/2019

**Degree Type:** MD  
**Degree Date:** 05/2023

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

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

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

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

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

<b>Sponsoring Institution:</b>	UNIVERSITY OF OKLAHOMA COLLEGE OF MEDICINE
<b>Sponsoring State:</b>	OKLAHOMA
<b>Program name:</b>	UNIVERSITY OF OKLAHOMA HEALTH SCIENCES CENTER PROGRAM
<b>Specialty:</b>	ANESTHESIOLOGY
<b>Training Type:</b>	SPECIALTY
<b>Dates:</b>	07/01/2023 - 06/30/2027
<b>Status:</b>	TRAINING IN PROGRESS

### Specialty board certification

NO DATA REPORTED AT THIS TIME

### Current and/or historical medical licensure

NO DATA REPORTED AT THIS TIME

### Action notifications reported to the AMA

**Medical Licensing Boards:** NO ACTIONS REPORTED AT THIS TIME

**Medicare/Medicaid Sanctions from DHHS:** NO ACTIONS REPORTED AT THIS TIME

**US DOJ Drug Enforcement Administration: NO ACTIONS REPORTED AT THIS TIME**

**U.S. Drug Enforcement Administration (DEA)**

NO DATA REPORTED AT THIS TIME

**ECFMG certification**

NOT APPLICABLE

**Profile information**

The content of the AMA Physician Profile is for credentialing use only. The content cannot be used or assembled for an employment purpose as defined under the Fair Credit Reporting Act. An organization's appropriate use of the data contained in the AMA Physician Professional Data™, formerly known as AMA Physician Masterfile, meets select primary source verification requirements of the Joint Commission, the Accreditation Association for Ambulatory Health Care (AAAHC) and the American Accreditation Health Care Commission (AAHCC)/ Utilization Review Accreditation Commission (URAC). The AMA Physician Professional Data is also an NCQA-approved source for verification of medical school, post-graduate medical training, ABMS Board Certification and federal DEA registration.

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

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

RECEIVED

JUN 12 2023

OKLAHOMA STATE BOARD OF MEDICAL LICENSURE AND SUPERVISION

OKLAHOMA STATE BOARD OF MEDICAL LICENSURE AND SUPERVISION
101 NE 51st STREET
OKLAHOMA CITY OK 73105
EVIDENCE OF STATUS - PART A

Full Legal Name: Brent Wesley Hickman
First Middle Last Maiden (if applicable)

Mailing Address: [Redacted]
Street Address or Post Office Box
[Redacted]
City State Zip Code Telephone Number Social Security #: [Redacted]

PRIMARY EVIDENCE OF CITIZENSHIP
(FOR US CITIZENS, US NATIONALS, OR PERMANENT LEGAL RESIDENT ALIENS)

If you are a U.S. citizen, U.S. national, or permanent legal resident alien, please attach a photocopy of one of the following documents to this form. Place a checkmark below to indicate the document that is attached.

- A birth certificate showing birth in one of the 50 States, the District of Columbia, Puerto Rico (on or after January 13, 1941), Guam, the U.S. Virgin Islands (on or after January 17, 1917), American Samoa, Swain's Island or the Northern Mariana Islands, unless the person was born to foreign diplomats residing in the U.S.
United States passport (except limited passports, which are issued for periods of less than five years)
Report of birth abroad of a U.S. citizen (FS-240) (issued by the Department of State to U.S. citizens)
Certificate of birth (FS-545) (issued by a foreign service post) or Certification of Report of Birth (DS1350) (issued by the Department of State), copies available from the Department of State
Certificate of Naturalization (N-550 or N-570) (issued by the INS through a Federal or State court, or through administrative naturalization after December 1990 to individuals who are individually naturalized; the N570 is a replacement certificate issued when the N-550 has been lost or mutilated or the individual's name has been changed)
Certificate of Citizenship (N-560 or N-561) (issued by the INS to individuals who derive U.S. citizenship through a parent; the N-561 is a replacement certificate issued when the N-560 has been lost or mutilated or the individual's name has been changed)
United States Citizen Identification Card (I-197) (issued by the INS until April 7, 1983 to U.S. citizens living near the Canadian or Mexican border who needed it for frequent border crossing) (formerly Form I-179, last issued in February 1974)
Northern Mariana Identification Card (issued by the INS to a collectively naturalized citizen of the U.S. who was born in the Northern Mariana Islands before November 3, 1986)
Statement provided by a U.S. consular officer certifying that the individual is a U.S. citizen (This is given to an individual born outside the U.S. who derives citizenship through a parent but does not have an FS-240, FS-545 or DS-1350);
American Indian Card with a classification code "KIC" and a statement on the back (identifying U.S. citizen members of the Texas Band of Kickapoos living near the U.S./Mexican border.)
Alien Lawfully Admitted for Permanent Residence:
INS Form I-551 (Alien Registration Receipt Card, commonly known as a "green card")
Alien Lawfully Admitted for Permanent Residence:
Unexpired Temporary I-551 stamp in foreign passport or on INS Form I-94

I declare under penalty of perjury, under the laws of the State of Oklahoma, that all information contained in this application and all accompanying documents provided to substantiate my Evidence of Status application are true and correct.

Signature: [Signature] Date: 6/9/23

Subscribed and sworn before me this 9 day of June

Notary Public: [Signature]

Commission Number: 10004295

My commission expires: 5/26/26



T 4/16/88 WB



**Kenna L. Shaw**

---

**From:** BillPay Webmaster <donotreply@www.ok.gov>  
**Sent:** Sunday, April 28, 2024 10:30 PM  
**To:** Dela Kwetey; Bill Pay; Sheila E. Brumfield; Chris Maloney; Licensing; Arlene Morris; Debra Reich  
**Subject:** [EXTERNAL] LICENSE - MD Training-to-Full License Fee 250.00 - Payment Made

BRENT HICKMAN has paid for a LICENSE - MD Training-to-Full License Fee 250.00 on 04/28/2024 10:04:29pm for \$250.00.

OKLAHOMA MD LICENSE NUMBER 41688

To view all transactions please go to <http://www.ok.gov/triton/> and login to your CMS account.

X 41688  
15

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JUN 12 2023

OKLAHOMA STATE BOARD OF MEDICAL LICENSURE AND SUPERVISION

OKLAHOMA STATE BOARD OF MEDICAL LICENSURE AND SUPERVISION  
101 NE 51<sup>ST</sup> STREET  
OKLAHOMA CITY OK 73105

Phone: (405)962-1400 Fax: (405)962-1440 email: [licensing@okmedicalboard.org](mailto:licensing@okmedicalboard.org)

To Request Examination Scores	
For National Board Scores National Board of Medical Examiners PO Box 48014 Newark, NJ 07101-4814 (215) 590-9500 <a href="http://www.NBME.org">www.NBME.org</a>	For FLEX or USMLE Scores Federation of State Medical Boards 400 Fuller Wiser Road Euless, TX 76039-3855 (817) 868-4000 <a href="http://www.FSMB.org">www.FSMB.org</a>

6. **Extended Background Check** – Applicants for licensure are required to request an Extended Background Check.
  7. **Evidence of Status Form** - In order to verify citizenship or qualified alien status, applicants for licensure by endorsement or examination or for reinstatement of their license, must submit an Evidence of Status Form and the required supporting documentation with their application. This form must be notarized and mailed to the office.
  8. **Photo and Oath Form** – Applicants for licensure will be required to complete the Photo and Oath Form. This form must be notarized and mailed to the office.
  9. **Telemedicine Form** – Applicants planning to practice telemedicine must submit the initialed and signed Telemedicine Questionnaire.
  10. **English Proficiency Exam** – Foreign applicants shall have a command of the English language that is satisfactory to the Board, demonstrated by the passage of an oral English competency exam. Applicant is required to call 405-962-1400 and speak with an application analyst in licensing.
- G. **Temporary Licensure (59 O.S. § 493.3)** – The Board may authorize the Secretary to issue a Temporary Medical License for the intervals between Board meetings. Such Temporary License shall be granted only when the Secretary is satisfied as to the qualifications of the applicant to be licensed under this Act but where such qualifications have not been verified to the Board. An application for Temporary Licensure must be made by written request and include all appropriate fees. Such a license shall:
1. Be granted only to an applicant demonstrably qualified for a full and unrestricted medical license;
  2. Automatically terminate on the date of the next Board meeting at which the applicant may be considered for a full and unrestricted medical license.
  3. We must be in receipt of the following in order for the Board Secretary to consider issuing a Temporary License:
    - a. Examination scores, and
    - b. Verification of licensure in all jurisdictions in which applicant has been licensed to practice medicine and surgery, and
    - c. Evidence of Status, and
    - d. Extended Background Check

I, the undersigned, have fully read and understand the instructions. I swear or affirm that the information submitted in and with the application is, to the best of my knowledge, true and factual. I understand that attempts to deceive or fraudulently portray information contained herein may result in cancellation of my application or charges of filing a fraudulent application that may result in subsequent revocation of licensure.

Brent Hickman                      Brent Hickman                      6/19/23  
Name of Applicant (type or print)                      Signature of Applicant                      Date

**Except as specifically may be waived by the Board, the Board shall not engage in any application process with any agent or representative of the applicant. 59 O.S. § 492.1 (C); Okla. Admin. Code § 435:10-4-1(c)**

Please return these signed instructions by mail to the address at the top of the page or email.

T 4/16/88  
WB



Name: Brent Hickman	Application # 41688
---------------------	---------------------

We must account *for any/all time from your 18th birthday to present.* Please complete this form to the best of your recollection for the times indicated.

EDUCATION							
Start Month	Start Year	End Month	End Year	Name of Institution	City	State	Degree
01	2012	05	2012	Union High School	Tulsa	OK	High school

WORK HISTORY							
Start Month	Start Year	End Month	End Year	Name of Employer	City	State	Job Title


  

OTHER ACTIVITY							
Start Month	Start Year	End Month	End Year	Other Activity (example: Unemployed, Summer Break, Stay at home parent, etc.)	City	State	
05	2012	08	2012	summer break	Tulsa	OK	

RECEIVED  
 JUN 09 2023  
 OKLAHOMA STATE BOARD OF  
 MEDICAL LICENSURE  
 AND SUPERVISION

T41688  
 SJ

05/12/2023

BRENT HICKMAN  


**Check Your Application  
Status Online at:**  
<http://www.okmedicalboard.org>  
**Username:AP72177579**  
**Password:Last 4 SSN**

RE: MD Application #41688

Dear BRENT HICKMAN,

**YOU CANNOT PRACTICE YOUR PROFESSION IN THE STATE  
OF OKLAHOMA UNTIL A VALID LICENSE HAS BEEN ISSUED.**

Your training application has been processed and the current deficiencies are listed below. Please be advised, these may not be the only deficiencies. You will be advised if any other deficiencies are added. You may check your application status online by logging in with the username and password provided above.

If you have further questions please email  
[oktraining@okmedicalboard.org](mailto:oktraining@okmedicalboard.org)

If a "Time Deficiency" is listed, please complete a time deficiency form and e-mail the document to  
[oktraining@okmedicalboard.org](mailto:oktraining@okmedicalboard.org)  
with your activities during the specified time frame.

Time Deficiency Form for: 1/2012-8/2012  
Exam verification date  
MedSchool-Transcript Univ Of Ok Coll Of Med, Oklahoma City Ok 73190  
MedSchool-Form 1 Univ Of Ok Coll Of Med, Oklahoma City Ok 73190  
PostGrad - Form 2 COLLEGE OF MEDICINE OKC  
USMLE Exams Incomplete  
Evidence of Status  
Application Instructions  
OATH  
Extended Background Check

Any of the required forms in the list above may be downloaded from our website:

<http://www.okmedicalboard.org/resources>



In order to check on the status of your application, please log on to our web site:

<https://secure.okmedicalboard.org/applicant/signin>

Your user name is AP72177579 (all caps and no spaces) and your password is the last 4 digits of your social security number.

If you did not provide a social security number with your application, your password will be your 4-digit year of birth in the form "YYYY".

If we may be of further assistance, please email.

[oktraining@okmedicalboard.org](mailto:oktraining@okmedicalboard.org)

Sincerely,

*Seema Jayachand*

Seema Jayachand

Dept. of Licensing

Encl

# Oklahoma State Board of Medical Licensure and Supervision Application Summary

Type	Number	Name
MD	41688	BRENT HICKMAN
MEDICAL DOCTOR		

**Incomplete Information (due to space limitations on this page, this may not be a complete list)**

Exam verification date PostGrad - Form 2 COLLEGE OF MEDICINE OKC USMLE Exams Incomplete
---

<b>Last Medical School Attended:</b> 039-01 Univ Of Ok Coll Of Med, Oklahoma City Ok 73190  <p style="text-align: center;">Number of Licenses Previously Granted to Graduates of this Medical School:7,276</p>
---

Application for: Resident \_\_\_\_\_ Full License \_\_\_\_\_ Reinstatement \_\_\_\_\_

**The Secretary of the Board has reviewed this application and:**

1) AUTHORIZED CIRCULARIZATION TO OTHER BOARD MEMBERS \_\_\_\_\_

- 2) ALL FIVE CRITERIA HAVE BEEN MET [Fast Track] \_\_\_\_\_
- Passed USMLE
  - No DUIs or Legal Issues
  - No Significant Malpractice Issues
  - US Graduate
  - Graduated Medical School on time

3) HAS ISSUED A TEMPORARY LICENSE THROUGH \_\_\_ / \_\_\_ / \_\_\_

4) HAS ISSUED A SPECIAL PGY-1 TRAINING LICENSE   AH   6-22-23

5) REQUESTS SPECIFIC CONSIDERATION OF:

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# Oklahoma State Board of Medical Licensure and Supervision Application Summary

Type	Number	Name
MD	41291	HADDON CLAUDE HILL
MEDICAL DOCTOR		

**Incomplete Information (due to space limitations on this page, this may not be a complete list)**

OTHER DEFICIENCIES: NEED EVALUATION  
 PostGrad - Form 2 COLLEGE OF MEDICINE OKC

**Last Medical School Attended:**  
 047-20 E TN STATE UNIV J H QUILLEN COLL OF MED, JOHNSON CITY TN 37614

**Number of Licenses Previously Granted to Graduates of this Medical School:33**

Application for: Resident \_\_\_\_\_ Full License \_\_\_\_\_ Reinstatement \_\_\_\_\_

**The Secretary of the Board has reviewed this application and:**

- 1) AUTHORIZED CIRCULARIZATION TO OTHER BOARD MEMBERS \_\_\_\_\_
- 2) ALL FIVE CRITERIA HAVE BEEN MET [Fast Track] \_\_\_\_\_
  - Passed USMLE
  - No DUIs or Legal Issues
  - No Malpractice Issues
  - US Graduate
  - Graduated Medical School in 4 years or less
- 3) HAS ISSUED A TEMPORARY LICENSE THROUGH \_\_\_ / \_\_\_ / \_\_\_
- 4) HAS ISSUED A SPECIAL PGY-1 TRAINING LICENSE \_\_\_\_\_

# Oklahoma State Board of Medical Licensure and Supervision

## Application Summary

**Type**    **Number**    **Name**  
 MD            41291    HADDON CLAUDE HILL  
 MEDICAL DOCTOR

**Practice Address:**

April 17, 2023

**Status:**

Res: MD

Received: 03/22/2023

Entered: 03/22/2023

**Temp Issued:****Temp Expires:**

Train Issued: 07/01/2023

Train Expires: 09/30/2024

Fed Rec: 05/28/2024

AMA Rec: 05/28/2024

**Board Action:**

License #: 41291

Sex: M

Ethnic Origin: 1

**Endorsed By:** USMLE

	<b>Test</b>	<b>Score</b>	<b>Date Taken</b>	<b>Date Verified</b>	<b>Attempts</b>
<b>Test 1:</b>	USMLE 3	PASS	09/23/23	5/17/24	1
<b>Test 2:</b>	USMLE 1	PASS	5/3/21	3/22/23	1
<b>Test 3:</b>	USMLE 2	PASS	6/6/22	3/22/23	1

Note: **PASS** means higher than 75

**Test AV:**  
**Total Possible:**  
**Okla Passing:**  
**Total Score:**

**PRE-MED EDUCATION****School Name:** EAST TENNESSEE STATE UNIVERSITY**City:** JOHNSON CITY**State:** TN    **Country:** UNITED STATES**Degree:** HEALTH SCIENCES-MICROBIOLOGY**From:** 7/2015    **To:** 5/2019    **Verified:****MEDICAL SCHOOL EDUCATION****Name:** E TN STATE UNIV J H QUILLEN COLL OF MED, JOHNSON CITY TN 37614**Foreign Name:****City:** Johnson City**State/Country:** United States of America**Degree:** DOCTOR OF MEDICINE    **From:** 7 / 2019    **To:** 5 / 2023    **Diploma Ver'd:** Y**POST GRADUATE EDUCATION****Facility:** COLLEGE OF MEDICINE OKC**Specialty:** SURGERY**Res. Fellowship:** Residency**City:** OKLAHOMA CITY**State:** OK    **Country:** UNITED STATES OF AMERICA**Verified:****From:** 7 / 2023    **To:** /**ACGME Ver'd:****Comments:**



## Oklahoma State Board of Medical Licensure and Supervision Application Summary

<b>Type</b>	<b>Number</b>	<b>Name</b>
MD	41291	HADDON CLAUDE HILL
MEDICAL DOCTOR		

PRACTICE HISTORY			
<b>Employed:</b> EAST TENNESSEE STATE UNIVERSITY	<b>Supervisor:</b>		
<b>City:</b> JOHNSON CITY	<b>State:</b> TN	<b>Country:</b> UNITED STATES	
<b>Specialty:</b> TUTOR	<b>From:</b> 7/ 2021	<b>To:</b> 10/ 2022	<b>Verified:</b>
<b>Comments:</b>			

Other Licenses					
State	Lic Type and Number	Status	Issued	Exp	Verif

<b>DEFICIENCIES</b>
OTHER DEFICIENCIES: NEED EVALUATION
PostGrad - Form 2 COLLEGE OF MEDICINE OKC

**RETURN FORM TO:**  
**OKLAHOMA STATE BOARD OF MEDICAL LICENSURE AND SUPERVISION**  
[oktraining@okmedicalboard.org](mailto:oktraining@okmedicalboard.org)

**QUESTIONNAIRE**  
 Please read and follow ALL instructions

**FORM INSTRUCTIONS:** Complete both pages of this form *only if* you are renewing or upgrading your training license. Attach the appropriate documentation and answer the confidential questions.

**PAYMENT INSTRUCTIONS:** If you **ARE FULLY LICENSED**, you **MUST** go online and renew your license – **DO NOT pay your renewal fee via these instructions (doing so will delay your renewal).**

**ATTESTATION STATEMENT:** By completing this document, I agree to pay the appropriate fee on **ONLINE BILL PAY**. If you are **UPGRADING** your training license to a full license, your fee will be \$250 & you will choose **MD TRAINING-TO-FULL**. If you are **RENEWING** your training license, your fee will be \$150 & you will choose **MD TRAINING LICENSE RENEWAL**.

**PLEASE PRINT ALL INFORMATION**

<p><b>FIRST NAME</b> <u>Haddon</u></p> <p><b>EMAIL ADDRESS</b> <span style="background-color: black; color: black;">[REDACTED]</span></p> <p><b>LICENSE NUMBER</b> <u>41291</u></p> <p><b>HOME ADDRESS</b> <span style="background-color: black; color: black;">[REDACTED]</span></p> <p><b>PROGRAM ATTENDING</b> <u>Ajay Jain, MD</u></p>	<p><b>LAST NAME</b> <u>Hill</u></p> <p><b>CELL PHONE</b> <span style="background-color: black; color: black;">[REDACTED]</span></p> <p><b>CITY/STATE/ZIP CODE</b> <span style="background-color: black; color: black;">[REDACTED]</span></p> <p><b>SPECIALTY</b> <u>General Surgery</u></p>
--	---

**DOCUMENTATION TO ATTACH**

PAYMENT COMPLETED	
<input type="checkbox"/> \$150 payment made on Billpay for <b>RENEWAL</b> of training license	<input type="checkbox"/> \$250 payment made on Billpay for <b>UPGRADE</b> of training license

DOCUMENTATION REQUIRED	
<input type="checkbox"/> Form 2 (must be received directly from program) <b>**ONLY FOR UPGRADE</b>	<input type="checkbox"/> Evaluation (must be received directly from program)
<input type="checkbox"/> USMLE Step 3 (must be received directly from USMLE)	<input checked="" type="checkbox"/> Answer confidential questions (on back of this form)

FOREIGN TRAINED STUDENTS	
<input type="checkbox"/> Current visa	<input type="checkbox"/> Social Security Number <b>**if not provided at initial application</b>
<input type="checkbox"/> Background Check <b>**if not done at initial application</b>	

**IF YOU ARE FULLY LICENSED – DO NOT COMPLETE THIS FORM. YOU MUST GO ONLINE AND RENEW AT <https://pay.apps.ok.gov/medlic/md/login.php> ENTER YOUR LICENSE NUMBER & PIN – COMPLETE YOUR RENEWAL AND PAY THE RENEWAL FEE.**



NAME Haddon Hill, MD**IF YOU HAVE ANY "YES" ANSWERS YOU MUST PROVIDE A NOTARIZED STATEMENT EXPLAINING YOUR ANSWER.**

<b>SINCE RENEWAL OF YOUR TRAINING LICENSE OR INITIAL ISSUE OF YOUR TRAINING LICENSE (whichever is most recent)</b>		
QUESTIONS	YES	NO
Have you failed any part of the USMLE exam (not previously disclosed)?	<input type="checkbox"/>	<input checked="" type="checkbox"/>
Have you been the subject of investigation or disciplinary action (including probation) by a hospital or training program?	<input type="checkbox"/>	<input checked="" type="checkbox"/>
Have you had any adverse judgment or settlement against you rising from a professional liability claim?	<input type="checkbox"/>	<input checked="" type="checkbox"/>
Have you been reported to the National Practitioner Data Bank (NPDB)?	<input type="checkbox"/>	<input checked="" type="checkbox"/>
Have you ever been denied, had removed, or suspended hospital privileges?	<input type="checkbox"/>	<input checked="" type="checkbox"/>
Have you surrendered hospital privileges while under investigation or to avoid investigation?	<input type="checkbox"/>	<input checked="" type="checkbox"/>
Have you entered into an Agreement with a Federal, State, or Local jurisdictional body to avoid formal action?	<input type="checkbox"/>	<input checked="" type="checkbox"/>
Has your application for licensure ever been denied?	<input type="checkbox"/>	<input checked="" type="checkbox"/>
Have you surrendered a license or had any disciplinary action taken on any license?	<input type="checkbox"/>	<input checked="" type="checkbox"/>
Have you been investigated by or requested to appear before a licensing or disciplinary agency (other than the Oklahoma State Board of Medical Licensure and Supervision)?	<input type="checkbox"/>	<input checked="" type="checkbox"/>
Have you obtained an assessment or been treated for use of any drug or chemical substance including alcohol?	<input type="checkbox"/>	<input checked="" type="checkbox"/>
Have you been arrested for, charged with, or convicted of a felony or misdemeanor other than a traffic violation?	<input type="checkbox"/>	<input checked="" type="checkbox"/>
Have you been arrested for, charged with, or convicted of a traffic violation involving the use of any drug or chemical substance?	<input type="checkbox"/>	<input checked="" type="checkbox"/>
Have you been addicted to or abused any drug or chemical substance including alcohol?	<input type="checkbox"/>	<input checked="" type="checkbox"/>
Have you been denied provider participation, terminated, sanctioned or penalized by any third-party payor including TRICARE, MEDICARE, or MEDICAID?	<input type="checkbox"/>	<input checked="" type="checkbox"/>
Have you surrendered or had any adverse action taken against any narcotic permit (State or Federal)?	<input type="checkbox"/>	<input checked="" type="checkbox"/>

I swear under penalty of perjury, that I am the person completing this Questionnaire and understand that any medical license procured or obtained by fraud or misrepresentation will result in disciplinary action taken against the licensee pursuant to the provisions of 59 O.S. § 508.

Signature Haddon HillDate 05/16/2024

# Oklahoma State Board of Medical Licensure and Supervision

PAGE 35 of 500

## APPLICATION FOR OKLAHOMA MEDICAL DOCTOR LICENSE

Received: 03/22/2023

Applicant Name: HILL, HADDON CLAUDE

MD 41291



Date Of Birth: [REDACTED]

Place Of Birth (City, State): OAK RIDGE, TN

Sex: M

Race: Caucasian

Education									
Type	Name	City	ST	Country	From	To	Degree	Comments	Veri
UG	EAST TENNESSEE STATE UNIVERSITY	JOHNSON CI	TN		7/2015	5/2019	HEALTH SCIENCES-MICRO BIOLOGY		

Medical School Name	City	State	Country	Comments	From	To
E TN STATE UNIV J H QUILLEN COLL OF MED, JOHNSON CITY TN 37614	Johnson City	TN	United States		7/2019	5/2023

Post-Graduate							
Facility	City	St	Country	Specialty	Comments	From	To
			UNITED S			/	/

Practice History								
Employer	Specialty	Supervisor	City	ST	Countr	From	To	Verif
EAST TENNESSEE STATE UNIVERSITY	TUTOR		JOHNSON CITY	TN		7/2021	10/2022	

Other/ Out-Of-State Licenses					
State	License #	Profession	Status	Issue Date	Exp Date

\$ 250

MD Exam				
Exam	State	Score	Date Taken	#
USMLE				



# Oklahoma State Board of Medical Licensure and Supervision

## APPLICATION FOR OKLAHOMA MEDICAL DOCTOR LICENSE

Received:03/22/2023

<b>Questions Answered 03/20/2023</b>	<b>Response</b>
A. Have you ever been denied provider participation, terminated, sanctioned, or penalized by any third party payor, to include TRICARE, MEDICARE, MEDICAID?	N
B. Have you ever surrendered or had any adverse action taken against any narcotic permit (state or federal)?	N
C. Have you ever been denied membership or had disciplinary action taken by a national, state or county professional organization?	N
D. Have you ever been denied or had removed or suspended hospital staff privileges?	N
E. Have you ever surrendered hospital staff privileges while under investigation or to avoid investigation?	N
F. Have you ever entered into an agreement with a federal, state or local jurisdictional body to avoid formal action?	N
G. Have you ever been the subject of an investigation, probation or disciplinary action by a hospital, clinic, practice group, training program or professional school?	N
H. Have you had any adverse judgment, settlement, or award against you arising from a professional liability claim?	N
I. Have you ever had professional liability coverage declined, canceled, issued on special terms, or renewal refused?	N
J. Have you ever been reported to the National Practitioners Data Bank (NPDB) or to the Healthcare Integrity and Protection Data Bank (HIPDB)? (If yes, enclose a copy of the report.)	N
K. Has your application for examination or a professional license ever been denied?	N
L. Have you ever failed any part of a licensure/certification/registration examination?	N
M. Have you ever surrendered a license or had a license revoked?	N
N. Has any disciplinary action been taken on any license?	N
O. Have you ever been subject of a review by professional licensing/regulatory agency based on a complaint filed against you?	N
P. Have you ever been arrested, charged with, or convicted of a felony or misdemeanor, other than traffic violations?	N
Q. Have you ever been arrested, charged with, or convicted of a traffic violation involving the use of any drug or chemical substance, including alcohol?	N
R. Are you now or have you within the past two years been addicted to or used in excess any drug or chemical substance, including alcohol?	N
S. Have you obtained an assessment or been treated for the use of any drug or chemical substance, including alcohol?	N
T. Do you currently have or have you had within the past two years any mental or physical disorder or condition which, if untreated, could affect your ability to practice competently?	N
U. Are you or your spouse currently on Active Duty in the U.S. Armed Forces?	N
V. Are you or your spouse currently Deployed on Active Duty in the U.S. Armed Forces?	N

Oklahoma State Board of Medical Licensure and Supervision

APPLICATION FOR OKLAHOMA MEDICAL DOCTOR LICENSE

Received:03/22/2023

If licensed, where do you intend to locate?

OK

Why do you seek Licensure in the state of Oklahoma?

Post-Graduate Training

In what manner will you be communicating with your Oklahoma patients (telephone, email, internet, video-conference, etc)?

Describe how you will examine each patient in person prior to diagnosis, treating, correcting, or prescribing for a patient in Oklahoma from the state, province, or country you are located:

Describe the manner in which you intend to practice medicine across state lines in Oklahoma:

Have you executed or been offered a contract in connection with practice in the state of Oklahoma?

Yes

If 'Yes', Name of practice:

University of Oklahoma Health Science Center

If so, Please identify with which category:

Residency

Name of Previous Carrier and Policy Holder

No previous carrier

Name of Current Carrier and policy Holder

No current carrier

Will your professional liability insurance policy cover your practice in Oklahoma

No

If NO, when do you expect to obtain liability insurance that will cover practice in Oklahoma

I will be covered by my institution's policy upon starting my residency.

I attest that all the above information is accurate as of March 21, 2023: \_\_\_\_\_ (Signed Online) \_\_\_\_\_





**Applicant:** In the presence of a notary public, sign this form with attached photo.

**Send this form to:** Oklahoma State Board of Medical Licensure and Supervision

**oktraining@okmedicalboard.org**

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

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

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

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

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

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

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MAR 22 2023

OKLAHOMA STATE BOARD OF MEDICAL LICENSURE AND SUPERVISION



*[Handwritten Signature]*

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

Hill, Haddon, C

Applicants printed last name, first name, middle initial, and suffix (e.g., Jr.)

3/21/2023

Date of signature (must correspond to the date of notarization)

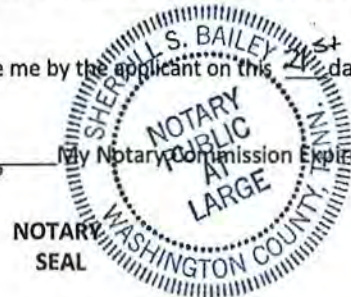
**NOTARY**

State of Tennessee, County of Washington

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

The statements on this document are subscribed and sworn to before me by the applicant on this 21<sup>st</sup> day of March, 2023

Notary Public Signature *[Handwritten Signature]*



My Notary Commission Expires 04/29/2026

T 41291 WB



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

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

PRIMARY  
SOURCE

**Recipient:** OKLAHOMA STATE BOARD OF  
MEDICAL LICENSURE & SUPERVISION

**Date:** 05/16/2024

**Examinee:** Hill, Haddon Claude  
**Alt Name(s):**

**Examinee ID:** 5-463-726-9  
**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. Pass/fail outcomes are based upon the minimum passing level in place at the time of test administration and are not altered by subsequent revisions to the minimum passing level. Effective April 1, 2013, two-digit scores will no longer be reported. Test results reported as passing represent an exam score of 75 or higher on a two-digit scale. Step 1 examinations taken on or after January 26, 2022 are reported as pass/fail, with no numeric score; Step 1 examinations taken before January 26, 2022 will continue to be reported with a 3-digit score.

### USMLE STEP 1

Test Date	Pass/Fail	Score	Minimum Pass	Comments
05/03/2021	Pass	257	(194)	

### USMLE STEP 2

#### *Clinical Knowledge (CK)*

Test Date	Pass/Fail	Score	Minimum Pass	Comments
06/06/2022	Pass	263	(209)	

### USMLE STEP 3

Test Date	Pass/Fail	Score	Minimum Pass	Comments
09/23/2023	Pass	246	(198)	

#### End of Exam History

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

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

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OKLAHOMA STATE BOARD OF  
MEDICAL LICENSURE  
AND SUPERVISION

T4291  
53





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

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

**Examinee:** Hill, Haddon Claude

**Examinee ID:** 5-463-726-9

**Date of Birth:** [REDACTED]

### INTERPRETATION OF RESULTS

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

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

### STEP 1 AND STEP 2 CLINICAL SKILLS (CS)

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

### ANNOTATIONS APPEARING UNDER "COMMENTS"

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

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

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

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

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

### ANNOTATIONS APPEARING AS "NOTE"

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

### PHYSICIAN DATA CENTER INFORMATION APPEARING AS "NOTE"

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

03/2015

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

Form 1 (MD)

Oklahoma State Board of Medical Licensure and Supervision  
101 NE 51st Street Oklahoma City, OK 73105  
OKTRAINING@OKMEDICALBOARD.ORG

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MAY 08 2023

This form must be completed by the institution and mailed or emailed directly from the institution. OKLAHOMA STATE BOARD OF MEDICAL LICENSURE AND SUPERVISION

Applicant's Name Haddon Hill  
Institution: James H. Quillen College of Medicine City/State Johnson City, TN

Our records indicate that the above named applicant attended our medical school on the following dates:

From 07/17/2019 To 05/05/2023 and was awarded the degree Doctor of Medicine  
Month Day Year Month Day Year

Please complete the following questions:

- 1. Does this individual's official record reflect (an) interruption(s) or extension(s) in his/her medical education? If yes, please explain.  YES  NO
- 2. Does this individual's official record reflect that he/she was ever placed on academic or disciplinary probation during his/her medical education? If yes, please explain.  YES  NO
- 3. Does this individual's official record reflect that he/she was ever the subject of negative reports for behavioral reasons or an investigation by the medical school or parent university? If yes, please explain below.  YES  NO
- 4. Does this individual's official record reflect that he/she was ever disciplined for unprofessional conduct/behavioral reasons by the medical school or parent university? If yes, please explain below.  YES  NO
- 5. Does this individual's official record reflect that there were any limitations or special requirements imposed on the individual because of questions of academic incompetence, disciplinary problems, or any other reason? If yes, please explain below.  YES  NO

Please explain any "YES" response from above: \_\_\_\_\_

I attest that the completion of the following has been completed by the program director and that the information above is an accurate account of this individual's records and is true and correct.

Name: Sherry S. Bailey Signature: Sherry S. Bailey  
Title of Signatory: Student Records Coordinator Date of Signature: 05/08/2023  
Tel: 423-439-2038 Fax: 423-439-2110 E-Mail: baileys@etsu.edu



If no seal is available, this form must be notarized

Notary Public \_\_\_\_\_

Commission # \_\_\_\_\_

My commission expires: \_\_\_\_\_

PRIMARY SOURCE

Notary Seal

T41291  
UCC



Record of: Haddon Claude Hill Current Name: Haddon Claude Hill Date Issued: 08-MAY-2023 Date of Birth: [REDACTED]

Course Level: Medical

Program of Study  
 Program : Medicine  
 Major : Medicine

Degree Awarded Doctor of Medicine 05-MAY-2023

SUBJ NO.	COURSE TITLE	CRED GRD	PTS R
PRE-SYSTEM INSTITUTION SUMMARY HOURS:			
Total Earned Credits		0.00	
PRE-SYSTEM TRANSFER SUMMARY HOURS:			
Total Earned Credits		0.00	
INSTITUTION CREDIT:			
Fall 2019 - Quillen COM			
ANTY 1314	Med Hum Gross Anat/Embryology	11.00 P	0.00
BCHM 1315	Cellular & Molecular Medicine	11.00 P	0.00
CSKL 1350	Doctoring I	20.00 +	0.00
HGEN 1311	Genetics	3.00 P	0.00
MEDU 1322	Clin Epidemiology & Biostats	2.00 P	0.00
PSYH 1312	Lifespan Development	1.00 P	0.00
Total Earned Credits		28.00	
Spring 2020 - Quillen COM (Advanced to 2nd Year 05/20/2020)			
CBIO 1312	Cell & Tissue Biology	7.00 P	0.00
CSKL 1350	Doctoring I	20.00 P	0.00
PHSY 1322	Medical Physiology	11.00 P	0.00
Total Earned Credits		38.00	
Fall 2020 - Quillen COM			
CSKL 2350	Doctoring II	10.00 +	0.00
MCRO 2321	Med Microbiology & Immunology	12.00 +	0.00
NEUR 2321	Clinical Neuroscience	6.00 P	0.00
PATH 2321	Medical Pathology	10.00 +	0.00
PHRM 2312	Medical Pharmacology	8.00 +	0.00
***** CONTINUED ON NEXT COLUMN *****			

SUBJ NO.	COURSE TITLE	CRED GRD	PTS R
Institution Information continued:			
PSYH 2312	Intro Clin Psychiatry	3.00 +	0.00
Total Earned Credits		6.00	

Spring 2021 - Quillen COM (Advanced to 3rd Year 04/14/2021)			
CSKL 2350	Doctoring II	10.00 P	0.00
MCRO 2321	Med Microbiology & Immunology	12.00 P	0.00
PATH 2321	Medical Pathology	10.00 P	0.00
PHRM 2312	Medical Pharmacology	8.00 P	0.00
PSYH 2312	Intro Clin Psychiatry	3.00 P	0.00
Total Earned Credits		43.00	

Fall 2021 - Quillen COM			
CSKL 3360	Doctoring - III	2.00 +	0.00
FMED 3002	Jr Family Med Clerkship	12.00 P	0.00
IMED 3013	Jr Internal Medicine Clerkship	16.00 +	0.00
OBYG 3004	Jr Obstetrics/Gynecology Clerk	12.00 P	0.00
PEDS 3005	Jr Pediatrics Clerkship	12.00 P	0.00
PSYH 3006	Jr Psychiatry Clerkship	12.00 P	0.00
Total Earned Credits		48.00	

Spring 2022 - Quillen COM			
COMD 3001	Jr Community Med Clerkship	12.00 P	0.00
CSKL 3360	Doctoring III	2.00 P	0.00
IMED 3013	Jr Internal Medicine Clerkship	16.00 P	0.00
MEDU 3011	Jr Clinical Experience	4.00 P	0.00
SURG 3018	Jr Surgery Clerkship	16.00 P	0.00
Total Earned Credits		50.00	

Fall 2022 - Quillen COM (Advanced to 4th Year 10/19/2022)			
ANTY 5002	Anatomy-CT & Cross-Sect Elec	4.00 P	0.00
***** CONTINUED ON PAGE 2 *****			

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PRIMARY  
 SOURCE

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Victoria Street, Assistant Dean

This is a true copy of the Record on file in the Office of the Registrar, East Tennessee State University, James H. Quillen College of Medicine. This official transcript is printed on green security paper with the signature printed in white. A raised seal is not required. When photocopied the word



Record of: Haddon Claude Hill Current Name: Haddon Claude Hill Date Issued: 08-MAY-2023 Date of Birth: XXXXXXXXXX

SUBJ NO.	COURSE TITLE	CRED GRD	PTS R
Institution Information continued:			
ANTY 5004	Anatomy-Surgical Elective	4.00 P	0.00
ANTY 5005	Anatomy - Ultrasound	4.00 P	0.00
IMED 4901	Int Med Ambulatory Care Selec	4.00 P	0.00
MEDU 5002	Medical Humanities Elective	4.00 P	0.00
MEDU 5016	Business of Medicine	4.00 P	0.00
SURG 4602	Trauma/Critical Care Sel-JCMC	4.00 P	0.00
SURG 4701	Gen Surgery Selective-JCMC	8.00 P	0.00
SURG 5100	Surgery Elective-Away	8.00 P	0.00
Total Earned Credits		44.00	
Spring 2023 - Quillen COM			
ANTY 5003	Anatomy-Orthopedic Elective	4.00 P	0.00
CSKL 4350	Doctoring IV	6.00 P	0.00
SURG 5024	Surg - Pediatric Surgery Elec	4.00 P	0.00
SURG 5028	Surgery-Cardio/Thoracic JCMC	8.00 P	0.00
Total Earned Credits		22.00	
***** END OF TRANSCRIPT *****			

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PRIMARY  
 SOURCE



Victoria Street, Assistant Dean

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 UKC







# AMA Physician Profile

PREPARED FOR

Oklahoma State Board of Licensure & Supervision, Oklahoma City, OK

**Name and Mailing Address**

HADDON CLAUDE HILL

**Primary Office Address**

WP 2400  
800 STANTON L YOUNG BLVD  
OKLAHOMA CITY, OK 73104-5018  
Phone UNKNOWN

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OKLAHOMA STATE BOARD OF  
MEDICAL LICENSURE  
AND SUPERVISION

**Birth date**

**Physician's major professional activity**

HOSPITAL BASED RESIDENTS - ALL YEARS

**AMA membership status**

MEMBER

PRIMARY SOURCE

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

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

NPI Number	Enumeration Date	Deactivation Date	Reactivation Date	Replacement Number	Last Reported Date
1720778152	05/09/2023	NOT RPTD	NOT RPTD	NOT RPTD	05/17/2024

**Current and/or historical medical school**

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

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

**School:** EAST TENNESSEE STATE UNIVERSITY J H QUILLEN COLLEGE OF MEDICINE

**Degree Awarded:** YES

**Degree Type:** MD

TU1583  
57



**Enrollment Date:** 07/2019

**Degree Date:** 05/2023

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

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

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

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

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

**Sponsoring Institution:** UNIVERSITY OF OKLAHOMA COLLEGE OF MEDICINE  
**Sponsoring State:** OKLAHOMA  
**Program name:** UNIVERSITY OF OKLAHOMA HEALTH SCIENCES CENTER PROGRAM  
**Specialty:** GENERAL SURGERY  
**Training Type:** SPECIALTY  
**Dates:** 07/01/2023 - 06/30/2028  
**Status:** TRAINING IN PROGRESS

### Specialty board certification

NO DATA REPORTED AT THIS TIME

### Current and/or historical medical licensure

License Number	MD / DO	Locale	Date Granted	Expiration Date	Renewal Date	Status	License Type	Last Reported	Name on License
41291	MD	OK	07/01/2023	09/30/2024		ACT	RES	05/06/2024	HADDON CLAUDE HILL

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

#### Action notifications reported to the AMA

**Medical Licensing Boards:** NO ACTIONS REPORTED AT THIS TIME

**Medicare/Medicaid Sanctions from DHHS:** NO ACTIONS REPORTED AT THIS TIME

**US DOJ Drug Enforcement Administration:** NO ACTIONS REPORTED AT THIS TIME

#### U.S. Drug Enforcement Administration (DEA)

NO DATA REPORTED AT THIS TIME

#### ECFMG certification

NOT APPLICABLE

#### Profile information

The content of the AMA Physician Profile is for credentialing use only. The content cannot be used or assembled for an employment purpose as defined under the Fair Credit Reporting Act. An organization's appropriate use of the data contained in the AMA Physician Professional Data™, formerly known as AMA Physician Masterfile, meets select primary source verification requirements of the Joint Commission, the Accreditation Association for Ambulatory Health Care (AAAHC) and the American Accreditation Health Care Commission (AAHCC)/ Utilization Review Accreditation Commission (URAC). The AMA Physician Professional Data is also an NCQA-approved source for verification of medical school, post-graduate medical training, ABMS Board Certification and federal DEA registration.

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

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



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OKLAHOMA STATE BOARD OF MEDICAL LICENSURE AND SUPERVISION  
EVIDENCE OF STATUS – PART A

NOTARIZED FORM CAN BE EMAILED TO OKTRAINING@OKMEDICALBOARD.ORG

Full Legal Name: Haddon Claude Hill  
First Middle Last Maiden (if applicable)  
Mailing Address: [Redacted]  
Street Address or Post Office Box  
[Redacted] City State Zip Code Telephone Number Social Security #: [Redacted]

PRIMARY EVIDENCE OF CITIZENSHIP  
(FOR US CITIZENS, US NATIONALS, OR PERMANENT LEGAL RESIDENT ALIENS)

If you are a U.S. citizen, U.S. national, or permanent legal resident alien, please attach a photocopy of one of the following documents to this form. Place a checkmark below to indicate the document that is attached.

- A birth certificate showing birth in one of the 50 States, the District of Columbia, Puerto Rico (on or after January 13, 1941), Guam, the U.S. Virgin Islands (on or after January 17, 1917), American Samoa, Swain's Island or the Northern Mariana Islands, unless the person was born to foreign diplomats residing in the U.S.
- United States passport (except limited passports, which are issued for periods of less than five years)
- Report of birth abroad of a U.S. citizen (FS-240) (issued by the Department of State to U.S. citizens)
- Certificate of birth (FS-545) (issued by a foreign service post) or Certification of Report of Birth (DS1350) (issued by the Department of State), copies available from the Department of State
- Certificate of Naturalization (N-550 or N-570) (issued by the INS through a Federal or State court, or through administrative naturalization after December 1990 to individuals who are individually naturalized; the N570 is a replacement certificate issued when the N-550 has been lost or mutilated or the individual's name has been changed)
- Certificate of Citizenship (N-560 or N-561) (issued by the INS to individuals who derive U.S. citizenship through a parent; the N-561 is a replacement certificate issued when the N-560 has been lost or mutilated or the individual's name has been changed)
- United States Citizen Identification Card (I-197) (issued by the INS until April 7, 1983 to U.S. citizens living near the Canadian or Mexican border who needed it for frequent border crossing) (formerly Form I-179, last issued in February 1974)
- Northern Mariana Identification Card (issued by the INS to a collectively naturalized citizen of the U.S. who was born in the Northern Mariana Islands before November 3, 1986)
- Statement provided by a U.S. consular officer certifying that the individual is a U.S. citizen (This is given to an individual born outside the U.S. who derives citizenship through a parent but does not have an FS-240, FS-545 or DS-1350);
- American Indian Card with a classification code "KIC" and a statement on the back (identifying U.S. citizen members of the Texas Band of Kickapoos living near the U.S./Mexican border.)
- Alien Lawfully Admitted for Permanent Residence: INS Form I-551 (Alien Registration Receipt Card, commonly known as a "green card")
- Alien Lawfully Admitted for Permanent Residence: Unexpired Temporary I-551 stamp in foreign passport or on INS Form I-94

I declare under penalty of perjury, under the laws of the State of Oklahoma, that all information contained in this application and all accompanying documents provided to substantiate my Evidence of Status application are true and correct.

Signature [Handwritten Signature] Date 3/21/2023

Subscribed and sworn before me this 21<sup>st</sup> day of March, 2023.

Notary Public [Handwritten Signature]  
Commission Number \_\_\_\_\_  
My commission expires 04/29/2026



T41291 VB





**TIME DEFICIENCY FORM**

<b>Name:</b> Haddon Hill	<b>Application #</b>
--------------------------	----------------------

This document is used a tool to help you complete your application.  
 Please note: we have to account for any/all time from your 18th birthday to present.

EDUCATION STARTING WITH HIGH SCHOOL							
Start Month	Start Year	End Month	End Year	Name of Institution	City	State	Degree
07	2015	05	2019	East Tennessee State University	Johnson City	TN	BS
07	2019	05	2023	James H. Quillen College of Medicine	Johnson City	TN	MD

EMPLOYMENT IF NEEDED TO FILL TIME GAP							
Start Month	Start Year	End Month	End Year	Name of Employer	City	State	Job Title

OTHER - UNEMPLOYED, STAY AT HOME PARENT, SUMMER BREAK, TRAVELING							
Start Month	Start Year	End Month	End Year	Other	City	State	

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OKLAHOMA STATE BOARD OF  
 MEDICAL LICENSURE  
 AND SUPERVISION

T 41291  
 WS

**Kenna L. Shaw**

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**From:** BillPay Webmaster <donotreply@www.ok.gov>  
**Sent:** Thursday, May 16, 2024 10:48 AM  
**To:** Dela Kwetey; Bill Pay; Sheila E. Brumfield; Chris Maloney; Licensing; Arlene Morris; Debra Reich  
**Subject:** [EXTERNAL] LICENSE - MD Training-to-Full License Fee 250.00 - Payment Made

HADDON HILL has paid for a LICENSE - MD Training-to-Full License Fee 250.00 on 05/16/2024 10:05:47am for \$250.00.

OKLAHOMA MD LICENSE NUMBER 41291

To view all transactions please go to <http://www.ok.gov/triton/> and login to your CMS account.

T41291  
10



05/02/2023

HADDON CLAUDE HILL  


**Check Your Application  
Status Online at:**  
<http://www.okmedicalboard.org>  
**Username:AP94810971**  
**Password:Last 4 SSN**

RE: MD Application #41291

Dear HADDON HILL,

**YOU CANNOT PRACTICE YOUR PROFESSION IN THE STATE  
OF OKLAHOMA UNTIL A VALID LICENSE HAS BEEN ISSUED.**

Your training application has been processed and the current deficiencies are listed below. Please be advised, these may not be the only deficiencies. You will be advised if any other deficiencies are added. You may check your application status online by logging in with the username and password provided above.

If you have further questions please email  
[oktraining@okmedicalboard.org](mailto:oktraining@okmedicalboard.org)

If a "Time Deficiency" is listed, please complete a time deficiency form and e-mail the document to  
[oktraining@okmedicalboard.org](mailto:oktraining@okmedicalboard.org)  
with your activities during the specified time frame.

USMLE Exams Incomplete  
MedSchool-Form 1 E TN STATE UNIV J H QUILLEN COLL OF MED, JOHNSON CITY TN 37614  
PostGrad - Form 2 COLLEGE OF MEDICINE OKC  
Exam verification date  
MedSchool-Transcript E TN STATE UNIV J H QUILLEN COLL OF MED, JOHNSON CITY TN 37614

Any of the required forms in the list above may be downloaded from our website:

<http://www.okmedicalboard.org/resources>

In order to check on the status of your application, please log on to our web site:

<https://secure.okmedicalboard.org/applicant/signin>

Your user name is AP94810971 (all caps and no spaces) and your password is the last 4 digits of your social security number.

If you did not provide a social security number with your application, your password will be your 4-digit year of birth in the form "YYYY".

If we may be of further assistance, please email.

[oktraining@okmedicalboard.org](mailto:oktraining@okmedicalboard.org)

Sincerely,

*Valeska Barr*

Valeska Barr

Dept. of Licensing

Encl



# Oklahoma State Board of Medical Licensure and Supervision Application Summary

Type	Number	Name
MD	41291	HADDON CLAUDE HILL
MEDICAL DOCTOR		

**Incomplete Information (due to space limitations on this page, this may not be a complete list)**

USMLE Exams Incomplete  
 Exam verification date  
 PostGrad - Form 2 COLLEGE OF MEDICINE OKC

**Last Medical School Attended:**  
 047-20 E TN STATE UNIV J H QUILLEN COLL OF MED, JOHNSON CITY TN 37614  
 Number of Licenses Previously Granted to Graduates of this Medical School:31

Application for: Resident  Full License \_\_\_\_\_ Reinstatement \_\_\_\_\_

**The Secretary of the Board has reviewed this application and:**

1) AUTHORIZED CIRCULARIZATION TO OTHER BOARD MEMBERS \_\_\_\_\_

2) ALL FIVE CRITERIA HAVE BEEN MET [Fast Track] \_\_\_\_\_

- Passed USMLE
- No DUIs or Legal Issues
- No Significant Malpractice Issues
- US Graduate
- Graduated Medical School on time

3) HAS ISSUED A TEMPORARY LICENSE THROUGH \_\_\_\_ / \_\_\_\_ / \_\_\_\_

4) HAS ISSUED A SPECIAL PGY-1 TRAINING LICENSE By 5-9-23

5) REQUESTS SPECIFIC CONSIDERATION OF:

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# Oklahoma State Board of Medical Licensure and Supervision

## Application Summary

Type	Number	Name
MD	39996	ALEX SAULKUMAR HONEST
MEDICAL DOCTOR		

**Incomplete Information (due to space limitations on this page, this may not be a complete list)**

Exam verification date  
 PostGrad - Form 2 ALLIANCE HEALTH  
 USMLE Exams Incomplete  
 OTHER DEFICIENCIES: NEED USMLE STEP 3 / QUESTIONNAIRE / \$250 UPGRADE FEE / EVALUATION

**Last Medical School Attended:**

495-76 N H L Municipal Med Coll, Gujarat Univ, Ahmedabad, Gujarat, India

**Number of Licenses Previously Granted to Graduates of this Medical School:34**

Application for: Resident \_\_\_\_\_ Full License \_\_\_\_\_ Reinstatement \_\_\_\_\_

**The Secretary of the Board has reviewed this application and:**

- 1) AUTHORIZED CIRCULARIZATION TO OTHER BOARD MEMBERS \_\_\_\_\_
- 2) ALL FIVE CRITERIA HAVE BEEN MET [Fast Track] \_\_\_\_\_
  - Passed USMLE
  - No DUIs or Legal Issues
  - No Malpractice Issues
  - US Graduate
  - Graduated Medical School in 4 years or less
- 3) HAS ISSUED A TEMPORARY LICENSE THROUGH \_\_\_ / \_\_\_ / \_\_\_
- 4) HAS ISSUED A SPECIAL PGY-1 TRAINING LICENSE \_\_\_\_\_



## Oklahoma State Board of Medical Licensure and Supervision Application Summary

**Type**    **Number**    **Name**  
 MD        39996        ALEX SAULKUMAR HONEST  
 MEDICAL DOCTOR

**Practice Address:**

July 05, 2022

**Status:**

Res: TR

Received: 07/03/2022

Entered: 07/03/2022

Temp Issued:

Temp Expires:

Train Issued: 07/25/2022

Train Expires: 09/30/2024

Fed Rec: 05/31/2024

AMA Rec: 05/31/2024

Board Action:

License #: 39996

Sex: M

Ethnic Origin: 6

Endorsed By: USMLE EXAMINATION

	Test	Score	Date Taken	Date Verified	Attempts
Test 1:	USMLE 1	PASS	10/10/18	7/12/22	1
Test 2:	USMLE 2	PASS	11/15/19	7/12/22	1
Test 3:	Note: <b>PASS</b> means higher than 75				
Test AV:					
Total Possible:					
Okla Passing:					
Total Score:					

### PRE-MED EDUCATION

School Name: JAY SOMNATH HIGHER SECONDARY SCHOOL

City: AHMEDABAD

State:    Country: INDIA

Degree:

From: 6/2003 To: 5/ 2005 Verified:

### MEDICAL SCHOOL EDUCATION

Name: N H L Municipal Med Coll, Gujarat Univ, Ahmedabad, Gujarat, India

Foreign Name:

City: Gujarat

State/Country: India

Degree: BACHELOR OF MED

From: 7 / 2005

To: 3 / 2011

Diploma Ver'd:

Y

### POST GRADUATE EDUCATION

Facility: ALLIANCE HEALTH

Specialty: FAMILY MEDICINE

Res. Fellowship: Residency

City: DURANT

State: OK    Country: UNITED STATES OF AM

Verified:

From: 7 / 2022

To: /

ACGME Ver'd: 07/05/2022

Comments: EVAL RCVD 6/19/23 (KS)

## Oklahoma State Board of Medical Licensure and Supervision Application Summary

**Type**    **Number**    **Name**  
 MD        39996        ALEX SAULKUMAR HONEST  
 MEDICAL DOCTOR

### PRACTICE HISTORY

<b>Employed:</b> JAMES CAMPBELL FAMILY MEDICINE CLINIC <b>City:</b> BROKEN ARROW <b>Specialty:</b> CLINIC MANAGER <b>Comments:</b>	<b>Supervisor:</b> <b>State:</b> OK <b>Country:</b> UNITED STATES <b>From:</b> 10/2017 <b>To:</b> / <b>Verified:</b>
<b>Employed:</b> REASOR'S <b>City:</b> TULSA <b>Specialty:</b> PHARMACY TECHNICIAN <b>Comments:</b>	<b>Supervisor:</b> <b>State:</b> OK <b>Country:</b> UNITED STATES <b>From:</b> 5/2015 <b>To:</b> 9/2017 <b>Verified:</b>
<b>Employed:</b> INDIAN RED CROSS SOCIETY <b>City:</b> AHMEDABAD <b>Specialty:</b> MEDICAL OFFICER <b>Comments:</b>	<b>Supervisor:</b> <b>State:</b> <b>Country:</b> INDIA <b>From:</b> 5/2014 <b>To:</b> 4/2015 <b>Verified:</b>
<b>Employed:</b> GVK EMRI <b>City:</b> AHMEDABAD <b>Specialty:</b> EMERGENCY RESPONSE CARE PHYSICIAN <b>Comments:</b>	<b>Supervisor:</b> <b>State:</b> <b>Country:</b> INDIA <b>From:</b> 2/2013 <b>To:</b> 4/2014 <b>Verified:</b>
<b>Employed:</b> AMC MET MEDICAL COLLEGE <b>City:</b> AHMEDABAD <b>Specialty:</b> JUNIOR RESIDENT <b>Comments:</b>	<b>Supervisor:</b> <b>State:</b> <b>Country:</b> INDIA <b>From:</b> 4/2011 <b>To:</b> 1/2013 <b>Verified:</b>

### Other Licenses

State	Lic Type and Number	Status	Issued	Exp	Verif
OK	PHARMACY TECH 20833	I	9/10/15	6/30/18	7/19/22

### DEFICIENCIES

Exam verification date  
 PostGrad - Form 2 ALLIANCE HEALTH  
 USMLE Exams Incomplete  
 OTHER DEFICIENCIES: NEED USMLE STEP 3 / QUESTIONNAIRE / \$250 UPGRADE FEE / EVALUATION



**Oklahoma State Board of Medical Licensure and Supervision** PAGE 58 of 500

**APPLICATION FOR OKLAHOMA MEDICAL DOCTOR LICENSE**

Received:07/03/2022

**Foreign Graduate**

**Applicant Name:** HONEST ALEX SAJI KUMAR

**MD 39996**

**Date Of Birth:** [REDACTED]

**Place Of Birth (City, State):** AHMEDABAD, INDIA

**Sex:** M

**Race:** Asian/Pacific Islander

<b>Education</b>									
Type	Name	City	ST	Country	From	To	Degree	Comments	Veri
HS	JAY SOMNATH HIGHER SECONDARY SCHOOL	AHMEDABAD		INDIA	6/2003	5/2005			

Medical School Name	City	State	Country	Comments	From	To
				User Entered:N H L Municipal I	7/2005	3/2011

<b>Post-Graduate</b>						
Facility	City	St	Country	Specialty	Comments	From To
ALLIANCE HEALTH	DURANT	OK	UNITED S	FAMILY MEDICINE		7/2022 /

<b>Practice History</b>								
Employer	Specialty	Supervisor	City	ST	Country	From	To	Verif
JAMES CAMPBELL FAMILY MEDICINE CLINIC	FAMILY MEDICINE		BROKEN ARROW	OK		10/2017		
REASOR'S	PHARMACY TECHNICIAN		TULSA	OK		5/2015	9/2017	
INDIAN RED CROSS SOCIETY	MEDICAL OFFICER		AHMEDABAD		INDIA	5/2014	4/2015	
GVK EMRI	EMERGENCY RESPONSE CARE PHYSICIAN		AHMEDABAD		INDIA	2/2013	4/2014	
AMC MET MEDICAL COLLEGE	JUNIOR RESIDENT		AHMEDABAD		INDIA	4/2011	1/2013	

<b>Other/ Out-Of-State Licenses</b>					
State	License #	Profession	Status	Issue Date	Exp Date

<b>MD Exam</b>				
Exam	State	Score	Date Taken	#
USMLE				

**Foreign Graduate**

**Oklahoma State Board of Medical Licensure and Supervision** PAGE 159 of 500

**APPLICATION FOR OKLAHOMA MEDICAL DOCTOR LICENSE**

Received:07/03/2022

**Foreign Graduate**

<b>Questions Answered 07/02/2022</b>	<b>Response</b>
A. Have you ever been denied provider participation, terminated, sanctioned, or penalized by any third party payor, to include TRICARE, MEDICARE, MEDICAID?	<b>N</b>
B. Have you ever surrendered or had any adverse action taken against any narcotic permit (state or federal)?	<b>N</b>
C. Have you ever been denied membership or had disciplinary action taken by a national, state or county professional organization?	<b>N</b>
D. Have you ever been denied or had removed or suspended hospital staff privileges?	<b>N</b>
E. Have you ever surrendered hospital staff privileges while under investigation or to avoid investigation?	<b>N</b>
F. Have you ever entered into an agreement with a federal, state or local jurisdictional body to avoid formal action?	<b>N</b>
G. Have you ever been the subject of an investigation, probation or disciplinary action by a hospital, clinic, practice group, training program or professional school?	<b>N</b>
H. Have you had any adverse judgment, settlement, or award against you arising from a professional liability claim?	<b>N</b>
I. Have you ever had professional liability coverage declined, canceled, issued on special terms, or renewal refused?	<b>N</b>
J. Have you ever been reported to the National Practitioners Data Bank (NPDB) or to the Healthcare Integrity and Protection Data Bank (HIPDB)? (If yes, enclose a copy of the report.)	<b>N</b>
K. Has your application for examination or a professional license ever been denied?	<b>N</b>
L. Have you ever failed any part of a licensure/certification/registration examination?	<b>N</b>
M. Have you ever surrendered a license or had a license revoked?	<b>N</b>
N. Has any disciplinary action been taken on any license?	<b>N</b>
O. Have you ever been subject of a review by professional licensing/regulatory agency based on a complaint filed against you?	<b>N</b>
P. Have you ever been arrested, charged with, or convicted of a felony or misdemeanor, other than traffic violations?	<b>N</b>
Q. Have you ever been arrested, charged with, or convicted of a traffic violation involving the use of any drug or chemical substance, including alcohol?	<b>N</b>
R. Are you now or have you within the past two years been addicted to or used in excess any drug or chemical substance, including alcohol?	<b>N</b>
S. Have you obtained an assessment or been treated for the use of any drug or chemical substance, including alcohol?	<b>N</b>
T. Do you currently have or have you had within the past two years any mental or physical disorder or condition which, if untreated, could affect your ability to practice competently?	<b>N</b>
U. Are you or your spouse currently on Active Duty in the U.S. Armed Forces?	<b>N</b>
V. Are you or your spouse currently Deployed on Active Duty in the U.S. Armed Forces?	<b>N</b>

**Foreign Graduate**



APPLICATION FOR OKLAHOMA MEDICAL DOCTOR LICENSE

Received:07/03/2022

Foreign Graduate

If licensed, where do you intend to locate?

OK

Why do you seek Licensure in the state of Oklahoma?

Post-Graduate Training

In what manner will you be communicating with your Oklahoma patients (telephone, email, internet, video-conference, etc)?

Describe how you will examine each patient in person prior to diagnosis, treating, correcting, or prescribing for a patient in Oklahoma from the state, province, or country you are located:

Describe the manner in which you intend to practice medicine across state lines in Oklahoma:

Have you executed or been offered a contract in connection with practice in the state of Oklahoma?

Yes

If 'Yes', Name of practice:

Alliance Health Durant Family Medicine Residency

If so, Please identify with which category:

Residency

Name of Previous Carrier and Policy Holder

N/A

Name of Current Carrier and policy Holder

I'll have malpractice insurance by Alliance Health Durant Family Medicine Residency training

Will your professional liability insurance policy cover your practice in Oklahoma

Yes

If NO, when do you expect to obtain liability insurance that will cover practice in Oklahoma

attest that all the above information is accurate as of July 02, 2022: \_\_\_\_\_ (Signed Online) \_\_\_\_\_

Foreign Graduate



Applicant: In the presence of a notary public, sign this form with attached photo.

Send this form to:

Oklahoma State Board of Medical Licensure and Supervision
101 NE 51st Street
Oklahoma City, OK 73105

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

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

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

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

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

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

RECEIVED

JUL 05 2022

OKLAHOMA STATE BOARD OF MEDICAL LICENSURE AND SUPERVISION



Handwritten signature of Alex Saulkumar

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

HONEST ALEX SAULKUMAR

Applicants printed last name, first name, middle initial, and suffix (e.g., Jr.)

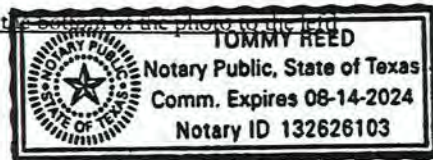
07/02/2022

Date of signature (must correspond to the date of notarization)

[Please note: The Notary Public seal should overlap the bottom of the photo to the left]

State of Texas, County of Collin

NOTARY



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

The statements on this document are subscribed and sworn to before me by the applicant on this 2nd day of JULY, 2022

Notary Public Signature [Signature] My Notary Commission Expires 08-14-2024

T39996 UKC





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

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

**RECEIVED**

JUL 12 2022

OKLAHOMA STATE BOARD OF  
MEDICAL LICENSURE  
AND SUPERVISION

**PRIMARY SOURCE**

**Recipient:** OKLAHOMA STATE BOARD OF  
MEDICAL LICENSURE & SUPERVISION

**Date:** 07/11/2022

**Examinee:** Honest, Alex Saulkumar  
**Alt Name(s):**

**Examinee ID:** 1-057-878-9  
**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. Pass/fail outcomes are based upon the minimum passing level in place at the time of test administration and are not altered by subsequent revisions to the minimum passing level. Effective April 1, 2013, two-digit scores will no longer be reported. Test results reported as passing represent an exam score of 75 or higher on a two-digit scale. Step 1 examinations taken on or after January 26, 2022 are reported as pass/fail, with no numeric score; Step 1 examinations taken before January 26, 2022 will continue to be reported with a 3-digit score.

**USMLE STEP 1**

Test Date	Pass/Fail	Score	Minimum Pass	Comments
10/10/2018	Pass	194	(194)	

**USMLE STEP 2**

*Clinical Knowledge (CK)*

Test Date	Pass/Fail	Score	Minimum Pass	Comments
11/15/2019	Pass	217	(209)	

**End of Exam History**

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

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

T 39996  
10



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

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

**Examinee:** Honest, Alex Saulkumar

**Examinee ID:** 1-057-878-9

**Date of Birth:** [REDACTED]

### INTERPRETATION OF RESULTS

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

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

### STEP 1 AND STEP 2 CLINICAL SKILLS (CS)

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

### ANNOTATIONS APPEARING UNDER "COMMENTS"

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

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

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

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

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

### ANNOTATIONS APPEARING AS "NOTE"

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

### PHYSICIAN DATA CENTER INFORMATION APPEARING AS "NOTE"

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

03/2015

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



Form 1 (MD)

Oklahoma State Board of Medical Licensure and Supervision  
101 NE 51<sup>st</sup> Street  
Oklahoma City, OK 73105

This form must be completed by the institution and mailed directly from the institution.

Applicant's Name Alex Saulkumar Honest  
Institution: Smt. NHL Municipal Medical College City/State Ahmedabad, Gujarat

Our records indicate that the above named applicant attended our medical school on the following dates:

From 07 / 01 / 2005 To 03 / 30 / 2011 and was awarded the degree Bachelor of Medicine and Bachelor of Surgery (M..B., B.S.)  
Month Day Year Month Day Year

- 1. Does this individual's official record reflect (an) interruption(s) or extension(s) in his/her medical education? If yes, please explain.  YES  NO
- 2. Does this individual's official record reflect that he/she was ever placed on academic or disciplinary probation during his/her medical education? If yes, please explain.  YES  NO
- 3. Does this individual's official record reflect that he/she was ever the subject of negative reports for behavioral reasons or an investigation by the medical school or parent university? If yes, please explain below.  YES  NO
- 4. Does this individual's official record reflect that he/she was ever disciplined for unprofessional conduct/behavioral reasons by the medical school or parent university? If yes, please explain below  YES  NO
- 5. Does this individual's official record reflect that there were any limitations or special requirements imposed on the individual because of questions of academic incompetence, disciplinary problems, or any other reason? If yes, please explain below  YES  NO

Please explain any "YES" response from above: \_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

Completion of the following is certification that the information above is an accurate account of this individual's records and is true and correct.

Name: Dr. Cherry K. Shah Signature *Cherry K. Shah*  
Title of Signatory: Dean Date of Signature 07/07/22  
Tel: 079-26576295 Fax: 26579282 E-Mail: dean-nhlmmc@yahoo-co-in



If no seal is available, this form must be notarized  
Notary Public \_\_\_\_\_  
Commission # \_\_\_\_\_  
My commission expires: \_\_\_\_\_

Notary Seal

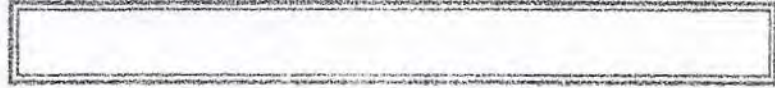
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PRIMARY SOURCE  
JUL 14 2022  
OKLAHOMA STATE BOARD OF  
MEDICAL LICENSURE  
AND SUPERVISION

T 39996  
UKL



We , the Chancellor, Vice Chancellor and Members  
of the Court of the Gujarat University Certify that

the withinsigned



**Honest Alex Saulkumar**

of N. H. L. M. Medical College

having been examined for the degree of  
Bachelor of Medicine & Bachelor of Surgery in the year 2010  
and adjudged to have passed in the same,  
having undergone the prescribed period of housemanship,

the degree of

**Bachelor of Medicine**

**&**

**Bachelor of Surgery**

has been conferred at Ahmedabad,  
on the twenty second day of the month of December  
in the year two thousand eleven.

In Testimony whereof are set the Seal,  
of the said University and  
the Signature of the said Chancellor.

PRIMARY  
SOURCE

RECEIVED

JUL 14 2022

OKLAHOMA STATE BOARD OF  
MEDICAL LICENSURE  
AND SUPERVISION



*[Handwritten Signature]*  
Chancellor





**Smt. Nathiba Hargovandas Lakhmichand**

**MUNICIPAL MEDICAL COLLEGE**

(Managed by AMC Medical Education Trust Regd No. G/14185 A'Bad)

Ellis Bridge, Ahmedabad-380 006.

GUJARAT STATE (INDIA)

Phone: 26576275, Fax: 26579282, Web site : www.nhlmmc.edu.in



**MEDICAL SCHOOL  
TRANSCRIPT**

This is to certify that **Dr. Honest Alex Saulkumar** was a bonafide student of this institution from **July 2005 to March 2011**. He has passed his final MBBS examination held in **January 2010** by Gujarat University.

**THE INSTITUTION**

Foundation in 1963, Smt. N.H.L. Municipal Medical College is one of the best medical colleges in the State of Gujarat in India. The institution is proud of having the unique clinical facilities which are provided and can be availed of by the students. Five civic hospitals with a total bed capacity of around 1500 beds are attached with this medical college which offers the students a wide variety of clinical experience. In addition to this, several local and outside hospitals are also recognized as a centre for posting the students there during their pregraduation internship. The students of this medical college have maintained an excellent academic record.

**THE CURRICULIM**

The under graduate medical course in India consists of five and a half years which is recognized by Medical Council of India. The first four and a half years are divided into Four academic years having terms of six months each First year having two semester, Second years having three semester, Final third year Part-I having two semester & Final third year Part-II having also two semester . The last year is of compulsory rotating pregraduation internship. The basis sciences are taught in the first and second M.B.B.S. while clinical training begins with the second M.B.B.S. right through till third M.B.B.S. Before the student starts M.B.B.S. course with basic sciences, a basic training is imparted to enable him to get practical idea about his future training.

During the period of his study at this institute as an under graduate student, he has put up the following hours of work as required to be put up by the medical student in different subject after his admission to this college and before graduation.

Subject	Hours
Anatomy	650
Physiology	480
Biochemistry	240
Pathology	300
Microbiology	250
Pharmacology	300
Forensic Medicine	100
Otorhinolaryngology	214
Ophthalmology	280
Community Medicine	442
Medicine Including Allied Branches	948
Surgery Including Allied Branches	1020
Obstetrics & Gynecology	832
Pediatrics	280

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## INTERNSHIP CERTIFICATE

After passing his final MBBS examination held in **January-2010**, he has satisfactorily completed his one year of compulsory rotating houseman ship [internship] as required under the university rules at the following NMC recognized centers from **16/03/2010 to 15/03/2011**.

NO.	CLINICAL DISCIPLINE	NAME OF HOSPITAL	TIME PERIOD
1.	MEDICINE inc. 15 days of psychiatry 2 Months	Smt.S.C.L.General Hospital,,Ahmedabad.	16/03/2010 to 15/05/2010
2.	SURGERY INC.15 days of Anesthesia 2 Months	Sheth L.G.Hospital,Ahmedabad.	16/05/2010 to 15/07/2010
3.	Gynec.inc.15 days of F.W.P.-2Months	Sheth V.S.General Hospital,Ahmedabad	16/11/2010 to 15/01/2011
4.	COMMUNITY MEDICINE 2 Months	Smt.N.H.L.Municipal Medical College,Ahmedbad.	16/07/2010 to 15/09/2010
5.	CASUALTY 15 days	Sheth V.S.General Hospital,Ahmedabad	01/11/2010 to 15/11/2010
6.	Elective ) 15 days	Sheth V.S.General Hospital,Ahmedabad	16/09/2010 to 30/09/2010
7.	ENT 15 days	Sheth V.S.General Hospital,Ahmedabad	16/10/2011 to 31/10/2011
8.	PEADIATRICS 1 Month	Sheth V.S.General Hospital,Ahmedabad	16/01/2011 to 15/02/2011
9.	OPHTHALMOLOGY 15 days	Sheth C.H.N. Eye Hospital	01/10/2010 to 15/10/2010
10.	Orthopedics 1 Month	Sheth V.S.General Hospital,Ahmedabad	16/02/2011 to 15/03/2011

He was regular in attendance and sincere to his work. The progress, conduct and behavior of the student reference was satisfactory. Also he bears a good moral character.

The medium of instruction throughout academic years of the medical study was **ENGLISH**.

**Date: 05/07/2022**  
**Ahmedabad, India**



*[Handwritten signature]*  
6/7/2022

*[Handwritten signature]*  
**(Dr. Cherry K. Shah)**  
**Dean**

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**Issue Date:** 21 Jul 2022**To:** STATE BOARD OF LICENSURE & SUPERVISION  
LISA CULLEN  
DIRECTOR OF LICENSING  
P.O. BOX 18256  
OKLAHOMA CITY, OK 73154-0256**State Board Code:**  
**037**Please include this number on  
all requests.**ECFMG<sup>®</sup> CERTIFICATION STATUS REPORT****USMLE<sup>®</sup>/ECFMG Identification Number:** 1-057-878-9**Applicant's Name:** Alex Saulkumar Honest**Applicant's Date of Birth:** [REDACTED]**ECFMG Certified:** Yes**Certificate Issue Date:** 15 Oct 2020**English Test Valid Through:** 31 Dec 2024**Clinical Skills Assessment Valid Through:** 31 Dec 2024**RECEIVED**

JUL 22 2022

OKLAHOMA STATE BOARD OF  
MEDICAL LICENSURE  
AND SUPERVISION**Passing Performance on Medical Science Examinations:**

Examination	Date	Two Digit Score	Three Digit Score
USMLE Step 1	10 Oct 2018	*	*
USMLE Step 2 CK	15 Nov 2019	*	*

**Most Recent Passing Performance on Clinical Skills Examination:**

Examination	Date
ECFMG Clinical Skills Pathway **	N/A

\*\* This individual met the clinical and communication skills requirements, including English language proficiency, for ECFMG Certification through one of the ECFMG Pathways. Prior to the ECFMG Pathways, IMGs met these requirements by passing the former USMLE Step 2 CS.

**Name of Medical School and Country:** Smt. N.H.L. Municipal Medical College, Ahmedabad, INDIA**Degree Year:** 2011**Medical Education Credentials Status<sup>†</sup>:** Complete**PRIMARY  
SOURCE****How to Verify the Authenticity of this Report:**

This report was issued to the named recipient on the date shown above. To verify the authenticity of this report, visit <https://cvsonline2.ecfm.org/verify/verify.asp> and enter the unique verification code listed below. The information contained in this report is current as of the issue date. Any changes to the physician's status after the issue date will not be reflected, and you are encouraged to request an updated report.

**Report Verification Code:** GVR28LD07G

The purpose of this Status Report is to indicate whether this individual is certified by ECFMG. It reflects only examinations that were used to fulfill requirements for ECFMG Certification. The most recent passing performance on the clinical skills examination is reflected, regardless of whether this individual was required to take a clinical skills examination for ECFMG Certification. This Status Report is not a complete score history of all examinations for this individual. This Status Report does not include examinations that were taken but not passed. Furthermore, if this individual passed examinations that were not used to fulfill the requirements for ECFMG Certification, these examinations are not included.

\* To obtain a complete USMLE examination history for this individual, contact the appropriate registration entity to request a USMLE transcript.

<sup>†</sup>Since July 1986, ECFMG has verified medical school credentials directly with the issuing medical schools, or through a reasonable alternative that has been approved by the ECFMG Medical Education Credentials Committee.

**Important Note:**

Requesting organizations must normally secure and retain the physician's signed authorization to obtain certification information. Organizations may not resell the information or make it available to any party beyond the initial request as authorized by the physician. The information may only be used to confirm ECFMG Certification for the purpose for which the physician provided authorization.

Last Updated: 7/19/2022 5:18:10 AM

**Technician Detail**

[Back](#)

<b>Name</b>	ALEX HONEST
<b>Type</b>	Technician
<b>Number</b>	20833
<b>City</b>	TULSA, OK 74105
<b>Status</b>	CANCELED
<b>Issue Date</b>	09/10/2015
<b>Renewed Date</b>	06/24/2017
<b>Expire Date</b>	06/30/2018
<b>End Date</b>	07/30/2018

**Disciplinary Action**

Click on any of the Underlined headings to sort by that column.

<u>Case Date</u>	<u>Case Number</u>
No Disciplinary Action	
<a href="#">&lt;</a> <a href="#">Prev</a> <a href="#">Next</a> <a href="#">&gt;</a>	

- **PRIMARY SOURCE VERIFICATION:** The Oklahoma State Board of Pharmacy maintains the information for the license verification function on its website and updates to the website and considers the website to be the primary source of verification.
- **ATTENTION NEW REGISTRANTS!** Website verification is required for all registrants. You cannot practice in Oklahoma until you have received your permit from the Board.
- **WRITTEN VERIFICATION OF LICENSURE (OR LETTER C)** is required for a certified verification of license from the Board. Web

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T 39996  
VO





# AMA Physician Profile

PREPARED FOR

Oklahoma State Board of Licensure & Supervision, Oklahoma City, OK

**Name and Mailing Address**

ALEX HONEST  
ALLIANCEHEALTH DURANT  
FAMILY MEDICINE PGM  
1800 W UNIVERSITY BLVD  
DURANT, OK 74701-3006

**Primary Office Address**

SAME AS MAILING ADDRESS

**Birth date**

[REDACTED]

**Phone** UNKNOWN

PRIMARY SOURCE

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MAY 31 2024  
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AND SUPERVISION

**Physician's major professional activity**

HOSPITAL BASED RESIDENTS - ALL YEARS

**AMA membership status**

NON MEMBER

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

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

NO DATA REPORTED AT THIS TIME

**Current and/or historical medical school**

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

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

**School:** SMT N H L MUNICIPAL MEDICAL COLLEGE

**Degree Awarded:** YES  
**Enrollment Date:** NOT REPORTED

**Degree Type:** MD  
**Degree Date:** 2011

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

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

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

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

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

<b>Sponsoring Institution:</b>	OKLAHOMA STATE UNIVERSITY CENTER FOR HEALTH SCIENCES
<b>Sponsoring State:</b>	OKLAHOMA
<b>Program name:</b>	OKLAHOMA STATE UNIVERSITY CENTER FOR HEALTH SCIENCES (DURANT) PROGRAM
<b>Specialty:</b>	FAMILY MEDICINE
<b>Training Type:</b>	SPECIALTY
<b>Dates:</b>	09/01/2022 - 08/31/2025
<b>Status:</b>	TRAINING IN PROGRESS

### Specialty board certification

NO DATA REPORTED AT THIS TIME

### Current and/or historical medical licensure

NO DATA REPORTED AT THIS TIME

### Action notifications reported to the AMA

**Medical Licensing Boards:** NO ACTIONS REPORTED AT THIS TIME



**Medicare/Medicaid Sanctions from DHHS: NO ACTIONS REPORTED AT THIS TIME**

**US DOJ Drug Enforcement Administration: NO ACTIONS REPORTED AT THIS TIME**

#### U.S. Drug Enforcement Administration (DEA)

NO DATA REPORTED AT THIS TIME

#### ECFMG certification

Applicant Number: 10578789

*The Educational Commission for Foreign Medical Graduates (ECFMG) applicant identification number does not imply current ECFMG certification status. To verify ECFMG status, contact the ECFMG Certification Verification Service online at <https://cvsonline2.ecfmg.org/>*

#### Profile information

The content of the AMA Physician Profile is for credentialing use only. The content cannot be used or assembled for an employment purpose as defined under the Fair Credit Reporting Act. An organization's appropriate use of the data contained in the AMA Physician Professional Data™, formerly known as AMA Physician Masterfile, meets select primary source verification requirements of the Joint Commission, the Accreditation Association for Ambulatory Health Care (AAAHC) and the American Accreditation Health Care Commission (AAHCC)/Utilization Review Accreditation Commission (URAC). The AMA Physician Professional Data is also an NCQA-approved source for verification of medical school, post-graduate medical training, ABMS Board Certification and federal DEA registration.

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

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

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OKLAHOMA STATE BOARD OF MEDICAL LICENSURE AND SUPERVISION

OKLAHOMA STATE BOARD OF MEDICAL LICENSURE AND SUPERVISION
101 NE 51st STREET
OKLAHOMA CITY OK 73105
EVIDENCE OF STATUS - PART A

Full Legal Name: Alex Saulkumar Honest
Mailing Address: [Redacted]
City: [Redacted] State: [Redacted] Zip Code: [Redacted] Telephone Number: [Redacted] Social Security #: [Redacted]

PRIMARY EVIDENCE OF CITIZENSHIP
(FOR US CITIZENS, US NATIONALS, OR PERMANENT LEGAL RESIDENT ALIENS)

If you are a U.S. citizen, U.S. national, or permanent legal resident alien, please attach a photocopy of one of the following documents to this form. Place a checkmark below to indicate the document that is attached.

- A birth certificate showing birth in one of the 50 States, the District of Columbia, Puerto Rico (on or after January 13, 1941), Guam, the U.S. Virgin Islands (on or after January 17, 1917), American Samoa, Swain's Island or the Northern Mariana Islands, unless the person was born to foreign diplomats residing in the U.S.
United States passport (except limited passports, which are issued for periods of less than five years)
Report of birth abroad of a U.S. citizen (FS-240) (issued by the Department of State to U.S. citizens)
Certificate of birth (FS-545) (issued by a foreign service post) or Certification of Report of Birth (DS1350) (issued by the Department of State), copies available from the Department of State
Certificate of Naturalization (N-550 or N-570) (issued by the INS through a Federal or State court, or through administrative naturalization after December 1990 to individuals who are individually naturalized; the N570 is a replacement certificate issued when the N-550 has been lost or mutilated or the individual's name has been changed)
Certificate of Citizenship (N-560 or N-561) (issued by the INS to individuals who derive U.S. citizenship through a parent; the N-561 is a replacement certificate issued when the N-560 has been lost or mutilated or the individual's name has been changed)
United States Citizen Identification Card (I-197) (issued by the INS until April 7, 1983 to U.S. citizens living near the Canadian or Mexican border who needed it for frequent border crossing) (formerly Form I-179, last issued in February 1974)
Northern Mariana Identification Card (issued by the INS to a collectively naturalized citizen of the U.S. who was born in the Northern Mariana Islands before November 3, 1986)
Statement provided by a U.S. consular officer certifying that the individual is a U.S. citizen (This is given to an individual born outside the U.S. who derives citizenship through a parent but does not have an FS-240, FS-545 or DS-1350);
American Indian Card with a classification code "KIC" and a statement on the back (identifying U.S. citizen members of the Texas Band of Kickapoos living near the U.S./Mexican border.)
Alien Lawfully Admitted for Permanent Residence:
INS Form I-551 (Alien Registration Receipt Card, commonly known as a "green card")
Alien Lawfully Admitted for Permanent Residence:
Unexpired Temporary I-551 stamp in foreign passport or on INS Form I-94

I declare under penalty of perjury, under the laws of the State of Oklahoma, that all information contained in this application and all accompanying documents provided to substantiate my Evidence of Status application are true and correct.

Signature [Signature] Date 07/02/2022

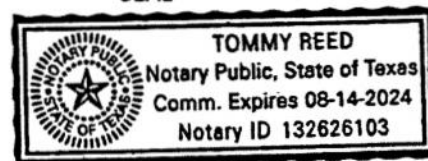
Subscribed and sworn before me this 2nd day of July, 2022

Notary Public [Signature]

Commission Number 132626103

My commission expires 08-14-2024

NOTARY SEAL



T39996
KCC



**Lisa Cullen**

---

**From:** Alex Honest [REDACTED]  
**Sent:** Tuesday, July 5, 2022 8:38 PM  
**To:** Lisa Cullen  
**Subject:** [EXTERNAL] Re: Oklahoma MD Application #39996 Deficiencies

Ms. Cullen,  
Thank you for your email.  
My medical college in India will mail the Form-1 with my transcript to OMB. At Dr. Campbell's clinic, I am working as the clinic manager and will continue working till I get my MD license approved and can join residency.  
If any more information is needed please let me know.  
Thank you again for your assistance in this process.

Sincerely,

Alex Honest  
[REDACTED]

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OKLAHOMA STATE BOARD OF  
MEDICAL LICENSURE  
AND SUPERVISION

On Tue, Jul 5, 2022 at 3:15 PM Lisa Cullen <[lcullen@okmedicalboard.org](mailto:lcullen@okmedicalboard.org)> wrote:

We have received your Oklahoma MD License Application. Attached is a letter listing the required items we have not yet received. It also includes a Username and instructions for checking the status of your application online.

T39996  
UKC

07/05/2022

ALEX SAULKUMAR HONEST  
[REDACTED]

**Check Your Application  
Status Online at:**  
<http://www.okmedicalboard.org>  
**Username:AP10008894**  
**Password:Last 4 SSN**

RE: MD Application #39996

Dear ALEX HONEST,

## **YOU CANNOT PRACTICE YOUR PROFESSION IN THE STATE OF OKLAHOMA UNTIL A VALID LICENSE HAS BEEN ISSUED.**

This deficiency list may or may not contain all required deficiencies. Please **allow 5 business days** for review by a licensing analyst, at which time you may check your updated status online by logging in with the username and password provided above. If you have further questions at that time, you may email the Licensing Staff at [licensing@okmedicalboard.org](mailto:licensing@okmedicalboard.org) or call (405) 962-1470.

Review of your application for special licensure to practice medicine and surgery in the state of Oklahoma reveals the following deficiencies:

MedSchool-Form 1 N H L Municipal Med Coll, Gujarat Univ, Ahmedabad, Gujarat, India  
 OTHER DEFICIENCIES: FCVS / WHAT IS YOUR JOB TITLE AT JAMES CAMPBELL FAMILY  
 MEDICINE CLINIC - ARE YOU PRACTICING WITHOUT A LICENSE & ARE YOU STILL WORKING  
 THERE, IF NOT WHEN WAS YOUR END DATE? / \*\*DO NOT NEED: AMA, FED, NPDB, EXAM  
 VERIF DATE, USMLE ST  
 Translations  
 ECFMG  
 PostGrad - Form 2 ALLIANCE HEALTH  
 USMLE Exams Incomplete  
 Verify License from OK  
 MedSchool-Transcript N H L Municipal Med Coll, Gujarat Univ, Ahmedabad, Gujarat, India  
 Extended Background Check  
 Exam verification date  
 INSTRUCTION SHEET  
 ECFMG Date

If a "Time Deficiency" is listed, please e-mail [licensing@okmedicalboard.org](mailto:licensing@okmedicalboard.org) with your activities during the specified time frame.

Any of the required forms in the list above may be downloaded from our website:

<http://www.okmedicalboard.org/resources>



In order to check on the status of your application, please log on to our web site ([www.okmedicalboard.org](http://www.okmedicalboard.org)). Your user name is AP10008894 (all caps and no spaces) and your password is the last 4 digits of your social security number. If you did not provide a social security number with your application, your password will be your 4-digit year of birth in the form "YYYY". To log in, scroll down the home page until you see the tabs in the middle of the page. Click on the tab labeled "eServices," then click "Online Application Status Check." This will open a webpage that allows you to enter your login information.

If we may be of further assistance, please email [licensing@okmedicalboard.org](mailto:licensing@okmedicalboard.org) or call (405) 962-1470.

Sincerely,

**Lisa Cullen**

Lisa Cullen  
Director of Licensing  
Dept. of Licensing

Encl

# Oklahoma State Board of Medical Licensure and Supervision Application Summary

Type	Number	Name
MD	39996	ALEX SAULKUMAR HONEST
MEDICAL DOCTOR		

**Incomplete Information (due to space limitations on this page, this may not be a complete list)**

NPDB Profile Not Received (to be completed by OSBMLS Staff)  
 Exam verification date  
 PostGrad - Form 2 ALLIANCE HEALTH  
 USMLE Exams Incomplete  
 OTHER DEFICIENCIES: \*\*DO NOT NEED: AMA, FED, NPDB, EXAM VERIF DATE, USMLE STEP 3, FORM  
 AMA Profile Not Received (to be completed by OSBMLS Staff)  
 Federation Clearance Not Received (to be completed by OSBMLS Staff)

**Last Medical School Attended:**  
 495-76 N H L Municipal Med Coll, Gujarat Univ, Ahmedabad, Gujarat, India

**Number of Licenses Previously Granted to Graduates of this Medical School:31**

Application for: Resident \_\_\_\_\_ Full License \_\_\_\_\_ Reinstatement \_\_\_\_\_

**The Secretary of the Board has reviewed this application and:**

1) AUTHORIZED CIRCULARIZATION TO OTHER BOARD MEMBERS \_\_\_\_\_

2) ALL FIVE CRITERIA HAVE BEEN MET [Fast Track] \_\_\_\_\_

- Passed USMLE
- No DUIs or Legal Issues
- No Significant Malpractice Issues
- US Graduate
- Graduated Medical School on time

3) HAS ISSUED A TEMPORARY LICENSE THROUGH \_\_\_/\_\_\_/\_\_\_

4) HAS ISSUED A SPECIAL PGY-1 TRAINING LICENSE *over 7-25-22*

5) REQUESTS SPECIFIC CONSIDERATION OF:

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RETURN FORM TO:  
OKLAHOMA STATE BOARD OF MEDICAL LICENSURE AND SUPERVISION

[oktraining@okmedicalboard.org](mailto:oktraining@okmedicalboard.org)

FORM **MUST BE** RETURNED BY THE PROGRAM, NOT THE APPLICANT

PRIMARY SOURCE

RECEIVED

JUN 19 2023

ANNUAL EVALUATION – TRAINING LICENSES ONLY  
**DO NOT COMPLETE FOR FULLY LICENSED PHYSICIANS**

OKLAHOMA STATE BOARD OF MEDICAL LICENSURE AND SUPERVISION

Name of Resident (please print) ALEX HONEST

License Number 39996 Specialty FAMILY MEDICINE

Institution Name ALLIANCE HEALTH DURANT FAMILY MEDICINE OSU-OMECO

Program Director (please print) Terry R. Gerard II, DO

Program Director Email trgerard2@yahoo.com

Instructions: Please rate each resident according to the scale below. If the score is rated in the 0 (Poor), 1 (Fair) or 2 (Below Average) YOU MUST PROVIDE WRITTEN DOCUMENTATION REGARDING THIS RATING.

ASSESSMENT	POOR	FAIR	BELOW AVERAGE	AVERAGE	ABOVE AVERAGE	OUTSTANDING
MEDICAL KNOWLEDGE	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input checked="" type="checkbox"/>
APPLICATION OF MEDICAL KNOWLEDGE	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input checked="" type="checkbox"/>
COMMUNICATION SKILLS	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input checked="" type="checkbox"/>
STABILITY IN WORKING RELATIONSHIP WITH OTHER PROFESSIONALS	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input checked="" type="checkbox"/>
THE INDIVIDUAL'S PERFORMANCE COMMENSURATE WITH PEER GROUP	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input checked="" type="checkbox"/>

REMARKS/COMMENTS \_\_\_\_\_

\_\_\_\_\_

COMPLETED BY (please print) Terry R. Gerard II, DO

SIGNATURE Terry R. Gerard II

DATE 6-19-23  
4-13-2023 TG.

Evaluation revised 4-2023

39996  
10



APR 13 2023

OKLAHOMA STATE BOARD OF  
 MEDICAL LICENSURE  
 AND SUPERVISION

**QUESTIONNAIRE**  
 Please read and follow ALL instructions

**FORM INSTRUCTIONS:** Complete both pages of this form *only if you are renewing or upgrading your training license.* Attach the appropriate documentation and answer the confidential questions.

**PAYMENT INSTRUCTIONS:** If you **ARE FULLY LICENSED**, you **MUST** go online and renew your license – **DO NOT pay your renewal fee via these instructions (doing so will delay your renewal)** for those needing to pay online please see the instructions of ATTACHMENT 2.

**ATTESTATION STATEMENT:** By completing this document, I agree to pay the appropriate fee on **ONLINE BILL PAY** If you are **UPGRADING** your training license to a full license, your fee will be \$250 & you will choose **MD TRAINING-TO-FULL**

If you are **RENEWING** your training license, your fee will be \$150 & you will choose **MD TRAINING LICENSE RENEWAL**

**PLEASE PRINT ALL INFORMATION**

FIRST NAME	ALEX	LAST NAME	HONEST
EMAIL ADDRESS	[REDACTED]		
LICENSE NUMBER	39996	CELL PHONE	[REDACTED]
HOME ADDRESS	[REDACTED]	CITY/STATE	[REDACTED]
PROGRAM ATTENDING	ALLIANCE HEALTH DURANT FAMILY MEDICINE RESIDENCY OMECO - OSU	SPECIALTY	FAMILY MEDICINE

**DOCUMENTATION TO ATTACH**

**PAYMENT COMPLETED**

<input checked="" type="checkbox"/> \$150 payment made on Billpay for <b>RENEWAL</b> of training license	<input type="checkbox"/> \$250 payment made on Billpay for <b>UPGRADE</b> of training license
--	---

**DOCUMENTATION REQUIRED**

<input type="checkbox"/> Form 2 (must be received directly from program) <b>**ONLY FOR UPGRADE - ATTACHMENT 3</b>	<input type="checkbox"/> Evaluation (must be received directly from program) - <b>ATTACHMENT 4</b>
<input type="checkbox"/> USMLE Step 3 (must be received directly from USMLE)	<input type="checkbox"/> Answer confidential questions (on back of this form)

**FOREIGN TRAINED STUDENTS**

<input type="checkbox"/> Current visa	<input type="checkbox"/> Social Security Number <b>**if not provided at initial application</b>
<input type="checkbox"/> Background Check <b>**if not done at initial application</b>	

**IF YOU ARE FULLY LICENSED – DO NOT COMPLETE THIS FORM. YOU MUST GO ONLINE AND RENEW AT <https://pay.apps.ok.gov/medlic/md/login.php> ENTER YOUR LICENSE NUMBER & PIN – COMPLETE YOUR RENEWAL AND PAY THE RENEWAL FEE.**

T 39996 WB



NAME ALEX HONEST

**PLEASE COMPLETE THE RENEWAL QUESTIONS BELOW, IF YOU HAVE ANY "YES" ANSWERS YOU MUST PROVIDE A NOTARIZED STATEMENT EXPLAINING YOUR ANSWER.**

SINCE RENEWAL OF YOUR TRAINING LICENSE OR INITIAL ISSUE OF YOUR TRAINING LICENSE (whichever is most recent)		
QUESTIONS	YES	NO
Have you failed any part of the USMLE exam (not previously disclosed)?	<input type="checkbox"/>	<input checked="" type="checkbox"/>
Have you been the subject of investigation or disciplinary action (including probation) by a hospital or training program?	<input type="checkbox"/>	<input checked="" type="checkbox"/>
Have you had any adverse judgment or settlement against you arising from a professional liability claim?	<input type="checkbox"/>	<input checked="" type="checkbox"/>
Have you been reported to the National Practitioner Data Bank (NPDB)?	<input type="checkbox"/>	<input checked="" type="checkbox"/>
Have you ever been denied, had removed, or suspended hospital privileges?	<input type="checkbox"/>	<input checked="" type="checkbox"/>
Have you surrendered hospital privileges while under investigation or to avoid investigation?	<input type="checkbox"/>	<input checked="" type="checkbox"/>
Have you entered into an Agreement with a Federal, State, or Local jurisdictional body to avoid formal action?	<input type="checkbox"/>	<input checked="" type="checkbox"/>
Has your application for licensure ever been denied?	<input type="checkbox"/>	<input checked="" type="checkbox"/>
Have you surrendered a license or had any disciplinary action taken on any license?	<input type="checkbox"/>	<input checked="" type="checkbox"/>
Have you been investigated by or requested to appear before a licensing or disciplinary agency (other than the Oklahoma State Board of Medical Licensure and Supervision)?	<input type="checkbox"/>	<input checked="" type="checkbox"/>
Have you obtained an assessment or been treated for use of any drug or chemical substance including alcohol?	<input type="checkbox"/>	<input checked="" type="checkbox"/>
Have you been arrested for, charged with, or convicted of a felony or misdemeanor other than a traffic violation?	<input type="checkbox"/>	<input checked="" type="checkbox"/>
Have you been arrested for, charged with, or convicted of a traffic violation involving the use of any drug or chemical substance?	<input type="checkbox"/>	<input checked="" type="checkbox"/>
Have you been addicted to or abused any drug or chemical substance including alcohol?	<input type="checkbox"/>	<input checked="" type="checkbox"/>
Have you been denied provider participation, terminated, sanctioned or penalized by any third-party payor including TRICARE, MEDICARE, or MEDICAID?	<input type="checkbox"/>	<input checked="" type="checkbox"/>
Have you surrendered or had any adverse action taken against any narcotic permit (State or Federal)?	<input type="checkbox"/>	<input checked="" type="checkbox"/>

I swear under penalty of perjury, that I am the person completing this Questionnaire and understand that any medical license procured or obtained by fraud or misrepresentation will result in disciplinary action taken against the licensee pursuant to the provisions of 59 O.S. § 508.

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APR 13 2023

Date 4/13/2023

OK  
BMS  
1-23-23

Signature [Signature]

OKLAHOMA STATE BOARD OF MEDICAL LICENSURE AND SUPERVISION

T 39996  
VB

# Oklahoma State Board of Medical Licensure and Supervision Application Summary

Type	Number	Name
MD	41602	CASEY LEE HOUSE
MEDICAL DOCTOR		

**Incomplete Information (due to space limitations on this page, this may not be a complete list)**

OTHER DEFICIENCIES: NEED FORM 2 AND EVAL UPON COMPLETION OF TRAINING, MUST COME DIRECTLY FROM YOUR PROGRAM  
 PostGrad - Form 2 COLLEGE OF MEDICINE TULSA

**Last Medical School Attended:**

039-06 OU Tulsa School of Community Medicine (Schusterman Center)

**Number of Licenses Previously Granted to Graduates of this Medical School:53**

Application for: Resident \_\_\_\_\_ Full License \_\_\_\_\_ Reinstatement \_\_\_\_\_

**The Secretary of the Board has reviewed this application and:**

1) AUTHORIZED CIRCULARIZATION TO OTHER BOARD MEMBERS \_\_\_\_\_

2) ALL FIVE CRITERIA HAVE BEEN MET [Fast Track] \_\_\_\_\_

- Passed USMLE
- No DUIs or Legal Issues
- No Malpractice Issues
- US Graduate
- Graduated Medical School in 4 years or less

3) HAS ISSUED A TEMPORARY LICENSE THROUGH \_\_\_\_ / \_\_\_\_ / \_\_\_\_

4) HAS ISSUED A SPECIAL PGY-1 TRAINING LICENSE \_\_\_\_\_



# Oklahoma State Board of Medical Licensure and Supervision

## Application Summary

**Type**    **Number**    **Name**  
 MD            41602    CASEY LEE HOUSE  
 MEDICAL DOCTOR

**Practice Address:**  
 May 02, 2023

**Status:**

Res: MD

Received: 04/25/2023

Entered: 04/25/2023

Temp Issued:

Temp Expires:

Train Issued: 07/01/2023

Train Expires: 09/30/2024

Fed Rec: 04/17/2024

AMA Rec: 04/17/2024

Board Action:

License #: 41602

Sex: M

Ethnic Origin: 3

Endorsed By: USMLE

	Test	Score	Date Taken	Date Verified	Attempts
Test 1:	USMLE 3	PASS	10/16/23	5/14/24	1
Test 2:	USMLE 1	PASS	6/4/21	4/26/23	1
Test 3:	USMLE 2	PASS	7/15/22	4/26/23	1

Note: **PASS** means higher than 75

Test AV:  
 Total Possible:  
 Okla Passing:  
 Total Score:

### PRE-MED EDUCATION

School Name: OKLAHOMA BAPTIST UNIVERSITY

City: SHAWNEE

State: OK Country: UNITED STATES

Degree: BS IN BIOCHEMISTRY

From: 8/2015 To: 5/2019 Verified:

### MEDICAL SCHOOL EDUCATION

Name: OU Tulsa School of Community Medicine (Schusterman Center)

Foreign Name:

City: Tulsa

State/Country: United States of America

Degree: MD

From: 8 / 2019

To: 5 / 2023

Diploma Ver'd:

Y

### POST GRADUATE EDUCATION

Facility: COLLEGE OF MEDICINE TULSA

Specialty: INTERNAL MEDICINE

Res. Fellowship: Residency

City: TULSA

State: OK Country: UNITED STATES OF AM

Verified:

From: 7 / 2023

To: /

ACGME Ver'd:

Comments:





# Oklahoma State Board of Medical Licensure and Supervision

## Application Summary

Type	Number	Name
MD	41602	CASEY LEE HOUSE

MEDICAL DOCTOR

**DEFICIENCIES**

OTHER DEFICIENCIES: NEED FORM 2 AND EVAL UPON COMPLETION OF TRAINING, MUST COME DIRECTLY FROM YOUR PROGRAM  
PostGrad - Form 2 COLLEGE OF MEDICINE TULSA

RETURN FORM TO:  
 OKLAHOMA STATE BOARD OF MEDICAL LICENSURE AND SUPERVISION  
[oktraining@okmedicalboard.org](mailto:oktraining@okmedicalboard.org)

RECEIVED

MAR 30 2024

**QUESTIONNAIRE**

Please read and follow ALL instructions

OKLAHOMA STATE BOARD OF  
 MEDICAL LICENSURE  
 AND SUPERVISION

**FORM INSTRUCTIONS:** Complete both pages of this form *only if* you are renewing or upgrading your training license. Attach the appropriate documentation and answer the confidential questions.

**PAYMENT INSTRUCTIONS:** If you **ARE FULLY LICENSED**, you **MUST** go online and renew your license – **DO NOT pay your renewal fee via these instructions (doing so will delay your renewal).**

**ATTESTATION STATEMENT:** By completing this document, I agree to pay the appropriate fee on **ONLINE BILL PAY**. If you are **UPGRADING** your training license to a full license, your fee will be \$250 & you will choose **MD TRAINING-TO-FULL**. If you are **RENEWING** your training license, your fee will be \$150 & you will choose **MD TRAINING LICENSE RENEWAL**.

PLEASE PRINT ALL INFORMATION

FIRST NAME	Casey	LAST NAME	House
EMAIL	[REDACTED]		
ADDRESS	[REDACTED]		
LICENSE NUMBER	41602	CELL PHONE	[REDACTED]
HOME ADDRESS	[REDACTED]	CITY/STATE	[REDACTED]
PROGRAM ATTENDING	OU Tulsa	ZIP CODE	[REDACTED]
		SPECIALTY	Internal Medicine

DOCUMENTATION TO ATTACH

PAYMENT COMPLETED			
<input type="checkbox"/>	\$150 payment made on Billpay for <b>RENEWAL</b> of training license	<input type="checkbox"/>	\$250 payment made on Billpay for <b>UPGRADE</b> of training license

DOCUMENTATION REQUIRED			
<input type="checkbox"/>	Form 2 (must be received directly from program) <b>**ONLY FOR UPGRADE</b>	<input type="checkbox"/>	Evaluation (must be received directly from program)
<input type="checkbox"/>	USMLE Step 3 (must be received directly from USMLE)	<input type="checkbox"/>	Answer confidential questions (on back of this form)

FOREIGN TRAINED STUDENTS			
<input type="checkbox"/>	Current visa	<input type="checkbox"/>	Social Security Number **if not provided at initial application
<input type="checkbox"/>	Background Check **if not done at initial application		

**IF YOU ARE FULLY LICENSED – DO NOT COMPLETE THIS FORM. YOU MUST GO ONLINE AND RENEW AT <https://pay.apps.ok.gov/medlic/md/login.php> ENTER YOUR LICENSE NUMBER & PIN – COMPLETE YOUR RENEWAL AND PAY THE RENEWAL FEE.**

41602  
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MAR 30 2024

OKLAHOMA STATE BOARD OF  
MEDICAL LICENSURE  
AND SUPERVISION

NAME Casey House

**IF YOU HAVE ANY "YES" ANSWERS YOU MUST PROVIDE A NOTARIZED STATEMENT EXPLAINING YOUR ANSWER.**

**SINCE RENEWAL OF YOUR TRAINING LICENSE OR INITIAL ISSUE OF YOUR TRAINING LICENSE (whichever is most recent)**

QUESTIONS	YES	NO
Have you failed any part of the USMLE exam (not previously disclosed)?	<input type="checkbox"/>	<input checked="" type="checkbox"/>
Have you been the subject of investigation or disciplinary action (including probation) by a hospital or training program?	<input type="checkbox"/>	<input checked="" type="checkbox"/>
Have you had any adverse judgment or settlement against you rising from a professional liability claim?	<input type="checkbox"/>	<input checked="" type="checkbox"/>
Have you been reported to the National Practitioner Data Bank (NPDB)?	<input type="checkbox"/>	<input checked="" type="checkbox"/>
Have you ever been denied, had removed, or suspended hospital privileges?	<input type="checkbox"/>	<input checked="" type="checkbox"/>
Have you surrendered hospital privileges while under investigation or to avoid investigation?	<input type="checkbox"/>	<input checked="" type="checkbox"/>
Have you entered into an Agreement with a Federal, State, or Local jurisdictional body to avoid formal action?	<input type="checkbox"/>	<input checked="" type="checkbox"/>
Has your application for licensure ever been denied?	<input type="checkbox"/>	<input checked="" type="checkbox"/>
Have you surrendered a license or had any disciplinary action taken on any license?	<input type="checkbox"/>	<input checked="" type="checkbox"/>
Have you been investigated by or requested to appear before a licensing or disciplinary agency (other than the Oklahoma State Board of Medical Licensure and Supervision)?	<input type="checkbox"/>	<input checked="" type="checkbox"/>
Have you obtained an assessment or been treated for use of any drug or chemical substance including alcohol?	<input type="checkbox"/>	<input checked="" type="checkbox"/>
Have you been arrested for, charged with, or convicted of a felony or misdemeanor other than a traffic violation?	<input type="checkbox"/>	<input checked="" type="checkbox"/>
Have you been arrested for, charged with, or convicted of a traffic violation involving the use of any drug or chemical substance?	<input type="checkbox"/>	<input checked="" type="checkbox"/>
Have you been addicted to or abused any drug or chemical substance including alcohol?	<input type="checkbox"/>	<input checked="" type="checkbox"/>
Have you been denied provider participation, terminated, sanctioned or penalized by any third-party payor including TRICARE, MEDICARE, or MEDICAID?	<input type="checkbox"/>	<input checked="" type="checkbox"/>
Have you surrendered or had any adverse action taken against any narcotic permit (State or Federal)?	<input type="checkbox"/>	<input checked="" type="checkbox"/>

I swear under penalty of perjury, that I am the person completing this Questionnaire and understand that any medical license procured or obtained by fraud or misrepresentation will result in disciplinary action taken against the licensee pursuant to the provisions of 59 O.S. § 508.

Signature Casey House

Date 3/30/2024

# Oklahoma State Board of Medical Licensure and Supervision

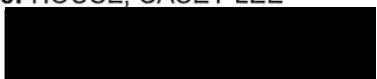
PAGE 87 of 500

## APPLICATION FOR OKLAHOMA MEDICAL DOCTOR LICENSE

Received:04/25/2023

Applicant Name: HOUSE, CASEY LEE

MD 41602



Date Of Birth: [REDACTED]

Place Of Birth (City, State): MCALESTER, OK

Sex: M

Race: American Indian

Education									
Type	Name	City	ST	Country	From	To	Degree	Comments	Veri
UG	OKLAHOMA BAPTIST UNIVERSITY	SHAWNEE	OK		8/2015	5/2019	BS IN BIOCHEMISTRY		

Medical School Name	City	State	Country	Comments	From	To
OU Tulsa School of Community Medicine (Schusterman Center)	Tulsa	OK	United States		8/2019	5/2023

Post-Graduate							
Facility	City	St	Country	Specialty	Comments	From	To
OU TULSA INTERNAL MEDICINE	TULSA	OK	UNITED S	INTERNAL MEDICINE		/	/

Practice History								
Employer	Specialty	Supervisor	City	ST	Country	From	To	Verif
WYZANT	WYZANT TUTOR		TULSA	OK		6/2020	7/2020	
DOORDASH	DOORDASH DRIVER		TULSA	OK		6/2019	7/2020	
OKLAHOMA BAPTIST UNIVERSITY	TUTOR AT THE MILBURN STUDENT SUCCESS CENTER		SHAWNEE	OK		8/2018	5/2019	
WALNUT GROVE LIVING CENTER	CERTIFIED NURSING ASSISTANT		MCALESTER	OK		5/2018	7/2018	
OKLAHOMA BAPTIST UNIVERSITY	LAB TEACHING ASSISTANT AND WORKER		SHAWNEE	OK		8/2017	5/2019	
KANSAS STATE UNIVERSITY RAFFERTY RESEARCH LABORATO	RESEARCH EXPERIENCE FOR UNDERGRADUATES - CHEMISTRY		MANHATTAN	KS		6/2017	8/2017	
MCALESTER COUNTRY CLUB	LIFEGUARD AND SWIM INSTRUCTOR		MCALESTER	OK		5/2011	8/2016	

Other/ Out-Of-State Licenses					
State	License #	Profession	Status	Issue Date	Exp Date

\$250

MD Exam				
Exam	State	Score	Date Taken	#
USMLE				



**Oklahoma State Board of Medical Licensure and Supervision**  
**APPLICATION FOR OKLAHOMA MEDICAL DOCTOR LICENSE**  
 Received:04/25/2023

<b>Questions Answered 04/24/2023</b>	<b>Response</b>
A. Have you ever been denied provider participation, terminated, sanctioned, or penalized by any third party payor, to include TRICARE, MEDICARE, MEDICAID?	<b>N</b>
B. Have you ever surrendered or had any adverse action taken against any narcotic permit (state or federal)?	<b>N</b>
C. Have you ever been denied membership or had disciplinary action taken by a national, state or county professional organization?	<b>N</b>
D. Have you ever been denied or had removed or suspended hospital staff privileges?	<b>N</b>
E. Have you ever surrendered hospital staff privileges while under investigation or to avoid investigation?	<b>N</b>
F. Have you ever entered into an agreement with a federal, state or local jurisdictional body to avoid formal action?	<b>N</b>
G. Have you ever been the subject of an investigation, probation or disciplinary action by a hospital, clinic, practice group, training program or professional school?	<b>N</b>
H. Have you had any adverse judgment, settlement, or award against you arising from a professional liability claim?	<b>N</b>
I. Have you ever had professional liability coverage declined, canceled, issued on special terms, or renewal refused?	<b>N</b>
J. Have you ever been reported to the National Practitioners Data Bank (NPDB) or to the Healthcare Integrity and Protection Data Bank (HIPDB)? (If yes, enclose a copy of the report.)	<b>N</b>
K. Has your application for examination or a professional license ever been denied?	<b>N</b>
L. Have you ever failed any part of a licensure/certification/registration examination?	<b>N</b>
M. Have you ever surrendered a license or had a license revoked?	<b>N</b>
N. Has any disciplinary action been taken on any license?	<b>N</b>
O. Have you ever been subject of a review by professional licensing/regulatory agency based on a complaint filed against you?	<b>N</b>
P. Have you ever been arrested, charged with, or convicted of a felony or misdemeanor, other than traffic violations?	<b>N</b>
Q. Have you ever been arrested, charged with, or convicted of a traffic violation involving the use of any drug or chemical substance, including alcohol?	<b>N</b>
R. Are you now or have you within the past two years been addicted to or used in excess any drug or chemical substance, including alcohol?	<b>N</b>
S. Have you obtained an assessment or been treated for the use of any drug or chemical substance, including alcohol?	<b>N</b>
T. Do you currently have or have you had within the past two years any mental or physical disorder or condition which, if untreated, could affect your ability to practice competently?	<b>N</b>
U. Are you or your spouse currently on Active Duty in the U.S. Armed Forces?	<b>N</b>
V. Are you or your spouse currently Deployed on Active Duty in the U.S. Armed Forces?	<b>N</b>

Oklahoma State Board of Medical Licensure and Supervision

APPLICATION FOR OKLAHOMA MEDICAL DOCTOR LICENSE

Received:04/25/2023

**If licensed, where do you intend to locate?**

OK

**Why do you seek Licensure in the state of Oklahoma?**

Post-Graduate Training

**In what manner will you be communicating with your Oklahoma patients (telephone, email, internet, video-conference, etc)?**

**Describe how you will examine each patient in person prior to diagnosis, treating, correcting, or prescribing for a patient in Oklahoma from the state, province, or country you are located:**

**Describe the manner in which you intend to practice medicine across state lines in Oklahoma:**

**Have you executed or been offered a contract in connection with practice in the state of Oklahoma?**

Yes

**If 'Yes', Name of practice:**

OU Tulsa Internal Medicine Residency Program

**If so, Please identify with which category:**

Residency

**Name of Previous Carrier and Policy Holder**

None

**Name of Current Carrier and policy Holder**

I will have malpractice insurance provided by the training program

**Will your professional liability insurance policy cover your practice in Oklahoma**

Yes

**If NO, when do you expect to obtain liability insurance that will cover practice in Oklahoma**

I attest that all the above information is accurate as of April 24, 2023: \_\_\_\_\_ (Signed Online)





**Applicant:** In the presence of a notary public, sign this form with attached photo.

**Send this form to:**

Oklahoma State Board of Medical Licensure and Supervision  
101 NE 51<sup>st</sup> Street  
Oklahoma City, OK 73105

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

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

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

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

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

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



RECEIVED

MAY 11 2023

*Casey House*

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

OKLAHOMA STATE BOARD OF  
MEDICAL LICENSURE  
AND SUPERVISION

*House, Casey L.*

Applicants printed last name, first name, middle initial, and suffix (e.g., Jr.)

*5/11/2023*

Date of signature (must correspond to the date of notarization)

(Please note: The Notary Public seal should overlap the bottom of the photo to the left)

**NOTARY**

State of Oklahoma, County of Tulsa

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

The statements on this document are subscribed and sworn to before me by the applicant on this 11<sup>th</sup> day of May, 2023

Notary Public Signature Anit Kalasuna My Notary Commission Expires January 21, 2024

T 41602  
WS



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

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

PRIMA  
SOURI

**Recipient:** OKLAHOMA STATE BOARD OF  
MEDICAL LICENSURE & SUPERVISION

**Date:** 05/13/2024

**Examinee:** House, Casey Lee  
**Alt Name(s):**

**Examinee ID:** 5-476-313-1  
**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. Pass/fail outcomes are based upon the minimum passing level in place at the time of test administration and are not altered by subsequent revisions to the minimum passing level. Effective April 1, 2013, two-digit scores will no longer be reported. Test results reported as passing represent an exam score of 75 or higher on a two-digit scale. Step 1 examinations taken on or after January 26, 2022 are reported as pass/fail, with no numeric score; Step 1 examinations taken before January 26, 2022 will continue to be reported with a 3-digit score.

### USMLE STEP 1

Test Date	Pass/Fail	Score	Minimum Pass	Comments
06/04/2021	Pass	232	(194)	

### USMLE STEP 2

#### *Clinical Knowledge (CK)*

Test Date	Pass/Fail	Score	Minimum Pass	Comments
07/15/2022	Pass	244	(214)	

### USMLE STEP 3

Test Date	Pass/Fail	Score	Minimum Pass	Comments
10/16/2023	Pass	232	(198)	

#### End of Exam History

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

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

RECEIVED

MAY 14 2024

OKLAHOMA STATE BOARD OF  
MEDICAL LICENSURE  
AND SUPERVISION

T241602  
S





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

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

**Examinee:** House, Casey Lee

**Examinee ID:** 5-476-313-1

**Date of Birth:** [REDACTED]

### INTERPRETATION OF RESULTS

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

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

### STEP 1 AND STEP 2 CLINICAL SKILLS (CS)

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

### ANNOTATIONS APPEARING UNDER "COMMENTS"

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

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

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

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

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

### ANNOTATIONS APPEARING AS "NOTE"

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

### PHYSICIAN DATA CENTER INFORMATION APPEARING AS "NOTE"

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

03/2015

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

Form 1 (MD)

Oklahoma State Board of Medical Licensure and Supervision  
101 NE 51<sup>st</sup> Street  
Oklahoma City, OK 73105

*This form must be completed by the institution and mailed directly from the institution.*

Applicant's Name Casey House  
Institution: OU College of Medicine, Tulsa SCM City/State Tulsa, OK

Our records indicate that the above named applicant attended our medical school on the following dates:

From 08 / 12 / 2019 To 05 / 19 / 2023 and was awarded the degree MD  
Month Day Year Month Day Year

- 1. Does this individual's official record reflect (an) interruption(s) or extension(s) in his/her medical education? If yes, please explain.  YES  NO
- 2. Does this individual's official record reflect that he/she was ever placed on academic or disciplinary probation during his/her medical education? If yes, please explain.  YES  NO
- 3. Does this individual's official record reflect that he/she was ever the subject of negative reports for behavioral reasons or an investigation by the medical school or parent university? If yes, please explain below.  YES  NO
- 4. Does this individual's official record reflect that he/she was ever disciplined for unprofessional conduct/behavioral reasons by the medical school or parent university? If yes, please explain below.  YES  NO
- 5. Does this individual's official record reflect that there were any limitations or special requirements imposed on the individual because of questions of academic incompetence, disciplinary problems, or any other reason? If yes, please explain below.  YES  NO

Please explain any "YES" response from above: \_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

Completion of the following is certification that the information above is an accurate account of this individual's records and is true and correct.

Name: Tammy Kuykendall Signature: [Signature]  
Title of Signatory: Clinical Programs Coordinator Date of Signature: 5/22/2023  
Tel: 918 660 3500 Fax: — E-Mail: tammy.kuykendall@ouhsc.edu

School Seal

If no seal is available, this form must be notarized

Notary Public \_\_\_\_\_  
Commission # \_\_\_\_\_  
My commission expires: \_\_\_\_\_

RECEIVED

JUN 05 2023

OKLAHOMA STATE BOARD OF  
MEDICAL LICENSURE  
AND SUPERVISION

Notary Seal

*Handwritten blue ink mark: T 41602*



The Oklahoma State Regents for Higher Education  
acting through

# The University of Oklahoma

have admitted

## Casey Lee House

to the degree of

## Doctor of Medicine

RECEIVED

JUN 05 2023

OKLAHOMA STATE BOARD OF  
NURSING REGULATION  
AND SUPERVISION

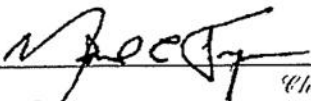
and all the honors, privileges and obligations belonging thereto,  
and in witness thereof have authorized the issuance of  
this Diploma duly signed and sealed.

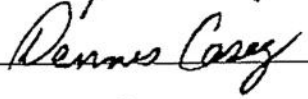
Issued at the University of Oklahoma at Oklahoma City, Oklahoma on the  
twentieth day of May two thousand and twenty-three.

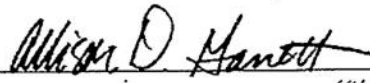
For the State Regents

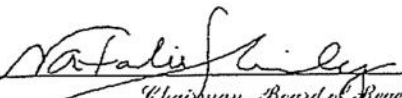
For the University

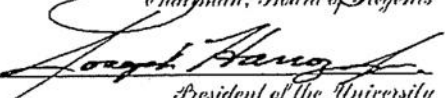


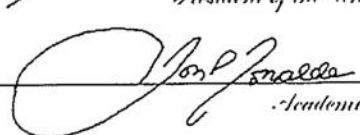
  
 \_\_\_\_\_  
 Chairman

  
 \_\_\_\_\_  
 Secretary

  
 \_\_\_\_\_  
 Chancellor

  
 \_\_\_\_\_  
 Chairman, Board of Regents

  
 \_\_\_\_\_  
 President of the University

  
 \_\_\_\_\_  
 Academic Dean



THE UNIVERSITY OF OKLAHOMA HEALTH SCIENCES CENTER  
Official Transcript

University of Oklahoma Health Sciences Center  
P. O. Box 26901  
Oklahoma City, OK 731260901  
United States

RECEIVED  
JUN 05 2023

Name : Casey House  
Student ID: 1795106  
Birthdate : [REDACTED]

OKLAHOMA STATE BOARD OF  
MEDICAL LICENSURE  
AND SUPERVISION

Spring 2020

----- Degrees Awarded -----

Degree : Doctor of Medicine  
Confer Date : 2023-05-20  
Plan : Medicine-School of Community Medicine

----- External Degrees -----

Oklahoma Baptist University  
2019-05-17 Bachelor of Science  
Field of Study : Biochemistry

----- Academic Program History -----

Program : Medicine MD  
2019-07-01 : Active in Program  
2019-07-01 : Medicine - Tulsa MD SCM Major  
2023-05-20 : Completed Program

----- Beginning of Medicine Record -----

Fall 2019

Course	Description	Attempted	Earned	Grade	Points
INDT 8110	Design/Analysis Clin Res	16.00	16.00	S	
INDT 8122	Clinical Medicine I	101.50	101.50	S	
INDT 8124	The Human Structure	130.00	130.00	S	
INDT 8125	Foundations of Medicine	136.00	136.00	S	
INDT 8162	LMHP1	37.00	37.00	S	
INDT 8244	PPSI	75.00	75.00	S	
INDT 9101	SCM Prologue	40.00	40.00	S	
TERM GPA :	0.000	GPH: 0.00	TOTALS : 535.50	535.50	0.000
OUHSC GPA :	0.000	GPH: 0.00	TOTALS : 535.50	535.50	0.000

Course	Description	Attempted	Earned	Grade	Points
INDT 8132	IMI	68.00	68.00	S	
INDT 8140	Gastrointestinal & Hepatobil	85.00	85.00	S	
INDT 8148	Endo, Metab & Nutri Biochem	85.00	85.00	S	
INDT 8156	Blood, Hematopoiesis & Lymph	77.00	77.00	S	

TERM GPA :	0.000	GPH: 0.00	TOTALS : 315.00	315.00	0.000
OUHSC GPA :	0.000	GPH: 0.00	TOTALS : 850.50	850.50	0.000

Fall 2020

Course	Description	Attempted	Earned	Grade	Points
INDT 8163	LMHP2	32.00	32.00	S	
INDT 8264	Cardiovasc, Resp, Renal	152.00	152.00	S	
INDT 8266	PPS II: Clinical Ethics	30.00	30.00	S	
INDT 8272	Neurosciences	151.00	151.00	S	
INDT 8275	Clinical Medicine II	99.00	99.00	S	
INDT 8301	Enrichment Program: Humanities	16.00	16.00	S	

Course Topic(s): America's Quest for Health

TERM GPA :	0.000	GPH: 0.00	TOTALS : 480.00	480.00	0.000
OUHSC GPA :	0.000	GPH: 0.00	TOTALS : 1330.50	1330.50	0.000

Spring 2021

Course	Description	Attempted	Earned	Grade	Points
INDT 8280	Reproduction	98.00	98.00	S	
INDT 9200	MS2 Capstone	70.00	70.00	S	
INDT 9201	Joint, Skin, and Bone	40.00	40.00	S	

TERM GPA :	0.000	GPH: 0.00	TOTALS : 208.00	208.00	0.000
OUHSC GPA :	0.000	GPH: 0.00	TOTALS : 1538.50	1538.50	0.000

This information is released in accordance with the Family Educational Rights and Privacy Act of 1974 and is also released under the condition that other parties will not have access to this information without the student's written consent.

T 4/16/02  
V

Lou Klein  
OUHSC Registrar



THE UNIVERSITY OF OKLAHOMA HEALTH SCIENCES CENTER  
Official Transcript

University of Oklahoma Health Sciences Center  
P. O. Box 26901  
Oklahoma City, OK 731260901  
United States

Name : Casey House  
Student ID: 1795106  
Birthdate : [REDACTED]

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OKLAHOMA STATE BOARD OF  
NURSING AND SUPERVISION

Summer II 2021

Course	Description	Attempted	Earned	Grade	Points
INDT 9050	HSSP	184.00	184.00	S	
INDT 9301	Clinical Transitions	40.00	40.00	S	
FM 9540	Family Medicine Clerkship	155.00	155.00	B	465.000
NEUR 9370	Neurology Clerkship	155.00	155.00	B	465.000
TERM GPA :	3.000	GPH: 310.00	TOTALS : 534.00	534.00	930.000
OUHSC GPA :	3.000	GPH: 310.00	TOTALS : 2072.50	2072.50	930.000

Fall 2021

Course	Description	Attempted	Earned	Grade	Points
SURG 9760	Surgery Clerkship	298.00	298.00	A	1192.000
MED 9250	Medicine Clerkship	298.00	298.00	B	894.000
TERM GPA :	3.500	GPH: 596.00	TOTALS : 596.00	596.00	2086.000
OUHSC GPA :	3.329	GPH: 906.00	TOTALS : 2668.50	2668.50	3016.000

Spring 2022

Course	Description	Attempted	Earned	Grade	Points
INDT 9160	Tribal Health	80.00	80.00	S	
EM 9101	EM Selective	80.00	80.00	S	
DERM 9101	Dermatology Selective	80.00	80.00	S	
OBGY 9210	Obstet & Gyn Clerkship	226.00	226.00	B	678.000
PEDI 9650	Pediatric Clerkship	226.00	226.00	B	678.000
PSBS 9520	Psychiatry Clerkship	226.00	226.00	A	904.000
TERM GPA :	3.333	GPH: 678.00	TOTALS : 918.00	918.00	2260.000
OUHSC GPA :	3.331	GPH: 1584.00	TOTALS : 3586.50	3586.50	5276.000

Summer II 2022

Course	Description	Attempted	Earned	Grade	Points
INDT 9300	Capstone	160.00	160.00	S	
GERI 9250	Geriatrics	160.00	160.00	S	
TERM GPA :	0.000	GPH: 0.00	TOTALS : 320.00	320.00	0.000
OUHSC GPA :	3.331	GPH: 1584.00	TOTALS : 3906.50	3906.50	5276.000

Fall 2022

Course	Description	Attempted	Earned	Grade	Points
INDT 9404	Research/Scholarship Elective	160.00	160.00	S	
Course Topic(s): MED Res/Scholarship Elective					
INDT 9401	Outpatient Elective	160.00	160.00	S	
Course Topic(s): MED Outpatient Elective					
INDT 9403	Subinternship Elective	160.00	160.00	A	640.000
Course Topic(s): MED Subinternship Elective					
TERM GPA :	4.000	GPH: 160.00	TOTALS : 480.00	480.00	640.000
OUHSC GPA :	3.392	GPH: 1744.00	TOTALS : 4386.50	4386.50	5916.000

Spring 2023

Course	Description	Attempted	Earned	Grade	Points
INDT 9406	Special Studies Elective	80.00	80.00	S	
Course Topic(s): MED Special Studies Elective					
INDT 9406	Special Studies Elective	80.00	80.00	S	
Course Topic(s): MED Special Studies Elective					
INDT 9401	Outpatient Elective	160.00	160.00	S	
Course Topic(s): MED Outpatient Elective					
INDT 9402	Mixed In/Outpatient Elective	160.00	160.00	S	
Course Topic(s): MED Mixed In/Outpatient Electi					
FM 9572	CH II	80.00	80.00	S	

This information is released in accordance with the Family Educational Rights and Privacy Act of 1974 and is also released under the condition that other parties will not have access to this information without the student's written consent.

*Lou Klein*

OUHSC Registrar

THE UNIVERSITY OF OKLAHOMA HEALTH SCIENCES CENTER  
Official Transcript

University of Oklahoma Health Sciences Center  
P. O. Box 26901  
Oklahoma City, OK 731260901  
United States

Name : Casey House  
Student ID: 1795106  
Birthdate : ██████████

Spring 2023 (cont.)

TERM GPA :	0.000	GPH:	0.00	TOTALS :	560.00	560.00	0.000
OUHSC GPA :	3.392	GPH:	1744.00	TOTALS :	4946.50	4946.50	5916.000
Medicine Career Totals							
OUHSC GPA :	3.392	GPH:	1744.00	TOTALS :	4946.50	4946.50	5916.000
Post-Baccalaureate Career Totals							
OUHSC GPA :	3.392	GPH:	109.00	TOTALS :	309.15	309.15	369.750
----- End Of Career (1 of 1) -----							
----- End Of Transcript -----							

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JUN 05 2023

OKLAHOMA STATE BOARD OF  
MEDICAL EXAMINERS  
AND SUPERVISION

*Lori Klein*





# AMA Physician Profile

PREPARED FOR

Oklahoma State Board of Licensure & Supervision, Oklahoma City, OK

**Name and Mailing Address**

CASEY LEE HOUSE

**Primary Office Address**

UNIV OK DEPT IM  
4502 E 41ST ST  
TULSA, OK 74135-2553  
Phone (918) 424-4421

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APR 17 2024  
OKLAHOMA STATE BOARD OF  
MEDICAL LICENSURE  
AND SUPERVISION

**Birth date**

**Physician's major professional activity**

HOSPITAL BASED RESIDENTS - ALL YEARS

**AMA membership status**

MEMBER

PRIMARY SOURCE

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

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

NPI Number	Enumeration Date	Deactivation Date	Reactivation Date	Replacement Number	Last Reported Date
1831718162	04/16/2020	NOT RPTD	NOT RPTD	NOT RPTD	03/15/2024

**Current and/or historical medical school**

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

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

**School:** UNIVERSITY OF OKLAHOMA COLLEGE OF MEDICINE

**Degree Awarded:** YES

**Degree Type:** MD

T41602  
57

**Enrollment Date:** 08/2019

**Degree Date:** 05/2023

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

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

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

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

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

**Sponsoring Institution:** UNIVERSITY OF OKLAHOMA SCHOOL OF COMMUNITY MEDICINE-TULSA  
**Sponsoring State:** OKLAHOMA  
**Program name:** UNIVERSITY OF OKLAHOMA SCHOOL OF COMMUNITY MEDICINE (TULSA) PROGRAM  
**Specialty:** INTERNAL MEDICINE  
**Training Type:** SPECIALTY  
**Dates:** 07/01/2023 - 07/01/2026  
**Status:** TRAINING IN PROGRESS

### Specialty board certification

NO DATA REPORTED AT THIS TIME

### Current and/or historical medical licensure

License Number	MD / DO	Locale	Date Granted	Expiration Date	Renewal Date	Status	License Type	Last Reported	Name on License
41602	MD	OK	07/01/2023	09/30/2024		ACT	RES	04/02/2024	CASEY LEE HOUSE



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

### Action notifications reported to the AMA

**Medical Licensing Boards:** NO ACTIONS REPORTED AT THIS TIME

**Medicare/Medicaid Sanctions from DHHS:** NO ACTIONS REPORTED AT THIS TIME

**US DOJ Drug Enforcement Administration:** NO ACTIONS REPORTED AT THIS TIME

### U.S. Drug Enforcement Administration (DEA)

NO DATA REPORTED AT THIS TIME

### ECFMG certification

NOT APPLICABLE

### Profile information

The content of the AMA Physician Profile is for credentialing use only. The content cannot be used or assembled for an employment purpose as defined under the Fair Credit Reporting Act. An organization's appropriate use of the data contained in the AMA Physician Professional Data™, formerly known as AMA Physician Masterfile, meets select primary source verification requirements of the Joint Commission, the Accreditation Association for Ambulatory Health Care (AAAHC) and the American Accreditation Health Care Commission (AAHCC)/ Utilization Review Accreditation Commission (URAC). The AMA Physician Professional Data is also an NCQA-approved source for verification of medical school, post-graduate medical training, ABMS Board Certification and federal DEA registration.

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

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

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APR 29 2023

OKLAHOMA STATE BOARD OF MEDICAL LICENSURE AND SUPERVISION

OKLAHOMA STATE BOARD OF MEDICAL LICENSURE AND SUPERVISION
101 NE 51st STREET
OKLAHOMA CITY OK 73105
EVIDENCE OF STATUS - PART A

Full Legal Name: Casey Lee House
Mailing Address: [Redacted]
City: [Redacted] State: [Redacted] Zip Code: [Redacted] Telephone Number: [Redacted] Social Security #: [Redacted]

PRIMARY EVIDENCE OF CITIZENSHIP
(FOR US CITIZENS, US NATIONALS, OR PERMANENT LEGAL RESIDENT ALIENS)

If you are a U.S. citizen, U.S. national, or permanent legal resident alien, please attach a photocopy of one of the following documents to this form. Place a checkmark below to indicate the document that is attached.

- [X] A birth certificate showing birth in one of the 50 States, the District of Columbia, Puerto Rico (on or after January 13, 1941), Guam, the U.S. Virgin Islands (on or after January 17, 1917), American Samoa, Swain's Island or the Northern Mariana Islands, unless the person was born to foreign diplomats residing in the U.S.
[ ] United States passport (except limited passports, which are issued for periods of less than five years)
[ ] Report of birth abroad of a U.S. citizen (FS-240) (issued by the Department of State to U.S. citizens)
[ ] Certificate of birth (FS-545) (issued by a foreign service post) or Certification of Report of Birth (DS1350) (issued by the Department of State), copies available from the Department of State
[ ] Certificate of Naturalization (N-550 or N-570) (issued by the INS through a Federal or State court, or through administrative naturalization after December 1990 to individuals who are individually naturalized; the N570 is a replacement certificate issued when the N-550 has been lost or mutilated or the individual's name has been changed)
[ ] Certificate of Citizenship (N-560 or N-561) (issued by the INS to individuals who derive U.S. citizenship through a parent; the N-561 is a replacement certificate issued when the N-560 has been lost or mutilated or the individual's name has been changed)
[ ] United States Citizen Identification Card (I-197) (issued by the INS until April 7, 1983 to U.S. citizens living near the Canadian or Mexican border who needed it for frequent border crossing) (formerly Form I-179, last issued in February 1974)
[ ] Northern Mariana Identification Card (issued by the INS to a collectively naturalized citizen of the U.S. who was born in the Northern Mariana Islands before November 3, 1986)
[ ] Statement provided by a U.S. consular officer certifying that the individual is a U.S. citizen (This is given to an individual born outside the U.S. who derives citizenship through a parent but does not have an FS-240, FS-545 or DS-1350);
[ ] American Indian Card with a classification code "KIC" and a statement on the back (identifying U.S. citizen members of the Texas Band of Kickapoos living near the U.S./Mexican border.)
[ ] Alien Lawfully Admitted for Permanent Residence: INS Form I-551 (Alien Registration Receipt Card, commonly known as a "green card")
[ ] Alien Lawfully Admitted for Permanent Residence: Unexpired Temporary I-551 stamp in foreign passport or on INS Form I-94

I declare under penalty of perjury, under the laws of the State of Oklahoma, that all information contained in this application and all accompanying documents provided to substantiate my Evidence of Status application are true and correct.

Signature Casey House Date 4/28/2023

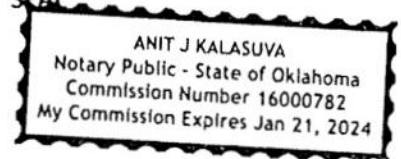
Subscribed and sworn before me this 28th day of April, 2023.

Notary Public Anit Kalasuva

Commission Number 16000782

My commission expires January 21, 2024

NOTARY SEAL



T41602 HS





**Kenna L. Shaw**

---

**From:** BillPay Webmaster <donotreply@www.ok.gov>  
**Sent:** Wednesday, April 17, 2024 2:04 PM  
**To:** Dela Kwetey; Bill Pay; Sheila E. Brumfield; Chris Maloney; Licensing; Arlene Morris; Debra Reich  
**Subject:** [EXTERNAL] LICENSE - MD Training-to-Full License Fee 250.00 - Payment Made

CASEY LEE HOUSE has paid for a LICENSE - MD Training-to-Full License Fee 250.00 on 04/17/2024 02:04:03pm for \$250.00.

OKLAHOMA MD LICENSE NUMBER 41602

To view all transactions please go to <http://www.ok.gov/triton/> and login to your CMS account.

T 41602  
W



05/02/2023

CASEY LEE HOUSE  


**Check Your Application  
Status Online at:**  
<http://www.okmedicalboard.org>  
**Username:AP38342044**  
**Password>Last 4 SSN**

RE: MD Application #41602

Dear CASEY HOUSE,

**YOU CANNOT PRACTICE YOUR PROFESSION IN THE STATE  
OF OKLAHOMA UNTIL A VALID LICENSE HAS BEEN ISSUED.**

Your training application has been processed and the current deficiencies are listed below. Please be advised, these may not be the only deficiencies. You will be advised if any other deficiencies are added. You may check your application status online by logging in with the username and password provided above.

If you have further questions please email  
[oktraining@okmedicalboard.org](mailto:oktraining@okmedicalboard.org)

If a "*Time Deficiency*" is listed, please complete a time deficiency form and e-mail the document to  
[oktraining@okmedicalboard.org](mailto:oktraining@okmedicalboard.org)  
with your activities during the specified time frame.

Evidence of Status  
PostGrad - Form 2 COLLEGE OF MEDICINE TULSA  
USMLE Exams Incomplete  
Application Instructions  
OATH  
Extended Background Check  
Exam verification date  
MedSchool-Transcript OU Tulsa School of Community Medicine (Schusterman Center)  
MedSchool-Form 1 OU Tulsa School of Community Medicine (Schusterman Center)

Any of the required forms in the list above may be downloaded from our website:

<http://www.okmedicalboard.org/resources>

In order to check on the status of your application, please log on to our web site:

<https://secure.okmedicalboard.org/applicant/signin>

Your user name is AP38342044 (all caps and no spaces) and your password is the last 4 digits of your social security number.

If you did not provide a social security number with your application, your password will be your 4-digit year of birth in the form "YYYY".

If we may be of further assistance, please email.

[oktraining@okmedicalboard.org](mailto:oktraining@okmedicalboard.org)

Sincerely,

*Valeska Barr*

Valeska Barr

Dept. of Licensing

Encl



# Oklahoma State Board of Medical Licensure and Supervision Application Summary

Type	Number	Name
MD	41602	CASEY LEE HOUSE
MEDICAL DOCTOR		

**Incomplete Information (due to space limitations on this page, this may not be a complete list)**

Exam verification date  
 MedSchool-Transcript OU Tulsa School of Community Medicine (Schusterman Center)  
 MedSchool-Form 1 OU Tulsa School of Community Medicine (Schusterman Center)  
 PostGrad - Form 2 COLLEGE OF MEDICINE TULSA  
 USMLE Exams Incomplete

**Last Medical School Attended:**

039-06 OU Tulsa School of Community Medicine (Schusterman Center)

**Number of Licenses Previously Granted to Graduates of this Medical School:33**

Application for: Resident  Full License \_\_\_\_\_ Reinstatement \_\_\_\_\_

**The Secretary of the Board has reviewed this application and:**

1) AUTHORIZED CIRCULARIZATION TO OTHER BOARD MEMBERS \_\_\_\_\_

2) ALL FIVE CRITERIA HAVE BEEN MET [Fast Track] \_\_\_\_\_

- Passed USMLE
- No DUIs or Legal Issues
- No Significant Malpractice Issues
- US Graduate
- Graduated Medical School on time

3) HAS ISSUED A TEMPORARY LICENSE THROUGH \_\_\_/\_\_\_/\_\_\_

4) HAS ISSUED A SPECIAL PGY-1 TRAINING LICENSE Yes 6-8-23

5) REQUESTS SPECIFIC CONSIDERATION OF:

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# Oklahoma State Board of Medical Licensure and Supervision

## Application Summary

Type	Number	Name
MD	41382	MITCHELL LANE HOWE
MEDICAL DOCTOR		

**Incomplete Information (due to space limitations on this page, this may not be a complete list)**

OTHER DEFICIENCIES: NEED FORM 2 AND EVAL UPON COMPLETION OF TRAINING, MUST COME DIRECTLY FROM YOUR PROGRAM/ NEED QUESTIONNAIRE  
 PostGrad - Form 2 GREAT PLAINS FAMILY PRACTICE RESIDENCY

**Last Medical School Attended:**  
 039-01 Univ Of Ok Coll Of Med, Oklahoma City Ok 73190

**Number of Licenses Previously Granted to Graduates of this Medical School:7,357**

Application for: Resident \_\_\_\_\_ Full License \_\_\_\_\_ Reinstatement \_\_\_\_\_

**The Secretary of the Board has reviewed this application and:**

- 1) AUTHORIZED CIRCULARIZATION TO OTHER BOARD MEMBERS \_\_\_\_\_
  
- 2) ALL FIVE CRITERIA HAVE BEEN MET [Fast Track] \_\_\_\_\_
  - Passed USMLE
  - No DUIs or Legal Issues
  - No Malpractice Issues
  - US Graduate
  - Graduated Medical School in 4 years or less
  
- 3) HAS ISSUED A TEMPORARY LICENSE THROUGH \_\_\_ / \_\_\_ / \_\_\_
  
- 4) HAS ISSUED A SPECIAL PGY-1 TRAINING LICENSE \_\_\_\_\_





## Oklahoma State Board of Medical Licensure and Supervision Application Summary

<b>Type</b>	<b>Number</b>	<b>Name</b>
MD	41382	MITCHELL LANE HOWE
MEDICAL DOCTOR		

POST GRADUATE EDUCATION			
<b>Facility:</b> GREAT PLAINS FAMILY PRACTICE RESIDENCY		<b>Specialty:</b> FAMILY PRACTICE	
<b>Res. Fellowship:</b> Residency			
<b>City:</b> OKLAHOMA CITY		<b>State:</b> OK	<b>Country:</b> UNITED STATES OF AM
<b>Verified:</b>	<b>From:</b> 7 / 2023	<b>To:</b> /	
<b>ACGME Ver'd:</b>			
<b>Comments:</b>			

PRACTICE HISTORY			
<b>Employed:</b>	<b>Supervisor:</b>		
<b>City:</b>	<b>State:</b>	<b>Country:</b>	
<b>Specialty:</b>	<b>From:</b> /	<b>To:</b> /	<b>Verified:</b>
<b>Comments:</b>			

Other Licenses			
State	Lic Type and Number	Status Issued	Exp Verif

DEFICIENCIES
OTHER DEFICIENCIES: NEED FORM 2 AND EVAL UPON COMPLETION OF TRAINING, MUST COME DIRECTLY FROM YOUR PROGRAM/ NEED QUESTIONNAIRE PostGrad - Form 2 GREAT PLAINS FAMILY PRACTICE RESIDENCY



RETURN FORM TO:  
OKLAHOMA STATE BOARD OF MEDICAL LICENSURE AND SUPERVISION  
oktraining@okmedicalboard.org

RECEIVED

MAY 10 2024

OKLAHOMA STATE BOARD OF  
MEDICAL LICENSURE  
AND SUPERVISION

**QUESTIONNAIRE**

Please read and follow ALL instructions

**FORM INSTRUCTIONS:** Complete both pages of this form *only if* you are renewing or upgrading your training license. Attach the appropriate documentation and answer the confidential questions.

**PAYMENT INSTRUCTIONS:** If you **ARE FULLY LICENSED**, you **MUST** go online and renew your license – **DO NOT** pay your renewal fee via these instructions (doing so will delay your renewal).

**ATTESTATION STATEMENT:** By completing this document, I agree to pay the appropriate fee on **ONLINE BILL PAY**. If you are **UPGRADING** your training license to a full license, your fee will be \$250 & you will choose **MD TRAINING-TO-FULL**

If you are **RENEWING** your training license, your fee will be \$150 & you will choose **MD TRAINING LICENSE RENEWAL**

**PLEASE PRINT ALL INFORMATION**

FIRST NAME	Mitchell	LAST NAME	Howe
EMAIL ADDRESS	[REDACTED]		
LICENSE NUMBER	41382	CELL PHONE	[REDACTED]
HOME ADDRESS	[REDACTED]	CITY/STATE	[REDACTED]
PROGRAM ATTENDING	Tomas Owens	SPECIALTY	Family Medicine

**DOCUMENTATION TO ATTACH**

PAYMENT COMPLETED	
<input type="checkbox"/> \$150 payment made on Billpay for <b>RENEWAL</b> of training license	<input checked="" type="checkbox"/> \$250 payment made on Billpay for <b>UPGRADE</b> of training license

DOCUMENTATION REQUIRED	
<input checked="" type="checkbox"/> Form 2 (must be received directly from program) <b>**ONLY FOR UPGRADE</b>	<input checked="" type="checkbox"/> Evaluation (must be received directly from program)
<input checked="" type="checkbox"/> USMLE Step 3 (must be received directly from USMLE)	<input checked="" type="checkbox"/> Answer confidential questions (on back of this form)

FOREIGN TRAINED STUDENTS	
<input type="checkbox"/> Current visa	<input type="checkbox"/> Social Security Number <b>**if not provided at initial application</b>
<input type="checkbox"/> Background Check <b>**if not done at initial application</b>	

**IF YOU ARE FULLY LICENSED – DO NOT COMPLETE THIS FORM. YOU MUST GO ONLINE AND RENEW AT <https://pay.apps.ok.gov/medlic/md/login.php> ENTER YOUR LICENSE NUMBER & PIN – COMPLETE YOUR RENEWAL AND PAY THE RENEWAL FEE.**

RENEWAL QUESTIONNAIRE  
UPDATED 03-2024

41382  
57



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MAY 10 2024

OKLAHOMA STATE BOARD OF  
MEDICAL LICENSURE  
AND SUPERVISION

NAME Mitchell Howe, M.D.

IF YOU HAVE ANY "YES" ANSWERS YOU MUST PROVIDE A NOTARIZED STATEMENT EXPLAINING YOUR ANSWER.

SINCE RENEWAL OF YOUR TRAINING LICENSE OR INITIAL ISSUE OF YOUR TRAINING LICENSE (whichever is most recent)		
QUESTIONS	YES	NO
Have you failed any part of the USMLE exam (not previously disclosed)?	<input type="checkbox"/>	<input checked="" type="checkbox"/>
Have you been the subject of investigation or disciplinary action (including probation) by a hospital or training program?	<input type="checkbox"/>	<input checked="" type="checkbox"/>
Have you had any adverse judgment or settlement against you arising from a professional liability claim?	<input type="checkbox"/>	<input checked="" type="checkbox"/>
Have you been reported to the National Practitioner Data Bank (NPDB)?	<input type="checkbox"/>	<input checked="" type="checkbox"/>
Have you ever been denied, had removed, or suspended hospital privileges?	<input type="checkbox"/>	<input checked="" type="checkbox"/>
Have you surrendered hospital privileges while under investigation or to avoid investigation?	<input type="checkbox"/>	<input checked="" type="checkbox"/>
Have you entered into an Agreement with a Federal, State, or Local jurisdictional body to avoid formal action?	<input type="checkbox"/>	<input checked="" type="checkbox"/>
Has your application for licensure ever been denied?	<input type="checkbox"/>	<input checked="" type="checkbox"/>
Have you surrendered a license or had any disciplinary action taken on any license?	<input type="checkbox"/>	<input checked="" type="checkbox"/>
Have you been investigated by or requested to appear before a licensing or disciplinary agency (other than the Oklahoma State Board of Medical Licensure and Supervision)?	<input type="checkbox"/>	<input checked="" type="checkbox"/>
Have you obtained an assessment or been treated for use of any drug or chemical substance including alcohol?	<input type="checkbox"/>	<input checked="" type="checkbox"/>
Have you been arrested for, charged with, or convicted of a felony or misdemeanor other than a traffic violation?	<input type="checkbox"/>	<input checked="" type="checkbox"/>
Have you been arrested for, charged with, or convicted of a traffic violation involving the use of any drug or chemical substance?	<input type="checkbox"/>	<input checked="" type="checkbox"/>
Have you been addicted to or abused any drug or chemical substance including alcohol?	<input type="checkbox"/>	<input checked="" type="checkbox"/>
Have you been denied provider participation, terminated, sanctioned or penalized by any third-party payor including TRICARE, MEDICARE, or MEDICAID?	<input type="checkbox"/>	<input checked="" type="checkbox"/>
Have you surrendered or had any adverse action taken against any narcotic permit (State or Federal)?	<input type="checkbox"/>	<input checked="" type="checkbox"/>

I swear under penalty of perjury, that I am the person completing this Questionnaire and understand that any medical license procured or obtained by fraud or misrepresentation will result in disciplinary action taken against the licensee pursuant to the provisions of 59 O.S. § 508.

Signature Mitchell Howe, M.D.

Date 5/16/2024



**Oklahoma State Board of Medical Licensure and Supervision** Page 12 of 500

**APPLICATION FOR OKLAHOMA MEDICAL DOCTOR LICENSE**

Received:04/01/2023

Applicant Name: HOWE, MITCHELL LANE

MD 41382



Date Of Birth: [Redacted]

Place Of Birth (City, State): OKEENE, OK

Sex: M

Race: Caucasian

Education									
Type	Name	City	ST	Country	From	To	Degree	Comments	Veri
UG	SOUTHWESTERN OKLAHOMA STATE UNIVERSITY	WEATHERFC	OK		8/2015	5/2019	BACHELORS OF SCIENCE		
HS	OKEENE JR/SR HIGH SCHOOL	OKEENE	OK		8/2011	5/2015	HIGH SCHOOL DIPLOMA		

Medical School Name	City	State	Country	Comments	From	To
Univ Of Ok Coll Of Med, Oklahoma City Ok 73190	Oklahoma City	OK	United States		8/2019	5/2023

Post-Graduate							
Facility	City	St	Country	Specialty	Comments	From	To
			UNITED S			/	/

Practice History							
Employer	Specialty	Supervisor	City	ST Countr	From	To	Verif
						/	

Other/ Out-Of-State Licenses					
State	License #	Profession	Status	Issue Date	Exp Date

\$250

MD Exam				
Exam	State	Score	Date Taken	#
USMLE				

**APPLICATION FOR OKLAHOMA MEDICAL DOCTOR LICENSE**

Received:04/01/2023

<b>Questions Answered 03/24/2023</b>		<b>Response</b>
A.	Have you ever been denied provider participation, terminated, sanctioned, or penalized by any third party payor, to include TRICARE, MEDICARE, MEDICAID?	<b>N</b>
B.	Have you ever surrendered or had any adverse action taken against any narcotic permit (state or federal)?	<b>N</b>
C.	Have you ever been denied membership or had disciplinary action taken by a national, state or county professional organization?	<b>N</b>
D.	Have you ever been denied or had removed or suspended hospital staff privileges?	<b>N</b>
E.	Have you ever surrendered hospital staff privileges while under investigation or to avoid investigation?	<b>N</b>
F.	Have you ever entered into an agreement with a federal, state or local jurisdictional body to avoid formal action?	<b>N</b>
G.	Have you ever been the subject of an investigation, probation or disciplinary action by a hospital, clinic, practice group, training program or professional school?	<b>N</b>
H.	Have you had any adverse judgment, settlement, or award against you arising from a professional liability claim?	<b>N</b>
I.	Have you ever had professional liability coverage declined, canceled, issued on special terms, or renewal refused?	<b>N</b>
J.	Have you ever been reported to the National Practitioners Data Bank (NPDB) or to the Healthcare Integrity and Protection Data Bank (HIPDB)? (If yes, enclose a copy of the report.)	<b>N</b>
K.	Has your application for examination or a professional license ever been denied?	<b>N</b>
L.	Have you ever failed any part of a licensure/certification/registration examination?	<b>N</b>
M.	Have you ever surrendered a license or had a license revoked?	<b>N</b>
N.	Has any disciplinary action been taken on any license?	<b>N</b>
O.	Have you ever been subject of a review by professional licensing/regulatory agency based on a complaint filed against you?	<b>N</b>
P.	Have you ever been arrested, charged with, or convicted of a felony or misdemeanor, other than traffic violations?	<b>N</b>
Q.	Have you ever been arrested, charged with, or convicted of a traffic violation involving the use of any drug or chemical substance, including alcohol?	<b>N</b>
R.	Are you now or have you within the past two years been addicted to or used in excess any drug or chemical substance, including alcohol?	<b>N</b>
S.	Have you obtained an assessment or been treated for the use of any drug or chemical substance, including alcohol?	<b>N</b>
T.	Do you currently have or have you had within the past two years any mental or physical disorder or condition which, if untreated, could affect your ability to practice competently?	<b>N</b>
U.	Are you or your spouse currently on Active Duty in the U.S. Armed Forces?	<b>N</b>
V.	Are you or your spouse currently Deployed on Active Duty in the U.S. Armed Forces?	<b>N</b>



If licensed, where do you intend to locate?

OK

Why do you seek Licensure in the state of Oklahoma?

Post-Graduate Training

In what manner will you be communicating with your Oklahoma patients (telephone, email, internet, video-conference, etc)?

Describe how you will examine each patient in person prior to diagnosis, treating, correcting, or prescribing for a patient in Oklahoma from the state, province, or country you are located:

Describe the manner in which you intend to practice medicine across state lines in Oklahoma:

Have you executed or been offered a contract in connection with practice in the state of Oklahoma?

Yes

If 'Yes', Name of practice:

Integris Great Plains Family Medicine

If so, Please identify with which category:

Residency

Name of Previous Carrier and Policy Holder

N.A.

Name of Current Carrier and policy Holder

N.A.

Will your professional liability insurance policy cover your practice in Oklahoma

No

If NO, when do you expect to obtain liability insurance that will cover practice in Oklahoma

06/2023

I attest that all the above information is accurate as of March 31, 2023; \_\_\_\_\_ (Signed Online) \_\_\_\_\_



**Applicant:** In the presence of a notary public, sign this form with attached photo.

Send this form to: Oklahoma State Board of Medical Licensure and Supervision

**oktraining@okmedicalboard.org**

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

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

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

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

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

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



*Mitchell Howe*

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

Howe Mitchell L.

Applicants printed last name, first name, middle initial, and suffix (e.g., Jr.)

03-31-2023

Date of signature (must correspond to the date of notarization)

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APR 06 2023

OKLAHOMA STATE BOARD OF MEDICAL LICENSURE AND SUPERVISION

**NOTARY**

State of Oklahoma, County of Grady



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

The statements on this document are subscribed and sworn to before me by the applicant on this 31 day of March, 2023

Notary Public Signature Lisa Lamar My Notary Commission Expires 2/28/27

NOTARY SEAL

T41382 WB





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

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

PRIMARY  
SOURCE

**Recipient:** OKLAHOMA STATE BOARD OF  
MEDICAL LICENSURE & SUPERVISION

**Date:** 05/06/2024

**Examinee:** Howe, Mitchell Lane  
**Alt Name(s):**

**Examinee ID:** 5-476-283-6  
**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. Pass/fail outcomes are based upon the minimum passing level in place at the time of test administration and are not altered by subsequent revisions to the minimum passing level. Effective April 1, 2013, two-digit scores will no longer be reported. Test results reported as passing represent an exam score of 75 or higher on a two-digit scale. Step 1 examinations taken on or after January 26, 2022 are reported as pass/fail, with no numeric score; Step 1 examinations taken before January 26, 2022 will continue to be reported with a 3-digit score.

### USMLE STEP 1

Test Date	Pass/Fail	Score	Minimum Pass	Comments
06/04/2021	Pass	243	(194)	

### USMLE STEP 2

#### *Clinical Knowledge (CK)*

Test Date	Pass/Fail	Score	Minimum Pass	Comments
07/25/2022	Pass	237	(214)	

### USMLE STEP 3

Test Date	Pass/Fail	Score	Minimum Pass	Comments
01/26/2024	Pass	226	(200)	

#### End of Exam History

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

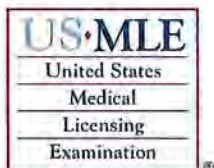
NOTE: A search of the Physician Data Center of the Federation of State Medical Boards (FSMB) reveals no reported information on this examinee.

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MAY 07 2024

OKLAHOMA STATE BOARD OF  
MEDICAL LICENSURE  
AND SUPERVISION

T4382  
57



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

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

**Examinee:** Howe, Mitchell Lane

**Examinee ID:** 5-476-283-6

**Date of Birth:** [REDACTED]

### INTERPRETATION OF RESULTS

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

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

### STEP 1 AND STEP 2 CLINICAL SKILLS (CS)

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

### ANNOTATIONS APPEARING UNDER "COMMENTS"

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

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

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

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

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

### ANNOTATIONS APPEARING AS "NOTE"

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

### PHYSICIAN DATA CENTER INFORMATION APPEARING AS "NOTE"

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

03/2015

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



Oklahoma State Board of Medical Licensure and Supervision
101 NE 51st Street
Oklahoma City, OK 73105

This form must be completed by the institution and mailed directly from the institution.

Applicant's Name Mitchell Howe

Institution: University of Oklahoma College of Medicine City/State Oklahoma City, OK

Our records indicate that the above named applicant attended our medical school on the following dates:

From 8 / 19 / 2019 To 5 / 20 / 2023 and was awarded the degree Doctor of Medicine

- 1. Does this individual's official record reflect (an) interruption(s) or extension(s) in his/her medical education? If yes, please explain. YES NO
2. Does this individual's official record reflect that he/she was ever placed on academic or disciplinary probation during his/her medical education? If yes, please explain. YES NO
3. Does this individual's official record reflect that he/she was ever the subject of negative reports for behavioral reasons or an investigation by the medical school or parent university? If yes, please explain below. YES NO
4. Does this individual's official record reflect that he/she was ever disciplined for unprofessional conduct/behavioral reasons by the medical school or parent university? If yes, please explain below. YES NO
5. Does this individual's official record reflect that there were any limitations or special requirements imposed on the individual because of questions of academic incompetence, disciplinary problems, or any other reason? If yes, please explain below. YES NO

Please explain any "YES" response from above:

Completion of the following is certification that the information above is an accurate account of this individual's records and is true and correct.

Name: Teresa Scordino, M.D. Signature [Handwritten Signature]

Title of Signatory: Associate Dean for Student Affairs Date of Signature 5/31/23

Tel: 405-271-2316 Fax: 405-271-2287 E-Mail: Teresa-Scordino@ouhsc.edu

If no seal is available, this form must be notarized

School Seal

Notary Public

Commission #

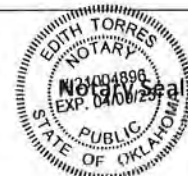
My commission expires:

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JUN 08 2023

OKLAHOMA STATE BOARD OF MEDICAL LICENSURE AND SUPERVISION

PRIMARY SOURCE



Handwritten number 741382 59



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Official Transcript

University of Oklahoma Health Sciences Center  
P. O. Box 26901  
Oklahoma City, OK 731260901  
United States

JUN 08 2023  
OKLAHOMA STATE BOARD OF  
MEDICAL LICENSURE  
AND SUPERVISION

Name : Mitchell Howe  
Student ID: 1798175  
Birthdate : [REDACTED]

T41382  
59

PRIMARY SOURCE

Degrees Awarded -----  
Degree : Doctor of Medicine  
Confer Date : 2023-05-20  
Plan : Medicine

Spring 2020 (cont.)  
TERM GPA : 0.000 GPH: 0.00 TOTALS : 315.00 315.00 0.000  
OUHSC GPA : 0.000 GPH: 0.00 TOTALS : 834.50 834.50 0.000

----- Academic Program History -----  
Program : Medicine MD  
2019-07-01 : Active in Program  
2019-07-01 : Medicine - MD Major  
2023-05-20 : Completed Program  
----- Beginning of Medicine Record -----

Fall 2020  

Course	Description	Attempted	Earned	Grade	Points
INDT 8264	Cardiovasc, Resp, Renal	164.00	164.00	S	
INDT 8266	PPS II: Clinical Ethics	35.00	35.00	S	
INDT 8272	Neurosciences	166.00	166.00	S	
INDT 8275	Clinical Medicine II	99.00	99.00	S	
INDT 8301	Enrichment Program: Humanities	16.00	16.00	S	

Fall 2019  

Course	Description	Attempted	Earned	Grade	Points
INDT 8110	Design/Analysis Clin Res	16.00	16.00	S	
INDT 8122	Clinical Medicine I	111.50	111.50	S	
INDT 8124	The Human Structure	130.00	130.00	S	
INDT 8125	Foundations of Medicine	151.00	151.00	S	
INDT 8244	PPSI	87.00	87.00	S	
INDT 8555	Req Orientation Documents I			0.00	CE
INDT 9100	Prologue	24.00	24.00	S	

  
TERM GPA : 0.000 GPH: 0.00 TOTALS : 519.50 519.50 0.000  
OUHSC GPA : 0.000 GPH: 0.00 TOTALS : 519.50 519.50 0.000

Course Topic(s): Spirituality & Medicine  
TERM GPA : 0.000 GPH: 0.00 TOTALS : 480.00 480.00 0.000  
OUHSC GPA : 0.000 GPH: 0.00 TOTALS : 1314.50 1314.50 0.000

Spring 2020  

Course	Description	Attempted	Earned	Grade	Points
INDT 8132	IMI	68.00	68.00	S	
INDT 8140	Gastrointestinal & Hepatobil	85.00	85.00	S	
INDT 8148	Endo, Metab & Nutri Biochem	85.00	85.00	S	
INDT 8156	Blood, Hematopoiesis & Lymph	77.00	77.00	S	

Spring 2021  

Course	Description	Attempted	Earned	Grade	Points
INDT 8280	Reproduction	98.00	98.00	S	
INDT 9200	MS2 Capstone	70.00	70.00	S	
INDT 9201	Joint, Skin, and Bone	40.00	40.00	S	

  
TERM GPA : 0.000 GPH: 0.00 TOTALS : 208.00 208.00 0.000  
OUHSC GPA : 0.000 GPH: 0.00 TOTALS : 1522.50 1522.50 0.000

Summer II 2021  

Course	Description	Attempted	Earned	Grade	Points
INDT 9301	Clinical Transitions	40.00	40.00	S	
PEDI 9650	Pediatric Clerkship	240.00	240.00	A	960.000
ORL 9101	Otorhinolaryngology Selective	80.00	80.00	S	

This official transcript is printed on burgundy security paper. A laser-produced signature of the Registrar, OUHSC is imprinted on each page in black ink. A raised seal is not required. When photocopied, the word COPY should appear. A BLACK AND WHITE OR COLOR COPY OF THIS TRANSCRIPT SHOULD NOT BE ACCEPTED.

This information is released in accordance with the Family Education Privacy Act of 1974 and is also released under the condition that other parties will not have access to this information without the student's written consent.



*Lou Klein*

REGISTRAR, OUHSC



**UNIT OF CREDIT:** The unit of credit for undergraduate and graduate courses is the semester hour. Prior to Summer 2002, the unit of credit for professional courses is the clock hour. The unit of credit for the College of Medicine (MD) is the clock hour. Each course taken at OUHSC is recorded on the student's transcript including courses passed, failed, repeated, exempted, audited, etc. All course work is residence credit unless otherwise indicated.

**GRADES USED AT OUHSC:**

**Grades Used in the Calculation of Grade Point Average (GPA)**

- A = Excellent (4 grade points)
- B = Good (3 grade points)
- C = Average (2 grade points)
- D = Poor (1 grade point) not considered passing in some programs
- F = Failing (0 grade points)

**Other Symbols**

- I = Incomplete (student lacks a test, project, paper, etc.)
- AU = Audit (no credit)
- W = Withdrawal
- AW = Administrative Withdrawal
- S = Satisfactory (GPA neutral, counted in the total number of attempted hours)
- U = Unsatisfactory (GPA neutral, counted in the total number of attempted hours)
- P = Passing (GPA neutral, counted in the total number of attempted hours)
- NP = No Pass (GPA neutral, counted in the total number of attempted hours)
- X = Graduate thesis or dissertation in progress (GPA neutral)

**Program Specific Symbols**

- CE = Continuing Education
- EX = Exempt from a required course, student has earned equivalent credit
- R = Requirements successfully completed
- Y = Year-Long Course
- H = College of Medicine Honors (GPA neutral, counted in total number of attempted hours)

**FULL-TIME COURSE LOAD:**

- Summer (Undergraduate) = 6 semester hours
- Summer (Graduate) = 4 semester hours
- Fall (Undergraduate) = 12 semester hours
- Fall (Graduate) = 9 semester hours
- Spring (Undergraduate) = 12 semester hours
- Spring (Graduate) = 9 semester hours

Professional students are considered full-time unless otherwise indicated.

**NORMAN/OKLAHOMA CITY/TULSA SCHUSTERMAN CAMPUSES:** Transcripts for all undergraduate and graduate students who were enrolled at OUHSC prior to Fall 1979 are located in the Office of Admissions and Records on the Norman campus. Work completed on the Norman campus prior to enrollment at OUHSC is maintained on the Norman campus.

Regardless of campus, copies of OUHSC records may be obtained through the transcript request process at the OUHSC Office of Admissions and Records, 1105 N. Stonewall, LIB 121, Oklahoma City, OK 73117-1221. Questions regarding the transcript request process may be directed to (405) 271-2359 or FAX (405) 271-2480.

**TERM DEFINITIONS:**

- Summer = 8 weeks in length
- Summer I = 8 weeks in length
- Summer II = 7-8 weeks in length
- Fall = 16 weeks in length
- Spring = 16 weeks in length

**TRANSCRIPT SUMMARY:**

- Career totals
- Transfer statistics (if posted)
- OUHSC statistics
- Combined statistics

**COURSE NUMBER:**

- 1000 – 1999 = Freshman level courses
- 2000 – 2999 = Sophomore level courses
- 3000 – 3999 = Junior level courses
- 4000 – 4999 = Senior level courses
- 5000 – 6999 = Graduate level courses
- 5000 – 5999 = Bachelor degree program in College of Pharmacy Undergraduate level courses
- 7000 – 9999 = Professional degree courses

**DEGREE HONORS:**

- Distinction
- Special Distinction
- Outstanding Distinction

OUHSC recognizes honors for degrees conferred by the Colleges of Allied Health, Dentistry, Medicine, Nursing, and Pharmacy.

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**JUN 08 2023**

**OKLAHOMA STATE BOARD OF  
MEDICAL LICENSURE  
AND SUPERVISION**

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Official Transcript

University of Oklahoma Health Sciences Center
P. O. Box 26901
Oklahoma City, OK 731260901
United States

JUN 08 2023

Name : Mitchell Howe
Student ID: 1798175
Birthdate :

OKLAHOMA STATE BOARD OF
MEDICAL LICENSURE
AND SUPERVISION

PRIMARY SOURCE

Summer II 2021 (cont.)

TERM GPA : 4.000 GPH: 240.00 TOTALS : 360.00 360.00 960.000
OUHSC GPA : 4.000 GPH: 240.00 TOTALS : 1882.50 1882.50 960.000

Fall 2021

Course Description Attempted Earned Grade Points
MED 9250 Medicine Clerkship 320.00 320.00 B 960.000
SURG 9760 Surgery Clerkship 320.00 320.00 B 960.000
TERM GPA : 3.000 GPH: 640.00 TOTALS : 640.00 640.00 1920.000
OUHSC GPA : 3.273 GPH: 880.00 TOTALS : 2522.50 2522.50 2880.000

Spring 2022

Course Description Attempted Earned Grade Points
EM 9101 EM Selective 80.00 80.00 S
OPHT 9101 Ophthalmology Selective 80.00 80.00 S
FM 9540 Fam Med Clerkship 160.00 160.00 A 640.000
NEUR 9370 Neurology Clerkship 160.00 160.00 A 640.000
PSBS 9520 Psychiatry Clerkship 240.00 240.00 B 720.000
OBGY 9210 Obstet & Gyn Clerkship 240.00 240.00 A 960.000
TERM GPA : 3.700 GPH: 800.00 TOTALS : 960.00 960.00 2960.000
OUHSC GPA : 3.476 GPH: 1680.00 TOTALS : 3482.50 3482.50 5840.000

Summer II 2022

Course Description Attempted Earned Grade Points
INDT 9300 Capstone 160.00 160.00 S
INDT 9403 Subinternship Elective 160.00 160.00 A 640.000
Course Topic(s): FM Subinternship Elective

Summer II 2022 (cont.)

TERM GPA : 4.000 GPH: 160.00 TOTALS : 320.00 320.00 640.000
OUHSC GPA : 3.522 GPH: 1840.00 TOTALS : 3802.50 3802.50 6480.000

Fall 2022

Course Description Attempted Earned Grade Points
INDT 9403 Subinternship Elective 160.00 160.00 A 640.000
Course Topic(s): FM Subinternship Elective
INDT 9407 Fourth Year Selective 160.00 160.00 S
Course Topic(s): Pharmacology Readings
Pharmacology Readings

Course Description Attempted Earned Grade Points
DERM 9101 Dermatology Selective 80.00 80.00 S
TERM GPA : 4.000 GPH: 160.00 TOTALS : 400.00 400.00 640.000
OUHSC GPA : 3.560 GPH: 2000.00 TOTALS : 4202.50 4202.50 7120.000

Spring 2023

Course Description Attempted Earned Grade Points
ANES 9110 Anesthesiology Selective 80.00 80.00 S
INDT 9406 Special Studies Elective 160.00 160.00 S
Course Topic(s): INDT Special Studies Elective
UROL 9101 Urology Selective 80.00 80.00 S
INDT 9406 Special Studies Elective 80.00 80.00 S
Course Topic(s): INDT Special Studies Elective
INDT 9402 Mixed In/Outpatient Elective 160.00 160.00 S
Course Topic(s): RADi Mixed In/Outpatient Elect
INDT 9407 Fourth Year Selective 80.00 80.00 S
TERM GPA : 0.000 GPH: 0.00 TOTALS : 640.00 640.00 0.000
OUHSC GPA : 3.560 GPH: 2000.00 TOTALS : 4842.50 4842.50 7120.000

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Law Klein

REGISTRAR, OUHSC



**UNIT OF CREDIT:** The unit of credit for undergraduate and graduate courses is the semester hour. Prior to Summer 2002, the unit of credit for professional courses is the clock hour. The unit of credit for the College of Medicine (MD) is the clock hour. Each course taken at OUHSC is recorded on the student's transcript including courses passed, failed, repeated, exempted, audited, etc. All course work is residence credit unless otherwise indicated.

**GRADES USED AT OUHSC:**

**Grades Used in the Calculation of Grade Point Average (GPA)**

- A = Excellent (4 grade points)
- B = Good (3 grade points)
- C = Average (2 grade points)
- D = Poor (1 grade point) not considered passing in some programs
- F = Failing (0 grade points)

**Other Symbols**

- I = Incomplete (student lacks a test, project, paper, etc.)
- AU = Audit (no credit)
- W = Withdrawal
- AW = Administrative Withdrawal
- S = Satisfactory (GPA neutral, counted in the total number of attempted hours)
- U = Unsatisfactory (GPA neutral, counted in the total number of attempted hours)
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- NP = No Pass (GPA neutral, counted in the total number of attempted hours)
- X = Graduate thesis or dissertation in progress (GPA neutral)

**Program Specific Symbols**

- CE = Continuing Education
- EX = Exempt from a required course, student has earned equivalent credit
- R = Requirements successfully completed
- Y = Year-Long Course
- H = College of Medicine Honors (GPA neutral, counted in total number of attempted hours)

**FULL-TIME COURSE LOAD:**

- Summer (Undergraduate) = 6 semester hours
- Summer (Graduate) = 4 semester hours
- Fall (Undergraduate) = 12 semester hours
- Fall (Graduate) = 9 semester hours
- Spring (Undergraduate) = 12 semester hours
- Spring (Graduate) = 9 semester hours

Professional students are considered full-time unless otherwise indicated.

**NORMAN/OKLAHOMA CITY/TULSA SCHUSTERMAN CAMPUSES:** Transcripts for all undergraduate and graduate students who were enrolled at OUHSC prior to Fall 1979 are located in the Office of Admissions and Records on the Norman campus. Work completed on the Norman campus prior to enrollment at OUHSC is maintained on the Norman campus.

Regardless of campus, copies of OUHSC records may be obtained through the transcript request process at the OUHSC Office of Admissions and Records, 1105 N. Stonewall, LIB 121, Oklahoma City, OK 73117-1221. Questions regarding the transcript request process may be directed to (405) 271-2359 or FAX (405) 271-2480.

**TERM DEFINITIONS:**

- Summer = 8 weeks in length
- Summer I = 8 weeks in length
- Summer II = 7-8 weeks in length
- Fall = 16 weeks in length
- Spring = 16 weeks in length

**TRANSCRIPT SUMMARY:**

- Career totals
- Transfer statistics (if posted)
- OUHSC statistics
- Combined statistics

**COURSE NUMBER:**

- 1000 – 1999 = Freshman level courses
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Official Transcript

University of Oklahoma Health Sciences Center  
P. O. Box 26901  
Oklahoma City, OK 731260901  
United States

Name : Mitchell Howe  
Student ID: 1798175  
Birthdate : [REDACTED]

Medicine Career Totals

Ouhsc GPA : 3.560 GPH: 2000.00 TOTALS : 4842.50 4842.50 7120.000

Post-Baccalaureate Career Totals

Ouhsc GPA : 3.560 GPH: 125.00 TOTALS : 302.65 302.65 445.000

----- End Of Career (1 of 1) -----

----- End Of Transcript -----

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PRIMARY  
SOURCE

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*Lou Klein*

REGISTRAR, OUHSC

THE UNIVERSITY OF OKLAHOMA HEALTH SCIENCES CENTER

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# AMA Physician Profile

PREPARED FOR

Oklahoma State Board of Licensure & Supervision, Oklahoma City, OK

PRIMARY SOURCE

**Name and Mailing Address**

MITCHELL LANE HOWE

**Primary Office Address**

**Phone** UNKNOWN

**Birth date**

**Physician's major professional activity**

HOSPITAL BASED RESIDENTS - ALL YEARS

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**AMA membership status**

MEMBER

MAY 22 2024

OKLAHOMA STATE BOARD OF MEDICAL LICENSURE AND SUPERVISION

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

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

NO DATA REPORTED AT THIS TIME

**Current and/or historical medical school**

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

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

**School:** UNIVERSITY OF OKLAHOMA COLLEGE OF MEDICINE

**Degree Awarded:** YES  
**Enrollment Date:** 08/2019

**Degree Type:** MD  
**Degree Date:** 05/2023

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

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

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

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

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

**Sponsoring Institution:** INTEGRIS HEALTH  
**Sponsoring State:** OKLAHOMA  
**Program name:** INTEGRIS HEALTH/GREAT PLAINS PROGRAM  
**Specialty:** FAMILY MEDICINE  
**Training Type:** SPECIALTY  
**Dates:** 07/01/2023 - 06/30/2026  
**Status:** TRAINING IN PROGRESS

### Specialty board certification

NO DATA REPORTED AT THIS TIME

### Current and/or historical medical licensure

License Number	MD / DO	Locale	Date Granted	Expiration Date	Renewal Date	Status	License Type	Last Reported	Name on License
41382	MD	OK	07/01/2023	09/30/2024		ACT	RES	05/06/2024	MITCHELL LANE HOWE

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

#### Action notifications reported to the AMA

**Medical Licensing Boards:** NO ACTIONS REPORTED AT THIS TIME

**Medicare/Medicaid Sanctions from DHHS:** NO ACTIONS REPORTED AT THIS TIME

**US DOJ Drug Enforcement Administration:** NO ACTIONS REPORTED AT THIS TIME

#### U.S. Drug Enforcement Administration (DEA)

NO DATA REPORTED AT THIS TIME

#### ECFMG certification

NOT APPLICABLE

#### Profile information

The content of the AMA Physician Profile is for credentialing use only. The content cannot be used or assembled for an employment purpose as defined under the Fair Credit Reporting Act. An organization's appropriate use of the data contained in the AMA Physician Professional Data™, formerly known as AMA Physician Masterfile, meets select primary source verification requirements of the Joint Commission, the Accreditation Association for Ambulatory Health Care (AAAHC) and the American Accreditation Health Care Commission (AAHCC)/ Utilization Review Accreditation Commission (URAC). The AMA Physician Professional Data is also an NCQA-approved source for verification of medical school, post-graduate medical training, ABMS Board Certification and federal DEA registration.

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

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



**OKLAHOMA STATE BOARD OF MEDICAL LICENSURE AND SUPERVISION  
EVIDENCE OF STATUS – PART A**

**NOTARIZED FORM CAN BE EMAILED TO OKTRAINING@OKMEDICALBOARD.ORG**

Full Legal Name: Mitchell Lane Howe Maiden (if applicable)

Mailing Address: [REDACTED]

[REDACTED] Social Security #: [REDACTED]

City State Zip Code Telephone Number

**PRIMARY EVIDENCE OF CITIZENSHIP  
(FOR US CITIZENS, US NATIONALS, OR PERMANENT LEGAL RESIDENT ALIENS)**

If you are a U.S. citizen, U.S. national, or permanent legal resident alien, please attach a photocopy of one of the following documents to this form. Place a checkmark below to indicate the document that is attached.

- A birth certificate showing birth in one of the 50 States, the District of Columbia, Puerto Rico (on or after January 13, 1941), Guam, the U.S. Virgin Islands (on or after January 17, 1917), American Samoa, Swain's Island or the Northern Mariana Islands, unless the person was born to foreign diplomats residing in the U.S.
- United States passport** (except limited passports, which are issued for periods of less than five years)
- Report of birth abroad of a U.S. citizen (FS-240)** (issued by the Department of State to U.S. citizens)
- Certificate of birth (FS-545)** (issued by a foreign service post); or **Certification of Report of Birth (DS1350)** (issued by the Department of State), copies available from the Department of State
- Certificate of Naturalization (N-550 or N-570)** (issued by the INS through a Federal or State court, or through administrative naturalization after December 1990 to individuals who are individually naturalized; the N570 is a replacement certificate issued when the N-550 has been lost or mutilated or the individual's name has been changed)
- Certificate of Citizenship (N-560 or N-561)** (issued by the INS to individuals who derive U.S. citizenship through a parent; the N-561 is a replacement certificate issued when the N-560 has been lost or mutilated or the individual's name has been changed)
- United States Citizen Identification Card (I-197)** (issued by the INS until April 7, 1983 to U.S. citizens living near the Canadian or Mexican border who needed it for frequent border crossing) (formerly Form I-179, last issued in February 1974)
- Northern Mariana Identification Card** (issued by the INS to a collectively naturalized citizen of the U.S. who was born in the Northern Mariana Islands before November 3, 1986)
- Statement provided by a U.S. consular officer certifying that the individual is a U.S. citizen** (This is given to an individual born outside the U.S. who derives citizenship through a parent but does not have an FS-240, FS-545 or DS-1350);
- American Indian Card with a classification code "KIC" and a statement on the back** (identifying U.S. citizen members of the Texas Band of Kickapoos living near the U.S./Mexican border.)
- Alien Lawfully Admitted for Permanent Residence:**  
**INS Form I-551 (Alien Registration Receipt Card, commonly known as a "green card")**
- Alien Lawfully Admitted for Permanent Residence:**  
**Unexpired Temporary I-551 stamp in foreign passport or on INS Form I-94**

I declare under penalty of perjury, under the laws of the State of Oklahoma, that all information contained in this application and all accompanying documents provided to substantiate my Evidence of Status application are true and correct.

Signature Mitchell Lane Howe Date 03-31-2023

Subscribed and sworn before me this 31 day of March, 20 23.

Notary Public Alea Senier

Commission Number 19002004

My commission expires 2/25/27

NOTARY SEAL



T 41382  
VB

**OKLAHOMA STATE BOARD OF MEDICAL LICENSURE AND SUPERVISION**  
**101 NE 51<sup>ST</sup> STREET**  
**OKLAHOMA CITY OK 73105**  
 Phone: (405)962-1400 Fax: (405)962-1440 email: oktraining@okmedicalboard.org

To Request Examination Scores	
For National Board Scores National Board of Medical Examiners PO Box 48014 Newark, NJ 07101-4814 (215) 590-9500 www.NBME.org	For FLEX or USMLE Scores Federation of State Medical Boards 400 Fuller Wiser Road Euless, TX 76039-3855 (817) 868-4000 www.FSMB.org

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 APR 06 2023  
 OKLAHOMA STATE BOARD OF  
 MEDICAL LICENSURE  
 AND SUPERVISION

6. **Extended Background Check** – Applicants for licensure are required to request an Extended Background Check.
  7. **Evidence of Status Form** - In order to verify citizenship or qualified alien status, applicants for licensure by endorsement or examination or for reinstatement of their license, must submit an Evidence of Status Form and the required supporting documentation with their application. This form must be notarized and mailed to the office.
  8. **Photo and Oath Form** – Applicants for licensure will be required to complete the Photo and Oath Form. This form must be notarized and mailed to the office.
  9. **Telemedicine Form** – Applicants planning to practice telemedicine must submit the initialed and signed Telemedicine Questionnaire.
  10. **English Proficiency Exam** – Foreign applicants shall have a command of the English language that is satisfactory to the Board, demonstrated by the passage of an oral English competency exam. Applicant is required to call 405-962-1400 and speak with an application analyst in licensing.
- G. Temporary Licensure (59 O.S. § 493.3)** – The Board may authorize the Secretary to issue a Temporary Medical License for the intervals between Board meetings. Such Temporary License shall be granted only when the Secretary is satisfied as to the qualifications of the applicant to be licensed under this Act but where such qualifications have not been verified to the Board. An application for Temporary Licensure must be made by written request and include all appropriate fees. Such a license shall:
1. Be granted only to an applicant demonstrably qualified for a full and unrestricted medical license;
  2. Automatically terminate on the date of the next Board meeting at which the applicant may be considered for a full and unrestricted medical license.
  3. We must be in receipt of the following in order for the Board Secretary to consider issuing a Temporary License:
    - a. Examination scores, and
    - b. Verification of licensure in all jurisdictions in which applicant has been licensed to practice medicine and surgery, and
    - c. Evidence of Status, and
    - d. Extended Background Check

**I, the undersigned, have fully read and understand the instructions. I swear or affirm that the information submitted in and with the application is, to the best of my knowledge, true and factual. I understand that attempts to deceive or fraudulently portray information contained herein may result in cancellation of my application or charges of filing a fraudulent application that may result in subsequent revocation of licensure.**

Mitchell Howe                      Mitchell Howe                      03-31-2023  
 Name of Applicant (type or print)                      Signature of Applicant                      Date

**Except as specifically may be waived by the Board, the Board shall not engage in any application process with any agent or representative of the applicant. 59 O.S. § 492.1 (C); Okla. Admin. Code § 435:10-4-1(c)**

**Please return these signed instructions by mail to the address at the top of the page or email.**

T 41382  
 VB



**Kenna L. Shaw**

---

**From:** BillPay Webmaster <donotreply@www.ok.gov>  
**Sent:** Monday, May 6, 2024 4:09 PM  
**To:** Dela Kwetey; Bill Pay; Sheila E. Brumfield; Chris Maloney; Licensing; Arlene Morris; Debra Reich  
**Subject:** [EXTERNAL] LICENSE - MD Training-to-Full License Fee 250.00 - Payment Made

MITCHELL LANE HOWE has paid for a LICENSE - MD Training-to-Full License Fee 250.00 on 05/06/2024 04:05:08pm for \$250.00.

OKLAHOMA MD LICENSE NUMBER 41382

To view all transactions please go to <http://www.ok.gov/triton/> and login to your CMS account.

T 41382  
KS

## TIME DEFICIENCY FORM

Name:	Mitchell Howe	Application #	
-------	---------------	---------------	--

This document is used a tool to help you complete your application.  
Please note: we have to account for any/all time from your 18th birthday to present.

EDUCATION STARTING WITH HIGH SCHOOL							
Start Month	Start Year	End Month	End Year	Name of Institution	City	State	Degree
08	2011	05	2015	Okeene High School	Okeene	OK	High School Diploma
08	2015	05	2019	Southwestern Oklahoma State University	Weatherford	OK	B.S.
08	2019	05	2023	University of Oklahoma College of Medicine	OKC	OK	M.D.
EMPLOYMENT IF NEEDED TO FILL TIME GAP							
Start Month	Start Year	End Month	End Year	Name of Employer	City	State	Job Title
OTHER - UNEMPLOYED, STAY AT HOME PARENT, SUMMER BREAK, TRAVELING							
Start Month	Start Year	End Month	End Year	Other	City	State	
05	2015	08	2015	Summer Break	Okeene	OK	
05	2019	08	2019	summer Break	Weatherford	OK	

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APR 06 2023

OKLAHOMA STATE BOARD OF  
MEDICAL LICENSURE  
AND REGULATIONT-41382  
WB



05/02/2023

MITCHELL LANE HOWE

**Check Your Application  
Status Online at:**  
<http://www.okmedicalboard.org>  
**Username:AP62708738**  
**Password:Last 4 SSN**

RE: MD Application #41382

Dear MITCHELL HOWE,

**YOU CANNOT PRACTICE YOUR PROFESSION IN THE STATE OF OKLAHOMA UNTIL A VALID LICENSE HAS BEEN ISSUED.**

Your training application has been processed and the current deficiencies are listed below. Please be advised, these may not be the only deficiencies. You will be advised if any other deficiencies are added. You may check your application status online by logging in with the username and password provided above.

If you have further questions please email [oktraining@okmedicalboard.org](mailto:oktraining@okmedicalboard.org)

If a "Time Deficiency" is listed, please complete a time deficiency form and e-mail the document to [oktraining@okmedicalboard.org](mailto:oktraining@okmedicalboard.org) with your activities during the specified time frame.

MedSchool-Form 1 Univ Of Ok Coll Of Med, Oklahoma City Ok 73190  
PostGrad - Form 2 GREAT PLAINS FAMILY PRACTICE RESIDENCY  
USMLE Exams Incomplete  
OTHER DEFICIENCIES: FCVS  
Exam verification date  
MedSchool-Transcript Univ Of Ok Coll Of Med, Oklahoma City Ok 73190

Any of the required forms in the list above may be downloaded from our website:

<http://www.okmedicalboard.org/resources>

In order to check on the status of your application, please log on to our web site:

<https://secure.okmedicalboard.org/applicant/signin>

Your user name is AP62708738 (all caps and no spaces) and your password is the last 4 digits of your social security number.

If you did not provide a social security number with your application, your password will be your 4-digit year of birth in the form "YYYY".

If we may be of further assistance, please email.

[oktraining@okmedicalboard.org](mailto:oktraining@okmedicalboard.org)

Sincerely,

*Valeska Barr*

Valeska Barr

Dept. of Licensing

Encl



# Oklahoma State Board of Medical Licensure and Supervision Application Summary

Type      Number      Name  
MD          41382      MITCHELL LANE HOWE  
MEDICAL DOCTOR

**Incomplete Information (due to space limitations on this page, this may not be a complete list)**

Exam verification date  
PostGrad - Form 2 GREAT PLAINS FAMILY PRACTICE RESIDENCY  
USMLE Exams Incomplete

**Last Medical School Attended:**  
039-01 Univ Of Ok Coll Of Med, Oklahoma City Ok 73190  
  
Number of Licenses Previously Granted to Graduates of this Medical School:7,275

Application for: Resident  Full License \_\_\_\_\_ Reinstatement \_\_\_\_\_

**The Secretary of the Board has reviewed this application and:**

1) AUTHORIZED CIRCULARIZATION TO OTHER BOARD MEMBERS \_\_\_\_\_

2) ALL FIVE CRITERIA HAVE BEEN MET [Fast Track] \_\_\_\_\_

- Passed USMLE
- No DUIs or Legal Issues
- No Significant Malpractice Issues
- US Graduate
- Graduated Medical School on time

3) HAS ISSUED A TEMPORARY LICENSE THROUGH 1 1 \_\_\_\_\_

4) HAS ISSUED A SPECIAL PGY-1 TRAINING LICENSE Boys 6-12-23 \_\_\_\_\_

5) REQUESTS SPECIFIC CONSIDERATION OF:

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# Oklahoma State Board of Medical Licensure and Supervision

## Application Summary

Type	Number	Name
MD	41439	SAMUEL HUANG
MEDICAL DOCTOR		

**Incomplete Information (due to space limitations on this page, this may not be a complete list)**

OTHER DEFICIENCIES: NEED FORM 2 AND EVAL UPON COMPLETION OF TRAINING, MUST COME DIRECTLY FROM YOUR PROGRAM  
 PostGrad - Form 2 COLLEGE OF MEDICINE OKC

**Last Medical School Attended:**  
 040-02 OR HLTH SCI UNIV SCH OF MED, PORTLAND OR 97201

**Number of Licenses Previously Granted to Graduates of this Medical School:61**

Application for: Resident \_\_\_\_\_ Full License \_\_\_\_\_ Reinstatement \_\_\_\_\_

**The Secretary of the Board has reviewed this application and:**

- 1) AUTHORIZED CIRCULARIZATION TO OTHER BOARD MEMBERS \_\_\_\_\_
  
- 2) ALL FIVE CRITERIA HAVE BEEN MET [Fast Track] \_\_\_\_\_
  - Passed USMLE
  - No DUIs or Legal Issues
  - No Malpractice Issues
  - US Graduate
  - Graduated Medical School in 4 years or less
  
- 3) HAS ISSUED A TEMPORARY LICENSE THROUGH \_\_\_\_ / \_\_\_\_ / \_\_\_\_
  
- 4) HAS ISSUED A SPECIAL PGY-1 TRAINING LICENSE \_\_\_\_\_



# Oklahoma State Board of Medical Licensure and Supervision

## Application Summary

**Type**    **Number**    **Name**  
 MD            41439    SAMUEL HUANG  
 MEDICAL DOCTOR

**Practice Address:**

April 10, 2023

**Status:**

Res: TR

Received: 04/06/2023

Entered: 04/06/2023

Temp Issued:

Temp Expires:

Train Issued: 07/05/2023

Train Expires: 09/30/2024

Fed Rec: 05/14/2024

AMA Rec: 05/14/2024

Board Action:

License #: 41439

Sex: M

Ethnic Origin: 6

Endorsed By: USMLE

	Test	Score	Date Taken	Date Verified	Attempts
Test 1:	USMLE 1	PASS	1/31/16	6/29/23	
Test 2:	USMLE 2	PASS	10/13/22	6/29/23	1
Test 3:	USMLE 3	PASS	10/28/23	4/29/24	1
Note: <b>PASS</b> means higher than 75					
Test AV:					
Total Possible:					
Okla Passing:					
Total Score:					

### PRE-MED EDUCATION

School Name: UNIVERSITY OF ROCHESTER

City: ROCHESTER

Degree: BS, BA

State: NY Country: UNITED STATES

From: 8/2010 To: 5/2014 Verified:

School Name: ALFRED-ALMOND CENTRAL SCHOOL

City: ALMOND

Degree: DIPLOMA

State: NY Country: UNITED STATES

From: 12/2009 To: 6/2010 Verified:

### MEDICAL SCHOOL EDUCATION

Name: OR HLTH SCI UNIV SCH OF MED, PORTLAND OR 97201

Foreign Name:

City: Portland

Degree: MD, PHD

State/Country: United States of America

From: 8 / 2014

To: 6 / 2023

Diploma Ver'd:

Y

# Oklahoma State Board of Medical Licensure and Supervision

## Application Summary

**Type**    **Number**    **Name**  
 MD            41439    SAMUEL HUANG  
 MEDICAL DOCTOR

POST GRADUATE EDUCATION			
<b>Facility:</b> COLLEGE OF MEDICINE OKC		<b>Specialty:</b> OPHTHALMOLOGY	
<b>Res. Fellowship:</b> Residency			
<b>City:</b> OKLAHOMA CITY		<b>State:</b>	<b>Country:</b> UNITED STATES OF AM
<b>Verified:</b>	<b>From:</b> 7 / 2023	<b>To:</b> /	
<b>ACGME Ver'd:</b>			
<b>Comments:</b>			

PRACTICE HISTORY			
<b>Employed:</b>		<b>Supervisor:</b>	
<b>City:</b>	<b>State:</b>	<b>Country:</b>	
<b>Specialty:</b>	<b>From:</b> /	<b>To:</b> /	<b>Verified:</b>
<b>Comments:</b>			

Other Licenses				
State	Lic Type and Number	Status Issued	Exp	Verif

**DEFICIENCIES**  
 OTHER DEFICIENCIES: NEED FORM 2 AND EVAL UPON COMPLETION OF TRAINING, MUST COME DIRECTLY FROM YOUR PROGRAM  
 PostGrad - Form 2 COLLEGE OF MEDICINE OKC



RETURN FORM TO:  
 OKLAHOMA STATE BOARD OF MEDICAL LICENSURE AND SUPERVISION  
[oktraining@okmedicalboard.org](mailto:oktraining@okmedicalboard.org)

RECEIVED

APR 28 2024

OKLAHOMA STATE BOARD OF  
 MEDICAL LICENSURE  
 AND SUPERVISION

**QUESTIONNAIRE**

Please read and follow ALL instructions

**FORM INSTRUCTIONS:** Complete both pages of this form *only if* you are renewing or upgrading your training license. Attach the appropriate documentation and answer the confidential questions.

**PAYMENT INSTRUCTIONS:** If you **ARE FULLY LICENSED**, you **MUST** go online and renew your license – **DO NOT** pay your renewal fee via these instructions (*doing so will delay your renewal*).

**ATTESTATION STATEMENT:** By completing this document, I agree to pay the appropriate fee on **ONLINE BILL PAY**  
 If you are **UPGRADING** your training license to a full license, your fee will be \$250 & you will choose **MD TRAINING-TO-FULL**  
 If you are **RENEWING** your training license, your fee will be \$150 & you will choose **MD TRAINING LICENSE RENEWAL**

**PLEASE PRINT ALL INFORMATION**

FIRST NAME	Samuel	LAST NAME	Huang
EMAIL ADDRESS	[REDACTED]		
LICENSE NUMBER	41439	CELL PHONE	[REDACTED]
HOME ADDRESS	[REDACTED]	CITY/STATE ZIP CODE	[REDACTED]
PROGRAM ATTENDING	University of Oklahoma	SPECIALTY	Ophthalmology

**DOCUMENTATION TO ATTACH**

PAYMENT COMPLETED			
<input type="checkbox"/>	\$150 payment made on Billpay for <b>RENEWAL</b> of training license	<input type="checkbox"/>	\$250 payment made on Billpay for <b>UPGRADE</b> of training license

DOCUMENTATION REQUIRED			
<input type="checkbox"/>	Form 2 (must be received directly from program) <b>**ONLY FOR UPGRADE</b>	<input type="checkbox"/>	Evaluation (must be received directly from program)
<input type="checkbox"/>	USMLE Step 3 (must be received directly from USMLE)	<input type="checkbox"/>	Answer confidential questions (on back of this form)

FOREIGN TRAINED STUDENTS			
<input type="checkbox"/>	Current visa	<input type="checkbox"/>	Social Security Number <b>**if not provided at initial application</b>
<input type="checkbox"/>	Background Check <b>**if not done at initial application</b>		

**IF YOU ARE FULLY LICENSED – DO NOT COMPLETE THIS FORM. YOU MUST GO ONLINE AND RENEW AT <https://pay.apps.ok.gov/medlic/md/login.php> ENTER YOUR LICENSE NUMBER & PIN – COMPLETE YOUR RENEWAL AND PAY THE RENEWAL FEE.**

T41439 SJ

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APR 28 2024

NAME Samuel Huang

OKLAHOMA STATE BOARD OF  
MEDICAL LICENSURE  
AND SUPERVISION

**IF YOU HAVE ANY "YES" ANSWERS YOU MUST PROVIDE A NOTARIZED STATEMENT EXPLAINING YOUR ANSWER.**

<b>SINCE RENEWAL OF YOUR TRAINING LICENSE OR INITIAL ISSUE OF YOUR TRAINING LICENSE (whichever is most recent)</b>		
QUESTIONS	YES	NO
Have you failed any part of the USMLE exam (not previously disclosed)?	<input type="checkbox"/>	<input checked="" type="checkbox"/>
Have you been the subject of investigation or disciplinary action (including probation) by a hospital or training program?	<input type="checkbox"/>	<input checked="" type="checkbox"/>
Have you had any adverse judgment or settlement against you rising from a professional liability claim?	<input type="checkbox"/>	<input checked="" type="checkbox"/>
Have you been reported to the National Practitioner Data Bank (NPDB)?	<input type="checkbox"/>	<input checked="" type="checkbox"/>
Have you ever been denied, had removed, or suspended hospital privileges?	<input type="checkbox"/>	<input checked="" type="checkbox"/>
Have you surrendered hospital privileges while under investigation or to avoid investigation?	<input type="checkbox"/>	<input checked="" type="checkbox"/>
Have you entered into an Agreement with a Federal, State, or Local jurisdictional body to avoid formal action?	<input type="checkbox"/>	<input checked="" type="checkbox"/>
Has your application for licensure ever been denied?	<input type="checkbox"/>	<input checked="" type="checkbox"/>
Have you surrendered a license or had any disciplinary action taken on any license?	<input type="checkbox"/>	<input checked="" type="checkbox"/>
Have you been investigated by or requested to appear before a licensing or disciplinary agency (other than the Oklahoma State Board of Medical Licensure and Supervision)?	<input type="checkbox"/>	<input checked="" type="checkbox"/>
Have you obtained an assessment or been treated for use of any drug or chemical substance including alcohol?	<input type="checkbox"/>	<input checked="" type="checkbox"/>
Have you been arrested for, charged with, or convicted of a felony or misdemeanor other than a traffic violation?	<input type="checkbox"/>	<input checked="" type="checkbox"/>
Have you been arrested for, charged with, or convicted of a traffic violation involving the use of any drug or chemical substance?	<input type="checkbox"/>	<input checked="" type="checkbox"/>
Have you been addicted to or abused any drug or chemical substance including alcohol?	<input type="checkbox"/>	<input checked="" type="checkbox"/>
Have you been denied provider participation, terminated, sanctioned or penalized by any third-party payor including TRICARE, MEDICARE, or MEDICAID?	<input type="checkbox"/>	<input checked="" type="checkbox"/>
Have you surrendered or had any adverse action taken against any narcotic permit (State or Federal)?	<input type="checkbox"/>	<input checked="" type="checkbox"/>

I swear under penalty of perjury, that I am the person completing this Questionnaire and understand that any medical license procured or obtained by fraud or misrepresentation will result in disciplinary action taken against the licensee pursuant to the provisions of 59 O.S. § 508.

Signature 

Date 4/28/2024



# Oklahoma State Board of Medical Licensure and Supervision

PAGE 140 of 500

## APPLICATION FOR OKLAHOMA MEDICAL DOCTOR LICENSE

Received:04/06/2023

Applicant Name: HUANG, SAMUEL

MD 41439



Date Of Birth: [Redacted]

Place Of Birth (City, State): URBANA, NY

Sex: M

Race: Asian/Pacific Islander

Education									
Type	Name	City	ST	Country	From	To	Degree	Comments	Veri
UG	UNIVERSITY OF ROCHESTER	ROCHESTER	NY		8/2010	5/2014	BS, BA		

Medical School Name	City	State	Country	Comments	From	To
OR HLTH SCI UNIV SCH OF MED, PORTLAND OR 97201	Portland	OR	United States		8/2014	6/2023

Post-Graduate							
Facility	City	St	Country	Specialty	Comments	From	To
			UNITED S			/	/

Practice History								
Employer	Specialty	Supervisor	City	ST	Countr	From	To	Verif
						/		

Other/ Out-Of-State Licenses					
State	License #	Profession	Status	Issue Date	Exp Date

\$ 250

MD Exam				
Exam	State	Score	Date Taken	#
USMLE				

**Oklahoma State Board of Medical Licensure and Supervision****APPLICATION FOR OKLAHOMA MEDICAL DOCTOR LICENSE**

PAGE 141 of 500

Received:04/06/2023

<b>Questions Answered 04/03/2023</b>	<b>Response</b>
A. Have you ever been denied provider participation, terminated, sanctioned, or penalized by any third party payor, to include TRICARE, MEDICARE, MEDICAID?	<b>N</b>
B. Have you ever surrendered or had any adverse action taken against any narcotic permit (state or federal)?	<b>N</b>
C. Have you ever been denied membership or had disciplinary action taken by a national, state or county professional organization?	<b>N</b>
D. Have you ever been denied or had removed or suspended hospital staff privileges?	<b>N</b>
E. Have you ever surrendered hospital staff privileges while under investigation or to avoid investigation?	<b>N</b>
F. Have you ever entered into an agreement with a federal, state or local jurisdictional body to avoid formal action?	<b>N</b>
G. Have you ever been the subject of an investigation, probation or disciplinary action by a hospital, clinic, practice group, training program or professional school?	<b>N</b>
H. Have you had any adverse judgment, settlement, or award against you arising from a professional liability claim?	<b>N</b>
I. Have you ever had professional liability coverage declined, canceled, issued on special terms, or renewal refused?	<b>N</b>
J. Have you ever been reported to the National Practitioners Data Bank (NPDB) or to the Healthcare Integrity and Protection Data Bank (HIPDB)? (If yes, enclose a copy of the report.)	<b>N</b>
K. Has your application for examination or a professional license ever been denied?	<b>N</b>
L. Have you ever failed any part of a licensure/certification/registration examination?	<b>N</b>
M. Have you ever surrendered a license or had a license revoked?	<b>N</b>
N. Has any disciplinary action been taken on any license?	<b>N</b>
O. Have you ever been subject of a review by professional licensing/regulatory agency based on a complaint filed against you?	<b>N</b>
P. Have you ever been arrested, charged with, or convicted of a felony or misdemeanor, other than traffic violations?	<b>N</b>
Q. Have you ever been arrested, charged with, or convicted of a traffic violation involving the use of any drug or chemical substance, including alcohol?	<b>N</b>
R. Are you now or have you within the past two years been addicted to or used in excess any drug or chemical substance, including alcohol?	<b>N</b>
S. Have you obtained an assessment or been treated for the use of any drug or chemical substance, including alcohol?	<b>N</b>
T. Do you currently have or have you had within the past two years any mental or physical disorder or condition which, if untreated, could affect your ability to practice competently?	<b>N</b>
U. Are you or your spouse currently on Active Duty in the U.S. Armed Forces?	<b>N</b>
V. Are you or your spouse currently Deployed on Active Duty in the U.S. Armed Forces?	<b>N</b>



Oklahoma State Board of Medical Licensure and Supervision

APPLICATION FOR OKLAHOMA MEDICAL DOCTOR LICENSE

PAGE 142 of 500

Received:04/06/2023

If licensed, where do you intend to locate?

OK

Why do you seek Licensure in the state of Oklahoma?

Post-Graduate Training

In what manner will you be communicating with your Oklahoma patients (telephone, email, internet, video-conference, etc)?

Describe how you will examine each patient in person prior to diagnosis, treating, correcting, or prescribing for a patient in Oklahoma from the state, province, or country you are located:

Describe the manner in which you intend to practice medicine across state lines in Oklahoma:

Have you executed or been offered a contract in connection with practice in the state of Oklahoma?

Yes

If 'Yes', Name of practice:

University of Oklahoma

If so, Please identify with which category:

Residency

Name of Previous Carrier and Policy Holder

Oregon Health & Science University

Name of Current Carrier and policy Holder

University of Oklahoma

Will your professional liability insurance policy cover your practice in Oklahoma

Yes

If NO, when do you expect to obtain liability insurance that will cover practice in Oklahoma

I attest that all the above information is accurate as of April 05, 2023: \_\_\_\_\_ (Signed Online) \_\_\_\_\_



**Applicant:** In the presence of a notary public, sign this form with attached photo.

**Send this form to:**

Oklahoma State Board of Medical Licensure and Supervision  
101 NE 51<sup>st</sup> Street  
Oklahoma City, OK 73105

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

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

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

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

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

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

RECEIVED

APR 06 2023

OKLAHOMA STATE BOARD OF  
MEDICAL LICENSURE  
AND SUPERVISION



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

HUANG, SAMUEL, J.  
Applicants printed last name, first name, middle initial, and suffix (e.g., Jr.)

4/3/2023  
Date of signature (must correspond to the date of notarization)

[Please note: The Notary Public seal should overlap the bottom of the photo to the left]

NOTARY

State of Oregon, County of Multnomah



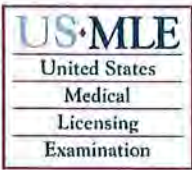
I certify that on the date set forth below, the individual named above did appear personally before me and that I did identify this applicant by (a) comparing his/her physical appearance with the photograph on the identifying document presented by the applicant and with the photograph affixed hereto,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

The statements on this document are subscribed and sworn to before me by the applicant on this 3<sup>rd</sup> day of April, 2023

Notary Public Signature [Signature] My Notary Commission Expires 12/01/2023

T 41439  
VB





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

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

PRIMARY  
SOURCE

**Recipient:** OKLAHOMA STATE BOARD OF  
MEDICAL LICENSURE & SUPERVISION

**Date:** 04/29/2024

**Examinee:** Huang, Samuel  
**Alt Name(s):**

**Examinee ID:** 5-365-376-2  
**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. Pass/fail outcomes are based upon the minimum passing level in place at the time of test administration and are not altered by subsequent revisions to the minimum passing level. Effective April 1, 2013, two-digit scores will no longer be reported. Test results reported as passing represent an exam score of 75 or higher on a two-digit scale. Step 1 examinations taken on or after January 26, 2022 are reported as pass/fail, with no numeric score; Step 1 examinations taken before January 26, 2022 will continue to be reported with a 3-digit score.

<b>USMLE STEP 1</b>				
Test Date	Pass/Fail	Score	Minimum Pass	Comments
01/31/2016	Pass	258	(192)	

<b>USMLE STEP 2</b>				
<i>Clinical Knowledge (CK)</i>				
Test Date	Pass/Fail	Score	Minimum Pass	Comments
10/13/2022	Pass	247	(214)	

<b>USMLE STEP 3</b>				
Test Date	Pass/Fail	Score	Minimum Pass	Comments
10/28/2023	Pass	234	(198)	

**End of Exam History**

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

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

RECEIVED

APR 29 2024

OKLAHOMA STATE BOARD OF  
MEDICAL LICENSURE  
AND SUPERVISION

T41439  
SJ



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

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

**Examinee:** Huang, Samuel

**Examinee ID:** 5-365-376-2

**Date of Birth:** [REDACTED]

### INTERPRETATION OF RESULTS

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

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

### STEP 1 AND STEP 2 CLINICAL SKILLS (CS)

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

### ANNOTATIONS APPEARING UNDER "COMMENTS"

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

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

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

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

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

### ANNOTATIONS APPEARING AS "NOTE"

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

### PHYSICIAN DATA CENTER INFORMATION APPEARING AS "NOTE"

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

03/2015

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



Form 1 (MD)



Oklahoma State Board of Medical Licensure and Supervision
101 NE 51st Street Oklahoma City, OK 73105
OKTRAINING@OKMEDICALBOARD.ORG

RECEIVED

JUL 03 2023

OKLAHOMA STATE BOARD OF MEDICAL LICENSURE AND SUPERVISION

This form must be completed by the institution and mailed or emailed directly from the institution.

Applicant's Name Samuel Huang

Institution: Oregon Health & Science University City/State Portland/OR

Our records indicate that the above named applicant attended our medical school on the following dates:

From 08 / 11 / 2014 To 06 / 23 / 2023 and was awarded the degree MD/PhD.

Please complete the following questions:

- 1. Does this individual's official record reflect (an) interruption(s) or extension(s) in his/her medical education? If yes, please explain. YES NO
2. Does this individual's official record reflect that he/she was ever placed on academic or disciplinary probation during his/her medical education? If yes, please explain. YES NO
3. Does this individual's official record reflect that he/she was ever the subject of negative reports for behavioral reasons or an investigation by the medical school or parent university? If yes, please explain below. YES NO
4. Does this individual's official record reflect that he/she was ever disciplined for unprofessional conduct/behavioral reasons by the medical school or parent university? If yes, please explain below. YES NO
5. Does this individual's official record reflect that there were any limitations or special requirements imposed on the individual because of questions of academic incompetence, disciplinary problems, or any other reason? If yes, please explain below. YES NO

Please explain any "YES" response from above:

Note Samuel Huang entered and graduated as md/phd student.

I attest that the completion of the following has been completed by the program director and that the information above is an accurate account of this individual's records and is true and correct.

Name: Tomo Ito, EdD Signature [Signature]

Title of Signatory: Assistant Dean, UME Curriculum Date of Signature 6/30/2023

Tel: 503-494-5100 Fax: 503-494-3400 E-Mail: itot@ohsu.edu

School Seal

If no seal is available, this form must be notarized

Notary Public

Commission #

My commission expires:



Notary Seal

T MD 41439
7/3/23
LKC

**Course Level : Medical Graduate**

**Current Program**  
 College : School of Medicine  
 Major: Physiology/Pharmacology

**Degree Information:**  
 Degree Awarded: Doctor of Philosophy 18-JUN-2021  
 Major: Physiology/Pharmacology

Doctoral Dissertation:  
 Transcription-dependent directed evolution of the adeno-associated virus Capsid



Subj No.	Title	Cred	Grade	Pts	R
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**INSTITUTION CREDIT:**

**Spring 2016**

CONJ 606MD	MD/PhD Journal Club	0.50	P	0.00
PHPH 601	Research	14.50	P	0.00

Earned Hrs	GPA-Hrs	QPts	GPA
15.00	0.00	0.00	0.00

**Summer 2016**

CONJ 606MD	MD/PhD Journal Club	0.50	P	0.00
PHPH 601	Research	9.00	P	0.00

Earned Hrs	GPA-Hrs	QPts	GPA
9.50	0.00	0.00	0.00

**Fall 2016**

CONJ 606MD	MD/PhD Journal Club	0.50	P	0.00
CONJ 650	Practice and Ethics of Science	1.00	P	0.00
PHPH 601	Research	11.50	P	0.00
PHPH 621	The Visual System	2.00	P	0.00

Earned Hrs	GPA-Hrs	QPts	GPA
15.00	0.00	0.00	0.00

**Winter 2017**

CONJ 606MD	MD/PhD Journal Club	0.50	P	0.00
PHPH 601	Research	12.50	P	0.00
PHPH 606	PHPH Journal Club	1.00	P	0.00
PHPH 607	Departmental Seminar Series	1.00	P	0.00

Earned Hrs	GPA-Hrs	QPts	GPA
15.00	0.00	0.00	0.00

Subj No.	Title	Cred	Grade	Pts	R
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**INSTITUTION CREDIT:**

**Spring 2017**

CONJ 606MD	MD/PhD Journal Club	0.50	P	0.00
PHPH 601	Research	12.50	P	0.00
PHPH 606	PHPH Journal Club	1.00	P	0.00
PHPH 607	Departmental Seminar Series	1.00	P	0.00

Earned Hrs	GPA-Hrs	QPts	GPA
15.00	0.00	0.00	0.00

**Summer 2017**

CONJ 606MD	MD/PhD Journal Club	0.50	P	0.00
PHPH 601	Research	15.50	P	0.00

Earned Hrs	GPA-Hrs	QPts	GPA
16.00	0.00	0.00	0.00

**Fall 2017**

CONJ 606MD	MD/PhD Journal Club	0.50	P	0.00
PHPH 601	Research	12.50	P	0.00
PHPH 606	PHPH Journal Club	1.00	P	0.00
PHPH 607	Departmental Seminar	1.00	P	0.00

Earned Hrs	GPA-Hrs	QPts	GPA
15.00	0.00	0.00	0.00

**Winter 2018**

CONJ 606MD	MD/PhD Journal Club	0.50	P	0.00
MGEN 624	Gene and Cell Therapy	2.00	A	8.00
PHPH 601	Research	11.50	P	0.00
PHPH 607	Departmental Seminar Series	1.00	P	0.00

Earned Hrs	GPA-Hrs	QPts	GPA
15.00	2.00	8.00	4.00

**Spring 2018**

CONJ 606MD	MD/PhD Journal Club	0.50	P	0.00
PHPH 601	Research	13.50	P	0.00
PHPH 607	Departmental Seminar Series	1.00	P	0.00

Earned Hrs	GPA-Hrs	QPts	GPA
15.00	0.00	0.00	0.00

**Summer 2018**

CONJ 606MD	MD/PhD Journal Club	0.50	P	0.00
CONJ 620	Introd Biostatistics/Basic Sci	3.00	A	12.00
PHPH 601	Research	11.50	P	0.00



Subj No.	Title	Cred	Grade	Pts	R
<b>INSTITUTION CREDIT:</b>					
<b>Earned Hrs</b>	<b>GPA-Hrs</b>	<b>QPts</b>	<b>GPA</b>		
15.00	3.00	12.00	4.00		
<b>Fall 2018</b>					
CONJ 606MD	MD/PhD Journal Club	0.50	P	0.00	
PHPH 601	Research	13.50	P	0.00	
PHPH 607	Departmental Seminar	1.00	P	0.00	
<b>Earned Hrs</b>	<b>GPA-Hrs</b>	<b>QPts</b>	<b>GPA</b>		
15.00	0.00	0.00	0.00		
<b>Winter 2019</b>					
CONJ 606MD	MD/PhD Journal Club	0.50	P	0.00	
PHPH 601	Research	13.50	P	0.00	
PHPH 607	Departmental Seminar Series	1.00	P	0.00	
<b>Earned Hrs</b>	<b>GPA-Hrs</b>	<b>QPts</b>	<b>GPA</b>		
15.00	0.00	0.00	0.00		
<b>Spring 2019</b>					
CONJ 606MD	MD/PhD Journal Club	0.50	P	0.00	
PHPH 601	Research	13.50	P	0.00	
PHPH 607	Departmental Seminar Series	1.00	P	0.00	
<b>Earned Hrs</b>	<b>GPA-Hrs</b>	<b>QPts</b>	<b>GPA</b>		
15.00	0.00	0.00	0.00		
<b>Summer 2019</b>					
CONJ 606MD	MD/PhD Journal Club	0.50	P	0.00	
PHPH 601	Research	14.50	P	0.00	
<b>Earned Hrs</b>	<b>GPA-Hrs</b>	<b>QPts</b>	<b>GPA</b>		
15.00	0.00	0.00	0.00		
<b>Fall 2019</b>					
CONJ 606MD	MD/PhD Journal Club	0.50	P	0.00	
PHPH 601	Research	13.50	P	0.00	
PHPH 607	Departmental Seminar	1.00	P	0.00	
<b>Earned Hrs</b>	<b>GPA-Hrs</b>	<b>QPts</b>	<b>GPA</b>		
15.00	0.00	0.00	0.00		
<b>Winter 2020</b>					
CONJ 606MD	MD/PhD Journal Club	0.50	P	0.00	
PHPH 601	Research	13.50	P	0.00	
PHPH 607	Departmental Seminar Series	1.00	P	0.00	

Subj No.	Title	Cred	Grade	Pts	R
<b>INSTITUTION CREDIT:</b>					
<b>Earned Hrs</b>	<b>GPA-Hrs</b>	<b>QPts</b>	<b>GPA</b>		
15.00	0.00	0.00	0.00		
<b>Spring 2020</b>					
CONJ 606MD	MD/PhD Journal Club	0.50	P	0.00	
PHPH 601	Research	7.50	P	0.00	
<b>Earned Hrs</b>	<b>GPA-Hrs</b>	<b>QPts</b>	<b>GPA</b>		
8.00	0.00	0.00	0.00		
<b>Summer 2020</b>					
CONJ 606MD	MD/PhD Journal Club	0.50	P	0.00	
PHPH 601	Research	14.50	P	0.00	
<b>Earned Hrs</b>	<b>GPA-Hrs</b>	<b>QPts</b>	<b>GPA</b>		
15.00	0.00	0.00	0.00		
<b>Fall 2020</b>					
CONJ 606MD	MD/PhD Journal Club	0.50	P	0.00	
PHPH 601	Research	13.50	P	0.00	
PHPH 607	Departmental Seminar	1.00	P	0.00	
<b>Earned Hrs</b>	<b>GPA-Hrs</b>	<b>QPts</b>	<b>GPA</b>		
15.00	0.00	0.00	0.00		
<b>Winter 2021</b>					
CONJ 606MD	MD/PhD Journal Club	0.50	P	0.00	
PHPH 603	Dissertation	14.50	P	0.00	
<b>Earned Hrs</b>	<b>GPA-Hrs</b>	<b>QPts</b>	<b>GPA</b>		
15.00	0.00	0.00	0.00		
<b>Spring 2021</b>					
CONJ 606MD	MD/PhD Journal Club	0.50	P	0.00	
PHPH 603	Dissertation	14.50	P	0.00	
<b>Earned Hrs</b>	<b>GPA-Hrs</b>	<b>QPts</b>	<b>GPA</b>		
15.00	0.00	0.00	0.00		
<b>Summer 2021</b>					
CONJ 606MD	MD/PhD Journal Club	0.50	AUD	0.00	
<b>Earned Hrs</b>	<b>GPA-Hrs</b>	<b>QPts</b>	<b>GPA</b>		
0.00	0.00	0.00	0.00		
<b>Fall 2021</b>					

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Gwen Hyatt  
 Registrar



Subj	No.	Title	Cred	Grade	Pts	R
<b>INSTITUTION CREDIT:</b>						
CONJ	606MD	MD/PhD Journal Club	0.50	AUD	0.00	
<b>Earned Hrs</b>	<b>GPA-Hrs</b>	<b>QPts</b>	<b>GPA</b>			
0.00	0.00	0.00	0.00			
<b>Winter 2022</b>						
CONJ	606MD	MD/PhD Journal Club	0.50	AUD	0.00	
<b>Earned Hrs</b>	<b>GPA-Hrs</b>	<b>QPts</b>	<b>GPA</b>			
0.00	0.00	0.00	0.00			
<b>Spring 2022</b>						
CONJ	606MD	MD/PhD Journal Club	0.50	AUD	0.00	
<b>Earned Hrs</b>	<b>GPA-Hrs</b>	<b>QPts</b>	<b>GPA</b>			
0.00	0.00	0.00	0.00			
<b>Summer 2022</b>						
CONJ	606MD	MD/PhD Journal Club	0.50	AUD	0.00	
<b>Earned Hrs</b>	<b>GPA-Hrs</b>	<b>QPts</b>	<b>GPA</b>			
0.00	0.00	0.00	0.00			
<b>Fall 2022</b>						
CONJ	606MD	MD/PhD Journal Club	0.50	AUD	0.00	
<b>Earned Hrs</b>	<b>GPA-Hrs</b>	<b>QPts</b>	<b>GPA</b>			
0.00	0.00	0.00	0.00			
<b>Winter 2023</b>						
CONJ	606MD	MD/PhD Journal Club	0.50	AUD	0.00	
<b>Earned Hrs</b>	<b>GPA-Hrs</b>	<b>QPts</b>	<b>GPA</b>			
0.00	0.00	0.00	0.00			
<b>Spring 2023</b>						
CONJ	606MD	MD/PhD Journal Club	0.50	AUD	0.00	
<b>Earned Hrs</b>	<b>GPA-Hrs</b>	<b>QPts</b>	<b>GPA</b>			
0.00	0.00	0.00	0.00			

Transcript Totals	Earned Hrs	GPA Hrs	Points	GPA
TOTAL INSTITUTION	303.50	5.00	20.00	4.00
TOTAL TRANSFER	0.00	0.00	0.00	0.00
OVERALL	303.50	5.00	20.00	4.00

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*Gwen Hyatt*  
 Gwen Hyatt  
 Registrar





**Course Level : Medical**

**Current Program**

College : School of Medicine  
 Major: Medicine

**Degree Information:**

Degree Awarded: Doctor of Medicine 23-JUN-2023  
 Major: Medicine

Subj No.	Title	Cred	Grade	Pts	R
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**INSTITUTION CREDIT:**

**Summer 2014**

FUND 710	Fundamentals	9.00	P	0.00	
TRAN 702	Transition to Medical School	2.00	P	0.00	

Earned Hrs	GPA-Hrs	QPts	GPA
11.00	0.00	0.00	0.00

**Fall 2014**

BCMB 705A	MD/PhD Journal Club	1.00	P	0.00	
BLHD 710	Blood & Host Defense	13.00	P	0.00	
FAMP 706K	SW Volunteer Clinic	1.00	AUD	0.00	
FUND 710	Fundamentals	9.00	P	0.00	
IPE 701	Fndn Pt Safety & IP Practice	1.00	P	0.00	
PREC 721	Preceptorship	1.00	P	0.00	

Earned Hrs	GPA-Hrs	QPts	GPA
25.00	0.00	0.00	0.00

**Winter 2015**

CARE 710	Cardiopulmonary & Renal	9.00	P	0.00	
PREC 722	Preceptorship	1.00	P	0.00	
SBM 710	Skin, Bones and Musculature	13.00	P	0.00	

Earned Hrs	GPA-Hrs	QPts	GPA
23.00	0.00	0.00	0.00

**Spring 2015**

CARE 710	Cardiopulmonary & Renal	18.00	P	0.00	
HODI 710	Hormones & Digestion	7.00	P	0.00	
PREC 723	Preceptorship	1.00	P	0.00	

Earned Hrs	GPA-Hrs	QPts	GPA
26.00	0.00	0.00	0.00

**Summer 2015**

Subj No.	Title	Cred	Grade	Pts	R
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**INSTITUTION CREDIT:**

HODI 710	Hormones & Digestion	11.00	P	0.00	
NSF 710	Nervious System & Function	13.00	P	0.00	
PREC 724	Preceptorship	0.50	P	0.00	

Earned Hrs	GPA-Hrs	QPts	GPA
24.50	0.00	0.00	0.00

**Fall 2015**

BCMB 705A	MD/PhD Journal Club	1.00	P	0.00	
DEVH 710	Developing Human	12.00	P	0.00	
NSF 710	Nervious System & Function	9.00	P	0.00	
PREC 724	Preceptorship	1.00	P	0.00	

Earned Hrs	GPA-Hrs	QPts	GPA
23.00	0.00	0.00	0.00

**Winter 2016**

PREP 700	Preparation for USMLE Step 1	5.00	P	0.00	
TRAN 703	Transition to Clinical Exp	2.00	P	0.00	

Earned Hrs	GPA-Hrs	QPts	GPA
7.00	0.00	0.00	0.00

**Spring 2016**

JCON 715	MD/PhD Longitudinal Clerkship	1.00	P	0.00	
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Earned Hrs	GPA-Hrs	QPts	GPA
1.00	0.00	0.00	0.00

**Fall 2016**

JCON 715	MD/PhD Longitudinal Clerkship	1.00	P	0.00	
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Earned Hrs	GPA-Hrs	QPts	GPA
1.00	0.00	0.00	0.00

**Winter 2017**

JCON 715	MD/PhD Longitudinal Clerkship	1.00	P	0.00	
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Earned Hrs	GPA-Hrs	QPts	GPA
1.00	0.00	0.00	0.00

**Spring 2017**

JCON 715	MD/PhD Longitudinal Clerkship	1.00	P	0.00	
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Earned Hrs	GPA-Hrs	QPts	GPA
1.00	0.00	0.00	0.00

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Subj No.	Title	Cred	Grade	Pts	R
<b>INSTITUTION CREDIT:</b>					
<b>Fall 2017</b>					
JCON 715	MD/PhD Longitudinal Clerkship	1.00	P	0.00	
<b>Earned Hrs</b>	<b>GPA-Hrs</b>	<b>QPts</b>	<b>GPA</b>		
1.00	0.00	0.00	0.00		
<b>Winter 2018</b>					
JCON 715	MD/PhD Longitudinal Clerkship	1.00	P	0.00	
<b>Earned Hrs</b>	<b>GPA-Hrs</b>	<b>QPts</b>	<b>GPA</b>		
1.00	0.00	0.00	0.00		
<b>Spring 2018</b>					
JCON 715	MD/PhD Longitudinal Clerkship	1.00	P	0.00	
<b>Earned Hrs</b>	<b>GPA-Hrs</b>	<b>QPts</b>	<b>GPA</b>		
1.00	0.00	0.00	0.00		
<b>Summer 2018</b>					
JCON 715	MD/PhD Longitudinal Clerkship	1.00	P	0.00	
<b>Earned Hrs</b>	<b>GPA-Hrs</b>	<b>QPts</b>	<b>GPA</b>		
1.00	0.00	0.00	0.00		
<b>Fall 2018</b>					
JCON 715	MD/PhD Longitudinal Clerkship	1.00	P	0.00	
<b>Earned Hrs</b>	<b>GPA-Hrs</b>	<b>QPts</b>	<b>GPA</b>		
1.00	0.00	0.00	0.00		
<b>Winter 2019</b>					
JCON 715	MD/PhD Longitudinal Clerkship	1.00	P	0.00	
<b>Earned Hrs</b>	<b>GPA-Hrs</b>	<b>QPts</b>	<b>GPA</b>		
1.00	0.00	0.00	0.00		
<b>Spring 2019</b>					
JCON 715	MD/PhD Longitudinal Clerkship	1.00	AUD	0.00	
<b>Earned Hrs</b>	<b>GPA-Hrs</b>	<b>QPts</b>	<b>GPA</b>		
0.00	0.00	0.00	0.00		
<b>Summer 2019</b>					
JCON 715	MD/PhD Longitudinal Clerkship	1.00	AUD	0.00	
<b>Earned Hrs</b>	<b>GPA-Hrs</b>	<b>QPts</b>	<b>GPA</b>		
0.00	0.00	0.00	0.00		

Subj No.	Title	Cred	Grade	Pts	R
<b>INSTITUTION CREDIT:</b>					
<b>Fall 2019</b>					
JCON 715	MD/PhD Longitudinal Clerkship	1.00	AUD	0.00	
<b>Earned Hrs</b>	<b>GPA-Hrs</b>	<b>QPts</b>	<b>GPA</b>		
0.00	0.00	0.00	0.00		
<b>Winter 2020</b>					
JCON 715	MD/PhD Longitudinal Clerkship	1.00	AUD	0.00	
<b>Earned Hrs</b>	<b>GPA-Hrs</b>	<b>QPts</b>	<b>GPA</b>		
0.00	0.00	0.00	0.00		
<b>Spring 2020</b>					
INTS 771	Interession - Cancer	2.00	P	0.00	
INTS 772	Interession - Cognitive	2.00	P	0.00	
INTS 773	Interession - Infection	2.00	P	0.00	
INTS 774	Interession - Pain Management	2.00	P	0.00	
<b>Earned Hrs</b>	<b>GPA-Hrs</b>	<b>QPts</b>	<b>GPA</b>		
8.00	0.00	0.00	0.00		
<b>Summer 2020</b>					
JCON 715	MD/PhD Longitudinal Clerkship	1.00	AUD	0.00	
<b>Earned Hrs</b>	<b>GPA-Hrs</b>	<b>QPts</b>	<b>GPA</b>		
0.00	0.00	0.00	0.00		
<b>Fall 2020</b>					
JCON 715	MD/PhD Longitudinal Clerkship	1.00	AUD	0.00	
<b>Earned Hrs</b>	<b>GPA-Hrs</b>	<b>QPts</b>	<b>GPA</b>		
0.00	0.00	0.00	0.00		
<b>Winter 2021</b>					
JCON 715	MD/PhD Longitudinal Clerkship	1.00	P	0.00	
<b>Earned Hrs</b>	<b>GPA-Hrs</b>	<b>QPts</b>	<b>GPA</b>		
1.00	0.00	0.00	0.00		
<b>Spring 2021</b>					
JCON 715	MD/PhD Longitudinal Clerkship	1.00	AUD	0.00	
<b>Earned Hrs</b>	<b>GPA-Hrs</b>	<b>QPts</b>	<b>GPA</b>		
0.00	0.00	0.00	0.00		
<b>Summer 2021</b>					

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Subj No.	Title	Cred	Grade	Pts	R
<b>INSTITUTION CREDIT:</b>					
NEUR 730	Neurology Core Clinical Exp	6.00	P	0.00	
PEDI 730	Pediatrics Core Clinical Exp	6.00	P	0.00	
PSYC 730	Psychiatry Core Clinical Exp	6.00	P	0.00	
<b>Earned Hrs</b>	<b>GPA-Hrs</b>	<b>QPts</b>	<b>GPA</b>		
18.00	0.00	0.00	0.00		
<b>Fall 2021</b>					
FAMP 730	Family Medicine Core Clin Exp	6.00	P	0.00	
IMED 730	Internal Med Core Clinical Exp	6.00	P	0.00	
INTS 770C	Neurology Testing Intersession	1.00	P	0.00	
INTS 770F	Psychiatry Testing Intersession	1.00	P	0.00	
<b>Earned Hrs</b>	<b>GPA-Hrs</b>	<b>QPts</b>	<b>GPA</b>		
14.00	0.00	0.00	0.00		
<b>Winter 2022</b>					
INTS 770A	FamilyMed Testing Intersession	1.00	P	0.00	
INTS 770B	Inter Med Testing Intersession	1.00	P	0.00	
INTS 770E	Peds Testing Intersession	1.00	WP	0.00	
OBYG 730	OBYGYN Core Clinical Exp	6.00	P	0.00	
<b>Earned Hrs</b>	<b>GPA-Hrs</b>	<b>QPts</b>	<b>GPA</b>		
8.00	0.00	0.00	0.00		
<b>Spring 2022</b>					
INTS 770D	OB/GYN Testing Intersession	1.00	P	0.00	
INTS 770G	Surgery Testing Intersession	1.00	P	0.00	
OPHT 709A	Advanced Ophthalmology	4.00	P	0.00	
SURG 730	Surgery Core Clinical Exp	6.00	P	0.00	
<b>Earned Hrs</b>	<b>GPA-Hrs</b>	<b>QPts</b>	<b>GPA</b>		
12.00	0.00	0.00	0.00		
<b>Summer 2022</b>					
CPX 702	Clinical Performance Exam	1.00	P	0.00	
INTS 770E	Peds Testing Intersession	1.00	P	0.00	
OPHT 701A	Ophthalmology Research	4.00	P	0.00	
OPHT 709X	Ophthalmology Special Elect	4.00	P	0.00	
RADD 709A	Diagnostic Radiology-General	4.00	P	0.00	
<b>Earned Hrs</b>	<b>GPA-Hrs</b>	<b>QPts</b>	<b>GPA</b>		
14.00	0.00	0.00	0.00		
<b>Fall 2022</b>					
JCON 700C	Preparation for USMLE Step 2CK	1.00	P	0.00	
JCON 725	Clin & Translational Research	8.00	P	0.00	

Subj No.	Title	Cred	Grade	Pts	R
<b>INSTITUTION CREDIT:</b>					
<b>Earned Hrs</b>	<b>GPA-Hrs</b>	<b>QPts</b>	<b>GPA</b>		
9.00	0.00	0.00	0.00		
<b>Winter 2023</b>					
ANST 709A	Anesthesiology	4.00	P	0.00	
OPHT 701A	Ophthalmology Research	4.00	P	0.00	
SCHI 703	Scholarly Project-Capstone	1.00	P	0.00	
TRAN 704	Transition to Residency	1.00	P	0.00	
<b>Earned Hrs</b>	<b>GPA-Hrs</b>	<b>QPts</b>	<b>GPA</b>		
10.00	0.00	0.00	0.00		
<b>Spring 2023</b>					
OPHT 711A	Ophthalmology Research	2.00	P	0.00	
<b>Earned Hrs</b>	<b>GPA-Hrs</b>	<b>QPts</b>	<b>GPA</b>		
2.00	0.00	0.00	0.00		
<b>Transcript Totals</b>					
		<b>Earned Hrs</b>	<b>GPA Hrs</b>	<b>Points</b>	<b>GPA</b>
TOTAL INSTITUTION		245.50	0.00	0.00	0.00
TOTAL TRANSFER		0.00	0.00	0.00	0.00
OVERALL		245.50	0.00	0.00	0.00
<b>END OF TRANSCRIPT</b>					

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OKLAHOMA STATE BOARD OF  
 MEDICAL LICENSURE  
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OKLAHOMA STATE BOARD OF  
 MEDICAL LICENSURE  
 AND SUPERVISION

*Gwen Hyatt*  
 Gwen Hyatt  
 Registrar

OREGON HEALTH & SCIENCE UNIVERSITY  
 PORTLAND, OREGON 97239

This transcript processed and delivered by Parchment





## OREGON HEALTH & SCIENCE UNIVERSITY

Office of the Registrar • (503) 494-7800 • [www.ohsu.edu](http://www.ohsu.edu)  
3181 SW Sam Jackson Park Road, Portland, Oregon 97239

*Under the provisions of Public Law 93-380 (as amended), the information contained in this document is not to be released to others without the written consent of the student named herein.*

### Grading System

Beginning August 1, 2013 for all Schools; Dentistry, Medicine and Nursing

A = Honors or Excellent	IP = In Progress
B = Near Honors or Good	I = Incomplete
C = Satisfactory or Fair	I/Final Grade = Incomplete/Final Grade
D = Marginal or Inferior	AUD = Audit
F = Failure	W = Withdrew
P = Pass	WP = Withdrew Passing
NP = No Pass	WNP = Withdrew Non-Passing
	WU = Withdrew from Audit

+ or - may be used with letter grades

**School of Medicine - MD Program - Prior to September 16, 1961:** I=91-100%, II=86-90%, III=81-85%, IV=76-80%, V=75% (barely passing). Beginning September 18, 1961: A=Exceptional, B=Superior, C=Average, D=Inferior, E=Conditional, F=Failure. Beginning September 12, 1977: H=Honors, Acc=Acceptable, M=Marginal, F=Failure, P=Pass, NP=No Pass, AU=Audit, I=Incomplete, W=Withdrew. Courses listing two grades, i.e. Acc/H are for knowledge/skills. Beginning June 12, 1988: H=Honors, NH=Near Honors, S=Satisfactory, M=Marginal, F=Failure, X=No Grade Received/No Basis for Grade, P=Pass, NP=No Pass, AU or AUD=Audit, I=Incomplete, W=Withdrew. The mark "M" necessitates remedial work with a mark of at least "S" or better on the academic record. The mark of "F" would require repeating the course. Beginning January 2006: I/(Grade)=Incomplete grade changed to final grade.

**School of Medicine - Graduate and Allied Health Programs - Prior to September 16, 1961:** I=91-100%, II=86-90%, III=81-85%, IV=76-80%, V=75% (barely passing). Beginning September 18, 1961: A=Exceptional, B=Superior, C=Average, D=Inferior, E=Conditional, F=Failure. Beginning September 1989: 4.0=Exceptional, 3.0=Superior, 2.0=Average, 1.0=Inferior, 0.0=Failure, P=Pass, NP=No Pass, AUD=Audit, I=Incomplete, X=No Grade Received/No Basis or Grade, W=Withdrew. Beginning September 2003 (for Graduate Programs only): A=Exceptional, B=Superior, C=Average, D=Inferior (+ or - may be used with letter grades), F=Failure, P=Pass, NP=No Pass, AU or AUD=Audit, I=Incomplete, X=No Grade Received/No Basis for Grade, W=Withdrew, WS=Withdrew Satisfactory, WU=Withdrew Unsatisfactory. Beginning January 2006: I/(Grade)=Incomplete grade changed to final grade.

**School of Nursing - Prior to June 21, 1971:** A=Exceptional, B=Superior, C=Average, D=Inferior, F=Failure. From June 21, 1971 to August 13, 1982: A=Exceptional, B=Superior, C=Average, P=Satisfactory or better, N=Unsatisfactory. Beginning September 27, 1982: 4.0=Exceptional, 3.0=Superior, 2.0=Average, 0.0=Failure, P=Pass, NP=No Pass, AUD=Audit, I=Incomplete, W=Withdrew, WS=Withdrew Satisfactory, WU=Withdrew Unsatisfactory, X=No Grade Received/No Basis for Grade, IP=In Progress. Beginning January 2006: I/(Grade)=Incomplete grade changed to final grade. *OHSU students on the Southern Oregon University (SOU) campus (formerly Southern Oregon State College (SOSC)): valid grades include A, B, C, D, F (with or without plus/minus), from September, 1993 through June, 1994 only.*

**OGI School of Science & Engineering - Beginning Fall 1998:** A=High Pass, B=Pass, C=Low Pass, (+ or - may be used with letter grades), F=Fail, P=Pass, NP=No Pass, W=Withdrawn, I=Incomplete, PI=Permanent Incomplete, AU=Audit, NG=No Grade Submitted. 2008: OGI School of Science & Engineering merged in to the School of Medicine. Beginning Fall 2008: Refer to School of Medicine - Graduate and Allied Health Programs.

**School of Dentistry - Beginning Fall 1979:** Grades of 4.0, 3.5, 3.0, 2.5, 2.0, 1.5, 1.0, 0.0 also designate quality points per credit hour. Other grades are F=Fail, P=Pass, NP=No Pass, EX=Exempt, AUD=Audit, I=Incomplete, W=Withdrew, WS=Withdrew Satisfactory, WU=Withdrew Unsatisfactory, \*no grade (for a continuing term course). Beginning Summer 2007: I/(Grade) - Incomplete grade changed to final grade.

### Former Names

1887: the University of Oregon established a medical school in Portland Oregon. 1926: the University of Oregon established a program in nursing. 1945: the University of Oregon established a dental school by incorporating the North Pacific College of Oregon (formerly known as the North Pacific Dental College). 1974: the Oregon Legislature established the University of Oregon Health Sciences Center as a free-standing institution within the Oregon State System of Higher Education. 1981: the health sciences center was renamed Oregon Health Sciences University. 2001: the Oregon Health Sciences University merged with the Oregon Graduate Institute of Science and Technology (formerly known as the Oregon Graduate Center prior to 1989) and was renamed Oregon Health & Science University.

### Accreditation

Oregon Health & Science University is accredited by the Northwest Commission on Colleges and Universities. In addition, all appropriate health care programs are accredited by specialized accrediting associations.

### Calendar

Oregon Health & Science University operates on the term or quarter system.

### Course Numbering System

200-299	Lower division level
300-499	Upper division level
500-599	Graduate courses offered primarily in support of master's level programs
600-699	Graduate courses offered primarily in support of doctoral level programs
700-799	Professional courses which may be applied to a professional degree

### OGI School of Science & Engineering (Prior to September 2003)

700	Master Thesis Research
800	Post Qualifying Ph.D. Research

### School of Dentistry (Prior to June 2006)

#### DMD courses:

610-619	Professional courses offered primarily in support of first year curriculum
620-629	Professional courses offered primarily in support of second year curriculum
630/730-639/739	Professional courses offered primarily in support of third year curriculum
640/740-649/749	Professional courses offered primarily in support of fourth year curriculum

#### Graduate courses:

500-599	Graduate courses offered primarily in support of master's level programs
600-699	Graduate courses offered primarily in support of the Orthodontics program
700-799	Graduate courses offered primarily in support of master's level programs

### Repeated Courses

A course followed by an E indicates the course has been repeated and has been excluded from the GPA calculation, the total earned credits and the degree requirements.

**Special Subject Codes:** IPE = Interprofessional education and collaborative practice.  
UNI = University course taught in a multiprofessional manner.

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OKLAHOMA STATE BOARD OF  
MEDICAL LICENSURE  
AND SUPERVISION

PRIMARY  
SOURCE





# AMA Physician Profile

PREPARED FOR

Oklahoma State Board of Licensure & Supervision, Oklahoma City, OK

Name and Mailing Address

SAMUEL JONATHAN HUANG

Primary Office Address

PRIMARY SOURCE

Birth date

Phone UNKNOWN

Physician's major professional activity

HOSPITAL BASED RESIDENTS - ALL YEARS

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MAY 14 2024

OKLAHOMA STATE BOARD OF MEDICAL LICENSURE AND SUPERVISION

AMA membership status MEMBER

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

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

NO DATA REPORTED AT THIS TIME

### Current and/or historical medical school

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

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

School: OREGON HEALTH & SCIENCE UNIVERSITY SCHOOL OF MEDICINE

Degree Awarded: YES  
Enrollment Date: 08/2014

Degree Type: MD  
Degree Date: 06/2023

T41439  
SD

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

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

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

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

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

<b>Sponsoring Institution:</b>	UNIVERSITY OF OKLAHOMA COLLEGE OF MEDICINE
<b>Sponsoring State:</b>	OKLAHOMA
<b>Program name:</b>	UNIVERSITY OF OKLAHOMA HEALTH SCIENCES CENTER PROGRAM
<b>Specialty:</b>	OPHTHALMOLOGY
<b>Training Type:</b>	SPECIALTY
<b>Dates:</b>	07/01/2023 - 06/30/2027
<b>Status:</b>	TRAINING IN PROGRESS

### Specialty board certification

NO DATA REPORTED AT THIS TIME

### Current and/or historical medical licensure

NO DATA REPORTED AT THIS TIME

### Action notifications reported to the AMA

**Medical Licensing Boards:** NO ACTIONS REPORTED AT THIS TIME

**Medicare/Medicaid Sanctions from DHHS:** NO ACTIONS REPORTED AT THIS TIME



**US DOJ Drug Enforcement Administration: NO ACTIONS REPORTED AT THIS TIME**

**U.S. Drug Enforcement Administration (DEA)**

NO DATA REPORTED AT THIS TIME

**ECFMG certification**

NOT APPLICABLE

**Profile information**

The content of the AMA Physician Profile is for credentialing use only. The content cannot be used or assembled for an employment purpose as defined under the Fair Credit Reporting Act. An organization's appropriate use of the data contained in the AMA Physician Professional Data™, formerly known as AMA Physician Masterfile, meets select primary source verification requirements of the Joint Commission, the Accreditation Association for Ambulatory Health Care (AAAHC) and the American Accreditation Health Care Commission (AAHCC)/ Utilization Review Accreditation Commission (URAC). The AMA Physician Professional Data is also an NCQA-approved source for verification of medical school, post-graduate medical training, ABMS Board Certification and federal DEA registration.

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

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

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OKLAHOMA STATE BOARD OF MEDICAL LICENSURE AND SUPERVISION

OKLAHOMA STATE BOARD OF MEDICAL LICENSURE AND SUPERVISION
101 NE 51st STREET
OKLAHOMA CITY OK 73105
EVIDENCE OF STATUS - PART A

Full Legal Name: SAMUEL JONATHAN HUANG
Mailing Address: [Redacted]
Social Security #: [Redacted]

PRIMARY EVIDENCE OF CITIZENSHIP
(FOR US CITIZENS, US NATIONALS, OR PERMANENT LEGAL RESIDENT ALIENS)

If you are a U.S. citizen, U.S. national, or permanent legal resident alien, please attach a photocopy of one of the following documents to this form. Place a checkmark below to indicate the document that is attached.

- A birth certificate showing birth in one of the 50 States, the District of Columbia, Puerto Rico...
United States passport (except limited passports, which are issued for periods of less than five years)
Report of birth abroad of a U.S. citizen (FS-240)
Certificate of birth (FS-545)
Certificate of Naturalization (N-550 or N-570)
Certificate of Citizenship (N-560 or N-561)
United States Citizen Identification Card (I-197)
Northern Mariana Identification Card
Statement provided by a U.S. consular officer certifying that the individual is a U.S. citizen
American Indian Card with a classification code "KIC"
Alien Lawfully Admitted for Permanent Residence: INS Form I-551
Alien Lawfully Admitted for Permanent Residence: Unexpired Temporary I-551 stamp

I declare under penalty of perjury, under the laws of the State of Oklahoma, that all information contained in this application and all accompanying documents provided to substantiate my Evidence of Status application are true and correct.

Signature [Handwritten Signature] Date 4/3/2023
Subscribed and sworn before me this 3rd day of April, 2023

Notary Public [Handwritten Signature]
Commission Number 994178
My commission expires 12/01/2023



T 41439 VB



**OKLAHOMA STATE BOARD OF MEDICAL LICENSURE AND SUPERVISION**  
**101 NE 51<sup>ST</sup> STREET**  
**OKLAHOMA CITY OK 73105**  
**Phone: (405)962-1400 Fax: (405)962-1440 email: oktraining@okmedicalboard.org**

To Request Examination Scores	
For National Board Scores National Board of Medical Examiners PO Box 48014 Newark, NJ 07101-4814 (215) 590-9500 www.NBME.org	For FLEX or USMLE Scores Federation of State Medical Boards 400 Fuller Wisser Road Euleess, TX 76039-3855 (817) 868-4000 www.FSMB.org


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 AND SUPERVISION

6. **Extended Background Check** – Applicants for licensure are required to request an Extended Background Check.
7. **Evidence of Status Form** - In order to verify citizenship or qualified alien status, applicants for licensure by endorsement or examination or for reinstatement of their license, must submit an Evidence of Status Form and the required supporting documentation with their application. This form must be notarized and mailed to the office.
8. **Photo and Oath Form** – Applicants for licensure will be required to complete the Photo and Oath Form. This form must be notarized and mailed to the office.
9. **Telemedicine Form** – Applicants planning to practice telemedicine must submit the initialed and signed Telemedicine Questionnaire.
10. **English Proficiency Exam** – Foreign applicants shall have a command of the English language that is satisfactory to the Board, demonstrated by the passage of an oral English competency exam. Applicant is required to call 405-962-1400 and speak with an application analyst in licensing.

G. **Temporary Licensure (59 O.S. § 493.3)** – The Board may authorize the Secretary to issue a Temporary Medical License for the intervals between Board meetings. Such Temporary License shall be granted only when the Secretary is satisfied as to the qualifications of the applicant to be licensed under this Act but where such qualifications have not been verified to the Board. An application for Temporary Licensure must be made by written request and include all appropriate fees. Such a license shall:

1. Be granted only to an applicant demonstrably qualified for a full and unrestricted medical license;
2. Automatically terminate on the date of the next Board meeting at which the applicant may be considered for a full and unrestricted medical license.
3. We must be in receipt of the following in order for the Board Secretary to consider issuing a Temporary License:
  - a. Examination scores, and
  - b. Verification of licensure in all jurisdictions in which applicant has been licensed to practice medicine and surgery, and
  - c. Evidence of Status, and
  - d. Extended Background Check

**I, the undersigned, have fully read and understand the instructions. I swear or affirm that the information submitted in and with the application is, to the best of my knowledge, true and factual. I understand that attempts to deceive or fraudulently portray information contained herein may result in cancellation of my application or charges of filing a fraudulent application that may result in subsequent revocation of licensure.**

Samuel Huang		04/04/2023
Name of Applicant (type or print)	Signature of Applicant	Date

**Except as specifically may be waived by the Board, the Board shall not engage in any application process with any agent or representative of the applicant. 59 O.S. § 492.1 (C); Okla. Admin. Code § 435:10-4-1(c)**

Please return these signed instructions by mail to the address at the top of the page or email.

T 41439  
WB

**Kenna L. Shaw**

---

**From:** BillPay Webmaster <donotreply@www.ok.gov>  
**Sent:** Sunday, April 28, 2024 4:18 PM  
**To:** Dela Kwetey; Bill Pay; Sheila E. Brumfield; Chris Maloney; Licensing; Arlene Morris; Debra Reich  
**Subject:** [EXTERNAL] LICENSE - MD Training-to-Full License Fee 250.00 - Payment Made

SAMUEL JONATHAN HUANG has paid for a LICENSE - MD Training-to-Full License Fee 250.00 on 04/28/2024 04:04:18pm for \$250.00.

OKLAHOMA MD LICENSE NUMBER 41439

To view all transactions please go to <http://www.ok.gov/triton/> and login to your CMS account.

7 41439  
✓





June 2, 2023

Subject: Degree Confirmation

To Whom It May Concern:

Samuel Huang will complete all his MD/PhD dual degree graduation requirements as of April 28<sup>th</sup> 2023 from Oregon Health & Science University, School of Medicine, MD Program. He will be available to attend orientation in June. There are no disciplinary actions pending against him.

His diploma date will be June 23<sup>rd</sup> 2023. His diploma will be available by the first week of August.

If you have any questions, please feel free to contact me at (503) 494-5100.

Sincerely,

Tomo Ito, Ed.D.  
Assistant Dean, UME Curriculum  
School of Medicine  
Oregon Health & Science University

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MEDICAL LICENSURE  
AND SUPERVISION

OHSU School of Medicine  
Office of the Dean  
tel 503 494-8220

Undergraduate Medical Education  
tel 503 494-8228  
fax 503 494-3400

Mail code: CL5MD  
2730 S. Moody Ave.  
Portland, OR 97201

[www.ohsu.edu/som](http://www.ohsu.edu/som)

Associate Dean, Undergraduate  
Medical Education  
Tracy Bumsted, MD, MPH

Assistant Deans, Student Affairs  
Rebecca Cantone, MD  
Benjamin Schneider, MD

Assistant Dean, UME Curriculum  
Tomo Ito, Ed.D, MEd.

Assistant Dean, Admissions  
Robert Cloutier, MD, MCR

Director, Undergraduate Medical  
Education  
Debbie Melton

Director, UME Assessments  
Alexandra Shuford, PhD, MA

Admissions  
Kathryn Guertlin-Davis, MS, Admin  
Manager

Teaching Services  
Emily Larson, Admin Manager

OASIS  
Erika Lenford, MAEd, Program  
Manager

PRIMARY  
SOURCE

T41439  
LKC

Lisa Cullen

OKLAHOMA STATE BOARD OF  
MEDICAL LICENSURE  
AND SUPERVISION

**From:** Samuel Huang [REDACTED]  
**Sent:** Wednesday, May 10, 2023 1:47 PM  
**To:** OK Training  
**Subject:** [EXTERNAL] Re: Oklahoma MD Application #41439 Follow-Up  
**Attachments:** USMLE\_Step2\_score\_report.pdf; USMLE\_Step1\_score\_report.pdf; huang\_OHSU Unofficial Transcript.pdf

To whom it may concern,

Thank you for your initial review of my application. Can you please answer the following questions about the listed deficiencies below in red?

>NEED EXPLANATION OF WHY MEDSCHOOL TOOK 9 YEARS

I was in the MD/PhD program and the PhD portion took 5 years. Do you require further explanation?

> Exam verification date

> USMLE Exams Incomplete

I believe these items may go together so I have attached my official USMLE Step 1 and Step 2 score reports.

> MedSchool-Transcript OR HLTH SCI UNIV SCH OF MED, PORTLAND OR 97201

Attached.

> MedSchool-Form 1 OR HLTH SCI UNIV SCH OF MED, PORTLAND OR 97201

My medical school is offering to fill out this form after I have officially graduated and conferred my MD. This would take place in late July. If you would like this filled out earlier, can you please offer some instruction on how to address the line regarding what degree I was awarded?

> PostGrad - Form 2 COLLEGE OF MEDICINE OKC

This form appears to be for any post-graduate training. Since I have not yet graduated, I have not completed any. Would you like me to submit the form in some way to indicate that it is not applicable?

Thank you very much for your assistance.

Sincerely,  
Samuel Huang

On Tue, May 2, 2023 at 6:02 AM Valeska Barr <[vbarr@okmedicalboard.org](mailto:vbarr@okmedicalboard.org)> wrote:

We have received your Oklahoma MD License Application. Attached is a follow-up letter listing the required items we still have not yet received. It also includes a Username and instructions for checking the status of your application online.

If you have any questions about the licensing process or any listed deficiencies, please direct them to:  
[oktraining@okmedicalboard.org](mailto:oktraining@okmedicalboard.org)



### TIME DEFICIENCY FORM

<b>Name:</b>	Samuel Huang	<b>Application #</b>	
--------------	--------------	----------------------	--

This document is used a tool to help you complete your application.  
Please note: we have to account for any/all time from your 18th birthday to present.

EDUCATION STARTING WITH HIGH SCHOOL							
Start Month	Start Year	End Month	End Year	Name of Institution	City	State	Degree
09	2006	06	2010	Alfred-Almond Central School	Almond	NY	
08	2010	05	2014	University of Rochester	Rochester	NY	BS, BA
08	2014	06	2023	Oregon Health & Science University	Portland	OR	MD,PhD
EMPLOYMENT IF NEEDED TO FILL TIME GAP							
Start Month	Start Year	End Month	End Year	Name of Employer	City	State	Job Title
OTHER - UNEMPLOYED, STAY AT HOME PARENT, SUMMER BREAK, TRAVELING							
Start Month	Start Year	End Month	End Year	Other	City	State	
06	2010	08	2010	Summer Break			
06	2014	08	2014	Summer Break			

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OKLAHOMA STATE BOARD OF  
MEDICAL LicensURE  
AND SUPERVISION

T41439  
VB

05/02/2023

SAMUEL HUANG

**Check Your Application  
Status Online at:**  
<http://www.okmedicalboard.org>  
**Username:AP90713505**  
**Password:Last 4 SSN**

RE: MD Application #41439

Dear SAMUEL HUANG,

**YOU CANNOT PRACTICE YOUR PROFESSION IN THE STATE OF OKLAHOMA UNTIL A VALID LICENSE HAS BEEN ISSUED.**

Your training application has been processed and the current deficiencies are listed below. Please be advised, these may not be the only deficiencies. You will be advised if any other deficiencies are added. You may check your application status online by logging in with the username and password provided above.

If you have further questions please email [oktraining@okmedicalboard.org](mailto:oktraining@okmedicalboard.org)

If a "Time Deficiency" is listed, please complete a time deficiency form and e-mail the document to [oktraining@okmedicalboard.org](mailto:oktraining@okmedicalboard.org) with your activities during the specified time frame.

OTHER DEFICIENCIES: NEED EXPLANATION OF WHY MEDSCHOOL TOOK 9 YEARS  
Exam verification date  
MedSchool-Transcript OR HLTH SCI UNIV SCH OF MED, PORTLAND OR 97201  
MedSchool-Form 1 OR HLTH SCI UNIV SCH OF MED, PORTLAND OR 97201  
PostGrad - Form 2 COLLEGE OF MEDICINE OKC  
USMLE Exams Incomplete

Any of the required forms in the list above may be downloaded from our website:

<http://www.okmedicalboard.org/resources>



In order to check on the status of your application, please log on to our web site:

<https://secure.okmedicalboard.org/applicant/signin>

Your user name is AP90713505 (all caps and no spaces) and your password is the last 4 digits of your social security number.

If you did not provide a social security number with your application, your password will be your 4-digit year of birth in the form "YYYY".

If we may be of further assistance, please email.

[oktraining@okmedicalboard.org](mailto:oktraining@okmedicalboard.org)

Sincerely,

*Valeska Barr*

Valeska Barr

Dept. of Licensing

Encl

# Oklahoma State Board of Medical Licensure and Supervision Application Summary

Type	Number	Name
MD	41439	SAMUEL HUANG
MEDICAL DOCTOR		

**Incomplete Information (due to space limitations on this page, this may not be a complete list)**

Exam verification date  
 PostGrad - Form 2 COLLEGE OF MEDICINE OKC  
 USMLE Exams Incomplete

**Last Medical School Attended:**

040-02 OR HLTH SCI UNIV SCH OF MED, PORTLAND OR 97201

Number of Licenses Previously Granted to Graduates of this Medical School:61

Application for: Resident  Full License \_\_\_\_\_ Reinstatement \_\_\_\_\_

**The Secretary of the Board has reviewed this application and:**

1) AUTHORIZED CIRCULARIZATION TO OTHER BOARD MEMBERS \_\_\_\_\_

- 2) ALL FIVE CRITERIA HAVE BEEN MET [Fast Track] \_\_\_\_\_
- Passed USMLE
  - No DUIs or Legal Issues
  - No Significant Malpractice Issues
  - US Graduate
  - Graduated Medical School on time

3) HAS ISSUED A TEMPORARY LICENSE THROUGH \_\_\_1\_\_\_1\_\_\_

4) HAS ISSUED A SPECIAL PGY-1 TRAINING LICENSE By 7-15-23

5) REQUESTS SPECIFIC CONSIDERATION OF:

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# Oklahoma State Board of Medical Licensure and Supervision

## Application Summary

Type	Number	Name
MD	39598	DAVID ALEJANDRO IRUEGAS NUNEZ
MEDICAL DOCTOR		

**Incomplete Information (due to space limitations on this page, this may not be a complete list)**

OTHER DEFICIENCIES: NEED CURRENT VISA / QUESTIONNAIRE / \$250 UPGRADE FEE / EVALUATION  
 PostGrad - Form 2 COLLEGE OF MEDICINE OKC  
 Extended Background Check

**Last Medical School Attended:**

649-52 Inst Tec Y De Est Sup De Monterrey, Esc De Med I.A.Santos, Monterrey

**Number of Licenses Previously Granted to Graduates of this Medical School:4**

Application for: Resident \_\_\_\_\_ Full License \_\_\_\_\_ Reinstatement \_\_\_\_\_

**The Secretary of the Board has reviewed this application and:**

- 1) AUTHORIZED CIRCULARIZATION TO OTHER BOARD MEMBERS \_\_\_\_\_
- 2) ALL FIVE CRITERIA HAVE BEEN MET [Fast Track] \_\_\_\_\_
  - Passed USMLE
  - No DUIs or Legal Issues
  - No Malpractice Issues
  - US Graduate
  - Graduated Medical School in 4 years or less
- 3) HAS ISSUED A TEMPORARY LICENSE THROUGH \_\_\_\_ / \_\_\_\_ / \_\_\_\_
- 4) HAS ISSUED A SPECIAL PGY-1 TRAINING LICENSE \_\_\_\_\_

# OKLAHOMA STATE BOARD OF MEDICAL BOARD OF LICENSURE AND SUPERVISION

*Note: This information was obtained from FAIMER (Foundation for Advancement of International Medical Education and Research).*

## INTERNATIONAL MEDICAL SCHOOL SUMMARY

**INSTITUTION:** TECNOLOGICO DE MONTERREY ESCUELA DE MEDICINA Y CIENCIAS DE LA SALUD CAMPUS MONTERREY  
**LOCATION:** MEXICO

**ALTERNATE NAMES** INSTITUTO TECNOLOGICO Y DE ESTUDIOS SUPERIORES DE MONTERREY (CURRENT)

### SCHOOL DETAILS

**School type:** PRIVATE  
**Year instruction started:** 1978  
**Operational status:** CURRENTLY OPERATIONAL  
**Additional information:** PRIOR TO 2001, THE DURATION OF THE MEDICO CIRUJANANO CURRICULUM WAS SEVEN YEARS WITHOUT SOCIAL SERVICE

### PROGRAM DETAILS

**Year instruction began:** 1978  
**Curriculum duration:** 6 YEARS  
**Language(s) of instruction:** SPANISH, CASITLIAN  
**Entrance exam:**  **IS REQUIRED**  **IS NOT REQUIRED**  **INFORMATION NOT PROVIDED**  
**Additional information:** THE PROGRAM IS SIX YEARS OF CURRICULUM PLUS ONE YEAR OF SOCIAL SERVICE. ADMISSION FOLLOWS COMPLETION OF UPPER SECONDARY EDUCATION

### SPONSOR NOTES

**Graduation Years:** to ; to ; 1984 to CURRENT  
**Additional Information:** \_\_\_\_\_

**Listed on approved list by California Medical Board:**  **YES**  **NO**

**The total number of graduates from this medical school who are licensed by the Oklahoma Board:**

0  1  2  3  4  5



# Oklahoma State Board of Medical Licensure and Supervision

## Application Summary

**Type**    **Number**    **Name**  
 MD        39598        DAVID ALEJANDRO IRUEGAS NUNEZ  
 MEDICAL DOCTOR

**Practice Address:**

April 20, 2022  
 HOSPITAL NARVAEZ  
 CALLE GUERRERO 790 SUR COLONIA CENTRO  
  
 CIUDAD ACUNA, 26200  
 NOT OKLAHOMA  
 COAHUILA  
 MEXICO

**Status:**

Res: MD

Received: 04/20/2022

Entered: 04/20/2022

Temp Issued:

Temp Expires:

Train Issued: 07/01/2022

Train Expires: 09/30/2024

Fed Rec: 05/31/2024

AMA Rec: 05/31/2024

Board Action:

License #: 39598

Sex: M

Ethnic Origin: 4

Endorsed By: USMLE

Test	Score	Date Taken	Date Verified	Attempts
Test 1: USMLE 3	PASS	02/22/22	4/20/22	1
Test 2: USMLE 2	PASS	02/27/21	4/20/22	1
Test 3: USMLE 1	PASS	10/15/20	4/20/22	1

Note: **PASS** means higher than 75

Test AV:  
 Total Possible:  
 Okla Passing:  
 Total Score:

**PRE-MED EDUCATION**

School Name: INSTITUTO HISPANOAMERICANO DE VILLA ACUNA

City: CIUDAD ACUNA

State: Country: MEXICO

Degree: HIGH SCHOOL

From: 8/2010 To: 7/2013 Verified:

**MEDICAL SCHOOL EDUCATION**

Name: Inst Tec Y De Est Sup De Monterrey, Esc De Med I.A.Santos, Monterrey

Foreign Name:

City: Monterrey

State/Country: Mexico

Degree: PHYSICIAN AND SU

From: 8/2013

To: 7/2020

Diploma Ver'd:

Y

**POST GRADUATE EDUCATION**

Facility: COLLEGE OF MEDICINE OKC

Specialty: INTERNAL MEDICINE

Res. Fellowship: Residency

City: OKLAHOMA CITY

State: OK

Country: UNITED STATES OF AM

Verified:

From: 7/2022

To: /

ACGME Ver'd: 04/25/2022

Comments: 07/03/2023 RCVD EVAL (LKC)

## Oklahoma State Board of Medical Licensure and Supervision

### Application Summary

Type	Number	Name
MD	39598	DAVID ALEJANDRO IRUEGAS NUNEZ
MEDICAL DOCTOR		

#### PRACTICE HISTORY

<b>Employed:</b> HOSPITAL NARVAEZ		<b>Supervisor:</b>	
<b>City:</b> CIUDAD ACUNA		<b>State:</b>	<b>Country:</b> MEXICO
<b>Specialty:</b> GENERAL PRACTITIONER AT EMERGENCY DEPARTMENT		<b>From:</b> 4/2021	<b>To:</b> 5/2022 <b>Verified:</b>
<b>Comments:</b> I AM CURRENTLY COVERING 6 MORNING SHIFTS A WEEK IN THE HOSPITAL'S ED.			

<b>Employed:</b> NONE		<b>Supervisor:</b>	
<b>City:</b> CIUDAD ACUNA		<b>State:</b>	<b>Country:</b> MEXICO
<b>Specialty:</b> UNEMPLOYED		<b>From:</b> 8/2020	<b>To:</b> 3/2021 <b>Verified:</b>
<b>Comments:</b> UNEMPLOYED, LIVING AT MY PARENTS' HOME. VOLUNTEERED WITH COVID TELEHEALTH REMOTE CARE FROM HOME.			

#### Other Licenses

State	Lic Type and Number	Status	Issued	Exp	Verif

#### DEFICIENCIES

OTHER DEFICIENCIES: NEED CURRENT VISA / QUESTIONNAIRE / \$250 UPGRADE FEE / EVALUATION  
PostGrad - Form 2 COLLEGE OF MEDICINE OKC  
Extended Background Check

# Oklahoma State Board of Medical Licensure and Supervision

APPLICATION FOR OKLAHOMA MEDICAL DOCTOR LICENSE

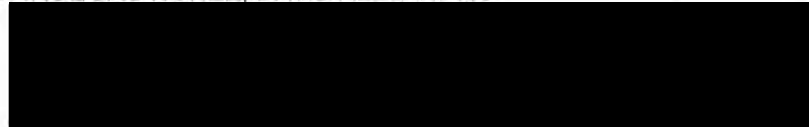
PAGE 170 of 500

Received:04/20/2022

Foreign Graduate

Applicant Name: IRUEGAS NUNEZ, DAVID ALEJANDRO

MD 39598



Date Of Birth: [Redacted] Place Of Birth (City, State): PIEDRAS NEGRAS, COAHUILA, MEXICO

Sex: M

Race: Hispanic

Education									
Type	Name	City	ST	Country	From	To	Degree	Comments	Veri
HS	INSTITUTO HISPANOAMERICANO DE VILLACUNA	CIUDAD ACU		MEXICO	8/2010	7/2013	HIGH SCHOOL		

Medical School Name	City	State	Country	Comments	From	To
Inst Tec Y De Est Sup De Monterrey, Esc De Med I.A.Santos, Monterrey	Monterrey		Mexico		8/2013	7/2020

Post-Graduate						
Facility	City	St	Country	Specialty	Comments	From To
						/ /

Practice History								
Employer	Specialty	Supervisor	City	ST	Countr	From	To	Verif
HOSPITAL NARVAEZ	GENERAL PRACTITIONER AT EMERGENCY DEPARTMENT		CIUDAD ACUNA		MEXICO	4/2021	0/0	
NA	UNEMPLOYED		CIUDAD ACUNA		MEXICO	8/2020	3/2021	

Other/ Out-Of-State Licenses					
State	License #	Profession	Status	Issue Date	Exp Date

\$250

MD Exam				
Exam	State	Score	Date Taken	#
USMLE				



# Oklahoma State Board of Medical Licensure and Supervision

APPLICATION FOR OKLAHOMA MEDICAL DOCTOR LICENSE

PAGE 171 of 500

Received:04/20/2022

Foreign Graduate

Questions Answered 04/07/2022	Response
A. Have you ever been denied provider participation, terminated, sanctioned, or penalized by any third party payor, to include TRICARE, MEDICARE, MEDICAID?	N
B. Have you ever surrendered or had any adverse action taken against any narcotic permit (state or federal)?	N
C. Have you ever been denied membership or had disciplinary action taken by a national, state or county professional organization?	N
D. Have you ever been denied or had removed or suspended hospital staff privileges?	N
E. Have you ever surrendered hospital staff privileges while under investigation or to avoid investigation?	N
F. Have you ever entered into an agreement with a federal, state or local jurisdictional body to avoid formal action?	N
G. Have you ever been the subject of an investigation, probation or disciplinary action by a hospital, clinic, practice group, training program or professional school?	N
H. Have you had any adverse judgment, settlement, or award against you arising from a professional liability claim?	N
I. Have you ever had professional liability coverage declined, canceled, issued on special terms, or renewal refused?	N
J. Have you ever been reported to the National Practitioners Data Bank (NPDB) or to the Healthcare Integrity and Protection Data Bank (HIPDB)? (If yes, enclose a copy of the report.)	N
K. Has your application for examination or a professional license ever been denied?	N
L. Have you ever failed any part of a licensure/certification/registration examination?	N
M. Have you ever surrendered a license or had a license revoked?	N
N. Has any disciplinary action been taken on any license?	N
O. Have you ever been subject of a review by professional licensing/regulatory agency based on a complaint filed against you?	N
P. Have you ever been arrested, charged with, or convicted of a felony or misdemeanor, other than traffic violations?	N
Q. Have you ever been arrested, charged with, or convicted of a traffic violation involving the use of any drug or chemical substance, including alcohol?	N
R. Are you now or have you within the past two years been addicted to or used in excess any drug or chemical substance, including alcohol?	N
S. Have you obtained an assessment or been treated for the use of any drug or chemical substance, including alcohol?	N
T. Do you currently have or have you had within the past two years any mental or physical disorder or condition which, if untreated, could affect your ability to practice competently?	N
U. Are you or your spouse currently on Active Duty in the U.S. Armed Forces?	N
V. Are you or your spouse currently Deployed on Active Duty in the U.S. Armed Forces?	N

Foreign Graduate

Oklahoma State Board of Medical Licensure and Supervision

APPLICATION FOR OKLAHOMA MEDICAL DOCTOR LICENSE

PAGE 172 of 500

Received:04/20/2022

Foreign Graduate

If licensed, where do you intend to locate?

OK

Why do you seek Licensure in the state of Oklahoma?

Post-Graduate Training

In what manner will you be communicating with your Oklahoma patients (telephone, email, internet, video-conference, etc)?

Describe how you will examine each patient in person prior to diagnosis, treating, correcting, or prescribing for a patient in Oklahoma from the state, province, or country you are located:

Describe the manner in which you intend to practice medicine across state lines in Oklahoma:

Have you executed or been offered a contract in connection with practice in the state of Oklahoma?

Yes

If 'Yes', Name of practice:

The University of Oklahoma Medical Sciences Center

If so, Please identify with which category:

Hospital

Name of Previous Carrier and Policy Holder

Not applicable

Name of Current Carrier and policy Holder

I will have malpractice insurance provided by the training program.

Will your professional liability insurance policy cover your practice in Oklahoma

Yes

If NO, when do you expect to obtain liability insurance that will cover practice in Oklahoma

I attest that all the above information is accurate as of April 19, 2022: \_\_\_\_\_ (Signed Online) \_\_\_\_\_

Foreign Graduate



**Applicant:** In the presence of a notary public, sign this form with attached photo.

**Send this form to:**

Oklahoma State Board of Medical Licensure and Supervision  
101 NE 51<sup>st</sup> Street  
Oklahoma City, OK 73105

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

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

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

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

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

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



*David Iruegas*

ID# 1305012206102

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

**Iruegas Nunez, David, A.**

Applicants printed last name, first name, middle initial, and suffix (e.g., Jr.)

April - 29 - 2022

Date of signature (must correspond to the date of notarization)

[Please note: The Notary Public seal should overlap the bottom of the photo to the left]

**NOTARY**

State of Coahuila, County of Acuña

RECEIVED  
MAY 02 2022  
OKLAHOMA STATE BOARD OF  
MEDICAL LICENSURE  
AND SUPERVISION

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

The statements on this document are subscribed and sworn to before me by the applicant on this 29 day of April, 2022

Notary Public Signature \_\_\_\_\_

My Notary Commission Expires N/A



T39598  
100A





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

**RECEIVED**

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

APR 20 2022

OKLAHOMA STATE BOARD OF  
MEDICAL LICENSURE  
AND SUPERVISION

**PRIMARY  
SOURCE**

**Recipient:** OKLAHOMA STATE BOARD OF  
MEDICAL LICENSURE & SUPERVISION

**Date:** 04/19/2022

**Examinee:** Iruegas Nunez, David Alejandro  
**Alt Name(s):**

**Examinee ID:** 1-098-406-0

**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. Pass/fail outcomes are based upon the minimum passing level in place at the time of test administration and are not altered by subsequent revisions to the minimum passing level. Effective April 1, 2013, two-digit scores will no longer be reported. Test results reported as passing represent an exam score of 75 or higher on a two-digit scale. Step 1 examinations taken on or after January 26, 2022 are reported as pass/fail, with no numeric score; Step 1 examinations taken before January 26, 2022 will continue to be reported with a 3-digit score.

**USMLE STEP 1**

Test Date	Pass/Fail	Score	Minimum Pass	Comments
10/15/2020	Pass	267	(194)	

**USMLE STEP 2**

*Clinical Knowledge (CK)*

Test Date	Pass/Fail	Score	Minimum Pass	Comments
02/27/2021	Pass	278	(209)	

**USMLE STEP 3**

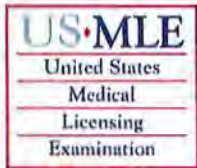
Test Date	Pass/Fail	Score	Minimum Pass	Comments
02/22/2022	Pass	246	(198)	

**End of Exam History**

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

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

TMD 39598  
SJ



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

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

**Examinee:** Iruegas Nunez, David Alejandro

**Examinee ID:** 1-098-406-0

**Date of Birth:** [REDACTED]

### INTERPRETATION OF RESULTS

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

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

### STEP 1 AND STEP 2 CLINICAL SKILLS (CS)

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

### ANNOTATIONS APPEARING UNDER "COMMENTS"

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

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

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

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

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

### ANNOTATIONS APPEARING AS "NOTE"

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

### PHYSICIAN DATA CENTER INFORMATION APPEARING AS "NOTE"

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

03/2015

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



RECEIVED

APR 25 2022

OKLAHOMA STATE BOARD OF MEDICAL LICENSURE AND SUPERVISION

Form 1 (MD)

Oklahoma State Board of Medical Licensure and Supervision
101 NE 51st Street
Oklahoma City, OK 73105

This form must be completed by the institution and mailed directly from the institution.

Applicant's Name David Alejandro Iruegas Núñez
Institution: Escuela de Medicina y Ciencias de la Salud City/State Monterrey, N.L., Mexico

Our records indicate that the above named applicant attended our medical school on the following dates:

From 08 / 05 / 2013 To 07 / 31 / 2020 and was awarded the degree Physician and Surgeon

- 1. Does this individual's official record reflect (an) interruption(s) or extension(s) in his/her medical education? If yes, please explain.
2. Does this individual's official record reflect that he/she was ever placed on academic or disciplinary probation during his/her medical education? If yes, please explain.
3. Does this individual's official record reflect that he/she was ever the subject of negative reports for behavioral reasons or an investigation by the medical school or parent university? If yes, please explain below.
4. Does this individual's official record reflect that he/she was ever disciplined for unprofessional conduct/behavioral reasons by the medical school or parent university? If yes, please explain below.
5. Does this individual's official record reflect that there were any limitations or special requirements imposed on the individual because of questions of academic incompetence, disciplinary problems, or any other reason? If yes, please explain below.

Please explain any "YES" response from above:

Completion of the following is certification that the information above is an accurate account of this individual's records and is true and correct.

Name: Jorge Eugenio Valdez García, MD PhD Signature: [Handwritten Signature]
Title of Signatory: Dean of School of Medicine and Health Sciences Date of Signature: April 21, 2022
Tel: +52 81 8888 2000 Fax: E-Mail: jorge.valdez@tec.mx



Escuela de Medicina y Ciencias de la Salud TecSalud

If no seal is available, this form must be notarized

Notary Public
Commission #
My commission expires:

PRIMARY SOURCE

Notary Seal

TMD39598 52





INSTITUTO TECNOLÓGICO  
Y DE ESTUDIOS SUPERIORES  
DE MONTERREY

Campus Monterrey

Certificate of studies \*

Folio 18- 8635 I

\* Official transcripts are issued only in Spanish.

The Office of the Registrar of the Instituto Tecnológico y de Estudios Superiores de Monterrey certifies that the student named in this document has credited the subjects listed below in the academic periods cited.

This certificate is only valid as an original copy when it bears the raised seals of the Institute. The studies certified by this document are officially valid in the entire country in accordance with the Presidential Decree of July 24, 1952, published in the Diario Oficial de la Federación of September 12, 1952 and Agreement Number 3438 issued by the Ministry of Public Education on February 28, 1974 and published in the Diario Oficial de la Federación on March 5 of the same year. The Tecnológico de Monterrey is accredited by the Commission on Colleges of the Southern Association of Colleges and Schools to award bachelor's, master's, and doctoral degrees. Contact the Commission on Colleges at 1866 Southern Lane, Decatur, Georgia 30033-4097 or call (+1) 404-679-4500 for questions about the accreditation of the Tecnológico de Monterrey. Courses are given in eighteen-week semesters, or in six-week periods, on an intensive basis. Semesters begin in August and January. Intensive courses begin in June and are given in the same number of hours as in the semesters. In some of the graduate programs, courses are given in twelve-week trimesters, beginning in January, April and September. The grading scale is from 1 to 100. The minimum passing grade is 70.

Name David Alejandro Iruegas Núñez

Date September 23rd, 2020

Registration number 815209

RECEIVED

APR 25 2022

OKLAHOMA STATE BOARD OF  
MEDICAL LICENSURE  
AND SUPERVISION

This certificate was issued at Monterrey, Nuevo León

(This is the translation and therefore is unsigned)  
Registrar

This document certifies studies in PHYSICIAN & SURGEON

Name of course	Grade	Name of course	Grade
<b>August - December 2013</b>		Morphofunctional Laboratory	95
Analysis and Verbal Expression	99	Microbiology and Parasitology	95
Chemical Foundations of Metabolism and Physiology	96	Musculoskeletal and Digestive Systems	92
Cell Biology	95	Biocontrol Systems	93
Historical Foundations in Health Sciences	100	Community I	100
Histology	96	<b>January - May 2015</b>	
Research and Technology in Health Sciences	99	Verbal Expression in the Workplace	96
Introduction to the Medical Doctor Academic Program	99	Ethics, Self and Society	97
<b>January - May 2014</b>		Defense and Hemostasis	97
Biostatistics	100	General Pharmacology and Toxicology	98
Metabolism and Functional Biochemistry	98	Vital Processes	91
Developmental Biology	96	History Taking and Clinical Examination I	93
Genetics for Health Sciences	95	Community II	100
Basic Morphophysiology	94	<b>August - December 2015</b>	
<b>August - December 2014</b>		Humanities and Fine Arts	100
Foreign Language	94	Pathophysiology of the Endocrine System	99
Healthy Environment and Self-care	100	Morphological and Functional Pathology I	89
CONTINUED NEXT COLUMN		Pathophysiology	92
		OVER	

PRIMARY  
SOURCE

PTO

TMD 39598  
SS

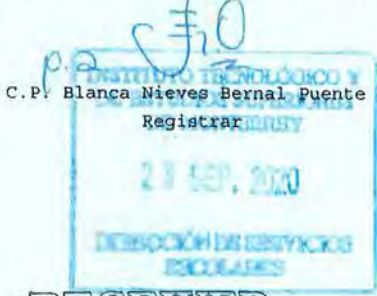


Name David Alejandro Iruegas Núñez

Registration number 815209

Name of course	Grade	Name of course	Grade
History Taking and Clinical Examination II	93	Quality Healthcare and Patient Safety	100
Community III	100	<b>June - September 2018</b>	
<b>January - May 2016</b>		Critical Appraisal of Medical Literature	100
Applied Pharmacology	97	Emergency Clinic	99
Pathophysiology of the Digestive System and Nutrition	92	Radiology Clinic	95
Renal Pathophysiology	95	Traumatology, Orthopedics and Rehabilitation Clinic	90
Community Research	100	Emergencies	88
Morphological and Functional Pathology II	94	Radiology	95
Health Psychology	98	Traumatology, Orthopedics and Rehabilitation	100
<b>August - December 2016</b>		<b>September - December 2018</b>	
Entrepreneurship	94	Dermatology Clinic	100
Pathophysiology of the Circulatory System	88	Oncology Clinic	100
Pathophysiology of Respiratory System	95	Rheumatology and Allergies Clinic	100
Clinical Pathology Laboratory	94	Dermatology	99
Legal and Forensic Medicine	92	Medical Immunology	94
Pre-hospitalization Care and Clinical Skills	93	Oncology and Palliative Care	98
Morphological and Functional Pathology III	92	Rheumatology and Allergies	96
<b>January - May 2017</b>		<b>January - March 2019</b>	
Citizenship	99	Geriatrics Clinic	99
Global Health and Preventive Medicine	96	Neurology and Neurosurgery Clinic	99
Pathophysiology of Nervous System	93	Psychiatry Clinic	99
Pathophysiology of Reproductive System	92	Geriatrics	88
Family Medicine	94	Neurology and Neurosurgery	86
Morphological and Functional Pathology IV	92	Psychiatry	96
Principles of Health Management	100	<b>March - June 2019</b>	
<b>June - September 2017</b>		Introduction to Professional Development	99
Cardiology and Metabolic Diseases	87	Professional Elective I	100
Internal Medicine Clinic	93	Professional Elective II	100
Complementary Medicine	100	Professional Elective Clinic	100
Internal Medicine	89	-----	
<b>September - December 2017</b>		This certificate covers 92 (NINETY TWO) courses that make up the entire curriculum for Physician & Surgeon (Version 2011).	
Surgery	95	Grade point average for all the courses included in this certificate	95.89
Surgery Clinic	100		
Otorhinolaryngology and Ophthalmology Clinic	100		
Otorhinolaryngology and Ophthalmology	96		
<b>January - March 2018</b>			
Legal Issues of Medical Practice	95		
Clinical Bioethics	100		
Obstetrics and Gynecology Clinic	100		
Obstetrics and Gynecology	89		
<b>March - June 2018</b>			
Bioethics	100		
Pediatrics Clinic	98		
Pediatrics	89		
CONTINUED NEXT COLUMN			

THIS IS THE OFFICIAL TRANSLATION OF THE TRANSCRIPT ISSUED BY INSTITUTO TECNOLÓGICO Y DE ESTUDIOS SUPERIORES DE MONTERREY



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APR 25 2022

PRIMARY SOURCE





**INSTITUTO TECNOLÓGICO  
Y DE ESTUDIOS SUPERIORES  
DE MONTERREY**

**Campus Monterrey**

*Constancia de historia académica*

Folio **18-7161**

*La Dirección de Servicios Escolares del Instituto Tecnológico y de Estudios Superiores de Monterrey del campus o de la entidad que se indica, hace constar que el alumno cuyo nombre aparece en este documento cursó en los períodos escolares indicados las materias que abajo se enumeran, habiendo obtenido en ellas las calificaciones finales que se indican.  
Esta constancia es válida y original únicamente si lleva el sello realizado del Instituto y las firmas de las autoridades correspondientes, registradas ante la Secretaría de Educación Pública. Los estudios realizados en el Instituto Tecnológico y de Estudios Superiores de Monterrey tienen validez oficial en todo el país, de acuerdo con el Decreto Presidencial del 24 de julio de 1952, publicado en el Diario Oficial de la Federación el 12 de septiembre de 1952 y el Acuerdo No. 3438 expedido por el Secretario de Educación Pública el 28 de febrero de 1974 y publicado en el Diario Oficial de la Federación el 5 de marzo del mismo año. El Tecnológico de Monterrey está acreditado por la Comisión de Universidades de la Asociación de Escuelas e Universidades del Sur de Estados Unidos para otorgar títulos profesionales y grados académicos de maestría y doctorado. Comuníquese con la Comisión de Universidades en la dirección 1866 Southern Lane, Decatur, Georgia 30033-4097, o llame al (+1) 404-679-4500, para preguntas sobre la acreditación del Tecnológico de Monterrey. Los cursos se desarrollan en semestres de 18 semanas o en cursos intensivos con duración de 6 semanas. Los semestres se inician en agosto y en enero. Los cursos intensivos se inician en junio y se imparten en un número de horas igual al de los semestres. Algunos programas de graduados se imparten en períodos trimestrales de doce semanas de duración. Los trimestres comienzan en enero, abril y septiembre. La escala de calificaciones es de 1 a 100. La calificación mínima para aprobar un curso es 70.*

Nombre del alumno David Alejandro Iruegas Núñez

Número de matrícula 815209

**RECEIVED**

**APR 25 2022**

OKLAHOMA STATE BOARD OF  
MEDICAL LICENSURE  
AND SUPERVISION

Fecha 21 de septiembre de 2020

Esta constancia se expidió en Monterrey, Nuevo León

*[Firma]*  
Lic. Angelberto Guardado Astorga  
Director de Servicios Escolares

Esta constancia ampara estudios de MÉDICO CIRUJANO

Nombre del curso	Calificación	Nombre del curso	Calificación
<b>Agosto - Diciembre 2013</b>		Microbiología y parasitología	95
Análisis y expresión verbal	99	Sistemas locomotor y digestivo	92
Bases químicas del metabolismo y la fisiología	96	Sistemas biocontroladores	93
Biología celular	95	Comunidad I	100
Fundamentos históricos en ciencias de la salud	100	<b>Enero - Mayo 2015</b>	
Histología	96	Expresión verbal en el ámbito profesional	96
Investigación y recursos tecnológicos en salud	99	Ética, persona y sociedad	97
Introducción a la carrera de MC	99	Defensa y homeostasia	97
<b>Enero - Mayo 2014</b>		Farmacología y toxicología general	98
Bioestadística	100	Procesos vitales	91
Metabolismo y bioquímica funcional	98	Propedéutica clínica I	93
Biología del desarrollo	96	Comunidad II	100
Genética para ciencias de la salud	95	<b>Agosto - Diciembre 2015</b>	
Morfofisiología básica	94	Humanidades y bellas artes	100
<b>Agosto - Diciembre 2014</b>		Fisiopatología del sistema endócrino	99
Lengua extranjera	94	Patología morfológica y funcional I	89
Entorno saludable y autocuidado	100	Procesos fisiopatológicos	92
Laboratorio morfofuncional basado en evidencias	95	Propedéutica clínica II	93
<b>AL FRENTE</b>		Comunidad III	100
		<b>Enero - Mayo 2016</b>	
		Farmacología aplicada	97
		<b>A LA VUELTA</b>	

No es válida si lleva raspaduras o empujaderos

**PRIMARY  
SOURCE**



Nombre del alumno David Alejandro Iruegas Núñez

Número de matrícula 815209

Nombre del curso	Calificación	Nombre del curso	Calificación
Fisiopatología del sistema digestivo y de la nutrición	92	Clínica de traumatología, ortopedia y rehabilitación	90
Fisiopatología del sistema renal	95	Emergencias	88
Investigación en la comunidad	100	Radiología	95
Patología morfológica y funcional II	94	Traumatología, ortopedia y rehabilitación	100
Psicología de la salud	98	<b>Septiembre - Diciembre 2018</b>	
<b>Agosto - Diciembre 2016</b>		Clínica de dermatología	100
Emprendimiento	94	Clínica de oncología	100
Fisiopatología del sistema circulatorio	88	Clínica de reumatología y alergias	100
Fisiopatología del sistema respiratorio	95	Dermatología	99
Laboratorio de patología clínica	94	Inmunología médica	94
Medicina legal y forense	92	Oncología y cuidados paliativos	98
Medicina prehospitalaria y habilidades clínicas	93	Reumatología y alergias	96
Patología morfológica y funcional III	92	<b>Enero - Marzo 2019</b>	
<b>Enero - Mayo 2017</b>		Clínica de geriatría	99
Ciudadanía	99	Clínica de neurología y neurocirugía	99
Salud global y medicina preventiva	96	Clínica de psiquiatría	99
Fisiopatología del sistema nervioso	93	Geriatría	88
Fisiopatología del sistema reproductor y del desarrollo	92	Neurología y neurocirugía	86
Medicina familiar	94	Psiquiatría	96
Patología morfológica y funcional IV	92	<b>Marzo - Junio 2019</b>	
Fundamentos de la gestión administrativa en el sector salud	100	Introducción a la vida profesional	99
<b>Junio - Septiembre 2017</b>		Optativa profesional I	100
Cardiología y enfermedades metabólicas	87	Optativa profesional II	100
Clínica de medicina interna	93	Clínica de optativa profesional	100
Medicina complementaria	100	-----	
Medicina interna	89	Esta constancia ampara 92 (noventa y dos) materias que cubren completamente el plan de estudios de Médico Cirujano (Plan 2011).	
<b>Septiembre - Diciembre 2017</b>			
Cirugía	95		
Clínica de cirugía	100		
Clínica de otorrinolaringología y oftalmología	100		
Otorrinolaringología y oftalmología	96		
<b>Enero - Marzo 2018</b>			
Aspectos legales de la práctica médica	95		
Bioética clínica	100		
Clínica de ginecología y obstetricia	100		
Ginecología y obstetricia	89		
<b>Marzo - Junio 2018</b>			
Bioética	100		
Clínica de pediatría	98		
Pediatría	89		
Calidad y seguridad del paciente	100		
<b>Junio - Septiembre 2018</b>			
Análisis crítico de la literatura médica	100		
Clínica de emergencias	99		
Clínica de radiología	95		
AL FRENTE			

No es válida si lleva respaldos o empuñaduras



RECEIVED

APR 25 2022

OKLAHOMA STATE BOARD OF  
MEDICAL LICENSURE  
AND SUPERVISION





Issue Date: 19 Apr 2022

To: STATE BOARD OF LICENSURE & SUPERVISION  
LISA CULLEN  
DIRECTOR OF LICENSING  
P.O. BOX 18256  
OKLAHOMA CITY, OK 73154-0256

State Board Code:

037

Please include this number on all requests.

**ECFMG® CERTIFICATION STATUS REPORT**

RECEIVED

APR 19 2022

OKLAHOMA STATE BOARD OF MEDICAL LICENSURE AND SUPERVISION

USMLE®/ECFMG Identification Number: 1-098-406-0  
Applicant's Name: David Alejandro Iruegas Nunez ✓  
Applicant's Date of Birth: [REDACTED] ✓  
ECFMG Certified: Yes ✓  
Certificate Issue Date: 14 May 2021  
English Test Valid Through: 31 Dec 2024  
Clinical Skills Assessment Valid Through: 31 Dec 2024

PRIMARY SOURCE

**Passing Performance on Medical Science Examinations:**

Examination	Date	Two Digit Score	Three Digit Score
USMLE Step 1	15 Oct 2020	*	*
USMLE Step 2 CK	27 Feb 2021	*	*

**Most Recent Passing Performance on Clinical Skills Examination:**

Examination	Date
ECFMG Clinical Skills Pathway **	N/A

\*\* This individual met the clinical and communication skills requirements, including English language proficiency, for ECFMG Certification through one of the Pathways developed in response to the suspension and subsequent discontinuation of USMLE Step 2 CS.

Name of Medical School and Country: Tecnológico de Monterrey Escuela de Medicina Monterrey, Monterrey, MEXICO

Degree Year: 2020

Medical Education Credentials Status†: Complete

**How to Verify the Authenticity of this Report:**

This report was issued to the named recipient on the date shown above. To verify the authenticity of this report, visit <https://cvsonline2.ecfm.org/verify/verify.asp> and enter the unique verification code listed below. The information contained in this report is current as of the issue date. Any changes to the physician's status after the issue date will not be reflected, and you are encouraged to request an updated report.

Report Verification Code: QY71DORVM6

The purpose of this Status Report is to indicate whether this individual is certified by ECFMG. It reflects only examinations that were used to fulfill requirements for ECFMG Certification. The most recent passing performance on the clinical skills examination is reflected, regardless of whether this individual was required to take a clinical skills examination for ECFMG Certification. This Status Report is not a complete score history of all examinations for this individual. This Status Report does not include examinations that were taken but not passed. Furthermore, if this individual passed examinations that were not used to fulfill the requirements for ECFMG Certification, these examinations are not included.

\* To obtain a complete USMLE examination history for this individual, contact the appropriate registration entity to request a USMLE transcript.

† Since July 1986, ECFMG has verified medical school credentials directly with the issuing medical schools, or through a reasonable alternative that has been approved by the ECFMG Medical Education Credentials Committee.

**Important Note:**

Requesting organizations must normally secure and retain the physician's signed authorization to obtain certification information. Organizations may not resell the information or make it available to any party beyond the initial request as authorized by the physician. The information may only be used to confirm ECFMG Certification for the purpose for which the physician provided authorization.

T 39598  
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# AMA Physician Profile

PREPARED FOR

Oklahoma State Board of Licensure & Supervision, Oklahoma City, OK

RECEIVED  
MAY 31 2024  
OKLAHOMA STATE BOARD OF  
MEDICAL LICENSURE  
AND SUPERVISION

**Name and Mailing Address**

DAVID ALEJANDRO IRUEGAS  
UNIV OF OKLAHOMA  
STE 6300  
800 STANTON L YOUNG BLVD  
OKLAHOMA CITY, OK 73104-5018

**Primary Office Address**

800 STANTON L YOUNG BLVD 6300  
OKLAHOMA CITY, OK 73104-5018

**Birth date** [REDACTED]

**Phone** UNKNOWN

PRIMARY SOURCE

**Physician's major professional activity**

HOSPITAL BASED RESIDENTS - ALL YEARS

**AMA membership status** MEMBER

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

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

NPI Number	Enumeration Date	Deactivation Date	Reactivation Date	Replacement Number	Last Reported Date
1952037657	07/26/2022	NOT RPTD	NOT RPTD	NOT RPTD	05/17/2024

**Current and/or historical medical school**

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

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

**School:** ESCUELA DE MEDICINA IGNACIO A SANTOS

T39598  
S7





**Degree Awarded:** YES  
**Enrollment Date:** NOT REPORTED  
**Degree Type:** MD  
**Degree Date:** 2020

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

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

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

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

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

**Sponsoring Institution:** UNIVERSITY OF OKLAHOMA COLLEGE OF MEDICINE  
**Sponsoring State:** OKLAHOMA  
**Program name:** UNIVERSITY OF OKLAHOMA HEALTH SCIENCES CENTER PROGRAM  
**Specialty:** INTERNAL MEDICINE  
**Training Type:** SPECIALTY  
**Dates:** 07/01/2022 - 06/30/2025  
**Status:** TRAINING IN PROGRESS

### Specialty board certification

NO DATA REPORTED AT THIS TIME

### Current and/or historical medical licensure

License Number	MD / DO	Locale	Date Granted	Expiration Date	Renewal Date	Status	License Type	Last Reported	Name on License
39598	MD	OK	07/01/2022	09/30/2024		ACT	RES	05/06/2024	DAVID ALEJANDRO IRUEGAS NUNEZ

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

### Action notifications reported to the AMA

**Medical Licensing Boards:** NO ACTIONS REPORTED AT THIS TIME

**Medicare/Medicaid Sanctions from DHHS:** NO ACTIONS REPORTED AT THIS TIME

**US DOJ Drug Enforcement Administration:** NO ACTIONS REPORTED AT THIS TIME

### U.S. Drug Enforcement Administration (DEA)

NO DATA REPORTED AT THIS TIME

### ECFMG certification

Applicant Number: 10984060

*The Educational Commission for Foreign Medical Graduates (ECFMG) applicant identification number does not imply current ECFMG certification status. To verify ECFMG status, contact the ECFMG Certification Verification Service online at <https://cvsonline2.ecfm.org/>*

### Profile information

The content of the AMA Physician Profile is for credentialing use only. The content cannot be used or assembled for an employment purpose as defined under the Fair Credit Reporting Act. An organization's appropriate use of the data contained in the AMA Physician Professional Data™, formerly known as AMA Physician Masterfile, meets select primary source verification requirements of the Joint Commission, the Accreditation Association for Ambulatory Health Care (AAAHC) and the American Accreditation Health Care Commission (AAHCC)/ Utilization Review Accreditation Commission (URAC). The AMA Physician Professional Data is also an NCQA-approved source for verification of medical school, post-graduate medical training, ABMS Board Certification and federal DEA registration.

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

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





**Lisa Cullen**

---

**From:** David Iruegas [REDACTED]  
**Sent:** Friday, April 29, 2022 1:32 PM  
**To:** Lisa Cullen  
**Subject:** [EXTERNAL] RE: Oklahoma MD Application #39598 Deficiencies  
**Attachments:** David Iruegas Evidence of Status.pdf; David Iruegas N Photo and Oath.pdf

Good afternoon. Attached to this mail are my notarized documents:

1. Evidence of Status along with a copy of mi B1/B2 current Visa (Expiry date: March 12 2030) and most recent I-94.
2. Photo and Oath

To answer the questions. Yes, in Mexico, we have 7 years of medical school, including a year of social service, before we can graduate and get our Physician and Surgeon title. I am still working in Hospital Narvaez. My last day here will be May 5th, 2022.

Thank you for your time and attention. Please do not hesitate to contact me if you need any more documents or information.

Best regards,  
David Iruegas

---

**De:** Lisa Cullen <lullen@okmedicalboard.org>  
**Enviado:** lunes, 25 de abril de 2022 14:28  
**Para:** [REDACTED]  
**Asunto:** Oklahoma MD Application #39598 Deficiencies

We have received your Oklahoma MD License Application. Attached is a letter listing the required items we have not yet received. It also includes a Username and instructions for checking the status of your application online.

RECEIVED  
MAY 02 2022  
OKLAHOMA STATE BOARD OF  
MEDICAL PROFESSIONS  
AND SUPERVISION

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ran



04/25/2022

DAVID ALEJANDRO IRUEGAS NUNEZ



**Check Your Application Status Online at:**  
<http://www.okmedicalboard.org>  
**Username:AP77238774**  
**Password:4 Digit Birth Year**

RE: MD Application #39598

Dear DAVID IRUEGAS NUNEZ,

**YOU CANNOT PRACTICE YOUR PROFESSION IN THE STATE OF OKLAHOMA UNTIL A VALID LICENSE HAS BEEN ISSUED.**

This deficiency list may or may not contain all required deficiencies. Please **allow 5 business days** for review by a licensing analyst, at which time you may check your updated status online by logging in with the username and password provided above. If you have further questions at that time, you may email the Licensing Staff at [licensing@okmedicalboard.org](mailto:licensing@okmedicalboard.org) or call (405) 962-1470.

Review of your application for special licensure to practice medicine and surgery in the state of Oklahoma reveals the following deficiencies:

- OATH
- Evidence of Status
- Visa Type (if non-US citizen)
- Visa Expiration Date (if non-US citizen)
- INSTRUCTION SHEET
- MedSchool-Form 1 Inst Tec Y De Est Sup De Monterrey, Esc De Med I.A.Santos, Monterrey
- PostGrad - Form 2
- PostGrad - Form 2 COLLEGE OF MEDICINE OKC
- OTHER DEFICIENCIES: HAVE YOU BEEN IN MED SCHOOL FOR 7 YEARS? / \*DO NOT NEED: FORM 2, STEP 3, AMA, FED, NPDB
- US Customs and Immigration Service (USCIS)
- Translations
- MedSchool-Transcript Inst Tec Y De Est Sup De Monterrey, Esc De Med I.A.Santos, Monterrey
- Social Security Number
- Extended Background Check
- Time DEFICIENCIES: ARE YOU STILL WORKING AT HOSPITAL NARVAEZ? IF NOT, WHEN DID/DOES JOB END?

If a "Time Deficiency" is listed, please e-mail [licensing@okmedicalboard.org](mailto:licensing@okmedicalboard.org) with your activities during the specified time frame.

Any of the required forms in the list above may be downloaded from our website:

<http://www.okmedicalboard.org/resources>

In order to check on the status of your application, please log on to our web site ([www.okmedicalboard.org](http://www.okmedicalboard.org)). Your user name is **AP77238774** (all caps and no spaces) and your password is the last 4 digits of your social security number. If you did not provide a social security number with your application, your password will be your 4-digit year of birth in the form "YYYY". To log in, scroll down the home page until you see the tabs in the middle of the page. Click on the tab labeled "eServices," then click "Online Application Status Check." This will open a webpage that allows you to enter your login information.

If we may be of further assistance, please email [licensing@okmedicalboard.org](mailto:licensing@okmedicalboard.org) or call (405) 962-1470.

Sincerely,

**Lisa Cullen**

Lisa Cullen  
Director of Licensing  
Dept. of Licensing

Encl



RETURN FORM TO:  
OKLAHOMA STATE BOARD OF MEDICAL LICENSURE AND SUPERVISION  
oktraining@okmedicalboard.org

RECEIVED

APR 04 2023

OKLAHOMA STATE BOARD OF  
MEDICAL LICENSURE  
AND SUPERVISION

QUESTIONNAIRE  
Please read and follow ALL instructions

**FORM INSTRUCTIONS:** Complete both pages of this form *only if you are renewing or upgrading your training license.* Attach the appropriate documentation and answer the confidential questions.

**PAYMENT INSTRUCTIONS:** If you **ARE FULLY LICENSED**, you **MUST** go online and renew your license – **DO NOT pay your renewal fee via these instructions (doing so will delay your renewal)** for those needing to pay online please see the instructions of ATTACHMENT 2.

**ATTESTATION STATEMENT:** By completing this document, I agree to pay the appropriate fee on **ONLINE BILL PAY** If you are **UPGRADING** your training license to a full license, your fee will be \$250 & you will choose **MD TRAINING-TO-FULL**

If you are **RENEWING** your training license, your fee will be \$150 & you will choose **MD TRAINING LICENSE RENEWAL**

PLEASE PRINT ALL INFORMATION

FIRST NAME	David	LAST NAME	Iruegas Nunez
EMAIL ADDRESS	[REDACTED]		
LICENSE NUMBER	39598	CELL PHONE	[REDACTED]
HOME ADDRESS	[REDACTED]	CITY/STATE	[REDACTED]
PROGRAM ATTENDING	University of Oklahoma Health Sciences Center	ZIP CODE	[REDACTED]
		SPECIALTY	Internal Medicine

DOCUMENTATION TO ATTACH

PAYMENT COMPLETED	
<input checked="" type="checkbox"/> \$150 payment made on Billpay for <b>RENEWAL</b> of training license	<input type="checkbox"/> \$250 payment made on Billpay for <b>UPGRADE</b> of training license

DOCUMENTATION REQUIRED	
<input type="checkbox"/> Form 2 (must be received directly from program) <b>**ONLY FOR UPGRADE - ATTACHMENT 3</b>	<input type="checkbox"/> Evaluation (must be received directly from program) - ATTACHMENT 4
<input type="checkbox"/> USMLE Step 3 (must be received directly from USMLE)	<input type="checkbox"/> Answer confidential questions (on back of this form)

FOREIGN TRAINED STUDENTS	
<input checked="" type="checkbox"/> Current visa	<input checked="" type="checkbox"/> Social Security Number <b>**if not provided at initial application</b>
<input type="checkbox"/> Background Check <b>**if not done at initial application</b>	

IF YOU ARE FULLY LICENSED – DO NOT COMPLETE THIS FORM. YOU MUST GO ONLINE AND RENEW AT <https://pay.apps.ok.gov/medlic/md/login.php> ENTER YOUR LICENSE NUMBER & PIN – COMPLETE YOUR RENEWAL AND PAY THE RENEWAL FEE.

T 39598  
WB



NAME David Iruegas Nunez

PLEASE COMPLETE THE RENEWAL QUESTIONS BELOW, IF YOU HAVE ANY "YES" ANSWERS YOU MUST PROVIDE A NOTARIZED STATEMENT EXPLAINING YOUR ANSWER.

SINCE RENEWAL OF YOUR TRAINING LICENSE OR INITIAL ISSUE OF YOUR TRAINING LICENSE (whichever is most recent)		
QUESTIONS	YES	NO
Have you failed any part of the USMLE exam (not previously disclosed)?	<input type="checkbox"/>	<input checked="" type="checkbox"/>
Have you been the subject of investigation or disciplinary action (including probation) by a hospital or training program?	<input type="checkbox"/>	<input checked="" type="checkbox"/>
Have you had any adverse judgment or settlement against you arising from a professional liability claim?	<input type="checkbox"/>	<input checked="" type="checkbox"/>
Have you been reported to the National Practitioner Data Bank (NPDB)?	<input type="checkbox"/>	<input checked="" type="checkbox"/>
Have you ever been denied, had removed, or suspended hospital privileges?	<input type="checkbox"/>	<input checked="" type="checkbox"/>
Have you surrendered hospital privileges while under investigation or to avoid investigation?	<input type="checkbox"/>	<input checked="" type="checkbox"/>
Have you entered into an Agreement with a Federal, State, or Local jurisdictional body to avoid formal action?	<input type="checkbox"/>	<input checked="" type="checkbox"/>
Has your application for licensure ever been denied?	<input type="checkbox"/>	<input checked="" type="checkbox"/>
Have you surrendered a license or had any disciplinary action taken on any license?	<input type="checkbox"/>	<input checked="" type="checkbox"/>
Have you been investigated by or requested to appear before a licensing or disciplinary agency (other than the Oklahoma State Board of Medical Licensure and Supervision)?	<input type="checkbox"/>	<input checked="" type="checkbox"/>
Have you obtained an assessment or been treated for use of any drug or chemical substance including alcohol?	<input type="checkbox"/>	<input checked="" type="checkbox"/>
Have you been arrested for, charged with, or convicted of a felony or misdemeanor other than a traffic violation?	<input type="checkbox"/>	<input checked="" type="checkbox"/>
Have you been arrested for, charged with, or convicted of a traffic violation involving the use of any drug or chemical substance?	<input type="checkbox"/>	<input checked="" type="checkbox"/>
Have you been addicted to or abused any drug or chemical substance including alcohol?	<input type="checkbox"/>	<input checked="" type="checkbox"/>
Have you been denied provider participation, terminated, sanctioned or penalized by any third-party payor including TRICARE, MEDICARE, or MEDICAID?	<input type="checkbox"/>	<input checked="" type="checkbox"/>
Have you surrendered or had any adverse action taken against any narcotic permit (State or Federal)?	<input type="checkbox"/>	<input checked="" type="checkbox"/>

I swear under penalty of perjury, that I am the person completing this Questionnaire and understand that any medical license procured or obtained by fraud or misrepresentation will result in disciplinary action taken against the licensee pursuant to the provisions of 59 O.S. § 508.

Signature David Iruegas

RECEIVED

APR 04 2023

Date 04/04/2023

OK  
Pava  
7-5-23  
T 39598  
MB



ATTACHMENT 4

RETURN FORM TO:  
 OKLAHOMA STATE BOARD OF MEDICAL LICENSURE AND SUPERVISION  
oktraining@okmedicalboard.org  
 FORM MUST BE RETURNED BY THE PROGRAM, NOT THE APPLICANT

RECEIVED

JUL 03 2023

OKLAHOMA STATE BOARD OF  
 MEDICAL LICENSURE  
 AND SUPERVISION

ANNUAL EVALUATION – TRAINING LICENSES ONLY  
DO NOT COMPLETE FOR FULLY LICENSED PHYSICIANS

Name of Resident (please print) David Alejandro Truegas Nunez  
 License Number 39598 Specialty Internal Medicine  
 Institution Name University of Oklahoma Health Sciences Center  
 Program Director (please print) Ajay P. Nadig, M.D.  
 Program Director Email Ajay-Nadig@ouhsc.edu

Instructions: Please rate each resident according to the scale below. If the score is rated in the 0 (Poor), 1 (Fair) or 2 (Below Average) YOU MUST PROVIDE WRITTEN DOCUMENTATION REGARDING THIS RATING.

ASSESSMENT	POOR	FAIR	BELOW AVERAGE	AVERAGE	ABOVE AVERAGE	OUTSTANDING
MEDICAL KNOWLEDGE	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input checked="" type="checkbox"/>	<input type="checkbox"/>
APPLICATION OF MEDICAL KNOWLEDGE	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input checked="" type="checkbox"/>	<input type="checkbox"/>
COMMUNICATION SKILLS	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input checked="" type="checkbox"/>	<input type="checkbox"/>
STABILITY IN WORKING RELATIONSHIP WITH OTHER PROFESSIONALS	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input checked="" type="checkbox"/>	<input type="checkbox"/>
THE INDIVIDUAL'S PERFORMANCE COMMENSURATE WITH PEER GROUP	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input checked="" type="checkbox"/>	<input type="checkbox"/>

REMARKS/COMMENTS \_\_\_\_\_  
 \_\_\_\_\_  
 \_\_\_\_\_

COMPLETED BY (please print) Ajay P. Nadig, M.D.  
 SIGNATURE Ajay P. Nadig, MD DATE 6/21/2023  
 Evaluation revised 1-2023

PRIMARY SOURCE

T39598  
 UKC

# Oklahoma State Board of Medical Licensure and Supervision Application Summary

Type	Number	Name
MD	39598	DAVID ALEJANDRO IRUEGAS NUNEZ
MEDICAL DOCTOR		

**Incomplete Information (due to space limitations on this page, this may not be a complete list)**

Social Security Number Extended Background Check AMA Profile Not Received (to be completed by OSBMLS Staff) PostGrad - Form 2 COLLEGE OF MEDICINE OKC Federation Clearance Not Received (to be completed by OSBMLS Staff) NPDB Profile Not Received (to be completed by OSBMLS Staff)
--

<b>Last Medical School Attended:</b> 649-52 Inst Tec Y De Est Sup De Monterrey, Esc De Med I.A.Santos, Monterrey  <p style="text-align: center;">Number of Licenses Previously Granted to Graduates of this Medical School:4</p>
---

Application for: Resident \_\_\_\_\_ Full License \_\_\_\_\_ Reinstatement \_\_\_\_\_

**The Secretary of the Board has reviewed this application and:**

1) AUTHORIZED CIRCULARIZATION TO OTHER BOARD MEMBERS \_\_\_\_\_

2) ALL FIVE CRITERIA HAVE BEEN MET [Fast Track] \_\_\_\_\_

- Passed USMLE
- No DUIs or Legal Issues
- No Significant Malpractice Issues
- US Graduate
- Graduated Medical School on time

3) HAS ISSUED A TEMPORARY LICENSE THROUGH \_\_\_ / \_\_\_ / \_\_\_

4) HAS ISSUED A SPECIAL PGY-1 TRAINING LICENSE July 6-13-22

5) REQUESTS SPECIFIC CONSIDERATION OF:

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## Oklahoma State Board of Medical Licensure and Supervision Application Summary

Type	Number	Name
MD	41512	AHMAD MICHAEL JAMALEDDINE
MEDICAL DOCTOR		

**Incomplete Information (due to space limitations on this page, this may not be a complete list)**

PostGrad - Form 2 COLLEGE OF MEDICINE TULSA  
OTHER DEFICIENCIES: NEED EVALUATION

**Last Medical School Attended:**

039-01 Univ Of Ok Coll Of Med, Oklahoma City Ok 73190

**Number of Licenses Previously Granted to Graduates of this Medical School:7,358**

Application for: Resident \_\_\_\_\_ Full License \_\_\_\_\_ Reinstatement \_\_\_\_\_

**The Secretary of the Board has reviewed this application and:**

- 1) AUTHORIZED CIRCULARIZATION TO OTHER BOARD MEMBERS \_\_\_\_\_
- 2) ALL FIVE CRITERIA HAVE BEEN MET [Fast Track] \_\_\_\_\_
  - Passed USMLE
  - No DUIs or Legal Issues
  - No Malpractice Issues
  - US Graduate
  - Graduated Medical School in 4 years or less
- 3) HAS ISSUED A TEMPORARY LICENSE THROUGH \_\_\_\_ / \_\_\_\_ / \_\_\_\_
- 4) HAS ISSUED A SPECIAL PGY-1 TRAINING LICENSE \_\_\_\_\_

## Oklahoma State Board of Medical Licensure and Supervision Application Summary

**Type**    **Number**    **Name**  
 MD            41512    AHMAD MICHAEL JAMALEDLINE  
 MEDICAL DOCTOR

**Practice Address:**

April 19, 2023

**Status:**

Res: TR

Received: 04/13/2023

Entered: 04/13/2023

**Temp Issued:****Temp Expires:****Train Issued:** 07/01/2023**Train Expires:** 09/30/2024**Fed Rec:** 05/30/2024**AMA Rec:** 05/30/2024**Board Action:****License #:** 41512**Sex:** M**Ethnic Origin:** 1**Endorsed By:** USMLE EXAMINATION

	<b>Test</b>	<b>Score</b>	<b>Date Taken</b>	<b>Date Verified</b>	<b>Attempts</b>
<b>Test 1:</b>	USMLE 3	PASS	05/06/24	5/30/24	2
<b>Test 2:</b>	USMLE 1	PASS	6/4/21	4/13/23	1
<b>Test 3:</b>	USMLE 2	PASS	7/1/22	4/13/23	1
Note: <b>PASS</b> means higher than 75					
<b>Test AV:</b>					
<b>Total Possible:</b>					
<b>Okla Passing:</b>					
<b>Total Score:</b>					

**PRE-MED EDUCATION****School Name:** OKLAHOMA STATE UNIVERSITY**City:** STILLWATER**Degree:** BACHELOR OF SCIENCE**State:** OK **Country:** UNITED STATES**From:** 8/2013 **To:** 5/2018 **Verified:****School Name:** JENKS HIGH SCHOOL**City:** JENKS**Degree:** HIGH SCHOOL DIPLOMA**State:** OK **Country:** UNITED STATES**From:** 8/2009 **To:** 5/2013 **Verified:****MEDICAL SCHOOL EDUCATION****Name:** Univ Of Ok Coll Of Med, Oklahoma City Ok 73190**Foreign Name:****City:** Oklahoma City**Degree:** DOCTOR OF MEDICINE**State/Country:** United States of America**From:** 8 / 2019**To:** 5 / 2023**Diploma Ver'd:**

Y



## Oklahoma State Board of Medical Licensure and Supervision Application Summary

**Type**    **Number**    **Name**  
 MD        41512    AHMAD MICHAEL JAMALEDLINE  
 MEDICAL DOCTOR

### POST GRADUATE EDUCATION

<b>Facility:</b> COLLEGE OF MEDICINE TULSA		<b>Specialty:</b> FAMILY AND COMMUNITY MEDICINE	
<b>Res. Fellowship:</b> Residency			
<b>City:</b> TULSA		<b>State:</b> OK	<b>Country:</b> UNITED STATES OF AM
<b>Verified:</b>	<b>From:</b> 7/2023	<b>To:</b> /	
<b>ACGME Ver'd:</b>			
<b>Comments:</b>			

### PRACTICE HISTORY

<b>Employed:</b> MOLECULAR TEMPLATES		<b>Supervisor:</b>	
<b>City:</b> AUSTIN		<b>State:</b> TX	<b>Country:</b> UNITED STATES
<b>Specialty:</b> RESEARCH ASSOCIATE 1	<b>From:</b> 6/2018	<b>To:</b> 7/2019	<b>Verified:</b>
<b>Comments:</b> RESEARCH ASSOCIATE IN R&D DEPARTMENT OF SMALL BIOTECH COMPANY.			

### Other Licenses

State	Lic Type and Number	Status	Issued	Exp	Verif
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### DEFICIENCIES

PostGrad - Form 2 COLLEGE OF MEDICINE TULSA  
 OTHER DEFICIENCIES: NEED EVALUATION

RETURN FORM TO:  
 OKLAHOMA STATE BOARD OF MEDICAL LICENSURE AND SUPERVISION  
[oktraining@okmedicalboard.org](mailto:oktraining@okmedicalboard.org)

RECEIVED

JUN 04 2024

OKLAHOMA STATE BOARD OF  
 MEDICAL LICENSURE  
 AND SUPERVISION

**QUESTIONNAIRE**  
 Please read and follow ALL instructions

**FORM INSTRUCTIONS:** Complete both pages of this form *only if* you are renewing or upgrading your training license. Attach the appropriate documentation and answer the confidential questions.

**PAYMENT INSTRUCTIONS:** If you **ARE FULLY LICENSED**, you **MUST** go online and renew your license – **DO NOT pay your renewal fee via these instructions (doing so will delay your renewal).**

**ATTESTATION STATEMENT:** By completing this document, I agree to pay the appropriate fee on **ONLINE BILL PAY**  
 If you are **UPGRADING** your training license to a full license, your fee will be \$250 & you will choose **MD TRAINING-TO-FULL**  
 If you are **RENEWING** your training license, your fee will be \$150 & you will choose **MD TRAINING LICENSE RENEWAL**

**PLEASE PRINT ALL INFORMATION**

FIRST NAME	Ahmad Michael	LAST NAME	Jamaledidine
EMAIL ADDRESS	[REDACTED]		
LICENSE NUMBER	41512	CELL PHONE	[REDACTED]
HOME ADDRESS	[REDACTED]	CITY/STATE	[REDACTED]
PROGRAM ATTENDING	OU-TU School of Community Medicine	SPECIALTY	Family Medicine

**DOCUMENTATION TO ATTACH**

PAYMENT COMPLETED	
<input type="checkbox"/> \$150 payment made on Billpay for <b>RENEWAL</b> of training license	<input checked="" type="checkbox"/> \$250 payment made on Billpay for <b>UPGRADE</b> of training license

DOCUMENTATION REQUIRED	
<input checked="" type="checkbox"/> Form 2 (must be received directly from program) <b>**ONLY FOR UPGRADE</b>	<input type="checkbox"/> Evaluation (must be received directly from program)
<input checked="" type="checkbox"/> USMLE Step 3 (must be received directly from USMLE)	<input checked="" type="checkbox"/> Answer confidential questions (on back of this form)

FOREIGN TRAINED STUDENTS	
<input type="checkbox"/> Current visa	<input type="checkbox"/> Social Security Number <b>**if not provided at initial application</b>
<input type="checkbox"/> Background Check <b>**if not done at initial application</b>	

**IF YOU ARE FULLY LICENSED – DO NOT COMPLETE THIS FORM. YOU MUST GO ONLINE AND RENEW AT <https://pay.apps.ok.gov/medlic/md/login.php> ENTER YOUR LICENSE NUMBER & PIN – COMPLETE YOUR RENEWAL AND PAY THE RENEWAL FEE.**

T41512  
 57




NAME\_Ahmad Michael Jamaledine\_\_\_\_\_

**IF YOU HAVE ANY "YES" ANSWERS YOU MUST PROVIDE A NOTARIZED STATEMENT EXPLAINING YOUR ANSWER.**

**SINCE RENEWAL OF YOUR TRAINING LICENSE OR INITIAL ISSUE OF YOUR TRAINING LICENSE (whichever is most recent)**

QUESTIONS	YES	NO
Have you failed any part of the USMLE exam (not previously disclosed)?	<input checked="" type="checkbox"/>	<input type="checkbox"/>
Have you been the subject of investigation or disciplinary action (including probation) by a hospital or training program?	<input type="checkbox"/>	<input checked="" type="checkbox"/>
Have you had any adverse judgment or settlement against you rising from a professional liability claim?	<input type="checkbox"/>	<input checked="" type="checkbox"/>
Have you been reported to the National Practitioner Data Bank (NPDB)?	<input type="checkbox"/>	<input checked="" type="checkbox"/>
Have you ever been denied, had removed, or suspended hospital privileges?	<input type="checkbox"/>	<input checked="" type="checkbox"/>
Have you surrendered hospital privileges while under investigation or to avoid investigation?	<input type="checkbox"/>	<input checked="" type="checkbox"/>
Have you entered into an Agreement with a Federal, State, or Local jurisdictional body to avoid formal action?	<input type="checkbox"/>	<input checked="" type="checkbox"/>
Has your application for licensure ever been denied?	<input type="checkbox"/>	<input checked="" type="checkbox"/>
Have you surrendered a license or had any disciplinary action taken on any license?	<input type="checkbox"/>	<input checked="" type="checkbox"/>
Have you been investigated by or requested to appear before a licensing or disciplinary agency (other than the Oklahoma State Board of Medical Licensure and Supervision)?	<input type="checkbox"/>	<input checked="" type="checkbox"/>
Have you obtained an assessment or been treated for use of any drug or chemical substance including alcohol?	<input type="checkbox"/>	<input checked="" type="checkbox"/>
Have you been arrested for, charged with, or convicted of a felony or misdemeanor other than a traffic violation?	<input type="checkbox"/>	<input checked="" type="checkbox"/>
Have you been arrested for, charged with, or convicted of a traffic violation involving the use of any drug or chemical substance?	<input type="checkbox"/>	<input checked="" type="checkbox"/>
Have you been addicted to or abused any drug or chemical substance including alcohol?	<input type="checkbox"/>	<input checked="" type="checkbox"/>
Have you been denied provider participation, terminated, sanctioned or penalized by any third-party payor including TRICARE, MEDICARE, or MEDICAID?	<input type="checkbox"/>	<input checked="" type="checkbox"/>
Have you surrendered or had any adverse action taken against any narcotic permit (State or Federal)?	<input type="checkbox"/>	<input checked="" type="checkbox"/>

I swear under penalty of perjury, that I am the person completing this Questionnaire and understand that any medical license procured or obtained by fraud or misrepresentation will result in disciplinary action taken against the licensee pursuant to the provisions of 59 O.S. § 508.

Signature 

Date 06/04/2024

JUN 04 2024

OKLAHOMA STATE BOARD OF  
MEDICAL LICENSURE  
AND SUPERVISION

May 28, 2024

To whom it may concern,

I failed my first attempt at USMLE Step 3 in November 2023. It was my first failure in the series of my USMLE exams and I was shocked. In retrospect, I did not prepare as well as I should have for the case-based questions. After receiving this news, I scheduled a new date, created a study plan, and studied specifically for the cases. I took the exam again in early May and after my dedicated study time along with a few more months of residency, I felt much more prepared. I am confident and hopeful that this re-take will result in a pass. Having learned my lesson, I now know not to underestimate any of the exams in the series of test required on the path to becoming a physician, and I am thankful for the continued opportunity to practice medicine. If the committee has any questions, I am happy to answer them. My email is [REDACTED] and my personal cellphone is [REDACTED].

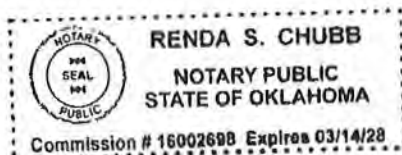
Kind regards,



Michael Jamaledine, MD



Notary: Renda S. Chubb Date: May 28, 2024  
State of Oklahoma, Tulsa County  
Commission Number: 16002898  
Expires: March 14, 2028





# Oklahoma State Board of Medical Licensure and Supervision

## APPLICATION FOR OKLAHOMA MEDICAL DOCTOR LICENSE

Received:04/13/2023

Applicant Name: JAMAL EDDINE AHMAD MICHAEL

MD 41512



Date Of Birth: [REDACTED]

Place Of Birth (City, State): TULSA, OK

Sex: M

Race: Caucasian

Education									
Type	Name	City	ST	Country	From	To	Degree	Comments	Veri
UG	OKLAHOMA STATE UNIVERSITY	STILLWATER	OK		8/2013	5/2018	BACHELOR OF SCIENCE		
HS	JENKS HIGH SCHOOL	JENKS	OK		8/2009	5/2013	HIGH SCHOOL DIPLOMA		

Medical School Name	City	State	Country	Comments	From	To
Univ Of Ok Coll Of Med, Oklahoma City Ok 73190	Oklahoma City	OK	United States		8/2019	5/2023

Post-Graduate							
Facility	City	St	Country	Specialty	Comments	From	To
			UNITED S			/	/

Practice History								
Employer	Specialty	Supervisor	City	ST	Countr	From	To	Verif
MOLECULAR TEMPLATES	RESEARCH ASSOCIATE 1		AUSTIN		TX	8/2018	7/2019	

Other/ Out-Of-State Licenses					
State	License #	Profession	Status	Issue Date	Exp Date

MD Exam				
Exam	State	Score	Date Taken	#
USMLE				

UKC

\$250

# Oklahoma State Board of Medical Licensure and Supervision

## APPLICATION FOR OKLAHOMA MEDICAL DOCTOR LICENSE

Received:04/13/2023

Questions Answered 04/12/2023	Response
A. Have you ever been denied provider participation, terminated, sanctioned, or penalized by any third party payor, to include TRICARE, MEDICARE, MEDICAID?	N
B. Have you ever surrendered or had any adverse action taken against any narcotic permit (state or federal)?	N
C. Have you ever been denied membership or had disciplinary action taken by a national, state or county professional organization?	N
D. Have you ever been denied or had removed or suspended hospital staff privileges?	N
E. Have you ever surrendered hospital staff privileges while under investigation or to avoid investigation?	N
F. Have you ever entered into an agreement with a federal, state or local jurisdictional body to avoid formal action?	N
G. Have you ever been the subject of an investigation, probation or disciplinary action by a hospital, clinic, practice group, training program or professional school?	N
H. Have you had any adverse judgment, settlement, or award against you arising from a professional liability claim?	N
I. Have you ever had professional liability coverage declined, canceled, issued on special terms, or renewal refused?	N
J. Have you ever been reported to the National Practitioners Data Bank (NPDB) or to the Healthcare Integrity and Protection Data Bank (HIPDB)? (If yes, enclose a copy of the report.)	N
K. Has your application for examination or a professional license ever been denied?	N
L. Have you ever failed any part of a licensure/certification/registration examination?	N
M. Have you ever surrendered a license or had a license revoked?	N
N. Has any disciplinary action been taken on any license?	N
O. Have you ever been subject of a review by professional licensing/regulatory agency based on a complaint filed against you?	N
P. Have you ever been arrested, charged with, or convicted of a felony or misdemeanor, other than traffic violations?	N
Q. Have you ever been arrested, charged with, or convicted of a traffic violation involving the use of any drug or chemical substance, including alcohol?	N
R. Are you now or have you within the past two years been addicted to or used in excess any drug or chemical substance, including alcohol?	N
S. Have you obtained an assessment or been treated for the use of any drug or chemical substance, including alcohol?	N
T. Do you currently have or have you had within the past two years any mental or physical disorder or condition which, if untreated, could affect your ability to practice competently?	N
U. Are you or your spouse currently on Active Duty in the U.S. Armed Forces?	N
V. Are you or your spouse currently Deployed on Active Duty in the U.S. Armed Forces?	N



Oklahoma State Board of Medical Licensure and Supervision

APPLICATION FOR OKLAHOMA MEDICAL DOCTOR LICENSE

Received:04/13/2023

If licensed, where do you intend to locate?

OK

Why do you seek Licensure in the state of Oklahoma?

Post-Graduate Training

In what manner will you be communicating with your Oklahoma patients (telephone, email, internet, video-conference, etc)?

Describe how you will examine each patient in person prior to diagnosis, treating, correcting, or prescribing for a patient in Oklahoma from the state, province, or country you are located:

Describe the manner in which you intend to practice medicine across state lines in Oklahoma:

Have you executed or been offered a contract in connection with practice in the state of Oklahoma?

No

If 'Yes', Name of practice:

If so, Please identify with which category:

Name of Previous Carrier and Policy Holder

University of Oklahoma College of Medicine

Name of Current Carrier and policy Holder

University of Oklahoma College of Medicine

Will your professional liability insurance policy cover your practice in Oklahoma

Yes

If NO, when do you expect to obtain liability insurance that will cover practice in Oklahoma

I attest that all the above information is accurate as of April 12, 2023: \_\_\_\_\_ (Signed Online)

ATTACHMENT 4



Applicant: In the presence of a notary public, sign this form with attached photo.

Send this form to: Oklahoma State Board of Medical Licensure and Supervision

oktraining@okmedicalboard.org

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

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

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

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

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

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



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

JAMALEDDINE AHMAD, M  
Applicant's printed last name, first name, middle initial, and suffix (e.g., Jr.)

04/17/23  
Date of signature (must correspond to the date of notarization)

RECEIVED

MAY 01 2023

NOTARY

State of Oklahoma, County of Tulsa

OKLAHOMA STATE BOARD OF MEDICAL LICENSURE AND SUPERVISION

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

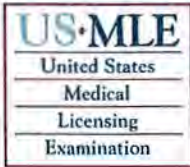
The statements on this document are subscribed and sworn to before me by the applicant on this 17 day of April, 2023

Notary Public Signature [Signature] My Notary Commission Expires 06/18/2024

LEANDERA JOHNSON  
NOTARY Notary Public, State of Oklahoma  
SEAL Commission # 20007297  
My Commission Expires 06-18-2024

T 41512 HS





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

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

PRIMARY SOURCE

**Recipient:** OKLAHOMA STATE BOARD OF  
MEDICAL LICENSURE & SUPERVISION

**Date:** 05/29/2024

**Examinee:** Jamaledine, Ahmad Michael  
**Alt Name(s):**

**Examinee ID:** 5-476-370-1  
**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. Pass/fail outcomes are based upon the minimum passing level in place at the time of test administration and are not altered by subsequent revisions to the minimum passing level. Effective April 1, 2013, two-digit scores will no longer be reported. Test results reported as passing represent an exam score of 75 or higher on a two-digit scale. Step 1 examinations taken on or after January 26, 2022 are reported as pass/fail, with no numeric score; Step 1 examinations taken before January 26, 2022 will continue to be reported with a 3-digit score.

**USMLE STEP 1**

Test Date	Pass/Fail	Score	Minimum Pass	Comments
06/04/2021	Pass	204	(194)	

**USMLE STEP 2**

*Clinical Knowledge (CK)*

Test Date	Pass/Fail	Score	Minimum Pass	Comments
07/01/2022	Pass	229	(214)	

**USMLE STEP 3**

Test Date	Pass/Fail	Score	Minimum Pass	Comments
05/06/2024	Pass	205	(200)	
11/11/2023	Fail	192	(198)	

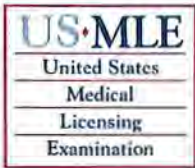
**End of Exam History**

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

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

**RECEIVED**  
MAY 30 2024  
OKLAHOMA STATE BOARD OF  
MEDICAL LICENSURE  
AND SUPERVISION

41512  
5J



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

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

**Examinee:** Jamaledidine, Ahmad Michael

**Examinee ID:** 5-476-370-1

**Date of Birth:** [REDACTED]

### INTERPRETATION OF RESULTS

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

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

### STEP 1 AND STEP 2 CLINICAL SKILLS (CS)

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

### ANNOTATIONS APPEARING UNDER "COMMENTS"

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

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

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

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

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

### ANNOTATIONS APPEARING AS "NOTE"

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

### PHYSICIAN DATA CENTER INFORMATION APPEARING AS "NOTE"

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

03/2015

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



Form 1 (MD)

Oklahoma State Board of Medical Licensure and Supervision
101 NE 51st Street
Oklahoma City, OK 73105

This form must be completed by the institution and mailed directly from the institution.

Applicant's Name Ahmad Jamaledine

Institution: University of Oklahoma College of Medicine City/State Oklahoma City, OK

Our records indicate that the above named applicant attended our medical school on the following dates:

From 8 / 19 / 2019 To 5 / 20 / 2023 and was awarded the degree Doctor of Medicine

- 1. Does this individual's official record reflect (an) interruption(s) or extension(s) in his/her medical education? If yes, please explain. YES NO
2. Does this individual's official record reflect that he/she was ever placed on academic or disciplinary probation during his/her medical education? If yes, please explain. YES NO
3. Does this individual's official record reflect that he/she was ever the subject of negative reports for behavioral reasons or an investigation by the medical school or parent university? If yes, please explain below. YES NO
4. Does this individual's official record reflect that he/she was ever disciplined for unprofessional conduct/behavioral reasons by the medical school or parent university? If yes, please explain below. YES NO
5. Does this individual's official record reflect that there were any limitations or special requirements imposed on the individual because of questions of academic incompetence, disciplinary problems, or any other reason? If yes, please explain below. YES NO

Please explain any "YES" response from above:

Completion of the following is certification that the information above is an accurate account of this individual's records and is true and correct.

Name: Teresa Scordino, M.D. Signature [Handwritten Signature]

Title of Signatory: Associate Dean for Student Affairs Date of Signature 5/31/23

Tel: 405-271-2316 Fax: 405-271-2287 E-Mail: Teresa-Scordino@ouhsc.edu

If no seal is available, this form must be notarized

School Seal

Notary Public

Commission #

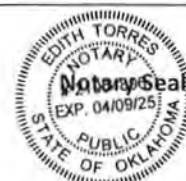
My commission expires:

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JUN 08 2023

OKLAHOMA STATE BOARD OF MEDICAL LICENSURE AND SUPERVISION

PRIMARY SOURCE



T41512 SJ



RECEIVED

Official Transcript

University of Oklahoma Health Sciences Center  
P. O. Box 26901  
Oklahoma City, OK 731260901  
United States

Name : Ahmad Jamaledidine  
Student ID: 1796759  
Birthdate : [REDACTED]

JUN 08 2023

OKLAHOMA STATE BOARD OF  
MEDICAL LICENSURE  
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PRIMARY SOURCE

5/15/23  
TJH/ML

THE UNIVERSITY OF OKLAHOMA HEALTH SCIENCES CENTER

----- Degrees Awarded -----

Degree : Doctor of Medicine  
Confer Date : 2023-05-20  
Plan : Medicine

----- External Degrees -----

Oklahoma St Univ-Stillwater  
2018-05-12 Bachelor of Science  
Field of Study : Sociology/Anthropology  
2018-05-12 Bachelor of Arts  
Field of Study : Philosophy  
2018-05-12 Bachelor of Science  
Field of Study : Microbio/Cell & Molecular Biol

----- Academic Program History -----

Program : Medicine MD  
2019-07-01 : Active in Program  
2019-07-01 : Medicine - MD Major  
2023-05-20 : Completed Program

----- Beginning of Medicine Record -----

Fall 2019

Course	Description	Attempted	Earned	Grade	Points
INDT 8110	Design/Analysis Clin Res	16.00	16.00	S	
INDT 8122	Clinical Medicine I	111.50	111.50	S	
INDT 8124	The Human Structure	130.00	130.00	S	
INDT 8125	Foundations of Medicine	151.00	151.00	S	
INDT 8244	PPSI	87.00	87.00	S	
INDT 8555	Req Orientation Documents I		0.00	CE	
INDT 9100	Prologue	24.00	24.00	S	
TERM GPA :	0.000 GPH: 0.00	TOTALS :	519.50	519.50	0.000
OUHSC GPA :	0.000 GPH: 0.00	TOTALS :	519.50	519.50	0.000

Spring 2020

Course	Description	Attempted	Earned	Grade	Points
INDT 8132	IMI	68.00	68.00	S	
INDT 8140	Gastrointestinal & Hepatobil	85.00	85.00	S	
INDT 8148	Endo, Metab & Nutri Biochem	85.00	85.00	S	
INDT 8156	Blood, Hematopoiesis & Lymph	77.00	77.00	S	
TERM GPA :	0.000 GPH: 0.00	TOTALS :	315.00	315.00	0.000
OUHSC GPA :	0.000 GPH: 0.00	TOTALS :	834.50	834.50	0.000

Fall 2020

Course	Description	Attempted	Earned	Grade	Points
INDT 8264	Cardiovasc, Resp, Renal	164.00	164.00	S	
INDT 8266	PFS II: Clinical Ethics	35.00	35.00	S	
INDT 8272	Neurosciences	166.00	166.00	S	
INDT 8275	Clinical Medicine II	99.00	99.00	S	
INDT 8301	Enrichment Program: Humanities	16.00	16.00	S	
Course Topic(s): Caring for the Dying Patient					
TERM GPA :	0.000 GPH: 0.00	TOTALS :	480.00	480.00	0.000
OUHSC GPA :	0.000 GPH: 0.00	TOTALS :	1314.50	1314.50	0.000

Spring 2021

Course	Description	Attempted	Earned	Grade	Points
INDT 8280	Reproduction	98.00	98.00	S	
INDT 9200	MS2 Capstone	70.00	70.00	S	
INDT 9201	Joint, Skin, and Bone	40.00	40.00	S	
TERM GPA :	0.000 GPH: 0.00	TOTALS :	208.00	208.00	0.000
OUHSC GPA :	0.000 GPH: 0.00	TOTALS :	1522.50	1522.50	0.000

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*Lou Klein*

REGISTRAR, OUHSC



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- Special Distinction
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JUN 08 2023

OKLAHOMA STATE BOARD OF  
MEDICAL LICENSURE  
AND SUPERVISION



RECEIVED

Official Transcript

University of Oklahoma Health Sciences Center  
P. O. Box 26901  
Oklahoma City, OK 731260901  
United States

JUN 08 2023

OKLAHOMA STATE BOARD OF  
MEDICAL LICENSURE  
AND SUPERVISION

Name : Ahmad Jamaledidine  
Student ID: 1796759  
Birthdate : [REDACTED]

PRIMARY SOURCE

Summer II 2021

Summer II 2022

Course	Description	Attempted	Earned	Grade	Points
INDT 9301	Clinical Transitions	40.00	40.00	S	
SURG 9760	Surgey Clerkship	320.00	320.00	B	960.000
TERM GPA :	3.000	GPH: 320.00	TOTALS : 360.00	360.00	960.000
OUHSC GPA :	3.000	GPH: 320.00	TOTALS : 1882.50	1882.50	960.000

Course	Description	Attempted	Earned	Grade	Points
INDT 9403	Subinternship Elective	160.00	160.00	A	640.000
Course Topic(s) : FM Subinternship Elective					
INDT 9403	Subinternship Elective	160.00	160.00	A	640.000
Course Topic(s) : FM Subinternship Elective					
TERM GPA :	4.000	GPH: 320.00	TOTALS : 320.00	320.00	1280.000
OUHSC GPA :	3.080	GPH: 2000.00	TOTALS : 3802.50	3802.50	6160.000

Fall 2021

Fall 2022

Course	Description	Attempted	Earned	Grade	Points
PEDI 9650	Pediatric Clerkship	240.00	240.00	B	720.000
NEUR 9370	Neurology Clerkship	160.00	160.00	C	320.000
FM 9540	Fam Med Clerkship	160.00	160.00	B	480.000
MED 9101	Geriatric Selective	80.00	80.00	S	
TERM GPA :	2.714	GPH: 560.00	TOTALS : 640.00	640.00	1520.000
OUHSC GPA :	2.818	GPH: 880.00	TOTALS : 2522.50	2522.50	2480.000

Course	Description	Attempted	Earned	Grade	Points
INDT 9300	Capstone	160.00	160.00	S	
UROL 9101	Urology Selective	80.00	80.00	S	
INDT 9407	Fourth Year Selective	80.00	80.00	S	
Course Topic(s) : Directed Readings in PHARM Directed Readings in PHARM					
TERM GPA :	0.000	GPH: 0.00	TOTALS : 320.00	320.00	0.000
OUHSC GPA :	3.080	GPH: 2000.00	TOTALS : 4122.50	4122.50	6160.000

Spring 2022

Spring 2023

Course	Description	Attempted	Earned	Grade	Points
MED 9250	Medicine Clerkship	320.00	320.00	B	960.000
RADI 9101	RADI Selective	80.00	80.00	S	
UROL 9101	Urology Selective	80.00	80.00	S	
OBGY 9210	Obstet & Gyn Clerkship	240.00	240.00	B	720.000
PSBS 9520	Psychiatry Clerkshp	240.00	240.00	B	720.000
TERM GPA :	3.000	GPH: 800.00	TOTALS : 960.00	960.00	2400.000
OUHSC GPA :	2.905	GPH: 1680.00	TOTALS : 3482.50	3482.50	4880.000

Course	Description	Attempted	Earned	Grade	Points
INDT 9407	Fourth Year Selective	80.00	80.00	S	
Course Topic(s) : Directed Readings in PHARM Directed Readings in PHARM					
INDT 9406	Special Studies Elective	160.00	160.00	S	
Course Topic(s) : INDT Special Studies Elective					
INDT 9406	Special Studies Elective	160.00	160.00	S	
Course Topic(s) : INDT Special Studies Elective					
INDT 9402	Mixed In/Outpatient Elective	160.00	160.00	S	
Course Topic(s) : MED Mixed In/Outpatient Electi					
FM 9569	CH I	80.00	80.00	S	

Interprofessional Education Tier I-Completed

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*Law Klein*

REGISTRAR, OUHSC

THE UNIVERSITY OF OKLAHOMA HEALTH SCIENCES CENTER



**EXPLANATION OF RECORD**  
**THE UNIVERSITY OF OKLAHOMA HEALTH SCIENCES CENTER**  
**OUHSC FICE CODE 5889**

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**JUN 08 2023**

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Official Transcript

University of Oklahoma Health Sciences Center  
P. O. Box 26901  
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Birthdate : [REDACTED]

OKLAHOMA STATE BOARD OF  
MEDICAL LICENSURE  
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JUN 08 2023

Spring 2023 (cont.)

PRIMARY  
SOURCE

Course	Description	Attempted	Earned	Grade	Points
FM 9572	CH II	80.00	80.00	s	
TERM GPA :	0.000	GPH: 0.00	TOTALS : 720.00	720.00	0.000
OUHSC GPA :	3.080	GPH: 2000.00	TOTALS : 4842.50	4842.50	6160.000
Medicine Career Totals					
OUHSC GPA :	3.080	GPH: 2000.00	TOTALS : 4842.50	4842.50	6160.000
Post-Baccalaureate Career Totals					
OUHSC GPA :	3.080	GPH: 125.00	TOTALS : 302.65	302.65	385.000
----- End Of Career (1 of 1) -----					
----- End Of Transcript -----					

THE UNIVERSITY OF OKLAHOMA HEALTH SCIENCES CENTER

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MAY 01 2023

OKLAHOMA STATE BOARD OF MEDICAL LICENSURE AND SUPERVISION  
EVIDENCE OF STATUS – PART A

NOTARIZED FORM CAN BE EMAILED TO OKTRAINING@OKMEDICALBOARD.ORG

OKLAHOMA STATE BOARD OF  
MEDICAL LICENSURE  
AND SUPERVISION

Full Legal Name: AHMAD MICHAEL JAMALDINE  
First Middle Last Maiden (if applicable)

Mailing Address: [REDACTED]  
Street Address Post Office Box

[REDACTED] [REDACTED] [REDACTED] [REDACTED] [REDACTED]  
City State Zip Code Telephone Number Social Security #

PRIMARY EVIDENCE OF CITIZENSHIP  
(FOR US CITIZENS, US NATIONALS, OR PERMANENT LEGAL RESIDENT ALIENS)

If you are a U.S. citizen, U.S. national, or permanent legal resident alien, please attach a photocopy of one of the following documents to this form. Place a checkmark below to indicate the document that is attached.

- A birth certificate showing birth in one of the 50 States, the District of Columbia, Puerto Rico (on or after January 13, 1941), Guam, the U.S. Virgin Islands (on or after January 17, 1917), American Samoa, Swain's Island or the Northern Mariana Islands, unless the person was born to foreign diplomats residing in the U.S.
- United States passport (except limited passports, which are issued for periods of less than five years)
- Report of birth abroad of a U.S. citizen (FS-240) (issued by the Department of State to U.S. citizens)
- Certificate of birth (FS-545) (issued by a foreign service post) or Certification of Report of Birth (DS1350) (issued by the Department of State), copies available from the Department of State
- Certificate of Naturalization (N-550 or N-570) (issued by the INS through a Federal or State court, or through administrative naturalization after December 1990 to individuals who are individually naturalized; the N570 is a replacement certificate issued when the N-550 has been lost or mutilated or the individual's name has been changed)
- Certificate of Citizenship (N-560 or N-561) (issued by the INS to individuals who derive U.S. citizenship through a parent; the N-561 is a replacement certificate issued when the N-560 has been lost or mutilated or the individual's name has been changed)
- United States Citizen Identification Card (I-197) (issued by the INS until April 7, 1983 to U.S. citizens living near the Canadian or Mexican border who needed it for frequent border crossing) (formerly Form I-179, last issued in February 1974)
- Northern Mariana Identification Card (issued by the INS to a collectively naturalized citizen of the U.S. who was born in the Northern Mariana Islands before November 3, 1986)
- Statement provided by a U.S. consular officer certifying that the individual is a U.S. citizen (This is given to an individual born outside the U.S. who derives citizenship through a parent but does not have an FS-240, FS-545 or DS-1350);
- American Indian Card with a classification code "KIC" and a statement on the back (identifying U.S. citizen members of the Texas Band of Kickapoos living near the U.S./Mexican border.)
- Alien Lawfully Admitted for Permanent Residence:  
INS Form I-551 (Alien Registration Receipt Card, commonly known as a "green card")
- Alien Lawfully Admitted for Permanent Residence:  
Unexpired Temporary I-551 stamp in foreign passport or on INS Form I-94

I declare under penalty of perjury, under the laws of the State of Oklahoma, that all information contained in this application and all accompanying documents provided to substantiate my Evidence of Status application are true and correct.

Signature [Signature] Date 04/17/23

Subscribed and sworn before me this 17th day of April, 2023.

Notary Public [Signature]

Commission Number 20007297

My commission expires 06-18-2024

NOTARY SEAL

LEANDERA JOHNSON  
Notary Public, State of Oklahoma  
Commission # 20007297  
My Commission Expires 06-18-2024

T 41512 #5



# AMA Physician Profile

PREPARED FOR

Oklahoma State Board of Licensure & Supervision, Oklahoma City, OK

PRIMARY SOURCE

**Name and Mailing Address**

AHMAD MICHAEL JAMALEDDINE



**Primary Office Address**

**Birth date**



**Phone** UNKNOWN

**Physician's major professional activity**

HOSPITAL BASED RESIDENTS - ALL YEARS

RECEIVED

MAY 30 2024

OKLAHOMA STATE BOARD OF MEDICAL LICENSURE AND SUPERVISION

**AMA membership status** MEMBER

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

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

NO DATA REPORTED AT THIS TIME

**Current and/or historical medical school**

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

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

**School:** UNIVERSITY OF OKLAHOMA COLLEGE OF MEDICINE

**Degree Awarded:** YES  
**Enrollment Date:** 08/2019

**Degree Type:** MD  
**Degree Date:** 05/2023

T41512  
57



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

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

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

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

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

**Sponsoring Institution:** UNIVERSITY OF OKLAHOMA SCHOOL OF COMMUNITY MEDICINE-TULSA  
**Sponsoring State:** OKLAHOMA  
**Program name:** UNIVERSITY OF OKLAHOMA SCHOOL OF COMMUNITY MEDICINE (TULSA) PROGRAM  
**Specialty:** FAMILY MEDICINE  
**Training Type:** SPECIALTY  
**Dates:** 07/01/2023 - 06/30/2026  
**Status:** TRAINING IN PROGRESS

### Specialty board certification

NO DATA REPORTED AT THIS TIME

### Current and/or historical medical licensure

License Number	MD / DO	Locale	Date Granted	Expiration Date	Renewal Date	Status	License Type	Last Reported	Name on License
41512	MD	OK	07/01/2023	09/30/2024		ACT	RES	05/06/2024	AHMAD MICHAEL JAMALEDDINE





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

#### Action notifications reported to the AMA

**Medical Licensing Boards:** NO ACTIONS REPORTED AT THIS TIME

**Medicare/Medicaid Sanctions from DHHS:** NO ACTIONS REPORTED AT THIS TIME

**US DOJ Drug Enforcement Administration:** NO ACTIONS REPORTED AT THIS TIME

#### U.S. Drug Enforcement Administration (DEA)

NO DATA REPORTED AT THIS TIME

#### ECFMG certification

NOT APPLICABLE

#### Profile information

The content of the AMA Physician Profile is for credentialing use only. The content cannot be used or assembled for an employment purpose as defined under the Fair Credit Reporting Act. An organization's appropriate use of the data contained in the AMA Physician Professional Data™, formerly known as AMA Physician Masterfile, meets select primary source verification requirements of the Joint Commission, the Accreditation Association for Ambulatory Health Care (AAAHC) and the American Accreditation Health Care Commission (AAHCC)/ Utilization Review Accreditation Commission (URAC). The AMA Physician Professional Data is also an NCQA-approved source for verification of medical school, post-graduate medical training, ABMS Board Certification and federal DEA registration.

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

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

RECEIVED

OKLAHOMA STATE BOARD OF MEDICAL LICENSURE AND SUPERVISION  
EVIDENCE OF STATUS - PART A

MAY 02 2023

NOTARIZED FORM CAN BE EMAILED TO OKTRAINING@OKMEDICALBOARD.ORG

OKLAHOMA STATE BOARD OF  
MEDICAL LICENSURE  
AND SUPERVISION

Full Legal Name: AHMAD MICHAEL JAMALDDINE  
First Middle Last Maiden (if applicable)

Mailing Address: [Redacted]  
Street Address or Post Office Box

[Redacted] City State Zip Code Telephone Number Social Security #: [Redacted]

PRIMARY EVIDENCE OF CITIZENSHIP  
(FOR US CITIZENS, US NATIONALS, OR PERMANENT LEGAL RESIDENT ALIENS)

If you are a U.S. citizen, U.S. national, or permanent legal resident alien, please attach a photocopy of one of the following documents to this form. Place a checkmark below to indicate the document that is attached.

- A birth certificate showing birth in one of the 50 States, the District of Columbia, Puerto Rico (on or after January 13, 1941), Guam, the U.S. Virgin Islands (on or after January 17, 1917), American Samoa, Swain's Island or the Northern Mariana Islands, unless the person was born to foreign diplomats residing in the U.S.
- United States passport (except limited passports, which are issued for periods of less than five years)
- Report of birth abroad of a U.S. citizen (FS-240) (issued by the Department of State to U.S. citizens)
- Certificate of birth (FS-545) (issued by a foreign service post) or Certification of Report of Birth (DS1350) (issued by the Department of State), copies available from the Department of State
- Certificate of Naturalization (N-550 or N-570) (issued by the INS through a Federal or State court, or through administrative naturalization after December 1990 to individuals who are individually naturalized; the N570 is a replacement certificate issued when the N-550 has been lost or mutilated or the individual's name has been changed)
- Certificate of Citizenship (N-560 or N-561) (issued by the INS to individuals who derive U.S. citizenship through a parent; the N-561 is a replacement certificate issued when the N-560 has been lost or mutilated or the individual's name has been changed)
- United States Citizen Identification Card (I-197) (issued by the INS until April 7, 1983 to U.S. citizens living near the Canadian or Mexican border who needed it for frequent border crossing) (formerly Form I-179, last issued in February 1974)
- Northern Mariana Identification Card (issued by the INS to a collectively naturalized citizen of the U.S. who was born in the Northern Mariana Islands before November 3, 1986)
- Statement provided by a U.S. consular officer certifying that the individual is a U.S. citizen (This is given to an individual born outside the U.S. who derives citizenship through a parent but does not have an FS-240, FS-545 or DS-1350);
- American Indian Card with a classification code "KIC" and a statement on the back (identifying U.S. citizen members of the Texas Band of Kickapoos living near the U.S./Mexican border.)
- Alien Lawfully Admitted for Permanent Residence: INS Form I-551 (Alien Registration Receipt Card, commonly known as a "green card")
- Alien Lawfully Admitted for Permanent Residence: Unexpired Temporary I-551 stamp in foreign passport or on INS Form I-94

I declare under penalty of perjury, under the laws of the State of Oklahoma, that all information contained in this application and all accompanying documents provided to substantiate my Evidence of Status application are true and correct.

Signature: [Signature] Date: 04/17/23

Subscribed and sworn before me this 17th day of April, 2023.

Notary Public: [Signature]

Commission Number: 20007297

My commission expires: 06-18-2024

NOTARY SEAL

LEANDERA JOHNSON  
Notary Public, State of Oklahoma  
Commission # 20007297  
My Commission Expires 06-18-2024

T 41512 #5



**OKLAHOMA STATE BOARD OF MEDICAL LICENSURE AND SUPERVISION**  
**101 NE 51<sup>ST</sup> STREET**  
**OKLAHOMA CITY OK 73105**  
 Phone: (405)962-1400 Fax: (405)962-1440 email: oktraining@okmedicalboard.org

To Request Examination Scores	
For National Board Scores National Board of Medical Examiners PO Box 48014 Newark, NJ 07101-4814 (215) 590-9500 www.NBME.org	For FLEX or USMLE Scores Federation of State Medical Boards 400 Fuller Wiser Road Euless, TX 76039-3855 (817) 868-4000 www.FSMB.org

**RECEIVED**

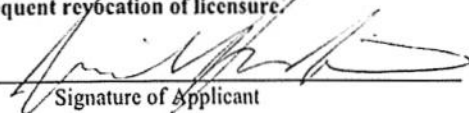
**MAY 01 2023**

OKLAHOMA STATE BOARD OF  
MEDICAL LICENSURE  
AND SUPERVISION

6. **Extended Background Check** – Applicants for licensure are required to request an Extended Background Check.
  7. **Evidence of Status Form** - In order to verify citizenship or qualified alien status, applicants for licensure by endorsement or examination or for reinstatement of their license, must submit an Evidence of Status Form and the required supporting documentation with their application. This form must be notarized and mailed to the office.
  8. **Photo and Oath Form** – Applicants for licensure will be required to complete the Photo and Oath Form. This form must be notarized and mailed to the office.
  9. **Telemedicine Form** – Applicants planning to practice telemedicine must submit the initialed and signed Telemedicine Questionnaire.
  10. **English Proficiency Exam** – Foreign applicants shall have a command of the English language that is satisfactory to the Board, demonstrated by the passage of an oral English competency exam. Applicant is required to call 405-962-1400 and speak with an application analyst in licensing.
- G. **Temporary Licensure (59 O.S. § 493.3)** – The Board may authorize the Secretary to issue a Temporary Medical License for the intervals between Board meetings. Such Temporary License shall be granted only when the Secretary is satisfied as to the qualifications of the applicant to be licensed under this Act but where such qualifications have not been verified to the Board. An application for Temporary Licensure must be made by written request and include all appropriate fees. Such a license shall:
1. Be granted only to an applicant demonstrably qualified for a full and unrestricted medical license;
  2. Automatically terminate on the date of the next Board meeting at which the applicant may be considered for a full and unrestricted medical license.
  3. We must be in receipt of the following in order for the Board Secretary to consider issuing a Temporary License:
    - a. Examination scores, and
    - b. Verification of licensure in all jurisdictions in which applicant has been licensed to practice medicine and surgery, and
    - c. Evidence of Status, and
    - d. Extended Background Check

**I, the undersigned, have fully read and understand the instructions. I swear or affirm that the information submitted in and with the application is, to the best of my knowledge, true and factual. I understand that attempts to deceive or fraudulently portray information contained herein may result in cancellation of my application or charges of filing a fraudulent application that may result in subsequent revocation of licensure.**

AHMAD M. LAHEL JANALE-DOINF  
Name of Applicant (type or print)

  
Signature of Applicant

04/17/2023  
Date

**Except as specifically may be waived by the Board, the Board shall not engage in any application process with any agent or representative of the applicant. 59 O.S. § 492.1 (C); Okla. Admin. Code § 435:10-4-1(c)**

Please return these signed instructions by mail to the address at the top of the page or email.

T 41512  
HS

ATTACHMENT 5

TIME DEFICIENCY FORM

Name:	MICHAEL JAMAL FODINE	Application #	41512
-------	----------------------	---------------	-------

This document is used a tool to help you complete your application.  
 Please note: we have to account for any/all time from your 18th birthday to present.

EDUCATION STARTING WITH HIGH SCHOOL							
Start Month	Start Year	End Month	End Year	Name of Institution	City	State	Degree
09	2009	05	2013	JENKS HIGH SCHOOL	JENKS	OK	HIGH SCHOOL DIP
08	2013	05	2018	OKLAHOMA STATE UNIVERSITY	STILLWATER	OK	BS/BA
07	2019	05	2023	UNIVERSITY OF OKLAHOMA COLLEGE OF MEDICINE	OKC	OK	MD

EMPLOYMENT IF NEEDED TO FILL TIME GAP							
Start Month	Start Year	End Month	End Year	Name of Employer	City	State	Job Title
06	2018	07	2019	MOLECULAR TEMPLATES	AUSTIN	TX	RESEARCH ASSISTANT

OTHER - UNEMPLOYED, STAY AT HOME PARENT, SUMMER BREAK, TRAVELING							
Start Month	Start Year	End Month	End Year	Other	City	State	
06	2013	08	2013	SUMMER BREAK	TULSA	OK	

RECEIVED

MAY 02 2023

OKLAHOMA STATE BOARD OF  
 MEDICAL LICENSURE  
 AND SUPERVISION

Duplicate

T41512  
 HS



**Kenna L. Shaw**

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**From:** BillPay Webmaster <donotreply@www.ok.gov>  
**Sent:** Tuesday, May 7, 2024 7:39 PM  
**To:** Dela Kwetey; Bill Pay; Sheila E. Brumfield; Chris Maloney; Licensing; Arlene Morris; Debra Reich  
**Subject:** [EXTERNAL] LICENSE - MD Training-to-Full License Fee 250.00 - Payment Made

AHMAD MICHAEL JAMALEDDINE has paid for a LICENSE - MD Training-to-Full License Fee 250.00 on 05/07/2024 07:05:38pm for \$250.00.

OKLAHOMA MD LICENSE NUMBER 41512

To view all transactions please go to <http://www.ok.gov/triton/> and login to your CMS account.

T 41512  
W

05/02/2023

AHMAD MICHAEL JAMALEDDINE  
[REDACTED]

**Check Your Application  
Status Online at:**  
<http://www.okmedicalboard.org>  
**Username:AP44275503**  
**Password:Last 4 SSN**

RE: MD Application #41512

Dear AHMAD JAMALEDDINE,

**YOU CANNOT PRACTICE YOUR PROFESSION IN THE STATE  
OF OKLAHOMA UNTIL A VALID LICENSE HAS BEEN ISSUED.**

Your training application has been processed and the current deficiencies are listed below. Please be advised, these may not be the only deficiencies. You will be advised if any other deficiencies are added. You may check your application status online by logging in with the username and password provided above.

If you have further questions please email  
[oktraining@okmedicalboard.org](mailto:oktraining@okmedicalboard.org)

If a "Time Deficiency" is listed, please complete a time deficiency form and e-mail the document to  
[oktraining@okmedicalboard.org](mailto:oktraining@okmedicalboard.org)  
with your activities during the specified time frame.

USMLE Exams Incomplete  
Evidence of Status  
Application Instructions  
OATH  
Extended Background Check  
Exam verification date  
MedSchool-Transcript Univ Of Ok Coll Of Med, Oklahoma City Ok 73190  
MedSchool-Form 1 Univ Of Ok Coll Of Med, Oklahoma City Ok 73190  
PostGrad - Form 2 COLLEGE OF MEDICINE TULSA

Any of the required forms in the list above may be downloaded from our website:

<http://www.okmedicalboard.org/resources>



In order to check on the status of your application, please log on to our web site:

<https://secure.okmedicalboard.org/applicant/signin>

Your user name is AP44275503 (all caps and no spaces) and your password is the last 4 digits of your social security number.

If you did not provide a social security number with your application, your password will be your 4-digit year of birth in the form "YYYY".

If we may be of further assistance, please email.

[oktraining@okmedicalboard.org](mailto:oktraining@okmedicalboard.org)

Sincerely,

**Lisa Cullen**

Lisa Cullen  
Director of Licensing  
Dept. of Licensing

Encl

# Oklahoma State Board of Medical Licensure and Supervision Application Summary

Type	Number	Name
MD	41512	AHMAD MICHAEL JAMALEDDINE
MEDICAL DOCTOR		

**Incomplete Information (due to space limitations on this page, this may not be a complete list)**

PostGrad - Form 2 COLLEGE OF MEDICINE TULSA USMLE Exams Incomplete Exam verification date
---

<b>Last Medical School Attended:</b> 039-01 Univ Of Ok Coll Of Med, Oklahoma City Ok 73190  <p style="text-align: center;">Number of Licenses Previously Granted to Graduates of this Medical School:7,275</p>
---

Application for: Resident  Full License \_\_\_\_\_ Reinstatement \_\_\_\_\_

**The Secretary of the Board has reviewed this application and:**

1) AUTHORIZED CIRCULARIZATION TO OTHER BOARD MEMBERS \_\_\_\_\_

2) ALL FIVE CRITERIA HAVE BEEN MET [Fast Track] \_\_\_\_\_

- Passed USMLE
- No DUIs or Legal Issues
- No Significant Malpractice Issues
- US Graduate
- Graduated Medical School on time

3) HAS ISSUED A TEMPORARY LICENSE THROUGH \_\_\_/\_\_\_/\_\_\_

4) HAS ISSUED A SPECIAL PGY-1 TRAINING LICENSE MLR 6-12-20

5) REQUESTS SPECIFIC CONSIDERATION OF:

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# Oklahoma State Board of Medical Licensure and Supervision Application Summary

Type	Number	Name
MD	41485	AOUS JARROUJ
MEDICAL DOCTOR		

**Incomplete Information (due to space limitations on this page, this may not be a complete list)**

OTHER DEFICIENCIES: NEED CURRENT VISA / NEED QUESTIONNAIRE / \$250 UPGRADE FEE / EVALUATION  
 PostGrad - Form 2 COLLEGE OF MEDICINE OKC

**Last Medical School Attended:**  
 875-01 UNIV OF DAMASCUS, FAC OF MED, DAMASCUS, SYRIA

**Number of Licenses Previously Granted to Graduates of this Medical School:98**

Application for: Resident \_\_\_\_\_ Full License \_\_\_\_\_ Reinstatement \_\_\_\_\_

**The Secretary of the Board has reviewed this application and:**

- 1) AUTHORIZED CIRCULARIZATION TO OTHER BOARD MEMBERS \_\_\_\_\_
- 2) ALL FIVE CRITERIA HAVE BEEN MET [Fast Track] \_\_\_\_\_
  - Passed USMLE
  - No DUIs or Legal Issues
  - No Malpractice Issues
  - US Graduate
  - Graduated Medical School in 4 years or less
- 3) HAS ISSUED A TEMPORARY LICENSE THROUGH \_\_\_\_ / \_\_\_\_ / \_\_\_\_
- 4) HAS ISSUED A SPECIAL PGY-1 TRAINING LICENSE \_\_\_\_\_

# Oklahoma State Board of Medical Licensure and Supervision

## Application Summary

**Type**    **Number**    **Name**  
 MD        41485        AOUS JARROUJ  
 MEDICAL DOCTOR

**Practice Address:**  
 May 03, 2023

**Status:**

Res: MD

Received: 04/11/2023

Entered: 04/11/2023

Temp Issued:

Temp Expires:

Train Issued: 07/06/2023

Train Expires: 09/30/2024

Fed Rec: 05/09/2024

AMA Rec: 05/09/2024

Board Action: PP

License #: 41485

Sex: M

Ethnic Origin: 5

Endorsed By: USMLE

	Test	Score	Date Taken	Date Verified	Attempts
Test 1:	USMLE 3	PASS	02/21/24	4/22/24	2
Test 2:	USMLE 1	PASS	11/29/21	4/28/23	2
Test 3:	USMLE 2	PASS	4/2/21	4/28/23	2

Note: **PASS** means higher than 75

Test AV:  
 Total Possible:  
 Okla Passing:  
 Total Score:

### PRE-MED EDUCATION

School Name: AL-NOUR

City: DAMASCUS

State:    Country: SYRIA

Degree: HIGH SCHOOL DEGREE

From: 9/1999 To: 9/ 2003 Verified:

### MEDICAL SCHOOL EDUCATION

Name: UNIV OF DAMASCUS, FAC OF MED, DAMASCUS, SYRIA

Foreign Name:

City: Damascus

State/Country: Syria

Degree: MD

From: 9 / 2003 To: 9 /2009 Diploma Ver'd:

Y





# Oklahoma State Board of Medical Licensure and Supervision

## Application Summary

Type	Number	Name
MD	41485	AOUS JARROUJ

MEDICAL DOCTOR

**DEFICIENCIES**

OTHER DEFICIENCIES: NEED CURRENT VISA / NEED QUESTIONNAIRE / \$250 UPGRADE FEE / EVALUATION  
PostGrad - Form 2 COLLEGE OF MEDICINE OKC



APPLICATION FOR OKLAHOMA MEDICAL DOCTOR LICENSE

Received:04/11/2023

Foreign Graduate

Applicant Name: JARROUJ, AOUS

MD 41485



Date Of Birth: [REDACTED]

Place Of Birth (City, State): DAMASCUS, SYRIA

Sex: M

Race: Other

Education								
Type Name	City	ST	Country	From	To	Degree	Comments	Veri
HS AL-NOUR	DAMASCUS		SYRIA	9/1999	9/2003	HIGH SCHOOL DEGREE		

Medical School Name	City	State	Country	Comments	From	To
UNIV OF DAMASCUS, FAC OF MED, DAMASCUS, SYRIA	Damascus		Syria		9/2003	9/2009

Post-Graduate							
Facility	City	St	Country	Specialty	Comments	From	To
TUCSON HOSPITALS MEDICAL EDUCATION PROGRAM	TUCSON	AZ	UNITED S	TRANSITIONAL		6/2022	6/2023
IBN AL-NAFEES	DAMASCUS		SYRIA	PLASTIC SURGERY		1/2010	1/2013

Practice History								
Employer	Specialty	Supervisor	City	ST	Countr	From	To	Verif
CHARLESTON AREA MEDICAL CENTER	RESEARCH		CHARLESTON	WV		2/2020	5/2022	
UNIVERSITY OF ARIZONA	RESEARCH		TUCSON	AZ		1/2013	1/2020	

Other/ Out-Of-State Licenses					
State	License #	Profession	Status	Issue Date	Exp Date
AZ	R79371		U	6/24/22	6/23/23

\$250

MD Exam				
Exam	State	Score	Date Taken	#
USMLE				

Foreign Graduate

APPLICATION FOR OKLAHOMA MEDICAL DOCTOR LICENSE

Received:04/11/2023

Foreign Graduate

Questions Answered 04/09/2023	Response
A. Have you ever been denied provider participation, terminated, sanctioned, or penalized by any third party payor, to include TRICARE, MEDICARE, MEDICAID?	N
B. Have you ever surrendered or had any adverse action taken against any narcotic permit (state or federal)?	N
C. Have you ever been denied membership or had disciplinary action taken by a national, state or county professional organization?	N
D. Have you ever been denied or had removed or suspended hospital staff privileges?	N
E. Have you ever surrendered hospital staff privileges while under investigation or to avoid investigation?	N
F. Have you ever entered into an agreement with a federal, state or local jurisdictional body to avoid formal action?	N
G. Have you ever been the subject of an investigation, probation or disciplinary action by a hospital, clinic, practice group, training program or professional school?	N
H. Have you had any adverse judgment, settlement, or award against you arising from a professional liability claim?	N
I. Have you ever had professional liability coverage declined, canceled, issued on special terms, or renewal refused?	N
J. Have you ever been reported to the National Practitioners Data Bank (NPDB) or to the Healthcare Integrity and Protection Data Bank (HIPDB)? (If yes, enclose a copy of the report.)	N
K. Has your application for examination or a professional license ever been denied?	N
L. Have you ever failed any part of a licensure/certification/registration examination?	N
M. Have you ever surrendered a license or had a license revoked?	N
N. Has any disciplinary action been taken on any license?	N
O. Have you ever been subject of a review by professional licensing/regulatory agency based on a complaint filed against you?	N
P. Have you ever been arrested, charged with, or convicted of a felony or misdemeanor, other than traffic violations?	N
Q. Have you ever been arrested, charged with, or convicted of a traffic violation involving the use of any drug or chemical substance, including alcohol?	N
R. Are you now or have you within the past two years been addicted to or used in excess any drug or chemical substance, including alcohol?	N
S. Have you obtained an assessment or been treated for the use of any drug or chemical substance, including alcohol?	N
T. Do you currently have or have you had within the past two years any mental or physical disorder or condition which, if untreated, could affect your ability to practice competently?	N
U. Are you or your spouse currently on Active Duty in the U.S. Armed Forces?	N
V. Are you or your spouse currently Deployed on Active Duty in the U.S. Armed Forces?	N

Foreign Graduate

APPLICATION FOR OKLAHOMA MEDICAL DOCTOR LICENSE

Received:04/11/2023

Foreign Graduate

**If licensed, where do you intend to locate?**  
OK

**Why do you seek Licensure in the state of Oklahoma?**  
Post-Graduate Training

**In what manner will you be communicating with your Oklahoma patients (telephone, email, internet, video-conference, etc)?**

**Describe how you will examine each patient in person prior to diagnosis, treating, correcting, or prescribing for a patient in Oklahoma from the state, province, or country you are located:**

**Describe the manner in which you intend to practice medicine across state lines in Oklahoma:**

**Have you executed or been offered a contract in connection with practice in the state of Oklahoma?**  
Yes

**If 'Yes', Name of practice:**  
The University of Oklahoma

**If so, Please identify with which category:**  
Residency

**Name of Previous Carrier and Policy Holder**  
none

**Name of Current Carrier and policy Holder**  
Tucson Medical Center

**Will your professional liability insurance policy cover your practice in Oklahoma**  
No

**If NO, when do you expect to obtain liability insurance that will cover practice in Oklahoma**  
07/01/2023

attest that all the above information is accurate as of April 10, 2023: \_\_\_\_\_ (Signed Online)





Applicant: In the presence of a notary public, sign this form with attached photo

Send this form to:

Oklahoma State Board of Medical Licensure and Supervision  
101 NE 51st Street  
Oklahoma City, OK 73105

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

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

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

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

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

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



*Aous Jarrouj*

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JUN 20 2023

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

OKLAHOMA STATE BOARD OF  
MEDICAL LICENSURE  
AND SUPERVISION

**Aous Jarrouj**

Applicants printed last name, first name, middle initial, and suffix (e.g., Jr.)

6/14/2023

Date of signature (must correspond to the date of notarization)

[Please note: The Notary Public seal should overlap the bottom of the photo to the left]

NOTARY

State of AZ, County of Pima

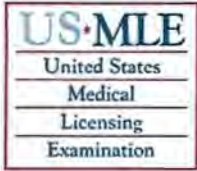
I certify that on the date set forth below, the individual named above did appear personally before me and that I did identify this applicant by (a) comparing his/her physical appearance with the photograph on the identifying document presented by the applicant and with the photograph affixed hereto,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

The statements on this document are subscribed and sworn to before me by the applicant on this 14 day of June, 2023



*Xochitl Idalia Garcia* My Notary Commission Expires 2/1/27

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

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

PRIMARY  
SOURCE

**Recipient:** OKLAHOMA STATE BOARD OF  
MEDICAL LICENSURE & SUPERVISION

**Date:** 04/21/2024

**Examinee:** Jarrouj, Aous  
**Alt Name(s):**

**Examinee ID:** 0-899-556-5  
**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. Pass/fail outcomes are based upon the minimum passing level in place at the time of test administration and are not altered by subsequent revisions to the minimum passing level. Effective April 1, 2013, two-digit scores will no longer be reported. Test results reported as passing represent an exam score of 75 or higher on a two-digit scale. Step 1 examinations taken on or after January 26, 2022 are reported as pass/fail, with no numeric score; Step 1 examinations taken before January 26, 2022 will continue to be reported with a 3-digit score.

### USMLE STEP 1

Test Date	Pass/Fail	Score	Minimum Pass	Comments
11/29/2021	Pass	194	(194)	
10/15/2021	Fail	188	(194)	

### USMLE STEP 2

#### Clinical Knowledge (CK)

Test Date	Pass/Fail	Score	Minimum Pass	Comments
04/02/2021	Pass	216	(209)	
04/20/2015	Fail	156	(209)	

### USMLE STEP 3

Test Date	Pass/Fail	Score	Minimum Pass	Comments
02/21/2024	Pass	201	(200)	
03/28/2023	Fail	189	(198)	

#### End of Exam History

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

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

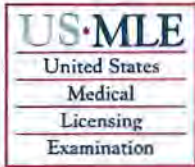
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OKLAHOMA STATE BOARD OF  
MEDICAL LICENSURE  
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## United States Medical Licensing Examination® (USMLE®) Certified Transcript of Scores

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

Examinee: Jarrouj, Aous

Examinee ID: 0-899-556-5

Date of Birth: [REDACTED]

### INTERPRETATION OF RESULTS

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

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

### STEP 1 AND STEP 2 CLINICAL SKILLS (CS)

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

### ANNOTATIONS APPEARING UNDER "COMMENTS"

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

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

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

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

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

### ANNOTATIONS APPEARING AS "NOTE"

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

### PHYSICIAN DATA CENTER INFORMATION APPEARING AS "NOTE"

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

03/2015

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



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OKLAHOMA STATE BOARD OF MEDICAL LICENSURE AND SUPERVISION

Form 1 (MD)

Oklahoma State Board of Medical Licensure and Supervision
101 NE 51st Street
Oklahoma City, OK 73105

This form must be completed by the institution and mailed directly from the institution.

Applicant's Name Aous Jarrouj
Institution: The University of Damascus City/State Damascus, Syria

Our records indicate that the above named applicant attended our medical school on the following dates:

From 09/01/2003 To 09/01/2009 and was awarded the degree MD

- 1. Does this individual's official record reflect (an) interruption(s) or extension(s) in his/her medical education? If yes, please explain.
2. Does this individual's official record reflect that he/she was ever placed on academic or disciplinary probation during his/her medical education? If yes, please explain.
3. Does this individual's official record reflect that he/she was ever the subject of negative reports for behavioral reasons or an investigation by the medical school or parent university? If yes, please explain below.
4. Does this individual's official record reflect that he/she was ever disciplined for unprofessional conduct/behavioral reasons by the medical school or parent university? If yes, please explain below.
5. Does this individual's official record reflect that there were any limitations or special requirements imposed on the individual because of questions of academic incompetence, disciplinary problems, or any other reason? If yes, please explain below.

Please explain any "YES" response from above:

Completion of the following is certification that the information above is an accurate account of this individual's records and is true and correct.

Name: Prof. Raed AbouHarb MD, PhD Signature

Title of Signatory: Dean Of Faculty Of Medicine Date of Signature 04/30/2023

Tel: +963 11 2117404 Fax: +963 11 2123664 E-Mail: Dean.med@Damascusuniversity.edu.sy



If no seal is available, this form must be notarized

Notary Public

Commission #

My commission expires:

Notary Seal

Handwritten number 141485 and other markings.



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**SYRIAN ARAB REPUBLIC  
DAMASCUS UNIVERSITY  
FACULTY OF MEDICINE**

OKLAHOMA STATE BOARD OF  
MEDICAL LICENSURE  
AND SUPERVISION

**ATTESTATION OF STUDENT'S TRANSCRIPT OF GRADES**

Name	<b>AOUS JARROUJ</b>
Father's Name	<b>TALAL</b>
Place & Date of Birth	Damascus, [REDACTED]
Nationality	Syrian National
Date of Registration	2003/2004
REGISTRATION PREREQUISITES	Syrian Secondary Study Diploma, Scientific

We list in what follows a transcript of his grades during the years of his study at the Faculty of Medicine, from the 2003/2004 academic year until the 2008/2009 academic year:

**First Year: 2003-2004 ACADEMIC YEAR**

Subjects	First Semester Grades
Medical Physics	64
General Chemistry	52
Cytology	59
Biology	59
Arabic Language	93
Foreign Language (English)	75
Subjects	Second Semester Grades
Genetics	52
Anatomy (Limbs)	54
Organic Chemistry	60
Medical Embryology	51
National Socialist Education	93
Foreign Language (English)	75
<b>GRAND TOTAL</b>	<b>787</b>
<b>AVERAGE</b>	<b>65.58</b>
<b>RESULT</b>	<b>Passed</b>

Translated on October 28, 2013

This is a true and correct word-for-word translation of the original written in Arabic  
AL AMAL TRANSLATION OFFICE, DAMASCUS, SYRIA, TEL: 963-11-3314723  
E-mail: amal.akaw@gmail.com



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[2]

OKLAHOMA STATE BOARD OF  
MEDICAL LICENSURE  
AND SUPERVISION**STUDENT: AOUS JARROUJ****Second Year: 2004-2005 ACADEMIC YEAR**

Subjects	First Semester Grades
Physiology (1)	50
Biochemistry (1)	53
General Histology	60
Anatomy (Nervous System)	51
Subjects	Second Semester Grades
Physiology (2)	52
Biochemistry (2)	63
Histology (Organ Systems)	53
Anatomy (Viscera)	57
Foreign Language (English)	85
<b>GRAND TOTAL</b>	<b>524</b>
<b>AVERAGE</b>	<b>58.22</b>
<b>RESULT</b>	<b>Passed</b>

**Third Year: 2005-2006 ACADEMIC YEAR**

Subjects	First Semester Grades
Pharmacology 1	54
Microbiology	68
Symptoms and Diagnosis	51
Patho-Physiology	52
Public Health	54
Medical Biostatistics	53
Subjects	Second Semester Grades
Pharmacology 2	49+1
General Pathology	58
Medical Parasitology	57
Minor Surgery	70
Clinical Patho-Chemistry	49+1
Medical Immunology	53
Foreign Language (English)	45+5
<b>GRAND TOTAL</b>	<b>713</b>
<b>AVERAGE</b>	<b>54.84</b>
<b>RESULT</b>	<b>Passed</b>

Translated on October 28, 2013

This is a true and correct word-for-word translation of the original written in Arabic

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E-mail: amal.akaw@gmail.com





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MEDICAL LICENSURE  
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[3]

**STUDENT: AOUS JARROUJ****Fourth Year: 2006-2007 ACADEMIC YEAR**

Subjects	First Semester Grades
Internal Medicine 1 (Gastroenterology – Rheumatology)	51
Surgery (General) 2	70
Obstetrics	52
Pediatrics 1	63
Specific Pathology	50
Otolaryngology Diseases	63
Foreign Language (English)	56
Subjects	Second Semester Grades
Internal Medicine 2 (Cardiology-Respiratory)	57
Surgery 3 (Cardiovascular -Thoracic)	66
Dermatology & Venereology	69
Pediatrics (2)	59
Forensic Medicine	67
Ethics of Medicine	80
<b>GRAND TOTAL</b>	<b>803</b>
<b>AVERAGE</b>	<b>61.76</b>
<b>RESULT</b>	<b>Passed</b>

Translated on October 28, 2013

This is a true and correct word-for-word translation of the original written in Arabic  
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 E-mail: amal.akaw@gmail.com

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MEDICAL LICENSURE  
AND SUPERVISION

[4]

**STUDENT: AOUS JARROUJ****Fifth Year: 2007-2008 ACADEMIC YEAR**

Subjects	First Semester Grades
Internal Medicine 3 (Neurology - Nephrology)	56
Internal Medicine 4 (Endocrinology, Geriatrics & Nutrition)	65
Surgery 4 (Neurosurgery -Urology-Pediatric)	59
Gynecology	72
Ophthalmology	72
Anesthesiology & Emergency Medicine	61
Psychiatry	68
Subjects	Second Semester Grades
Radiology	68
Preventive Medicine	59
Internal Medicine 5 (Hematology-Oncology-Infectious Diseases)	57
Surgery 5 (Orthopedic- Plastic)	68
Family Medicine	76
Foreign Language (English)	54
<b>GRAND TOTAL</b>	<b>835</b>
<b>AVERAGE</b>	<b>64.23</b>
<b>RESULT</b>	<b>Passed</b>

Translated on October 28, 2013

This is a true and correct word-for-word translation of the original written in Arabic  
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 E-mail: amal.akaw@gmail.com



Handwritten signature and blue circular stamp. The stamp contains the text 'AL AMAL TRANSLATION OFFICE' and 'DAMASCUS, SYRIA'. To the right of the stamp, the handwritten number '741485' is written vertically.

[5]

**STUDENT: AOUS JARROUJ****FACULTY OF MEDICINE - SIXTH YEAR –****2008/2009 ACADEMIC YEAR**

<u>SESSION</u>	<u>GRADES</u>
Internal Medicine	70
Surgical Diseases	73
Pediatrics	64
Obstetrics & Gynecology	67
<b>6TH YEAR TOTAL GRADES</b>	<b>: 274</b>
<b>6TH YEAR AVERAGE</b>	<b>: 68.50%</b>
<b>RESULT</b>	<b>: Graduated</b>

Accordingly, he was awarded the **Doctor of Medicine Diploma with a rating of Good and a graduation average of 62.18%** as a result of the 2008/2009 academic year National July session examinations, per Damascus University Board Resolution No. 3488 of 09/08/2009.

Upon his request he was given this transcript, having paid its fee to the Damascus University treasury per receipt # 9013 of 11/14/2012.

Damascus,

Head, Examination Department  
(Signature & Seal)

Dean, Faculty of Medicine  
(Signature & Seal)

Translated on October 28, 2013

*This is a true and correct word-for-word translation of the original written in Arabic*  
AL AMAL TRANSLATION OFFICE, DAMASCUS, SYRIA, TEL: 963-11-3314723  
E-mail: amal.akaw@gmail.com

*A. Al Jarrouj*



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الجمهورية العربية السورية  
جامعة دمشق  
كلية الطب



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OKLAHOMA STATE BOARD OF  
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SOURCE

مصدقة كدفعة علامات الطالب : أوس جروج

اسم الطالب : أوس جروج

اسم الأب : طلال

محل وتاريخ الولادة : دمشق ١٩٨٤

الجنسية : العربية السورية

موجبات التسجيل : ثانوية سورية علمية

تاريخ التسجيل : ٢٠٠٤/٢٠٠٣

ندرج فيما يلي كشفا بعلاماته خلال سنتي دراسته في كلية الطب البشري  
بدءاً من العام الدراسي ٢٠٠٣ / ٢٠٠٤ ولغاية العام الدراسي ٢٠٠٨ / ٢٠٠٩

## السنة الأولى ٢٠٠٤/٢٠٠٣

## الفصل الأول

الدرجة		رقما	اسم المقرر
كتابة			
أربع وستون		٦٤	الفيزياء الطبية
اثنتان وخمسون		٥٢	الكيمياء العامة
تسع وخمسون		٥٩	علم الخلية
تسع وخمسون		٥٩	علم الحياة
ثلاث وتسعون		٩٣	اللغة العربية
خمس وسبعون		٧٥	اللغة الأجنبية (١)

## الفصل الثاني

الدرجة		رقما	اسم المقرر
كتابة			
اثنتان وخمسون		٥٢	علم الوراثة
أربع وخمسون		٥٤	التشريح (١) (الهيكل والأطراف)
ستون فقط		٦٠	الكيمياء العضوية
إحدى وخمسون		٥١	علم الجنين الطبي
ثلاث وتسعون		٩٣	الثقافة القومية الاشتراكية
خمس وسبعون		٧٥	اللغة الأجنبية (٢)
النتيجة : ناجح		٦٥.٥٨	المجموع : ٧٨٧ المعدل :

دققها

ربيع السدران

نظمها

فراس سراجي

الاسم :

التوقيع :

الجمهورية العربية السورية  
جامعة دمشق  
كلية الطب



مصدقة كدفعة علامات الطالب : أوس جروج

السنة الثانية ٢٠٠٥/٢٠٠٤		
الفصل الأول		
الدرجة	اسم المقرر	
كتابة	رقما	
خمسون فقط	٥٠	علم وظائف الأعضاء (١)
ثلاث وخمسون	٥٣	الكيمياء الحيوية الطبية (١)
ستون فقط	٦٠	علم النسيج العام
إحدى وخمسون	٥١	التشريح (٢) الرأس والعنق والجملة العصبية والحواس
الفصل الثاني		
الدرجة	اسم المقرر	
كتابة	رقما	
اثنان وخمسون	٥٢	علم وظائف الأعضاء (٢)
ثلاث وستون	٦٣	الكيمياء الحيوية الطبية (٢)
ثلاث وخمسون	٥٣	علم النسيج الخاص
سبع وخمسون	٥٧	التشريح (٣) ( الصدر والبطن والحوض)
خمس وثمانون	٨٥	اللغة الأجنبية
النتيجة : ناجح		المجموع : ٥٢٤
المعدل: ٥٨.٢٢		

دققها

ربيع السدران

نظمها

فواز سرايحي

الاسم :

التوقيع:

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الجمهورية العربية السورية  
جامعة دمشق  
كلية الطب



مصدقة لحفظ علامات الطالب : أوس جروج

السنة الثالثة ٢٠٠٥/٢٠٠٦		
الفصل الأول		
الدرجة	اسم المقرر	
	رقما	كتابة
أربع وخمسون	٥٤	علم الادوية العام
ثمان وستون	٦٨	الأحياء الدقيقة (١) الجراثيم والفيروسات
إحدى وخمسون	٥١	الاعراض والتشخيص
اثنان وخمسون	٥٢	علم وظائف الأعضاء المرضي
أربع وخمسون	٥٤	الصحة العامة
ثلاث وخمسون	٥٣	الاحصاء الطبي الحيوي
الفصل الثاني		
الدرجة	اسم المقرر	
	رقما	كتابة
تسع وأربعون مساعد بدرجة واحدة	١+٤٩	الأدوية (٢)
ثمان وخمسون	٥٨	التشريح المرضي العام
سبع وخمسون	٥٧	الأحياء الدقيقة (٢) ( الطفيليات )
سبعون فقط	٧٠	الجراحة (١) (مدخل الى الجراحة)
تسع وأربعون مساعد بدرجة واحدة	١+٤٩	الكيمياء المرضية
ثلاث وخمسون	٥٣	علم المناعة
خمس وأربعون مساعد بخمس درجات	٥+٤٥	اللغة الاجنبية
النتيجة : ناجح		المعدل : ٧١٣
٥٤.٨٤		

رئيس اللجنة

دقق  
ربيع السدران

نظمي  
فراس سراجي  
الاسم :  
التوقيع :

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الجمهورية العربية السورية  
جامعة دمشق  
كلية الطب

مصدقة كختم علامات الطالب : أوس جروج

المنحة الرابعة ٢٠٠٦/٢٠٠٧		
الفصل الأول		
الدرجة	اسم المقرر	
رقما	رقما	اسم المقرر
إحدى وخمسون	٥١	الأمراض الباطنة (١) (أمراض جهاز الهضم والجهاز الحركي)
سبعون فقط	٧٠	الجراحة (٢) (الجراحة العامة وجراحة البطن)
اثنان وخمسون	٥٢	التوليد
ثلاث وستون	٦٣	أمراض الأطفال (١)
خمسون فقط	٥٠	التشريح المرضي الخاص
ثلاث وستون	٦٣	الأمراض الجلدية والأمراض المنقولة بالجنس
ست وخمسون	٥٦	اللغة الأجنبية
الفصل الثاني		
الدرجة	اسم المقرر	
رقما	رقما	اسم المقرر
سبع وخمسون	٥٧	الأمراض الباطنة (٢) (أمراض القلب والأوعية وأمراض الصدر)
ست وستون	٦٦	الجراحة (٣) (جراحة القلب والصدر والأوعية)
تسع وستون	٦٩	أمراض الأنف والأذن والحنجرة
تسع وخمسون	٥٩	أمراض الأطفال (٢)
سبع وستون	٦٧	الطب الشرعي
ثمانون فقط	٨٠	آداب الطب
النتيجة : ناجح	٦١.٧٦	المعدل : ٨٠.٣

دققها  
ربيع السدران

نظمها  
فراس سرايبي  
التوقيع:

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MAY 22 2023

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PRIMARY  
SOURCE



مصدقة كفاءة علامات الطالب : أوس جروج

السنة المأخوذة ٢٠٠٨ / ٢٠٠٩		
سبعون فقط	٧٠	جلسة الطب الباطني
ثلاث وسبعون	٧٣	جلسة الأمراض الجراحية
أربع وستون	٦٤	جلسة طب الأطفال
سبع وستون	٦٧	جلسة التوليد و أمراض النساء
النتيجة: متخرج		المعدل: ٦٨.٥٠
		المجموع: ٢٧٤

وبذا فقد منح اجازة دكتور في الطب البشري نتيجة امتحانات دورة / تموز / للعام الدراسي ٢٠٠٨ / ٢٠٠٩  
بمرتبة / جيد / ومعدل عام قدره / ٦٢.١٨ / اثنتان وستون درجة وثمانية عشرة جزءاً بالمائة  
بقرار مجلس جامعة دمشق رقم / ٣٤٨٨ / تاريخ / ٨ / ٩ / ٢٠٠٩  
وبناء على طلبه منح هذه المصدقة المسددة رسمها إلى صندوق جامعة دمشق  
بالإيصال رقم (٩٠١٣) تاريخ ٢٠١٢/١١/١٤

ربيع السدران  
دققها:

دققها:

فراس سرايحي

نظمها:

التوقيع

رئيسة قسم الامتحانات

عميد كلية الطب  
الأستاذ الدكتور صلاح شفيقة

رئيسة قسم الامتحانات  
الأستاذة هاجر كرم التوقيع

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SOURCE





مصدقة كختم للامامات الطالب : أوس جروج

السنة الخامسة ١٠٠٧/١٠٠٨		
الفصل الأول		
الدرجة		اسم المقرر
رقما	كتابة	
٥٦	ست وخمسون	الأمراض الباطنة (٣) ( الأمراض العصبية وأمراض الكلية )
٦٥	خمس وستون	الأمراض الباطنة (٤) ( أمراض الغدد والأستقلاب والشيخوخة )
٥٩	تسع وخمسون	الجراحة (٤) الجراحة العصبية والبولية وجراحة الأطفال
٧٢	اثنتان وسبعون	الامراض النسائية
٧٢	اثنتان وسبعون	امراض العين وجراحاتها
٦١	إحدى وستون	طب الطوارئ والتخدير
٦٨	ثمان وستون	علم الأمراض النفسية
الفصل الثاني		
الدرجة		اسم المقرر
رقما	كتابة	
٦٨	ثمان وستون	علم الأشعة والمعالجة الشعاعية
٥٩	تسع وخمسون	الطب الوقائي والمهني
٥٧	سبع وخمسون	الامراض الباطنة (٥) الأمراض الخمجية وأمراض الدم
٦٨	ثمان وستون	الأمراض الجراحية (٥) ( الجراحة العظمية وجراحة التجميل )
٧٦	ست وسبعون	طب الاسرة
٥٤	أربع وخمسون	اللغة الأجنبية
٦٤.٢٣	النتيجة : ناجح	المجموع : ٨٣٥ المعدل :

جامعة دمشق

دققها

ربيع السدران

نظمها

فواز سراجي

الاسم :

التوقيع :

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BAC 041262



نسخة ثانية بدل ضائع  
صورة طبق الأصل  
دمشق في ١١ / ١٤٤١  
الموافق ٢٠٢٠  
مستشفى جليلي  
مستشفى جليلي

الجمهورية العربية السورية  
وزارة التعليم العالي والبحث العلمي  
مجلس جامعة دمشق

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SOURCE

# إجازة دكتور في الطب البشري

قرر مجلس جامعة دمشق في السنة الأولى من الأجل مع السيد زينة  
بعد أن أطلع على نتيجة الامتحان النهائي بكلية الطب البشري  
من السيد د. س. ب. طلال جرجج من موهبي الجمهورية العربية السورية المولود  
في دمشق عام ألف وتسعمائة واربعمائة ودرجته إجازة دكتور في الطب البشري  
بمرتبة جيد فحاز بذلك حقوق هذه الدرجة ولا مفاضلة لها  
ومش في ٢١ رمضان عام ١٤٤١ الموافق ٢١ أيار عام ٢٠٢٠



رئيس جامعة دمشق

الدكتور محمد صالح باصبي

عميد كلية الطب البشري

الدكتور محمد سويخ العوا

الرقم ٤٥٧١ / ٢١٩٤٧





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AND SUPERVISION

**Syrian Arab Republic  
Ministry of Higher Education  
Damascus University**

**Doctor of Medicine Diploma (M.D)**

The Damascus university board has decided on 8<sup>th</sup> of September 2009, having verified the result of the final examination at the Faculty of Medicine, to award **MR. AOUS JARROUJ**

**Father's name: TALAL,**

citizen of the Syrian Arab Republic, born in Damascus in 1984, **the Doctor of Medicine Diploma (M.D)**, with a rating of **Good**.

Accordingly, he is entitled to have the rights and privileges pertaining to this degree.

Damascus: 21/May/2020

**Dean of the Faculty of Medicine / name and signed**

**Damascus University Chairman / name and signed**

**Damascus University / Sealed**

**Duly Certified**

No: 21947/4571

True translation of the attached diploma

Damascus: 30/04/2023

Sworn translator



روان البريجاري

30/4/2023



Oklahoma State Board of Medical Licensure and Supervision

OKTRAINING@okmedicalboard.org

This form must be completed and sent directly to the Board by the training institution

Verification of Graduate Medical Education

Applicant's Name Aous Jarrouj

Institution: TMC Health Medical Education Program City/State Tucson, AZ

Training Level: 1 Specialty/Subspecialty Transitional From: 06/24/2022 To: 06/23/2023

Accredited By: [X] ACGME [ ] AOA Successfully Completed? [X] YES [ ] NO [ ] IN PROGRESS

Training Level: Specialty/Subspecialty From: / / To: / /

Accredited By: [ ] ACGME [ ] AOA Successfully Completed? [ ] YES [ ] NO [ ] IN PROGRESS

Training Level: Specialty/Subspecialty From: / / To: / /

Accredited By: [ ] ACGME [ ] AOA Successfully Completed? [ ] YES [ ] NO [ ] IN PROGRESS

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

Please explain any "YES" response from above:

Completion of the following is attesting that the information above is an accurate account of this individual's records and is true and correct. The signature line must contain the original signature of the program director (M.D./D.O. only)

Name: David Teeple, MD Signature [Handwritten Signature]

Title of Signatory: Transitional Residency Program Director Date of Signature 6/30/2023

Tel: 520-324-5095 Fax: 520-324-5231 E-Mail: thmep@tmcaz.com

If no seal is available, this form must be notarized

Notary Public

Commission #

My commission expires:



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PRIMARY SOURCE JUL 05 2023 OKLAHOMA STATE BOARD OF MEDICAL LICENSURE AND SUPERVISION

NOTARY SEAL

T41485 UKL





EDUCATIONAL COMMISSION FOR  
FOREIGN MEDICAL GRADUATES

3624 Market Street  
Philadelphia, PA 19104-2685 USA  
215-386-5900 | 215-386-9767 FAX  
www.ecfmg.org

**Issue Date:** 27 Apr 2023

**To:** STATE BOARD OF LICENSURE & SUPERVISION  
LISA CULLEN  
DIRECTOR OF LICENSING  
P.O. BOX 18256  
OKLAHOMA CITY, OK 73154-0256

**State Board Code:**

**037**

Please include this number on  
all requests.

**ECFMG® CERTIFICATION STATUS REPORT**

**RECEIVED**

**USMLE®/ECFMG Identification Number:** 0-899-556-5

**Applicant's Name:** Aous Jarrouj

**Applicant's Date of Birth:** [REDACTED]

**ECFMG Certified:** Yes

**Certificate Issue Date:** 28 Dec 2021

**English Test Valid Through:** 31 Dec 2024

**Clinical Skills Assessment Valid Through:** 31 Dec 2024

**PRIMARY  
SOURCE**

**MAY 01 2023**

OKLAHOMA STATE BOARD OF  
MEDICAL LICENSURE  
AND SUPERVISION

**Passing Performance on Medical Science Examinations:**

Examination	Date	Two Digit Score	Three Digit Score
USMLE Step 1	29 Nov 2021	*	*
USMLE Step 2 CK	02 Apr 2021	*	*

**Most Recent Passing Performance on Clinical Skills Examination:**

Examination	Date
ECFMG Clinical Skills Pathway **	N/A

\*\* This individual met the clinical and communication skills requirements, including English language proficiency, for ECFMG Certification through one of the ECFMG Pathways. Prior to the ECFMG Pathways, IMGs met these requirements by passing the former USMLE Step 2 CS.

**Name of Medical School and Country:** University of Damascus Faculty of Medicine, Damascus, SYRIA

**Degree Year:** 2009

**Medical Education Credentials Status†:** Complete

**How to Verify the Authenticity of this Report:**

This report was issued to the named recipient on the date shown above. To verify the authenticity of this report, visit <https://cvsonline2.ecfmg.org/verify/verify.asp> and enter the unique verification code listed below. The information contained in this report is current as of the issue date. Any changes to the physician's status after the issue date will not be reflected, and you are encouraged to request an updated report.

**Report Verification Code:** ML27432S3M

The purpose of this Status Report is to indicate whether this individual is certified by ECFMG. It reflects only examinations that were used to fulfill requirements for ECFMG Certification. The most recent passing performance on the clinical skills examination is reflected, regardless of whether this individual was required to take a clinical skills examination for ECFMG Certification. This Status Report is not a complete score history of all examinations for this individual. This Status Report does not include examinations that were taken but not passed. Furthermore, if this individual passed examinations that were not used to fulfill the requirements for ECFMG Certification, these examinations are not included.

\* To obtain a complete USMLE examination history for this individual, contact the appropriate registration entity to request a USMLE transcript.

† Since July 1986, ECFMG has verified medical school credentials directly with the issuing medical schools, or through a reasonable alternative that has been approved by the ECFMG Medical Education Credentials Committee.

**Important Note:**

Requesting organizations must normally secure and retain the physician's signed authorization to obtain certification information. Organizations may not resell the information or make it available to any party beyond the initial request as authorized by the physician. The information may only be used to confirm ECFMG Certification for the purpose for which the physician provided authorization.

T41485  
5J



# AMA Physician Profile

PREPARED FOR

Oklahoma State Board of Licensure & Supervision, Oklahoma City, OK

PRIMARY SOURCE

**Name and Mailing Address**

AOUS JARROUJ  
OU HEALTH SCIENCES CTR  
L100  
800 NE 10TH ST  
OKLAHOMA CITY, OK 73104-5418

**Primary Office Address**

SAME AS MAILING ADDRESS

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MEDICAL LICENSURE  
AND SUPERVISION

**Birth date**

[REDACTED]

**Phone** UNKNOWN

**Physician's major professional activity**

HOSPITAL BASED RESIDENTS - ALL YEARS

**AMA membership status**

MEMBER

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

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

NO DATA REPORTED AT THIS TIME

**Current and/or historical medical school**

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

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

**School:** UNIVERSITY OF DAMASCUS FACULTY OF MEDICINE

**Degree Awarded:** YES  
**Enrollment Date:** NOT REPORTED

**Degree Type:** MD  
**Degree Date:** 2009

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

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

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

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

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

**Sponsoring Institution:** UNIVERSITY OF OKLAHOMA COLLEGE OF MEDICINE  
**Sponsoring State:** OKLAHOMA  
**Program name:** UNIVERSITY OF OKLAHOMA HEALTH SCIENCES CENTER PROGRAM  
**Specialty:** RADIATION ONCOLOGY  
**Training Type:** SPECIALTY  
**Dates:** 07/01/2023 - 06/30/2027  
**Status:** TRAINING IN PROGRESS

**Sponsoring Institution:** TMC HEALTH MEDICAL EDUCATION PROGRAM, INC. (THMEP)  
**Sponsoring State:** ARIZONA  
**Program name:** TMC HEALTH MEDICAL EDUCATION PROGRAM INC (THMEP) PROGRAM  
**Specialty:** TRANSITIONAL YEAR  
**Training Type:** SPECIALTY  
**Dates:** 06/24/2022 - 06/23/2023  
**Status:** COMPLETED

### Specialty board certification

NO DATA REPORTED AT THIS TIME



### Current and/or historical medical licensure

NO DATA REPORTED AT THIS TIME

### Action notifications reported to the AMA

**Medical Licensing Boards:** NO ACTIONS REPORTED AT THIS TIME

**Medicare/Medicaid Sanctions from DHHS:** NO ACTIONS REPORTED AT THIS TIME

**US DOJ Drug Enforcement Administration:** NO ACTIONS REPORTED AT THIS TIME

### U.S. Drug Enforcement Administration (DEA)

NO DATA REPORTED AT THIS TIME

### ECFMG certification

Applicant Number: 08995565

*The Educational Commission for Foreign Medical Graduates (ECFMG) applicant identification number does not imply current ECFMG certification status. To verify ECFMG status, contact the ECFMG Certification Verification Service online at <https://cvsonline2.ecfm.org/>*

### Profile information

The content of the AMA Physician Profile is for credentialing use only. The content cannot be used or assembled for an employment purpose as defined under the Fair Credit Reporting Act. An organization's appropriate use of the data contained in the AMA Physician Professional Data™, formerly known as AMA Physician Masterfile, meets select primary source verification requirements of the Joint Commission, the Accreditation Association for Ambulatory Health Care (AAAHC) and the American Accreditation Health Care Commission (AAHCC)/ Utilization Review Accreditation Commission (URAC). The AMA Physician Professional Data is also an NCQA-approved source for verification of medical school, post-graduate medical training, ABMS Board Certification and federal DEA registration.

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

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



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MAY 01 2023

OKLAHOMA STATE BOARD OF MEDICAL LICENSURE AND SUPERVISION

OKLAHOMA STATE BOARD OF MEDICAL LICENSURE AND SUPERVISION
101 NE 51st STREET
OKLAHOMA CITY OK 73105
EVIDENCE OF STATUS - PART B

Full Legal Name: AOUS Jarrouj
Mailing Address: [Redacted]
City State Zip Code Telephone Number Social Security # [Redacted]

DOCUMENTATION TO DETERMINE QUALIFIED ALIEN STATUS

If you are a qualified alien, please submit a notarized copy of the original, unexpired documents. Place a checkmark below to indicate the document that will be submitted.

Form with multiple sections: Immigrant or Non-Immigrant Visa Status, Asylee, Refugee, Alien Paroled Into the U.S. for a least One Year, Alien Whose Deportation or Removal Was Withheld, Alien Granted Conditional Entry, Cuban/Haitian Entrant, Alien Who Has Been Battered or Subjected to Extreme Cruelty, Other Document (please list).

I declare under penalty of perjury, under the laws of the State of Oklahoma, that all information contained in this application and all accompanying documents provided to substantiate my Evidence of Status application are true and correct.

Signature [Handwritten Signature]

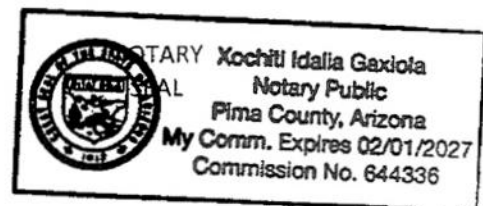
Date 4/11/23

Subscribed and sworn before me this 11 day of April, 2023

Notary Public Xochitl I Gaxiola

Commission Number 644336

My commission expires 2/1/27



T41485 WB





Name: Aous Jarrouj	Application # 41485
--------------------	---------------------

We must account *for any/all time from your 18th birthday to present.* Please complete this form to the best of your recollection for the times indicated.

EDUCATION							
Start Month	Start Year	End Month	End Year	Name of Institution	City	State	Degree

WORK HISTORY							
Start Month	Start Year	End Month	End Year	Name of Employer	City	State	Job Title

OTHER ACTIVITY							
Start Month	Start Year	End Month	End Year	Other Activity <small>(example: Unemployed, Summer Break, Stay at home parent, etc.)</small>	City	State	
09	2009	01	2010	break before starting residency	Damascus	Syria	


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AND SUPERVISION

T 41485  
V

05/03/2023

AOUS JARROUJ  


**Check Your Application  
Status Online at:**  
<http://www.okmedicalboard.org>  
**Username:AP27542279**  
**Password:Last 4 SSN**

RE: MD Application #41485

Dear AOUS JARROUJ,

**YOU CANNOT PRACTICE YOUR PROFESSION IN THE STATE OF OKLAHOMA UNTIL A VALID LICENSE HAS BEEN ISSUED.**

Your training application has been processed and the current deficiencies are listed below. Please be advised, these may not be the only deficiencies. You will be advised if any other deficiencies are added. You may check your application status online by logging in with the username and password provided above.

If you have further questions please email  
[oktraining@okmedicalboard.org](mailto:oktraining@okmedicalboard.org)

If a "Time Deficiency" is listed, please complete a time deficiency form and e-mail the document to  
[oktraining@okmedicalboard.org](mailto:oktraining@okmedicalboard.org)  
 with your activities during the specified time frame.

Translations  
 ECFMG  
 ECFMG Date  
 MedSchool-Transcript UNIV OF DAMASCUS, FAC OF MED, DAMASCUS, SYRIA  
 MedSchool-Form 1 UNIV OF DAMASCUS, FAC OF MED, DAMASCUS, SYRIA  
 PostGrad - Form 2 TUCSON HOSPITALS MEDICAL EDUCATION PROGRAM  
 OTHER DEFICIENCIES: FCVS /  
 Verify License from AZ R79371  
 Exam verification date  
 PostGrad - Certificate COLLEGE OF MEDICINE OKC  
 PostGrad - Form 2 COLLEGE OF MEDICINE OKC  
 Exam USMLE 3 Requires Date  
 US Customs and Immigration Service (USCIS)  
 Evidence of Status  
 Visa Type (if non-US citizen)  
 Visa Expiration Date (if non-US citizen)  
 Application Instructions  
 OATH  
 Extended Background Check  
 Time Deficiency Form for: 9/2009 - 1/2010 -- MUST USE TIME DEFICIENCY FORM



Any of the required forms in the list above may be downloaded from our website:

<http://www.okmedicalboard.org/resources>

In order to check on the status of your application, please log on to our web site:

<https://secure.okmedicalboard.org/applicant/signin>

Your user name is AP27542279 (all caps and no spaces) and your password is the last 4 digits of your social security number.

If you did not provide a social security number with your application, your password will be your 4-digit year of birth in the form "YYYY".

If we may be of further assistance, please email.

[oktraining@okmedicalboard.org](mailto:oktraining@okmedicalboard.org)

Sincerely,

*Valeska Barr*

Valeska Barr

Dept. of Licensing

Encl

June 14, 2023

Dear Board Secretary,

I am writing this letter to offer my sincere apologies for a mistake made in my application. I made the incorrect selection in error for the question regarding USMLE failures. I failed USMLE Step 2 back in 2015 but passed it in 2021 on the second attempt. I also failed USMLE Step 1 in 2021 and passed on the second attempt in the same year.

Please contact me if any further clarification is needed.

Kind regards,

*Aous Jarrouj*

Aous Jarrouj

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JUN 14 2023

OKLAHOMA STATE BOARD OF  
MEDICAL LICENSURE  
AND SUPERVISION

*THURS  
14*



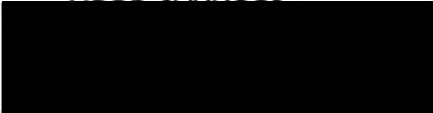
# Oklahoma State Board of Medical Licensure and Supervision

101 NE 51st St  
Oklahoma City, OK 73105

Phone: (405) 962-1400 FAX: (405) 962-1440 email:licensing@okmedicalboard.org

06/29/2023

AOUS JARROUJ



**Check Your Application  
Status Online at:**  
<http://www.okmedicalboard.org>  
**Username:AP27542279**  
**Password:Last 4 SSN**

RE: MD Application #41485

Dear AOUS JARROUJ,

On June 29, 2023 the Oklahoma State Board of Medical Licensure and Supervision approved your application for MD licensure **pending receipt of the following item(s):**

OTHER DEFICIENCIES: RECEIVED FORM 5, NEED FORM 2 REFLECTING SUCCESSFUL ✓  
COMPLETION OF THE PROGRAM  
~~Verify License from AZ R79371~~ unable to verify resident license (LCC)  
Exam verification date ✓  
PostGrad - Form 2 TUCSON HOSPITALS MEDICAL EDUCATION PROGRAM ✓  
PostGrad - Form 2 COLLEGE OF MEDICINE OKC  
USMLE Exams Incomplete ✓

Any of the required forms in the list above may be downloaded from our website:

<http://www.okmedicalboard.org/resources>

Upon receipt of the missing documentation and its verification by the Board Secretary, your license will be sent to you.

If you have any questions, please contact the Board office at 405-962-1400.

Sincerely,

*Lisa Cullen*

Lisa Cullen  
Director of Licensing

**APPROVED** for 2nd year  
training license & full

*July 7-6-23*



# Oklahoma State Board of Medical Licensure and Supervision Application Summary

Type	Number	Name
MD	39627	LARAIB JAVED
MEDICAL DOCTOR		

**Incomplete Information (due to space limitations on this page, this may not be a complete list)**

OTHER DEFICIENCIES: NEED CURRENT VISA / QUESTIONNAIRE / \$250 UPGRADE FEE / EVALUATION  
PostGrad - Form 2 COLLEGE OF MEDICINE OKC

**Last Medical School Attended:**  
704-25 Aga Khan Med Coll, Aga Khan Univ, Karachi, Pakistan

**Number of Licenses Previously Granted to Graduates of this Medical School:69**

Application for: Resident \_\_\_\_\_ Full License \_\_\_\_\_ Reinstatement \_\_\_\_\_

**The Secretary of the Board has reviewed this application and:**

1) AUTHORIZED CIRCULARIZATION TO OTHER BOARD MEMBERS \_\_\_\_\_

2) ALL FIVE CRITERIA HAVE BEEN MET [Fast Track] \_\_\_\_\_

- Passed USMLE
- No DUIs or Legal Issues
- No Malpractice Issues
- US Graduate
- Graduated Medical School in 4 years or less

3) HAS ISSUED A TEMPORARY LICENSE THROUGH \_\_\_\_ / \_\_\_\_ / \_\_\_\_

4) HAS ISSUED A SPECIAL PGY-1 TRAINING LICENSE \_\_\_\_\_



## Oklahoma State Board of Medical Licensure and Supervision Application Summary

**Type**    **Number**    **Name**  
 MD            39627    LARAIB JAVED  
 MEDICAL DOCTOR

**Practice Address:**

April 25, 2022

**Status:**

Res: MD

Received: 04/22/2022

Entered: 04/22/2022

Temp Issued:

Temp Expires:

Train Issued: 07/01/2022

Train Expires: 09/30/2024

Fed Rec: 06/04/2024

AMA Rec: 06/04/2024

Board Action:

License #: 39627

Sex: F

Ethnic Origin: 5

Endorsed By: USMLE

	Test	Score	Date Taken	Date Verified	Attempts
Test 1:	USMLE 2CS	PASS	06/07/19	4/22/22	1
Test 2:	USMLE 2CK	PASS	08/20/21	4/22/22	1
Test 3:	USMLE 1	PASS	08/28/20	4/22/22	1
	USMLE 3	PASS	5/10/22	8/7/23	1
Test AV:	Note: <b>PASS</b> means higher than 75				
Total Possible:					
Okla Passing:					
Total Score:					

**PRE-MED EDUCATION**

School Name: LAHORE GRAMMAR SCHOOL

City: LAHORE

Degree:

State:    Country: PAKISTAN

From: 12/2012 To: 7/2014 Verified:

**MEDICAL SCHOOL EDUCATION**

Name: Aga Khan Med Coll, Aga Khan Univ, Karachi, Pakistan

Foreign Name:

City: Karachi

State/Country: Pakistan

Degree: BACHELOR OF ME

From: 12 / 2014

To: 11 / 2019

Diploma Ver'd:

Y

## Oklahoma State Board of Medical Licensure and Supervision Application Summary

**Type**    **Number**    **Name**  
 MD            39627    LARAIB JAVED  
 MEDICAL DOCTOR

POST GRADUATE EDUCATION			
<b>Facility:</b> COLLEGE OF MEDICINE OKC <b>Res. Fellowship:</b> Residency <b>City:</b> OKLAHOMA CITY <b>Verified:</b> <b>ACGME Ver'd:</b> <b>Comments:</b>	<b>Specialty:</b> INTERNAL MEDICINE  <b>State:</b> OK <b>Country:</b> UNITED STATES <b>From:</b> 7 / 2023 <b>To:</b> /		
<b>Facility:</b> COLLEGE OF MEDICINE OKC <b>Res. Fellowship:</b> Residency <b>City:</b> OKLAHOMA CITY <b>Verified:</b> 07/26/2023 <b>ACGME Ver'd:</b> 04/27/2022 <b>Comments:</b>	<b>Specialty:</b> INTERNAL MEDICINE  <b>State:</b> OK <b>Country:</b> UNITED STATES OF AM <b>From:</b> 7 / 2022 <b>To:</b> 6 / 2023		

PRACTICE HISTORY			
<b>Employed:</b> NONE <b>City:</b> OKLAHOMA CITY <b>Specialty:</b> VISITING FAMILY <b>Comments:</b>	<b>Supervisor:</b> <b>State:</b> OK <b>Country:</b> <b>From:</b> 12 / 2021 <b>To:</b> 5 / 2022 <b>Verified:</b>		
<b>Employed:</b> SERVICES HOSPITAL <b>City:</b> LAHORE <b>Specialty:</b> INTERNSHIP <b>Comments:</b>	<b>Supervisor:</b> <b>State:</b> <b>Country:</b> PAKISTAN <b>From:</b> 1 / 2021 <b>To:</b> 7 / 2021 <b>Verified:</b>		
<b>Employed:</b> NONE <b>City:</b> LAHORE <b>Specialty:</b> UNEMPLOYED <b>Comments:</b> STUDYING FOR EXAMS	<b>Supervisor:</b> <b>State:</b> <b>Country:</b> PAKISTAN <b>From:</b> 12 / 2019 <b>To:</b> 12 / 2021 <b>Verified:</b>		
<b>Employed:</b> NONE <b>City:</b> LAHORE <b>Specialty:</b> UNEMPLOYED <b>Comments:</b>	<b>Supervisor:</b> <b>State:</b> <b>Country:</b> PAKISTAN <b>From:</b> 9 / 2014 <b>To:</b> 11 / 2014 <b>Verified:</b>		

Other Licenses			
State	Lic Type and Number	Status Issued	Exp    Verif

**DEFICIENCIES**  
 OTHER DEFICIENCIES: NEED CURRENT VISA / QUESTIONNAIRE / \$250 UPGRADE FEE / EVALUATION  
 PostGrad - Form 2 COLLEGE OF MEDICINE OKC

# Oklahoma State Board of Medical Licensure and Supervision

PAGE 263 of 500

## APPLICATION FOR OKLAHOMA MEDICAL DOCTOR LICENSE

Received: 04/22/2022

Foreign Graduate

Applicant Name: JAVED LARAIB

MD 39627



Date Of Birth: [REDACTED]

Place Of Birth (City, State): BELFAST, IRELAND

Sex: F

Race: Other

Education									
Type	Name	City	ST	Country	From	To	Degree	Comments	Veri
HS	LAHORE GRAMMAR SCHOOL	LAHORE		PAKISTAN	12/2013	7/2014			

Medical School Name	City	State	Country	Comments	From	To
Aga Khan Med Coll, Aga Khan Univ, Karachi, Pakistan	Karachi		Pakistan		10/2014	11/2019

Post-Graduate							
Facility	City	St	Country	Specialty	Comments	From	To
			UNITED S			/	/

Practice History								
Employer	Specialty	Supervisor	City	ST	Countr	From	To	Verif
								/

Other/ Out-Of-State Licenses					
State	License #	Profession	Status	Issue Date	Exp Date

MD Exam					
Exam	State	Score	Date Taken	#	
USMLE					

*\$250/r*



# Oklahoma State Board of Medical Licensure and Supervision

## APPLICATION FOR OKLAHOMA MEDICAL DOCTOR LICENSE

PAGE 264 of 500

Received:04/22/2022

Foreign Graduate

Questions Answered 04/12/2022	Response
A. Have you ever been denied provider participation, terminated, sanctioned, or penalized by any third party payor, to include TRICARE, MEDICARE, MEDICAID?	N
B. Have you ever surrendered or had any adverse action taken against any narcotic permit (state or federal)?	N
C. Have you ever been denied membership or had disciplinary action taken by a national, state or county professional organization?	N
D. Have you ever been denied or had removed or suspended hospital staff privileges?	N
E. Have you ever surrendered hospital staff privileges while under investigation or to avoid investigation?	N
F. Have you ever entered into an agreement with a federal, state or local jurisdictional body to avoid formal action?	N
G. Have you ever been the subject of an investigation, probation or disciplinary action by a hospital, clinic, practice group, training program or professional school?	N
H. Have you had any adverse judgment, settlement, or award against you arising from a professional liability claim?	N
I. Have you ever had professional liability coverage declined, canceled, issued on special terms, or renewal refused?	N
J. Have you ever been reported to the National Practitioners Data Bank (NPDB) or to the Healthcare Integrity and Protection Data Bank (HIPDB)? (If yes, enclose a copy of the report.)	N
K. Has your application for examination or a professional license ever been denied?	N
L. Have you ever failed any part of a licensure/certification/registration examination?	N
M. Have you ever surrendered a license or had a license revoked?	N
N. Has any disciplinary action been taken on any license?	N
O. Have you ever been subject of a review by professional licensing/regulatory agency based on a complaint filed against you?	N
P. Have you ever been arrested, charged with, or convicted of a felony or misdemeanor, other than traffic violations?	N
Q. Have you ever been arrested, charged with, or convicted of a traffic violation involving the use of any drug or chemical substance, including alcohol?	N
R. Are you now or have you within the past two years been addicted to or used in excess any drug or chemical substance, including alcohol?	N
S. Have you obtained an assessment or been treated for the use of any drug or chemical substance, including alcohol?	N
T. Do you currently have or have you had within the past two years any mental or physical disorder or condition which, if untreated, could affect your ability to practice competently?	N
U. Are you or your spouse currently on Active Duty in the U.S. Armed Forces?	N
V. Are you or your spouse currently Deployed on Active Duty in the U.S. Armed Forces?	N

Foreign Graduate

Oklahoma State Board of Medical Licensure and Supervision

APPLICATION FOR OKLAHOMA MEDICAL DOCTOR LICENSE

Received:04/22/2022

Foreign Graduate

If licensed, where do you intend to locate?

OK

Why do you seek Licensure in the state of Oklahoma?

Post-Graduate Training

In what manner will you be communicating with your Oklahoma patients (telephone, email, internet, video-conference, etc)?

Describe how you will examine each patient in person prior to diagnosis, treating, correcting, or prescribing for a patient in Oklahoma from the state, province, or country you are located:

Describe the manner in which you intend to practice medicine across state lines in Oklahoma:

Have you executed or been offered a contract in connection with practice in the state of Oklahoma?

Yes

If 'Yes', Name of practice:

University of Oklahoma

If so, Please identify with which category:

Residency

Name of Previous Carrier and Policy Holder

none

Name of Current Carrier and policy Holder

None at the moment

Will your professional liability insurance policy cover your practice in Oklahoma

Yes

If NO, when do you expect to obtain liability insurance that will cover practice in Oklahoma

I attest that all the above information is accurate as of April 21, 2022: \_\_\_\_\_ (Signed Online)





Applicant: In the presence of a notary public, sign this form with attached photo.

Send this form to:  
Oklahoma State Board of Medical Licensure and Supervision  
101 NE 51<sup>st</sup> Street  
Oklahoma City, OK 73105

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

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

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

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

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

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



*Javed*

RECEIVED

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

APR 26 2022

Javed Laraib

OKLAHOMA STATE BOARD OF MEDICAL LICENSURE AND SUPERVISION

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

*April 25, 2022*  
Date of signature (must correspond to the date of notarization)

[Please note: The Notary Public seal should overlap the bottom of the photo to the left]

M. SALEEM KHAN  
Advocate High Court  
NOTARY PUBLIC LAHORE

NOTARY

State of PUNJAB, County of PAKISTAN

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

The statements on this document are subscribed and sworn to before me by the applicant on this 25 day of APRIL, 20 22.

Notary Public Signature *[Signature]*

My Notary Commission Expires

T39627  
VW





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

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

**Recipient:** OKLAHOMA STATE BOARD OF  
MEDICAL LICENSURE & SUPERVISION

**Date:** 08/07/2023

**Examinee:** Javed, Laraib  
**Alt Name(s):**

**Examinee ID:** 1-063-674-4  
**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. Pass/fail outcomes are based upon the minimum passing level in place at the time of test administration and are not altered by subsequent revisions to the minimum passing level. Effective April 1, 2013, two-digit scores will no longer be reported. Test results reported as passing represent an exam score of 75 or higher on a two-digit scale. Step 1 examinations taken on or after January 26, 2022 are reported as pass/fail, with no numeric score; Step 1 examinations taken before January 26, 2022 will continue to be reported with a 3-digit score.

### USMLE STEP 1

Test Date	Pass/Fail	Score	Minimum Pass	Comments
08/28/2020	Pass	272	(194)	

### USMLE STEP 2

#### Clinical Knowledge (CK)

Test Date	Pass/Fail	Score	Minimum Pass	Comments
08/20/2021	Pass	256	(209)	

#### Clinical Skills (CS)

Test Date	Pass/Fail	Comments
06/07/2019	Pass	

### USMLE STEP 3

Test Date	Pass/Fail	Score	Minimum Pass	Comments
05/10/2022	Pass	231	(198)	

#### End of Exam History

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

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

**RECEIVED**

AUG 07 2023

OKLAHOMA STATE BOARD OF  
MEDICAL LICENSURE  
AND SUPERVISION

T39027  
UCC



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

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

**Examinee:** Javed, Laraib

**Examinee ID:** 1-063-674-4

**Date of Birth:** [REDACTED]

### INTERPRETATION OF RESULTS

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

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

### STEP 1 AND STEP 2 CLINICAL SKILLS (CS)

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

### ANNOTATIONS APPEARING UNDER "COMMENTS"

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

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

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

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

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

### ANNOTATIONS APPEARING AS "NOTE"

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

### PHYSICIAN DATA CENTER INFORMATION APPEARING AS "NOTE"

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

03/2015

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



506701

Form 1 (MD)

Oklahoma State Board of Medical Licensure and Supervision  
101 NE 51<sup>st</sup> Street  
Oklahoma City, OK 73105

This form must be completed by the institution and mailed directly from the institution.

RECEIVED

APR 15 2022

OKLAHOMA STATE BOARD OF  
MEDICAL LICENSURE  
AND SUPERVISION

Applicant's Name Laraib Javed

Institution: Aga Khan University

City/State Karachi

Our records indicate that the above named applicant attended our medical school on the following dates:

From 12 / 15 / 2014  
Month Day Year

To 10 / 31 / 2019  
Month Day Year

and was awarded the degree BACHELOR OF MEDICINE,  
BACHELOR OF SURGERY  
DEGREE CONFERRED: 11/30/2019

- Does this individual's official record reflect (an) interruption(s) or extension(s) in his/her medical education? If yes, please explain.  YES  NO
- Does this individual's official record reflect that he/she was ever placed on academic or disciplinary probation during his/her medical education? If yes, please explain.  YES  NO
- Does this individual's official record reflect that he/she was ever the subject of negative reports for behavioral reasons or an investigation by the medical school or parent university? If yes, please explain below.  YES  NO
- Does this individual's official record reflect that he/she was ever disciplined for unprofessional conduct/behavioral reasons by the medical school or parent university? If yes, please explain below.  YES  NO
- Does this individual's official record reflect that there were any limitations or special requirements imposed on the individual because of questions of academic incompetence, disciplinary problems, or any other reason? If yes, please explain below.  YES  NO

Please explain any "YES" response from above: N/A

Completion of the following is certification that the information above is an accurate account of this individual's records and is true and correct.

Name: AMIN KEASHWANI

Signature *Amin Keashwani*  
AMIN KEASHWANI  
Associate Registrar

Title of Signatory: ASSOCIATE REGISTRAR

Date of Signature APR 15 2022  
Office of the Registrar  
Aga Khan University  
Stadium Road, P.O. Box 3500  
Karachi-74800, Pakistan

Tel: +9221 3486 4537

Fax: +9221 34934294

E-Mail: student.records@aku.edu



If no seal is available, this form must be notarized

Notary Public \_\_\_\_\_

Commission # \_\_\_\_\_

My commission expires: \_\_\_\_\_

Notary Seal

PRIMARY SOURCE

MD 3967  
SJ





Official Transcript

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THE AGA KHAN UNIVERSITY

44773

Name: Laraib Javed  
Student Number: 506701  
Date of Birth: [REDACTED]  
Academic Unit: Medical College, Pakistan  
Programme: Bachelor of Medicine; Bachelor of Surgery

Date of Issue: April 21, 2022  
Date of Admission: December 2014  
Date of Completion: October 2019  
Date of Convocation: November 30, 2019  
Programme Status: Graduated

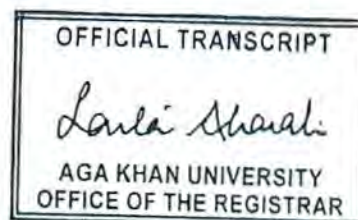
Course Title	Grade	Remarks
<b>Term: Dec 2014 - Nov 2015</b>		
<u>Dec 2014 - Jan 2015</u>		
Humanities	Exploration in Contemporary Art & New Media	S -
Humanities	Pakistan Studies	S -
Humanities	Photography	S -
Humanities	Religions of Pakistan	S -
Humanities	Spanish Language	S -
Humanities	Urdu Communication	S -
<u>Feb 2015 - Mar 2015</u>		
Process Assessment	Blood Module	P -
Summative Examination	Blood Module	82 -
<u>Mar 2015 - Apr 2015</u>		
Process Assessment	Inflammation & Neoplasia	P -
Summative Examination	Inflammation & Neoplasia	85 -
<u>Apr 2015 - May 2015</u>		
Process Assessment	GIT, Nutrition & Metabolism	P -
Summative Examination	GIT, Nutrition & Metabolism	82 -
<u>Jun 2015 - Aug 2015</u>		
Process Assessment	Respiration & Circulation	P -
Summative Examination	Respiration & Circulation	77 -
<u>Aug 2015 - Sep 2015</u>		
Process Assessment	Renal Module	P -
Summative Examination	Renal Module	80 -
<u>Sep 2015 - Oct 2015</u>		
Process Assessment	Multisystem-I	P -
<u>Oct 2015</u>		
OSCE Year 1	Objective Structured Clinical Examination - 1	AT -
<u>Nov 2015</u>		
MBBS Part I-A Examination	Anatomy	P Honours
MBBS Part I-A Examination	Biochemistry	P Honours

PRIMARY SOURCE

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APR 25 2022

OKLAHOMA STATE BOARD OF  
MEDICAL LICENSURE  
AND SUPERVISION





Official Transcript

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**THE AGA KHAN UNIVERSITY**

44774

**Name:** Laraib Javed  
**Student Number:** 506701

**Date of Issue:** April 21, 2022  
**Date of Admission:** December 2014

Course Title	Grade	Remarks
MBBS Part I-A Examination	Community Health Sciences	P -
MBBS Part I-A Examination	Microbiology	P Honours
MBBS Part I-A Examination	Pathology	P Honours
MBBS Part I-A Examination	Pharmacology	P Honours
MBBS Part I-A Examination	Physiology	P -
<b>Term: Nov 2015 - Oct 2016</b>		
<u>Nov 2015 - Jan 2016</u>		
Process Assessment	Musculoskeletal System	P -
Summative Examination	Musculoskeletal System	84 -
<u>Jan 2016 - Mar 2016</u>		
Process Assessment	Neurosciences	P -
Summative Examination	Neurosciences	79 -
<u>Mar 2016 - Apr 2016</u>		
Process Assessment	Head & Neck and special senses	P -
Summative Examination	Head & Neck and special senses	88 -
<u>Apr 2016 - May 2016</u>		
Process Assessment	Endocrine & Reproduction	P -
Summative Examination	Endocrine & Reproduction	88 -
<u>Jun 2016 - Jul 2016</u>		
Process Assessment	Immunity & Infectious Diseases	P -
Summative Examination	Immunity & Infectious Diseases	88 -
<u>Aug 2016</u>		
Social Sciences	Introduction to Research	P -
<u>Aug 2016 - Sep 2016</u>		
Process Assessment	Multisystem-II	P -
<u>Oct 2016</u>		
OSCE Year 2	Objective Structured Clinical Examination - 2	P -
MBBS Part I-B Examination	Anatomy	P Honours
MBBS Part I-B Examination	Biochemistry	P Honours
MBBS Part I-B Examination	Community Health Sciences	P -
MBBS Part I-B Examination	Microbiology	P Honours
MBBS Part I-B Examination	Pathology	P Honours
MBBS Part I-B Examination	Pharmacology	P Honours
MBBS Part I-B Examination	Physiology	P -

PRIMARY  
SOURCE

RECEIVED

APR 25 2022

OKLAHOMA STATE BOARD OF  
MEDICAL LICENSURE  
AND SUPERVISION

OFFICIAL TRANSCRIPT

Laraib Javed

AGA KHAN UNIVERSITY  
OFFICE OF THE REGISTRAR





## Official Transcript

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THE AGA KHAN UNIVERSITY

44775

Name: Laraib Javed  
Student Number: 506701

Date of Issue: April 21, 2022  
Date of Admission: December 2014

Course Title	Grade	Remarks
<b>Term: Oct 2016 - Oct 2017</b>		
<u>Oct 2016 - Sep 2017</u>		
Clerkship - Year 3	Family Medicine	66 -
Clerkship - Year 3	General Medicine	69 -
Clerkship - Year 3	General Surgery	84 -
Clerkship - Year 3	Infectious Diseases & Microbiology	82 -
Clerkship - Year 3	Maternal and Neonatal Child Health	72 -
Clerkship - Year 3	Ophthalmology	75 -
Clerkship - Year 3	Orthopaedics	73 -
Clerkship - Year 3	Otolaryngology	71 -
Clerkship - Year 3	Radiology	77 -
<u>Oct 2017</u>		
OSCE Year 3	Objective Structured Clinical Examination - 3	P -
MBBS Part II Examination	Forensic Medicine	P -
MBBS Part II Examination	Ophthalmology	P -
MBBS Part II Examination	Otolaryngology	P -
<b>Term: Oct 2017 - Sep 2018</b>		
<u>Oct 2017 - Aug 2018</u>		
Clerkship - Year 4	Anaesthesia	61 -
Clerkship - Year 4	Community Health Sciences	74 -
Clerkship - Year 4	Dermatology	79 -
Clerkship - Year 4	Hospital Based Paediatrics	74 -
Clerkship - Year 4	Medicine	75 -
Clerkship - Year 4	Obstetrics & Gynaecology	73 -
Clerkship - Year 4	Psychiatry	65 -
<u>Sep 2018</u>		
MBBS Part III Examination	Obstetrics & Gynaecology	P -
MBBS Part III Examination	Paediatrics	P -
MBBS Part III Examination	Psychiatry	P -
<b>Term: Oct 2018 - Oct 2019</b>		
<u>Oct 2018 - Sep 2019</u>		
Clerkship - Year 5	Family Medicine / Emergency Medicine	73 -
Clerkship - Year 5	Interventional Radiology	S -
Clerkship - Year 5	Medicine	77 -

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OKLAHOMA STATE BOARD OF  
MEDICAL LICENSURE  
AND SUPERVISIONPRIMARY  
SOURCE

OFFICIAL TRANSCRIPT

Laraib Javed

AGA KHAN UNIVERSITY  
OFFICE OF THE REGISTRAR





## Official Transcript

This transcript is printed on security paper with a green background and does not require a raised seal. The transcript is considered official only if bearing the University Registrar's signature stamp.

THE AGA KHAN UNIVERSITY

44776

Name: Laraib Javed

Date of Issue: April 21, 2022

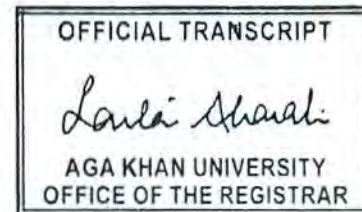
Student Number: 506701

Date of Admission: December 2014

	Course Title	Grade	Remarks
Clerkship - Year 5	Nephrology	S	-
Clerkship - Year 5	Pain	S	-
Clerkship - Year 5	Surgery	72	-
<u>Sep 2019</u>			
Examination	ECOES Exam: Ensuring Competency of Essential Skills	S	-
<u>Oct 2019</u>			
MBBS Part IV Examination	Family Medicine	P	-
MBBS Part IV Examination	Medicine	P	-
MBBS Part IV Examination	Surgery	P	-

Awarded: Bachelor of Medicine; Bachelor of Surgery, November 30, 2019

\*\*\*\*\* End of Official Transcript \*\*\*\*\*



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SOURCE

## AGA KHAN UNIVERSITY

OFFICE OF THE REGISTRAR  
[registrar@aku.edu]

## MBBS Programme

## Transcript Guide

AGA KHAN UNIVERSITY: Chartered in 1983, Aga Khan University is a private, autonomous international university with campuses and programmes in Kenya, Pakistan, Tanzania, Uganda and the United Kingdom. The University offers undergraduate, graduate and postgraduate degrees; the language of instruction is English.

Letter Grade	Description
F	< 50%
P	Pass
I	Incomplete
IP	In Progress
F	Fail
ING	Ineligible
S	Satisfactory
U	Unsatisfactory
AL	Approved Leave
AB	Absent
AT	Attended
W	Withdrawn

## COURSE NUMBERING

100 – 999	Certificate Courses
1000 – 1999	Diploma and First Year Undergraduate Courses
2000 – 2999	Second Year Undergraduate
3000 – 3999	Third Year Undergraduate
4000 – 4999	Fourth Year Undergraduate
5000 – 5999	Fifth Year Undergraduate
6000 – 6999	Sixth Year Undergraduate
7000 – 7999	Advanced Diploma, First and Second Year Master's Level Courses
8000 – 8999	Third and Fourth Year Master's Level Courses
9000 – 9999	Doctoral Level Courses

## REGISTRATION STATUS

**ACTIVE:** Student currently enrolled in programme.  
**INACTIVE:** Student currently not enrolled in programme.  
**WITHDRAWN:** Student has officially left the programme.  
**GRADUATED:** Student has completed the programme.

## NOTES

## PROCESS ASSESSMENT

The Process Assessment covers assessment in terms of regularity, punctuality, group participation and communication skills in problem-based learning and Problem Solving Integrated Learning (PSIL) sessions. Students are declared Pass or Fail; no numerical grades are awarded.

## SUMMATIVE EXAMINATION

Summative examinations are held after all the modules except for Multisystem Modules. In order to be eligible to write the MBBS 1A and 1B examinations, by the end of Year 1 and 2, respectively, students must achieve an aggregate score of:

- 55% in summative examinations;
- 50% in practical examinations/ATP examinations;
- Satisfactory Process assessment and attendance; and
- Satisfactory assessment in all longitudinal themes, HASS courses and the Introduction to Research course.

Please see Examination and Promotion policies available on website [www.aku.edu](http://www.aku.edu) for details.

## OBJECTIVE STRUCTURED CLINICAL EXAMINATION 1

A mandatory formative examination.

OBJECTIVE STRUCTURED CLINICAL EXAMINATION 2  
OBJECTIVE STRUCTURED CLINICAL EXAMINATION 3

To be promoted, students are required to pass these examinations conducted at the end of Years 2 and 3 respectively.

## CERTIFYING EXAMINATIONS

The five-year MBBS programme is assessed by four Certifying Examinations. MBBS Part I examination is written in two parts, MBBS 1A and MBBS 1B, at the end of Years 1 and 2, respectively. MBBS Part II, III and IV examination are written at the end of Years 3, 4 and 5.

The Aga Khan University does not disclose scores of the Professional Examination to students. The Certifying examinations are graded as pass/fail, as per AKU policies.

## RE-SIT AND REPEAT POLICY

Please see Examination and Promotion policies available on website [www.aku.edu](http://www.aku.edu) for Re-sit and Repeat policy.

## HONOURS

Honours in Basic and Community Health Sciences are awarded at the end of Year 5. A score of at least 80% may qualify for Pass with Honours, subject to satisfactory performance in the Basic and Community Health Sciences components in Years 3, 4 and 5. Students securing 80% or more are invited for the 'honours viva' in the clinical disciplines. If more than 5 students score 80% or more in a discipline, top 5 will be called for the 'honours viva'.

*Our academic programmes scheduled to end in 2020 continued into 2021 due to disrupted Covid-19 terms.*

*The Aga Khan University transcript is printed on security paper with a green background and does not require a raised seal. The transcript is considered official only if bearing the University Registrar's signature stamp.*

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APR 25 2022

OKLAHOMA STATE BOARD OF  
MEDICAL LICENSURE  
AND SUPERVISION

December 2020

PRIMARY  
SOURCE



Form 2 (MD - TRAINING)

ATTACHMENT 3

Oklahoma State Board of Medical Licensure and Supervision

OKTRAINING@okmedicalboard.org

This form must be completed and sent directly to the Board by the training institution

Verification of Graduate Medical Education

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JUL 26 2023

OKLAHOMA STATE BOARD OF MEDICAL LICENSURE AND SUPERVISION

Applicant's Name Laraib Jared

Institution: University of Oklahoma H.S.C. City/State Oklahoma City, Oklahoma

Training Level: (e.g. 1, 2, 3, etc.) 1 Specialty/Subspecialty Internal Medicine From: 07/01/2022 To: 06/30/2023

Internship  Residency Successfully Completed?  YES  NO  IN PROGRESS

Accredited By:  ACGME  AOA

Training Level: (e.g. 1, 2, 3, etc.) \_\_\_\_\_ Specialty/Subspecialty \_\_\_\_\_ From: \_\_\_\_/\_\_\_\_/\_\_\_\_ To: \_\_\_\_/\_\_\_\_/\_\_\_\_

Internship  Residency Successfully Completed?  YES  NO  IN PROGRESS

Accredited By:  ACGME  AOA

Training Level: (e.g. 1, 2, 3, etc.) \_\_\_\_\_ Specialty/Subspecialty \_\_\_\_\_ From: \_\_\_\_/\_\_\_\_/\_\_\_\_ To: \_\_\_\_/\_\_\_\_/\_\_\_\_

Internship  Residency Successfully Completed?  YES  NO  IN PROGRESS

Accredited By:  ACGME  AOA

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

Please explain any "YES" response from above: \_\_\_\_\_

Completion of the following is attesting that the information above is an accurate account of this individual's records and is true and correct. The signature line must contain the original signature of the program director (M.D./D.O. only)

Name: Ajay P. Nadig, M.D. Signature Ajay P. Nadig, M.D.

Title of Signatory: Program Director Date of Signature 6/21/23

Tel: 405) 271-5963 Fax: 405-271-1476 E-Mail: Ajay-Nadig@ouhsc.edu

PRIMARY SOURCE

School Seal

If no seal is available, this form must be notarized

Notary Public \_\_\_\_\_

Commission # \_\_\_\_\_

My commission expires: \_\_\_\_\_

NOTARY SEAL

739627  
WKL





EDUCATIONAL COMMISSION FOR  
FOREIGN MEDICAL GRADUATES

3624 Market Street  
Philadelphia, PA 19104-2685 USA  
215-386-5900 | 215-386-9767 FAX  
www.ecfm.org

Issue Date: 21 Apr 2022

To: STATE BOARD OF LICENSURE & SUPERVISION  
LISA CULLEN  
DIRECTOR OF LICENSING  
P.O. BOX 18256  
OKLAHOMA CITY, OK 73154-0256

State Board Code:

037

Please include this number on  
all requests.

PRIMARY  
SOURCE

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APR 21 2022

OKLAHOMA STATE BOARD OF  
MEDICAL LICENSURE  
AND SUPERVISION

### ECFMG® CERTIFICATION STATUS REPORT

USMLE®/ECFMG Identification Number: 1-063-674-4

Applicant's Name: Laraib Javed

Applicant's Date of Birth: [REDACTED]

ECFMG Certified: Yes

Certificate Issue Date: 09 Sep 2021

English Test Valid Through: Valid Indefinitely

Clinical Skills Assessment Valid Through: Valid Indefinitely

#### Passing Performance on Medical Science Examinations:

Examination	Date	Two Digit Score	Three Digit Score
USMLE Step 1	28 Aug 2020	*	*
USMLE Step 2 CK	20 Aug 2021	*	*

#### Most Recent Passing Performance on Clinical Skills Examination:

Examination	Date
USMLE Step 2 CS	07 Jun 2019

Name of Medical School and Country: Aga Khan University Medical College, Karachi, PAKISTAN

Degree Year: 2019

Medical Education Credentials Status†: Complete

#### How to Verify the Authenticity of this Report:

This report was issued to the named recipient on the date shown above. To verify the authenticity of this report, visit <https://cvsonline2.ecfm.org/verify/verify.asp> and enter the unique verification code listed below. The information contained in this report is current as of the issue date. Any changes to the physician's status after the issue date will not be reflected, and you are encouraged to request an updated report.

Report Verification Code: 2SJ24NS5FE

The purpose of this Status Report is to indicate whether this individual is certified by ECFMG. It reflects only examinations that were used to fulfill requirements for ECFMG Certification. The most recent passing performance on the clinical skills examination is reflected, regardless of whether this individual was required to take a clinical skills examination for ECFMG Certification. This Status Report is not a complete score history of all examinations for this individual. This Status Report does not include examinations that were taken but not passed. Furthermore, if this individual passed examinations that were not used to fulfill the requirements for ECFMG Certification, these examinations are not included.

\* To obtain a complete USMLE examination history for this individual, contact the appropriate registration entity to request a USMLE transcript.

† Since July 1986, ECFMG has verified medical school credentials directly with the issuing medical schools, or through a reasonable alternative that has been approved by the ECFMG Medical Education Credentials Committee.

#### Important Note:

Requesting organizations must normally secure and retain the physician's signed authorization to obtain certification information. Organizations may not resell the information or make it available to any party beyond the initial request as authorized by the physician. The information may only be used to confirm ECFMG Certification for the purpose for which the physician provided authorization.

TMD 39627  
S



# AMA Physician Profile

PREPARED FOR

Oklahoma State Board of Licensure & Supervision, Oklahoma City, OK

PRIMARY SOURCE

### Name and Mailing Address

LARAIB JAVED  
UNIV OF OKLAHOMA  
STE 6300  
800 STANTON L YOUNG BLVD  
OKLAHOMA CITY, OK 73104-5018

### Primary Office Address

WP 2400  
800 STANTON L YOUNG BLVD  
OKLAHOMA CITY, OK 73104-5018

Birth date [REDACTED]

Phone UNKNOWN

### Physician's major professional activity

HOSPITAL BASED RESIDENTS - ALL YEARS

AMA membership status MEMBER

RECEIVED

JUN 03 2024

OKLAHOMA STATE BOARD OF  
MEDICAL LICENSURE  
AND SUPERVISION

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

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

NPI Number	Enumeration Date	Deactivation Date	Reactivation Date	Replacement Number	Last Reported Date
1104546746	09/01/2022	NOT RPTD	NOT RPTD	NOT RPTD	05/17/2024

### Current and/or historical medical school

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

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

**School:** AGA KHAN UNIVERSITY MEDICAL COLLEGE

T39627  
57



**Degree Awarded:** YES **Degree Type:** MD  
**Enrollment Date:** NOT REPORTED **Degree Date:** 2019

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

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

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

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

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

**Sponsoring Institution:** UNIVERSITY OF OKLAHOMA COLLEGE OF MEDICINE  
**Sponsoring State:** OKLAHOMA  
**Program name:** UNIVERSITY OF OKLAHOMA HEALTH SCIENCES CENTER PROGRAM  
**Specialty:** INTERNAL MEDICINE  
**Training Type:** SPECIALTY  
**Dates:** 07/01/2022 - 06/30/2025  
**Status:** TRAINING IN PROGRESS

### Specialty board certification

NO DATA REPORTED AT THIS TIME

### Current and/or historical medical licensure

License Number	MD / DO	Locale	Date Granted	Expiration Date	Renewal Date	Status	License Type	Last Reported	Name on License
39627	MD	OK	07/01/2022	09/30/2024		ACT	RES	05/06/2024	LARAIB JAVED



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

### Action notifications reported to the AMA

**Medical Licensing Boards:** NO ACTIONS REPORTED AT THIS TIME

**Medicare/Medicaid Sanctions from DHHS:** NO ACTIONS REPORTED AT THIS TIME

**US DOJ Drug Enforcement Administration:** NO ACTIONS REPORTED AT THIS TIME

### U.S. Drug Enforcement Administration (DEA)

NO DATA REPORTED AT THIS TIME

### ECFMG certification

Applicant Number: 10636744

*The Educational Commission for Foreign Medical Graduates (ECFMG) applicant identification number does not imply current ECFMG certification status. To verify ECFMG status, contact the ECFMG Certification Verification Service online at <https://cvsonline2.ecfm.org/>*

### Profile information

The content of the AMA Physician Profile is for credentialing use only. The content cannot be used or assembled for an employment purpose as defined under the Fair Credit Reporting Act. An organization's appropriate use of the data contained in the AMA Physician Professional Data™, formerly known as AMA Physician Masterfile, meets select primary source verification requirements of the Joint Commission, the Accreditation Association for Ambulatory Health Care (AAAHC) and the American Accreditation Health Care Commission (AAHCC)/ Utilization Review Accreditation Commission (URAC). The AMA Physician Professional Data is also an NCQA-approved source for verification of medical school, post-graduate medical training, ABMS Board Certification and federal DEA registration.

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

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



OKLAHOMA STATE BOARD OF MEDICAL LICENSURE AND SUPERVISION  
101 NE 51<sup>st</sup> STREET  
OKLAHOMA CITY OK 73105  
**EVIDENCE OF STATUS – PART B**

Full Legal Name: JAVED Last Maiden (if applicable)  
Social Security #: [REDACTED]

**DOCUMENTATION TO DETERMINE QUALIFIED ALIEN STATUS**

If you are a qualified alien, please submit a notarized copy of the original, unexpired documents. Place a checkmark below to indicate the document that will be submitted.

<b>Immigrant or Non-Immigrant Visa Status:</b>	
<input checked="" type="checkbox"/>	INS Form I-94
<input type="checkbox"/>	INS Form I-688B
<b>Asylee:</b>	
<input type="checkbox"/>	INS Form I-94 annotated with stamp showing grant of asylum under §208 of the INA
<input type="checkbox"/>	INS Form I-688B (Employment Authorization Card) annotated "27a .12 (a) (5)"
<input type="checkbox"/>	INS Form I-766 (Employment Authorization Document) annotated "AS"
<input type="checkbox"/>	Grant letter from the Asylum Office of INS
<input type="checkbox"/>	Order of an Immigration judge granting asylum
<b>Refugee:</b>	
<input type="checkbox"/>	INS Form I-94 annotated with stamp showing admission under §207 of the INA
<input type="checkbox"/>	INS Form I-688B (Employment Authorization Card) annotated "274 a.12 (a) (3)"
<input type="checkbox"/>	INS Form I-766 (Employment Authorization Document) annotated "A3"
<input type="checkbox"/>	INS Form I-571 (Refugee Travel Document)
<b>Alien Paroled into the U.S. for a least One Year:</b>	
<input type="checkbox"/>	INS Form I-94 with stamp showing admission for at least one year under §212 (d) (5) of the INA. (Applicant cannot aggregate periods of admission for less than one year to meet the one-year requirement.)
<b>Alien Whose Deportation or Removal Was Withheld:</b>	
<input type="checkbox"/>	INS Form I-688B (Employment Authorization Card) annotated "274 a.12 (a) (10)"
<input type="checkbox"/>	INS Form I-766 (Employment Authorization Document) annotated "A10"
<input type="checkbox"/>	Order from an Immigration judge showing deportation withheld under §243 (h) of the INA as in effect prior to April 1, 1997, or removal withheld under §241 (b) (3) of the INA
<b>Alien Granted Conditional Entry:</b>	
<input type="checkbox"/>	INS Form I-94 with stamp showing admission under §203 (a) (7) of the INA
<input type="checkbox"/>	INS Form I-688B (Employment Authorization Card) annotated "274 a.12 (a) (3)"
<input type="checkbox"/>	INS Form I-766 (Employment Authorization Document) annotated "A3"
<b>Cuban/Haitian Entrant:</b>	
<input type="checkbox"/>	INS Form I-551 (Alien Registration Receipt Card, commonly known as a "green card") with the code CU6, CU7, or CH6
<input type="checkbox"/>	Unexpired temporary I-551 stamp in foreign passport or on INS Form I-94 with the code CU6 or CU7
<input type="checkbox"/>	INS Form I-94 with stamp showing parole as "Cuban/Haitian Entrant" under § 212 (d) (5) of the INA
<b>Alien Who Has Been Battered or Subjected to Extreme Cruelty:</b>	
<input type="checkbox"/>	INS petition and appropriate supporting documentation
<b>Other Document (please list)</b>	
<input type="checkbox"/>	

I declare under penalty of perjury, under the laws of the State of Oklahoma, that all information contained in this application and all accompanying documents provided to substantiate my Evidence of Status application are true and correct.

Signature Javed

Date April 25 2022

Subscribed and sworn before me this 25 day of APRIL, 2022

Notary Public Gulzar

Commission Number \_\_\_\_\_

My commission expires \_\_\_\_\_

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MAY 02 2022

OKLAHOMA STATE BOARD OF MEDICAL LICENSURE AND SUPERVISION



T 37627 car

## TIME DEFICIENCY

Name:	Laraib Javed	Application #	
-------	--------------	---------------	--

We have to account for any/all time from age 18 to present. Please complete this form to the best of your recollection for the times indicated.

EDUCATION							
Start Month	Start Year	End Month	End Year	Name of Institution	City	State	Degree
✓ Dec	2014	Nov	2019	Aga Khan University	Karachi	.	MBBS
✓ Dec	2012	Aug	2014	Lahore Grammar School	Lahore		High School
EMPLOYMENT							
Start Month	Start Year	End Month	End Year	Name of Employer	City	State	Job Title
OTHER							
Start Month	Start Year	End Month	End Year	Other (Unemployed, Stay at home parent, etc.)	City	State	
✓ Dec	2019	Dec	2021	Unemployed/at home/studying for exams	Lahore		
✓ Jan	2021	Jul	2021	Internship at Services Hospital	Lahore		
✓ Dec	2021	May	2022	Visiting family in the US	Oklahoma City	Oklahoma	
✓ Sep	2014	Nov	2014	Unemployed/at home	Lahore		

12/2012-12/2013  
1/2019-Present

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MAY 02 2022

OKLAHOMA STATE BOARD OF  
MEDICAL PROFESSIONS  
AND SUPERVISION

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04/27/2022

LARAIB JAVED  


**Check Your Application  
Status Online at:**  
<http://www.okmedicalboard.org>  
**Username:AP29718216**  
**Password:4 Digit Birth Year**

RE: MD Application #39627

Dear LARAIB JAVED,

## **YOU CANNOT PRACTICE YOUR PROFESSION IN THE STATE OF OKLAHOMA UNTIL A VALID LICENSE HAS BEEN ISSUED.**

This deficiency list may or may not contain all required deficiencies. Please **allow 5 business days** for review by a licensing analyst, at which time you may check your updated status online by logging in with the username and password provided above. If you have further questions at that time, you may email the Licensing Staff at [licensing@okmedicalboard.org](mailto:licensing@okmedicalboard.org) or call (405) 962-1470.

Review of your application for special licensure to practice medicine and surgery in the state of Oklahoma reveals the following deficiencies:

Social Security Number  
 Evidence of Status  
 Visa Type (if non-US citizen)  
 Visa Expiration Date (if non-US citizen)  
 INSTRUCTION SHEET  
 OATH  
 Extended Background Check  
 Time DEFICIENCIES: 12/2012-12/2013, 11/2019-PRESENT (PLEASE USE TIME DEFICIENCY FORM FOR EXPLANATIONS)  
 OTHER DEFICIENCIES: \*\*\*DO NOT NEED FORM2, STEP3, FED, AMA OR NPDB\*\*\*  
 Exam verification date  
 US Customs and Immigration Service (USCIS)  
 Translations  
 MedSchool-Transcript Aga Khan Med Coll, Aga Khan Univ, Karachi, Pakistan  
 PostGrad - Form 2 COLLEGE OF MEDICINE OKC  
 USMLE Exams Incomplete

If a "Time Deficiency" is listed, please e-mail [licensing@okmedicalboard.org](mailto:licensing@okmedicalboard.org) with your activities during the specified time frame.

Any of the required forms in the list above may be downloaded from our website:

<http://www.okmedicalboard.org/resources>



In order to check on the status of your application, please log on to our web site ([www.okmedicalboard.org](http://www.okmedicalboard.org)). Your user name is AP29718216 (all caps and no spaces) and your password is the last 4 digits of your social security number. If you did not provide a social security number with your application, your password will be your 4-digit year of birth in the form "YYYY". To log in, scroll down the home page until you see the tabs in the middle of the page. Click on the tab labeled "eServices," then click "Online Application Status Check." This will open a webpage that allows you to enter your login information.

If we may be of further assistance, please email [licensing@okmedicalboard.org](mailto:licensing@okmedicalboard.org) or call (405) 962-1470.

Sincerely,

**Lisa Cullen**

Lisa Cullen  
Director of Licensing  
Dept. of Licensing

Encl

# Oklahoma State Board of Medical Licensure and Supervision Application Summary

Type	Number	Name
MD	39627	LARAIB JAVED
MEDICAL DOCTOR		

**Incomplete Information (due to space limitations on this page, this may not be a complete list)**

AMA Profile Not Received (to be completed by OSBMLS Staff)  
 Federation Clearance Not Received (to be completed by OSBMLS Staff)  
 Social Security Number  
 Extended Background Check  
 OTHER DEFICIENCIES: \*\*\*DO NOT NEED FORM2, STEP3, FED, AMA OR NPDB\*\*\*  
 NPDB Profile Not Received (to be completed by OSBMLS Staff)  
 Exam verification date  
 PostGrad - Form 2 COLLEGE OF MEDICINE OKC

**Last Medical School Attended:**  
 704-25 Aga Khan Med Coll, Aga Khan Univ, Karachi, Pakistan

**Number of Licenses Previously Granted to Graduates of this Medical School:58**

Application for: Resident \_\_\_\_\_ Full License \_\_\_\_\_ Reinstatement \_\_\_\_\_

**The Secretary of the Board has reviewed this application and:**

1) AUTHORIZED CIRCULARIZATION TO OTHER BOARD MEMBERS \_\_\_\_\_

2) ALL FIVE CRITERIA HAVE BEEN MET [Fast Track] \_\_\_\_\_

- Passed USMLE
- No DUIs or Legal Issues
- No Significant Malpractice Issues
- US Graduate
- Graduated Medical School on time

3) HAS ISSUED A TEMPORARY LICENSE THROUGH \_\_\_ / \_\_\_ / \_\_\_

4) HAS ISSUED A SPECIAL PGY-1 TRAINING LICENSE But 6-15-22

5) REQUESTS SPECIFIC CONSIDERATION OF:

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RETURN FORM TO:  
OKLAHOMA STATE BOARD OF MEDICAL LICENSURE AND SUPERVISION  
[oktraining@okmedicalboard.org](mailto:oktraining@okmedicalboard.org)

**QUESTIONNAIRE**  
Please read and follow ALL instructions

**FORM INSTRUCTIONS:** Complete both pages of this form *only if* you are renewing or upgrading your training license. Attach the appropriate documentation and answer the confidential questions.

**PAYMENT INSTRUCTIONS:** If you **ARE FULLY LICENSED**, you **MUST** go online and renew your license – **DO NOT pay your renewal fee via these instructions (doing so will delay your renewal)** for those needing to pay online please see the instructions of ATTACHMENT 2.

**ATTESTATION STATEMENT:** By completing this document, I agree to pay the appropriate fee on **ONLINE BILL PAY** If you are **UPGRADING** your training license to a full license, your fee will be \$250 & you will choose **MD TRAINING-TO-FULL**

If you are **RENEWING** your training license, your fee will be \$150 & you will choose **MD TRAINING LICENSE RENEWAL**

**PLEASE PRINT ALL INFORMATION**

FIRST NAME	LARAIB	LAST NAME	JAVED
EMAIL ADDRESS	[REDACTED]		
LICENSE NUMBER	39627	PHONE	[REDACTED]
HOME ADDRESS	[REDACTED]	CITY/STATE	[REDACTED]
PROGRAM ATTENDING	UNIVERSITY OF OKLAHOMA HEALTH SCIENCES PROGRAM	SPECIALTY	INTERNAL MEDICINE

**DOCUMENTATION TO ATTACH**

PAYMENT COMPLETED	
<input checked="" type="checkbox"/> \$150 payment made on Billpay for <b>RENEWAL</b> of training license	<input type="checkbox"/> \$250 payment made on Billpay for <b>UPGRADE</b> of training license

DOCUMENTATION REQUIRED	
<input checked="" type="checkbox"/> Form 2 (must be received directly from program) <b>**ONLY FOR UPGRADE - ATTACHMENT 3</b>	<input checked="" type="checkbox"/> Evaluation (must be received directly from program) - ATTACHMENT 4
<input checked="" type="checkbox"/> USMLE Step 3 (must be received directly from USMLE) <b>SENT INITIALLY</b>	<input checked="" type="checkbox"/> Answer confidential questions (on back of this form)

FOREIGN TRAINED STUDENTS	
<input checked="" type="checkbox"/> Current visa	<input checked="" type="checkbox"/> Social Security Number <b>**if not provided at initial application</b>
<input checked="" type="checkbox"/> Background Check <b>**if not done at initial application</b>	

**IF YOU ARE FULLY LICENSED – DO NOT COMPLETE THIS FORM. YOU MUST GO ONLINE AND RENEW AT <https://pay.apps.ok.gov/medlic/md/login.php> ENTER YOUR LICENSE NUMBER & PIN – COMPLETE YOUR RENEWAL AND PAY THE RENEWAL FEE.**



NAME LARAIB JAWED

**PLEASE COMPLETE THE RENEWAL QUESTIONS BELOW, IF YOU HAVE ANY "YES" ANSWERS YOU MUST PROVIDE A NOTARIZED STATEMENT EXPLAINING YOUR ANSWER.**

<b>SINCE RENEWAL OF YOUR TRAINING LICENSE OR INITIAL ISSUE OF YOUR TRAINING LICENSE (whichever is most recent)</b>		
<b>QUESTIONS</b>	<b>YES</b>	<b>NO</b>
Have you failed any part of the USMLE exam (not previously disclosed)?	<input type="checkbox"/>	<input checked="" type="checkbox"/>
Have you been the subject of investigation or disciplinary action (including probation) by a hospital or training program?	<input type="checkbox"/>	<input checked="" type="checkbox"/>
Have you had any adverse judgment or settlement against you rising from a professional liability claim?	<input type="checkbox"/>	<input checked="" type="checkbox"/>
Have you been reported to the National Practitioner Data Bank (NPDB)?	<input type="checkbox"/>	<input checked="" type="checkbox"/>
Have you ever been denied, had removed, or suspended hospital privileges?	<input type="checkbox"/>	<input checked="" type="checkbox"/>
Have you surrendered hospital privileges while under investigation or to avoid investigation?	<input type="checkbox"/>	<input checked="" type="checkbox"/>
Have you entered into an Agreement with a Federal, State, or Local jurisdictional body to avoid formal action?	<input type="checkbox"/>	<input checked="" type="checkbox"/>
Has your application for licensure ever been denied?	<input type="checkbox"/>	<input checked="" type="checkbox"/>
Have you surrendered a license or had any disciplinary action taken on any license?	<input type="checkbox"/>	<input checked="" type="checkbox"/>
Have you been investigated by or requested to appear before a licensing or disciplinary agency (other than the Oklahoma State Board of Medical Licensure and Supervision)?	<input type="checkbox"/>	<input checked="" type="checkbox"/>
Have you obtained an assessment or been treated for use of any drug or chemical substance including alcohol?	<input type="checkbox"/>	<input checked="" type="checkbox"/>
Have you been arrested for, charged with, or convicted of a felony or misdemeanor other than a traffic violation?	<input type="checkbox"/>	<input checked="" type="checkbox"/>
Have you been arrested for, charged with, or convicted of a traffic violation involving the use of any drug or chemical substance?	<input type="checkbox"/>	<input checked="" type="checkbox"/>
Have you been addicted to or abused any drug or chemical substance including alcohol?	<input type="checkbox"/>	<input checked="" type="checkbox"/>
Have you been denied provider participation, terminated, sanctioned or penalized by any third-party payor including TRICARE, MEDICARE, or MEDICAID?	<input type="checkbox"/>	<input checked="" type="checkbox"/>
Have you surrendered or had any adverse action taken against any narcotic permit (State or Federal)?	<input type="checkbox"/>	<input checked="" type="checkbox"/>

I swear under penalty of perjury, that I am the person completing this Questionnaire and understand that any medical license procured or obtained by fraud or misrepresentation will result in disciplinary action taken against the licensee pursuant to the provisions of 59 O.S. § 508.

*OK  
7-28-23*

Signature Jawed

Date 07/15/23



ATTACHMENT 4

RETURN FORM TO:  
 OKLAHOMA STATE BOARD OF MEDICAL LICENSURE AND SUPERVISION  
oktraining@okmedicalboard.org  
 FORM MUST BE RETURNED BY THE PROGRAM, NOT THE APPLICANT

RECEIVED

JUL 03 2023

ANNUAL EVALUATION – TRAINING LICENSES ONLY  
DO NOT COMPLETE FOR FULLY LICENSED PHYSICIANS

OKLAHOMA STATE BOARD OF  
 MEDICAL LICENSURE  
 AND SUPERVISION

Name of Resident (please print) Karaib Javed

License Number 39627 Specialty Internal Medicine

Institution Name University of Oklahoma Health Sciences Center

Program Director (please print) Ajay P. Nadig, M.D.

Program Director Email Ajay-Nadig@ouhsc.edu

Instructions: Please rate each resident according to the scale below. If the score is rated in the 0 (Poor), 1 (Fair) or 2 (Below Average) YOU MUST PROVIDE WRITTEN DOCUMENTATION REGARDING THIS RATING.

ASSESSMENT	POOR	FAIR	BELOW AVERAGE	AVERAGE	ABOVE AVERAGE	OUTSTANDING
MEDICAL KNOWLEDGE	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input checked="" type="checkbox"/>	<input type="checkbox"/>
APPLICATION OF MEDICAL KNOWLEDGE	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input checked="" type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
COMMUNICATION SKILLS	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input checked="" type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
STABILITY IN WORKING RELATIONSHIP WITH OTHER PROFESSIONALS	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input checked="" type="checkbox"/>	<input type="checkbox"/>
THE INDIVIDUAL'S PERFORMANCE COMMENSURATE WITH PEER GROUP	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input checked="" type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

REMARKS/COMMENTS \_\_\_\_\_

COMPLETED BY (please print) Ajay P. Nadig, M.D.

SIGNATURE Ajay P. Nadig, MD

DATE 10/21/2023



## Oklahoma State Board of Medical Licensure and Supervision Application Summary

Type	Number	Name
MD	41556	NATHAN ROBERT JENSEN
MEDICAL DOCTOR		

**Incomplete Information (due to space limitations on this page, this may not be a complete list)**

PostGrad - Form 2 COLLEGE OF MEDICINE OKC  
OTHER DEFICIENCIES: NEED QUESTIONNAIRE / \$250 UPGRADE FEE / EVALUATION

**Last Medical School Attended:**

049-01 Univ Of Ut Sch Of Med, Salt Lake Cty Ut 84132

**Number of Licenses Previously Granted to Graduates of this Medical School:106**

Application for: Resident \_\_\_\_\_ Full License \_\_\_\_\_ Reinstatement \_\_\_\_\_

**The Secretary of the Board has reviewed this application and:**

- 1) AUTHORIZED CIRCULARIZATION TO OTHER BOARD MEMBERS \_\_\_\_\_
  
- 2) ALL FIVE CRITERIA HAVE BEEN MET [Fast Track] \_\_\_\_\_
  - Passed USMLE
  - No DUIs or Legal Issues
  - No Malpractice Issues
  - US Graduate
  - Graduated Medical School in 4 years or less
  
- 3) HAS ISSUED A TEMPORARY LICENSE THROUGH \_\_\_\_ / \_\_\_\_ / \_\_\_\_
  
- 4) HAS ISSUED A SPECIAL PGY-1 TRAINING LICENSE \_\_\_\_\_

## Oklahoma State Board of Medical Licensure and Supervision Application Summary

**Type**    **Number**    **Name**  
 MD        41556        NATHAN ROBERT JENSEN  
 MEDICAL DOCTOR

**Practice Address:**

April 18, 2023  
 UNIVERSITY OF OKLAHOMA MEDICAL CENTER  
 700 NE 13TH ST,

OKLAHOMA CITY, OK 73104  
 OKLAHOMA

**Status:**

Res: MD

Received: 04/18/2023

Entered: 04/18/2023

Temp Issued:

Temp Expires:

Train Issued: 07/01/2023

Train Expires: 09/30/2024

Fed Rec: 05/03/2024

AMA Rec: 05/03/2024

Board Action:

License #: 41556

Sex: M

Ethnic Origin: 1

**Endorsed By:** USMLE EXAMINATION

	Test	Score	Date Taken	Date Verified	Attempts
Test 1:	USMLE 3	PASS	12/09/23	5/2/24	1
Test 2:	USMLE 1	PASS	7/2/20	5/8/23	1
Test 3:	USMLE 2	PASS	7/23/21	5/8/23	1

Note: **PASS** means higher than 75

Test AV:  
 Total Possible:  
 Okla Passing:  
 Total Score:

**PRE-MED EDUCATION**

**School Name:** UNIVERSITY OF UTAH

**City:** SALT LAKE CITY

**Degree:** SPANISH

**State:** UT **Country:** UNITED STATES

**From:** 8/2012 **To:** 5/ 2017 **Verified:**

**School Name:** HIGHLAND HIGH SCHOOL

**City:** SALT LAKE CITY

**Degree:**

**State:** UT **Country:** UNITED STATES

**From:** 7/2006 **To:** 7/ 2010 **Verified:**

**MEDICAL SCHOOL EDUCATION**

**Name:** Univ Of Ut Sch Of Med, Salt Lake Cty Ut 84132

**Foreign Name:**

**City:** Salt Lake Cty

**Degree:**

**State/Country:** United States of America

**From:** 8 / 2018 **To:** 5 / 2023 **Diploma Ver'd:** Y



## Oklahoma State Board of Medical Licensure and Supervision Application Summary

**Type**    **Number**    **Name**  
 MD        41556        NATHAN ROBERT JENSEN  
 MEDICAL DOCTOR

POST GRADUATE EDUCATION	
<b>Facility:</b> COLLEGE OF MEDICINE OKC	<b>Specialty:</b> OPHTHALMOLOGY
<b>Res. Fellowship:</b> Residency	
<b>City:</b> OKLAHOMA CITY	<b>State:</b> OK <b>Country:</b> UNITED STATES OF AM
<b>Verified:</b>	<b>From:</b> 7 / 2023 <b>To:</b> /
<b>ACGME Ver'd:</b>	
<b>Comments:</b>	

PRACTICE HISTORY	
<b>Employed:</b> UNIVERSITY OF UTAH SCHOOL OF MEDICINE	<b>Supervisor:</b>
<b>City:</b> SALT LAKE CITY	<b>State:</b> UT <b>Country:</b> UNITED STATES
<b>Specialty:</b> OFFICE OF HEALTH EQUITY, DIVERSITY, AND INCLUSION	<b>From:</b> 6 / 2022 <b>To:</b> / <b>Verified:</b>
<b>Comments:</b>	
<b>Employed:</b> INDIANA UNIVERSITY HEALTH	<b>Supervisor:</b>
<b>City:</b> INDIANAPOLIS	<b>State:</b> IN <b>Country:</b> UNITED STATES
<b>Specialty:</b> OPHTHALMIC TECHNICIAN	<b>From:</b> 3 / 2022 <b>To:</b> 6 / 2022 <b>Verified:</b>
<b>Comments:</b>	
<b>Employed:</b> WEST SIDE NURSERY	<b>Supervisor:</b>
<b>City:</b> MURRAY	<b>State:</b> UT <b>Country:</b> UNITED STATES
<b>Specialty:</b> LANDSCAPING	<b>From:</b> 4 / 2015 <b>To:</b> 4 / 2016 <b>Verified:</b>
<b>Comments:</b>	
<b>Employed:</b> UNIVERISTY OF UTAH HEALTH	<b>Supervisor:</b>
<b>City:</b> SALT LAKE CITY	<b>State:</b> UT <b>Country:</b> UNITED STATES
<b>Specialty:</b> BLOOD GAS TECHNICIAN	<b>From:</b> 4 / 2014 <b>To:</b> 7 / 2018 <b>Verified:</b>
<b>Comments:</b>	
<b>Employed:</b> LINGUISTIA INTERNATIONAL	<b>Supervisor:</b>
<b>City:</b> MURRAY	<b>State:</b> UT <b>Country:</b> UNITED STATES
<b>Specialty:</b> INTERPRETING	<b>From:</b> 7 / 2012 <b>To:</b> 8 / 2014 <b>Verified:</b>
<b>Comments:</b>	
<b>Employed:</b> CHURCH OF JESUS CHRIST OF LATTER DAY SAINTS	<b>Supervisor:</b>
<b>City:</b> CUSCO	<b>State:</b> <b>Country:</b> PERU
<b>Specialty:</b> MISSIONARY	<b>From:</b> 7 / 2010 <b>To:</b> 7 / 2012 <b>Verified:</b>
<b>Comments:</b>	

Other Licenses					
State	Lic Type and Number	Status	Issued	Exp	Verif

# Oklahoma State Board of Medical Licensure and Supervision

## Application Summary

Type	Number	Name
MD	41556	NATHAN ROBERT JENSEN

MEDICAL DOCTOR

### **DEFICIENCIES**

PostGrad - Form 2 COLLEGE OF MEDICINE OKC

OTHER DEFICIENCIES: NEED QUESTIONNAIRE / \$250 UPGRADE FEE / EVALUATION

# Oklahoma State Board of Medical Licensure and Supervision

PAGE 293 of 500

## APPLICATION FOR OKLAHOMA MEDICAL DOCTOR LICENSE

Received:04/18/2023

Applicant Name: JENSEN, NATHAN ROBERT

MD 41556



Date Of Birth: [REDACTED]

Place Of Birth (City, State): SALT LAKE CITY, UT

Sex: M

Race: Caucasian

Education									
Type	Name	City	ST	Country	From	To	Degree	Comments	Veri
UG	UNIVERSITY OF UTAH	SALT LAKE C	UT		8/2012	5/2017	SPANISH		
HS	HIGHLAND HIGH SCHOOL	SALT LAKE C	UT		7/2006	7/2010			

Medical School Name	City	State	Country	Comments	From	To
Univ Of Ut Sch Of Med, Salt Lake Cty Ut 84132	Salt Lake Cty	UT	United States		8/2018	5/2023

Post-Graduate							
Facility	City	St	Country	Specialty	Comments	From	To
COLLEGE OF MEDICINE OKC	OKLAHOMA CITY	OK	UNITED S	OPHTHALMOLOGY		7/2023	/
			UNITED S			/	/
			UNITED S			/	/

Practice History								
Employer	Specialty	Supervisor	City	ST	Countr	From	To	Verif
UNIVERSITY OF UTAH SCHOOL OF MEDICINE	OFFICE OF HEALTH EQUITY, DIVERSITY, AND INCLUSION		SALT LAKE CITY	UT		6/2022	0/0	
INDIANA UNIVERSITY HEALTH	OPHTHALMIC TECHNICIAN		INDIANAPOLIS	IN		3/2022	6/2022	
WEST SIDE NURSERY	LANDSCAPING		MURRAY	UT		4/2015	4/2016	
UNIVERISTY OF UTAH HEALTH	BLOOD GAS TECHNICIAN		SALT LAKE CITY	UT		4/2014	7/2018	
LINGUISTIA INTERNATIONAL	INTERPRETING		MURRAY	UT		7/2012	8/2014	

Other/ Out-Of-State Licenses					
State	License #	Profession	Status	Issue Date	Exp Date

MD Exam				
Exam	State	Score	Date Taken	#
USMLE				

*\$250*

*JRC*



# Oklahoma State Board of Medical Licensure and Supervision

## APPLICATION FOR OKLAHOMA MEDICAL DOCTOR LICENSE

PAGE 294 of 500

Received:04/18/2023

Questions Answered 04/17/2023	Response
A. Have you ever been denied provider participation, terminated, sanctioned, or penalized by any third party payor, to include TRICARE, MEDICARE, MEDICAID?	N
B. Have you ever surrendered or had any adverse action taken against any narcotic permit (state or federal)?	N
C. Have you ever been denied membership or had disciplinary action taken by a national, state or county professional organization?	N
D. Have you ever been denied or had removed or suspended hospital staff privileges?	N
E. Have you ever surrendered hospital staff privileges while under investigation or to avoid investigation?	N
F. Have you ever entered into an agreement with a federal, state or local jurisdictional body to avoid formal action?	N
G. Have you ever been the subject of an investigation, probation or disciplinary action by a hospital, clinic, practice group, training program or professional school?	N
H. Have you had any adverse judgment, settlement, or award against you arising from a professional liability claim?	N
I. Have you ever had professional liability coverage declined, canceled, issued on special terms, or renewal refused?	N
J. Have you ever been reported to the National Practitioners Data Bank (NPDB) or to the Healthcare Integrity and Protection Data Bank (HIPDB)? (If yes, enclose a copy of the report.)	N
K. Has your application for examination or a professional license ever been denied?	N
L. Have you ever failed any part of a licensure/certification/registration examination?	N
M. Have you ever surrendered a license or had a license revoked?	N
N. Has any disciplinary action been taken on any license?	N
O. Have you ever been subject of a review by professional licensing/regulatory agency based on a complaint filed against you?	N
P. Have you ever been arrested, charged with, or convicted of a felony or misdemeanor, other than traffic violations?	N
Q. Have you ever been arrested, charged with, or convicted of a traffic violation involving the use of any drug or chemical substance, including alcohol?	N
R. Are you now or have you within the past two years been addicted to or used in excess any drug or chemical substance, including alcohol?	N
S. Have you obtained an assessment or been treated for the use of any drug or chemical substance, including alcohol?	N
T. Do you currently have or have you had within the past two years any mental or physical disorder or condition which, if untreated, could affect your ability to practice competently?	N
U. Are you or your spouse currently on Active Duty in the U.S. Armed Forces?	N
V. Are you or your spouse currently Deployed on Active Duty in the U.S. Armed Forces?	N

Oklahoma State Board of Medical Licensure and Supervision

APPLICATION FOR OKLAHOMA MEDICAL DOCTOR LICENSE

PAGE 295 of 500

Received:04/18/2023

If licensed, where do you intend to locate?

OK

Why do you seek Licensure in the state of Oklahoma?

Post-Graduate Training

In what manner will you be communicating with your Oklahoma patients (telephone, email, internet, video-conference, etc)?

Describe how you will examine each patient in person prior to diagnosis, treating, correcting, or prescribing for a patient in Oklahoma from the state, province, or country you are located:

Describe the manner in which you intend to practice medicine across state lines in Oklahoma:

Have you executed or been offered a contract in connection with practice in the state of Oklahoma?

No

If 'Yes', Name of practice:

If so, Please identify with which category:

Name of Previous Carrier and Policy Holder

N/A

Name of Current Carrier and policy Holder

N/A

Will your professional liability insurance policy cover your practice in Oklahoma

No

If NO, when do you expect to obtain liability insurance that will cover practice in Oklahoma

07/01/2023

I attest that all the above information is accurate as of April 17, 2023: \_\_\_\_\_ (Signed Online) \_\_\_\_\_



**Applicant:** In the presence of a notary public, sign this form with attached photo.

**Send this form to:** Oklahoma State Board of Medical Licensure and Supervision

**oktraining@okmedicalboard.org**

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

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

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

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

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

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

RECEIVED

APR 14 2023

OKLAHOMA STATE BOARD OF MEDICAL LICENSURE AND SUPERVISION



*Nathan R. Jensen*  
Applicant's signature (must be signed in the presence of a notary)

JENSEN, NATHAN, R.  
Applicants printed last name, first name, middle initial, and suffix (e.g., Jr.)

04/10/2023  
Date of signature (must correspond to the date of notarization)

**NOTARY**

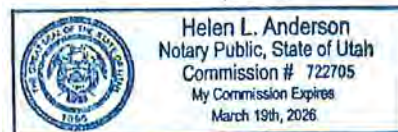
State of Utah, County of Salt Lake

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

The statements on this document are subscribed and sworn to before me by the applicant on this 10 day of April, 2023

Notary Public Signature *Helen L. Anderson* My Notary Commission Expires 3/19/2026

NOTARY SEAL



T 41556 KB





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

PRIMARY SOURCE

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

**Recipient:** OKLAHOMA STATE BOARD OF  
MEDICAL LICENSURE & SUPERVISION

**Date:** 05/01/2024

**Examinee:** Jensen, Nathan  
**Alt Name(s):**

**Examinee ID:** 5-453-605-7  
**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. Pass/fail outcomes are based upon the minimum passing level in place at the time of test administration and are not altered by subsequent revisions to the minimum passing level. Effective April 1, 2013, two-digit scores will no longer be reported. Test results reported as passing represent an exam score of 75 or higher on a two-digit scale. Step 1 examinations taken on or after January 26, 2022 are reported as pass/fail, with no numeric score; Step 1 examinations taken before January 26, 2022 will continue to be reported with a 3-digit score.

### USMLE STEP 1

Test Date	Pass/Fail	Score	Minimum Pass	Comments
07/02/2020	Pass	235	(194)	

### USMLE STEP 2

#### *Clinical Knowledge (CK)*

Test Date	Pass/Fail	Score	Minimum Pass	Comments
07/23/2021	Pass	230	(209)	

### USMLE STEP 3

Test Date	Pass/Fail	Score	Minimum Pass	Comments
12/09/2023	Pass	212	(198)	

#### End of Exam History

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

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

RECEIVED

MAY 02 2024

OKLAHOMA STATE BOARD OF  
MEDICAL LICENSURE  
AND SUPERVISION

T41556  
SJ



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

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

**Examinee:** Jensen, Nathan

**Examinee ID:** 5-453-605-7

**Date of Birth:** [REDACTED]

### INTERPRETATION OF RESULTS

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

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

### STEP 1 AND STEP 2 CLINICAL SKILLS (CS)

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

### ANNOTATIONS APPEARING UNDER "COMMENTS"

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

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

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

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

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

### ANNOTATIONS APPEARING AS "NOTE"

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

### PHYSICIAN DATA CENTER INFORMATION APPEARING AS "NOTE"

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

03/2015

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



Form 1 (MD)

Oklahoma State Board of Medical Licensure and Supervision  
101 NE 51st Street Oklahoma City, OK 73105  
OKTRAINING@OKMEDICALBOARD.ORG

This form must be completed by the institution and mailed or emailed directly from the institution.

Applicant's Name Nathan R. Jensen

Institution: Spencer Fox Eccles School of Medicine City/State Salt Lake City, Utah

Our records indicate that the above named applicant attended our medical school on the following dates:

From 08 / 06 / 2018 To 05 / 19 / 2023 and was awarded the degree Doctor of Medicine  
Month Day Year Month Day Year

Please complete the following questions:

1. Does this individual's official record reflect (an) interruption(s) or extension(s) in his/her medical education? If yes, please explain.  YES  NO
2. Does this individual's official record reflect that he/she was ever placed on academic or disciplinary probation during his/her medical education? If yes, please explain.  YES  NO
3. Does this individual's official record reflect that he/she was ever the subject of negative reports for behavioral reasons or an investigation by the medical school or parent university? If yes, please explain below.  YES  NO
4. Does this individual's official record reflect that he/she was ever disciplined for unprofessional conduct/behavioral reasons by the medical school or parent university? If yes, please explain below.  YES  NO
5. Does this individual's official record reflect that there were any limitations or special requirements imposed on the individual because of questions of academic incompetence, disciplinary problems, or any other reason? If yes, please explain below.  YES  NO

Please explain any "YES" response from above: Nathan took a leave of absence to pursue research from 06/01/2021 to 05/31/2022.

I attest that the completion of the following has been completed by the program director and that the information above is an accurate account of this individual's records and is true and correct.

Name: Helen Anderson Signature 

Title of Signatory: School of Medicine Registrar Date of Signature 05/22/2023

Tel: 801-581-7202 Fax: N/A E-Mail: somregistrar@hsc.utah.edu

School Seal

If no seal is available, this form must be notarized

Notary Public \_\_\_\_\_

Commission # \_\_\_\_\_

My commission expires: \_\_\_\_\_

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PRO SOL

Notary Seal

TU1554 UKC



Name: JENSEN, NATHAN ROBERT  
Student ID: 00600937  
SSN: [REDACTED]  
Birthdate: [REDACTED]

UNIVERSITY OF UTAH DEGREES  
Bachelor of Arts  
Major in Spanish  
Confer Date: December 15, 2017  
Degree GPA: 3.836

Doctor of Medicine  
Major in Medicine  
Confer Date: May 19, 2023 ✓

Course	Description	Units Enrolled	Units Earned	Grade
Spring 2013				
LANG 2010	Intro Stdy Lit & Cultr	3.00	3.00	A-
MATH 1210	Calculus I	4.00	4.00	A
Quant Reas (Math & Stat/Log)				
SPAN 3060	Adv Grammar & Comp	3.00	3.00	A
UC 1020	Introduction to Premed	1.00	1.00	CR
UC 1030	Intro to Predental	1.00	1.00	CR
WRTG 2010	Intermediate Writing	3.00	3.00	A
Writing Requirement 2				
Term GPA: 3.931		15.000	15.000	
Dean's List				

BEGINNING OF UNDERGRADUATE SEMESTER CAREER

Course	Description	Units Enrolled	Units Earned	Grade	Course	Description	Units Enrolled	Units Earned	Grade
Summer 2013									
BIOL 2420	Human Physiology	4.00	4.00	A-					
Applied Science									
ESS 2600	Sport-Amer Society	3.00	3.00	A					
Soc/Behav Science Exploration									
SPAN 4560	Cultr/Cust Span America	3.00	3.00	A					
Term GPA: 3.880		10.000	10.000						
Fall 2013									
CHEM 1210	General Chemistry I	4.00	4.00	B+					
Physical/Life Sci Explor									
CHEM 1215	General Chemistry Lab I	1.00	1.00	A					
H EDU 5300	Diversity & Health	3.00	3.00	A					
Comm/Writing and Diversity									
LANG 2020	Language in Society	3.00	3.00	A					
PRTS 1412	NR-Snowshoe/Ski Bakpak	2.00	2.00	CR					
SPAN 5242	Span Pronun/Phonetics	3.00	3.00	A					
Term GPA: 3.800		16.000	16.000						
Dean's List									
Spring 2014									
CHEM 1220	General Chemistry II	4.00	4.00	B					
Physical/Life Sci Explor									
CHEM 1225	General Chem Lab II	1.00	1.00	A					
Term GPA: 4.000		16.000	16.000						
Dean's List									

Continued Page 2

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OKLAHOMA STATE BOARD OF  
MEDICAL LICENSURE  
AND SUPERVISION

*Michele A. Neary*  
Michele A. Neary  
Interim Registrar



TUSSLER



Name: JENSEN, NATHAN ROBERT  
Student ID: 00600937  
SSN: [REDACTED]  
Birthdate: [REDACTED]

Course	Description	Units Enrolled	Units Earned	Grade	Course	Description	Units Enrolled	Units Earned	Grade
					Spring 2015 (Continued)				
Term GPA: 4.000					12.000 12.000				
Dean's List									
					Fall 2015				
PHYS 2010	General Physics I	4.00	4.00	B+	CHEM 3510	Biological Chemistry I	3.00	3.00	B
	Physical/Life Sci Explor				LANG 4990	Lang and Lit Capstone	1.00	1.00	A
SOC 1010	Intro To Sociology	4.00	4.00	A-	QUECH 2010	Interm. QUECH I	4.00	4.00	A
	Soc/Behav Science Exploration				SPAN 4510	Business Spanish	3.00	3.00	A
SPAN 4900	Special Topics	3.00	3.00	A	SPAN 4620	Intro Span Literature	3.00	3.00	A
	Spanish in the U.S.				-----				
Term GPA: 3.500					14.000 14.000				
Dean's List									
					Spring 2016				
					BIOL 2020	Princ of Cell Biology	3.00	3.00	B+
					PHYS 3111	Phys of Body II	4.00	4.00	A
SPAN 4900	Special Topics	3.00	3.00	A	QUECH 2020	Intrm. QUECH II	4.00	4.00	A
	Spanishes of the Wolrd				SPAN 4520	Spanish Business II	3.00	3.00	A
Term GPA: 4.000					-----				
3.000 3.000					Term GPA: 3.850				
Dean's List					Dean's List				
					Fall 2014				
CHEM 2310	Organic Chemistry I	4.00	4.00	A					
CHEM 2315	Organic Chemistry Lab I	2.00	2.00	B+					
MUSC 3600	World Music	3.00	3.00	A					
	Int'l Reg & Fine Arts Explor								
QUECH 1010	Beg. QUECH I	4.00	4.00	A					
SPAN 4630	Intro Span Amer Lit	3.00	3.00	B+					
Term GPA: 3.781									
Dean's List									
					Fall 2017				
					BIOL 2325	Human Anatomy	4.00	4.00	A
					PHYS 2015	General Physics Lab I	1.00	1.00	A
					PHYS 2025	General Physics Lab II	1.00	1.00	A
Term GPA: 4.000					-----				
6.000 6.000					CAREER SUMMARY-----				
Cumulative GPA: 3.836									
Cumulative GPA Units: 131.000									
Units Enrolled: 138.000									
U of U Units Earned: 138.000									
Total Transfer Units: 4.000									
Total Test Credit: 18.000									
Total Other Credit: 0.000									
Cumulative Units 160.000									
					END OF UNDERGRADUATE SEMESTER CAREER				
					Continued Page 3				

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AND SUPERVISION

*Michele A. Neary*  
Michele A. Neary  
Interim Registrar





Name: JENSEN, NATHAN ROBERT  
Student ID: 00600937  
SSN: [REDACTED]  
Birthdate: [REDACTED]

Course	Description	Units Enrolled	Units Earned	Grade	Course	Description	Units Enrolled	Units Earned	Grade
Fall 2020									
INTMD 7200	IM Clerkship	6.00	6.00	P					
OPPTH 7590	Ophthalmology Research	2.00	2.00	P					
OPPTH 7595	Intro to Ophthalmology	2.00	2.00	P					
PED 7010	PEDS Clerkship	4.00	4.00	P					
SURG 7020	SURG Clerkship	6.00	6.00	P					
SURG 7495	Intro Urology	2.00	2.00	P					
SURG 7535	Into to Cardiothoracic	2.00	2.00	P					
-----									
BEGINNING OF MEDICINE SEMESTER CAREER									
Fall 2018									
MD ID 7001	CMC 1	3.00	3.00	P					
MD ID 7101	Layers of Medicine 1	1.00	1.00	P					
MD ID 7300	Foundations of Med	17.00	17.00	P					
Term GPA: 0.000		21.000	21.000						
-----									
Spring 2019									
MD ID 7002	CMC 2	5.00	5.00	P					
MD ID 7102	Layers of Medicine 2	1.00	1.00	P					
MD ID 7310	Molecules, Cell, Cancer	8.00	8.00	P					
MD ID 7320	Host and Defense	9.00	9.00	P					
MD ID 7500	Year 1 Assessment	1.00	1.00	P					
UUHSC 6201	Foundation of IPE	0.50	0.50	P					
Term GPA: 0.000		24.500	24.500						
-----									
Fall 2019									
MD ID 7003	CMC 3	5.00	5.00	P					
MD ID 7103	Layers of Medicine 3	1.00	1.00	P					
MD ID 7350	Metabolism & Reprodctn	9.00	9.00	P					
MD ID 7360	Circ, Resp, Regulation	12.00	12.00	P					
UUHSC 6301	Interprofessional Telem	0.50	0.50	P					
Term GPA: 0.000		24.500	24.500						
-----									
Spring 2021									
ANES 7040	Anesthesiology Clrkshp	2.00	2.00	P					
FP MD 7180	FM Clerkship	4.00	4.00	P					
NEURO 7900	NEURO Clerkship	4.00	4.00	P					
OBST 7010	OBGYN Clerkship	4.00	4.00	P					
PSYCT 7200	Psychiatry Clerkship	4.00	4.00	P					
UUHSC 6601	IPE SIM Hosp Patient	0.50	0.50	P					
Term GPA: 0.000		18.500	18.500						
-----									
Fall 2022									
OPPTH 7000	Ophthalmology Away	8.00	8.00	P					
OPPTH 7590	Ophthalmology Research	2.00	2.00	P					
OPPTH 7600	Ophthalmology Precept	4.00	4.00	P					
UUHSC 6801	Preparedness & Response	0.50	0.50	P					
Term GPA: 0.000		14.500	14.500						
-----									
Spring 2023									
INTMD 7500	Advanced IM	4.00	4.00	P					
MD ID 7240	Med Sch Admissions Exp	2.00	2.00	P					
MD ID 7410	Transition	2.00	2.00	P					
MD ID 7600	Critical Care	4.00	4.00	P					
SURG 7610	Core Sub-Internship EM	4.00	4.00	P					
UUHSC 6701	IPE Transitions of Care	0.50	0.50	P					
Term GPA: 0.000		16.500	16.500						
Term GPA: 0.000		22.000	22.000						

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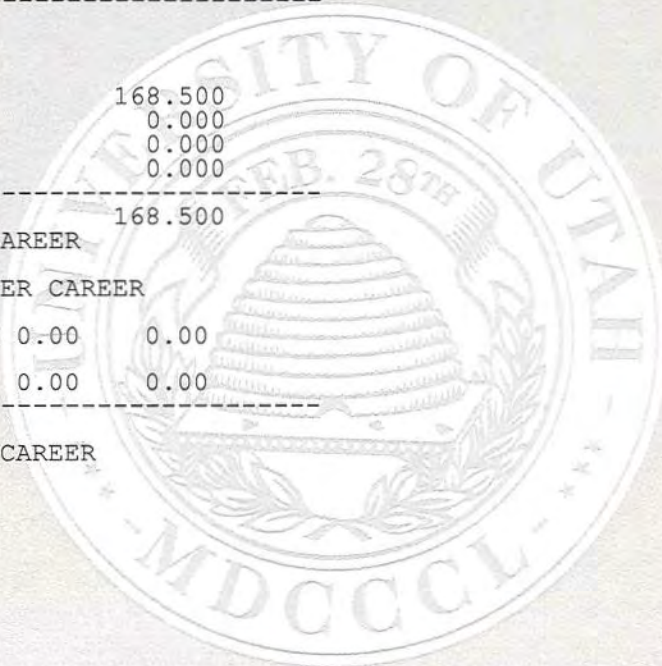
*Michele A. Neary*  
Michele A. Neary  
Interim Registrar





Name: JENSEN, NATHAN ROBERT  
Student ID: 00600937  
SSN: [REDACTED]  
Birthdate: [REDACTED]

Course	Description	Units Enrolled	Units Earned	Grade
-----CAREER SUMMARY-----				
Cumulative GPA:		0.000		
Cumulative GPA Units:		0.000		
Units Enrolled:		168.500		
U of U Units Earned:		168.500		
Total Transfer Units:		0.000		
Total Test Credit:		0.000		
Total Other Credit:		0.000		
-----		-----		
Cumulative Units		168.500		
END OF MEDICINE SEMESTER CAREER				
BEGINNING OF NON-CREDIT SEMESTER CAREER				
Fall 2007				
YESPR	42 High School Diving (Grade 9-12)	0.00	0.00	
Spring 2013				
MATH	15 Precalculus Review	0.00	0.00	
-----				
END OF NON-CREDIT SEMESTER CAREER				
End of Transcript				



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*Michele A. Neary*  
Michele A. Neary  
Interim Registrar





**THE UNIVERSITY OF UTAH**  
**OFFICE OF THE REGISTRAR**  
**TRANSCRIPT INFORMATION**  
**FICE CODE: 003675**  
**www.registrar.utah.edu**

**ACCREDITATION** - Northwest Commission on Colleges and Universities. See the general catalog for other accreditations.

**CREDIT HOURS** - Unless otherwise noted, all credit hours on the U of U transcript through summer quarter 1998 are quarter hours except that Law courses with a # sign in the Units column indicates semester hours. All credit hours beginning with fall semester 1998 are semester hours. The University converted to a semester calendar fall 1998.

**GRADING SYSTEM**

GRADE		GRADE POINTS PER UNIT
A	Excellent	4.0
A-	Excellent	3.7
B+	Good	3.3
B	Good	3.0
B-	Good	2.7
C+	Standard	2.3
C	Standard	2.0
C-	Standard	1.7
D+	Substandard	1.3
D	Substandard	1.0
D-	Substandard	0.7
E	Failure	0.0
X	Condition	0.0
WF	Withdrawn Failing	0.0
EW	Withdrawn for Nonperformance	0.0
EU	Unofficial Withdrawal	0.0
F	Fail	0.0
P	Pass	
I	Incomplete	
T	Work in Progress	
CR	Credit (Work at a C- level or above)	
NC	No Credit	
S	Satisfactory	
U	Unsatisfactory	
W	Withdrawn	
WP	Withdrawn Passing	
V	Visitor (Audit)	
***	Grade has not been submitted by the instructor.	

**ACADEMIC RENEWAL**      Grade not computed in GPA  
**COURSE REPEATED**      Grade not computed in GPA  
**NONDEGREE CREDIT**      Not computed in GPA  
**CONTINUING EDUCATION UNIT**      One CEU is awarded for each 10 contact hours. Not computed in GPA or hours passed.

**COURSE NUMBERING**

Through summer quarter 1969  
1-99 Lower Division  
100-199 Upper Division. (Recognized as graduate credit if baccalaureate degree has been awarded.)  
200+ Graduate Courses

Beginning fall quarter 1969  
1-99 Noncredit  
100-199 Lower Division (Freshman & Sophomore Courses)  
201-299 Honors - Lower Division  
301-399 Upper Division (Junior & Senior Courses)  
401-499 Honors - Upper Division  
501-599 Upper Division & Graduate Courses  
601-799 Graduate Courses

Beginning fall quarter 1971  
001-099 Noncredit & CEU  
100-299 Lower Division (Freshman & Sophomore Courses)  
300-499 Upper Division (Junior & Senior Courses)  
500-599 Upper Division & Graduate Courses  
(Graduate credit permitted for departmental majors)  
600-799 Graduate Courses

Beginning fall semester 1998  
0001-0999 Noncredit  
1000-2999 Lower Division (Freshman & Sophomore Courses)  
3000-4999 Upper Division (Junior & Senior Courses)  
5000-5999 Upper Division & Graduate Courses  
(Graduate credit permitted for departmental majors)  
6000-6999 Masters Level  
7000-7999 Doctoral Level

**GENERAL EDUCATION CODES**

Courses which fulfill General Education requirements prior to fall quarter 1977 are identified as follows:  
AI American Institutions  
EN English  
FA Fine Arts  
LS Life Science  
PS Physical Science  
SS Social and Behavioral Science  
WC Western Civilization

**LIBERAL EDUCATION CODES**

Courses which fulfill the Liberal Education requirements beginning fall quarter 1977 through summer quarter 1998 are identified as follows:  
BC Social and Behavioral Science Core  
BD Social and Behavioral Science Distribution  
FC Fine Arts Core  
FD Fine Arts Distribution  
HC Humanities Core  
HD Humanities Distribution  
SC Science Core  
SD Science Distribution  
AI American Institutions  
EN English  
WR Writing

**GENERAL EDUCATION DESCRIPTIONS**

Courses which fulfill General Education requirements have a message printed below each applicable course.

**MESSAGE BELOW A COURSE**

Additional information pertaining to a course (i.e. Honors, Correspondence, etc.).

**COURSE DESCRIPTOR CODES**

CEL Community Engaged Learning  
SL Service Learning  
WE Writing Emphasis  
WI Writing Intensive

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# AMA Physician Profile

PREPARED FOR

Oklahoma State Board of Licensure & Supervision, Oklahoma City, OK

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AND SUPERVISION

PRIMARY SOURCE

Name and Mailing Address

NATHAN JENSEN



Primary Office Address

Phone UNKNOWN

Birth date



Physician's major professional activity

HOSPITAL BASED RESIDENTS - ALL YEARS

AMA membership status

MEMBER

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

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

NO DATA REPORTED AT THIS TIME

### Current and/or historical medical school

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

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

School: SPENCER FOX ECCLES SCHOOL OF MEDICINE AT THE UNIVERSITY OF UTAH

Degree Awarded: YES  
Enrollment Date: 08/2018

Degree Type: MD  
Degree Date: 05/2023

THISS



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

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

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

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

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

**Sponsoring Institution:** UNIVERSITY OF OKLAHOMA COLLEGE OF MEDICINE  
**Sponsoring State:** OKLAHOMA  
**Program name:** UNIVERSITY OF OKLAHOMA HEALTH SCIENCES CENTER PROGRAM  
**Specialty:** OPHTHALMOLOGY  
**Training Type:** SPECIALTY  
**Dates:** 07/01/2023 - 06/30/2027  
**Status:** TRAINING IN PROGRESS

### Specialty board certification

NO DATA REPORTED AT THIS TIME

### Current and/or historical medical licensure

License Number	MD / DO	Locale	Date Granted	Expiration Date	Renewal Date	Status	License Type	Last Reported	Name on License
41556	MD	OK	07/01/2023	09/30/2024		ACT	RES	05/06/2024	NATHAN ROBERT JENSEN

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

### Action notifications reported to the AMA

**Medical Licensing Boards:** NO ACTIONS REPORTED AT THIS TIME

**Medicare/Medicaid Sanctions from DHHS:** NO ACTIONS REPORTED AT THIS TIME

**US DOJ Drug Enforcement Administration:** NO ACTIONS REPORTED AT THIS TIME

### U.S. Drug Enforcement Administration (DEA)

NO DATA REPORTED AT THIS TIME

### ECFMG certification

NOT APPLICABLE

### Profile information

The content of the AMA Physician Profile is for credentialing use only. The content cannot be used or assembled for an employment purpose as defined under the Fair Credit Reporting Act. An organization's appropriate use of the data contained in the AMA Physician Professional Data™, formerly known as AMA Physician Masterfile, meets select primary source verification requirements of the Joint Commission, the Accreditation Association for Ambulatory Health Care (AAAHC) and the American Accreditation Health Care Commission (AAHCC)/ Utilization Review Accreditation Commission (URAC). The AMA Physician Professional Data is also an NCQA-approved source for verification of medical school, post-graduate medical training, ABMS Board Certification and federal DEA registration.

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

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



APR 14 2023

OKLAHOMA STATE BOARD OF MEDICAL LICENSURE AND SUPERVISION

OKLAHOMA STATE BOARD OF MEDICAL LICENSURE AND SUPERVISION  
EVIDENCE OF STATUS – PART A

NOTARIZED FORM CAN BE EMAILED TO OKTRAINING@OKMEDICALBOARD.ORG

Full Legal Name: NATHAN ROBERT JENSEN Maiden (if applicable)

Mailing Address: [Redacted]  
Street Address or Post Office Box  
[Redacted] City State Zip Code Telephone Number Social Security #: [Redacted]

PRIMARY EVIDENCE OF CITIZENSHIP  
(FOR US CITIZENS, US NATIONALS, OR PERMANENT LEGAL RESIDENT ALIENS)

If you are a U.S. citizen, U.S. national, or permanent legal resident alien, please attach a photocopy of one of the following documents to this form. Place a checkmark below to indicate the document that is attached.

- A birth certificate showing birth in one of the 50 States, the District of Columbia, Puerto Rico (on or after January 13, 1941), Guam, the U.S. Virgin Islands (on or after January 17, 1917), American Samoa, Swain's Island or the Northern Mariana Islands, unless the person was born to foreign diplomats residing in the U.S.
- United States passport (except limited passports, which are issued for periods of less than five years)
- Report of birth abroad of a U.S. citizen (FS-240) (issued by the Department of State to U.S. citizens)
- Certificate of birth (FS-545) (issued by a foreign service post) or Certification of Report of Birth (DS1350) (issued by the Department of State), copies available from the Department of State
- Certificate of Naturalization (N-550 or N-570) (issued by the INS through a Federal or State court, or through administrative naturalization after December 1990 to individuals who are individually naturalized; the N570 is a replacement certificate issued when the N-550 has been lost or mutilated or the individual's name has been changed)
- Certificate of Citizenship (N-560 or N-561) (issued by the INS to individuals who derive U.S. citizenship through a parent; the N-561 is a replacement certificate issued when the N-560 has been lost or mutilated or the individual's name has been changed)
- United States Citizen Identification Card (I-197) (issued by the INS until April 7, 1983 to U.S. citizens living near the Canadian or Mexican border who needed it for frequent border crossing) (formerly Form I-179, last issued in February 1974)
- Northern Mariana Identification Card (issued by the INS to a collectively naturalized citizen of the U.S. who was born in the Northern Mariana Islands before November 3, 1986)
- Statement provided by a U.S. consular officer certifying that the individual is a U.S. citizen (This is given to an individual born outside the U.S. who derives citizenship through a parent but does not have an FS-240, FS-545 or DS-1350);
- American Indian Card with a classification code "KIC" and a statement on the back (identifying U.S. citizen members of the Texas Band of Kickapoos living near the U.S./Mexican border.)
- Alien Lawfully Admitted for Permanent Residence:  
INS Form I-551 (Alien Registration Receipt Card, commonly known as a "green card")
- Alien Lawfully Admitted for Permanent Residence:  
Unexpired Temporary I-551 stamp in foreign passport or on INS Form I-94

I declare under penalty of perjury, under the laws of the State of Oklahoma, that all information contained in this application and all accompanying documents provided to substantiate my Evidence of Status application are true and correct.

Signature [Handwritten Signature] Date 04/10/23

Subscribed and sworn before me this 10 day of April, 2023.

Notary Public [Handwritten Signature]

Commission Number 722705

My commission expires 3/19/2026



T 41556  
WB







05/02/2023

NATHAN ROBERT JENSEN



**Check Your Application  
Status Online at:**  
<http://www.okmedicalboard.org>  
**Username:AP40273524**  
**Password:Last 4 SSN**

RE: MD Application #41556

Dear NATHAN JENSEN,

**YOU CANNOT PRACTICE YOUR PROFESSION IN THE STATE OF OKLAHOMA UNTIL A VALID LICENSE HAS BEEN ISSUED.**

Your training application has been processed and the current deficiencies are listed below. Please be advised, these may not be the only deficiencies. You will be advised if any other deficiencies are added. You may check your application status online by logging in with the username and password provided above.

If you have further questions please email [oktraining@okmedicalboard.org](mailto:oktraining@okmedicalboard.org)

If a "Time Deficiency" is listed, please complete a time deficiency form and e-mail the document to [oktraining@okmedicalboard.org](mailto:oktraining@okmedicalboard.org) with your activities during the specified time frame.

- Evidence of Status
- Application Instructions
- MedSchool-Transcript Univ Of Ut Sch Of Med, Salt Lake Cty Ut 84132
- MedSchool-Form 1 Univ Of Ut Sch Of Med, Salt Lake Cty Ut 84132
- PostGrad - Form 2 COLLEGE OF MEDICINE OKC
- USMLE Exams Incomplete
- OATH
- Extended Background Check
- Time Deficiency Form for: 07/2010-07/2012
- Exam verification date

Any of the required forms in the list above may be downloaded from our website:

<http://www.okmedicalboard.org/resources>



In order to check on the status of your application, please log on to our web site:

<https://secure.okmedicalboard.org/applicant/signin>

Your user name is AP40273524 (all caps and no spaces) and your password is the last 4 digits of your social security number.

If you did not provide a social security number with your application, your password will be your 4-digit year of birth in the form "YYYY".

If we may be of further assistance, please email.

[oktraining@okmedicalboard.org](mailto:oktraining@okmedicalboard.org)

Sincerely,

**Lisa Cullen**

Lisa Cullen  
Director of Licensing  
Dept. of Licensing

Encl

# Oklahoma State Board of Medical Licensure and Supervision Application Summary

Type	Number	Name
MD	41556	NATHAN ROBERT JENSEN
MEDICAL DOCTOR		

**Incomplete Information (due to space limitations on this page, this may not be a complete list)**

PostGrad - Form 2 COLLEGE OF MEDICINE OKC Exam verification date USMLE Exams Incomplete
---

<b>Last Medical School Attended:</b> 049-01 Univ Of Ut Sch Of Med, Salt Lake Cty Ut 84132  <p style="text-align: right;">Number of Licenses Previously Granted to Graduates of this Medical School:103</p>
---

Application for: Resident  Full License \_\_\_\_\_ Reinstatement \_\_\_\_\_

**The Secretary of the Board has reviewed this application and:**

1) AUTHORIZED CIRCULARIZATION TO OTHER BOARD MEMBERS \_\_\_\_\_

2) ALL FIVE CRITERIA HAVE BEEN MET [Fast Track] \_\_\_\_\_

- Passed USMLE
- No DUIs or Legal Issues
- No Significant Malpractice Issues
- US Graduate
- Graduated Medical School on time *Research*

3) HAS ISSUED A TEMPORARY LICENSE THROUGH 1/1

4) HAS ISSUED A SPECIAL PGY-1 TRAINING LICENSE July 6-22-23

5) REQUESTS SPECIFIC CONSIDERATION OF:

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# Oklahoma State Board of Medical Licensure and Supervision

## Application Summary

Type	Number	Name
MD	41325	RYAN GARRETT JONES
MEDICAL DOCTOR		

**Incomplete Information (due to space limitations on this page, this may not be a complete list)**

PostGrad - Form 2 GREAT PLAINS FAMILY PRACTICE RESIDENCY  
 OTHER DEFICIENCIES: NEED FORM 2 AND EVAL UPON COMPLETION OF TRAINING, MUST COME DIRECTLY FROM YOUR PROGRAM

**Last Medical School Attended:**

039-01 Univ Of Ok Coll Of Med, Oklahoma City Ok 73190

**Number of Licenses Previously Granted to Graduates of this Medical School:7,356**

Application for: Resident \_\_\_\_\_ Full License \_\_\_\_\_ Reinstatement \_\_\_\_\_

**The Secretary of the Board has reviewed this application and:**

- 1) AUTHORIZED CIRCULARIZATION TO OTHER BOARD MEMBERS \_\_\_\_\_
  
- 2) ALL FIVE CRITERIA HAVE BEEN MET [Fast Track] \_\_\_\_\_
  - Passed USMLE
  - No DUIs or Legal Issues
  - No Malpractice Issues
  - US Graduate
  - Graduated Medical School in 4 years or less
  
- 3) HAS ISSUED A TEMPORARY LICENSE THROUGH \_\_\_\_ / \_\_\_\_ / \_\_\_\_
  
- 4) HAS ISSUED A SPECIAL PGY-1 TRAINING LICENSE \_\_\_\_\_

# Oklahoma State Board of Medical Licensure and Supervision Application Summary

**Type**    **Number**    **Name**  
 MD            41325    RYAN GARRETT JONES  
 MEDICAL DOCTOR

**Practice Address:**  
 April 21, 2023

**Status:**  
**Res:** TR  
**Received:** 03/28/2023  
**Entered:** 03/28/2023  
**Temp Issued:**  
**Temp Expires:**  
**Train Issued:** 07/01/2023  
**Train Expires:** 09/30/2024  
**Fed Rec:** 05/17/2024  
**AMA Rec:** 05/17/2024  
**Board Action:**  
**License #:** 41325  
**Sex:** M  
**Ethnic Origin:** 1

**Endorsed By:** USMLE EXAMINATION

	Test	Score	Date Taken	Date Verified	Attempts
<b>Test 1:</b>	USMLE 3	PASS	03/08/24	5/3/24	1
<b>Test 2:</b>	USMLE 1	PASS	5/21/21	4/27/23	1
<b>Test 3:</b>	USMLE 2	PASS	8/22/22	4/27/23	1
Note: <b>PASS</b> means higher than 75					
<b>Test AV:</b>					
<b>Total Possible:</b>					
<b>Okla Passing:</b>					
<b>Total Score:</b>					

PRE-MED EDUCATION	
<b>School Name:</b> UNIVERSITY OF OKLAHOMA HEALTH SCIENCES CENTER	<b>State:</b> OK <b>Country:</b> UNITED STATES
<b>City:</b> OKLAHOMA CITY	<b>From:</b> 8/2018 <b>To:</b> 7/2019 <b>Verified:</b>
<b>Degree:</b> M.P.H. IN EPIDEMIOLOGY	
<hr/>	
<b>School Name:</b> OKLAHOMA CHRISTIAN UNIVERSITY	<b>State:</b> OK <b>Country:</b> UNITED STATES
<b>City:</b> OKLAHOMA CITY	<b>From:</b> 8/2013 <b>To:</b> 4/2017 <b>Verified:</b>
<b>Degree:</b> B.S. CELLULAR AND MOLECULAR BIOLOGY	
<hr/>	
MEDICAL SCHOOL EDUCATION	
<b>Name:</b> Univ Of Ok Coll Of Med, Oklahoma City Ok 73190	
<b>Foreign Name:</b>	<b>State/Country:</b> United States of America
<b>City:</b> Oklahoma City	<b>From:</b> 8 / 2019 <b>To:</b> 5 / 2023 <b>Diploma Ver'd:</b> Y
<b>Degree:</b> M.D.	



# Oklahoma State Board of Medical Licensure and Supervision

## Application Summary

**Type**    **Number**    **Name**  
 MD            41325    RYAN GARRETT JONES  
 MEDICAL DOCTOR

### POST GRADUATE EDUCATION

**Facility:** GREAT PLAINS FAMILY PRACTICE RESIDENCY    **Specialty:** FAMILY MEDICINE

**Res. Fellowship:** Residency

**City:** OKLAHOMA CITY

**State:** OK    **Country:** UNITED STATES OF AM

**Verified:**

**From:** 7/ 2023    **To:** /

**ACGME Ver'd:**

**Comments:**

### PRACTICE HISTORY

**Employed:** OKLAHOMA CHRISTIAN UNIVERSITY

**Supervisor:**

**City:** OKLAHOMA CITY

**State:** OK    **Country:** UNITED STATES

**Specialty:** ASSOCIATE DIRECTOR    **From:** 5/ 2018    **To:** 7/ 2018    **Verified:**  
 HONORS SUMMER  
 ACADEMY

**Comments:** COORDINATED A WEEKLONG ACADEMIC SUMMER CAMP FOR HIGH SCHOOL STUDENTS AT OKLAHOMA CHRISTIAN

**Employed:** VIPKID

**Supervisor:**

**City:** SAN FRANCISCO

**State:** CA    **Country:** UNITED STATES

**Specialty:** ONLINE ENGLISH TUTOR    **From:** 3/ 2018    **To:** 4/ 2018    **Verified:**  
 CONTRACTOR

**Comments:** CONTRACTED FOR VIPKID, PROVIDING ONLINE ENGLISH TUTORING TO STUDENTS LARGELY IN CHINA

**Employed:** INSTITUTO DE EDUCACION SECUNDARIA  
 SON FERRER

**Supervisor:**

**City:** SON FERRER

**State:**    **Country:** SPAIN

**Specialty:** LANGUAGE AND CULTURE    **From:** 9/ 2017    **To:** 2/ 2018    **Verified:**  
 AMBASSADOR

**Comments:** TAUGHT CONVERSATIONAL ENGLISH AND AMERICAN CULTURE TO MIDDLE/HIGH SCHOOL STUDENTS IN SPAIN

**Employed:** EDMOND MEMORIAL HIGH SCHOOL BAND

**Supervisor:**

**City:** EDMOND

**State:** OK    **Country:** UNITED STATES

**Specialty:** PERCUSSION TECHNICIAN    **From:** 7/ 2017    **To:** 9/ 2017    **Verified:**

**Comments:** CONTRACTOR FOR EMHS BANDS, TEACHING PERCUSSION TO HIGH SCHOOL STUDENTS.

**Employed:** OKLAHOMA CHRISTIAN UNIVERSITY

**Supervisor:**

**City:** OKLAHOMA CITY

**State:** OK    **Country:** UNITED STATES

**Specialty:** HONORS SUMMER    **From:** 5/ 2017    **To:** 7/ 2017    **Verified:**  
 ACADEMY OFFICE  
 ASSISTANT

**Comments:** ASSISTED IN COORDINATING AN ACADEMIC SUMMER CAMP FOR HIGH SCHOOL STUDENTS

### Other Licenses

State	Lic Type and Number	Status	Issued	Exp	Verif

# Oklahoma State Board of Medical Licensure and Supervision

## Application Summary

Type	Number	Name
MD	41325	RYAN GARRETT JONES

MEDICAL DOCTOR

**DEFICIENCIES**

PostGrad - Form 2 GREAT PLAINS FAMILY PRACTICE RESIDENCY

OTHER DEFICIENCIES: NEED FORM 2 AND EVAL UPON COMPLETION OF TRAINING, MUST COME DIRECTLY FROM YOUR PROGRAM



RETURN FORM TO:  
 OKLAHOMA STATE BOARD OF MEDICAL LICENSURE AND SUPERVISION  
 oktraining@okmedicalboard.org

RECEIVED

MAY 02 2024

OKLAHOMA STATE BOARD OF  
 MEDICAL LICENSURE  
 AND SUPERVISION

**QUESTIONNAIRE**  
 Please read and follow ALL instructions

**FORM INSTRUCTIONS:** Complete both pages of this form *only if* you are renewing or upgrading your training license. Attach the appropriate documentation and answer the confidential questions.

**PAYMENT INSTRUCTIONS:** If you **ARE FULLY LICENSED**, you **MUST** go online and renew your license – **DO NOT pay your renewal fee via these instructions (doing so will delay your renewal)**.

**ATTESTATION STATEMENT:** By completing this document, I agree to pay the appropriate fee on **ONLINE BILL PAY**  
 If you are **UPGRADING** your training license to a full license, your fee will be \$250 & you will choose **MD TRAINING-TO-FULL**  
 If you are **RENEWING** your training license, your fee will be \$150 & you will choose **MD TRAINING LICENSE RENEWAL**

**PLEASE PRINT ALL INFORMATION**

FIRST NAME	Ryan	LAST NAME	Jones
EMAIL ADDRESS	[REDACTED]		
LICENSE NUMBER	41325	CELL PHONE	[REDACTED]
HOME ADDRESS	[REDACTED]	CITY/STATE	[REDACTED]
PROGRAM ATTENDING	Integris Health - OK	SPECIALTY	Family Medicine

**DOCUMENTATION TO ATTACH**

PAYMENT COMPLETED	
<input type="checkbox"/> \$150 payment made on Billpay for <b>RENEWAL</b> of training license	<input checked="" type="checkbox"/> \$250 payment made on Billpay for <b>UPGRADE</b> of training license

DOCUMENTATION REQUIRED	
<input type="checkbox"/> Form 2 (must be received directly from program) <b>**ONLY FOR UPGRADE</b>	<input type="checkbox"/> Evaluation (must be received directly from program)
<input checked="" type="checkbox"/> USMLE Step 3 (must be received directly from USMLE)	<input checked="" type="checkbox"/> Answer confidential questions (on back of this form)

FOREIGN TRAINED STUDENTS	
<input type="checkbox"/> Current visa	<input type="checkbox"/> Social Security Number **if not provided at initial application
<input type="checkbox"/> Background Check **if not done at initial application	

IF YOU ARE FULLY LICENSED – DO NOT COMPLETE THIS FORM. YOU MUST GO ONLINE AND RENEW AT <https://pay.apps.ok.gov/medlic/md/login.php> ENTER YOUR LICENSE NUMBER & PIN – COMPLETE YOUR RENEWAL AND PAY THE RENEWAL FEE.

RENEWAL QUESTIONNAIRE  
 UPDATED 03-2024

T41325  
 SJ

MAY 02 2024

OKLAHOMA STATE BOARD OF  
MEDICAL LICENSURE  
AND SUPERVISION

NAME Ryan Jones, MD

**IF YOU HAVE ANY "YES" ANSWERS YOU MUST PROVIDE A NOTARIZED STATEMENT EXPLAINING YOUR ANSWER.**

<i>SINCE RENEWAL OF YOUR TRAINING LICENSE OR INITIAL ISSUE OF YOUR TRAINING LICENSE (whichever is most recent)</i>		
QUESTIONS	YES	NO
Have you failed any part of the USMLE exam (not previously disclosed)?	<input type="checkbox"/>	<input checked="" type="checkbox"/>
Have you been the subject of investigation or disciplinary action (including probation) by a hospital or training program?	<input type="checkbox"/>	<input checked="" type="checkbox"/>
Have you had any adverse judgment or settlement against you rising from a professional liability claim?	<input type="checkbox"/>	<input checked="" type="checkbox"/>
Have you been reported to the National Practitioner Data Bank (NPDB)?	<input type="checkbox"/>	<input checked="" type="checkbox"/>
Have you ever been denied, had removed, or suspended hospital privileges?	<input type="checkbox"/>	<input checked="" type="checkbox"/>
Have you surrendered hospital privileges while under investigation or to avoid investigation?	<input type="checkbox"/>	<input checked="" type="checkbox"/>
Have you entered into an Agreement with a Federal, State, or Local jurisdictional body to avoid formal action?	<input type="checkbox"/>	<input checked="" type="checkbox"/>
Has your application for licensure ever been denied?	<input type="checkbox"/>	<input checked="" type="checkbox"/>
Have you surrendered a license or had any disciplinary action taken on any license?	<input type="checkbox"/>	<input checked="" type="checkbox"/>
Have you been investigated by or requested to appear before a licensing or disciplinary agency (other than the Oklahoma State Board of Medical Licensure and Supervision)?	<input type="checkbox"/>	<input checked="" type="checkbox"/>
Have you obtained an assessment or been treated for use of any drug or chemical substance including alcohol?	<input type="checkbox"/>	<input checked="" type="checkbox"/>
Have you been arrested for, charged with, or convicted of a felony or misdemeanor other than a traffic violation?	<input type="checkbox"/>	<input checked="" type="checkbox"/>
Have you been arrested for, charged with, or convicted of a traffic violation involving the use of any drug or chemical substance?	<input type="checkbox"/>	<input checked="" type="checkbox"/>
Have you been addicted to or abused any drug or chemical substance including alcohol?	<input type="checkbox"/>	<input checked="" type="checkbox"/>
Have you been denied provider participation, terminated, sanctioned or penalized by any third-party payor including TRICARE, MEDICARE, or MEDICAID?	<input type="checkbox"/>	<input checked="" type="checkbox"/>
Have you surrendered or had any adverse action taken against any narcotic permit (State or Federal)?	<input type="checkbox"/>	<input checked="" type="checkbox"/>

I swear under penalty of perjury, that I am the person completing this Questionnaire and understand that any medical license procured or obtained by fraud or misrepresentation will result in disciplinary action taken against the licensee pursuant to the provisions of 59 O.S. § 508.

Signature  Ryan Jones, MD

Date 5/2/24



# Oklahoma State Board of Medical Licensure and Supervision

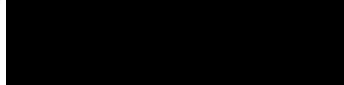
PAGE 320 of 500

## APPLICATION FOR OKLAHOMA MEDICAL DOCTOR LICENSE

Received:03/28/2023

**Applicant Name:** JONES, RYAN GARRETT

**MD 41325**



**Date Of Birth:** [REDACTED]

**Place Of Birth (City, State):** OKLAHOMA CITY, OK

**Sex:** M

**Race:** Caucasian

Education									
Type	Name	City	ST	Country	From	To	Degree	Comments	Veri
GD	UNIVERSITY OF OKLAHOMA HEALTH SCIENCES CENTER	OKLAHOMA C	OK		8/2018	7/2019	M.P.H. IN EPIDEMIOLOGY		
UG	OKLAHOMA CHRISTIAN UNIVERSITY	OKLAHOMA C	OK		8/2013	4/2017	B.S. CELLULAR AND MOLECULAR BIOLOGY		

Medical School Name	City	State	Country	Comments	From	To
Univ Of Ok Coll Of Med, Oklahoma City Ok 73190	Oklahoma City	OK	United States		8/2019	5/2023

Post-Graduate							
Facility	City	St	Country	Specialty	Comments	From	To
INTEGRIS HEALTH	OKLAHOMA CITY	OK	UNITED S	FAMILY MEDICINE		/	6/2026

Practice History								
Employer	Specialty	Supervisor	City	ST	Countr	From	To	Verif
OKLAHOMA CHRISTIAN UNIVERSITY	ASSOCIATE DIRECTOR HONORS SUMMER ACADEMY		OKLAHOMA CITY	OK		5/2018	7/2018	
VIPKID	ONLINE ENGLISH TUTOR CONTRACTOR		SAN FRANCISCO	CA		3/2018	4/2018	
INSTITUTO DE EDUCACION SECUNDARIA SON FERRER	LANGUAGE AND CULTURE AMBASSADOR		SON FERRER		SPAIN	9/2017	2/2018	
EDMOND MEMORIAL HIGH SCHOOL BAND	PERCUSSION TECHNICIAN		EDMOND	OK		7/2017	9/2017	
OKLAHOMA CHRISTIAN UNIVERSITY	HONORS SUMMER ACADEMY OFFICE ASSISTANT		OKLAHOMA CITY	OK		5/2017	7/2017	

Other/ Out-Of-State Licenses					
State	License #	Profession	Status	Issue Date	Exp Date

MD Exam				
Exam	State	Score	Date Taken	#
USMLE				

*UKC*  
*\$250*

# Oklahoma State Board of Medical Licensure and Supervision

## APPLICATION FOR OKLAHOMA MEDICAL DOCTOR LICENSE

Received:03/28/2023

<b>Questions Answered 03/27/2023</b>	<b>Response</b>
A. Have you ever been denied provider participation, terminated, sanctioned, or penalized by any third party payor, to include TRICARE, MEDICARE, MEDICAID?	<b>N</b>
B. Have you ever surrendered or had any adverse action taken against any narcotic permit (state or federal)?	<b>N</b>
C. Have you ever been denied membership or had disciplinary action taken by a national, state or county professional organization?	<b>N</b>
D. Have you ever been denied or had removed or suspended hospital staff privileges?	<b>N</b>
E. Have you ever surrendered hospital staff privileges while under investigation or to avoid investigation?	<b>N</b>
F. Have you ever entered into an agreement with a federal, state or local jurisdictional body to avoid formal action?	<b>N</b>
G. Have you ever been the subject of an investigation, probation or disciplinary action by a hospital, clinic, practice group, training program or professional school?	<b>N</b>
H. Have you had any adverse judgment, settlement, or award against you arising from a professional liability claim?	<b>N</b>
I. Have you ever had professional liability coverage declined, canceled, issued on special terms, or renewal refused?	<b>N</b>
J. Have you ever been reported to the National Practitioners Data Bank (NPDB) or to the Healthcare Integrity and Protection Data Bank (HIPDB)? (If yes, enclose a copy of the report.)	<b>N</b>
K. Has your application for examination or a professional license ever been denied?	<b>N</b>
L. Have you ever failed any part of a licensure/certification/registration examination?	<b>N</b>
M. Have you ever surrendered a license or had a license revoked?	<b>N</b>
N. Has any disciplinary action been taken on any license?	<b>N</b>
O. Have you ever been subject of a review by professional licensing/regulatory agency based on a complaint filed against you?	<b>N</b>
P. Have you ever been arrested, charged with, or convicted of a felony or misdemeanor, other than traffic violations?	<b>N</b>
Q. Have you ever been arrested, charged with, or convicted of a traffic violation involving the use of any drug or chemical substance, including alcohol?	<b>N</b>
R. Are you now or have you within the past two years been addicted to or used in excess any drug or chemical substance, including alcohol?	<b>N</b>
S. Have you obtained an assessment or been treated for the use of any drug or chemical substance, including alcohol?	<b>N</b>
T. Do you currently have or have you had within the past two years any mental or physical disorder or condition which, if untreated, could affect your ability to practice competently?	<b>N</b>
U. Are you or your spouse currently on Active Duty in the U.S. Armed Forces?	<b>N</b>
V. Are you or your spouse currently Deployed on Active Duty in the U.S. Armed Forces?	<b>N</b>



Oklahoma State Board of Medical Licensure and Supervision

APPLICATION FOR OKLAHOMA MEDICAL DOCTOR LICENSE

Received:03/28/2023

If licensed, where do you intend to locate?

OK

Why do you seek Licensure in the state of Oklahoma?

Post-Graduate Training

In what manner will you be communicating with your Oklahoma patients (telephone, email, internet, video-conference, etc)?

Describe how you will examine each patient in person prior to diagnosis, treating, correcting, or prescribing for a patient in Oklahoma from the state, province, or country you are located:

Describe the manner in which you intend to practice medicine across state lines in Oklahoma:

Have you executed or been offered a contract in connection with practice in the state of Oklahoma?

Yes

If 'Yes', Name of practice:

Integris Health (Great Plains Family Medicine)

If so, Please identify with which category:

Teaching Facility

Name of Previous Carrier and Policy Holder

University of Oklahoma College of Medicine

Name of Current Carrier and policy Holder

University of Oklahoma College of Medicine

Will your professional liability insurance policy cover your practice in Oklahoma

Yes

If NO, when do you expect to obtain liability insurance that will cover practice in Oklahoma

I attest that all the above information is accurate as of March 27, 2023: \_\_\_\_\_ (Signed Online)



**Applicant:** In the presence of a notary public, sign this form with attached photo.

**Send this form to:**

Oklahoma State Board of Medical Licensure and Supervision  
101 NE 51<sup>st</sup> Street  
Oklahoma City, OK 73105

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

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

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

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

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

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



RECEIVED

APR 28 2023

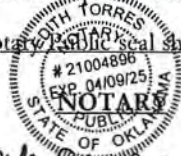
Applicant's signature (must be signed in the presence of a notary)

OKLAHOMA STATE BOARD OF MEDICAL LICENSURE AND SUPERVISION

Applicants printed last name, first name, middle initial, and suffix (e.g., Jr.)

Date of signature (must correspond to the date of notarization)

[Please note: The Notary Seal should overlap the bottom of the photo to the left]



State of Oklahoma, County of Oklahoma

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

The statements on this document are subscribed and sworn to before me by the applicant on this 21 day of April, 2023

Notary Public Signature: Edith Torres My Notary Commission Expires 4/9/2025

T 41325 HS





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

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

PRIMARY SOURCE

**Recipient:** OKLAHOMA STATE BOARD OF  
MEDICAL LICENSURE & SUPERVISION

**Date:** 05/02/2024

**Examinee:** Jones, Ryan Garrett  
**Alt Name(s):**

**Examinee ID:** 5-476-249-7  
**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. Pass/fail outcomes are based upon the minimum passing level in place at the time of test administration and are not altered by subsequent revisions to the minimum passing level. Effective April 1, 2013, two-digit scores will no longer be reported. Test results reported as passing represent an exam score of 75 or higher on a two-digit scale. Step 1 examinations taken on or after January 26, 2022 are reported as pass/fail, with no numeric score; Step 1 examinations taken before January 26, 2022 will continue to be reported with a 3-digit score.

<b>USMLE STEP 1</b>				
Test Date	Pass/Fail	Score	Minimum Pass	Comments
05/21/2021	Pass	242	(194)	

<b>USMLE STEP 2</b>				
<i>Clinical Knowledge (CK)</i>				
Test Date	Pass/Fail	Score	Minimum Pass	Comments
08/22/2022	Pass	249	(214)	

<b>USMLE STEP 3</b>				
Test Date	Pass/Fail	Score	Minimum Pass	Comments
03/08/2024	Pass	251	(200)	

**End of Exam History**

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

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

RECEIVED

MAY 03 2024

OKLAHOMA STATE BOARD OF  
MEDICAL LICENSURE  
AND SUPERVISION

T41325  
SJ



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

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

**Examinee:** Jones, Ryan Garrett

**Examinee ID:** 5-476-249-7

**Date of Birth:** [REDACTED]

### INTERPRETATION OF RESULTS

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

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

### STEP 1 AND STEP 2 CLINICAL SKILLS (CS)

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

### ANNOTATIONS APPEARING UNDER "COMMENTS"

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

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

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

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

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

### ANNOTATIONS APPEARING AS "NOTE"

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

### PHYSICIAN DATA CENTER INFORMATION APPEARING AS "NOTE"

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

03/2015

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



Oklahoma State Board of Medical Licensure and Supervision
101 NE 51st Street
Oklahoma City, OK 73105

This form must be completed by the institution and mailed directly from the institution.

Applicant's Name Ryan Jones

Institution: University of Oklahoma College of Medicine City/State Oklahoma City, OK

Our records indicate that the above named applicant attended our medical school on the following dates:

From 8 / 19 / 2019 To 5 / 20 / 2023 and was awarded the degree Doctor of Medicine

- 1. Does this individual's official record reflect (an) interruption(s) or extension(s) in his/her medical education? If yes, please explain. YES NO
2. Does this individual's official record reflect that he/she was ever placed on academic or disciplinary probation during his/her medical education? If yes, please explain. YES NO
3. Does this individual's official record reflect that he/she was ever the subject of negative reports for behavioral reasons or an investigation by the medical school or parent university? If yes, please explain below. YES NO
4. Does this individual's official record reflect that he/she was ever disciplined for unprofessional conduct/behavioral reasons by the medical school or parent university? If yes, please explain below. YES NO
5. Does this individual's official record reflect that there were any limitations or special requirements imposed on the individual because of questions of academic incompetence, disciplinary problems, or any other reason? If yes, please explain below. YES NO

Please explain any "YES" response from above:

Completion of the following is certification that the information above is an accurate account of this individual's records and is true and correct.

Name: Teresa Scordino, M.D. Signature [Handwritten Signature]

Title of Signatory: Associate Dean for Student Affairs Date of Signature 5/31/23

Tel: 405-271-2316 Fax: 405-271-2287 E-Mail: Teresa-Scordino@ouhsc.edu

If no seal is available, this form must be notarized

School Seal

Notary Public

Commission #

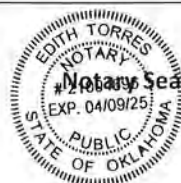
My commission expires:

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OKLAHOMA STATE BOARD OF MEDICAL LICENSURE AND SUPERVISION

PRIMA SOURCE



T41325 SJ



Official Transcript

University of Oklahoma Health Sciences Center  
P. O. Box 26901  
Oklahoma City, OK 731260901  
United States

Name : Ryan Jones  
Student ID: 1770778  
Birthdate : [REDACTED]

5/23/23  
LSGHT

----- Degrees Awarded -----  
Degree : Certificate  
Confer Date : 2019-05-10  
Plan : Certificate in Public Health

Undergraduate Career Totals  
OUHSC GPA : 0.000 GPH: 0.00 TOTALS : 3.00 3.00 0.000  
----- End Of Career (1 of 3) -----

-----  
Degree : Master of Public Health  
Confer Date : 2019-07-29  
Plan : Epidemiology

-----  
Degree : Doctor of Medicine  
Confer Date : 2023-05-20  
Degree Honors : With Distinction  
Plan : Medicine

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MEDICAL LICENSURE  
AND SUPERVISION

PRIMARY  
SOURCE

----- External Degrees -----  
Oklahoma Christian University  
2017-04-28 Bachelor of Science  
Field of Study : Cell & Molec Bio/Spanish

----- Academic Program History -----  
Program : Undergraduate Graduate  
2015-05-15 : Active in Program  
2015-05-15 : SURE Program Major  
2015-08-04 : Discontinued

----- Beginning of Undergraduate Record -----  
Summer I 2015

Course	Description	Attempted	Earned	Grade	Points
BMSC 4113	Adv Stud Biomed Res	3.00	3.00	S	
TERM GPA :	0.000	GPH: 0.00	TOTALS : 3.00	3.00	0.000
OUHSC GPA :	0.000	GPH: 0.00	TOTALS : 3.00	3.00	0.000

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*Lou Klein*

REGISTRAR, OUHSC

THE UNIVERSITY OF OKLAHOMA HEALTH SCIENCES CENTER

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OKLAHOMA STATE BOARD OF  
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Degree : Certificate  
Confer Date : 2019-05-10  
Plan : Certificate in Public Health

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Plan : Epidemiology

Degree : Doctor of Medicine  
Confer Date : 2023-05-20  
Degree Honors : With Distinction  
Plan : Medicine

PRIMARY SOURCE

Spring 2020

Course	Description	Attempted	Earned	Grade	Points
INDT 8132	IMI	68.00	68.00	S	
INDT 8140	Gastrointestinal & Hepatobil	85.00	85.00	S	
INDT 8148	Endo, Metab & Nutri Biochem	85.00	85.00	S	
INDT 8156	Blood, Hematopoiesis & Lymph	77.00	77.00	S	
TERM GPA :	0.000 GPH: 0.00	TOTALS :	315.00	315.00	0.000
OUHSC GPA :	0.000 GPH: 0.00	TOTALS :	834.50	834.50	0.000

Fall 2020

Course	Description	Attempted	Earned	Grade	Points
INDT 8264	Cardiovasc, Resp, Renal	164.00	164.00	S	
INDT 8266	PPS II: Clinical Ethics	35.00	35.00	S	
INDT 8272	Neurosciences	166.00	166.00	S	
INDT 8275	Clinical Medicine II	99.00	99.00	S	
INDT 8301	Enrichment Program: Humanities	16.00	16.00	S	

Course Topic(s): Economics in Medicine  
Economics in Medicine

TERM GPA :	0.000 GPH: 0.00	TOTALS :	480.00	480.00	0.000
OUHSC GPA :	0.000 GPH: 0.00	TOTALS :	1314.50	1314.50	0.000

----- Academic Program History -----

Program : Medicine MD  
2019-07-01 : Active in Program  
2019-07-01 : Medicine - MD Major  
2023-05-20 : Completed Program

----- Beginning of Medicine Record -----

Fall 2019

Course	Description	Attempted	Earned	Grade	Points
INDT 8110	Design/Analysis Clin Res	16.00	16.00	S	
INDT 8122	Clinical Medicine I	111.50	111.50	S	
INDT 8124	The Human Structure	130.00	130.00	S	
INDT 8125	Foundations of Medicine	151.00	151.00	S	
INDT 8244	PPSI	87.00	87.00	S	
INDT 8555	Req Orientation Documents I		0.00	CE	
INDT 9100	Prologue	24.00	24.00	S	
TERM GPA :	0.000 GPH: 0.00	TOTALS :	519.50	519.50	0.000
OUHSC GPA :	0.000 GPH: 0.00	TOTALS :	519.50	519.50	0.000

Spring 2021

Course	Description	Attempted	Earned	Grade	Points
INDT 8280	Reproduction	98.00	98.00	S	
INDT 9200	MS2 Capstone	70.00	70.00	S	
INDT 9201	Joint, Skin, and Bone	40.00	40.00	S	
TERM GPA :	0.000 GPH: 0.00	TOTALS :	208.00	208.00	0.000
OUHSC GPA :	0.000 GPH: 0.00	TOTALS :	1522.50	1522.50	0.000

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*Lou Klein*

REGISTRAR, OUHSC



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**OKLAHOMA STATE BOARD OF  
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Official Transcript

University of Oklahoma Health Sciences Center  
P. O. Box 26901  
Oklahoma City, OK 731260901  
United States

Name : Ryan Jones  
Student ID: 1770778  
Birthdate : [REDACTED]

Summer II 2021

Summer II 2022

Course	Description	Attempted	Earned	Grade	Points
INDT 9301	Clinical Transitions	40.00	40.00	S	
PEDI 9650	Pediatric Clerkship	240.00	240.00	A	960.000
TERM GPA :	4.000	GPH: 240.00	TOTALS : 280.00	280.00	960.000
OUHSC GPA :	4.000	GPH: 240.00	TOTALS : 1802.50	1802.50	960.000

Course	Description	Attempted	Earned	Grade	Points
INDT 9300	Capstone	160.00	160.00	S	
OPHT 9101	Ophthalmology Selective	80.00	80.00	S	
INDT 9407	Fourth Year Selective	80.00	80.00	S	
TERM GPA :	0.000	GPH: 0.00	TOTALS : 320.00	320.00	0.000
OUHSC GPA :	4.000	GPH: 1680.00	TOTALS : 3802.50	3802.50	6720.000

Fall 2021

Fall 2022

Course	Description	Attempted	Earned	Grade	Points
NEUR 9370	Neurology Clerkship	160.00	160.00	A	640.000
PSBS 9520	Psychiatry Clerkship	240.00	240.00	A	960.000
OBGY 9210	Obstet & Gyn Clerkship	240.00	240.00	A	960.000
RADI 9101	RADI Selective	80.00	80.00	S	
TERM GPA :	4.000	GPH: 640.00	TOTALS : 720.00	720.00	2560.000
OUHSC GPA :	4.000	GPH: 880.00	TOTALS : 2522.50	2522.50	3520.000

Course	Description	Attempted	Earned	Grade	Points
INDT 9404	Research/Scholarship Elective	160.00	160.00	S	
Course Topic(s): CELL Res/Scholarship Elective					
INDT 9407	Fourth Year Selective	160.00	160.00	S	
Course Topic(s): Pharmacology Readings Pharmacology Readings					
INDT 9403	Subinternship Elective	160.00	160.00	A	640.000
Course Topic(s): FM Subinternship Elective					
TERM GPA :	4.000	GPH: 160.00	TOTALS : 480.00	480.00	640.000
OUHSC GPA :	4.000	GPH: 1840.00	TOTALS : 4282.50	4282.50	7360.000

Spring 2022

Spring 2023

Course	Description	Attempted	Earned	Grade	Points
MED 9250	Medicine Clerkship	320.00	320.00	A	1280.000
SURG 9760	Surgery Clerkship	320.00	320.00	A	1280.000
FM 9540	Fam Med Clerkship	160.00	160.00	A	640.000
ANES 9110	Anesthesiology Selective	80.00	80.00	S	
EM 9101	EM Selective	80.00	80.00	S	
TERM GPA :	4.000	GPH: 800.00	TOTALS : 960.00	960.00	3200.000
OUHSC GPA :	4.000	GPH: 1680.00	TOTALS : 3482.50	3482.50	6720.000

Course	Description	Attempted	Earned	Grade	Points
INDT 9401	Outpatient Elective	160.00	160.00	S	
Course Topic(s): DERM Outpatient Elective					
INDT 9403	Subinternship Elective	160.00	160.00	A	640.000
Course Topic(s): FM Subinternship Elective					
INDT 9406	Special Studies Elective	80.00	80.00	S	
Course Topic(s): PEDI Special Studies Elective					
FM 9569	CH I	80.00	80.00	S	
FM 9572	CH II	80.00	80.00	S	

Interprofessional Education Tier I-Completed

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REGISTRAR, OUHSC

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United States

Name : Ryan Jones  
Student ID: 1770778  
Birthdate : [REDACTED]

Spring 2023 (cont.)

TERM GPA :	4.000	GPH: 160.00	TOTALS :	560.00	560.00	640.000
OUHSC GPA :	4.000	GPH: 2000.00	TOTALS :	4842.50	4842.50	8000.000
Medicine Career Totals						
OUHSC GPA :	4.000	GPH: 2000.00	TOTALS :	4842.50	4842.50	8000.000
Post-Baccalaureate Career Totals						
OUHSC GPA :	4.000	GPH: 168.00	TOTALS :	347.65	347.65	672.000
- - - - - End Of Career (2 of 3) - - - - -						

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PRIMARY  
SOURCE

*Lou Klein*



REGISTRAR, OUHSC

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THE UNIVERSITY OF OKLAHOMA HEALTH SCIENCES CENTER

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**EXPLANATION OF RECORD**  
**THE UNIVERSITY OF OKLAHOMA HEALTH SCIENCES CENTER**  
**OUHSC FICE CODE 5889**

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- Distinction
- Special Distinction
- Outstanding Distinction

OUHSC recognizes honors for degrees conferred by the Colleges of Allied Health, Dentistry, Medicine, Nursing, and Pharmacy.

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JUN 08 2023

OKLAHOMA STATE BOARD OF  
MEDICAL LICENSURE  
AND SUPERVISION



**RECEIVED**

Official Transcript

University of Oklahoma Health Sciences Center  
 P. O. Box 26901  
 Oklahoma City, OK 731260901  
 United States

Name : Ryan Jones  
 Student ID: 1770778  
 Birthdate : ██████████

JUN 08 2023

OKLAHOMA STATE BOARD OF  
 MEDICAL LICENSURE  
 AND SUPERVISION

**PRIMARY SOURCE**

----- Degrees Awarded -----

Degree : Certificate  
 Confer Date : 2019-05-10  
 Plan : Certificate in Public Health

Fall 2018 (cont.)

TERM GPA :	4.000	GPH:	21.00	TOTALS :	21.00	21.00	84.000
OUHSC GPA :	4.000	GPH:	21.00	TOTALS :	21.00	21.00	84.000

Degree : Master of Public Health  
 Confer Date : 2019-07-29  
 Plan : Epidemiology

Spring 2019

Degree : Doctor of Medicine  
 Confer Date : 2023-05-20  
 Degree Honors : With Distinction  
 Plan : Medicine

Course	Description	Attempted	Earned	Grade	Points
BSE 5001	Biostatistics and Epidemiology	1.00	1.00	A	4.000
BSE 5153	Clinical Trials	3.00	3.00	A	12.000
BSE 5173	Biostatistics Methods II	3.00	3.00	A	12.000
BSE 5193	Intermediate Epidemiol Methods	3.00	3.00	A	12.000
BSE 5303	Epi of Infectious Disease	3.00	3.00	A	12.000
BSE 5763	Applied Bayesian Stats	3.00	3.00	A	12.000
BSE 6151	Appl. Stat. Methods	1.00	1.00	A	4.000
BSE 6192	Grant Writing in Epidemiology	2.00	2.00	A	8.000
CPH 7003	Integrated Public Health	3.00	3.00	A	12.000
CPH 7941	Practicum Prep	1.00	1.00	S	

----- Academic Program History -----

Program : Public Health Professional  
 2018-07-27 : Active in Program  
 2018-07-27 : Intdisp Public Health - MPH Major  
 2018-12-17 : Active in Program  
 2018-12-17 : Epidemiology - MPH Major  
 2019-07-29 : Completed Program  
 Program : Public Hlth Profession Non-Deg  
 2018-07-17 : Active in Program  
 2018-07-17 : Certificate in Public Health Major  
 2019-05-10 : Completed Program

TERM GPA :	4.000	GPH:	22.00	TOTALS :	23.00	23.00	88.000
OUHSC GPA :	4.000	GPH:	43.00	TOTALS :	44.00	44.00	172.000

Summer I 2019

----- Beginning of Public Health Professional Record -----

Course	Description	Attempted	Earned	Grade	Points
CPH 7950	PH Practicum	1.00	1.00	S	

Fall 2018

Course	Description	Attempted	Earned	Grade	Points
BSE 5013	Microcomputer Data Analysis	3.00	3.00	A	12.000
BSE 5113	Principles of Epidemiology	3.00	3.00	A	12.000
BSE 5163	Biostatistics Methods I	3.00	3.00	A	12.000
BSE 5363	Epi Prev Chron Disease	3.00	3.00	A	12.000
HAP 5453	U.S. Health Care Systems	3.00	3.00	A	12.000
HPS 5213	Soc & Beh Sci in Public Health	3.00	3.00	A	12.000
OEH 5013	Environmental Health	3.00	3.00	A	12.000

TERM GPA :	0.000	GPH:	0.00	TOTALS :	1.00	1.00	0.000
OUHSC GPA :	4.000	GPH:	43.00	TOTALS :	45.00	45.00	172.000

*Law Klein*



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REGISTRAR, OUHSC



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University of Oklahoma Health Sciences Center  
P. O. Box 26901  
Oklahoma City, OK 731260901  
United States

Name : Ryan Jones  
Student ID: 1770778  
Birthdate : [REDACTED]

Public Health Professional Career Totals

OUHSC GPA : 4.000 GPH: 43.00 TOTALS : 45.00 45.00 172.000

Post-Baccalaureate Career Totals

OUHSC GPA : 4.000 GPH: 168.00 TOTALS : 347.65 347.65 672.000

----- End Of Career (3 of 3) -----  
----- End Of Transcript -----

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# AMA Physician Profile

PREPARED FOR

Oklahoma State Board of Licensure & Supervision, Oklahoma City, OK

**Name and Mailing Address**

RYAN GARRETT JONES

**Primary Office Address**

[REDACTED]

Phone UNKNOWN

**Birth date**

[REDACTED]

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MAY 17 2024  
OKLAHOMA STATE BOARD OF  
MEDICAL LICENSURE  
AND SUPERVISION

**Physician's major professional activity**

HOSPITAL BASED RESIDENTS - ALL YEARS

**AMA membership status**

MEMBER

PRIMARY SOURCE

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

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

NPI Number	Enumeration Date	Deactivation Date	Reactivation Date	Replacement Number	Last Reported Date
1881215689	05/03/2020	NOT RPTD	NOT RPTD	NOT RPTD	04/19/2024

**Current and/or historical medical school**

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

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

**School:** UNIVERSITY OF OKLAHOMA COLLEGE OF MEDICINE

**Degree Awarded:** YES

**Degree Type:** MD

T41325  
55



**Enrollment Date:** 08/2019

**Degree Date:** 05/2023

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

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

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

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

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

**Sponsoring Institution:** INTEGRIS HEALTH  
**Sponsoring State:** OKLAHOMA  
**Program name:** INTEGRIS HEALTH/GREAT PLAINS PROGRAM  
**Specialty:** FAMILY MEDICINE  
**Training Type:** SPECIALTY  
**Dates:** 07/01/2023 - 06/30/2026  
**Status:** TRAINING IN PROGRESS

**Specialty board certification**

NO DATA REPORTED AT THIS TIME

**Current and/or historical medical licensure**

License Number	MD / DO	Locale	Date Granted	Expiration Date	Renewal Date	Status	License Type	Last Reported	Name on License
41325	MD	OK	07/01/2023	09/30/2024		ACT	RES	05/06/2024	RYAN GARRETT JONES

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

### Action notifications reported to the AMA

**Medical Licensing Boards:** NO ACTIONS REPORTED AT THIS TIME

**Medicare/Medicaid Sanctions from DHHS:** NO ACTIONS REPORTED AT THIS TIME

**US DOJ Drug Enforcement Administration:** NO ACTIONS REPORTED AT THIS TIME

### U.S. Drug Enforcement Administration (DEA)

NO DATA REPORTED AT THIS TIME

### ECFMG certification

NOT APPLICABLE

### Profile information

The content of the AMA Physician Profile is for credentialing use only. The content cannot be used or assembled for an employment purpose as defined under the Fair Credit Reporting Act. An organization's appropriate use of the data contained in the AMA Physician Professional Data™, formerly known as AMA Physician Masterfile, meets select primary source verification requirements of the Joint Commission, the Accreditation Association for Ambulatory Health Care (AAAHC) and the American Accreditation Health Care Commission (AAHCC)/ Utilization Review Accreditation Commission (URAC). The AMA Physician Professional Data is also an NCQA-approved source for verification of medical school, post-graduate medical training, ABMS Board Certification and federal DEA registration.

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

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



OKLAHOMA STATE BOARD OF MEDICAL LICENSURE AND SUPERVISION  
101 NE 51<sup>ST</sup> STREET  
OKLAHOMA CITY OK 73105  
**EVIDENCE OF STATUS – PART A**

APR 28 2023

OKLAHOMA STATE BOARD OF  
MEDICAL LICENSURE  
AND SUPERVISION

Full Legal Name: Ryan Garrett Jones  
First Middle Last Maiden (if applicable)  
Mailing Address: \_\_\_\_\_  
Street Address or Post Office Box  
\_\_\_\_\_  
City State Zip Code Telephone Number Social Security #: \_\_\_\_\_

**PRIMARY EVIDENCE OF CITIZENSHIP**  
**(FOR US CITIZENS, US NATIONALS, OR PERMANENT LEGAL RESIDENT ALIENS)**

If you are a U.S. citizen, U.S. national, or permanent legal resident alien, please attach a photocopy of one of the following documents to this form. Place a checkmark below to indicate the document that is attached.

- A birth certificate showing birth in one of the 50 States, the District of Columbia, Puerto Rico (on or after January 13, 1941), Guam, the U.S. Virgin Islands (on or after January 17, 1917), American Samoa, Swain's Island or the Northern Mariana Islands, unless the person was born to foreign diplomats residing in the U.S.
- United States passport** (except limited passports, which are issued for periods of less than five years)
- Report of birth abroad of a U.S. citizen (FS-240)** (issued by the Department of State to U.S. citizens)
- Certificate of birth (FS-545)** (issued by a foreign service post) or **Certification of Report of Birth (DS1350)** (issued by the Department of State), copies available from the Department of State
- Certificate of Naturalization (N-550 or N-570)** (issued by the INS through a Federal or State court, or through administrative naturalization after December 1990 to individuals who are individually naturalized; the N570 is a replacement certificate issued when the N-550 has been lost or mutilated or the individual's name has been changed)
- Certificate of Citizenship (N-560 or N-561)** (issued by the INS to individuals who derive U.S. citizenship through a parent; the N-561 is a replacement certificate issued when the N-560 has been lost or mutilated or the individual's name has been changed)
- United States Citizen Identification Card (I-197)** (issued by the INS until April 7, 1983 to U.S. citizens living near the Canadian or Mexican border who needed it for frequent border crossing) (formerly Form I-179, last issued in February 1974)
- Northern Mariana Identification Card** (issued by the INS to a collectively naturalized citizen of the U.S. who was born in the Northern Mariana Islands before November 3, 1986)
- Statement provided by a U.S. consular officer certifying that the individual is a U.S. citizen** (This is given to an individual born outside the U.S. who derives citizenship through a parent but does not have an FS-240, FS-545 or DS-1350);
- American Indian Card with a classification code "KIC" and a statement on the back** (identifying U.S. citizen members of the Texas Band of Kickapoos living near the U.S./Mexican border.)
- Alien Lawfully Admitted for Permanent Residence: INS Form I-551** (Alien Registration Receipt Card, commonly known as a "green card")
- Alien Lawfully Admitted for Permanent Residence: Unexpired Temporary I-551 stamp** in foreign passport or on INS Form I-94

I declare under penalty of perjury, under the laws of the State of Oklahoma, that all information contained in this application and all accompanying documents provided to substantiate my Evidence of Status application are true and correct.

Signature [Signature] Date 4/27/23

Subscribed and sworn before me this 27 day of April, 2023.

Notary Public [Signature]

Commission Number 21004894

My commission expires 4/9/2025



T41325 #5







**Kenna L. Shaw**

---

**From:** BillPay Webmaster <donotreply@www.ok.gov>  
**Sent:** Thursday, May 2, 2024 4:36 PM  
**To:** Dela Kwetey; Bill Pay; Sheila E. Brumfield; Chris Maloney; Licensing; Arlene Morris; Debra Reich  
**Subject:** [EXTERNAL] LICENSE - MD Training-to-Full License Fee 250.00 - Payment Made

RYAN JONES has paid for a LICENSE - MD Training-to-Full License Fee 250.00  
on 05/02/2024 04:05:35pm for \$250.00.

OKLAHOMA MD LICENSE NUMBER 41325

To view all transactions please go to <http://www.ok.gov/triton/> and  
login to your CMS account.

T41325  
10

05/02/2023

RYAN GARRETT JONES  
[REDACTED]

RE: MD Application #41325

**Check Your Application  
Status Online at:**  
<http://www.okmedicalboard.org>  
**Username:AP79013870**  
**Password:Last 4 SSN**

Dear RYAN JONES,

**YOU CANNOT PRACTICE YOUR PROFESSION IN THE STATE  
OF OKLAHOMA UNTIL A VALID LICENSE HAS BEEN ISSUED.**

Your training application has been processed and the current deficiencies are listed below. Please be advised, these may not be the only deficiencies. You will be advised if any other deficiencies are added. You may check your application status online by logging in with the username and password provided above.

If you have further questions please email  
[oktraining@okmedicalboard.org](mailto:oktraining@okmedicalboard.org)

If a "*Time Deficiency*" is listed, please complete a time deficiency form and e-mail the document to  
[oktraining@okmedicalboard.org](mailto:oktraining@okmedicalboard.org)  
with your activities during the specified time frame.

Evidence of Status  
Application Instructions  
OATH  
Exam verification date  
MedSchool-Transcript Univ Of Ok Coll Of Med, Oklahoma City Ok 73190  
MedSchool-Form 1 Univ Of Ok Coll Of Med, Oklahoma City Ok 73190  
PostGrad - Form 2 GREAT PLAINS FAMILY PRACTICE RESIDENCY  
USMLE Exams Incomplete

Any of the required forms in the list above may be downloaded from our website:

<http://www.okmedicalboard.org/resources>



In order to check on the status of your application, please log on to our web site:

<https://secure.okmedicalboard.org/applicant/signin>

Your user name is AP79013870 (all caps and no spaces) and your password is the last 4 digits of your social security number.

If you did not provide a social security number with your application, your password will be your 4-digit year of birth in the form "YYYY".

If we may be of further assistance, please email.

[oktraining@okmedicalboard.org](mailto:oktraining@okmedicalboard.org)

Sincerely,

**Lisa Cullen**

Lisa Cullen  
Director of Licensing  
Dept. of Licensing

Encl

# Oklahoma State Board of Medical Licensure and Supervision Application Summary

Type      Number      Name  
MD          41325      RYAN GARRETT JONES  
MEDICAL DOCTOR

**Incomplete Information (due to space limitations on this page, this may not be a complete list)**

Exam verification date  
PostGrad - Form 2 GREAT PLAINS FAMILY PRACTICE RESIDENCY  
USMLE Exams Incomplete

**Last Medical School Attended:**  
039-01 Univ Of Ok Coll Of Med, Oklahoma City Ok 73190  
  
Number of Licenses Previously Granted to Graduates of this Medical School:7,275

Application for: Resident  Full License \_\_\_\_\_ Reinstatement \_\_\_\_\_

**The Secretary of the Board has reviewed this application and:**

1) AUTHORIZED CIRCULARIZATION TO OTHER BOARD MEMBERS \_\_\_\_\_

2) ALL FIVE CRITERIA HAVE BEEN MET [Fast Track] \_\_\_\_\_

- Passed USMLE
- No DUIs or Legal Issues
- No Significant Malpractice Issues
- US Graduate
- Graduated Medical School on time

3) HAS ISSUED A TEMPORARY LICENSE THROUGH \_\_\_/\_\_\_/\_\_\_

4) HAS ISSUED A SPECIAL PGY-1 TRAINING LICENSE AW 6-12-23

5) REQUESTS SPECIFIC CONSIDERATION OF:

\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_



# Oklahoma State Board of Medical Licensure and Supervision Application Summary

Type	Number	Name
MD	41618	SAURAV PRASHANT KADATANE
MEDICAL DOCTOR		

**Incomplete Information (due to space limitations on this page, this may not be a complete list)**

OTHER DEFICIENCIES: NEED FORM 2 AND EVAL UPON COMPLETION OF TRAINING, MUST COME DIRECTLY FROM YOUR PROGRAM  
 PostGrad - Form 2 COLLEGE OF MEDICINE OKC

**Last Medical School Attended:**  
 038-44 Northeastern OH Univ Coll of Med & Pharm, Rootstown, OH

**Number of Licenses Previously Granted to Graduates of this Medical School:48**

Application for: Resident \_\_\_\_\_ Full License \_\_\_\_\_ Reinstatement \_\_\_\_\_

**The Secretary of the Board has reviewed this application and:**

1) AUTHORIZED CIRCULARIZATION TO OTHER BOARD MEMBERS \_\_\_\_\_

2) ALL FIVE CRITERIA HAVE BEEN MET [Fast Track] \_\_\_\_\_

- Passed USMLE
- No DUIs or Legal Issues
- No Malpractice Issues
- US Graduate
- Graduated Medical School in 4 years or less

3) HAS ISSUED A TEMPORARY LICENSE THROUGH \_\_\_\_ / \_\_\_\_ / \_\_\_\_

4) HAS ISSUED A SPECIAL PGY-1 TRAINING LICENSE \_\_\_\_\_

# Oklahoma State Board of Medical Licensure and Supervision

## Application Summary

**Type**    **Number**    **Name**  
 MD        41618    SAURAV PRASHANT KADATANE  
 MEDICAL DOCTOR

**Practice Address:**  
 May 02, 2023

**Status:**

Res: TR

Received: 04/26/2023

Entered: 04/26/2023

**Temp Issued:****Temp Expires:**

Train Issued: 07/01/2023

Train Expires: 09/30/2024

Fed Rec: 05/22/2024

AMA Rec: 05/22/2024

**Board Action:**

License #: 41618

Sex: M

Ethnic Origin: 6

**Endorsed By:** USMLE EXAMINATION

	Test	Score	Date Taken	Date Verified	Attempts
Test 1:	USMLE 3	PASS	03/22/24	5/9/24	1
Test 2:	USMLE 1	PASS	7/18/20	4/26/23	1
Test 3:	USMLE 2	PASS	7/6/22	4/26/23	1

Note: **PASS** means higher than 75

**Test AV:**  
**Total Possible:**  
**Okla Passing:**  
**Total Score:**

**PRE-MED EDUCATION****School Name:** KENT STATE UNIVERSITY**City:** KENT**State:** OH **Country:** UNITED STATES**Degree:** BACHELOR OF SCIENCE**From:** 7/2016 **To:** 7/2018 **Verified:****MEDICAL SCHOOL EDUCATION****Name:** Northeastern OH Univ Coll of Med & Pharm, Rootstown, OH**Foreign Name:****City:** Rootstown**State/Country:** United States of America**Degree:** DOCTOR OF MEDICINE **From:** 8 / 2018 **To:** 4 / 2023 **Diploma Ver'd:** Y**POST GRADUATE EDUCATION****Facility:** COLLEGE OF MEDICINE OKC**Specialty:** INTERNAL  
MEDICINE/PEDIATRICS**Res. Fellowship:** Residency**City:** OKLAHOMA CITY**State:** OK **Country:** UNITED STATES OF AMERICA**Verified:****From:** 7 / 2023 **To:** /**ACGME Ver'd:****Comments:**



## Oklahoma State Board of Medical Licensure and Supervision Application Summary

Type	Number	Name
MD	41618	SAURAV PRASHANT KADATANE
MEDICAL DOCTOR		

### PRACTICE HISTORY

<b>Employed:</b> NORTHEAST OHIO MEDICAL UNIVERSITY		<b>Supervisor:</b>	
<b>City:</b> ROOTSTOWN		<b>State:</b> OH	<b>Country:</b> UNITED STATES
<b>Specialty:</b> RESEARCH	<b>From:</b> 6 / 2019	<b>To:</b> 8 / 2019	<b>Verified:</b>
<b>Comments:</b> STUDENT RESEARCHER IN A LAB			

### Other Licenses

State	Lic Type and Number	Status	Issued	Exp	Verif

### DEFICIENCIES

OTHER DEFICIENCIES: NEED FORM 2 AND EVAL UPON COMPLETION OF TRAINING, MUST COME DIRECTLY FROM YOUR PROGRAM  
PostGrad - Form 2 COLLEGE OF MEDICINE OKC

RETURN FORM TO:  
 OKLAHOMA STATE BOARD OF MEDICAL LICENSURE AND SUPERVISION  
[oktraining@okmedicalboard.org](mailto:oktraining@okmedicalboard.org)

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MAY 08 2024

OKLAHOMA STATE BOARD OF  
 MEDICAL LICENSURE  
 AND SUPERVISION

**QUESTIONNAIRE**

Please read and follow ALL instructions

**FORM INSTRUCTIONS:** Complete both pages of this form *only if* you are renewing or upgrading your training license. Attach the appropriate documentation and answer the confidential questions.

**PAYMENT INSTRUCTIONS:** If you **ARE FULLY LICENSED**, you **MUST** go online and renew your license – **DO NOT pay your renewal fee via these instructions (doing so will delay your renewal).**

**ATTESTATION STATEMENT:** By completing this document, I agree to pay the appropriate fee on **ONLINE BILL PAY**. If you are **UPGRADING** your training license to a full license, your fee will be \$250 & you will choose **MD TRAINING-TO-FULL**

If you are **RENEWING** your training license, your fee will be \$150 & you will choose **MD TRAINING LICENSE RENEWAL**

**PLEASE PRINT ALL INFORMATION**

FIRST NAME	<u>SAURAV</u>	LAST NAME	<u>KADATANE</u>
EMAIL	[REDACTED]		
ADDRESS	[REDACTED]		
LICENSE NUMBER	<u>41618</u>	CELL PHONE	[REDACTED]
HOME ADDRESS	[REDACTED]	CITY/STATE	[REDACTED]
PROGRAM ATTENDING	<u>Dr. Catherine Mims</u>	SPECIALTY	<u>Medicine - Pediatrics</u>

**DOCUMENTATION TO ATTACH**

PAYMENT COMPLETED			
<input type="checkbox"/>	\$150 payment made on Billpay for <b>RENEWAL</b> of training license	<input checked="" type="checkbox"/>	\$250 payment made on Billpay for <b>UPGRADE</b> of training license

DOCUMENTATION REQUIRED			
<input type="checkbox"/>	Form 2 (must be received directly from program) <b>**ONLY FOR UPGRADE</b>	<input type="checkbox"/>	Evaluation (must be received directly from program)
<input type="checkbox"/>	USMLE Step 3 (must be received directly from USMLE)	<input type="checkbox"/>	Answer confidential questions (on back of this form)

FOREIGN TRAINED STUDENTS			
<input type="checkbox"/>	Current visa	<input type="checkbox"/>	Social Security Number **if not provided at initial application
<input type="checkbox"/>	Background Check **if not done at initial application		

**IF YOU ARE FULLY LICENSED – DO NOT COMPLETE THIS FORM. YOU MUST GO ONLINE AND RENEW AT <https://pay.apps.ok.gov/medlic/md/login.php> ENTER YOUR LICENSE NUMBER & PIN – COMPLETE YOUR RENEWAL AND PAY THE RENEWAL FEE.**

T41618  
 SJ



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OKLAHOMA STATE BOARD OF  
MEDICAL LICENSURE  
AND SUPERVISION

NAME Saurav Kadatane

**IF YOU HAVE ANY "YES" ANSWERS YOU MUST PROVIDE A NOTARIZED STATEMENT EXPLAINING YOUR ANSWER.**

**SINCE RENEWAL OF YOUR TRAINING LICENSE OR INITIAL ISSUE OF YOUR TRAINING LICENSE (whichever is most recent)**

QUESTIONS	YES	NO
Have you failed any part of the USMLE exam (not previously disclosed)?	<input type="checkbox"/>	<input checked="" type="checkbox"/>
Have you been the subject of investigation or disciplinary action (including probation) by a hospital or training program?	<input type="checkbox"/>	<input checked="" type="checkbox"/>
Have you had any adverse judgment or settlement against you rising from a professional liability claim?	<input type="checkbox"/>	<input checked="" type="checkbox"/>
Have you been reported to the National Practitioner Data Bank (NPDB)?	<input type="checkbox"/>	<input checked="" type="checkbox"/>
Have you ever been denied, had removed, or suspended hospital privileges?	<input type="checkbox"/>	<input checked="" type="checkbox"/>
Have you surrendered hospital privileges while under investigation or to avoid investigation?	<input type="checkbox"/>	<input checked="" type="checkbox"/>
Have you entered into an Agreement with a Federal, State, or Local jurisdictional body to avoid formal action?	<input type="checkbox"/>	<input checked="" type="checkbox"/>
Has your application for licensure ever been denied?	<input type="checkbox"/>	<input checked="" type="checkbox"/>
Have you surrendered a license or had any disciplinary action taken on any license?	<input type="checkbox"/>	<input checked="" type="checkbox"/>
Have you been investigated by or requested to appear before a licensing or disciplinary agency (other than the Oklahoma State Board of Medical Licensure and Supervision)?	<input type="checkbox"/>	<input checked="" type="checkbox"/>
Have you obtained an assessment or been treated for use of any drug or chemical substance including alcohol?	<input type="checkbox"/>	<input checked="" type="checkbox"/>
Have you been arrested for, charged with, or convicted of a felony or misdemeanor other than a traffic violation?	<input type="checkbox"/>	<input checked="" type="checkbox"/>
Have you been arrested for, charged with, or convicted of a traffic violation involving the use of any drug or chemical substance?	<input type="checkbox"/>	<input checked="" type="checkbox"/>
Have you been addicted to or abused any drug or chemical substance including alcohol?	<input type="checkbox"/>	<input checked="" type="checkbox"/>
Have you been denied provider participation, terminated, sanctioned or penalized by any third-party payor including TRICARE, MEDICARE, or MEDICAID?	<input type="checkbox"/>	<input checked="" type="checkbox"/>
Have you surrendered or had any adverse action taken against any narcotic permit (State or Federal)?	<input type="checkbox"/>	<input checked="" type="checkbox"/>

I swear under penalty of perjury, that I am the person completing this Questionnaire and understand that any medical license procured or obtained by fraud or misrepresentation will result in disciplinary action taken against the licensee pursuant to the provisions of 59 O.S. § 508.

Signature 

Date 05/08/24

# Oklahoma State Board of Medical Licensure and Supervision

PAGE 353 of 500

## APPLICATION FOR OKLAHOMA MEDICAL DOCTOR LICENSE

Received:04/26/2023

Applicant Name: KADATANE, SAURAV PRASHANT

MD 41618



Date Of Birth: [REDACTED]

Place Of Birth (City, State): WALCHANDNAGAR, MAHARASHTRA, INDIA

Sex: M

Race: Asian/Pacific Islander

Education									
Type	Name	City	ST	Country	From	To	Degree	Comments	Veri
UG	KENT STATE UNIVERSITY	KENT	OH		7/2016	7/2018	BACHELOR OF SCIENCE		

Medical School Name	City	State	Country	Comments	From	To
Northeastern OH Univ Coll of Med & Pharm, Rootstown, OH	Rootstown	OH	United States		8/2016	5/2023

Post-Graduate							
Facility	City	St	Country	Specialty	Comments	From	To
COLLEGE OF MEDICINE OKC	OKLAHOMA CITY	OK	UNITED S	INTERNAL MEDICINE/PEDIATRICS		7/2023	/

Practice History								
Employer	Specialty	Supervisor	City	ST	Country	From	To	Verif
NORTHEAST OHIO MEDICAL UNIVERSITY	RESEARCH		ROOTSTOWN	OH		6/2019	8/2019	

Other/ Out-Of-State Licenses					
State	License #	Profession	Status	Issue Date	Exp Date

MD Exam				
Exam	State	Score	Date Taken	#
USMLE				

*UKL*

*\$250*



# Oklahoma State Board of Medical Licensure and Supervision

## APPLICATION FOR OKLAHOMA MEDICAL DOCTOR LICENSE

Received:04/26/2023

<b>Questions Answered 04/19/2023</b>	<b>Response</b>
A. Have you ever been denied provider participation, terminated, sanctioned, or penalized by any third party payor, to include TRICARE, MEDICARE, MEDICAID?	<b>N</b>
B. Have you ever surrendered or had any adverse action taken against any narcotic permit (state or federal)?	<b>N</b>
C. Have you ever been denied membership or had disciplinary action taken by a national, state or county professional organization?	<b>N</b>
D. Have you ever been denied or had removed or suspended hospital staff privileges?	<b>N</b>
E. Have you ever surrendered hospital staff privileges while under investigation or to avoid investigation?	<b>N</b>
F. Have you ever entered into an agreement with a federal, state or local jurisdictional body to avoid formal action?	<b>N</b>
G. Have you ever been the subject of an investigation, probation or disciplinary action by a hospital, clinic, practice group, training program or professional school?	<b>N</b>
H. Have you had any adverse judgment, settlement, or award against you arising from a professional liability claim?	<b>N</b>
I. Have you ever had professional liability coverage declined, canceled, issued on special terms, or renewal refused?	<b>N</b>
J. Have you ever been reported to the National Practitioners Data Bank (NPDB) or to the Healthcare Integrity and Protection Data Bank (HIPDB)? (If yes, enclose a copy of the report.)	<b>N</b>
K. Has your application for examination or a professional license ever been denied?	<b>N</b>
L. Have you ever failed any part of a licensure/certification/registration examination?	<b>N</b>
M. Have you ever surrendered a license or had a license revoked?	<b>N</b>
N. Has any disciplinary action been taken on any license?	<b>N</b>
O. Have you ever been subject of a review by professional licensing/regulatory agency based on a complaint filed against you?	<b>N</b>
P. Have you ever been arrested, charged with, or convicted of a felony or misdemeanor, other than traffic violations?	<b>N</b>
Q. Have you ever been arrested, charged with, or convicted of a traffic violation involving the use of any drug or chemical substance, including alcohol?	<b>N</b>
R. Are you now or have you within the past two years been addicted to or used in excess any drug or chemical substance, including alcohol?	<b>N</b>
S. Have you obtained an assessment or been treated for the use of any drug or chemical substance, including alcohol?	<b>N</b>
T. Do you currently have or have you had within the past two years any mental or physical disorder or condition which, if untreated, could affect your ability to practice competently?	<b>N</b>
U. Are you or your spouse currently on Active Duty in the U.S. Armed Forces?	<b>N</b>
V. Are you or your spouse currently Deployed on Active Duty in the U.S. Armed Forces?	<b>N</b>

**Oklahoma State Board of Medical Licensure and Supervision**

**APPLICATION FOR OKLAHOMA MEDICAL DOCTOR LICENSE**

Received:04/26/2023

**If licensed, where do you intend to locate?**

OK

**Why do you seek Licensure in the state of Oklahoma?**

Post-Graduate Training

**In what manner will you be communicating with your Oklahoma patients (telephone, email, internet, video-conference, etc)?**

**Describe how you will examine each patient in person prior to diagnosis, treating, correcting, or prescribing for a patient in Oklahoma from the state, province, or country you are located:**

**Describe the manner in which you intend to practice medicine across state lines in Oklahoma:**

**Have you executed or been offered a contract in connection with practice in the state of Oklahoma?**

No

**If 'Yes', Name of practice:**

**If so, Please identify with which category:**

**Name of Previous Carrier and Policy Holder**

Illinois Union Insurance Company (Chubb; Surplus Lines)

**Name of Current Carrier and policy Holder**

Hudson Excess Insurance Company (surplus lines/non-admitted)

**Will your professional liability insurance policy cover your practice in Oklahoma**

No

**If NO, when do you expect to obtain liability insurance that will cover practice in Oklahoma**

Before starting residency in July,2023

**I attest that all the above information is accurate as of April 25, 2023: \_\_\_\_\_ (Signed Online)**





**Applicant:** In the presence of a notary public, sign this form with attached photo.

Send this form to: Oklahoma State Board of Medical Licensure and Supervision

**oktraining@okmedicalboard.org**

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

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

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

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

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

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

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JUN 19 2023

OKLAHOMA STATE BOARD OF MEDICAL LICENSURE AND SUPERVISION



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

KADATANE, SAURAV, P  
Applicants printed last name, first name, middle initial, and suffix (e.g., Jr.)

04/26/2023  
Date of signature (must correspond to the date of notarization)

**NOTARY**

State of Ohio, County of Summit

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

The statements on this document are subscribed and sworn to before me by the applicant on the 26 day of April, 2023

Notary Public Signature [Signature]



Commission Expires 01/25/2026

Tyler B

PRIMARY SOURCE



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

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

**Recipient:** OKLAHOMA STATE BOARD OF  
MEDICAL LICENSURE & SUPERVISION

**Date:** 05/08/2024

**Examinee:** Kadatane, Saurav Prashant  
**Alt Name(s):**

**Examinee ID:** 5-455-281-5  
**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. Pass/fail outcomes are based upon the minimum passing level in place at the time of test administration and are not altered by subsequent revisions to the minimum passing level. Effective April 1, 2013, two-digit scores will no longer be reported. Test results reported as passing represent an exam score of 75 or higher on a two-digit scale. Step 1 examinations taken on or after January 26, 2022 are reported as pass/fail, with no numeric score; Step 1 examinations taken before January 26, 2022 will continue to be reported with a 3-digit score.

**USMLE STEP 1**

Test Date	Pass/Fail	Score	Minimum Pass	Comments
07/18/2020	Pass	232	(194)	

**USMLE STEP 2**

*Clinical Knowledge (CK)*

Test Date	Pass/Fail	Score	Minimum Pass	Comments
07/06/2022	Pass	244	(214)	

**USMLE STEP 3**

Test Date	Pass/Fail	Score	Minimum Pass	Comments
03/22/2024	Pass	230	(200)	

**End of Exam History**

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

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

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MAY 09 2024

OKLAHOMA STATE BOARD OF  
MEDICAL LICENSURE  
AND SUPERVISION

T41618  
57





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

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

**Examinee:** Kadatane, Saurav Prashant

**Examinee ID:** 5-455-281-5

**Date of Birth:** [REDACTED]

### INTERPRETATION OF RESULTS

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

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

### STEP 1 AND STEP 2 CLINICAL SKILLS (CS)

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

### ANNOTATIONS APPEARING UNDER "COMMENTS"

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

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

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

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

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

### ANNOTATIONS APPEARING AS "NOTE"

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

### PHYSICIAN DATA CENTER INFORMATION APPEARING AS "NOTE"

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

03/2015

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

Form 1 (MD)

Oklahoma State Board of Medical Licensure and Supervision  
101 NE 51st Street Oklahoma City, OK 73105  
OKTRAINING@OKMEDICALBOARD.ORG

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MAY 09 2023

OKLAHOMA STATE BOARD OF  
MEDICAL LICENSURE  
AND SUPERVISION

This form must be completed by the institution and mailed or emailed directly from the institution.

Applicant's Name Saurav Kadatane

Institution: Northeast Ohio Medical University City/State Rootstown, Ohio

Our records indicate that the above named applicant attended our medical school on the following dates:

From 8 / 27 / 2018 To 4 / 14 / 2023 and was awarded the degree Doctor of Medicine  
Month Day Year Month Day Year

Please complete the following questions:

1. Does this individual's official record reflect (an) interruption(s) or extension(s) in his/her medical education? If yes, please explain.  YES  NO
2. Does this individual's official record reflect that he/she was ever placed on academic or disciplinary probation during his/her medical education? If yes, please explain.  YES  NO
3. Does this individual's official record reflect that he/she was ever the subject of negative reports for behavioral reasons or an investigation by the medical school or parent university? If yes, please explain below.  YES  NO
4. Does this individual's official record reflect that he/she was ever disciplined for unprofessional conduct/behavioral reasons by the medical school or parent university? If yes, please explain below.  YES  NO
5. Does this individual's official record reflect that there were any limitations or special requirements imposed on the individual because of questions of academic incompetence, disciplinary problems, or any other reason? If yes, please explain below.  YES  NO

Please explain any "YES" response from above: Took an approved medical leave of absence from 7/13/2020 to 7/11/2021.

I attest that the completion of the following has been completed by the program director and that the information above is an accurate account of this individual's records and is true and correct.

Name: Katherine Miranda Signature Katherine Miranda

Title of Signatory: Registrar Date of Signature 5/9/2023

Tel: 330-325-6175 Fax: 330-325-5905 E-Mail: registrar@neomed.edu



If no seal is available, this form must be notarized

Notary Public \_\_\_\_\_

Commission # \_\_\_\_\_

My commission expires: \_\_\_\_\_

PRIMARY SOURCE

Notary Seal

T41618  
KB





Northeast Ohio Medical University  
4209 State Route 44  
Rootstown, OH 44272

Record of: Saurav P. Kadatane

Issued to: OKLAHOMA STATE BOARD OF MEDICAL LICENSURE  
Parchment DocumentID: TWBQA02G

Date issued: 23-MAY-2023

Date of birth: [REDACTED]

Student ID: @00054149

Level: Professional

Course Level: Professional				SUBJ NO.	COURSE TITLE	CRED GRD	PTS R
Program				Institution Information continued:			
Doctor of Medicine				Spring 2020			
Program : Doctor of Medicine				FMCM 72202	Principles of Clinical Med II	2.50 P	0.00
College : College of Medicine				FMCM 72304	Human Values in Medicine IV	1.00 P	0.00
Degrees Awarded Doctor of Medicine 06-MAY-2023				GMED 72310	Principles of Med Science II A	16.00 P	0.00
				MST3 30112	Deliberate Practice & Dev II	1.00 P	0.00
				Total Earned Credits 20.50			
				Maymester 2020			
				GMED 72310	Principles of Med Science II B	0.50 P	0.00
				Total Earned Credits 0.50			
INSTITUTION CREDIT:				Clinical Term AY 21-22			
Fall 2018				EMED 83007	Emergency Medicine Clerkship	3.00 P	0.00
IST1 10100	Prologue	2.00 P	0.00	FMCM 83006	Family Medicine Clerkship	5.00 HP	0.00
IST1 10106	Evidence Based Medicine I	1.50 P	0.00	FMCM 83010	Applications of Clinical Med	3.00 P	0.00
IST1 10201	Professional Foundations I	2.00 P	0.00	FMCM 83011	Human Values in Medicine V	0.50 P	0.00
MST1 10101	Human Development/Structure	10.50 P	0.00	GMED 83000	Prereq to Clinical Curriculum	5.00 P	0.00
MST1 10110	Community Experience I	1.00 P	0.00	GMED 83003	USMLE Step Prep	0.50 P	0.00
MST1 10111	Foundations Clinical Med I	2.00 P	0.00	IMED 83001	Internal Medicine Clerkship	10.00 P	0.00
MST1 10112	Human Values in Medicine I	1.50 P	0.00	MELE 83020	Pulmonary	4.00 P	0.00
Total Earned Credits 20.50				OBGY 83003	Obstetric/Gynecology Clerkship	5.00 P	0.00
Spring 2019				PEDS 83004	Pediatrics Clerkship	5.00 P	0.00
IST2 20206	Evidence Based Medicine II	1.00 P	0.00	PSYC 83005	Psychiatry Clerkship	5.00 HP	0.00
IST2 20213	Professional Foundations II	0.50 P	0.00	SURG 83002	Surgery Clerkship	5.00 P	0.00
MST2 20101	Medical Neuroscience	5.50 P	0.00	Total Earned Credits 51.00			
MST2 20210	Community Experience II	1.50 P	0.00	Clinical Term AY 22-23			
MST2 20211	Foundations Clinical Med II	3.00 P	0.00	FMCM 84001	Quality Improvement	0.50 P	0.00
MST2 20212	Human Values in Medicine II	1.00 P	0.00	FMCM 84002	Social Determinants of Health	0.50 P	0.00
MST2 20214	Molecules to Cells for MD	8.00 P	0.00	GMED 84000	Clinical Epilogue and Capstone	2.00 P	0.00
MST2 20215	Physiological Basis Med for MD	5.50 P	0.00	IMED 84000	Internal Medicine	4.00 P	0.00
Total Earned Credits 26.00				IMED 84007	Coronary Intensive Care	4.00 H	0.00
Fall 2019				IMED 84011	Hematology/Oncology	4.00 P	0.00
FMCM 72102	Principles of Clinical Med I	3.00 P	0.00	NEUR 84000	Neurology	4.00 H	0.00
FMCM 72204	Human Values in Medicine III	0.50 P	0.00	PEDS 84009	Pediatric Intensive Care Unit	4.00 P	0.00
GMED 72210	Principles of Med Science I	10.00 P	0.00	PEDS 84011	Pediatric Infectious Disease	4.00 P	0.00
MST2 20102	Infection and Immunity	7.00 P	0.00	Total Earned Credits 27.00			
MST2 20106	General Pathology	1.00 P	0.00	***** CONTINUED ON PAGE 2 *****			
MST3 30111	Deliberate Practice & Devel I	0.50 P	0.00	***** CONTINUED ON NEXT COLUMN *****			
Total Earned Credits 22.00							

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OKLAHOMA STATE BOARD OF  
MEDICAL LICENSURE  
AND SUPERVISION

PRIMARY  
SOURCE

T 4/6/18  
V

Katherine Miranda



Northeast Ohio Medical University  
 4209 State Route 44  
 Rootstown, OH 44272

Record of: Saurav P. Kadatane

Issued to:

Date issued: 23-MAY-2023

Date of birth: [REDACTED]

Student ID: @00054149

Level: Professional

\*\*\*\*\* TRANSCRIPT TOTALS \*\*\*\*\*

	Earned Hrs	GPA Hrs	Points	GPA
TOTAL INSTITUTION	167.50	0.00	0.00	0.00
TOTAL TRANSFER	0.00	0.00	0.00	0.00
OVERALL	167.50	0.00	0.00	0.00

\*\*\*\*\* END OF TRANSCRIPT \*\*\*\*\*



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OKLAHOMA STATE BOARD OF  
 MEDICAL LICENSURE  
 AND SUPERVISION

PRIMARY  
 SOURCE

*Katherine Miranda*

University Registrar



**Name Change History**

On April 29, 2011, House Bill 139 was signed and approved by the Ohio General Assembly to officially change the name of the Northeastern Ohio Universities College of Medicine (NEOUCOM) to Northeast Ohio Medical University (NEOMED). NEOMED consists of three Colleges – Graduate Studies, Medicine and Pharmacy. Doctoral degrees are offered through all three Colleges. The College of Graduate Studies also offers master's degrees and Graduate certificates.

**Accreditation**

NEOMED is accredited by Higher Learning Commission, one of six regional institutional accreditors in the United States. This accreditation covers each degree and certificate program that is offered at NEOMED.

**The College of Medicine (COM)**

The Ohio Legislature established the College of Medicine in 1973 in consortium with three major public universities of Ohio: The University of Akron, Kent State University and Youngstown State University. All medical students are required to pass Step 1 and Step 2 CK of the United States Medical Licensure Exams for promotion and graduation eligibility. The College of Medicine M.D. degree program is accredited by the Liaison Committee on Medical Education (LCME) which is sponsored by the American Medical Association (AMA) and the Association of American Medical Colleges (AAMC).

**The College of Pharmacy (COP)**

The Ohio Board of Regents established the College of Pharmacy in 2005. The College of Pharmacy Doctor of Pharmacy program is also accredited by the Accreditation Council for Pharmacy Education (ACPE).

**The College of Graduate Studies (COGS)**

The Ohio Board of Regents established the College of Graduate Studies in July 2009. In addition, the Master of Public Health is fully accredited by the Council on Education for Public Health (CEPH).

**Calendar System**

The COM used a semester calendar of non-traditional length Fall 2006 – Spring 2019. First and second medical school years consisted of 35 weeks; the third year was a 12-month calendar; and the fourth medical year included nine elective sections with durations of four weeks each. The COP was on a semester calendar. The first year of coursework was 38 weeks of instruction; second year was 37 weeks; and third year was 36 weeks. The fourth year consisted of ten month long elective sections that were four weeks in duration each. The COGS was on a semester calendar with fall and spring semesters lasting approximately 16 weeks and one condensed summer semester.

Beginning June 1, 2019, all NEOMED colleges moved to a traditional semester calendar system consisting of Summer, Fall, Spring and a Maymester. Clinicals and concurrent courses for the M3, M4 and P4 student cohorts are in a year-long clinical term.

**Prior to June 1, 2019, Contact Hours, Weeks, Months, Points & Credits**

The COM first and second-year courses were recorded in contact hours. Third year and fourth year electives were recorded in weeks and referred to the actual number of weeks spent on a rotation. In the COP, all first, second and third-year courses were recorded in contact hours, fourth-year electives were recorded in months. HVM courses were computed with points. COGS courses remain recorded in semester credit hours. Starting June 1, 2019, all COM and COP courses are recorded in semester credit hours.

**Transcript Authenticity**

Transcripts are printed from our student records system in portrait format. A transcript is official when it bears the facsimile or original signature of the University Registrar displays the University seal and the date of issuance.

**Student Privacy/Release of Information**

"In accordance with the U.S.C. 438 (6)(4)(8) (The Family Educational Rights and Privacy Act of 1974) you are hereby notified that this information is provided upon the condition that you, your agents, or employees will not permit any other party access to this record without the consent of the student. Alterations of this transcript may be a criminal offense" (Rooker et al. 2012, 133).

**Course Numbering System**

*Effective June 1, 2019*

60000 – 69999 Master Level courses

70000 – 89999 Doctoral and Professional Level Courses

*Previous Course Numbering System, June 1, 2005- May 31, 2019*

10000 – 29999 First-year courses College of Medicine

30000 – 39999 Second-year courses College of Medicine

40000 – 49999 Third-year courses College of Medicine

50000 – 59999 Fourth-year courses College of Medicine

*COP also shared integrated courses with COM that begin with numbers 1-5*

61000 – 61999 First year courses College of Pharmacy

62000 – 62999 Second year courses College of Pharmacy

63000 – 63999 Third year courses College of Pharmacy

64000 – 64999 Fourth year courses College of Pharmacy

70000 – 79999 All Courses College of Graduate Studies

**Grading System**

The Colleges of Medicine and Pharmacy use an Honors/Pass/Fail grading System for their courses. The College of Graduate Studies uses letter grades and a Grade Point average (GPA).

Starting June 1, 2019, new COM students will have a Pass/Fail grading system in the M1 and M2 years, the clinical years have an Honors/Pass/Fail grading system. Starting July 13, 2020, the M3 clinical year will have an Honors/High Pass/Pass/Fail grading system.

These are the grade notations currently in use at the University:

AU	Audit	P	Pass
A	Superior Competency (4 points)	T	Transfer Credit
B	Satisfactory Competency (3 points)	W	Withdrawn
C	Fair Competency (2 points)	NG	No Grade Reported
F	Fail (0 points)	NC	No-Credit
H	Honors	F/P	Successfully Remediated
HP	High Pass	F/F	Failed Remediation
AI	Academic Incomplete	F/Z	Successful Re-remediation
I	Incomplete	F/X	Failed Re-remediation
IP	In Progress		

*Other notations prior to COM Class of 2020:*

F/F/P	Successful Re-remediation	F/F/F	Failed Re-remediation
-------	---------------------------	-------	-----------------------

*Other notations prior to COM Class of 2009:*

CM	Commendation	CU	Conditional Unsatisfactory
S	Satisfactory	U	Unsatisfactory

CM (Commendation) was only awarded for third year clerkships; became effective 1996/97 and ended in 2009. Also ending in 2009, CU was a temporary grade; it no longer appears on the official transcript. It served as a temporary designation, assigned in the case of marginal performance, to be adjusted following remediation to either S or U. The CU will only appear on this transcript if the grade was remediated through repetition of the course or if the student withdrew prior to remediation.

**Repeated Courses**

All grades appear on the transcript. If a course was initially failed and then repeated, both the original and the repeated grades will appear. A repeated course was noted as "Repeat" prior to June 1, 2019. In the new academic calendar model, repeated courses will show an "I" after the grade, meaning they are included as a repeated course.

**Withdrawal or Dismissal**

A student's date of withdrawal or dismissal from the University will be noted on the transcript.

**Academic Requirements**

For more information about degree and certificate requirements, please consult [The NEOMED Compass](#), the academic catalog and student handbook resource at [www.neomed.edu/registrar/catalog](http://www.neomed.edu/registrar/catalog).





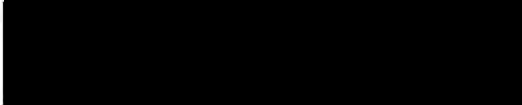
# AMA Physician Profile

PREPARED FOR

Oklahoma State Board of Licensure & Supervision, Oklahoma City, OK

### Name and Mailing Address

SAURAV PRASHANT KADATANE



### Primary Office Address

OU HEALTH SCIENCES CENTER  
DEPT OF UROLOGY  
1200 CHILDRENS AVE  
OKLAHOMA CITY, OK 73104-4637

Phone UNKNOWN

Birth date



PRIMARY SOURCE

Physician's major professional activity

HOSPITAL BASED RESIDENTS - ALL YEARS

AMA membership status

MEMBER

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

OKLAHOMA STATE BOARD OF MEDICAL LICENSURE AND SUPERVISION

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

NPI Number	Enumeration Date	Deactivation Date	Reactivation Date	Replacement Number	Last Reported Date
1609550839	06/08/2023	NOT RPTD	NOT RPTD	NOT RPTD	05/17/2024

### Current and/or historical medical school

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

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

School: NORTHEAST OHIO MEDICAL UNIVERSITY

T41618 SJ



**Degree Awarded:** YES  
**Enrollment Date:** 08/2018

**Degree Type:** MD  
**Degree Date:** 05/2023

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

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

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

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

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

**Sponsoring Institution:** UNIVERSITY OF OKLAHOMA COLLEGE OF MEDICINE  
**Sponsoring State:** OKLAHOMA  
**Program name:** UNIVERSITY OF OKLAHOMA HEALTH SCIENCES CENTER PROGRAM  
**Specialty:** INTERNAL MEDICINE/PEDIATRICS  
**Training Type:** SPECIALTY  
**Dates:** 07/01/2023 - 06/30/2027  
**Status:** TRAINING IN PROGRESS

### Specialty board certification

NO DATA REPORTED AT THIS TIME

### Current and/or historical medical licensure

License Number	MD / DO	Locale	Date Granted	Expiration Date	Renewal Date	Status	License Type	Last Reported	Name on License
41618	MD	OK	07/01/2023	09/30/2024		ACT	RES	05/06/2024	SAURAV PRASHANT KADATANE

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

### Action notifications reported to the AMA

**Medical Licensing Boards:** NO ACTIONS REPORTED AT THIS TIME

**Medicare/Medicaid Sanctions from DHHS:** NO ACTIONS REPORTED AT THIS TIME

**US DOJ Drug Enforcement Administration:** NO ACTIONS REPORTED AT THIS TIME

### U.S. Drug Enforcement Administration (DEA)

NO DATA REPORTED AT THIS TIME

### ECFMG certification

NOT APPLICABLE

### Profile information

The content of the AMA Physician Profile is for credentialing use only. The content cannot be used or assembled for an employment purpose as defined under the Fair Credit Reporting Act. An organization's appropriate use of the data contained in the AMA Physician Professional Data™, formerly known as AMA Physician Masterfile, meets select primary source verification requirements of the Joint Commission, the Accreditation Association for Ambulatory Health Care (AAAHC) and the American Accreditation Health Care Commission (AAHCC)/ Utilization Review Accreditation Commission (URAC). The AMA Physician Professional Data is also an NCQA-approved source for verification of medical school, post-graduate medical training, ABMS Board Certification and federal DEA registration.

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

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



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OKLAHOMA STATE BOARD OF MEDICAL LICENSURE AND SUPERVISION  
EVIDENCE OF STATUS - PART A

OKLAHOMA STATE BOARD OF MEDICAL LICENSURE AND SUPERVISION

NOTARIZED FORM CAN BE EMAILED TO OKTRAINING@OKMEDICALBOARD.ORG

Full Legal Name: SAURAV PRASHANT KADATANE  
First Middle Last Maiden (if applicable)

Mailing Address: [Redacted]  
Street Address or Post Office Box  
[Redacted] Social Security #: [Redacted]  
City State Zip Code Telephone Number

PRIMARY EVIDENCE OF CITIZENSHIP  
(FOR US CITIZENS, US NATIONALS, OR PERMANENT LEGAL RESIDENT ALIENS)

If you are a U.S. citizen, U.S. national, or permanent legal resident alien, please attach a photocopy of one of the following documents to this form. Place a checkmark below to indicate the document that is attached.

- A birth certificate showing birth in one of the 50 States, the District of Columbia, Puerto Rico (on or after January 13, 1941), Guam, the U.S. Virgin Islands (on or after January 17, 1917), American Samoa, Swain's Island or the Northern Mariana Islands, unless the person was born to foreign diplomats residing in the U.S.
- United States passport (except limited passports, which are issued for periods of less than five years)
- Report of birth abroad of a U.S. citizen (FS-240) (issued by the Department of State to U.S. citizens)
- Certificate of birth (FS-545) (issued by a foreign service post) or Certification of Report of Birth (DS1350) (issued by the Department of State), copies available from the Department of State
- Certificate of Naturalization (N-550 or N-570) (issued by the INS through a Federal or State court, or through administrative naturalization after December 1990 to individuals who are individually naturalized; the N570 is a replacement certificate issued when the N-550 has been lost or mutilated or the individual's name has been changed)
- Certificate of Citizenship (N-560 or N-561) (Issued by the INS to individuals who derive U.S. citizenship through a parent; the N-561 is a replacement certificate issued when the N-560 has been lost or mutilated or the individual's name has been changed)
- United States Citizen Identification Card (I-197) (issued by the INS until April 7, 1983 to U.S. citizens living near the Canadian or Mexican border who needed it for frequent border crossing) (formerly Form I-179, last issued in February 1974)
- Northern Mariana Identification Card (issued by the INS to a collectively naturalized citizen of the U.S. who was born in the Northern Mariana Islands before November 3, 1986)
- Statement provided by a U.S. consular officer certifying that the individual is a U.S. citizen (This is given to an individual born outside the U.S. who derives citizenship through a parent but does not have an FS-240, FS-545 or DS-1350);
- American Indian Card with a classification code "KIC" and a statement on the back (identifying U.S. citizen members of the Texas Band of Kickapoos living near the U.S./Mexican border.)
- Alien Lawfully Admitted for Permanent Residence: INS Form I-551 (Alien Registration Receipt Card, commonly known as a "green card")
- Alien Lawfully Admitted for Permanent Residence: Unexpired Temporary I-551 stamp in foreign passport or on INS Form I-94

I declare under penalty of perjury, under the laws of the State of Oklahoma, that all information contained in this application and all accompanying documents provided to substantiate my Evidence of Status application are true and correct.

Signature [Signature] Date 04/26/2023

Subscribed and sworn before me this 26 day of April, 2023.

Notary Public [Signature]

Commission Number 2021-RE-825702

My commission expires 01/25/2026



Tullers

**OKLAHOMA STATE BOARD OF MEDICAL LICENSURE AND SUPERVISION**  
**101 NE 51<sup>ST</sup> STREET**  
**OKLAHOMA CITY OK 73105**  
**Phone: (405)962-1400 Fax: (405)962-1440 email: oktraining@okmedicalboard.org**

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OKLAHOMA STATE BOARD OF  
MEDICAL LICENSURE  
AND SUPERVISION

To Request Examination Scores	
For National Board Scores National Board of Medical Examiners PO Box 48014 Newark, NJ 07101-4814 (215) 590-9500 www.NBME.org	For FLEX or USMLE Scores Federation of State Medical Boards 400 Fuller Wisser Road Euless, TX 76039-3855 (817) 868-4000 www.FSMB.org

6. **Extended Background Check** – Applicants for licensure are required to request an Extended Background Check.
  7. **Evidence of Status Form** - In order to verify citizenship or qualified alien status, applicants for licensure by endorsement or examination or for reinstatement of their license, must submit an Evidence of Status Form and the required supporting documentation with their application. This form must be notarized and mailed to the office.
  8. **Photo and Oath Form** – Applicants for licensure will be required to complete the Photo and Oath Form. This form must be notarized and mailed to the office.
  9. **Telemedicine Form** – Applicants planning to practice telemedicine must submit the initialed and signed Telemedicine Questionnaire.
  10. **English Proficiency Exam** – Foreign applicants shall have a command of the English language that is satisfactory to the Board, demonstrated by the passage of an oral English competency exam. Applicant is required to call 405-962-1400 and speak with an application analyst in licensing.
- G. **Temporary Licensure (59 O.S. § 493.3)** – The Board may authorize the Secretary to issue a Temporary Medical License for the intervals between Board meetings. Such Temporary License shall be granted only when the Secretary is satisfied as to the qualifications of the applicant to be licensed under this Act but where such qualifications have not been verified to the Board. An application for Temporary Licensure must be made by written request and include all appropriate fees. Such a license shall:
1. Be granted only to an applicant demonstrably qualified for a full and unrestricted medical license;
  2. Automatically terminate on the date of the next Board meeting at which the applicant may be considered for a full and unrestricted medical license.
  3. We must be in receipt of the following in order for the Board Secretary to consider issuing a Temporary License:
    - a. Examination scores, and
    - b. Verification of licensure in all jurisdictions in which applicant has been licensed to practice medicine and surgery, and
    - c. Evidence of Status, and
    - d. Extended Background Check

I, the undersigned, have fully read and understand the instructions. I swear or affirm that the information submitted in and with the application is, to the best of my knowledge, true and factual. I understand that attempts to deceive or fraudulently portray information contained herein may result in cancellation of my application or charges of filing a fraudulent application that may result in subsequent revocation of licensure.

SAURAV P. KADATANE      *Saurav P. Kadatane*      04/26/2023  
 Name of Applicant (type or print)      Signature of Applicant      Date

**Except as specifically may be waived by the Board, the Board shall not engage in any application process with any agent or representative of the applicant, 59 O.S. § 492.1 (C); Okla. Admin. Code § 435:10-4-1(c)**

Please return these signed instructions by mail to the address at the top of the page or email.

*Tyler B*



**Kenna L. Shaw**

---

**From:** BillPay Webmaster <donotreply@www.ok.gov>  
**Sent:** Wednesday, May 8, 2024 1:50 PM  
**To:** Dela Kwetey; Bill Pay; Sheila E. Brumfield; Chris Maloney; Licensing; Arlene Morris; Debra Reich  
**Subject:** [EXTERNAL] LICENSE - MD Training-to-Full License Fee 250.00 - Payment Made

SAURAV P KADATANE has paid for a LICENSE - MD Training-to-Full License Fee 250.00 on 05/08/2024 01:05:50pm for \$250.00.

OKLAHOMA MD LICENSE NUMBER 41618

To view all transactions please go to <http://www.ok.gov/triton/> and login to your CMS account.

T 4/16/18  
B

## ATTACHMENT 5

## TIME DEFICIENCY FORM

Name:	SAURAV P. KADATANE	Application #	
-------	--------------------	---------------	--

This document is used a tool to help you complete your application.  
Please note: we have to account for any/all time from your 18th birthday to present.

EDUCATION STARTING WITH HIGH SCHOOL							
Start Month	Start Year	End Month	End Year	Name of Institution	City	State	Degree
Aug	2012	May	2016	Dublin Scioto High School	Dublin	OH	General Diploma
Jun	2016	May	2018	Kent State University	Kent	OH	Bachelor of Science
Aug	2018	May	2023	Northeast Ohio Medical University	Rootstown	OH	Doctor of Medicine
EMPLOYMENT IF NEEDED TO FILL TIME GAP							
Start Month	Start Year	End Month	End Year	Name of Employer	City	State	Job Title
Jun	2019	Aug	2019	Northeast Ohio Medical University	Rootstown	OH	Student Researcher
OTHER - UNEMPLOYED, STAY AT HOME PARENT, SUMMER BREAK, TRAVELING							
Start Month	Start Year	End Month	End Year	Other	City	State	
Jun	2018	Jul	2018	Summer Break	Stow	OH	
Jul	2018	Aug	2018	Volunteer Research	Rootstown	OH	
May	2020	Jul	2020	Summer Break	Stow	OH	
Aug	2020	Jun	2021	Gap Year	Stow	OH	

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OKLAHOMA STATE BOARD OF  
MEDICAL LICENSURE  
AND SUPERVISION

*I need  
Tyler's*



05/02/2023

SAURAV PRASHANT KADATANE  


**Check Your Application  
Status Online at:**  
<http://www.okmedicalboard.org>  
**Username:AP23313337**  
**Password:Last 4 SSN**

RE: MD Application #41618

Dear SAURAV KADATANE,

**YOU CANNOT PRACTICE YOUR PROFESSION IN THE STATE  
OF OKLAHOMA UNTIL A VALID LICENSE HAS BEEN ISSUED.**

Your training application has been processed and the current deficiencies are listed below. Please be advised, these may not be the only deficiencies. You will be advised if any other deficiencies are added. You may check your application status online by logging in with the username and password provided above.

If you have further questions please email  
[oktraining@okmedicalboard.org](mailto:oktraining@okmedicalboard.org)

If a "*Time Deficiency*" is listed, please complete a time deficiency form and e-mail the document to  
[oktraining@okmedicalboard.org](mailto:oktraining@okmedicalboard.org)  
 with your activities during the specified time frame.

USMLE Exams Incomplete  
 Evidence of Status  
 Visa Type (if non-US citizen)  
 Visa Expiration Date (if non-US citizen)  
 Application Instructions  
 OATH  
 Extended Background Check  
 Exam verification date  
 MedSchool-Transcript Northeastern OH Univ Coll of Med & Pharm, Rootstown, OH  
 MedSchool-Form 1 Northeastern OH Univ Coll of Med & Pharm, Rootstown, OH  
 PostGrad - Form 2 COLLEGE OF MEDICINE OKC

Any of the required forms in the list above may be downloaded from our website:

<http://www.okmedicalboard.org/resources>

In order to check on the status of your application, please log on to our web site:

<https://secure.okmedicalboard.org/applicant/signin>

Your user name is AP23313337 (all caps and no spaces) and your password is the last 4 digits of your social security number.

If you did not provide a social security number with your application, your password will be your 4-digit year of birth in the form "YYYY".

If we may be of further assistance, please email.

[oktraining@okmedicalboard.org](mailto:oktraining@okmedicalboard.org)

Sincerely,

**Lisa Cullen**

Lisa Cullen  
Director of Licensing  
Dept. of Licensing

Encl



# Oklahoma State Board of Medical Licensure and Supervision Application Summary

Type	Number	Name
MD	41618	SAURAV PRASHANT KADATANE
MEDICAL DOCTOR		

**Incomplete Information (due to space limitations on this page, this may not be a complete list)**

Exam verification date  
 PostGrad - Form 2 COLLEGE OF MEDICINE OKC  
 USMLE Exams Incomplete

**Last Medical School Attended:**  
 038-44 Northeastern OH Univ Coll of Med & Pharm, Rootstown, OH

**Number of Licenses Previously Granted to Graduates of this Medical School:46**

Application for: **Resident**  Full License  Reinstatement

**The Secretary of the Board has reviewed this application and:**

1) AUTHORIZED CIRCULARIZATION TO OTHER BOARD MEMBERS \_\_\_\_\_

- 2) ALL FIVE CRITERIA HAVE BEEN MET [Fast Track] \_\_\_\_\_
- Passed USMLE
  - No DUIs or Legal Issues
  - No Significant Malpractice Issues
  - US Graduate
  - Graduated Medical School on time

3) HAS ISSUED A TEMPORARY LICENSE THROUGH \_\_\_/\_\_\_/\_\_\_

4) HAS ISSUED A SPECIAL PGY-1 TRAINING LICENSE BY SA 6-28-23

5) REQUESTS SPECIFIC CONSIDERATION OF:

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# Oklahoma State Board of Medical Licensure and Supervision Application Summary

Type	Number	Name
MD	43983	ASHLYN HOPE KAMRATH
MEDICAL DOCTOR		

**Incomplete Information (due to space limitations on this page, this may not be a complete list)**

Exam verification date MedSchool-Transcript Univ Of ND Sch Of Med and Hlth Sci, Grand Forks Nd 58201 USMLE Exams Incomplete
---

<b>Last Medical School Attended:</b> 037-01 Univ Of ND Sch Of Med and Hlth Sci, Grand Forks Nd 58201  <p style="text-align: right;"><b>Number of Licenses Previously Granted to Graduates of this Medical School:66</b></p>
--

Application for: Resident \_\_\_\_\_ Full License \_\_\_\_\_ Reinstatement \_\_\_\_\_

**The Secretary of the Board has reviewed this application and:**

1) AUTHORIZED CIRCULARIZATION TO OTHER BOARD MEMBERS \_\_\_\_\_

2) ALL FIVE CRITERIA HAVE BEEN MET [Fast Track] \_\_\_\_\_

- Passed USMLE
- No DUIs or Legal Issues
- No Malpractice Issues
- US Graduate
- Graduated Medical School in 4 years or less

3) HAS ISSUED A TEMPORARY LICENSE THROUGH \_\_\_\_ / \_\_\_\_ / \_\_\_\_

4) HAS ISSUED A SPECIAL PGY-1 TRAINING LICENSE \_\_\_\_\_



# Oklahoma State Board of Medical Licensure and Supervision

## Application Summary

**Type**    **Number**    **Name**  
 MD            43983    ASHLYN HOPE KAMRATH  
 MEDICAL DOCTOR

**Practice Address:**  
 June 10, 2024

**Status:**

**Res:** MD

**Received:** 06/09/2024

**Entered:** 06/09/2024

**Temp Issued:**

**Temp Expires:**

**Train Issued:**

**Train Expires:**

**Fed Rec:** 06/10/2024

**AMA Rec:** 06/10/2024

**Board Action:**

**License #:** 43983

**Sex:** F

**Ethnic Origin:** 1

**Endorsed By:** USMLE

	Test	Score	Date Taken	Date Verified	Attempts
	Test 1:	USMLE			
	Test 2:	Note: <i>PASS</i> means higher than 75			
	Test 3:				
	Test AV:				
	Total Possible:				
	Okla Passing:				
	Total Score:				

### PRE-MED EDUCATION

**School Name:** NORTH DAKOTA STATE UNIVERSITY

**City:** FARGO

**State:** ND **Country:** UNITED STATES

**Degree:** BACHELORS OF SCIENCE IN EXERCISE SCIENCE, MINOR IN CHEMISTRY

**From:** 8/2012 **To:** 5/2016 **Verified:**

**School Name:** LAKOTA HIGH SCHOOL

**City:** LAKOTA

**State:** ND **Country:** UNITED STATES

**Degree:** HIGH SCHOOL DIPLOMA

**From:** 8/2008 **To:** 5/2012 **Verified:**

### MEDICAL SCHOOL EDUCATION

**Name:** Univ Of ND Sch Of Med and Hlth Sci, Grand Forks Nd 58201

**Foreign Name:**

**City:** Grand Forks

**State/Country:** United States of America

**Degree:** DOCTOR OF MEDICINE

**From:** 8 / 2016

**To:** 5 / 2020

**Diploma Ver'd:**

Y

## Oklahoma State Board of Medical Licensure and Supervision Application Summary

**Type**    **Number**    **Name**  
 MD        43983    ASHLYN HOPE KAMRATH  
 MEDICAL DOCTOR

### POST GRADUATE EDUCATION

<b>Facility:</b> COLLEGE OF MEDICINE TULSA	<b>Specialty:</b> OBSTETRICS/GYNECOLOGY
<b>Res. Fellowship:</b> Residency	
<b>City:</b> TULSA	<b>State:</b> OK <b>Country:</b> UNITED STATES
<b>Verified:</b> Waived	<b>From:</b> 7 / 2024 <b>To:</b> /
<b>ACGME Ver'd:</b> Waived	
<b>Comments:</b> ELIGIBLE FOR FULL LICENSURE (LKC)	
<b>Facility:</b> ALTRU FAMILY MEDICINE RESIDENCY	<b>Specialty:</b> FAMILY MEDICINE SURGICAL OBSTETRICS
<b>Res. Fellowship:</b> Fellowship	
<b>City:</b> GRAND FORKS	<b>State:</b> ND <b>Country:</b> UNITED STATES OF AM
<b>Verified:</b> 06/10/2024	<b>From:</b> 7 / 2023 <b>To:</b> 7 / 2024
<b>ACGME Ver'd:</b>	
<b>Comments:</b> NON ACGME ACCREDITED FELLOWSHIP. CURRENTLY IN PROGRAM. WILL COMPLETE ON 7/7/2024.	
<b>Facility:</b> ALTRU FAMILY MEDICINE RESIDENCY	<b>Specialty:</b> FAMILY MEDICINE
<b>Res. Fellowship:</b> Residency	
<b>City:</b> GRAND FORKS	<b>State:</b> ND <b>Country:</b> UNITED STATES OF AM
<b>Verified:</b> 06/10/2024	<b>From:</b> 6 / 2020 <b>To:</b> 6 / 2023
<b>ACGME Ver'd:</b> 06/10/2024	
<b>Comments:</b>	

### PRACTICE HISTORY

<b>Employed:</b>	<b>Supervisor:</b>
<b>City:</b>	<b>State:</b> <b>Country:</b>
<b>Specialty:</b>	<b>From:</b> / <b>To:</b> / <b>Verified:</b>
<b>Comments:</b>	

#### Other Licenses

State	Lic Type and Number	Status	Issued	Exp	Verif
ND	MD 19653	A	4/28/23	11/29/25	6/10/24
ND	MD RL16602	I	7/1/20	7/1/20	6/10/24

#### DEFICIENCIES

Exam verification date  
 MedSchool-Transcript Univ Of ND Sch Of Med and Hlth Sci, Grand Forks Nd 58201  
 USMLE Exams Incomplete



# Oklahoma State Board of Medical Licensure and Supervision

APPLICATION FOR OKLAHOMA MEDICAL DOCTOR LICENSE

PAGE 376 of 500

Received:06/09/2024

Applicant Name: KAMRATH, ASHLYN HOPE - Nelson

MD 43983

[REDACTED]

[REDACTED]

Date Of Birth: [REDACTED]

Place Of Birth (City, State): GRAND FORKS, ND

Sex: F

Race: Caucasian

Education									
Type	Name	City	ST	Country	From	To	Degree	Comments	Veri
UG	NORTH DAKOTA STATE UNIVERSITY	FARGO	ND		8/2012	5/2016	BACHELORS OF SCIENCE IN EXERCISE SCIENCE, MINOR IN CHEMISTRY		

Medical School Name	City	State	Country	Comments	From	To
Univ Of ND Sch Of Med and Hlth Sci, Grand Forks Nd 58201	Grand Forks	ND	United States		8/2016	5/2020

Post-Graduate						
Facility	City	St	Country	Specialty	Comments	From To
ALTRU FAMILY MEDICINE RESIDENCY	GRAND FORKS	ND	UNITED S	FAMILY MEDICINE SURGICAL OBSTETRICS		7/2023 7/2024
ALTRU FAMILY MEDICINE RESIDENCY	GRAND FORKS	ND	UNITED S	FAMILY MEDICINE		6/2020 6/2023

Practice History							
Employer	Specialty	Supervisor	City	ST	Countr	From	To Verif
/							

Other/ Out-Of-State Licenses					
State	License #	Profession	Status	Issue Date	Exp Date
ND	19653		U	11/30/23	11/29/25

MD Exam				
Exam	State	Score	Date Taken	#
USMLE				

*8000*  
*5*

# Oklahoma State Board of Medical Licensure and Supervision

## APPLICATION FOR OKLAHOMA MEDICAL DOCTOR LICENSE

PAGE 377 of 500

Received:06/09/2024

### Questions Answered 06/08/2024

	Response
A. Have you ever been denied provider participation, terminated, sanctioned, or penalized by any third-party payor, to include TRICARE, MEDICARE, MEDICAID?	N
B. Have you ever surrendered a license or had any adverse action taken against any narcotic permit (state or federal)?	N
C. Have you ever been denied membership or had disciplinary action taken by a national, state or county professional organization?	N
D. Have you ever been denied or had removed or suspended hospital staff privileges?	N
E. Have you ever surrendered hospital staff privileges while under investigation or to avoid investigation?	N
F. Have you ever entered into an agreement with a federal, state or local jurisdictional body to avoid formal action?	N
G. Have you ever been the subject of an investigation, probation or disciplinary action by a hospital, clinic, practice group, or training program?	N
H. Have you had any adverse judgment, settlement, or award against you arising from a professional liability claim?	N
I. Have you ever had professional liability coverage declined, canceled, issued on special terms, or renewal refused?	N
J. Have you been reported to the National Practitioner Data Bank (NPDB)?	N
K. Has your application for a professional license been denied?	N
M. Have you surrendered a license or had a license revoked?	N
N. Has any disciplinary action been taken on any license?	N
O. Have you been the subject of a review by a professional licensing/regulatory agency, other than the Oklahoma State Board, based on a complaint filed against you?	N
P. Have you ever been arrested or convicted of a felony or misdemeanor, or are charges currently pending against you?	N
U. Are you or your spouse currently on Active Duty in the U.S. Armed Forces?	N
V. Are you or your spouse currently Deployed on Active Duty in the U.S. Armed Forces?	N



Oklahoma State Board of Medical Licensure and Supervision

APPLICATION FOR OKLAHOMA MEDICAL DOCTOR LICENSE

PAGE 378 of 500

Received:06/09/2024

If licensed, where do you intend to locate?

OK

Why do you seek Licensure in the state of Oklahoma?

Post-Graduate Training

In what manner will you be communicating with your Oklahoma patients (telephone, email, internet, video-conference, etc)?

Describe how you will examine each patient in person prior to diagnosis, treating, correcting, or prescribing for a patient in Oklahoma from the state, province, or country you are located:

Describe the manner in which you intend to practice medicine across state lines in Oklahoma:

Have you executed or been offered a contract in connection with practice in the state of Oklahoma?

Yes

If 'Yes', Name of practice:

University of Oklahoma School of Community Medicine Department of Obstetrics and Gynecology

If so, Please identify with which category:

Residency

Name of Previous Carrier and Policy Holder

Vaaler Insurance, COPIC Insurance Company; Altru Health System; Ashlyn Kamrath MD

Name of Current Carrier and policy Holder

University of Oklahoma School of Community Medicine Department of Obstetrics and Gynecology

Will your professional liability insurance policy cover your practice in Oklahoma

Yes

If NO, when do you expect to obtain liability insurance that will cover practice in Oklahoma

I attest that all the above information is accurate as of June 08, 2024: \_\_\_\_\_ (Signed Online) \_\_\_\_\_



Applicant: In the presence of a notary public, sign this form with attached photo.

Send this form to: Oklahoma State Board of Medical Licensure and Supervision

**OKTRAINING@okmedicalboard.org**

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

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

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

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

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

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



*[Handwritten Signature]*

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

*Kamrath, Ashlyn Hope*

Applicants printed last name, first name, middle initial, and suffix (e.g., Jr.)

*6/9/2024*

Date of signature (must correspond to the date of notarization)

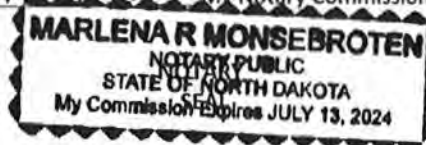
**NOTARY**

State of North Dakota, County of Grand Forks

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

The statements on this document are subscribed and sworn to before me by the applicant on this 9<sup>th</sup> day of June, 20 24

Notary Public Signature *Marlena R Monsebroten* My Notary Commission Expires July 13, 2024



RECEIVED 6/10/2024  
T43983  
SJ



Form 1 (MD)

Oklahoma State Board of Medical Licensure and Supervision  
101 NE 51<sup>st</sup> Street Oklahoma City, OK 73105 ~ (405) 962-1470

PRIMARY  
SOURCE

Email form to: [OKTRAINING@okmedicalboard.org](mailto:OKTRAINING@okmedicalboard.org)

*This form must be completed by the institution and sent directly from the institution.*

Applicant's Name Ashlyn Kamrath

Institution: University of North Dakota School of Medicine City/State Grand Forks, ND

Our records indicate that the above named applicant attended your medical school on the following dates:

From 08/01/2010 To 5/10/2020  
Month Day Year Month Day Year

Awarded degree of Doctor of Medicine on 5/10/2020  
Month Day Year

- 1. Does this individual's official record reflect (an) interruption(s) or extension(s) in his/her medical education? If yes, please explain.  YES  NO
- 2. Does this individual's official record reflect that he/she was ever placed on academic or disciplinary probation during his/her medical education? If yes, please explain.  YES  NO
- 3. Does this individual's official record reflect that he/she was ever the subject of negative reports for behavioral reasons or an investigation by the medical school or parent university? If yes, please explain below.  YES  NO
- 4. Does this individual's official record reflect that he/she was ever disciplined for unprofessional conduct/behavioral reasons by the medical school or parent university? If yes, please explain below.  YES  NO
- 5. Does this individual's official record reflect that there were any limitations or special requirements imposed on the individual because of questions of academic incompetence, disciplinary problems, or any other reason? If yes, please explain below.  YES  NO

Please explain any "YES" response from above: \_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

Completion of the following is certification that the information above is an accurate account of this individual's records and are true and correct.

Name: Mandi Eckman Signature: Mandi Eckman  
Title of Signatory: Grade & Enrollment Coordinator Signature Date: 6/11/24  
Phone: 701-777-2840 Fax: 701-777-4942 E-Mail: mandi.eckman@und.edu



Oklahoma State Board of Medical Licensure and Supervision  
101 NE 51<sup>st</sup> Street Oklahoma City, OK 73105 ~ (405) 962-1470

PRIMARY  
SOURCE

Email form to: OKTRAINING@okmedicalboard.org

**This form must be completed and sent directly to the Board by the training institution**

Verification of Graduate Medical Education

Applicant's Name Ashlyn Kamrath

Institution: Altru Family Medicine Residency City/State Grand Forks, ND

Training Level: (e.g. 1, 2, 3, etc.)	Specialty/Subspecialty	Family Medicine	From: <u>06/29/2020</u>	To: <u>06/25/2023</u>
<input type="checkbox"/> Internship	<input checked="" type="checkbox"/> Residency	<input type="checkbox"/> Chief Residency	<input type="checkbox"/> Fellowship	<input type="checkbox"/> Research
Accredited By:	<input checked="" type="checkbox"/> ACGME	<input type="checkbox"/> LCGME	<input type="checkbox"/> RSC	<input type="checkbox"/> CFPC
	<input type="checkbox"/> RCPSC	<input type="checkbox"/> None of these		
Successfully Completed?			<input checked="" type="checkbox"/> YES	<input type="checkbox"/> NO
			<input type="checkbox"/> IN PROGRESS	

Training Level: (e.g. 1, 2, 3, etc.)	Specialty/Subspecialty	Family Medicine Surgical Obstetrics	From: <u>07/10/2023</u>	To: <u>07/07/2024</u>
<input type="checkbox"/> Internship	<input type="checkbox"/> Residency	<input type="checkbox"/> Chief Residency	<input checked="" type="checkbox"/> Fellowship	<input type="checkbox"/> Research
Accredited By:	<input type="checkbox"/> ACGME	<input type="checkbox"/> LCGME	<input type="checkbox"/> RSC	<input type="checkbox"/> CFPC
	<input type="checkbox"/> RCPSC	<input checked="" type="checkbox"/> None of these		
Successfully Completed?			<input checked="" type="checkbox"/> YES	<input type="checkbox"/> NO
			<input checked="" type="checkbox"/> IN PROGRESS	


Training Level: (e.g. 1, 2, 3, etc.)	Specialty/Subspecialty		From: / /	To: / /
<input type="checkbox"/> Internship	<input type="checkbox"/> Residency	<input type="checkbox"/> Chief Residency	<input type="checkbox"/> Fellowship	<input type="checkbox"/> Research
Accredited By:	<input type="checkbox"/> ACGME	<input type="checkbox"/> LCGME	<input type="checkbox"/> RSC	<input type="checkbox"/> CFPC
	<input type="checkbox"/> RCPSC	<input type="checkbox"/> None of these		
Successfully Completed?			<input type="checkbox"/> YES	<input type="checkbox"/> NO
			<input type="checkbox"/> IN PROGRESS	

Training Level: (e.g. 1, 2, 3, etc.)	Specialty/Subspecialty		From: / /	To: / /
<input type="checkbox"/> Internship	<input type="checkbox"/> Residency	<input type="checkbox"/> Chief Residency	<input type="checkbox"/> Fellowship	<input type="checkbox"/> Research
Accredited By:	<input type="checkbox"/> ACGME	<input type="checkbox"/> LCGME	<input type="checkbox"/> RSC	<input type="checkbox"/> CFPC
	<input type="checkbox"/> RCPSC	<input type="checkbox"/> None of these		
Successfully Completed?			<input type="checkbox"/> YES	<input type="checkbox"/> NO
			<input type="checkbox"/> IN PROGRESS	

- Did this individual ever take a leave of absence or break from his/her training?  YES  NO
- Was this individual ever placed on probation?  YES  NO
- Was this individual ever disciplined or placed under investigation?  YES  NO
- Were there any negative reports for behavioral reasons ever filed by instructors?  YES  NO
- Were any limitations or special requirements placed upon this individual because of questions of academic incompetence, disciplinary problems or any other reason?  YES  NO

Please attach separate document for "YES" response(s) from above

Completion of the following is certification that the information above is an accurate account of this individual's records and is true and correct. The signature line must contain the original signature of the program director (M.D./D.O. only)

Name: Heidi Philpot, MD Signature: 

Title of Signatory: Program Director Signature Date: 6/10/24

Phone: 701-780-6810 Fax: 701-780-4579 E-Mail: hphilpot@altru.org





# AMA Physician Profile

PREPARED FOR

Oklahoma State Board of Licensure & Supervision, Oklahoma City, OK

**Name and Mailing Address**

ASHLYN HOPE KAMRATH



**Birth date**



**Primary Office Address**

725 HAMLIN ST  
GRAND FORKS, ND 58203-2819

**Phone** UNKNOWN

RECEIVED  
JUN 10 2024

OKLAHOMA STATE BOARD OF  
MEDICAL LICENSURE  
AND SUPERVISION

PRIMARY  
SOURCE

**Physician's major professional activity**

HOSPITAL BASED RESIDENTS - ALL YEARS

**AMA membership status**

NON MEMBER

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

---

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

NPI Number	Enumeration Date	Deactivation Date	Reactivation Date	Replacement Number	Last Reported Date
1922628551	04/23/2020	NOT RPTD	NOT RPTD	NOT RPTD	05/17/2024

**Current and/or historical medical school**

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

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

**School:** UNIVERSITY OF NORTH DAKOTA SCHOOL OF MEDICINE & HEALTH SCIENCES

**Degree Awarded:** YES

**Degree Type:** MD

143983  
SD



**Enrollment Date:** 08/2016

**Degree Date:** 05/2020

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

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

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

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

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

**Sponsoring Institution:** ALTRU HEALTH SYSTEM HOSPITAL  
**Sponsoring State:** NORTH DAKOTA  
**Program name:** ALTRU HEALTH SYSTEM (GRAND FORKS) PROGRAM  
**Specialty:** FAMILY MEDICINE  
**Training Type:** SPECIALTY  
**Dates:** 06/29/2020 - 06/30/2023  
**Status:** COMPLETED

### Specialty board certification

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

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

**Certifying board:** AMERICAN BOARD OF FAMILY MEDICINE





Certificate: FAMILY MEDICINE  
 Certificate type: GENERAL

Duration	Status	Effective Date	Expiration Date	Reverify Date	Occurrence	Last Reported	Participating in MOC
MOC <sup>+</sup>	Active	06/29/2023	n/a	02/15/2025	INITIAL	06/04/2024	Y

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

*This information is proprietary data maintained in a copyrighted database compilation owned by the American Board of Medical Specialties (ABMS). Copyright 2024 American Board of Medical Specialties. All rights reserved.*

*+The above certifying board has implemented standards which specify that the board certification is contingent upon meeting ongoing requirements of Maintenance of Certification (MOC). Only certificates issued by a MOC participating board will reflect a reverification date.*

#### Current and/or historical medical licensure

License Number	MD/DO	Locale	Date Granted	Expiration Date	Renewal Date	Status	License Type	Last Reported	Name on License
19653	MD	ND	04/28/2023	11/29/2025	11/29/2025	ACT	UNL	06/04/2024	Ashlyn Hope Kamrath

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

#### Action notifications reported to the AMA

**Medical Licensing Boards: NO ACTIONS REPORTED AT THIS TIME**

**Medicare/Medicaid Sanctions from DHHS: NO ACTIONS REPORTED AT THIS TIME**

**US DOJ Drug Enforcement Administration: NO ACTIONS REPORTED AT THIS TIME**

#### U.S. Drug Enforcement Administration (DEA)

DEA Number*	Business Activity†	Drug Schedule	Activity	Expiration Date	Payment Indicator	Last Reported	Address
-----771	C-0	22N 33N 4 5	Active	12/31/2025	Paid	05/30/2024	725 Hamline St



DEA Number*	Business Activity†	Drug Schedule	Activity	Expiration Date	Payment Indicator	Last Reported	Address
-------------	--------------------	---------------	----------	-----------------	-------------------	---------------	---------

Grand Forks, ND 58203-2819

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

† Business Activity key: C-0 = Practitioner, C-2 = Practitioner–Military, C-7 = Practitioner–Department of Defense Contractor, C-Q = Practitioner–Federal

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

### ECFMG certification

NOT APPLICABLE

### Profile information

The content of the AMA Physician Profile is for credentialing use only. The content cannot be used or assembled for an employment purpose as defined under the Fair Credit Reporting Act. An organization's appropriate use of the data contained in the AMA Physician Professional Data™, formerly known as AMA Physician Masterfile, meets select primary source verification requirements of the Joint Commission, the Accreditation Association for Ambulatory Health Care (AAAHC) and the American Accreditation Health Care Commission (AAHCC)/ Utilization Review Accreditation Commission (URAC). The AMA Physician Professional Data is also an NCQA-approved source for verification of medical school, post-graduate medical training, ABMS Board Certification and federal DEA registration.

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

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



OKLAHOMA STATE BOARD OF MEDICAL LICENSURE AND SUPERVISION  
EVIDENCE OF STATUS – PART A

NOTARIZED FORM CAN BE EMAILED TO OKTRAINING@OKMEDICALBOARD.ORG

Full Legal Name: Ashlyn Hope Kamrath Nelson  
Mailing Address: [Redacted]  
City State Zip Code Telephone Number Social Security #: [Redacted]

PRIMARY EVIDENCE OF CITIZENSHIP  
(FOR US CITIZENS, US NATIONALS, OR PERMANENT LEGAL RESIDENT ALIENS)

If you are a U.S. citizen, U.S. national, or permanent legal resident alien, please attach a photocopy of one of the following documents to this form. Place a checkmark below to indicate the document that is attached.

- A birth certificate showing birth in one of the 50 States, the District of Columbia, Puerto Rico (on or after January 13, 1941), Guam, the U.S. Virgin Islands (on or after January 17, 1917), American Samoa, Swain’s Island or the Northern Mariana Islands, unless the person was born to foreign diplomats residing in the U.S.
United States passport (except limited passports, which are issued for periods of less than five years)
Report of birth abroad of a U.S. citizen (FS-240) (issued by the Department of State to U.S. citizens)
Certificate of birth (FS-545) (issued by a foreign service post) or Certification of Report of Birth (DS1350) (issued by the Department of State), copies available from the Department of State
Certificate of Naturalization (N-550 or N-570) (issued by the INS through a Federal or State court, or through administrative naturalization after December 1990 to individuals who are individually naturalized; the N570 is a replacement certificate issued when the N-550 has been lost or mutilated or the individual’s name has been changed)
Certificate of Citizenship (N-560 or N-561) (issued by the INS to individuals who derive U.S. citizenship through a parent; the N-561 is a replacement certificate issued when the N-560 has been lost or mutilated or the individual’s name has been changed)
United States Citizen Identification Card (I-197) (issued by the INS until April 7, 1983 to U.S. citizens living near the Canadian or Mexican border who needed it for frequent border crossing) (formerly Form I-179, last issued in February 1974)
Northern Mariana Identification Card (issued by the INS to a collectively naturalized citizen of the U.S. who was born in the Northern Mariana Islands before November 3, 1986)
Statement provided by a U.S. consular officer certifying that the individual is a U.S. citizen (This is given to an individual born outside the U.S. who derives citizenship through a parent but does not have an FS-240, FS-545 or DS-1350);
American Indian Card with a classification code “KIC” and a statement on the back (identifying U.S. citizen members of the Texas Band of Kickapoos living near the U.S./Mexican border.)
Alien Lawfully Admitted for Permanent Residence:
INS Form I-551 (Alien Registration Receipt Card, commonly known as a “green card”)
Alien Lawfully Admitted for Permanent Residence:
Unexpired Temporary I-551 stamp in foreign passport or on INS Form I-94

I declare under penalty of perjury, under the laws of the State of Oklahoma, that all information contained in this application and all accompanying documents provided to substantiate my Evidence of Status application are true and correct.

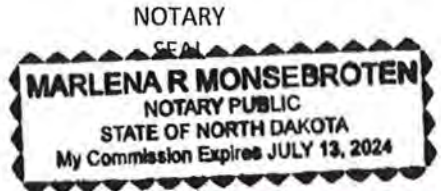
Signature [Signature] Date 6/9/2024

Subscribed and sworn before me this 9th day of June, 2024

Notary Public [Signature]

Commission Number

My commission expires July 13, 2024



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T43983  
SJ

## TIME DEFICIENCY FORM

<b>Name:</b> Ashlyn Kamrath	<b>Application #</b> 412368
-----------------------------	-----------------------------

This document is used a tool to help you complete your application.  
Please note: we have to account for any/all time from your 18th birthday to present.

EDUCATION STARTING WITH HIGH SCHOOL							
Start Month	Start Year	End Month	End Year	Name of Institution	City	State	Degree
08	2008	05	2012	Lakota High School	Lakota	ND	High School Diploma
08	2012	05	2016	North Dakota State University	Fargo	ND	Bachelors of Science
08	2016	05	2020	University of North Dakota School of Medicine	Grand Forks	ND	Medical Degree
06	2020	06	2023	Altru Family Medicine Residency	Grand Forks	ND	Family Medicine
07	2023	07	2024	Altru Family Medicine Surgical Obstetrics	Grand Forks	ND	OB Fellow
EMPLOYMENT IF NEEDED TO FILL TIME GAP							
Start Month	Start Year	End Month	End Year	Name of Employer	City	State	Job Title
05	2016	08	2016	Achieve Therapy	Grand Forks	ND	Exercise Scientist
OTHER - UNEMPLOYED, STAY AT HOME PARENT, SUMMER BREAK, TRAVELING							
Start Month	Start Year	End Month	End Year	Other	City	State	
05	2012	08	2012	Summer Break	Lakota	ND	

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T43983  
SJ



OKLAHOMA STATE BOARD OF MEDICAL LICENSURE AND SUPERVISION  
101 NE 51<sup>ST</sup> STREET  
OKLAHOMA CITY OK 73105  
Phone: (405)962-1400 Email: OKTRAINING@okmedicalboard.org

To Request Examination Scores	
For National Board Scores National Board of Medical Examiners PO Box 48014 Newark, NJ 07101-4814 (215) 590-9500 www.NBME.org	For FLEX or USMLE Scores Federation of State Medical Boards 400 Fuller Wisser Road Euless, TX 76039-3855 (817) 868-4000 www.FSMB.org

6. **Extended Background Check** – Applicants for licensure are required to request an Extended Background Check.
  7. **Evidence of Status Form** - In order to verify citizenship or qualified alien status, applicants for licensure by endorsement or examination or for reinstatement of their license, must submit an Evidence of Status Form and the required supporting documentation with their application. This form must be notarized and mailed to the office.
  8. **Photo and Oath Form** – Applicants for licensure will be required to complete the Photo and Oath Form. This form must be notarized and mailed to the office.
  9. **Telemedicine Form** – Applicants planning to practice telemedicine must submit the initialed and signed Telemedicine Questionnaire.
  10. **English Proficiency Exam** – Foreign applicants shall have a command of the English language that is satisfactory to the Board, demonstrated by the passage of an oral English competency exam. Applicant is required to call 405-962-1400 and speak with an application analyst in licensing.
- G. **Temporary Licensure (59 O.S. § 493.3)** – The Board may authorize the Secretary to issue a Temporary Medical License for the intervals between Board meetings. Such Temporary License shall be granted only when the Secretary is satisfied as to the qualifications of the applicant to be licensed under this Act but where such qualifications have not been verified to the Board. An application for Temporary Licensure must be made by written request and include all appropriate fees. Such a license shall:
1. Be granted only to an applicant demonstrably qualified for a full and unrestricted medical license;
  2. Automatically terminate on the date of the next Board meeting at which the applicant may be considered for a full and unrestricted medical license.
  3. We must be in receipt of the following in order for the Board Secretary to consider issuing a Temporary License:
    - a. Examination scores, and
    - b. Verification of licensure in all jurisdictions in which applicant has been licensed to practice medicine and surgery, and
    - c. Evidence of Status, and
    - d. Extended Background Check

I, the undersigned, have fully read and understand the instructions. I swear or affirm that the information submitted in and with the application is, to the best of my knowledge, true and factual. I understand that attempts to deceive or fraudulently portray information contained herein may result in cancellation of my application or charges of filing a fraudulent application that may result in subsequent revocation of licensure.

Ashlyn Kamrath  
Name of Applicant (type or print) \_\_\_\_\_  
  
Signature of Applicant \_\_\_\_\_  
06/07/2024  
Date \_\_\_\_\_

**Except as specifically may be waived by the Board, the Board shall not engage in any application process with any agent or representative of the applicant. 59 O.S. § 492.1 (C); Okla. Admin. Code § 435:10-4-1(c)**

Please return these signed instructions by email to the address at the top of the page.

06/11/2024

ASHLYN HOPE KAMRATH  


RE: MD Application #43983

**Check Your Application  
Status Online at:**  
<http://www.okmedicalboard.org>  
**Username:AP62860251**  
**Password:Last 4 SSN**

Dear ASHLYN KAMRATH,

**YOU CANNOT PRACTICE YOUR PROFESSION IN THE STATE  
OF OKLAHOMA UNTIL A VALID LICENSE HAS BEEN ISSUED.**

Your training application has been processed and the current deficiencies are listed below. Please be advised, these may not be the only deficiencies. You will be advised if any other deficiencies are added. You may check your application status online by logging in with the username and password provided above.

If you have further questions please email  
[oktraining@okmedicalboard.org](mailto:oktraining@okmedicalboard.org)

If a "Time Deficiency" is listed, please complete a time deficiency form and e-mail the document to  
[oktraining@okmedicalboard.org](mailto:oktraining@okmedicalboard.org)  
with your activities during the specified time frame.

OTHER DEFICIENCIES: FCVS  
Exam verification date  
MedSchool-Transcript Univ Of ND Sch Of Med and Hlth Sci, Grand Forks Nd 58201  
MedSchool-Form 1 Univ Of ND Sch Of Med and Hlth Sci, Grand Forks Nd 58201  
USMLE Exams Incomplete

Any of the required forms in the list above may be downloaded from our website:

<http://www.okmedicalboard.org/resources>



In order to check on the status of your application, please log on to our web site:

<https://secure.okmedicalboard.org/applicant/signin>

Your user name is AP62860251 (all caps and no spaces) and your password is the last 4 digits of your social security number.

If you did not provide a social security number with your application, your password will be your 4-digit year of birth in the form "YYYY".

If we may be of further assistance, please email.

[oktraining@okmedicalboard.org](mailto:oktraining@okmedicalboard.org)

Sincerely,

*Seema Jayachand*

Seema Jayachand

Dept. of Licensing

Encl

# Oklahoma State Board of Medical Licensure and Supervision

## Application Summary

Type	Number	Name
MD	41486	BRANDON LAKE KANNADY
MEDICAL DOCTOR		

**Incomplete Information (due to space limitations on this page, this may not be a complete list)**

OTHER DEFICIENCIES: NEED FORM 2 AND EVAL UPON COMPLETION OF TRAINING, MUST COME DIRECTLY FROM YOUR PROGRAM  
 PostGrad - Form 2 COLLEGE OF MEDICINE OKC

**Last Medical School Attended:**

019-02 Univ Of KS Sch Of Med, Kansas City Ks 66103

**Number of Licenses Previously Granted to Graduates of this Medical School:679**

Application for: Resident \_\_\_\_\_ Full License \_\_\_\_\_ Reinstatement \_\_\_\_\_

**The Secretary of the Board has reviewed this application and:**

- 1) AUTHORIZED CIRCULARIZATION TO OTHER BOARD MEMBERS \_\_\_\_\_
- 2) ALL FIVE CRITERIA HAVE BEEN MET [Fast Track] \_\_\_\_\_
  - Passed USMLE
  - No DUIs or Legal Issues
  - No Malpractice Issues
  - US Graduate
  - Graduated Medical School in 4 years or less
- 3) HAS ISSUED A TEMPORARY LICENSE THROUGH \_\_\_\_ / \_\_\_\_ / \_\_\_\_
- 4) HAS ISSUED A SPECIAL PGY-1 TRAINING LICENSE \_\_\_\_\_



# Oklahoma State Board of Medical Licensure and Supervision

## Application Summary

**Type**    **Number**    **Name**  
 MD            41486    BRANDON LAKE KANNADY  
 MEDICAL DOCTOR

**Practice Address:**  
 May 03, 2023

**Status:**

Res: TR

Received: 04/11/2023

Entered: 04/11/2023

Temp Issued:

Temp Expires:

Train Issued: 07/01/2023

Train Expires: 09/30/2024

Fed Rec: 05/10/2024

AMA Rec: 05/10/2024

Board Action:

License #: 41486

Sex: M

Ethnic Origin: 1

**Endorsed By:** USMLE

	Test	Score	Date Taken	Date Verified	Attempts
<b>Test 1:</b>	USMLE 3	PASS	01/19/24	4/15/24	1
<b>Test 2:</b>	USMLE 1	PASS	5/13/21	5/10/23	1
<b>Test 3:</b>	USMLE 2	PASS	6/17/22	5/10/23	1
Note: <b>PASS</b> means higher than 75					
<b>Test AV:</b>					
<b>Total Possible:</b>					
<b>Okla Passing:</b>					
<b>Total Score:</b>					

### PRE-MED EDUCATION

**School Name:** UNIVERSITY OF KANSAS

**City:** LAWRENCE

**State:** KS    **Country:** UNITED STATES

**Degree:** BACHELOR??S OF SCIENCE

**From:** 8/2015    **To:** 12/2018    **Verified:**

**School Name:** BLUE VALLEY NORTH HIGH SCHOOL

**City:** LEAWOOD

**State:** KS    **Country:** UNITED STATES

**Degree:** DIPLOMA

**From:** 4/2015    **To:** 5/2015    **Verified:**

### MEDICAL SCHOOL EDUCATION

**Name:** Univ Of KS Sch Of Med, Kansas City Ks 66103

**Foreign Name:**

**City:** Kansas City

**State/Country:** United States of America

**Degree:** M.D.

**From:** 7 / 2019

**To:** 5/ 2023

**Diploma Ver'd:**

Y

# Oklahoma State Board of Medical Licensure and Supervision

## Application Summary

<b>Type</b>	<b>Number</b>	<b>Name</b>
MD	41486	BRANDON LAKE KANNADY
MEDICAL DOCTOR		

POST GRADUATE EDUCATION			
<b>Facility:</b> COLLEGE OF MEDICINE OKC		<b>Specialty:</b> UROLOGY	
<b>Res. Fellowship:</b> Residency			
<b>City:</b> OKLAHOMA CITY		<b>State:</b> OK	<b>Country:</b> UNITED STATES OF AM
<b>Verified:</b>	<b>From:</b> 7 / 2023	<b>To:</b> /	
<b>ACGME Ver'd:</b>			
<b>Comments:</b>			

PRACTICE HISTORY			
<b>Employed:</b> JOYRUN		<b>Supervisor:</b>	
<b>City:</b> LAWRENCE		<b>State:</b> KS	<b>Country:</b> UNITED STATES
<b>Specialty:</b> DELIVERY		<b>From:</b> 12 / 2018	<b>To:</b> 5 / 2019
<b>Comments:</b>		<b>Verified:</b>	

Other Licenses				
State	Lic Type and Number	Status Issued	Exp	Verif

DEFICIENCIES
OTHER DEFICIENCIES: NEED FORM 2 AND EVAL UPON COMPLETION OF TRAINING, MUST COME DIRECTLY FROM YOUR PROGRAM PostGrad - Form 2 COLLEGE OF MEDICINE OKC



**RECEIVED**

APR 14 2024

OKLAHOMA STATE BOARD OF  
MEDICAL LICENSURE  
AND SUPERVISION

**RETURN FORM TO:**  
**OKLAHOMA STATE BOARD OF MEDICAL LICENSURE AND SUPERVISION**  
[oktraining@okmedicalboard.org](mailto:oktraining@okmedicalboard.org)

**QUESTIONNAIRE**  
Please read and follow ALL instructions

**FORM INSTRUCTIONS:** Complete both pages of this form *only if you are renewing or upgrading your training license.* Attach the appropriate documentation and answer the confidential questions.

**PAYMENT INSTRUCTIONS:** If you **ARE FULLY LICENSED**, you **MUST** go online and renew your license – **DO NOT pay your renewal fee via these instructions** (doing so will delay your renewal).

**ATTESTATION STATEMENT:** By completing this document, I agree to pay the appropriate fee on **ONLINE BILL PAY**  
If you are **UPGRADING** your training license to a full license, your fee will be \$250 & you will choose **MD TRAINING-TO-FULL**  
If you are **RENEWING** your training license, your fee will be \$150 & you will choose **MD TRAINING LICENSE RENEWAL**

**PLEASE PRINT ALL INFORMATION**

<b>FIRST NAME</b>	Brandon	<b>LAST NAME</b>	Kannady
<b>EMAIL ADDRESS</b>	[REDACTED]		
<b>LICENSE NUMBER</b>	41486	<b>CELL PHONE</b>	[REDACTED]
<b>HOME ADDRESS</b>	[REDACTED]	<b>CITY/STATE</b>	[REDACTED]
<b>PROGRAM ATTENDING</b>	<u>University of Oklahoma Health Sciences</u>		<b>SPECIALTY</b> <u>Urology</u>

**DOCUMENTATION TO ATTACH**

PAYMENT COMPLETED	
<input type="checkbox"/> \$150 payment made on Billpay for <b>RENEWAL</b> of training license	<input checked="" type="checkbox"/> \$250 payment made on Billpay for <b>UPGRADE</b> of training license

DOCUMENTATION REQUIRED	
<input checked="" type="checkbox"/> Form 2 (must be received directly from program) <b>**ONLY FOR UPGRADE</b>	<input checked="" type="checkbox"/> Evaluation (must be received directly from program)
<input checked="" type="checkbox"/> USMLE Step 3 (must be received directly from USMLE)	<input checked="" type="checkbox"/> Answer confidential questions (on back of this form)

FOREIGN TRAINED STUDENTS	
<input type="checkbox"/> Current visa	<input type="checkbox"/> Social Security Number <b>**if not provided at initial application</b>
<input type="checkbox"/> Background Check <b>**if not done at initial application</b>	

**IF YOU ARE FULLY LICENSED – DO NOT COMPLETE THIS FORM. YOU MUST GO ONLINE AND RENEW AT <https://pay.apps.ok.gov/medlic/md/login.php> ENTER YOUR LICENSE NUMBER & PIN – COMPLETE YOUR RENEWAL AND PAY THE RENEWAL FEE.**

**RENEWAL QUESTIONNAIRE  
UPDATED 03-2024**

41486  
57



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APR 14 2024

NAME Brandon KannadyOKLAHOMA STATE BOARD OF  
MEDICAL LICENSURE  
AND SUPERVISION**IF YOU HAVE ANY "YES" ANSWERS YOU MUST PROVIDE A NOTARIZED STATEMENT EXPLAINING YOUR ANSWER.***SINCE RENEWAL OF YOUR TRAINING LICENSE OR INITIAL ISSUE OF YOUR TRAINING LICENSE (whichever is most recent)*

QUESTIONS	YES	NO
Have you failed any part of the USMLE exam (not previously disclosed)?	<input type="checkbox"/>	<input checked="" type="checkbox"/>
Have you been the subject of investigation or disciplinary action (including probation) by a hospital or training program?	<input type="checkbox"/>	<input checked="" type="checkbox"/>
Have you had any adverse judgment or settlement against you rising from a professional liability claim?	<input type="checkbox"/>	<input checked="" type="checkbox"/>
Have you been reported to the National Practitioner Data Bank (NPDB)?	<input type="checkbox"/>	<input checked="" type="checkbox"/>
Have you ever been denied, had removed, or suspended hospital privileges?	<input type="checkbox"/>	<input checked="" type="checkbox"/>
Have you surrendered hospital privileges while under investigation or to avoid investigation?	<input type="checkbox"/>	<input checked="" type="checkbox"/>
Have you entered into an Agreement with a Federal, State, or Local jurisdictional body to avoid formal action?	<input type="checkbox"/>	<input checked="" type="checkbox"/>
Has your application for licensure ever been denied?	<input type="checkbox"/>	<input checked="" type="checkbox"/>
Have you surrendered a license or had any disciplinary action taken on any license?	<input type="checkbox"/>	<input checked="" type="checkbox"/>
Have you been investigated by or requested to appear before a licensing or disciplinary agency (other than the Oklahoma State Board of Medical Licensure and Supervision)?	<input type="checkbox"/>	<input checked="" type="checkbox"/>
Have you obtained an assessment or been treated for use of any drug or chemical substance including alcohol?	<input type="checkbox"/>	<input checked="" type="checkbox"/>
Have you been arrested for, charged with, or convicted of a felony or misdemeanor other than a traffic violation?	<input type="checkbox"/>	<input checked="" type="checkbox"/>
Have you been arrested for, charged with, or convicted of a traffic violation involving the use of any drug or chemical substance?	<input type="checkbox"/>	<input checked="" type="checkbox"/>
Have you been addicted to or abused any drug or chemical substance including alcohol?	<input type="checkbox"/>	<input checked="" type="checkbox"/>
Have you been denied provider participation, terminated, sanctioned or penalized by any third-party payor including TRICARE, MEDICARE, or MEDICAID?	<input type="checkbox"/>	<input checked="" type="checkbox"/>
Have you surrendered or had any adverse action taken against any narcotic permit (State or Federal)?	<input type="checkbox"/>	<input checked="" type="checkbox"/>

I swear under penalty of perjury, that I am the person completing this Questionnaire and understand that any medical license procured or obtained by fraud or misrepresentation will result in disciplinary action taken against the licensee pursuant to the provisions of 59 O.S. § 508.

Signature



Date

4-13-2024



**Oklahoma State Board of Medical Licensure and Supervision** PAGE 1396 of 500

**APPLICATION FOR OKLAHOMA MEDICAL DOCTOR LICENSE**

Received:04/11/2023

Applicant Name: KANNADY, BRANDON LAKE

MD 41486



Date Of Birth: [REDACTED]

Place Of Birth (City, State): KANSAS CITY, MO

Sex: M

Race: Caucasian

Education									
Type	Name	City	ST	Country	From	To	Degree	Comments	Veri
UG	UNIVERSITY OF KANSAS	LAWRENCE	KS		8/2015	12/2018	BACHELOR??S OF SCIENCE		

Medical School Name	City	State	Country	Comments	From	To
Univ Of KS Sch Of Med, Kansas City Ks 66103	Kansas City	KS	United States		7/2019	5/2023

Post-Graduate							
Facility	City	St	Country	Specialty	Comments	From	To
			UNITED S			/	/

Practice History								
Employer	Specialty	Supervisor	City	ST	Countr	From	To	Verif
						/		

Other/ Out-Of-State Licenses					
State	License #	Profession	Status	Issue Date	Exp Date

MD Exam				
Exam	State	Score	Date Taken	#
USMLE				

**APPLICATION FOR OKLAHOMA MEDICAL DOCTOR LICENSE**

Received:04/11/2023

<b>Questions Answered 04/10/2023</b>		<b>Response</b>
A.	Have you ever been denied provider participation, terminated, sanctioned, or penalized by any third party payor, to include TRICARE, MEDICARE, MEDICAID?	<b>N</b>
B.	Have you ever surrendered or had any adverse action taken against any narcotic permit (state or federal)?	<b>N</b>
C.	Have you ever been denied membership or had disciplinary action taken by a national, state or county professional organization?	<b>N</b>
D.	Have you ever been denied or had removed or suspended hospital staff privileges?	<b>N</b>
E.	Have you ever surrendered hospital staff privileges while under investigation or to avoid investigation?	<b>N</b>
F.	Have you ever entered into an agreement with a federal, state or local jurisdictional body to avoid formal action?	<b>N</b>
G.	Have you ever been the subject of an investigation, probation or disciplinary action by a hospital, clinic, practice group, training program or professional school?	<b>N</b>
H.	Have you had any adverse judgment, settlement, or award against you arising from a professional liability claim?	<b>N</b>
I.	Have you ever had professional liability coverage declined, canceled, issued on special terms, or renewal refused?	<b>N</b>
J.	Have you ever been reported to the National Practitioners Data Bank (NPDB) or to the Healthcare Integrity and Protection Data Bank (HIPDB)? (If yes, enclose a copy of the report.)	<b>N</b>
K.	Has your application for examination or a professional license ever been denied?	<b>N</b>
L.	Have you ever failed any part of a licensure/certification/registration examination?	<b>N</b>
M.	Have you ever surrendered a license or had a license revoked?	<b>N</b>
N.	Has any disciplinary action been taken on any license?	<b>N</b>
O.	Have you ever been subject of a review by professional licensing/regulatory agency based on a complaint filed against you?	<b>N</b>
P.	Have you ever been arrested, charged with, or convicted of a felony or misdemeanor, other than traffic violations?	<b>N</b>
Q.	Have you ever been arrested, charged with, or convicted of a traffic violation involving the use of any drug or chemical substance, including alcohol?	<b>N</b>
R.	Are you now or have you within the past two years been addicted to or used in excess any drug or chemical substance, including alcohol?	<b>N</b>
S.	Have you obtained an assessment or been treated for the use of any drug or chemical substance, including alcohol?	<b>N</b>
T.	Do you currently have or have you had within the past two years any mental or physical disorder or condition which, if untreated, could affect your ability to practice competently?	<b>N</b>
U.	Are you or your spouse currently on Active Duty in the U.S. Armed Forces?	<b>N</b>
V.	Are you or your spouse currently Deployed on Active Duty in the U.S. Armed Forces?	<b>N</b>



APPLICATION FOR OKLAHOMA MEDICAL DOCTOR LICENSE

Received:04/11/2023

**If licensed, where do you intend to locate?**

OK

**Why do you seek Licensure in the state of Oklahoma?**

Post-Graduate Training

**In what manner will you be communicating with your Oklahoma patients (telephone, email, internet, video-conference, etc)?**

**Describe how you will examine each patient in person prior to diagnosis, treating, correcting, or prescribing for a patient in Oklahoma from the state, province, or country you are located:**

**Describe the manner in which you intend to practice medicine across state lines in Oklahoma:**

**Have you executed or been offered a contract in connection with practice in the state of Oklahoma?**

Yes

**If 'Yes', Name of practice:**

The University of Oklahoma Health Sciences Center

**If so, Please identify with which category:**

Hospital

**Name of Previous Carrier and Policy Holder**

N/A

**Name of Current Carrier and policy Holder**

Liability insurance to be provided by training institution.

**Will your professional liability insurance policy cover your practice in Oklahoma**

Yes

**If NO, when do you expect to obtain liability insurance that will cover practice in Oklahoma**

I attest that all the above information is accurate as of April 10, 2023: \_\_\_\_\_ (Signed Online)



Applicant: In the presence of a notary public, sign this form with attached photo.

Send this form to: Oklahoma State Board of Medical Licensure and Supervision

oktraining@okmedicalboard.org

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

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

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

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

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

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

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APR 18 2023

OKLAHOMA STATE BOARD OF MEDICAL LICENSURE AND SUPERVISION



[Handwritten signature]

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

Brandon L Kannady

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

4-11-2023

Date of signature (must correspond to the date of notarization)

State of Kansas, County of Wyandotte <sup>NOTARY</sup>

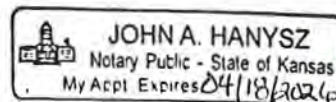
I certify that on the date set forth below, the individual named above did appear personally before me and that I did identify this applicant by (a) comparing his/her physical appearance with the photograph on the identifying document presented by the applicant and with the photograph affixed hereto,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

The statements on this document are subscribed and sworn to before me by the applicant on this 11th day of April, 2023

Notary Public Signature [Handwritten Signature]

My Notary Commission Expires 04/18/2026

NOTARY SEAL



T 41484 WS





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

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

PRIMARY SOURCE

**Recipient:** OKLAHOMA STATE BOARD OF  
MEDICAL LICENSURE & SUPERVISION

**Date:** 04/14/2024

**Examinee:** Kannady, Brandon Lake  
**Alt Name(s):**

**Examinee ID:** 5-465-830-7  
**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. Pass/fail outcomes are based upon the minimum passing level in place at the time of test administration and are not altered by subsequent revisions to the minimum passing level. Effective April 1, 2013, two-digit scores will no longer be reported. Test results reported as passing represent an exam score of 75 or higher on a two-digit scale. Step 1 examinations taken on or after January 26, 2022 are reported as pass/fail, with no numeric score; Step 1 examinations taken before January 26, 2022 will continue to be reported with a 3-digit score.

### USMLE STEP 1

Test Date	Pass/Fail	Score	Minimum Pass	Comments
05/13/2021	Pass	235	(194)	

### USMLE STEP 2

*Clinical Knowledge (CK)*

Test Date	Pass/Fail	Score	Minimum Pass	Comments
06/17/2022	Pass	244	(209)	

### USMLE STEP 3

Test Date	Pass/Fail	Score	Minimum Pass	Comments
01/19/2024	Pass	235	(200)	

**End of Exam History**

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

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

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400 Fuller Wisser Road, Euless, TX 76039-3856 - Telephone (817) 868-4000

**Examinee:** Kannady, Brandon Lake

**Examinee ID:** 5-465-830-7

**Date of Birth:** [REDACTED]

### INTERPRETATION OF RESULTS

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

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

### STEP 1 AND STEP 2 CLINICAL SKILLS (CS)

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

### ANNOTATIONS APPEARING UNDER "COMMENTS"

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

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

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

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

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

### ANNOTATIONS APPEARING AS "NOTE"

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

### PHYSICIAN DATA CENTER INFORMATION APPEARING AS "NOTE"

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

03/2015

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



Form 1 (MD)

Oklahoma State Board of Medical Licensure and Supervision  
101 NE 51st Street Oklahoma City, OK 73105  
OKTRAINING@OKMEDICALBOARD.ORG

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MAY 25 2023

This form must be completed by the institution and mailed or emailed directly from the institution to the Oklahoma State Board of Medical Licensure and Supervision.

Applicant's Name Brandon Kanwaly

Institution: The University of Kansas City/State Kansas City, KS

Our records indicate that the above named applicant attended our medical school on the following dates:

From 07 12 2019 To 05 12 2023 and was awarded the degree Doctor of Medicine 05/14/2023  
Month Day Year Month Day Year

Please complete the following questions:

- 1. Does this individual's official record reflect (an) interruption(s) or extension(s) in his/her medical education? If yes, please explain.  YES  NO
- 2. Does this individual's official record reflect that he/she was ever placed on academic or disciplinary probation during his/her medical education? If yes, please explain.  YES  NO
- 3. Does this individual's official record reflect that he/she was ever the subject of negative reports for behavioral reasons or an investigation by the medical school or parent university? If yes, please explain below.  YES  NO
- 4. Does this individual's official record reflect that he/she was ever disciplined for unprofessional conduct/behavioral reasons by the medical school or parent university? If yes, please explain below.  YES  NO
- 5. Does this individual's official record reflect that there were any limitations or special requirements imposed on the individual because of questions of academic incompetence, disciplinary problems, or any other reason? If yes, please explain below.  YES  NO

Please explain any "YES" response from above: \_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

I attest that the completion of the following has been completed by the program director and that the information above is an accurate account of this individual's records and is true and correct.

Name: Caroline Scale Signature [Signature]

Title of Signatory: Campus Registrar Date of Signature 05/16/2023

Tel: 913-588-7055 Fax: 913-588-8841 E-Mail: Kumc/registrat@kumc.edu



If no seal is available, this form must be notarized

Notary Public \_\_\_\_\_

Commission # \_\_\_\_\_

My commission expires: \_\_\_\_\_

PRIMARY SOURCE

Notary Seal

T41486  
UKC

University of Kansas  
Lawrence, KS

Official KU Academic Record  
Name: Brandon Kannady  
Student ID: 2836176

Institution Info: University of Kansas  
Lawrence, KS 66045  
CEEB: 06871 ACT: 1470

SSN: \*\*\*-\*\*-6879  
Birthdate: Apr 13

Print Date: 05/24/2023

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MAY 25 2023

OKLAHOMA STATE BOARD OF  
MEDICAL LICENSURE  
AND SUPERVISION

To: OK Board

Test Credits Applied Toward Liberal Arts&Sci Undergraduate

Course	Units	Description	Attempted	Earned	Grade	Points
BIOL	100	Principles of Biology	3.000	3.000	CR	0.000
CHEM	130	Advanced Placement General Chemistry I	5.000	0.000	CR	0.000
Repeated: ENGL	105	Advanced Placement Course Repeated Freshman Honors English	3.000	3.000	CR	0.000
Repeated: ENGL	105	Advanced Placement Original Attempt of Course Freshman Honors English	3.000	0.000	CR	0.000
Repeated: HIST	114	Advanced Placement Course Repeated Renaissno-Rev: Europe 1500-1789	3.000	3.000	CR	0.000
HIST	115	Advanced Placement Fr Rev-Presnt: Europe 1789-Pres	3.000	3.000	CR	0.000
HIST	128	Histry of US Through Civil War	3.000	3.000	CR	0.000
HIST	129	Advanced Placement Hist of US After the Civil War	3.000	3.000	CR	0.000
MATH	125	Calculus I Advanced Placement	4.000	4.000	CR	0.000
Test Trans GPA:	0.000	Transfer Totals:	22.000	22.000		0.000

Beginning of Undergraduate Record

2015 Fall						
Program:	Liberal Arts&Sci Undergraduate					
Course		Description	Attempted	Earned	Grade	Points
BIOL	105	Biology Orientation Seminar	1.000	1.000	S	0.000
BIOL	150	Pm Molecular&Cellular Biology	4.000	4.000	A	16.000
CHEM	130	General Chemistry I	5.000	5.000	A	20.000
Repeated: JOUR	177	Original Attempt of Course First Year Seminar: 45 Words:Five 1st Amend Rights	3.000	3.000	A	12.000
Course Topic: REL	171	Religion in American Society	3.000	3.000	A	12.000

Term Honor: CLAS HONOR ROLL

			Attempted	Earned	GPA Units	Points
Term GPA	4.000	Term Totals	16.000	16.000	15.000	60.000
Cum GPA	4.000	Cum Totals	16.000	16.000	15.000	60.000

2016 Spring

2016 Spring						
Program:	Liberal Arts&Sci Undergraduate					
Course		Description	Attempted	Earned	Grade	Points
BIOL	152	Princpls of Organismal Biology	4.000	4.000	A	16.000
CHEM	135	General Chemistry II	5.000	5.000	A	20.000
COMS	130	Speaker-Audience Communication	3.000	3.000	A	12.000
SOC	104	Elements of Sociology	3.000	3.000	A	12.000

Term Honor: CLAS HONOR ROLL

			Attempted	Earned	GPA Units	Points
Term GPA	4.000	Term Totals	15.000	15.000	15.000	60.000
Cum GPA	4.000	Cum Totals	31.000	31.000	30.000	120.000

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SOURCE

Casey J. Wallace

Casey L. Wallace  
Interim University Registrar

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require a raised seal. To confirm  
authenticity, see instructions on reverse side.

T414870  
UKC



Official KU Academic Record

University of Kansas  
Lawrence, KS

Name: Brandon Kannady  
Student ID: 2836176

2016 Fall

Program: Liberal Arts&Sci Undergraduate

Course	Description	Attempted	Earned	Grade	Points
BIOL 350	Principles of Genetics	4.000	4.000	A-	14.800
BIOL 413	History&Diversity of Organisms	3.000	3.000	A	12.000
CHEM 330	Organic Chemistry I	3.000	3.000	A	12.000
CHEM 331	Organic Chemistry I Laboratory	2.000	2.000	B+	6.600
PSYC 104	General Psychology	3.000	3.000	A	12.000
Term Honor: CLAS HONOR ROLL					
		<u>Attempted</u>	<u>Earned</u>	<u>GPA Units</u>	<u>Points</u>
Term GPA	3.830 Term Totals	15.000	15.000	15.000	57.400
Cum GPA	3.940 Cum Totals	46.000	46.000	45.000	177.400

2017 Spring

Program: Liberal Arts&Sci Undergraduate

Course	Description	Attempted	Earned	Grade	Points
BIOL 412	Evolutionary Biology	4.000	4.000	A-	14.800
CHEM 335	Organic Chemistry II	3.000	3.000	B-	8.100
GEOG 102	People, Place, and Society	3.000	3.000	A	12.000
HEIM 210	Introduction to Healthcare	1.000	1.000	C	2.000
PHSX 114	College Physics I	4.000	4.000	A	16.000
Term Honor: CLAS HONOR ROLL					
		<u>Attempted</u>	<u>Earned</u>	<u>GPA Units</u>	<u>Points</u>
Term GPA	3.530 Term Totals	15.000	15.000	15.000	52.900
Cum GPA	3.840 Cum Totals	61.000	61.000	60.000	230.300

2017 Fall

Program: Liberal Arts&Sci Undergraduate

Course	Description	Attempted	Earned	Grade	Points
BIOL 414	Principles of Ecology	3.000	3.000	A	12.000
BIOL 416	Cell Structure and Function	3.000	3.000	A	12.000
BIOL 600	Introd Biochemistry, Lectures	3.000	3.000	A	12.000
EVRN 336	Ethics, Ideas and Nature	3.000	3.000	A	12.000
PHSX 115	College Physics II	4.000	4.000	A	16.000
Term Honor: CLAS HONOR ROLL					
		<u>Attempted</u>	<u>Earned</u>	<u>GPA Units</u>	<u>Points</u>
Term GPA	4.000 Term Totals	16.000	16.000	16.000	64.000
Cum GPA	3.870 Cum Totals	77.000	77.000	76.000	294.300

2018 Spring

Program: Liberal Arts&Sci Undergraduate

Course	Description	Attempted	Earned	Grade	Points
BIOL 417	Biology of Development	3.000	3.000	A	12.000
BIOL 420	Seminar: Comparative Animal Behavior	3.000	3.000	A	12.000
BIOL 424	Independent Study	3.000	3.000	A	12.000
BIOL 546	Mammalian Physiology	3.000	3.000	B	9.000
BIOL 647	Mammalian Physiology Laboratory	2.000	2.000	A	8.000
Term Honor: CLAS HONOR ROLL					
		<u>Attempted</u>	<u>Earned</u>	<u>GPA Units</u>	<u>Points</u>
Term GPA	3.790 Term Totals	14.000	14.000	14.000	53.000
Cum GPA	3.860 Cum Totals	91.000	91.000	90.000	347.300

2018 Fall

Program: Liberal Arts&Sci Undergraduate

Course	Description	Attempted	Earned	Grade	Points
BIOL 400	Fundamentals of Microbiology	3.000	3.000	A	12.000
BIOL 544	Comparative Animal Physiology	3.000	3.000	A	12.000
BIOL 570	Introduction to Biostatistics	4.000	4.000	A	16.000
BIOL 599	Senior Seminar: Ecol Eval & Org Biology	1.000	1.000	A	4.000
Term Honor: CLAS HONOR ROLL					
		<u>Attempted</u>	<u>Earned</u>	<u>GPA Units</u>	<u>Points</u>
Term GPA	4.000 Term Totals	11.000	11.000	11.000	44.000
Cum GPA	3.870 Cum Totals	102.000	102.000	101.000	391.300

Undergraduate Career Totals

Cum GPA: 3.870 Cum Totals 102.000 102.000 101.000 391.300

End of Undergraduate Academic Record

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Beginning of Medicine Record

MAY 25 2023

OKLAHOMA STATE BOARD OF  
MEDICAL LICENSURE  
AND SUPERVISION

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*Casey J. Wallace*

Casey L. Wallace  
Interim University Registrar

PRIMARY SOURCE

Official KU Academic Record

Name: Brandon Kannady

Student ID: 2836176

University of Kansas  
Lawrence, KS

2019 Fall						
Program:	Medicine Professional					
Course	Description	Attempted	Earned	Grade	Points	
ACED	800	Introduction to Doctoring	3.000	3.000	P	0.000
ACED	805	Molecular & Cellular Medicine	8.000	8.000	P	0.000
ACED	810	Infection, Blood & Immunity	8.000	8.000	P	0.000
			<u>Attempted</u>	<u>Earned</u>	<u>GPA Units</u>	<u>Points</u>
Term GPA	0.000	Term Totals	19.000	19.000	0.000	0.000
Cum GPA	0.000	Cum Totals	19.000	19.000	0.000	0.000

2020 Spring						
Program:	Medicine Professional					
Course	Description	Attempted	Earned	Grade	Points	
ACED	815	Respiration and Circulation	8.000	8.000	P	0.000
ACED	820	Gastrointestinal and Renal	8.000	8.000	P	0.000
GSMC	501	Interprofessional Collab I	0.000	0.000	NE	0.000
			<u>Attempted</u>	<u>Earned</u>	<u>GPA Units</u>	<u>Points</u>
Term GPA	0.000	Term Totals	16.000	16.000	0.000	0.000
Cum GPA	0.000	Cum Totals	35.000	35.000	0.000	0.000

2020 Summer						
Program:	Medicine Professional					
Course	Description	Attempted	Earned	Grade	Points	
IDSP	800	Special Programs	4.000	4.000	P	0.000
			<u>Attempted</u>	<u>Earned</u>	<u>GPA Units</u>	<u>Points</u>
Term GPA	0.000	Term Totals	4.000	4.000	0.000	0.000
Cum GPA	0.000	Cum Totals	39.000	39.000	0.000	0.000

2020 Fall						
Program:	Medicine Professional					
Course	Description	Attempted	Earned	Grade	Points	
ACED	825	Muscles and Movement	8.000	8.000	P	0.000
ACED	830	Brain, Mind and Behavior	8.000	8.000	P	0.000
ACED	835	Reprod., Developmnt & Sexuality	0.000	0.000	IP	0.000
GSMC	502	Interprofessional Collab II	0.000	0.000	NE	0.000
			<u>Attempted</u>	<u>Earned</u>	<u>GPA Units</u>	<u>Points</u>
Term GPA	0.000	Term Totals	16.000	16.000	0.000	0.000

2021 Spring						
Program:	Medicine Professional					
Course	Description	Attempted	Earned	Grade	Points	
ACED	835	Reprod., Developmnt & Sexuality	8.000	8.000	P	0.000
ACED	840	Medicine Capstone	8.000	8.000	P	0.000
IDSP	806	Prsnl Pffessorl Development	0.000	0.000	NE	0.000
			<u>Attempted</u>	<u>Earned</u>	<u>GPA Units</u>	<u>Points</u>
Term GPA	0.000	Term Totals	16.000	16.000	0.000	0.000
Cum GPA	0.000	Cum Totals	71.000	71.000	0.000	0.000

2021 Fall						
Program:	Medicine Professional					
Course	Description	Attempted	Earned	Grade	Points	
FAPR	955	Family Medicine Clerkship	8.000	8.000	P	24.000
GYNO	900	Obstetric/Gynecology Clerkship	8.000	8.000	P	24.000
ICM	900	Issues Clin Med	0.000	0.000	P	0.000
NEUR	900	Neurology Clerkship	4.000	4.000	P	12.000
PYCH	955	Psychiatry Clerkship	4.000	4.000	P	12.000
SURG	900	Surgery Clerkship	0.000	0.000	IP	0.000
			<u>Attempted</u>	<u>Earned</u>	<u>GPA Units</u>	<u>Points</u>
Term GPA	3.000	Term Totals	24.000	24.000	24.000	72.000
Cum GPA	3.000	Cum Totals	95.000	95.000	24.000	72.000

2022 Spring						
Program:	Medicine Professional					
Course	Description	Attempted	Earned	Grade	Points	
GSMC	503	Interprofessional Collab III	0.000	0.000	NE	0.000
ICM	900	Issues Clin Med	0.000	0.000	P	0.000
MED	900	Internal Medicine Clerkship	8.000	8.000	P	24.000
PED	900	Pediatrics Clerkship	8.000	8.000	P	24.000
SURG	900	Surgery Clerkship	8.000	8.000	P	24.000
			<u>Attempted</u>	<u>Earned</u>	<u>GPA Units</u>	<u>Points</u>
Term GPA	3.000	Term Totals	24.000	24.000	24.000	72.000
Cum GPA	3.000	Cum Totals	119.000	119.000	48.000	144.000

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OKLAHOMA STATE BOARD OF  
MEDICAL LICENSURE  
AND SUPERVISION

*Casey J. Wallace*

Casey L. Wallace  
Interim University Registrar

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SOURCE



Official KU Academic Record

University of Kansas  
Lawrence, KS

Name: Brandon Kannady  
Student ID: 2836176

2022 Fall

Course	Description	Attempted	Earned	Grade	Points
DIAG 910	Diagnostic Radiolg	4.000	4.000	P	0.000
IDSP 806	Prsnl Prfessonl Development	0.000	0.000	NE	0.000
IDSP 806	Prsnl Prfessonl Development	0.000	0.000	NE	0.000
IDSP 806	Prsnl Prfessonl Development	0.000	0.000	NE	0.000
IDSP 900	Special Program	4.000	4.000	P	0.000
IDSP 900	Special Program	4.000	4.000	P	0.000
SURG 910	Surg Subtn-Urology	4.000	4.000	P	0.000
		<u>Attempted</u>	<u>Earned</u>	<u>GPA Units</u>	<u>Points</u>
Term GPA	0.000 Term Totals	16.000	16.000	0.000	0.000
Cum GPA	3.000 Cum Totals	135.000	135.000	48.000	144.000

End of Medicine Academic Record

Note: The University of Kansas does not include earned transfer hours in the cumulative earned hours, for eligibility for graduation and total hours; the transfer hours earned and KU earned hours could be combined.

----- Degrees Awarded -----

Degree: Bachelor of Science  
Confer Date: 12/31/2018  
Plan: Bachelor of Science in Biology

Degree: Doctor of Medicine  
Confer Date: 05/14/2023  
Plan: Doctor of Medicine

2023 Spring

Course	Description	Attempted	Earned	Grade	Points
ANES 910	Anesthesiology	4.000	4.000	P	0.000
FAPR 900	Rural Preceptorship	4.000	4.000	P	0.000
IDSP 806	Prsnl Prfessonl Development	0.000	0.000	NE	0.000
IDSP 806	Prsnl Prfessonl Development	0.000	0.000	NE	0.000
SURG 929	Crit Care Surg ICU	4.000	4.000	P	0.000
		<u>Attempted</u>	<u>Earned</u>	<u>GPA Units</u>	<u>Points</u>
Term GPA	0.000 Term Totals	12.000	12.000	0.000	0.000
Cum GPA	3.000 Cum Totals	147.000	147.000	48.000	144.000
Medicine Career Totals					
Cum GPA:	3.000 Cum Totals	147.000	147.000	48.000	144.000

End of Official KU Academic Record

Non-Course Milestones

United States Medical Licensure Exam, Step 1  
Status: Completed  
Program: Medicine Professional  
Date Completed: 07/07/2021  
Date Attempted: 07/07/2021 Completed

United States Medical Licensure Exam, Step 2 CK  
Status: Completed  
Program: Medicine Professional  
Date Completed: 06/29/2022  
Date Attempted: 06/29/2022 Completed

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OKLAHOMA STATE BOARD OF  
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Interim University Registrar

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# AMA Physician Profile

PREPARED FOR

Oklahoma State Board of Licensure & Supervision, Oklahoma City, OK

**Name and Mailing Address**

BRANDON LAKE KANNADY  
UNIV OF OKLAHOMA HEALTH SCIENCES CTR  
WP 2140  
920 STANTON L YOUNG BLVD  
OKLAHOMA CITY, OK 73104-5020

**Primary Office Address**

SAME AS MAILING ADDRESS

PRIMARY SOURCE

Phone UNKNOWN

**Birth date**



**Physician's major professional activity**

HOSPITAL BASED RESIDENTS ALL YEARS

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MAY 10 2024

OKLAHOMA STATE BOARD OF MEDICAL LICENSURE AND SUPERVISION

**AMA membership status**

MEMBER

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

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

NO DATA REPORTED AT THIS TIME

**Current and/or historical medical school**

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

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

**School:** UNIVERSITY OF KANSAS SCHOOL OF MEDICINE

**Degree Awarded:**

YES

**Degree Type:**

MD

**Enrollment Date:**

07/2019

**Degree Date:**

05/2023

741488  
SD



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

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

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

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

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

<b>Sponsoring Institution:</b>	UNIVERSITY OF OKLAHOMA COLLEGE OF MEDICINE
<b>Sponsoring State:</b>	OKLAHOMA
<b>Program name:</b>	UNIVERSITY OF OKLAHOMA HEALTH SCIENCES CENTER PROGRAM
<b>Specialty:</b>	UROLOGY
<b>Training Type:</b>	SPECIALTY
<b>Dates:</b>	07/01/2023 - 06/30/2028
<b>Status:</b>	TRAINING IN PROGRESS

### Specialty board certification

NO DATA REPORTED AT THIS TIME

### Current and/or historical medical licensure

NO DATA REPORTED AT THIS TIME

### Action notifications reported to the AMA

**Medical Licensing Boards:** NO ACTIONS REPORTED AT THIS TIME

**Medicare/Medicaid Sanctions from DHHS:** NO ACTIONS REPORTED AT THIS TIME

**US DOJ Drug Enforcement Administration: NO ACTIONS REPORTED AT THIS TIME**

**U.S. Drug Enforcement Administration (DEA)**

NO DATA REPORTED AT THIS TIME

**ECFMG certification**

NOT APPLICABLE

**Profile information**

The content of the AMA Physician Profile is for credentialing use only. The content cannot be used or assembled for an employment purpose as defined under the Fair Credit Reporting Act. An organization's appropriate use of the data contained in the AMA Physician Professional Data™, formerly known as AMA Physician Masterfile, meets select primary source verification requirements of the Joint Commission, the Accreditation Association for Ambulatory Health Care (AAAHC) and the American Accreditation Health Care Commission (AAHCC)/ Utilization Review Accreditation Commission (URAC). The AMA Physician Professional Data is also an NCQA-approved source for verification of medical school, post-graduate medical training, ABMS Board Certification and federal DEA registration.

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

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



OKLAHOMA STATE BOARD OF MEDICAL LICENSURE AND SUPERVISION  
EVIDENCE OF STATUS – PART A

RECEIVED

APR 18 2023

NOTARIZED FORM CAN BE EMAILED TO OKTRAINING@OKMEDICALBOARD.ORG

OKLAHOMA STATE BOARD OF  
MEDICAL LICENSURE  
AND SUPERVISION

Full Legal Name: Brandon Lake Kannady  
First Middle Last Maiden (if applicable)

Mailing Address: \_\_\_\_\_  
Street Address or Post Office Box

\_\_\_\_\_  
City State Zip Code Telephone Number Social Security #: \_\_\_\_\_

PRIMARY EVIDENCE OF CITIZENSHIP  
(FOR US CITIZENS, US NATIONALS, OR PERMANENT LEGAL RESIDENT ALIENS)

If you are a U.S. citizen, U.S. national, or permanent legal resident alien, please attach a photocopy of one of the following documents to this form. Place a checkmark below to indicate the document that is attached.

- A birth certificate showing birth in one of the 50 States, the District of Columbia, Puerto Rico (on or after January 13, 1941), Guam, the U.S. Virgin Islands (on or after January 17, 1917), American Samoa, Swain's Island or the Northern Mariana Islands, unless the person was born to foreign diplomats residing in the U.S.
- United States passport (except limited passports, which are issued for periods of less than five years)
- Report of birth abroad of a U.S. citizen (FS-240) (issued by the Department of State to U.S. citizens)
- Certificate of birth (FS-545) (issued by a foreign service post) or Certification of Report of Birth (DS1350) (issued by the Department of State), copies available from the Department of State
- Certificate of Naturalization (N-550 or N-570) (issued by the INS through a Federal or State court, or through administrative naturalization after December 1990 to individuals who are individually naturalized; the N570 is a replacement certificate issued when the N-550 has been lost or mutilated or the individual's name has been changed)
- Certificate of Citizenship (N-560 or N-561) (issued by the INS to individuals who derive U.S. citizenship through a parent; the N-561 is a replacement certificate issued when the N-560 has been lost or mutilated or the individual's name has been changed)
- United States Citizen Identification Card (I-197) (issued by the INS until April 7, 1983 to U.S. citizens living near the Canadian or Mexican border who needed it for frequent border crossing) (formerly Form I-179, last issued in February 1974)
- Northern Mariana Identification Card (issued by the INS to a collectively naturalized citizen of the U.S. who was born in the Northern Mariana Islands before November 3, 1986)
- Statement provided by a U.S. consular officer certifying that the individual is a U.S. citizen (This is given to an individual born outside the U.S. who derives citizenship through a parent but does not have an FS-240, FS-545 or DS-1350);
- American Indian Card with a classification code "KIC" and a statement on the back (identifying U.S. citizen members of the Texas Band of Kickapoos living near the U.S./Mexican border.)
- Alien Lawfully Admitted for Permanent Residence:  
INS Form I-551 (Alien Registration Receipt Card, commonly known as a "green card")
- Alien Lawfully Admitted for Permanent Residence:  
Unexpired Temporary I-551 stamp in foreign passport or on INS Form I-94

I declare under penalty of perjury, under the laws of the State of Oklahoma, that all information contained in this application and all accompanying documents provided to substantiate my Evidence of Status application are true and correct.

Signature [Signature] Date 4-11-2023

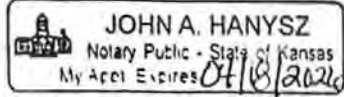
Subscribed and sworn before me this 11th day of April, 2023.

Notary Public [Signature]

Commission Number 1196083

My commission expires 04/18/2026

NOTARY SEAL



T 41484 VB

**OKLAHOMA STATE BOARD OF MEDICAL LICENSURE AND SUPERVISION**  
**101 NE 51<sup>ST</sup> STREET**  
**OKLAHOMA CITY OK 73105**

Phone: (405)962-1400 Fax: (405)962-1440 email: oktraining@okmedicalboard.org

**RECEIVED**

APR 18 2023

To Request Examination Scores	
For National Board Scores National Board of Medical Examiners PO Box 48014 Newark, NJ 07101-4814 (215) 590-9500 www.NBME.org	For FLEX or USMLE Scores Federation of State Medical Boards 400 Fuller Wiser Road Euless, TX 76039-3855 (817) 868-4000 www.FSMB.org

OKLAHOMA STATE BOARD OF  
MEDICAL LICENSURE  
AND SUPERVISION

6. **Extended Background Check** – Applicants for licensure are required to request an Extended Background Check.
7. **Evidence of Status Form** - In order to verify citizenship or qualified alien status, applicants for licensure by endorsement or examination or for reinstatement of their license, must submit an Evidence of Status Form and the required supporting documentation with their application. This form must be notarized and mailed to the office.
8. **Photo and Oath Form** – Applicants for licensure will be required to complete the Photo and Oath Form. This form must be notarized and mailed to the office.
9. **Telemedicine Form** – Applicants planning to practice telemedicine must submit the initialed and signed Telemedicine Questionnaire.
10. **English Proficiency Exam** – Foreign applicants shall have a command of the English language that is satisfactory to the Board, demonstrated by the passage of an oral English competency exam. Applicant is required to call 405-962-1400 and speak with an application analyst in licensing.

G. **Temporary Licensure (59 O.S. § 493.3)** – The Board may authorize the Secretary to issue a Temporary Medical License for the intervals between Board meetings. Such Temporary License shall be granted only when the Secretary is satisfied as to the qualifications of the applicant to be licensed under this Act but where such qualifications have not been verified to the Board. An application for Temporary Licensure must be made by written request and include all appropriate fees. Such a license shall:

1. Be granted only to an applicant demonstrably qualified for a full and unrestricted medical license;
2. Automatically terminate on the date of the next Board meeting at which the applicant may be considered for a full and unrestricted medical license.
3. We must be in receipt of the following in order for the Board Secretary to consider issuing a Temporary License:
  - a. Examination scores, and
  - b. Verification of licensure in all jurisdictions in which applicant has been licensed to practice medicine and surgery, and
  - c. Evidence of Status, and
  - d. Extended Background Check

I, the undersigned, have fully read and understand the instructions. I swear or affirm that the information submitted in and with the application is, to the best of my knowledge, true and factual. I understand that attempts to deceive or fraudulently portray information contained herein may result in cancellation of my application or charges of filing a fraudulent application that may result in subsequent revocation of licensure.

Brandon Kannady  
Name of Applicant (type or print)

[Signature]  
Signature of Applicant

4-11-2023  
Date

**Except as specifically may be waived by the Board, the Board shall not engage in any application process with any agent or representative of the applicant. 59 O.S. § 492.1 (C); Okla. Admin. Code § 435:10-4-1(c)**

Please return these signed instructions by mail to the address at the top of the page or email.

T 41486  
WB



### TIME DEFICIENCY FORM

Name: <u>Brandon Kannady</u>	Application #
------------------------------	---------------

This document is used a tool to help you complete your application.  
Please note: we have to account for any/all time from your 18th birthday to present.

EDUCATION STARTING WITH HIGH SCHOOL							
Start Month	Start Year	End Month	End Year	Name of Institution	City	State	Degree
April	2015	May	2015	Blue Valley North High School	Leawood	KS	High School Diploma
Aug	2015	Dec	2018	University of Kansas	Lawrence	KS	B.S.
July	2019	May	2023	University of Kansas School of Medicine	Kansas City	KS	M.D.
EMPLOYMENT IF NEEDED TO FILL TIME GAP							
Start Month	Start Year	End Month	End Year	Name of Employer	City	State	Job Title
September	2017	December	2018	Kansas Biological Survey	Lawrence	KS	Research Asst
December	2018	May	2019	Jay Run	Lawrence	KS	Delivery
OTHER - UNEMPLOYED, STAY AT HOME PARENT, SUMMER BREAK, TRAVELING							
Start Month	Start Year	End Month	End Year	Other	City	State	
May	2015	August	2015	Summer Break	Overland Park	KS	
May	2016	August	2016	Summer Break	Overland Park	KS	
May	2017	August	2017	Summer Break	Overland Park	KS	
May	2019	July	2019	Summer Break	Overland Park	KS	
May	2020	July	2020	Summer Research	Kansas City	KS	

4/15-8/15; 12/18-7/19

RECEIVED

APR 18 2023

OKLAHOMA STATE BOARD OF  
MEDICAL LICENSURE  
AND SUPERVISION

T 41486  
MB

**Kenna L. Shaw**

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**From:** BillPay Webmaster <donotreply@www.ok.gov>  
**Sent:** Sunday, April 14, 2024 2:04 PM  
**To:** Dela Kwezey; Bill Pay; Sheila E. Brumfield; Chris Maloney; Licensing; Arlene Morris; Debra Reich  
**Subject:** [EXTERNAL] LICENSE - MD Training-to-Full License Fee 250.00 - Payment Made

BRANDON LAKE KANNADY has paid for a LICENSE - MD Training-to-Full License Fee 250.00 on 04/14/2024 02:04:03pm for \$250.00.

OKLAHOMA MD LICENSE NUMBER 41486

To view all transactions please go to <http://www.ok.gov/triton/> and login to your CMS account.

T 39602  
D



05/03/2023

BRANDON LAKE KANNADY



**Check Your Application  
Status Online at:**  
<http://www.okmedicalboard.org>  
**Username:**AP31383605  
**Password:**Last 4 SSN

RE: MD Application #41486

Dear BRANDON KANNADY,

**YOU CANNOT PRACTICE YOUR PROFESSION IN THE STATE OF OKLAHOMA UNTIL A VALID LICENSE HAS BEEN ISSUED.**

Your training application has been processed and the current deficiencies are listed below. Please be advised, these may not be the only deficiencies. You will be advised if any other deficiencies are added. You may check your application status online by logging in with the username and password provided above.

If you have further questions please email [oktraining@okmedicalboard.org](mailto:oktraining@okmedicalboard.org)

If a "Time Deficiency" is listed, please complete a time deficiency form and e-mail the document to [oktraining@okmedicalboard.org](mailto:oktraining@okmedicalboard.org) with your activities during the specified time frame.

- Time Deficiency Form for: 4/15 - 8/15, 12/18 - 7/19
- Application Instructions
- OATH
- Exam verification date
- Extended Background Check
- Evidence of Status
- MedSchool-Transcript Univ Of KS Sch Of Med, Kansas City Ks 66103
- MedSchool-Form 1 Univ Of KS Sch Of Med, Kansas City Ks 66103
- PostGrad - Form 2 COLLEGE OF MEDICINE OKC
- USMLE Exams Incomplete

Any of the required forms in the list above may be downloaded from our website:

<http://www.okmedicalboard.org/resources>

In order to check on the status of your application, please log on to our web site:

<https://secure.okmedicalboard.org/applicant/signin>

Your user name is AP31383605 (all caps and no spaces) and your password is the last 4 digits of your social security number.

If you did not provide a social security number with your application, your password will be your 4-digit year of birth in the form "YYYY".

If we may be of further assistance, please email.

[oktraining@okmedicalboard.org](mailto:oktraining@okmedicalboard.org)

Sincerely,

*Kenna Shaw*

Kenna Shaw

Dept. of Licensing

Encl



# Oklahoma State Board of Medical Licensure and Supervision Application Summary

Type	Number	Name
MD	41486	BRANDON LAKE KANNADY
MEDICAL DOCTOR		

**Incomplete Information (due to space limitations on this page, this may not be a complete list)**

Exam verification date  
 PostGrad - Form 2 COLLEGE OF MEDICINE OKC  
 USMLE Exams Incomplete

**Last Medical School Attended:**

019-02 Univ Of KS Sch Of Med, Kansas City Ks 66103

**Number of Licenses Previously Granted to Graduates of this Medical School:668**

Application for: Resident  Full License \_\_\_\_\_ Reinstatement \_\_\_\_\_

**The Secretary of the Board has reviewed this application and:**

1) AUTHORIZED CIRCULARIZATION TO OTHER BOARD MEMBERS \_\_\_\_\_

2) ALL FIVE CRITERIA HAVE BEEN MET [Fast Track] \_\_\_\_\_

- Passed USMLE
- No DUIs or Legal Issues
- No Significant Malpractice Issues
- US Graduate
- Graduated Medical School on time

3) HAS ISSUED A TEMPORARY LICENSE THROUGH \_\_\_/\_\_\_/\_\_\_

4) HAS ISSUED A SPECIAL PGY-1 TRAINING LICENSE       *Bo* 6-1-23      

5) REQUESTS SPECIFIC CONSIDERATION OF:

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# Oklahoma State Board of Medical Licensure and Supervision Application Summary

Type	Number	Name
MD	41333	MAAZ AHSAN KHAN
MEDICAL DOCTOR		

**Incomplete Information (due to space limitations on this page, this may not be a complete list)**

PostGrad - Form 2 COLLEGE OF MEDICINE OKC  
 OTHER DEFICIENCIES: NEED FORM 2 AND EVAL UPON COMPLETION OF TRAINING, MUST COME DIRECTLY FROM YOUR PROGRAM

**Last Medical School Attended:**

039-01 Univ Of Ok Coll Of Med, Oklahoma City Ok 73190

**Number of Licenses Previously Granted to Graduates of this Medical School:7,353**

Application for: Resident \_\_\_\_\_ Full License \_\_\_\_\_ Reinstatement \_\_\_\_\_

**The Secretary of the Board has reviewed this application and:**

- 1) AUTHORIZED CIRCULARIZATION TO OTHER BOARD MEMBERS \_\_\_\_\_
- 2) ALL FIVE CRITERIA HAVE BEEN MET [Fast Track] \_\_\_\_\_
  - Passed USMLE
  - No DUIs or Legal Issues
  - No Malpractice Issues
  - US Graduate
  - Graduated Medical School in 4 years or less
- 3) HAS ISSUED A TEMPORARY LICENSE THROUGH \_\_\_\_ / \_\_\_\_ / \_\_\_\_
- 4) HAS ISSUED A SPECIAL PGY-1 TRAINING LICENSE \_\_\_\_\_



# Oklahoma State Board of Medical Licensure and Supervision

## Application Summary

**Type**    **Number**    **Name**  
 MD        41333    MAAZ AHSAN KHAN  
 MEDICAL DOCTOR

**Practice Address:**  
 May 03, 2023

**Status:**

Res: MD

Received: 03/29/2023

Entered: 03/29/2023

Temp Issued:

Temp Expires:

Train Issued: 07/01/2023

Train Expires: 09/30/2024

Fed Rec: 04/15/2024

AMA Rec: 04/15/2024

Board Action:

License #: 41333

Sex: M

Ethnic Origin: 6

Endorsed By: USMLE

	Test	Score	Date Taken	Date Verified	Attempts
Test 1:	USMLE 3	PASS	11/20/23	3/19/24	1
Test 2:	USMLE 1	PASS	5/28/21	3/28/23	1
Test 3:	USMLE 2	PASS	7/25/22	3/28/23	1

Note: **PASS** means higher than 75

Test AV:  
 Total Possible:  
 Okla Passing:  
 Total Score:

### PRE-MED EDUCATION

School Name: UNIVERSITY OF OKLAHOMA

City: NORMAN

Degree: BS

State:OK Country: UNITED STATES

From: 8/2015 To: 5/2018 Verified:

### MEDICAL SCHOOL EDUCATION

Name: Univ Of Ok Coll Of Med, Oklahoma City Ok 73190

Foreign Name:

City: Oklahoma City

Degree: MD

State/Country: United States of America

From: 8 / 2019 To: 5 / 2023 Diploma Ver'd: Y

### POST GRADUATE EDUCATION

Facility:COLLEGE OF MEDICINE OKC

Specialty:INTERNAL MEDICINE

Res. Fellowship: Residency

City: OKLAHOMA CITY

State:OK Country:UNITED STATES OF AM

Verified:

From: 7 / 2023 To: /

ACGME Ver'd:

Comments:

## Oklahoma State Board of Medical Licensure and Supervision Application Summary

**Type**      **Number**      **Name**  
 MD            41333      MAAZ AHSAN KHAN  
 MEDICAL DOCTOR

### PRACTICE HISTORY

<b>Employed:</b> STEPHENSON CANCER CENTER		<b>Supervisor:</b>	
<b>City:</b> OKLAHOMA CITY		<b>State:</b> OK	<b>Country:</b> UNITED STATES
<b>Specialty:</b> RESEARCH ASSISTANT	<b>From:</b> 8/ 2018	<b>To:</b> 7/ 2019	<b>Verified:</b>
<b>Comments:</b>			

<b>Employed:</b> NONE		<b>Supervisor:</b>	
<b>City:</b> EDMOND		<b>State:</b> OK	<b>Country:</b> UNITED STATES
<b>Specialty:</b> SUMMER BREAK	<b>From:</b> 5/ 2018	<b>To:</b> 8/ 2018	<b>Verified:</b>
<b>Comments:</b>			

<b>Employed:</b> NONE		<b>Supervisor:</b>	
<b>City:</b> OKLAHOMA CITY		<b>State:</b> OK	<b>Country:</b> UNITED STATES
<b>Specialty:</b> SUMMER BREAK	<b>From:</b> 5/ 2015	<b>To:</b> 8/ 2015	<b>Verified:</b>
<b>Comments:</b>			

#### Other Licenses

State	Lic Type and Number	Status	Issued	Exp	Verif
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#### DEFICIENCIES

PostGrad - Form 2 COLLEGE OF MEDICINE OKC  
 OTHER DEFICIENCIES: NEED FORM 2 AND EVAL UPON COMPLETION OF TRAINING, MUST COME DIRECTLY FROM YOUR PROGRAM



RETURN FORM TO:  
OKLAHOMA STATE BOARD OF MEDICAL LICENSURE AND SUPERVISION

[oktraining@okmedicalboard.org](mailto:oktraining@okmedicalboard.org)

RECEIVED

MAR 18 2024

QUESTIONNAIRE

Please read and follow ALL instructions

OKLAHOMA STATE BOARD OF  
MEDICAL LICENSURE  
AND SUPERVISION

**FORM INSTRUCTIONS:** Complete both pages of this form *only if* you are renewing or upgrading your training license. Attach the appropriate documentation and answer the confidential questions.

**PAYMENT INSTRUCTIONS:** If you **ARE FULLY LICENSED**, you **MUST** go online and renew your license – **DO NOT pay your renewal fee via these instructions (doing so will delay your renewal).**

**ATTESTATION STATEMENT:** By completing this document, I agree to pay the appropriate fee on **ONLINE BILL PAY**. If you are **UPGRADING** your training license to a full license, your fee will be \$250 & you will choose **MD TRAINING-TO-FULL**

If you are **RENEWING** your training license, your fee will be \$150 & you will choose **MD TRAINING LICENSE RENEWAL**

PLEASE PRINT ALL INFORMATION

FIRST NAME	Maaz	LAST NAME	Khan
EMAIL ADDRESS	[REDACTED]		
LICENSE NUMBER	41333	CELL PHONE	[REDACTED]
HOME ADDRESS	[REDACTED]	CITY/STATE ZIP CODE	[REDACTED]
PROGRAM ATTENDING	Ajay Nadig	SPECIALTY	Internal Medicine

DOCUMENTATION TO ATTACH

PAYMENT COMPLETED			
<input type="checkbox"/>	\$150 payment made on Billpay for <b>RENEWAL</b> of training license	<input checked="" type="checkbox"/>	\$250 payment made on Billpay for <b>UPGRADE</b> of training license

DOCUMENTATION REQUIRED			
<input checked="" type="checkbox"/>	Form 2 (must be received directly from program) <b>**ONLY FOR UPGRADE</b>	<input checked="" type="checkbox"/>	Evaluation (must be received directly from program)
<input checked="" type="checkbox"/>	USMLE Step 3 (must be received directly from USMLE)	<input checked="" type="checkbox"/>	Answer confidential questions (on back of this form)

FOREIGN TRAINED STUDENTS			
<input type="checkbox"/>	Current visa	<input type="checkbox"/>	Social Security Number <b>**if not provided at initial application</b>
<input type="checkbox"/>	Background Check <b>**if not done at initial application</b>		

**IF YOU ARE FULLY LICENSED – DO NOT COMPLETE THIS FORM. YOU MUST GO ONLINE AND RENEW AT <https://pay.apps.ok.gov/medlic/md/login.php> ENTER YOUR LICENSE NUMBER & PIN – COMPLETE YOUR RENEWAL AND PAY THE RENEWAL FEE.**

41333  
SJ

NAME Maaz Khan

**IF YOU HAVE ANY "YES" ANSWERS YOU MUST PROVIDE A NOTARIZED STATEMENT EXPLAINING YOUR ANSWER.**

**SINCE RENEWAL OF YOUR TRAINING LICENSE OR INITIAL ISSUE OF YOUR TRAINING LICENSE (whichever is most recent)**

QUESTIONS	YES	NO
Have you failed any part of the USMLE exam (not previously disclosed)?	<input type="checkbox"/>	<input checked="" type="checkbox"/>
Have you been the subject of investigation or disciplinary action (including probation) by a hospital or training program?	<input type="checkbox"/>	<input checked="" type="checkbox"/>
Have you had any adverse judgment or settlement against you arising from a professional liability claim?	<input type="checkbox"/>	<input checked="" type="checkbox"/>
Have you been reported to the National Practitioner Data Bank (NPDB)?	<input type="checkbox"/>	<input checked="" type="checkbox"/>
Have you ever been denied, had removed, or suspended hospital privileges?	<input type="checkbox"/>	<input checked="" type="checkbox"/>
Have you surrendered hospital privileges while under investigation or to avoid investigation?	<input type="checkbox"/>	<input checked="" type="checkbox"/>
Have you entered into an Agreement with a Federal, State, or Local jurisdictional body to avoid formal action?	<input type="checkbox"/>	<input checked="" type="checkbox"/>
Has your application for licensure ever been denied?	<input type="checkbox"/>	<input checked="" type="checkbox"/>
Have you surrendered a license or had any disciplinary action taken on any license?	<input type="checkbox"/>	<input checked="" type="checkbox"/>
Have you been investigated by or requested to appear before a licensing or disciplinary agency (other than the Oklahoma State Board of Medical Licensure and Supervision)?	<input type="checkbox"/>	<input checked="" type="checkbox"/>
Have you obtained an assessment or been treated for use of any drug or chemical substance including alcohol?	<input type="checkbox"/>	<input checked="" type="checkbox"/>
Have you been arrested for, charged with, or convicted of a felony or misdemeanor other than a traffic violation?	<input type="checkbox"/>	<input checked="" type="checkbox"/>
Have you been arrested for, charged with, or convicted of a traffic violation involving the use of any drug or chemical substance?	<input type="checkbox"/>	<input checked="" type="checkbox"/>
Have you been addicted to or abused any drug or chemical substance including alcohol?	<input type="checkbox"/>	<input checked="" type="checkbox"/>
Have you been denied provider participation, terminated, sanctioned or penalized by any third-party payor including TRICARE, MEDICARE, or MEDICAID?	<input type="checkbox"/>	<input checked="" type="checkbox"/>
Have you surrendered or had any adverse action taken against any narcotic permit (State or Federal)?	<input type="checkbox"/>	<input checked="" type="checkbox"/>

I swear under penalty of perjury, that I am the person completing this Questionnaire and understand that any medical license procured or obtained by fraud or misrepresentation will result in disciplinary action taken against the licensee pursuant to the provisions of 59 O.S. § 508.

Signature Maaz Khan  
Signer ID: L5MVO6LO12...

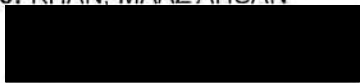
Date 3/18/24



**Oklahoma State Board of Medical Licensure and Supervision**  
 APPLICATION FOR OKLAHOMA MEDICAL DOCTOR LICENSE  
 Received: 03/29/2023

**Applicant Name:** KHAN, MAAZ AHSAN

**MD 41333**



**Date Of Birth:** [REDACTED]

**Place Of Birth (City, State):** WICHITA, KS

**Sex:** M

**Race:** Asian/Pacific Islander

Education									
Type	Name	City	ST	Country	From	To	Degree	Comments	Veri
UG	UNIVERSITY OF OKLAHOMA	NORMAN	OK		8/2015	5/2018	BS		

Medical School Name	City	State	Country	Comments	From	To
Univ Of Ok Coll Of Med, Oklahoma City Ok 73190	Oklahoma City	OK	United States		8/2019	5/2023

Post-Graduate						
Facility	City	St	Country	Specialty	Comments	From To
OU HEALTH	OKLAHOMA CITY	OK	UNITED S	INTERNAL MEDICINE		/ 7/2026
			UNITED S			/ /

Practice History								
Employer	Specialty	Supervisor	City	ST	Countr	From	To	Verif
STEPHENSON CANCER CENTER	RESEARCH ASSISTANT		OKLAHOMA CITY	OK		8/2018	7/2019	

Other/ Out-Of-State Licenses					
State	License #	Profession	Status	Issue Date	Exp Date

\$250<sup>00</sup>

MD Exam				
Exam	State	Score	Date Taken	#
USMLE				

**Oklahoma State Board of Medical Licensure and Supervision**

PAGE 423 of 500

**APPLICATION FOR OKLAHOMA MEDICAL DOCTOR LICENSE**

Received:03/29/2023

<b>Questions Answered 03/22/2023</b>	<b>Response</b>
A. Have you ever been denied provider participation, terminated, sanctioned, or penalized by any third party payor, to include TRICARE, MEDICARE, MEDICAID?	<b>N</b>
B. Have you ever surrendered or had any adverse action taken against any narcotic permit (state or federal)?	<b>N</b>
C. Have you ever been denied membership or had disciplinary action taken by a national, state or county professional organization?	<b>N</b>
D. Have you ever been denied or had removed or suspended hospital staff privileges?	<b>N</b>
E. Have you ever surrendered hospital staff privileges while under investigation or to avoid investigation?	<b>N</b>
F. Have you ever entered into an agreement with a federal, state or local jurisdictional body to avoid formal action?	<b>N</b>
G. Have you ever been the subject of an investigation, probation or disciplinary action by a hospital, clinic, practice group, training program or professional school?	<b>N</b>
H. Have you had any adverse judgment, settlement, or award against you arising from a professional liability claim?	<b>N</b>
I. Have you ever had professional liability coverage declined, canceled, issued on special terms, or renewal refused?	<b>N</b>
J. Have you ever been reported to the National Practitioners Data Bank (NPDB) or to the Healthcare Integrity and Protection Data Bank (HIPDB)? (If yes, enclose a copy of the report.)	<b>N</b>
K. Has your application for examination or a professional license ever been denied?	<b>N</b>
L. Have you ever failed any part of a licensure/certification/registration examination?	<b>N</b>
M. Have you ever surrendered a license or had a license revoked?	<b>N</b>
N. Has any disciplinary action been taken on any license?	<b>N</b>
O. Have you ever been subject of a review by professional licensing/regulatory agency based on a complaint filed against you?	<b>N</b>
P. Have you ever been arrested, charged with, or convicted of a felony or misdemeanor, other than traffic violations?	<b>N</b>
Q. Have you ever been arrested, charged with, or convicted of a traffic violation involving the use of any drug or chemical substance, including alcohol?	<b>N</b>
R. Are you now or have you within the past two years been addicted to or used in excess any drug or chemical substance, including alcohol?	<b>N</b>
S. Have you obtained an assessment or been treated for the use of any drug or chemical substance, including alcohol?	<b>N</b>
T. Do you currently have or have you had within the past two years any mental or physical disorder or condition which, if untreated, could affect your ability to practice competently?	<b>N</b>
U. Are you or your spouse currently on Active Duty in the U.S. Armed Forces?	<b>N</b>
V. Are you or your spouse currently Deployed on Active Duty in the U.S. Armed Forces?	<b>N</b>



Oklahoma State Board of Medical Licensure and Supervision

APPLICATION FOR OKLAHOMA MEDICAL DOCTOR LICENSE

Received:03/29/2023

If licensed, where do you intend to locate?

OK

Why do you seek Licensure in the state of Oklahoma?

Post-Graduate Training

In what manner will you be communicating with your Oklahoma patients (telephone, email, internet, video-conference, etc)?

Describe how you will examine each patient in person prior to diagnosis, treating, correcting, or prescribing for a patient in Oklahoma from the state, province, or country you are located:

Describe the manner in which you intend to practice medicine across state lines in Oklahoma:

Have you executed or been offered a contract in connection with practice in the state of Oklahoma?

Yes

If 'Yes', Name of practice:

OU Health

If so, Please identify with which category:

Residency

Name of Previous Carrier and Policy Holder

APIC  
OU Health

Name of Current Carrier and policy Holder

APIC  
OU Health

Will your professional liability insurance policy cover your practice in Oklahoma

Yes

If NO, when do you expect to obtain liability insurance that will cover practice in Oklahoma

I attest that all the above information is accurate as of March 28, 2023: \_\_\_\_\_ (Signed Online) \_\_\_\_\_



Applicant: In the presence of a notary public, sign this form with attached photo.

Send this form to: Oklahoma State Board of Medical Licensure and Supervision

oktraining@okmedicalboard.org

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

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

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

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

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

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



*Maaz Khan*

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

Khan, Maaz, A.

Applicants printed last name, first name, middle initial, and suffix (e.g., Jr.)

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MAR 29 2023

OKLAHOMA STATE BOARD OF MEDICAL LICENSURE AND SUPERVISION

3-28-23

Date of signature (must correspond to the date of notarization)

NOTARY

State of Oklahoma, County of Oklahoma

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

The statements on this document are subscribed and sworn to before me by the applicant on this 28 day of March, 2023

Notary Public Signature *[Signature]* My Notary Commission Expires 3/17/26



T 41333





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

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

**Recipient:** OKLAHOMA STATE BOARD OF  
MEDICAL LICENSURE & SUPERVISION

**Date:** 03/19/2024

**Examinee:** Khan, Maaz  
**Alt Name(s):**

**Examinee ID:** 5-476-287-7  
**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. Pass/fail outcomes are based upon the minimum passing level in place at the time of test administration and are not altered by subsequent revisions to the minimum passing level. Effective April 1, 2013, two-digit scores will no longer be reported. Test results reported as passing represent an exam score of 75 or higher on a two-digit scale. Step 1 examinations taken on or after January 26, 2022 are reported as pass/fail, with no numeric score; Step 1 examinations taken before January 26, 2022 will continue to be reported with a 3-digit score.

### USMLE STEP 1

Test Date	Pass/Fail	Score	Minimum Pass	Comments
05/28/2021	Pass	238	(194)	

### USMLE STEP 2

*Clinical Knowledge (CK)*

Test Date	Pass/Fail	Score	Minimum Pass	Comments
07/25/2022	Pass	258	(214)	

### USMLE STEP 3

Test Date	Pass/Fail	Score	Minimum Pass	Comments
11/20/2023	Pass	238	(198)	

**End of Exam History**

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

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

RECEIVED

MAR 19 2024

OKLAHOMA STATE BOARD OF  
MEDICAL LICENSURE  
AND SUPERVISION

T41353  
MST



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

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400 Fuller Wisner Road, Euless, TX 76039-3856 - Telephone (817) 868-4000

**Examinee:** Khan, Maaz

**Examinee ID:** 5-476-287-7

**Date of Birth:** [REDACTED]

### INTERPRETATION OF RESULTS

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

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

### STEP 1 AND STEP 2 CLINICAL SKILLS (CS)

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

### ANNOTATIONS APPEARING UNDER "COMMENTS"

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

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

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

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

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

### ANNOTATIONS APPEARING AS "NOTE"

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

### PHYSICIAN DATA CENTER INFORMATION APPEARING AS "NOTE"

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

03/2015

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



Oklahoma State Board of Medical Licensure and Supervision
101 NE 51st Street
Oklahoma City, OK 73105

This form must be completed by the institution and mailed directly from the institution.

Applicant's Name Maaz Khan

Institution: University of Oklahoma College of Medicine City/State Oklahoma City, OK

Our records indicate that the above named applicant attended our medical school on the following dates:

From 8 / 19 / 2019 To 5 / 20 / 2023 and was awarded the degree Doctor of Medicine

- 1. Does this individual's official record reflect (an) interruption(s) or extension(s) in his/her medical education? If yes, please explain. YES NO
2. Does this individual's official record reflect that he/she was ever placed on academic or disciplinary probation during his/her medical education? If yes, please explain. YES NO
3. Does this individual's official record reflect that he/she was ever the subject of negative reports for behavioral reasons or an investigation by the medical school or parent university? If yes, please explain below. YES NO
4. Does this individual's official record reflect that he/she was ever disciplined for unprofessional conduct/behavioral reasons by the medical school or parent university? If yes, please explain below. YES NO
5. Does this individual's official record reflect that there were any limitations or special requirements imposed on the individual because of questions of academic incompetence, disciplinary problems, or any other reason? If yes, please explain below. YES NO

Please explain any "YES" response from above:

Completion of the following is certification that the information above is an accurate account of this individual's records and is true and correct.

Name: Teresa Scordino, M.D. Signature [Handwritten Signature]

Title of Signatory: Associate Dean for Student Affairs Date of Signature 5/31/23

Tel: 405-271-2316 Fax: 405-271-2287 E-Mail: Teresa-Scordino@ouhsc.edu

School Seal

If no seal is available, this form must be notarized

Notary Public

Commission #

My commission expires:

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JUN 08 2023

OKLAHOMA STATE BOARD OF MEDICAL LICENSURE AND SUPERVISION

PRIMA SOURCE



TH1333



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Official Transcript

JUN 08 2023

OKLAHOMA STATE BOARD OF  
MEDICAL LICENSURE  
AND SUPERVISION

Name : Maaz Khan  
Student ID: 1790267  
Birthdate : [REDACTED]

University of Oklahoma Health Sciences Center  
P. O. Box 26901  
Oklahoma City, OK 731260901  
United States

----- Degrees Awarded -----  
Degree : Doctor of Medicine  
Confer Date : 2023-05-20  
Plan : Medicine  
----- External Degrees -----

PRIMARY SOURCE

University of Oklahoma  
2018-05-11 Bachelor of Science  
Field of Study : Chemistry and Biochemistry  
----- Academic Program History -----

Program : Medicine MD  
2019-08-16 : Active in Program  
2019-08-16 : Medicine - MD Major  
2023-05-20 : Completed Program  
----- Beginning of Medicine Record -----

Course	Description	Attempted	Earned	Grade	Points
INDT	8110 Design/Analysis Clin Res	16.00	16.00	S	
INDT	8122 Clinical Medicine I	111.50	111.50	S	
INDT	8124 The Human Structure	130.00	130.00	S	
INDT	8125 Foundations of Medicine	151.00	151.00	S	
INDT	8244 PPSI	87.00	87.00	S	
INDT	8555 Req Orientation Documents I			0.00	CE
INDT	9100 Prologue	24.00	24.00	S	
TERM GPA :	0.000	GPH: 0.00	TOTALS : 519.50	519.50	0.000
OUHSC GPA :	0.000	GPH: 0.00	TOTALS : 519.50	519.50	0.000

Course	Description	Attempted	Earned	Grade	Points
INDT	8132 IMI	68.00	68.00	S	
INDT	8140 Gastrointestinal & Hepatobil	85.00	85.00	S	
INDT	8148 Endo, Metab & Nutri Biochem	85.00	85.00	S	
INDT	8156 Blood, Hematopoiesis & Lymph	77.00	77.00	S	

Spring 2020  
TERM GPA : 0.000 GPH: 0.00 TOTALS : 315.00 315.00 0.000  
OUHSC GPA : 0.000 GPH: 0.00 TOTALS : 834.50 834.50 0.000

Course	Description	Attempted	Earned	Grade	Points
INDT	8264 Cardiovasc, Resp, Renal	164.00	164.00	S	
INDT	8266 PPS II: Clinical Ethics	35.00	35.00	S	
INDT	8272 Neurosciences	166.00	166.00	S	
INDT	8275 Clinical Medicine II	99.00	99.00	S	
INDT	8301 Enrichment Program: Humanities	16.00	16.00	S	
Course Topic(s) : History of Medicine					

Fall 2020  
TERM GPA : 0.000 GPH: 0.00 TOTALS : 480.00 480.00 0.000  
OUHSC GPA : 0.000 GPH: 0.00 TOTALS : 1314.50 1314.50 0.000

Course	Description	Attempted	Earned	Grade	Points
INDT	8280 Reproduction	98.00	98.00	S	
INDT	9200 MS2 Capstone	70.00	70.00	S	
INDT	9201 Joint, Skin, and Bone	40.00	40.00	S	

Spring 2021  
TERM GPA : 0.000 GPH: 0.00 TOTALS : 208.00 208.00 0.000  
OUHSC GPA : 0.000 GPH: 0.00 TOTALS : 1522.50 1522.50 0.000

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This information is released in accordance with the Family Education Privacy Act of 1974 and is also released under the condition that other parties will not have access to this information without the student's written consent.



Law Klein  
T41333  
[Signature]

REGISTRAR, OUHSC



**UNIT OF CREDIT:** The unit of credit for undergraduate and graduate courses is the semester hour. Prior to Summer 2002, the unit of credit for professional courses is the clock hour. The unit of credit for the College of Medicine (MD) is the clock hour. Each course taken at OUHSC is recorded on the student's transcript including courses passed, failed, repeated, exempted, audited, etc. All course work is residence credit unless otherwise indicated.

**GRADES USED AT OUHSC:**

**Grades Used in the Calculation of Grade Point Average (GPA)**

- A = Excellent (4 grade points)
- B = Good (3 grade points)
- C = Average (2 grade points)
- D = Poor (1 grade point) not considered passing in some programs
- F = Failing (0 grade points)

**Other Symbols**

- I = Incomplete (student lacks a test, project, paper, etc.)
- AU = Audit (no credit)
- W = Withdrawal
- AW = Administrative Withdrawal
- S = Satisfactory (GPA neutral, counted in the total number of attempted hours)
- U = Unsatisfactory (GPA neutral, counted in the total number of attempted hours)
- P = Passing (GPA neutral, counted in the total number of attempted hours)
- NP = No Pass (GPA neutral, counted in the total number of attempted hours)
- X = Graduate thesis or dissertation in progress (GPA neutral)

**Program Specific Symbols**

- CE = Continuing Education
- EX = Exempt from a required course, student has earned equivalent credit
- R = Requirements successfully completed
- Y = Year-Long Course
- H = College of Medicine Honors (GPA neutral, counted in total number of attempted hours)

**FULL-TIME COURSE LOAD:**

- Summer (Undergraduate) = 6 semester hours
- Summer (Graduate) = 4 semester hours
- Fall (Undergraduate) = 12 semester hours
- Fall (Graduate) = 9 semester hours
- Spring (Undergraduate) = 12 semester hours
- Spring (Graduate) = 9 semester hours

Professional students are considered full-time unless otherwise indicated.

**NORMAN/OKLAHOMA CITY/TULSA SCHUSTERMAN CAMPUSES:** Transcripts for all undergraduate and graduate students who were enrolled at OUHSC prior to Fall 1979 are located in the Office of Admissions and Records on the Norman campus. Work completed on the Norman campus prior to enrollment at OUHSC is maintained on the Norman campus.

Regardless of campus, copies of OUHSC records may be obtained through the transcript request process at the OUHSC Office of Admissions and Records, 1105 N. Stonewall, LIB 121, Oklahoma City, OK 73117-1221. Questions regarding the transcript request process may be directed to (405) 271-2359 or FAX (405) 271-2480.

**TERM DEFINITIONS:**

- Summer = 8 weeks in length
- Summer I = 8 weeks in length
- Summer II = 7-8 weeks in length
- Fall = 16 weeks in length
- Spring = 16 weeks in length

**TRANSCRIPT SUMMARY:**

- Career totals
- Transfer statistics (if posted)
- OUHSC statistics
- Combined statistics

**COURSE NUMBER:**

- 1000 – 1999 = Freshman level courses
- 2000 – 2999 = Sophomore level courses
- 3000 – 3999 = Junior level courses
- 4000 – 4999 = Senior level courses
- 5000 – 6999 = Graduate level courses
- 5000 – 5999 = Bachelor degree program in College of Pharmacy Undergraduate level courses
- 7000 – 9999 = Professional degree courses

**DEGREE HONORS:**

- Distinction
- Special Distinction
- Outstanding Distinction

OUHSC recognizes honors for degrees conferred by the Colleges of Allied Health, Dentistry, Medicine, Nursing, and Pharmacy.

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**JUN 08 2023**

**OKLAHOMA STATE BOARD OF  
MEDICAL LICENSURE  
AND SUPERVISION**

**TO TEST FOR AUTHENTICITY:** The face of this transcript is printed on burgundy security paper.

**ADDITIONAL TESTS:** When photocopied, a patent security statement containing the institutional name and the words COPY COPY COPY appear over the face of the entire document. When this paper is touched by fresh liquid bleach, an authentic document will stain. A black and white or color copy of this document is not an original and should not be accepted as an official institutional document. This document cannot be released to a third party without the written consent of the student. This is in accordance with the Family Educational Rights and Privacy Act of 1974. If you have any questions about this document, please contact our office at (405) 271-2359. **ALTERATION OF THIS DOCUMENT MAY BE A CRIMINAL OFFENSE!**



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Official Transcript

JUN 08 2023

Name : Maaz Khan  
 Student ID: 1790267  
 Birthdate : [REDACTED]

University of Oklahoma Health Sciences Center  
 P. O. Box 26901  
 Oklahoma City, OK 731260901  
 United States

OKLAHOMA STATE BOARD OF  
 MEDICAL LICENSURE  
 AND SUPERVISION

PRIMARY  
 SOURCE

Summer II 2021					Summer II 2022						
Course	Description	Attempted	Earned	Grade	Points	Course	Description	Attempted	Earned	Grade	Points
INDT 9301	Clinical Transitions	40.00	40.00	S		INDT 9300	Capstone	160.00	160.00	S	
PEDI 9650	Pediatric Clerkship	240.00	240.00	B	720.000	INDT 9403	Subinternship Elective	160.00	160.00	A	640.000
ORL 9101	Otorhinolaryngology Selective	80.00	80.00	S		Course Topic(s): MED Subinternship Elective					
TERM GPA :	3.000	GPH: 240.00	TOTALS : 360.00	360.00	720.000	TERM GPA :	4.000	GPH: 160.00	TOTALS : 320.00	320.00	640.000
OUHSC GPA :	3.000	GPH: 240.00	TOTALS : 1882.50	1882.50	720.000	OUHSC GPA :	3.391	GPH: 1840.00	TOTALS : 3802.50	3802.50	6240.000
Fall 2021					Fall 2022						
Course	Description	Attempted	Earned	Grade	Points	Course	Description	Attempted	Earned	Grade	Points
OBGY 9210	Obstet & Gyn Clerkship	240.00	240.00	B	720.000	INDT 9406	Special Studies Elective	160.00	160.00	S	
SURG 9760	Surgery Clerkship	320.00	320.00	B	960.000	Course Topic(s): FM Special Studies Elective					
RADI 9101	RADI Selective	80.00	80.00	S		INDT 9403	Subinternship Elective	160.00	160.00	A	640.000
TERM GPA :	3.000	GPH: 560.00	TOTALS : 640.00	640.00	1680.000	Course Topic(s): EM Subinternship Elective					
OUHSC GPA :	3.000	GPH: 800.00	TOTALS : 2522.50	2522.50	2400.000	INDT 9407	Fourth Year Selective	160.00	160.00	S	
Spring 2022					Spring 2023						
Course	Description	Attempted	Earned	Grade	Points	Course	Description	Attempted	Earned	Grade	Points
FM 9540	Fam Med Clerkship	160.00	160.00	B	480.000	INDT 9403	Subinternship Elective	160.00	160.00	A	640.000
MED 9101	Geriatric Selective	80.00	80.00	S		Course Topic(s): MED Subinternship Elective					
PSBS 9520	Psychiatry Clerkship	240.00	240.00	A	960.000	INDT 9406	Special Studies Elective	160.00	160.00	S	
NEUR 9370	Neurology Clerkship	160.00	160.00	B	480.000	Course Topic(s): INDT Special Studies Elective					
MED 9250	Medicine Clerkship	320.00	320.00	A	1280.000	ANES 9110	Anesthesiology Selective	80.00	80.00	S	
TERM GPA :	3.636	GPH: 880.00	TOTALS : 960.00	960.00	3200.000	FM 9569	CH I	80.00	80.00	S	
OUHSC GPA :	3.333	GPH: 1680.00	TOTALS : 3482.50	3482.50	5600.000	FM 9572	CH II	80.00	80.00	S	

Interprofessional Education Tier I-Completed

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*Low Klein*

REGISTRAR, OUHSC



**EXPLANATION OF RECORD**  
**THE UNIVERSITY OF OKLAHOMA HEALTH SCIENCES CENTER**  
**OUHSC FICE CODE 5889**

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- P = Passing (GPA neutral, counted in the total number of attempted hours)
- NP = No Pass (GPA neutral, counted in the total number of attempted hours)
- X = Graduate thesis or dissertation in progress (GPA neutral)

**Program Specific Symbols**

- CE = Continuing Education
- EX = Exempt from a required course, student has earned equivalent credit
- R = Requirements successfully completed
- Y = Year-Long Course
- H = College of Medicine Honors (GPA neutral, counted in total number of attempted hours)

**FULL-TIME COURSE LOAD:**

- Summer (Undergraduate) = 6 semester hours
- Summer (Graduate) = 4 semester hours
- Fall (Undergraduate) = 12 semester hours
- Fall (Graduate) = 9 semester hours
- Spring (Undergraduate) = 12 semester hours
- Spring (Graduate) = 9 semester hours

Professional students are considered full-time unless otherwise indicated.

**NORMAN/OKLAHOMA CITY/TULSA SCHUSTERMAN CAMPUSES:** Transcripts for all undergraduate and graduate students who were enrolled at OUHSC prior to Fall 1979 are located in the Office of Admissions and Records on the Norman campus. Work completed on the Norman campus prior to enrollment at OUHSC is maintained on the Norman campus.

Regardless of campus, copies of OUHSC records may be obtained through the transcript request process at the OUHSC Office of Admissions and Records, 1105 N. Stonewall, LIB 121, Oklahoma City, OK 73117-1221. Questions regarding the transcript request process may be directed to (405) 271-2359 or FAX (405) 271-2480.

**TERM DEFINITIONS:**

- Summer = 8 weeks in length
- Summer I = 8 weeks in length
- Summer II = 7-8 weeks in length
- Fall = 16 weeks in length
- Spring = 16 weeks in length

**TRANSCRIPT SUMMARY:**

- Career totals
- Transfer statistics (if posted)
- OUHSC statistics
- Combined statistics

**COURSE NUMBER:**

- 1000 – 1999 = Freshman level courses
- 2000 – 2999 = Sophomore level courses
- 3000 – 3999 = Junior level courses
- 4000 – 4999 = Senior level courses
- 5000 – 6999 = Graduate level courses
- 5000 – 5999 = Bachelor degree program in College of Pharmacy Undergraduate level courses
- 7000 – 9999 = Professional degree courses

**DEGREE HONORS:**

- Distinction
- Special Distinction
- Outstanding Distinction

OUHSC recognizes honors for degrees conferred by the Colleges of Allied Health, Dentistry, Medicine, Nursing, and Pharmacy.

**RECEIVED**

**JUN 08 2023**

**OKLAHOMA STATE BOARD OF  
MEDICAL LICENSURE  
AND SUPERVISION**

**TO TEST FOR AUTHENTICITY:** The face of this transcript is printed on burgundy security paper.

**ADDITIONAL TESTS:** When photocopied, a patent security statement containing the institutional name and the words COPY COPY COPY appear over the face of the entire document. When this paper is touched by fresh liquid bleach, an authentic document will stain. A black and white or color copy of this document is not an original and should not be accepted as an official institutional document. This document cannot be released to a third party without the written consent of the student. This is in accordance with the Family Educational Rights and Privacy Act of 1974. If you have any questions about this document, please contact our office at (405) 271-2359.  
**ALTERATION OF THIS DOCUMENT MAY BE A CRIMINAL OFFENSE!**



Official Transcript

University of Oklahoma Health Sciences Center  
 P. O. Box 26901  
 Oklahoma City, OK 731260901  
 United States

Name : Maaz Khan  
 Student ID: 1790267  
 Birthdate : [REDACTED]

Spring 2023 (cont.)

TERM GPA : 4.000 GPH: 160.00 TOTALS : 560.00 560.00 640.000

OUHSC GPA : 3.481 GPH: 2160.00 TOTALS : 4842.50 4842.50 7520.000

Medicine Career Totals

OUHSC GPA : 3.481 GPH: 2160.00 TOTALS : 4842.50 4842.50 7520.000

Post-Baccalaureate Career Totals

OUHSC GPA : 3.481 GPH: 135.00 TOTALS : 302.65 302.65 470.000

----- End Of Career (1 of 1) -----  
 ----- End Of Transcript -----

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JUN 08 2023

PRIMARY SOURCE

OKLAHOMA STATE BOARD OF  
 MEDICAL LICENSURE  
 AND SUPERVISION

This official transcript is printed on burgundy security paper. A laser-produced signature of the Registrar, OUHSC is imprinted on each page in black ink. A raised seal is not required. When photocopied, the word COPY should appear. A BLACK AND WHITE OR COLOR COPY OF THIS TRANSCRIPT SHOULD NOT BE ACCEPTED.

This information is released in accordance with the Family Education Privacy Act of 1974 and is also released under the condition that other parties will not have access to this information without the student's written consent.



*Lou Klein*

REGISTRAR, OUHSC

THE UNIVERSITY OF OKLAHOMA HEALTH SCIENCES CENTER

THE UNIVERSITY OF OKLAHOMA HEALTH SCIENCES CENTER



**EXPLANATION OF RECORD**  
**THE UNIVERSITY OF OKLAHOMA HEALTH SCIENCES CENTER**  
**OUHSC FICE CODE 5889**

**UNIT OF CREDIT:** The unit of credit for undergraduate and graduate courses is the semester hour. Prior to Summer 2002, the unit of credit for professional courses is the clock hour. The unit of credit for the College of Medicine (MD) is the clock hour. Each course taken at OUHSC is recorded on the student's transcript including courses passed, failed, repeated, exempted, audited, etc. All course work is residence credit unless otherwise indicated.

**GRADES USED AT OUHSC:**

**Grades Used in the Calculation of Grade Point Average (GPA)**

- A = Excellent (4 grade points)
- B = Good (3 grade points)
- C = Average (2 grade points)
- D = Poor (1 grade point) not considered passing in some programs
- F = Failing (0 grade points)

**Other Symbols**

- I = Incomplete (student lacks a test, project, paper, etc.)
- AU = Audit (no credit)
- W = Withdrawal
- AW = Administrative Withdrawal
- S = Satisfactory (GPA neutral, counted in the total number of attempted hours)
- U = Unsatisfactory (GPA neutral, counted in the total number of attempted hours)
- P = Passing (GPA neutral, counted in the total number of attempted hours)
- NP = No Pass (GPA neutral, counted in the total number of attempted hours)
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JUN 08 2023

OKLAHOMA STATE BOARD OF  
MEDICAL LICENSURE  
AND SUPERVISION

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**ALTERATION OF THIS DOCUMENT MAY BE A CRIMINAL OFFENSE!**





# AMA Physician Profile

PREPARED FOR

Oklahoma State Board of Licensure & Supervision, Oklahoma City, OK

Name and Mailing Address

MAAZ KHAN



PRIMARY SOURCE

Primary Office Address

RECEIVED

APR 15 2024

OKLAHOMA STATE BOARD OF MEDICAL LICENSURE AND SUPERVISION

Birth date



Phone UNKNOWN

Physician's major professional activity

HOSPITAL BASED RESIDENTS - ALL YEARS

AMA membership status

MEMBER

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

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

NO DATA REPORTED AT THIS TIME

### Current and/or historical medical school

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

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

School: UNIVERSITY OF OKLAHOMA COLLEGE OF MEDICINE

Degree Awarded:

YES

Degree Type:

MD

Enrollment Date:

08/2019

Degree Date:

05/2023

41333  
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### Current and/or historical ACGME-accredited graduate medical training programs

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

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

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

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

**Sponsoring Institution:** UNIVERSITY OF OKLAHOMA COLLEGE OF MEDICINE  
**Sponsoring State:** OKLAHOMA  
**Program name:** UNIVERSITY OF OKLAHOMA HEALTH SCIENCES CENTER PROGRAM  
**Specialty:** INTERNAL MEDICINE  
**Training Type:** SPECIALTY  
**Dates:** 07/01/2023 - 06/30/2026  
**Status:** TRAINING IN PROGRESS

### Specialty board certification

NO DATA REPORTED AT THIS TIME

### Current and/or historical medical licensure

NO DATA REPORTED AT THIS TIME

### Action notifications reported to the AMA

**Medical Licensing Boards:** NO ACTIONS REPORTED AT THIS TIME

**Medicare/Medicaid Sanctions from DHHS:** NO ACTIONS REPORTED AT THIS TIME

**US DOJ Drug Enforcement Administration: NO ACTIONS REPORTED AT THIS TIME**

**U.S. Drug Enforcement Administration (DEA)**

NO DATA REPORTED AT THIS TIME

**ECFMG certification**

NOT APPLICABLE

**Profile information**

The content of the AMA Physician Profile is for credentialing use only. The content cannot be used or assembled for an employment purpose as defined under the Fair Credit Reporting Act. An organization's appropriate use of the data contained in the AMA Physician Professional Data™, formerly known as AMA Physician Masterfile, meets select primary source verification requirements of the Joint Commission, the Accreditation Association for Ambulatory Health Care (AAAHC) and the American Accreditation Health Care Commission (AAHCC)/ Utilization Review Accreditation Commission (URAC). The AMA Physician Professional Data is also an NCQA-approved source for verification of medical school, post-graduate medical training, ABMS Board Certification and federal DEA registration.

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

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



RECEIVED

MAR 29 2023

OKLAHOMA STATE BOARD OF MEDICAL LICENSURE AND SUPERVISION  
EVIDENCE OF STATUS - PART A

OKLAHOMA STATE BOARD OF  
MEDICAL LICENSURE  
AND SUPERVISION

NOTARIZED FORM CAN BE EMAILED TO OKTRAINING@OKMEDICALBOARD.ORG

Full Legal Name: Maaz A Khan Maiden (if applicable)

Mailing Address: [Redacted]

[Redacted] [Redacted] [Redacted] [Redacted] [Redacted] [Redacted] [Redacted] [Redacted] [Redacted] [Redacted]

City State Zip Code Telephone Number Social Security #: [Redacted]

PRIMARY EVIDENCE OF CITIZENSHIP  
(FOR US CITIZENS, US NATIONALS, OR PERMANENT LEGAL RESIDENT ALIENS)

If you are a U.S. citizen, U.S. national, or permanent legal resident alien, please attach a photocopy of one of the following documents to this form. Place a checkmark below to indicate the document that is attached.

- A birth certificate showing birth in one of the 50 States, the District of Columbia, Puerto Rico (on or after January 13, 1941), Guam, the U.S. Virgin Islands (on or after January 17, 1917), American Samoa, Swain's Island or the Northern Mariana Islands, unless the person was born to foreign diplomats residing in the U.S.
- United States passport (except limited passports, which are issued for periods of less than five years)
- Report of birth abroad of a U.S. citizen (FS-240) (issued by the Department of State to U.S. citizens)
- Certificate of birth (FS-545) (issued by a foreign service post) or Certification of Report of Birth (DS1350) (issued by the Department of State), copies available from the Department of State
- Certificate of Naturalization (N-550 or N-570) (issued by the INS through a Federal or State court, or through administrative naturalization after December 1990 to individuals who are individually naturalized; the N570 is a replacement certificate issued when the N-550 has been lost or mutilated or the individual's name has been changed)
- Certificate of Citizenship (N-560 or N-561) (issued by the INS to individuals who derive U.S. citizenship through a parent; the N-561 is a replacement certificate issued when the N-560 has been lost or mutilated or the individual's name has been changed)
- United States Citizen Identification Card (I-197) (issued by the INS until April 7, 1983 to U.S. citizens living near the Canadian or Mexican border who needed it for frequent border crossing) (formerly Form I-179, last issued in February 1974)
- Northern Mariana Identification Card (issued by the INS to a collectively naturalized citizen of the U.S. who was born in the Northern Mariana Islands before November 3, 1986)
- Statement provided by a U.S. consular officer certifying that the individual is a U.S. citizen (This is given to an individual born outside the U.S. who derives citizenship through a parent but does not have an FS-240, FS-545 or DS-1350);
- American Indian Card with a classification code "KIC" and a statement on the back (identifying U.S. citizen members of the Texas Band of Kickapoos living near the U.S./Mexican border.)
- Alien Lawfully Admitted for Permanent Residence: INS Form I-551 (Alien Registration Receipt Card, commonly known as a "green card")
- Alien Lawfully Admitted for Permanent Residence: Unexpired Temporary I-551 stamp in foreign passport or on INS Form I-94

I declare under penalty of perjury, under the laws of the State of Oklahoma, that all information contained in this application and all accompanying documents provided to substantiate my Evidence of Status application are true and correct.

Signature Maaz Khan Date 3-28-23

Subscribed and sworn before me this 28th day of March, 2023.

Notary Public [Signature]

Commission Number 22003740

My commission expires 03/17/26



T 41333





### TIME DEFICIENCY FORM

Name: Maaz Khan	Application #	
-----------------	---------------	--

This document is used a tool to help you complete your application.  
Please note: we have to account for any/all time from your 18th birthday to present.

EDUCATION STARTING WITH HIGH SCHOOL							
Start Month	Start Year	End Month	End Year	Name of Institution	City	State	Degree
08	2013	05	2015	Oklahoma School of Science and Math	Oklahoma City	OK	High school
08	2015	05	2018	University of Oklahoma	Norman	OK	BS
08	2019	05	2023	University of Oklahoma	Oklahoma City	OK	MD
EMPLOYMENT IF NEEDED TO FILL TIME GAP							
Start Month	Start Year	End Month	End Year	Name of Employer	City	State	Job Title
08	2018	07	2019	Stephenson Cancer Center	Oklahoma City	OK	Research Assistant
OTHER - UNEMPLOYED, STAY AT HOME PARENT, SUMMER BREAK, TRAVELING							
Start Month	Start Year	End Month	End Year	Other	City	State	
05	2015	08	2015	Summer break	Oklahoma City	OK	
05	2018	08	2018	Summer break	Edmond	OK	

**RECEIVED**  
MAR 29 2023  
OKLAHOMA STATE BOARD OF  
MEDICAL LICENSURE  
AND SUPERVISION

T 41333  
D

05/03/2023

MAAZ AHSAN KHAN  


RE: MD Application #41333

**Check Your Application  
Status Online at:**  
<http://www.okmedicalboard.org>  
**Username:AP31617478**  
**Password:Last 4 SSN**

Dear MAAZ KHAN,

**YOU CANNOT PRACTICE YOUR PROFESSION IN THE STATE OF OKLAHOMA UNTIL A VALID LICENSE HAS BEEN ISSUED.**

Your training application has been processed and the current deficiencies are listed below. Please be advised, these may not be the only deficiencies. You will be advised if any other deficiencies are added. You may check your application status online by logging in with the username and password provided above.

If you have further questions please email  
[oktraining@okmedicalboard.org](mailto:oktraining@okmedicalboard.org)

If a "*Time Deficiency*" is listed, please complete a time deficiency form and e-mail the document to  
[oktraining@okmedicalboard.org](mailto:oktraining@okmedicalboard.org)  
with your activities during the specified time frame.

Exam verification date  
USMLE Exams Incomplete  
PostGrad - Form 2 COLLEGE OF MEDICINE OKC  
MedSchool-Form 1 Univ Of Ok Coll Of Med, Oklahoma City Ok 73190  
MedSchool-Transcript Univ Of Ok Coll Of Med, Oklahoma City Ok 73190

Any of the required forms in the list above may be downloaded from our website:

<http://www.okmedicalboard.org/resources>



In order to check on the status of your application, please log on to our web site:

<https://secure.okmedicalboard.org/applicant/signin>

Your user name is AP31617478 (all caps and no spaces) and your password is the last 4 digits of your social security number.

If you did not provide a social security number with your application, your password will be your 4-digit year of birth in the form "YYYY".

If we may be of further assistance, please email.

[oktraining@okmedicalboard.org](mailto:oktraining@okmedicalboard.org)

Sincerely,

*Kenna Shaw*

Kenna Shaw

Dept. of Licensing

Encl

**Kenna L. Shaw**

---

**From:** BillPay Webmaster <donotreply@www.ok.gov>  
**Sent:** Monday, March 18, 2024 10:42 PM  
**To:** Dela Kwetey; Bill Pay; Sheila E. Brumfield; Chris Maloney; Licensing; Arlene Morris; Debra Reich  
**Subject:** [EXTERNAL] LICENSE - MD Training-to-Full License Fee 250.00 - Payment Made

MAAZ AHSAN KHAN has paid for a LICENSE - MD Training-to-Full License Fee 250.00 on 03/18/2024 10:03:42pm for \$250.00.

OKLAHOMA MD LICENSE NUMBER 41333

To view all transactions please go to <http://www.ok.gov/triton/> and login to your CMS account.

T 41333  
10



# Oklahoma State Board of Medical Licensure and Supervision Application Summary

Type	Number	Name
MD	41333	MAAZ AHSAN KHAN
MEDICAL DOCTOR		

**Incomplete Information (due to space limitations on this page, this may not be a complete list)**

Exam verification date  
 PostGrad - Form 2 COLLEGE OF MEDICINE OKC  
 USMLE Exams Incomplete

**Last Medical School Attended:**  
 039-01 Univ Of Ok Coll Of Med, Oklahoma City Ok 73190

Number of Licenses Previously Granted to Graduates of this Medical School:7,275

Application for: Resident  Full License \_\_\_\_\_ Reinstatement \_\_\_\_\_

**The Secretary of the Board has reviewed this application and:**

1) AUTHORIZED CIRCULARIZATION TO OTHER BOARD MEMBERS \_\_\_\_\_

2) ALL FIVE CRITERIA HAVE BEEN MET [Fast Track] \_\_\_\_\_

- Passed USMLE
- No DUIs or Legal Issues
- No Significant Malpractice Issues
- US Graduate
- Graduated Medical School on time

3) HAS ISSUED A TEMPORARY LICENSE THROUGH \_\_\_ 1 \_\_\_ 1 \_\_\_

4) HAS ISSUED A SPECIAL PGY-1 TRAINING LICENSE MR 6-12-23

5) REQUESTS SPECIFIC CONSIDERATION OF:

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## Oklahoma State Board of Medical Licensure and Supervision Application Summary

Type	Number	Name
MD	39638	MUHAMMAD TAHA KHAN
MEDICAL DOCTOR		

**Incomplete Information (due to space limitations on this page, this may not be a complete list)**

PostGrad - Form 2 COLLEGE OF MEDICINE OKC USMLE Exams Incomplete Exam verification date Extended Background Check OTHER DEFICIENCIES: NEED CURRENT VISA / USMLE STEP 3 / QUESTIONNAIRE / \$250 UPGRADE FEE / EVALUATION AMA Profile Not Received (to be completed by OSBMLS Staff)
---

**Last Medical School Attended:**

704-02 Dow Med Coll, Univ Of Karachi, Karachi, Pakistan

**Number of Licenses Previously Granted to Graduates of this Medical School:150**

Application for: Resident \_\_\_\_\_ Full License \_\_\_\_\_ Reinstatement \_\_\_\_\_

**The Secretary of the Board has reviewed this application and:**

- 1) AUTHORIZED CIRCULARIZATION TO OTHER BOARD MEMBERS \_\_\_\_\_
  
- 2) ALL FIVE CRITERIA HAVE BEEN MET [Fast Track] \_\_\_\_\_
  - Passed USMLE
  - No DUIs or Legal Issues
  - No Malpractice Issues
  - US Graduate
  - Graduated Medical School in 4 years or less
  
- 3) HAS ISSUED A TEMPORARY LICENSE THROUGH \_\_\_\_ / \_\_\_\_ / \_\_\_\_
  
- 4) HAS ISSUED A SPECIAL PGY-1 TRAINING LICENSE \_\_\_\_\_



# Oklahoma State Board of Medical Licensure and Supervision

## Application Summary

**Type**    **Number**    **Name**  
 MD        39638        MUHAMMAD TAHA KHAN  
 MEDICAL DOCTOR

**Practice Address:**  
 April 28, 2022

**Status:**

**Res:** TR

**Received:** 04/24/2022

**Entered:** 04/24/2022

**Temp Issued:**

**Temp Expires:**

**Train Issued:** 07/01/2022

**Train Expires:** 09/30/2024

**Fed Rec:** 06/04/2024

**AMA Rec:**

**Board Action:**

**License #:** 39638

**Sex:** M

**Ethnic Origin:** 6

**Endorsed By:** USMLE

	Test	Score	Date Taken	Date Verified	Attempts
<b>Test 1:</b>	USMLE 2	PASS	09/07/21	4/26/22	1
<b>Test 2:</b>	USMLE 1	PASS	10/08/20	4/26/22	1
<b>Test 3:</b>	Note: <b>PASS</b> means higher than 75				
<b>Test AV:</b>					
<b>Total Possible:</b>					
<b>Okla Passing:</b>					
<b>Total Score:</b>					

### PRE-MED EDUCATION

**School Name:** THE CAMBRIDGE HIGH SCHOOL

**City:** ABU DHABI

**State:**    **Country:** UNITED ARAB  
 EMIRATES

**Degree:** GCE A-LEVELS

**From:** 9/2013 **To:** 6/ 2015 **Verified:**

### MEDICAL SCHOOL EDUCATION

**Name:** Dow Med Coll, Univ Of Karachi, Karachi, Pakistan

**Foreign Name:**

**City:** Karachi

**State/Country:** Pakistan

**Degree:** M.B.B.S

**From:** 12 / 2015 **To:** 7 / 2021 **Diploma Ver'd:**

Y

## Oklahoma State Board of Medical Licensure and Supervision Application Summary

**Type**    **Number**    **Name**  
 MD        39638        MUHAMMAD TAHA KHAN  
 MEDICAL DOCTOR

### POST GRADUATE EDUCATION

<b>Facility:</b> COLLEGE OF MEDICINE OKC		<b>Specialty:</b> INTERNAL MEDICINE	
<b>Res. Fellowship:</b> Residency			
<b>City:</b> OKLAHOMA CITY		<b>State:</b> OK	<b>Country:</b> UNITED STATES
<b>Verified:</b>		<b>From:</b> 7 / 2023	<b>To:</b> /
<b>ACGME Ver'd:</b>			
<b>Comments:</b>			
<b>Facility:</b> COLLEGE OF MEDICINE OKC		<b>Specialty:</b> INTERNAL MEDICINE	
<b>Res. Fellowship:</b> Residency			
<b>City:</b> OKLAHOMA CITY		<b>State:</b> OK	<b>Country:</b> UNITED STATES
<b>Verified:</b> 07/26/2023		<b>From:</b> 7 / 2022	<b>To:</b> 6 / 2023
<b>ACGME Ver'd:</b> 05/03/2022			
<b>Comments:</b>			
<b>Facility:</b> AGA KHAN UNIVERSITY HOSPITAL		<b>Specialty:</b> MEDICINE/SURGERY	
<b>Res. Fellowship:</b>			
<b>City:</b> KARACHI		<b>State:</b>	<b>Country:</b> PAKISTAN
<b>Verified:</b> Waived		<b>From:</b> 3 / 2022	<b>To:</b> 5 / 2022
<b>ACGME Ver'd:</b>			
<b>Comments:</b>			
<b>Facility:</b> DOW UNIVERSITY HOSPITAL		<b>Specialty:</b> MEDICINE/SURGERY	
<b>Res. Fellowship:</b>			
<b>City:</b> KARACHI		<b>State:</b>	<b>Country:</b> PAKISTAN
<b>Verified:</b> Waived		<b>From:</b> 11 / 2021	<b>To:</b> 1 / 2022
<b>ACGME Ver'd:</b>			
<b>Comments:</b>			





# Oklahoma State Board of Medical Licensure and Supervision

APPLICATION FOR OKLAHOMA MEDICAL DOCTOR LICENSE

PAGE 449 of 500

Received: 04/24/2022

Foreign Graduate

Applicant Name: KHAN, MUHAMMAD TAHA

MD 39638



Date Of Birth: [REDACTED]

Place Of Birth (City, State): TANDO ALLAHYAR, PAKISTAN

Sex: M

Race: Asian/Pacific Islander

Education									
Type	Name	City	ST	Country	From	To	Degree	Comments	Veri
HS	THE CAMBRIDGE HIGH SCHOOL	ABU DHABI		UNITED ARAE	9/2013	6/2015	GCE A-LEVELS		

Medical School Name	City	State	Country	Comments	From	To
Dow Med Coll, Univ Of Karachi, Karachi, Pakistan	Karachi		Pakistan		12/2015	7/2021

Post-Graduate							
Facility	City	St	Country	Specialty	Comments	From	To
AGA KHAN UNIVERSITY HOSPITAL	KARACHI		PAKISTAN	MEDICINE/SURGERY		3/2022	5/2022
DOW UNIVERSITY HOSPITAL	KARACHI		PAKISTAN	MEDICINE/SURGERY		11/2021	1/2022

Practice History								
Employer	Specialty	Supervisor	City	ST	Countr	From	To	Verif
NONE	EDUCATION AND PROFESSIONAL ACTIVITIES		KARACHI		PAKISTA N	7/2021	10/2021	

Other/ Out-Of-State Licenses					
State	License #	Profession	Status	Issue Date	Exp Date

MD Exam					
Exam	State	Score	Date Taken	#	
USMLE					

\$250/-



# Oklahoma State Board of Medical Licensure and Supervision

APPLICATION FOR OKLAHOMA MEDICAL DOCTOR LICENSE

PAGE 450 of 500

Received:04/24/2022

Foreign Graduate

Questions Answered 04/20/2022	Response
A. Have you ever been denied provider participation, terminated, sanctioned, or penalized by any third party payor, to include TRICARE, MEDICARE, MEDICAID?	N
B. Have you ever surrendered or had any adverse action taken against any narcotic permit (state or federal)?	N
C. Have you ever been denied membership or had disciplinary action taken by a national, state or county professional organization?	N
D. Have you ever been denied or had removed or suspended hospital staff privileges?	N
E. Have you ever surrendered hospital staff privileges while under investigation or to avoid investigation?	N
F. Have you ever entered into an agreement with a federal, state or local jurisdictional body to avoid formal action?	N
G. Have you ever been the subject of an investigation, probation or disciplinary action by a hospital, clinic, practice group, training program or professional school?	N
H. Have you had any adverse judgment, settlement, or award against you arising from a professional liability claim?	N
I. Have you ever had professional liability coverage declined, canceled, issued on special terms, or renewal refused?	N
J. Have you ever been reported to the National Practitioners Data Bank (NPDB) or to the Healthcare Integrity and Protection Data Bank (HIPDB)? (If yes, enclose a copy of the report.)	N
K. Has your application for examination or a professional license ever been denied?	N
L. Have you ever failed any part of a licensure/certification/registration examination?	N
M. Have you ever surrendered a license or had a license revoked?	N
N. Has any disciplinary action been taken on any license?	N
O. Have you ever been subject of a review by professional licensing/regulatory agency based on a complaint filed against you?	N
P. Have you ever been arrested, charged with, or convicted of a felony or misdemeanor, other than traffic violations?	N
Q. Have you ever been arrested, charged with, or convicted of a traffic violation involving the use of any drug or chemical substance, including alcohol?	N
R. Are you now or have you within the past two years been addicted to or used in excess any drug or chemical substance, including alcohol?	N
S. Have you obtained an assessment or been treated for the use of any drug or chemical substance, including alcohol?	N
T. Do you currently have or have you had within the past two years any mental or physical disorder or condition which, if untreated, could affect your ability to practice competently?	N
U. Are you or your spouse currently on Active Duty in the U.S. Armed Forces?	N
V. Are you or your spouse currently Deployed on Active Duty in the U.S. Armed Forces?	N

Foreign Graduate

Oklahoma State Board of Medical Licensure and Supervision

APPLICATION FOR OKLAHOMA MEDICAL DOCTOR LICENSE

PAGE 451 of 500

Received:04/24/2022

Foreign Graduate

If licensed, where do you intend to locate?

OK

Why do you seek Licensure in the state of Oklahoma?

Post-Graduate Training

In what manner will you be communicating with your Oklahoma patients (telephone, email, internet, video-conference, etc)?

Describe how you will examine each patient in person prior to diagnosis, treating, correcting, or prescribing for a patient in Oklahoma from the state, province, or country you are located:

Describe the manner in which you intend to practice medicine across state lines in Oklahoma:

Have you executed or been offered a contract in connection with practice in the state of Oklahoma?

Yes

If 'Yes', Name of practice:

University Of Oklahoma Internal Medicine Residency

If so, Please identify with which category:

Residency

Name of Previous Carrier and Policy Holder

none

Name of Current Carrier and policy Holder

none

Will your professional liability insurance policy cover your practice in Oklahoma

Yes

If NO, when do you expect to obtain liability insurance that will cover practice in Oklahoma

I attest that all the above information is accurate as of April 23, 2022: \_\_\_\_\_ (Signed Online) \_\_\_\_\_





**Applicant:** In the presence of a notary public, sign this form with attached photo.

**Send this form to:**

Oklahoma State Board of Medical Licensure and Supervision  
101 NE 51<sup>st</sup> Street  
Oklahoma City, OK 73105

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

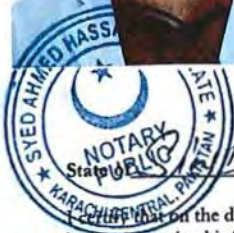
I acknowledge that I have read and understand the application and have answered all questions contained in the application truthfully and completely. I further acknowledge that failure on my part to answer questions truthfully and completely may lead to my being prosecuted under appropriate federal and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

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

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

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

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



RECEIVED

APR 25 2022

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

KHAN, MUHAMMAD TAHA

Applicants printed last name, first name, middle initial, and suffix (e.g., Jr.)

04/18/2022

Date of signature (must correspond to the date of notarization)

[Please note: The Notary Public seal should overlap the bottom of the photo to the left]

NOTARY

County of PAKISTAN

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

The statements on this document are subscribed and sworn to before me by the applicant on this 18<sup>th</sup> day of APRIL, 2022

Notary Public Signature

My Notary Commission Expires

01/09/2023

T391638  
Nah



**FCVS**

**FEDERATION CREDENTIALS  
VERIFICATION SERVICE**

**RECEIVED**

**APR 26 2022**

**OKLAHOMA STATE BOARD OF  
MEDICAL LICENSURE  
AND SUPERVISION**

**PRIMARY  
SOURCE**

**Medical Professional  
Information Profile**

*This report provides credentialing information for:*

**Name: Khan, Muhammad Taha**

**Social Security Number:** [REDACTED]

**Date of Birth:** [REDACTED]

**FID#: 304459985**

**Recipient: OK - Oklahoma State Board  
of Medical Licensure &  
Supervision**

**Delivery Date: 04/25/2022**

**ABOUT THIS PROFILE**

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

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

This FCVS Medical Professional Information Profile ("Profile") is compiled and provided by the Federation of State Medical Boards of the United States, Inc. (Federation) as a reference source for, and only for, its member boards and other entities authorized by the Federation. The Profile embodies and contains confidential business information because the information, and the format and presentation of that information, comprise trade secrets of the Federation and because the Profile's disclosure would harm the Federation by providing others with an unfair business advantage in competing with the Federation's FCVS services. Further, the form of the Profile and the contents of this Profile, including the compilation of information in this Profile, are the Federation's copyrighted works and proprietary, confidential information and are subject to the protections of United States laws governing copyright, trademark and trade secrets, as well as various state laws protecting the Federation's trade secrets and other intellectual property rights. This Profile and its contents may not be (1) copied, reformatted, modified, published or displayed publicly or (2) used, disclosed, distributed, shared or sold, in whole or part, for any purpose, including use to establish any database or files as a compendium or otherwise, all of which is strictly prohibited without the express written consent of the Federation's CEO.



**FEDERATION OF  
STATE MEDICAL BOARDS**

*TMD 39638  
SJ*



**FCVS**

FEDERATION CREDENTIALS  
VERIFICATION SERVICE

**Affidavit and Release**

**fsmb**

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

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

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

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

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



*Muhammad Taha Khan*

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

**KHAN**

Applicant's Printed Last Name

**MUHAMMAD T**

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

**04/19/2022**

Date of Signature (must correspond to date of notarization)

State of Virginia, County of Williamsburg

I certify that on the date set forth below the individual named above did appear personally before me and that I did identify this applicant by: (a) comparing his/her physical appearance with the photograph on the identifying document presented by the applicant and with the photograph affixed hereto, and (b) comparing the applicant's signature made in my presence on this form with the signature on his/her identifying document. The statements on this document are subscribed and sworn to before me by the applicant on this 19 day of April, 2022.

Notary Public Signature: *Aleksandra Dzwonik*

My Notary Commission Expires: 03/31/2024

Completed via Remote Online Notarization using 2way Audio/Video technology

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

**400 FULLER WISER ROAD | EULESS, TX 76039 | TEL (817) 868.5000**

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FCVS ID Number

FID Number



**FCVS**FEDERATION CREDENTIALS  
VERIFICATION SERVICE**Identity**

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**Biographic Information**

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Medical professional Name(s): **Khan, Muhammad Taha**

Date of Birth: [REDACTED]

Place of Birth: Tando Allah Yar, Sindh, PAKISTAN

---

**Contact Information**

---

Business Address: [REDACTED]

Mobile Phone: [REDACTED]

Business Phone: [REDACTED]

Email: [REDACTED]

---

**Credentials Analysis Information for Identity**

---

There is no Omission/Discrepancy/Miscellaneous information identified.



**CERTIFICATION OF IDENTIFICATION**  
Certification by Notary Public Is Required

Applicant Full Legal Name: KHAN MUHAMMAD TAHA  
Last First Middle

FCVS ID Number: 304459985

**Notary – Please complete the section below:**

State of Virginia County of Williamsburg

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

The statements on this document are subscribed and sworn to before me by the applicant on this (Day) 19, of (Month) April, (Year) 2022.

Notary Public Signature: Aleksandra Duzik Abbondanzo

Commission Expiration Date\* (Month) 03 / (Day) 31 / (Year) 2024

Completed via Remote Online Notarization using 2way Audio/Video technology  
\* The notary's commission expiration date must be current and legible. If no expiration date, such as 'lifetime', an explanation must be provided.



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

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



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

Start Date	End Date	Activity Type	Location
12/28/2015	03/28/2021	Medical Education	Dow University of Health Sciences Karachi Sindh PAKISTAN
04/01/2021	04/30/2021	PGT/Education	Virtual Observer with Dr Kohli at Linden Medical Centre Brooklyn New York UNITED STATES
05/01/2021	05/31/2021	PGT/Education	Virtual Observer with Dr Lawler at Elmhurst Memorial Medical Clinic Elmhurst Illinois UNITED STATES
06/01/2021	08/22/2021	Vacation	Step 2 CK preparation, research/volunteering, ERAS application.
08/22/2021	09/17/2021	PGT/Education	Virtual Observership Program, University of Miami International Medicine Inst. Miami Florida UNITED STATES
09/18/2021	10/31/2021	Vacation	Personal time off for interviewing at programs, travel, volunteering.
11/01/2021	01/28/2022	PGT/Education	House Officer at Dow University Hospital Karachi Sindh PAKISTAN
01/29/2022	02/28/2022	Vacation	Personal time off to visit my parents and siblings in Abu Dhabi
03/01/2022		PGT/Education	Intern at Aga Khan University Hospital Karachi Sindh PAKISTAN

End of Chronology of Activities report for: Khan, Muhammad Taha



**FCVS**FEDERATION CREDENTIALS  
VERIFICATION SERVICE**Medical Education****fsmb**

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**Medical Education**

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**Medical School: Dow University of Health Sciences**Location: Karachi, SD  
PAKISTAN

---

**Credentials Analysis Information for Medical Education**

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There is no Omission/Discrepancy/Miscellaneous information identified.



VERIFICATION OF MEDICAL EDUCATION

INSTRUCTIONS TO THE DEAN

The individual identified on the attached Medical School Release Request, Certification of Identification Form, or Certification Statement has authorized your medical school to provide to the Educational Commission for Foreign Medical Graduates (ECFMG) any and all information pertaining to his/her education at your institution. Please complete this VERIFICATION OF MEDICAL EDUCATION form and return it to ECFMG with the attached medical diploma and a final medical school transcript in the enclosed, addressed envelope.

RE: Muhammad Taha Khan 1-100-644-2 Dow International Medical College (DIMC) Suparco Road, Off Main University Road Cutzar-e-Hijri, Scheme-33 Karachi PAKISTAN

Please notify ECFMG if the name of your institution has changed or is different from the name displayed.

SECTION 1: MEDICAL SCHOOL TRANSCRIPT

Attach an official medical school transcript in the original language that displays course grades or marks, not just hours, to this Verification of Medical Education form and return to ECFMG - Affix your official stamp to the transcript - Non-English language transcripts must include a word-for-word English language translation prepared by a recognized translator - An official English language version medical school transcript is also acceptable - Transcripts returned to ECFMG under separate cover must include the individual's ECFMG Identification Number to prevent processing delays.

SECTION 2A: CERTIFICATION

By my signature below, I certify: (1) the information provided on this form is an accurate account of the above named individual's official records maintained in this medical school and is true and correct to my knowledge, and, (2) that I am authorized to certify this on behalf of this institution as reported to ECFMG on an Authorized Signature List for Medical School Officials or other official notification from this institution.

Signature, Printed Name, Title and Official Seal must match samples provided to ECFMG by the medical school



SEAL VERIFIED

Signature:

[Handwritten signature]

Printed Name: Ramiah Naz

Title: Vice Principal

Date of Signature: 24 November 2021

Phone: 0334-2877666

Fax: \_\_\_\_\_

Email: vp.dimc@duhs.edu.pk

SECTION 2B: DEGREE CERTIFICATION

This individual:

Was conferred/issued the degree of M.B.B.S on 03/07/2021 (dd/mm/yyyy) and the attached medical diploma is authentic and correct.

- Or -

Was not conferred/issued a degree or the attached diploma is not authentic and correct because:

\_\_\_\_\_



**SECTION 3A: PRE-MEDICAL EDUCATION**

Years of education required for admission to your medical school : **12 years**

Credential/degree presented by the applicant for admission to your medical school : **HIGH SCHOOL DIPLOMA**

Did this individual transfer credits to your medical school from another institution? YES ( ) NO (X)

If you checked 'YES' please print the name of the institution(s) from where the credits were transferred:

\_\_\_\_\_

**SECTION 3B: MEDICAL EDUCATION**

Enrollment and Participation: Our records indicate that **Muhammad Taha Khan** attended our medical school for total of **180** weeks of medical education on the following dates:

From **29/12/2015** (dd/mm/yyyy) To **29/03/2021** (dd/mm/yyyy)

**SECTION 4: UNUSUAL CIRCUMSTANCES**

The following questions apply to unusual circumstances that occurred during any part of the individual's medical education. Please provide dates and requested information if you check "YES" to questions 1-5.

1. Does this individual's official record reflect (an) interruption(s) or extension(s) in his/her medical education? YES ( ) NO (X)

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

	<u>From Month/Year</u>	<u>To Month/Year</u>	<u>Approved</u>	<u>Unapproved</u>
<u>Personal/Family</u>	<u>  /  /  </u>	<u>  /  /  </u>	( )	( )
<u>Academic remediation</u>	<u>  /  /  </u>	<u>  /  /  </u>	( )	( )
<u>Health</u>	<u>  /  /  </u>	<u>  /  /  </u>	( )	( )
<u>Financial</u>	<u>  /  /  </u>	<u>  /  /  </u>	( )	( )
Participation in joint degree				
<u>Program (e.g., MD/PhD)</u>	<u>  /  /  </u>	<u>  /  /  </u>	( )	( )
Participation in non-research special study (e.g., fellowship, international experience)				
<u>international experience)</u>	<u>  /  /  </u>	<u>  /  /  </u>	( )	( )
Participation in non-degree research				
<u>research</u>	<u>  /  /  </u>	<u>  /  /  </u>	( )	( )
<u>Other</u>	<u>  /  /  </u>	<u>  /  /  </u>	( )	( )

Please Specify: \_\_\_\_\_

2. Does this individual's official record reflect that he/she was ever placed on academic or disciplinary probation during his/her medical education? YES ( ) NO (X)

If you checked "YES" please select the reason(s) for the probation, indicate the date(s) of placement on and removal from probation and attach additional documentation to this report.

\_\_\_\_\_

	<u>From Month / Year</u>	<u>To Month / Year</u>
Academic Probation _____	_ / _	_ / _
Probation for unprofessional conduct/behavioral _____	_ / _	_ / _
Probation for other reason _____	_ / _	_ / _

Please specify reason: \_\_\_\_\_

3. Does this individual's official record reflect that he/she was ever disciplined for unprofessional conduct/behavioral reasons by the medical school or parent university? YES ( ) NO (X)

If you checked "YES" please provide detailed documentation/information about the circumstances and outcome(s):

\_\_\_\_\_

\_\_\_\_\_

4. Does this individual's official record reflect that he/she was ever the subject of negative reports or an investigation by the medical school or parent university? YES ( ) NO (X)

If you checked "YES" please provide detailed documentation/information about the circumstances and outcome(s):

\_\_\_\_\_

\_\_\_\_\_

5. Does this individual's official record reflect that there were any limitations or special requirements imposed on the individual because of questions of academic incompetence, disciplinary problems, or any other reason? YES ( ) NO (X)

If you checked "YES" please provide detailed documentation/information about the nature of the limitations or special requirements:

\_\_\_\_\_

\_\_\_\_\_

Enrolment No: 04/2015/010

Serial No.008822



# Dow University of Health Sciences

*Having pursued the prescribed course of study for the Degree of*  
**MBBS**

*and passed the required Professional Examinations,*

*Dow University of Health Sciences hereby admits*

*Muhammad Taha Khan*

*s/o*

*Usman Ghani*

*To the Degree of*

**Bachelor of Medicine Bachelor of Surgery**

*in the Year 2021*

*In witness whereof, we have set our signatures and the seal of this University is*  
*herewith affixed*

*This Third day of July, 2021*

*, at Karachi, Pakistan.*



Affixed by medical school on:  
24 November 2021



*[Signature]*  
Registrar

*[Signature]*  
Vice Chancellor

**SEAL  
VERIFIED**

Detailed transcripts of examination results have been issued separately

**SECURITY FEATURES OVERLEAF**





**OFFICE OF THE PRINCIPAL  
DOW INTERNATIONAL MEDICAL COLLEGE  
DOW UNIVERSITY OF HEALTH SCIENCES  
KARACHI.**



KDA Scheme 33,  
Gulzar-e-Hijri Suparco,  
Karachi, Pakistan.  
Tele No. 92-021-99261492  
Fax No. 92-021-99261490  
E-mail: p.dimc@dohs.edu.pk

### CONSOLIDATED MARKS CERTIFICATE

**Name :** Muhammad Taha Khan  
**Father's Name :** Usman Ghani  
**Date of Graduation :** 29<sup>th</sup> March, 2021  
**Enrolment No :** DUHS/DIMC/04/2015/010

**FIRST YEAR SEMESTER I, M.B.B.S. EXAMINATION HELD IN 2016 WITH SEAT NO. 1504010**

Course	Description	Credit Hours	Grades	Grade Points	GPA
Paper I	Theory Module*	6.00	C	12.00	
Paper II	Theory Module**	6.00	B	18.00	
Paper III A	Structured Viva*	3.00	A-	11.10	2.62
Paper III B	Structured Viva**	3.00	C	6.00	
<b>Total</b>		<b>18.00</b>		<b>47.10</b>	

**FIRST YEAR SEMESTER II, M.B.B.S. EXAMINATION HELD IN 2016 WITH SEAT NO. 1504010**

Course	Description	Credit Hours	Grades	Grade Points	GPA
Paper I	Theory Module*	6.00	C+	13.80	
Paper II	Theory Module**	3.00	B-	8.10	
Paper III	Theory Module***	3.00	B	9.00	3.05
Paper IV A	Structured Viva*	3.00	A+	12.00	
Paper IV A	Structured Viva**	1.50	A	6.00	
Paper IV B	Structured Viva***	1.50	A+	6.00	
<b>Total</b>		<b>18.00</b>		<b>54.90</b>	

**SECOND YEAR SEMESTER III, M.B.B.S. EXAMINATION HELD IN 2017 WITH SEAT NO. 1504010**

Course	Description	Credit Hours	Grades	Grade Points	GPA
Paper I	Theory Module*	4.50	A-	16.65	
Paper II	Theory Module**	4.50	A-	16.65	
Paper III	Theory Module***	3.00	A-	11.10	3.70
Paper IV A	Structured Viva*	2.50	B+	8.25	
Paper IV B	Structured Viva**	2.00	A	8.00	
Paper IV C	Structured Viva***	1.50	A+	6.00	
<b>Total</b>		<b>18.00</b>		<b>66.65</b>	

**SECOND YEAR SEMESTER IV, M.B.B.S. EXAMINATION HELD IN 2017 WITH SEAT NO. 1504010**

Course	Description	Credit Hours	Grades	Grade Points	GPA
Paper -I	Theory Module*	6.00	B+	19.80	
Paper -II	Theory Module**	3.00	A-	11.10	
Paper -III	Theory Module***	3.00	B	9.00	3.47
Paper -IV A	Structured Viva*	3.00	A	12.00	
Paper -IV B	Structured Viva**	1.50	A-	5.55	
Paper -IV C	Structured Viva***	1.50	B+	4.95	
<b>Total</b>		<b>18.00</b>		<b>62.40</b>	



Affixed by medical school on:  
24 November 2021

**SEAL**

**VERIFIED**



**OFFICE OF THE PRINCIPAL  
DOW INTERNATIONAL MEDICAL COLLEGE  
DOW UNIVERSITY OF HEALTH SCIENCES  
KARACHI.**



KDA Scheme 33,  
Gulzar-e-Hijri Suparco,  
Karachi, Pakistan.  
Tele/ No. 92-021-99261492  
Fax No. 92-021-99261490  
E-mail: p.dimc@dohs.edu.pk

**CONTINUED**

**THIRD YEAR SEMESTER V, M.B.B.S. EXAMINATION HELD IN 2018 WITH SEAT NO. 1504010**

Course	Description	Credit Hours	Grades	Grade Points	GPA
Paper -I	Theory Module*	3.00	C+	6.90	
Paper -II	Theory Module**	3.00	B	9.00	
Paper -III	Theory Module***	3.00	B+	9.90	
Paper -IV	Theory Module****	3.00	B	9.00	3.02
Paper -V A	Structured Viva*	1.50	A-	5.55	
Paper -V B	Structured Viva**	1.50	B+	4.95	
Paper -V C	Structured Viva***	1.50	C	3.00	
Paper -V D	Structured Viva****	1.50	A+	6.00	
<b>Total</b>		<b>18.00</b>		<b>54.30</b>	

**THIRD YEAR SEMESTER VI, M.B.B.S. EXAMINATION HELD IN 2018 WITH SEAT NO. 1504010**

Course	Description	Credit Hours	Grades	Grade Points	GPA
Paper -I	Theory Module*	6.00	C	12.00	
Paper -II	Theory Module**	3.00	B+	9.90	
Paper -III	Theory Module***	3.00	B-	8.10	2.78
Paper -IV A	Structured Viva*	3.00	A-	11.10	
Paper -IV B	Structured Viva**	1.50	A	6.00	
Paper -IV C	Structured Viva***	1.50	C	3.00	
<b>Total</b>		<b>18.00</b>		<b>50.10</b>	

**FOURTH PROFESSIONAL M.B.B.S. ANNUAL EXAMINATION HELD IN 2019 WITH SEAT NO. 1504010**

Course	Description	Credit Hours	Marks				Grade	Grade Points	
			Theory		Practical				
			Max.	Obt.	Max.	Obt.			
NEU1	400	Neurosciences Module-II	9.00	100	67.00	100	89.00	A	36.00
OPH	400	EYE Module	4.50	100	82.00	150	106.00	A	18.00
DPS, GEN & PNR	400	Dermatology, Rehabilitation & Genetics module	4.50	100	68.00	-	-	B+	14.85
ENT	400	ENT Module	4.50	100	80.00	150	89.00	A-	16.65
REP2	400	Reproductive Module - II	7.50	100	74.00	150	123.00	A	30.00
MSK	400	Musculoskeletal Module	6.00	100	67.00	150	116.00	A-	22.20

Total Marks: 1300

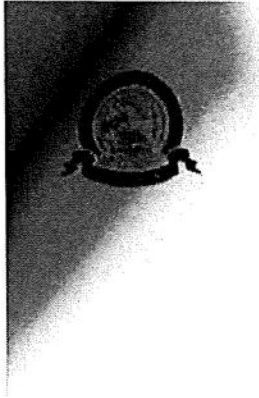
Obtained Marks: 961

Undergraduate Career Total

Term GPA: 3.82

137.70





**OFFICE OF THE PRINCIPAL  
DOW INTERNATIONAL MEDICAL COLLEGE  
DOW UNIVERSITY OF HEALTH SCIENCES  
KARACHI.**



KDA Scheme 33,  
Gulzar-e-Hijri Suparco,  
Karachi, Pakistan.  
Tele/ No. 92-021-99261492  
Fax No. 92-021-99261490  
E-mail: p.dimc@dohs.edu.pk

**CONTINUED**

**FINAL PROFESSIONAL M.B.B.S. ANNUAL EXAMINATION HELD IN 2020 WITH SEAT NO. 1504010**

Course	Description	Credit Hours	Marks				Grade	Grade Points
			Theory		Practical			
			Max.	Obl.	Max.	Obl.		
SURG	500 SURGERY	13.50	300	207	300	213	A-	49.95
OBG	500 GYNAE & OBS	4.50	300	227	300	210	A-	16.65
MED	500 MEDICINE	13.50	300	230	300	239	A	54.00
PAEDS	500 PAEDS	4.50	150	104	150	96	B+	14.85

Total Marks: 2100  
Obtained Marks: 1526

Undergraduate Career Total

Term GPA: 3.76	36.00	135.45
----------------	-------	--------



*Fozia Perveen*  
**Prof. Dr. Fozia Perveen**  
**MBBS, MCPS FCPS**  
**Principal**  
**Dow International Medical College**  
**Dow University Hospital, Karachi**





**OFFICE OF THE PRINCIPAL  
DOW INTERNATIONAL MEDICAL COLLEGE  
DOW UNIVERSITY OF HEALTH SCIENCES  
KARACHI.**



KDA Scheme 33,  
Gulzar-e-Hijri Suparco,  
Karachi, Pakistan.  
Tele/ No. 92-021-99261492  
Fax No. 92-021-99261490  
E-mail: p.dmic@dohs.edu.pk

**TRANSCRIPT OF GRADES OBTAINED DURING  
CLINICAL ROTATIONS.**

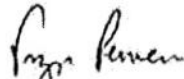
This is a detailed academic record of clinical rotations and grades obtained by **Dr. Muhammad Taha Khan S/O Usman Ghani** while he was a student in 3<sup>rd</sup>, 4<sup>th</sup>, and Final Year M.B.B.S. at Dow International Medical College, Dow University of Health Sciences, Karachi.

<u>CLINICAL DISCIPLINE</u>	<u>SUPERVISING FACULTY</u>	<u>DATE</u>	<u>GRADES (OUT OF 10)</u>
<b><u>THIRD YEAR (Roll No 010)</u></b>			
01. NIL/GID	Prof. Dr. Syed Muhammad Zahid Azam	06.02.18 to 20.02.18	6+
02. Pulmonology	Prof. Dr. Nisar Ahmed Rao	21.02.18 to 07.03.18	6+
03. Internal Medicine	Dr. Syed Shayan Ali	06.03.18 to 02.04.18	7+
04. Paediatrics	Prof. Dr. Imran Rasheed Ahmad	03.04.18 to 30.04.18	8
05. Ophthalmology	Prof. Dr. Mazhar Ul Hasan	02.05.18 to 28.05.18	7+
06. Surgery Unit II	Prof. Dr. Shahida Parveen Afridi	20.08.18 to 16.09.18	8
07. LNT	Prof. Dr. M. Shuja Farrukh	17.09.18 to 14.10.18	6+
08. Gynae & Obs Unit II	Prof. Dr. Riffat Jaleel	15.10.18 to 11.11.18	7
<b><u>FOURTH YEAR (Roll No 010)</u></b>			
01. Gynae & Obs Unit I	Prof. Dr. Jahan Ara Hasan	28.01.19 to 23.02.19	7
02. ENT	Prof. Dr. Iqbal A. Muhammad Khyani	01.04.19 to 28.04.19	6+
03. Orthopedic	Prof. Dr. Syed Imat Hussain Zaidi	29.04.19 to 12.05.19	7+
04. Dermatology	Dr. Sadaf Ahmed Asim	13.05.19 to 26.05.19	8
05. Psychiatry	Dr. Sheeb Ahmed	03.07.19 to 21.08.19	9+
<b><u>Exam Break 20/07 to 11/08</u></b>			
06. Internal Medicine	Prof. Dr. Iftekhar Ahmed	22.08.19 to 18.09.19	8+
07. Ophthalmology	Prof. Dr. Mazhar Ul Hasan	19.09.19 to 16.10.19	7
08. Paediatrics	Prof. Dr. Imran Rasheed Ahmad	17.10.19 to 13.11.19	9+
<b><u>FINAL YEAR (Roll No 010)</u></b>			
01. Radiology	Dr. Amjad Sattar	20.01.20 to 31.01.20	8
02. Surgery Unit I	Prof. Dr. Faisal Ghani Siddiqui	01.02.20 to 29.02.20	9+
03. Gynae & Obs Unit I	Prof. Dr. Jahan Ara Hasan	01.10.20 to 22.10.20	8
04. Hepatobiliary	Dr. Jahanzaib Halder	23.10.20 to 03.11.20	6+
05. Thoracic Surgery	Dr. Niaz Hussain Soomro	04.11.20 to 13.11.20	8+
06. Internal Medicine	Prof. Dr. Iftekhar Ahmed	16.11.20 to 20.01.21	9
<b><u>The gap in posting dates is/were due to Covid-19</u></b>			
07. NIL/GID	Prof. Dr. Syed Muhammad Zahid Azam	11.01.21 to 20.01.21	8+
08. Pulmonology	Dr. Faisal Falyaz Zuberi	21.01.21 to 30.01.21	8
09. Paediatrics	Prof. Dr. Imran Rasheed Ahmad	21.01.21 to 11.02.21	7
10. Neurology	Dr. Jawwad Ul Salam	01.02.21 to 11.02.21	9+
11. Cardiology	Dr. M. Tariq Farman	12.02.21 to 22.02.21	8+

**CLASSIFICATION OF GRADES**

Grades 9-10	Excellent & Exceptional
Grades 7-8	Very Good
Grades 6	Good
Grades 5	Satisfactory
Grades 4	Poor & Needs Attention



  
**Prof. Dr. Fouzia Perveen**  
 MBBS, MCPS, FCPS  
 Principal  
 Dow International Medical College  
 Dow University Hospital, Karachi

**FCVS**FEDERATION CREDENTIALS  
VERIFICATION SERVICE**Applicant Reported  
Unusual Circumstances****Medical School**

Medical Professional Name: Khan, Muhammad Taha

Dow University of Health Sciences

**Unusual Circumstances**

<b>Did you have any interruption(s) or extension(s) in your medical education?</b>	<b>No</b>
<b>Were you ever placed on probation?</b>	<b>No</b>
<b>Were you ever disciplined or placed under investigation?</b>	<b>No</b>
<b>Were any negative reports for behavioral reasons ever filed by instructors?</b>	<b>No</b>
<b>Were any limitations or special requirements imposed on you because of academic performance, incompetence, disciplinary problems or for any other reason?</b>	<b>No</b>

End of Applicant Reported Unusual Circumstances report for: Khan, Muhammad Taha



EDUCATIONAL COMMISSION FOR  
FOREIGN MEDICAL GRADUATES

3624 Market Street  
Philadelphia, PA 19104-2685 USA  
215-386-5900 | 215-386-9767 FAX  
www.ecfm.org

**Issue Date:** 25 Apr 2022

**To:** STATE BOARD OF LICENSURE & SUPERVISION  
LISA CULLEN  
DIRECTOR OF LICENSING  
P.O. BOX 18256  
OKLAHOMA CITY, OK 73154-0256

**State Board Code:**

**037**

Please include this number on  
all requests.

### ECFMG® CERTIFICATION STATUS REPORT

**USMLE®/ECFMG Identification Number:** 1-100-644-2

**Applicant's Name:** Muhammad Taha Khan

**Applicant's Date of Birth:** [REDACTED]

**ECFMG Certified:** Yes

**Certificate Issue Date:** 22 Dec 2021

**English Test Valid Through:** 31 Dec 2024

**Clinical Skills Assessment Valid Through:** 31 Dec 2024

#### Passing Performance on Medical Science Examinations:

Examination	Date	Two Digit Score	Three Digit Score
USMLE Step 1	08 Oct 2020	*	*
USMLE Step 2 CK	07 Sep 2021	*	*

#### Most Recent Passing Performance on Clinical Skills Examination:

Examination	Date
ECFMG Clinical Skills Pathway **	N/A

\*\* This individual met the clinical and communication skills requirements, including English language proficiency, for ECFMG Certification through one of the Pathways developed in response to the suspension and subsequent discontinuation of USMLE Step 2 CS.

**Name of Medical School and Country:** Dow International Medical College (DIMC), Karachi, PAKISTAN

**Degree Year:** 2021

**Medical Education Credentials Status<sup>†</sup>:** Complete

#### How to Verify the Authenticity of this Report:

This report was issued to the named recipient on the date shown above. To verify the authenticity of this report, visit <https://cvsonline2.ecfm.org/verify/verify.asp> and enter the unique verification code listed below. The information contained in this report is current as of the issue date. Any changes to the physician's status after the issue date will not be reflected, and you are encouraged to request an updated report.

#### Report Verification Code: S4393HLFOM

The purpose of this Status Report is to indicate whether this individual is certified by ECFMG. It reflects only examinations that were used to fulfill requirements for ECFMG Certification. The most recent passing performance on the clinical skills examination is reflected, regardless of whether this individual was required to take a clinical skills examination for ECFMG Certification. This Status Report is not a complete score history of all examinations for this individual. This Status Report does not include examinations that were taken but not passed. Furthermore, if this individual passed examinations that were not used to fulfill the requirements for ECFMG Certification, these examinations are not included.

\* To obtain a complete USMLE examination history for this individual, contact the appropriate registration entity to request a USMLE transcript.

<sup>†</sup>Since July 1986, ECFMG has verified medical school credentials directly with the issuing medical schools, or through a reasonable alternative that has been approved by the ECFMG Medical Education Credentials Committee.

#### Important Note:

Requesting organizations must normally secure and retain the physician's signed authorization to obtain certification information. Organizations may not resell the information or make it available to any party beyond the initial request as authorized by the physician. The information may only be used to confirm ECFMG Certification for the purpose for which the physician provided authorization.



**FCVS**FEDERATION CREDENTIALS  
VERIFICATION SERVICE**Postgraduate Training****fsmb**

---

**Postgraduate Training**

---

**No training reported by applicant**

---

**Credentials Analysis Information for Postgraduate Training**

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**Issue:**

The Medical Professional Information Profile does not include verification of any Post Graduate Training programs.

**Solution:**

The Medical Professional reports no accredited Post Graduate training performed in the United States or Canada.

**FCVS**

FEDERATION CREDENTIALS  
VERIFICATION SERVICE

**Licensure / Examinations**



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**Licensure / Examinations**

---

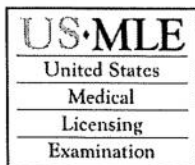
Exam: USMLE

---

**Credential Analysis Information for Licensure / Examinations**

---

There is no Omission/Discrepancy/Miscellaneous information identified.



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

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

**Date:** 04/22/2022

Federation Credentials Verification Service

ATTN: FCVS

**FCVSID:** 648178

**Examinee:** Khan, Muhammad Taha

**Alt Name(s):**

**Examinee ID:** 1-100-644-2

**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. Pass/fail outcomes are based upon the minimum passing level in place at the time of test administration and are not altered by subsequent revisions to the minimum passing level. Effective April 1, 2013, two-digit scores will no longer be reported. Test results reported as passing represent an exam score of 75 or higher on a two-digit scale. Step 1 examinations taken on or after January 26, 2022 are reported as pass/fail, with no numeric score; Step 1 examinations taken before January 26, 2022 will continue to be reported with a 3-digit score.

### USMLE STEP 1

Test Date	Pass/Fail	Score	Minimum Pass	Comments
10/08/2020	Pass	247	(194)	

### USMLE STEP 2

#### *Clinical Knowledge (CK)*

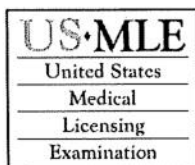
Test Date	Pass/Fail	Score	Minimum Pass	Comments
09/07/2021	Pass	255	(209)	

#### End of Exam History

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

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





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

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

**Examinee:** Khan, Muhammad Taha

**Examinee ID:** 1-100-644-2

**Date of Birth:** [REDACTED]

### INTERPRETATION OF RESULTS

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

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

### STEP 1 AND STEP 2 CLINICAL SKILLS (CS)

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

### ANNOTATIONS APPEARING UNDER "COMMENTS"

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

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

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

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

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

### ANNOTATIONS APPEARING AS "NOTE"

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

### PHYSICIAN DATA CENTER INFORMATION APPEARING AS "NOTE"

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

03/2015

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

Form 2 (MD - TRAINING)

ATTACHMENT 3

Oklahoma State Board of Medical Licensure and Supervision

OKTRAINING@okmedicalboard.org

This form must be completed and sent directly to the Board by the training institution

RECEIVED

JUL 26 2023

Verification of Graduate Medical Education

OKLAHOMA STATE BOARD OF MEDICAL LICENSURE AND SUPERVISION

Applicant's Name Muhammad Taha Khan

Institution: University of Oklahoma H.S.C. City/State Oklahoma City, Oklahoma

Training Level: 1 Specialty/Subspecialty Internal Medicine From: 07/01/2022 To: 06/30/2023

Internship  Residency Successfully Completed?  YES  NO  IN PROGRESS

Accredited By:  ACGME  AOA

Training Level: \_\_\_\_\_ Specialty/Subspecialty \_\_\_\_\_ From: \_\_\_\_/\_\_\_\_/\_\_\_\_ To: \_\_\_\_/\_\_\_\_/\_\_\_\_

Internship  Residency Successfully Completed?  YES  NO  IN PROGRESS

Accredited By:  ACGME  AOA

Training Level: \_\_\_\_\_ Specialty/Subspecialty \_\_\_\_\_ From: \_\_\_\_/\_\_\_\_/\_\_\_\_ To: \_\_\_\_/\_\_\_\_/\_\_\_\_

Internship  Residency Successfully Completed?  YES  NO  IN PROGRESS

Accredited By:  ACGME  AOA

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

Please explain any "YES" response from above: \_\_\_\_\_

Completion of the following is attesting that the information above is an accurate account of this individual's records and is true and correct. The signature line must contain the original signature of the program director (M.D./D.O. only)

Name: Ajay P. Nadig, M.D. Signature Ajay P. Nadig, MD

Title of Signatory: Program Director Date of Signature 6/21/23

Tel: 405)271-5963 Fax: 405-271-1476 E-Mail: Ajay-Nadig@ouhsc.edu

PRIMARY SOURCE

If no seal is available, this form must be notarized

School Seal

Notary Public \_\_\_\_\_

Commission # \_\_\_\_\_

My commission expires: \_\_\_\_\_

T39038  
UKC





EDUCATIONAL COMMISSION FOR  
FOREIGN MEDICAL GRADUATES

3624 Market Street  
Philadelphia, PA 19104-2685 USA  
215-386-5900 | 215-386-9767 FAX  
www.ecfm.org

Issue Date: 25 Apr 2022

To: STATE BOARD OF LICENSURE & SUPERVISION  
LISA CULLEN  
DIRECTOR OF LICENSING  
P.O. BOX 18256  
OKLAHOMA CITY, OK 73154-0256

PRIMARY SOURCE

State Board Code:

037

Please include this number on all requests.

**ECFMG® CERTIFICATION STATUS REPORT**

RECEIVED

APR 26 2022

OKLAHOMA STATE BOARD OF  
MEDICAL LICENSURE  
AND SUPERVISION

USMLE®/ECFMG Identification Number: 1-100-644-2

Applicant's Name: Muhammad Taha Khan

Applicant's Date of Birth: [REDACTED]

ECFMG Certified: Yes

Certificate Issue Date: 22 Dec 2021

English Test Valid Through: 31 Dec 2024

Clinical Skills Assessment Valid Through: 31 Dec 2024

**Passing Performance on Medical Science Examinations:**

Examination	Date	Two Digit Score	Three Digit Score
USMLE Step 1	08 Oct 2020	*	*
USMLE Step 2 CK	07 Sep 2021	*	*

**Most Recent Passing Performance on Clinical Skills Examination:**

Examination	Date
ECFMG Clinical Skills Pathway **	N/A

\*\* This individual met the clinical and communication skills requirements, including English language proficiency, for ECFMG Certification through one of the Pathways developed in response to the suspension and subsequent discontinuation of USMLE Step 2 CS.

Name of Medical School and Country: Dow International Medical College (DIMC), Karachi, PAKISTAN

Degree Year: 2021

Medical Education Credentials Status†: Complete

**How to Verify the Authenticity of this Report:**

This report was issued to the named recipient on the date shown above. To verify the authenticity of this report, visit <https://cvsonline2.ecfm.org/verify/verify.asp> and enter the unique verification code listed below. The information contained in this report is current as of the issue date. Any changes to the physician's status after the issue date will not be reflected, and you are encouraged to request an updated report.

Report Verification Code: S4393HLFOM

The purpose of this Status Report is to indicate whether this individual is certified by ECFMG. It reflects only examinations that were used to fulfill requirements for ECFMG Certification. The most recent passing performance on the clinical skills examination is reflected, regardless of whether this individual was required to take a clinical skills examination for ECFMG Certification. This Status Report is not a complete score history of all examinations for this individual. This Status Report does not include examinations that were taken but not passed. Furthermore, if this individual passed examinations that were not used to fulfill the requirements for ECFMG Certification, these examinations are not included.

\* To obtain a complete USMLE examination history for this individual, contact the appropriate registration entity to request a USMLE transcript.

†Since July 1986, ECFMG has verified medical school credentials directly with the issuing medical schools, or through a reasonable alternative that has been approved by the ECFMG Medical Education Credentials Committee.

**Important Note:**

Requesting organizations must normally secure and retain the physician's signed authorization to obtain certification information. Organizations may not resell the information or make it available to any party beyond the initial request as authorized by the physician. The information may only be used to confirm ECFMG Certification for the purpose for which the physician provided authorization.

TMD39638  
S



RECEIVED

APR 25 2022

OKLAHOMA STATE BOARD OF MEDICAL LICENSURE AND SUPERVISION  
 101 NE 51<sup>ST</sup> STREET  
 OKLAHOMA CITY OK 73105  
**EVIDENCE OF STATUS – PART B**

OKLAHOMA STATE BOARD OF  
 MEDICAL LICENSURE  
 AND SUPERVISION

Full Legal Name: MUHAMMAD TAHA KHAN  
First Middle Last Maiden (if applicable)

Mailing Address: [REDACTED]

[REDACTED] Social Security #: [REDACTED]  
City State Zip Code Telephone Number

**DOCUMENTATION TO DETERMINE QUALIFIED ALIEN STATUS**

If you are a qualified alien, please submit a notarized copy of the original, unexpired documents. Place a checkmark below to indicate the document that will be submitted.

<b>Immigrant or Non-Immigrant Visa Status:</b>	
<input type="checkbox"/>	INS Form I-94
<input type="checkbox"/>	INS Form I-688B
<b>Asylee:</b>	
<input type="checkbox"/>	INS Form I-94 annotated with stamp showing grant of asylum under §208 of the INA
<input type="checkbox"/>	INS Form I-688B (Employment Authorization Card) annotated "27a .12 (a) (5)"
<input type="checkbox"/>	INS Form I-766 (Employment Authorization Document) annotated "AS"
<input type="checkbox"/>	Grant letter from the Asylum Office of INS
<input type="checkbox"/>	Order of an immigration judge granting asylum
<b>Refugee:</b>	
<input type="checkbox"/>	INS Form I-94 annotated with stamp showing admission under §207 of the INA
<input type="checkbox"/>	INS Form I-688B (Employment Authorization Card) annotated "274 a.12 (a) (3)"
<input type="checkbox"/>	INS Form I-766 (Employment Authorization Document) annotated "A3"
<input type="checkbox"/>	INS Form I-571 (Refugee Travel Document)
<b>Alien Paroled into the U.S. for at least One Year:</b>	
<input type="checkbox"/>	INS Form I-94 with stamp showing admission for at least one year under §212 (d) (5) of the INA. (Applicant cannot aggregate periods of admission for less than one year to meet the one-year requirement.)
<b>Alien Whose Deportation or Removal Was Withheld:</b>	
<input type="checkbox"/>	INS Form I-688B (Employment Authorization Card) annotated "274 a.12 (a) (10)"
<input type="checkbox"/>	INS Form I-766 (Employment Authorization Document) annotated "A10"
<input type="checkbox"/>	Order from an immigration judge showing deportation withheld under §243 (h) of the INA as in effect prior to April 1, 1997, or removal withheld under §241 (b) (3) of the INA
<b>Alien Granted Conditional Entry:</b>	
<input type="checkbox"/>	INS Form I-94 with stamp showing admission under §203 (a) (7) of the INA
<input type="checkbox"/>	INS Form I-688B (Employment Authorization Card) annotated "274 a.12 (a) (3)"
<input type="checkbox"/>	INS Form I-766 (Employment Authorization Document) annotated "A3"
<b>Cuban/Haitian Entrant:</b>	
<input type="checkbox"/>	INS Form I-551 (Alien Registration Receipt Card, commonly known as a "green card") with the code CU6, CU7, or CH6
<input type="checkbox"/>	Unexpired temporary I-551 stamp in foreign passport or on INS Form I-94 with the code CU6 or CU7
<input type="checkbox"/>	INS Form I-94 with stamp showing parole as "Cuba/Haitian Entrant" under § 212 (d) (5) of the INA
<b>Alien Who Has Been Battered or Subjected to Extreme Cruelty:</b>	
<input type="checkbox"/>	INS petition and appropriate supporting documentation
<b>Other Document (please list)</b>	
<input checked="" type="checkbox"/>	PASSPORT COPY

I declare under penalty of perjury, under the laws of the State of Oklahoma, that all information contained in this application and all accompanying documents provided to substantiate my Evidence of Status application are true and correct.

Signature [Signature]

Date 04/18/2022

Subscribed and sworn before me this 18th day of APRIL, 2022

Notary Public SYED AHMED HASSAN

Commission Number 5001/3-21/2015

My commission expires 01/09/2023



T 37638  
New

**OKLAHOMA STATE BOARD OF MEDICAL LICENSURE AND SUPERVISION**  
**101 NE 51<sup>ST</sup> STREET**  
**OKLAHOMA CITY OK 73105**  
**Phone: (405)962-1400 Fax: (405)962-1440 email: licensing@okmedicalboard.org**

To Request Examination Scores	
For National Board Scores National Board of Medical Examiners PO Box 48014 Newark, NJ 07101-4814 (215) 590-9500 www.NBME.org	For FLEX or USMLE Scores Federation of State Medical Boards 400 Fuller Wisser Road Euleess, TX 76039-3855 (817) 868-4000 www.FSMB.org

6. **Extended Background Check** – Applicants for licensure are required to request an Extended Background Check.
  7. **Evidence of Status Form** - In order to verify citizenship or qualified alien status, applicants for licensure by endorsement or examination or for reinstatement of their license, must submit an Evidence of Status Form and the required supporting documentation with their application. This form must be notarized and mailed to the office.
  8. **Photo and Oath Form** – Applicants for licensure will be required to complete the Photo and Oath Form. This form must be notarized and mailed to the office.
  9. **Telemedicine Form** – Applicants planning to practice telemedicine must submit the initialed and signed Telemedicine Questionnaire.
  10. **English Proficiency Exam** – Foreign applicants shall have a command of the English language that is satisfactory to the Board, demonstrated by the passage of an oral English competency exam. Applicant is required to call 405-962-1400 and speak with an application analyst in licensing.
- G. **Temporary Licensure (59 O.S. § 493.3)** – The Board may authorize the Secretary to issue a Temporary Medical License for the intervals between Board meetings. Such Temporary License shall be granted only when the Secretary is satisfied as to the qualifications of the applicant to be licensed under this Act but where such qualifications have not been verified to the Board. An application for Temporary Licensure must be made by written request and include all appropriate fees. Such a license shall:
1. Be granted only to an applicant demonstrably qualified for a full and unrestricted medical license;
  2. Automatically terminate on the date of the next Board meeting at which the applicant may be considered for a full and unrestricted medical license.
  3. We must be in receipt of the following in order for the Board Secretary to consider issuing a Temporary License:
    - a. Examination scores, and
    - b. Verification of licensure in all jurisdictions in which applicant has been licensed to practice medicine and surgery, and
    - c. Evidence of Status, and
    - d. Extended Background Check

**I, the undersigned, have fully read and understand the instructions. I swear or affirm that the information submitted in and with the application is, to the best of my knowledge, true and factual. I understand that attempts to deceive or fraudulently portray information contained herein may result in cancellation of my application or charges of filing a fraudulent application that may result in subsequent revocation of licensure.**

Muhammad Taha Khan  
 Name of Applicant (type or print)

  
 Signature of Applicant

04/23/2022  
 Date

**Except as specifically may be waived by the Board, the Board shall not engage in any application process with any agent or representative of the applicant. 59 O.S. § 492.1 (C); Okla. Admin. Code § 435:10-4-1(c)**

Please return these signed instructions by mail to the address at the top of the page or email.

**RECEIVED**

APR 25 2022

OKLAHOMA STATE BOARD OF  
 MEDICAL LICENSURE  
 AND SUPERVISION

T39638  
 New



## TIME DEFICIENCY

Name:	MUHAMMAD TAHAKHAN	Application #	
-------	-------------------	---------------	--

We have to account for any/all time from age 18 to present. Please complete this form to the best of your recollection for the times indicated.

EDUCATION							
Start Month	Start Year	End Month	End Year	Name of Institution	City	State	Degree
✓ 09	2013	06	2015	THE CAMBRIDGE HIGH SCHOOL	ABU DHABI	U.A.E	A-LEVELS
✓ 12	2015	07	2021	DOU INTERNATIONAL MEDICAL COLLEGE	KARACHI	PAKISTAN	M.B.B.S
EMPLOYMENT							
Start Month	Start Year	End Month	End Year	Name of Employer	City	State	Job Title
✓ 11	2021	01	2022	DOU UNIVERSITY HOSPITAL	KARACHI	PAKISTAN	HOUSE OFFICER
✓ 03	2022	PRESENT		AGA KHAN UNIVERSITY HOSPITAL	KARACHI	PAKISTAN	INTERN
OTHER							
Start Month	Start Year	End Month	End Year	Other (Unemployed, Stay at home parent, etc.)	City	State	
07	2022	08	2022	STEP 2 CK prep, Research, Volunteering	KARACHI	PAKISTAN	
08	2022	09	2022	Virtual Observer at University of Miami	MIAMI	FLORIDA	
09	2022	10	2022	Attending Rendering Interviews & Volunteering	KARACHI	PAKISTAN	
01	2022	02	2022	Personal time off to visit parents in Abu Dhabi.	ABU DHABI	UAE.	

6/2015-12/2015  
7/2021-11/2021

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APR 25 2022

OKLAHOMA STATE BOARD OF  
MEDICAL LICENSURE  
AND SUPERVISION





05/03/2022

MUHAMMAD TAHA KHAN



**Check Your Application Status Online at:**  
<http://www.okmedicalboard.org>  
**Username:AP32452986**  
**Password:4 Digit Birth Year**

RE: MD Application #39638

Dear MUHAMMAD TAHA KHAN,

**YOU CANNOT PRACTICE YOUR PROFESSION IN THE STATE OF OKLAHOMA UNTIL A VALID LICENSE HAS BEEN ISSUED.**

This deficiency list may or may not contain all required deficiencies. Please **allow 5 business days** for review by a licensing analyst, at which time you may check your updated status online by logging in with the username and password provided above. If you have further questions at that time, you may email the Licensing Staff at [licensing@okmedicalboard.org](mailto:licensing@okmedicalboard.org) or call (405) 962-1470.

Review of your application for special licensure to practice medicine and surgery in the state of Oklahoma reveals the following deficiencies:

- Exam verification date
- USMLE Exams Incomplete
- Social Security Number
- Evidence of Status
- Visa Type (if non-US citizen)
- Visa Expiration Date (if non-US citizen)
- Extended Background Check
- Time DEFICIENCIES: 6/2015-12/2015, NOT ADDRESS IN FORM RECEIVED (PLEASE USE TIME DEFICIENCY FORM FOR EXPLANATIONS)
- OTHER DEFICIENCIES: RCVD EVD OF STATUS WAITING ON SAVE / \*\*\*DO NOT NEED FORM2, STEP3, FED, AMA OR NPDB\*\*\*
- US Customs and Immigration Service (USCIS)
- PostGrad - Form 2 COLLEGE OF MEDICINE OKC

If a "Time Deficiency" is listed, please e-mail [licensing@okmedicalboard.org](mailto:licensing@okmedicalboard.org) with your activities during the specified time frame.

Any of the required forms in the list above may be downloaded from our website:

<http://www.okmedicalboard.org/resources>

In order to check on the status of your application, please log on to our web site ([www.okmedicalboard.org](http://www.okmedicalboard.org)). Your user name is AP32452986 (all caps and no spaces) and your password is the last 4 digits of your social security number. If you did not provide a social security number with your application, your password will be your 4-digit year of birth in the form "YYYY". To log in, scroll down the home page until you see the tabs in the middle of the page. Click on the tab labeled "eServices," then click "Online Application Status Check." This will open a webpage that allows you to enter your login information.

If we may be of further assistance, please email [licensing@okmedicalboard.org](mailto:licensing@okmedicalboard.org) or call (405) 962-1470.

Sincerely,

**Lisa Cullen**

Lisa Cullen  
Director of Licensing  
Dept. of Licensing

Encl



# Oklahoma State Board of Medical Licensure and Supervision Application Summary

Type	Number	Name
MD	39638	MUHAMMAD TAHA KHAN
MEDICAL DOCTOR		

**Incomplete Information (due to space limitations on this page, this may not be a complete list)**

OTHER DEFICIENCIES: \*\*\*DO NOT NEED FORM2, STEP3, FED, AMA OR NPDB\*\*\*  
 AMA Profile Not Received (to be completed by OSBMLS Staff)  
 USMLE Exams Incomplete  
 PostGrad - Form 2 COLLEGE OF MEDICINE OKC  
 Extended Background Check  
 NPDB Profile Not Received (to be completed by OSBMLS Staff)  
 Exam verification date  
 Social Security Number  
 Federation Clearance Not Received (to be completed by OSBMLS Staff)

**Last Medical School Attended:**  
 704-02 Dow Med Coll, Univ Of Karachi, Karachi, Pakistan

**Number of Licenses Previously Granted to Graduates of this Medical School:138**

Application for: Resident \_\_\_\_\_ Full License \_\_\_\_\_ Reinstatement \_\_\_\_\_

**The Secretary of the Board has reviewed this application and:**

1) AUTHORIZED CIRCULARIZATION TO OTHER BOARD MEMBERS \_\_\_\_\_

2) ALL FIVE CRITERIA HAVE BEEN MET [Fast Track] \_\_\_\_\_

- Passed USMLE
- No DUIs or Legal Issues
- No Significant Malpractice Issues
- US Graduate
- Graduated Medical School on time

3) HAS ISSUED A TEMPORARY LICENSE THROUGH \_\_\_ / \_\_\_ / \_\_\_

4) HAS ISSUED A SPECIAL PGY-1 TRAINING LICENSE 8/20/21/22

5) REQUESTS SPECIFIC CONSIDERATION OF:

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RETURN FORM TO:  
 OKLAHOMA STATE BOARD OF MEDICAL LICENSURE AND SUPERVISION  
 oktraining@okmedicalboard.org

RECEIVED

JUL 11 2023

OKLAHOMA STATE BOARD OF  
 MEDICAL LICENSURE  
 AND SUPERVISION

**QUESTIONNAIRE**  
 Please read and follow ALL instructions

**FORM INSTRUCTIONS:** Complete both pages of this form *only if* you are renewing or upgrading your training license. Attach the appropriate documentation and answer the confidential questions.

**PAYMENT INSTRUCTIONS:** If you **ARE FULLY LICENSED**, you **MUST** go online and renew your license – **DO NOT pay your renewal fee via these instructions (doing so will delay your renewal)** for those needing to pay online please see the instructions of ATTACHMENT 2.

**ATTESTATION STATEMENT:** By completing this document, I agree to pay the appropriate fee on **ONLINE BILL PAY** If you are **UPGRADING** your training license to a full license, your fee will be \$250 & you will choose **MD TRAINING-TO-FULL**

If you are **RENEWING** your training license, your fee will be \$150 & you will choose **MD TRAINING LICENSE RENEWAL**

**PLEASE PRINT ALL INFORMATION**

FIRST NAME	MUHAMMAD TAHA	LAST NAME	KHAN
EMAIL ADDRESS	[REDACTED]		
LICENSE NUMBER	39638	CELL PHONE	[REDACTED]
HOME ADDRESS	[REDACTED]	CITY/STATE	[REDACTED]
PROGRAM ATTENDING	ASAT NAQIG	SPECIALTY	INTERNAL MEDICINE

**DOCUMENTATION TO ATTACH**

PAYMENT COMPLETED	
<input checked="" type="checkbox"/> \$150 payment made on Billpay for RENEWAL of training license	<input type="checkbox"/> \$250 payment made on Billpay for UPGRADE of training license

DOCUMENTATION REQUIRED	
<input type="checkbox"/> Form 2 (must be received directly from program) <b>**ONLY FOR UPGRADE - ATTACHMENT 3</b>	<input checked="" type="checkbox"/> Evaluation (must be received directly from program) - ATTACHMENT 4
<input type="checkbox"/> USMLE Step 3 (must be received directly from USMLE)	<input checked="" type="checkbox"/> Answer confidential questions (on back of this form)

FOREIGN TRAINED STUDENTS	
<input checked="" type="checkbox"/> Current visa	<input type="checkbox"/> Social Security Number <b>**if not provided at initial application</b>
<input type="checkbox"/> Background Check <b>**if not done at initial application</b>	

IF YOU ARE FULLY LICENSED – DO NOT COMPLETE THIS FORM. YOU MUST GO ONLINE AND RENEW AT <https://pay.apps.ok.gov/medlic/md/login.php> ENTER YOUR LICENSE NUMBER & PIN – COMPLETE YOUR RENEWAL AND PAY THE RENEWAL FEE.

T39638  
 UKC



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JUL 11 2023

OKLAHOMA STATE BOARD OF  
MEDICAL LICENSURE  
AND SUPERVISION

NAME MUHAMMAD TAHA KHAN

PLEASE COMPLETE THE RENEWAL QUESTIONS BELOW, IF YOU HAVE ANY "YES" ANSWERS YOU MUST PROVIDE A NOTARIZED STATEMENT EXPLAINING YOUR ANSWER.

SINCE RENEWAL OF YOUR TRAINING LICENSE OR INITIAL ISSUE OF YOUR TRAINING LICENSE (whichever is most recent)		
QUESTIONS	YES	NO
Have you failed any part of the USMLE exam (not previously disclosed)?	<input type="checkbox"/>	<input checked="" type="checkbox"/>
Have you been the subject of investigation or disciplinary action (including probation) by a hospital or training program?	<input type="checkbox"/>	<input checked="" type="checkbox"/>
Have you had any adverse judgment or settlement against you rising from a professional liability claim?	<input type="checkbox"/>	<input checked="" type="checkbox"/>
Have you been reported to the National Practitioner Data Bank (NPDB)?	<input type="checkbox"/>	<input checked="" type="checkbox"/>
Have you ever been denied, had removed, or suspended hospital privileges?	<input type="checkbox"/>	<input checked="" type="checkbox"/>
Have you surrendered hospital privileges while under investigation or to avoid investigation?	<input type="checkbox"/>	<input checked="" type="checkbox"/>
Have you entered into an Agreement with a Federal, State, or Local jurisdictional body to avoid formal action?	<input type="checkbox"/>	<input checked="" type="checkbox"/>
Has your application for licensure ever been denied?	<input type="checkbox"/>	<input checked="" type="checkbox"/>
Have you surrendered a license or had any disciplinary action taken on any license?	<input type="checkbox"/>	<input checked="" type="checkbox"/>
Have you been investigated by or requested to appear before a licensing or disciplinary agency (other than the Oklahoma State Board of Medical Licensure and Supervision)?	<input type="checkbox"/>	<input checked="" type="checkbox"/>
Have you obtained an assessment or been treated for use of any drug or chemical substance including alcohol?	<input type="checkbox"/>	<input checked="" type="checkbox"/>
Have you been arrested for, charged with, or convicted of a felony or misdemeanor other than a traffic violation?	<input type="checkbox"/>	<input checked="" type="checkbox"/>
Have you been arrested for, charged with, or convicted of a traffic violation involving the use of any drug or chemical substance?	<input type="checkbox"/>	<input checked="" type="checkbox"/>
Have you been addicted to or abused any drug or chemical substance including alcohol?	<input type="checkbox"/>	<input checked="" type="checkbox"/>
Have you been denied provider participation, terminated, sanctioned or penalized by any third-party payor including TRICARE, MEDICARE, or MEDICAID?	<input type="checkbox"/>	<input checked="" type="checkbox"/>
Have you surrendered or had any adverse action taken against any narcotic permit (State or Federal)?	<input type="checkbox"/>	<input checked="" type="checkbox"/>

I swear under penalty of perjury, that I am the person completing this Questionnaire and understand that any medical license procured or obtained by fraud or misrepresentation will result in disciplinary action taken against the licensee pursuant to the provisions of 58 O.S. § 508.

Signature \_\_\_\_\_

Date \_\_\_\_\_

7/11/23

OK  
Boyd  
7-28-23

RENEWAL QUESTIONNAIRE UPDATED 01-2023

T391038  
LKC



ATTACHMENT 4

RETURN FORM TO:  
 OKLAHOMA STATE BOARD OF MEDICAL LICENSURE AND SUPERVISION  
oktraining@okmedicalboard.org  
 FORM MUST BE RETURNED BY THE PROGRAM, NOT THE APPLICANT

RECEIVED

JUL 03 2023

ANNUAL EVALUATION – TRAINING LICENSES ONLY  
DO NOT COMPLETE FOR FULLY LICENSED PHYSICIANS

OKLAHOMA STATE BOARD OF  
 MEDICAL LICENSURE  
 AND SUPERVISION

Name of Resident (please print) Muhammad Taha Khan

License Number 39638 Specialty Internal Medicine

Institution Name University of Oklahoma Health Sciences Center

Program Director (please print) Ajay P. Nadig, M.D.

Program Director Email Ajay-nadig@ouhsc.edu

Instructions: Please rate each resident according to the scale below. If the score is rated in the 0 (Poor), 1 (Fair) or 2 (Below Average) YOU MUST PROVIDE WRITTEN DOCUMENTATION REGARDING THIS RATING.

ASSESSMENT	POOR	FAIR	BELOW AVERAGE	AVERAGE	ABOVE AVERAGE	OUTSTANDING
MEDICAL KNOWLEDGE	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input checked="" type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
APPLICATION OF MEDICAL KNOWLEDGE	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input checked="" type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
COMMUNICATION SKILLS	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input checked="" type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
STABILITY IN WORKING RELATIONSHIP WITH OTHER PROFESSIONALS	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input checked="" type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
THE INDIVIDUAL'S PERFORMANCE COMMENSURATE WITH PEER GROUP	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input checked="" type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

REMARKS/COMMENTS \_\_\_\_\_  
 \_\_\_\_\_  
 \_\_\_\_\_

COMPLETED BY (please print) Ajay P. Nadig, M.D.

SIGNATURE Ajay P. Nadig, MD

DATE 10/21/2023

Evaluation revised 1-2023

PRIMARY SOURCE

T39638  
 UKL

## Oklahoma State Board of Medical Licensure and Supervision Application Summary

<b>Type</b>	<b>Number</b>	<b>Name</b>
MD	43872	RAZA KHAN
MEDICAL DOCTOR		

**Incomplete Information (due to space limitations on this page, this may not be a complete list)**

Application Instructions  
 Time Deficiency Form for: 5/2018-10/2018 NEED CITY AND STATE FOR THIS GAP MUST USE TIME DEFICIENCY FORM FOR EXPLANATIONS  
 OTHER DEFICIENCIES: NEED FORM 2 UPON COMPLETION OF TRAINING, MUST COME DIRECTLY FROM YOUR PROGRAM  
 MedSchool-Transcript Univ Of Ok Coll Of Med, Oklahoma City Ok 73190  
 MedSchool-Form 1 Univ Of Ok Coll Of Med, Oklahoma City Ok 73190  
 PostGrad - Form 2 MEDICAL CITY HEALTHCARE UNT-TCU GME PROGRAM

**Last Medical School Attended:**

039-01 Univ Of Ok Coll Of Med, Oklahoma City Ok 73190

**Number of Licenses Previously Granted to Graduates of this Medical School:7,359**

Application for: Resident \_\_\_\_\_ Full License \_\_\_\_\_ Reinstatement \_\_\_\_\_

**The Secretary of the Board has reviewed this application and:**

- 1) AUTHORIZED CIRCULARIZATION TO OTHER BOARD MEMBERS \_\_\_\_\_
  
- 2) ALL FIVE CRITERIA HAVE BEEN MET [Fast Track] \_\_\_\_\_
  - Passed USMLE
  - No DUIs or Legal Issues
  - No Malpractice Issues
  - US Graduate
  - Graduated Medical School in 4 years or less
  
- 3) HAS ISSUED A TEMPORARY LICENSE THROUGH \_\_\_\_ / \_\_\_\_ / \_\_\_\_
  
- 4) HAS ISSUED A SPECIAL PGY-1 TRAINING LICENSE \_\_\_\_\_

# Oklahoma State Board of Medical Licensure and Supervision Application Summary

**Type**    **Number**    **Name**  
 MD       43872       RAZA KHAN  
 MEDICAL DOCTOR

**Practice Address:**

May 22, 2024  
 OU DEPARTMENT OF RADIOLOGY  
 1100 N LINDSAY AVE

OKLAHOMA CITY, OK 73104  
 OKLAHOMA

**Status:**

**Res:** TP

**Received:** 05/22/2024

**Entered:** 05/22/2024

**Temp Issued:**

**Temp Expires:**

**Train Issued:**

**Train Expires:**

**Fed Rec:** 05/24/2024

**AMA Rec:** 05/24/2024

**Board Action:**

**License #:** 43872

**Sex:** M

**Ethnic Origin:** 6

**Endorsed By:** USMLE

	Test	Score	Date Taken	Date Verified	Attempts
<b>Test 1:</b>	USMLE 3	PASS	05/08/24	6/3/24	1
<b>Test 2:</b>	USMLE 1	PASS	06/07/21	6/3/24	1
<b>Test 3:</b>	USMLE 2	PASS	07/07/22	6/3/24	1
Note: <i>PASS</i> means higher than 75					
<b>Test AV:</b>					
<b>Total Possible:</b>					
<b>Okla Passing:</b>					
<b>Total Score:</b>					

**PRE-MED EDUCATION**

**School Name:** UNIVERSITY OF ROCHESTER

**City:** ROCHESTER

**State:** NY **Country:** UNITED STATES

**Degree:** B.S. IN NEUROSCIENCE

**From:** 8/2014 **To:** 5/ 2018 **Verified:**

**MEDICAL SCHOOL EDUCATION**

**Name:** Univ Of Ok Coll Of Med, Oklahoma City Ok 73190

**Foreign Name:**

**City:** Oklahoma City

**State/Country:** United States of America

**Degree:** M.D.

**From:** 8 / 2019

**To:** 5 / 2023

**Diploma Ver'd:**

Y



## Oklahoma State Board of Medical Licensure and Supervision Application Summary

**Type**    **Number**    **Name**  
 MD        43872        RAZA KHAN  
 MEDICAL DOCTOR

### POST GRADUATE EDUCATION

<b>Facility:</b> COLLEGE OF MEDICINE OKC		<b>Specialty:</b> RADIOLOGY	
<b>Res. Fellowship:</b> Residency			
<b>City:</b> OKLAHOMA CITY		<b>State:</b> OK	<b>Country:</b> UNITED STATES
<b>Verified:</b>	Waived	<b>From:</b> 7 / 2024	<b>To:</b> /
<b>ACGME Ver'd:</b>	Waived		
<b>Comments:</b> ELIGIBLE FOR FULL LICENSURE (LKC)			
<hr/>			
<b>Facility:</b> MEDICAL CITY HEALTHCARE UNT-TCU GME PRG		<b>Specialty:</b> TRANSITIONAL YEAR	
<b>Res. Fellowship:</b> Residency			
<b>City:</b> PLANO		<b>State:</b> TX	<b>Country:</b> UNITED STATES OF AM
<b>Verified:</b>		<b>From:</b> 7 / 2023	<b>To:</b> 6 / 2024
<b>ACGME Ver'd:</b>			
<b>Comments:</b>			

### PRACTICE HISTORY

<b>Employed:</b> ENVISION		<b>Supervisor:</b>	
<b>City:</b> NASHVILLE		<b>State:</b> TN	<b>Country:</b> UNITED STATES
<b>Specialty:</b> MEDICAL SCRIBE		<b>From:</b> 10 / 2018	<b>To:</b> 6 / 2019 <b>Verified:</b>
<b>Comments:</b> MEDICAL SCRIBE IN ER AT OUHSC			
<hr/>			
<b>Employed:</b> NONE		<b>Supervisor:</b>	
<b>City:</b> NEED CITY AND STATE		<b>State:</b>	<b>Country:</b>
<b>Specialty:</b> UNEMPLOYED		<b>From:</b> 5 / 2018	<b>To:</b> 10 / 2018 <b>Verified:</b>
<b>Comments:</b>			

### Other Licenses

State	Lic Type and Number	Status	Issued	Exp	Verif
TX	MD BP10084210	A	7/1/23	6/30/24	5/24/24

### DEFICIENCIES

Application Instructions  
 Time Deficiency Form for: 5/2018-10/2018    NEED CITY AND STATE FOR THIS GAP    MUST USE TIME DEFICIENCY FORM FOR EXPLANATIONS  
 OTHER DEFICIENCIES: NEED FORM 2 UPON COMPLETION OF TRAINING, MUST COME DIRECTLY FROM YOUR PROGRAM  
 MedSchool-Transcript Univ Of Ok Coll Of Med, Oklahoma City Ok 73190  
 MedSchool-Form 1 Univ Of Ok Coll Of Med, Oklahoma City Ok 73190  
 PostGrad - Form 2 MEDICAL CITY HEALTHCARE UNT-TCU GME PROGRAM

# Oklahoma State Board of Medical Licensure and Supervision

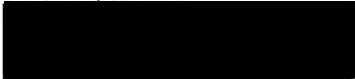
APPLICATION FOR OKLAHOMA MEDICAL DOCTOR LICENSE

PAGE 488 of 500

Received:05/22/2024

Applicant Name: KHAN, RAZA

MD 43872



Date Of Birth: [Redacted]

Place Of Birth (City, State): KARACHI, PAKISTAN

Sex: M

Race: Asian/Pacific Islander

Education									
Type	Name	City	ST	Country	From	To	Degree	Comments	Veri
UG	UNIVERSITY OF ROCHESTER	ROCHESTER	NY		8/2014	5/2018	B.S. IN NEUROSCIENCE		

Medical School Name	City	State	Country	Comments	From	To
Univ Of Ok Coll Of Med, Oklahoma City Ok 73190	Oklahoma City	OK	United States		8/2019	5/2023

Post-Graduate							
Facility	City	St	Country	Specialty	Comments	From	To
MEDICAL CITY HEALTHCARE UNT-TCU GME PROGRAM	PLANO	TX	UNITED S	TRANSITIONAL YEAR		7/2023	6/2024

Practice History							
Employer	Specialty	Supervisor	City	ST Countr	From	To	Verif
ENVISION	MEDICAL SCRIBE		NASHVILLE	TN	10/2018	6/2019	

Other/ Out-Of-State Licenses					
State	License #	Profession	Status	Issue Date	Exp Date
TX	BP10084210		U	7/1/23	6/30/24

MD Exam				
Exam	State	Score	Date Taken	#
USMLE				

\$500/-

S

# Oklahoma State Board of Medical Licensure and Supervision

APPLICATION FOR OKLAHOMA MEDICAL DOCTOR LICENSE

PAGE 489 of 500

Received:05/22/2024

## Questions Answered 05/20/2024

	Response
A. Have you ever been denied provider participation, terminated, sanctioned, or penalized by any third-party payor, to include TRICARE, MEDICARE, MEDICAID?	N
B. Have you ever surrendered a license or had any adverse action taken against any narcotic permit (state or federal)?	N
C. Have you ever been denied membership or had disciplinary action taken by a national, state or county professional organization?	N
D. Have you ever been denied or had removed or suspended hospital staff privileges?	N
E. Have you ever surrendered hospital staff privileges while under investigation or to avoid investigation?	N
F. Have you ever entered into an agreement with a federal, state or local jurisdictional body to avoid formal action?	N
G. Have you ever been the subject of an investigation, probation or disciplinary action by a hospital, clinic, practice group, or training program?	N
H. Have you had any adverse judgment, settlement, or award against you arising from a professional liability claim?	N
I. Have you ever had professional liability coverage declined, canceled, issued on special terms, or renewal refused?	N
J. Have you been reported to the National Practitioner Data Bank (NPDB)?	N
K. Has your application for a professional license been denied?	N
M. Have you surrendered a license or had a license revoked?	N
N. Has any disciplinary action been taken on any license?	N
O. Have you been the subject of a review by a professional licensing/regulatory agency, other than the Oklahoma State Board, based on a complaint filed against you?	N
P. Have you ever been arrested or convicted of a felony or misdemeanor, or are charges currently pending against you?	N
U. Are you or your spouse currently on Active Duty in the U.S. Armed Forces?	N
V. Are you or your spouse currently Deployed on Active Duty in the U.S. Armed Forces?	N



Oklahoma State Board of Medical Licensure and Supervision

APPLICATION FOR OKLAHOMA MEDICAL DOCTOR LICENSE

PAGE 490 of 500

Received:05/22/2024

If licensed, where do you intend to locate?

OK

Why do you seek Licensure in the state of Oklahoma?

Post-Graduate Training

In what manner will you be communicating with your Oklahoma patients (telephone, email, internet, video-conference, etc)?

Describe how you will examine each patient in person prior to diagnosis, treating, correcting, or prescribing for a patient in Oklahoma from the state, province, or country you are located:

Describe the manner in which you intend to practice medicine across state lines in Oklahoma:

Have you executed or been offered a contract in connection with practice in the state of Oklahoma?

Yes

If 'Yes', Name of practice:

OUSHC Diagnostic Radiology Program

If so, Please identify with which category:

Residency

Name of Previous Carrier and Policy Holder

N/A

Name of Current Carrier and policy Holder

N/A

Will your professional liability insurance policy cover your practice in Oklahoma

No

If NO, when do you expect to obtain liability insurance that will cover practice in Oklahoma

Start of residency (07/01/24)

I attest that all the above information is accurate as of May 21, 2024: \_\_\_\_\_ (Signed Online) \_\_\_\_\_





**Applicant:** In the presence of a notary public, sign this form with attached photo.

**Send this form to:**

Oklahoma State Board of Medical Licensure and Supervision  
101 NE 51<sup>st</sup> Street  
Oklahoma City, OK 73105

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

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

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

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

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

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

RECEIVED

MAY 29 2024

OKLAHOMA STATE BOARD OF  
MEDICAL LICENSURE  
AND SUPERVISION



*[Handwritten signature]*

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

Khan, Raza, A.

Applicants printed last name, first name, middle initial, and suffix (e.g., Jr.)

05/29/2024

Date of signature (must correspond to the date of notarization)



Please note: The Notary Public seal should overlap the bottom of the photo to the left!

NOTARY

State of Texas, County of Collin

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

The statements on this document are subscribed and sworn to before me by the applicant on this 29 day of May, 2024

Notary Public Signature

*[Handwritten signature]*

My Notary Commission Expires

03/27/2025

143872  
SJ





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

**RECEIVED**

**JUN 03 2024**

OKLAHOMA STATE BOARD OF  
MEDICAL LICENSURE  
AND SUPERVISION

This document was prepared by

Federation of State Medical Boards of the United States, Inc. (FSMB)

Fuller Wisser Road, Euless, TX 76039-3856 - Telephone (817) 868-4000

**Recipient:** OKLAHOMA STATE BOARD OF  
MEDICAL LICENSURE & SUPERVISION

**Date:** 05/30/2024

**Examinee:** Khan, Raza Ahmed  
**Alt Name(s):**

**Examinee ID:** 5-476-349-5  
**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. Pass/fail outcomes are based upon the minimum passing level in place at the time of test administration and are not altered by subsequent revisions to the minimum passing level. Effective April 1, 2013, two-digit scores will no longer be reported. Test results reported as passing represent an exam score of 75 or higher on a two-digit scale. Step 1 examinations taken on or after January 26, 2022 are reported as pass/fail, with no numeric score; Step 1 examinations taken before January 26, 2022 will continue to be reported with a 3-digit score.

<b>USMLE STEP 1</b>				
Test Date	Pass/Fail	Score	Minimum Pass	Comments
06/07/2021	Pass	241	(194)	

<b>USMLE STEP 2</b>				
<i>Clinical Knowledge (CK)</i>				
Test Date	Pass/Fail	Score	Minimum Pass	Comments
07/07/2022	Pass	268	(214)	

<b>USMLE STEP 3</b>				
Test Date	Pass/Fail	Score	Minimum Pass	Comments
05/08/2024	Pass	238	(200)	

**End of Exam History**

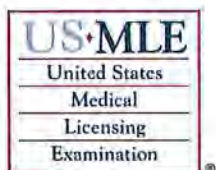
NOTE: The USMLE Step 2 CS examination was last administered March 16, 2020. Examinees with a failing outcome may not have had an opportunity to retest. The USMLE defines successful completion of its examination sequence as passing Step 1, Step 2 CK, and Step 3.

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

**PRIMARY SOURCE**

T43872  
50





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

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

**Examinee:** Khan, Raza Ahmed

**Examinee ID:** 5-476-349-5

**Date of Birth:** [REDACTED]

### INTERPRETATION OF RESULTS

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

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

### STEP 1 AND STEP 2 CLINICAL SKILLS (CS)

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

### ANNOTATIONS APPEARING UNDER "COMMENTS"

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

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

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

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

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

### ANNOTATIONS APPEARING AS "NOTE"

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

### PHYSICIAN DATA CENTER INFORMATION APPEARING AS "NOTE"

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

03/2015

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



# AMA Physician Profile

PAGE 494 of 500

PREPARED FOR

Oklahoma State Board of Licensure & Supervision, Oklahoma City, OK

PRIMARY SOURCE

**Name and Mailing Address**

RAZA AHMED KHAN  
HCA HEALTHCARE - MEDICAL CITY PLANO  
GRADUATE MEDICAL EDUCATION  
3901 W 15TH ST  
PLANO, TX 75075-7738

**Primary Office Address**

SAME AS MAILING ADDRESS

**Birth date**

[REDACTED]

**Phone** UNKNOWN

**Physician's major professional activity**

HOSPITAL BASED RESIDENTS - ALL YEARS

RECEIVED

MAY 23 2024

OKLAHOMA STATE BOARD OF  
MEDICAL LICENSURE  
AND SUPERVISION

**AMA membership status**

NON MEMBER

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

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

NO DATA REPORTED AT THIS TIME

**Current and/or historical medical school**

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

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

**School:** UNIVERSITY OF OKLAHOMA COLLEGE OF MEDICINE

**Degree Awarded:** YES  
**Enrollment Date:** 08/2019

**Degree Type:** MD  
**Degree Date:** 05/2023

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

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

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

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

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

<b>Sponsoring Institution:</b>	HCA MEDICAL CITY HEALTHCARE UNT-TCU GME
<b>Sponsoring State:</b>	TEXAS
<b>Program name:</b>	HCA MEDICAL CITY HEALTHCARE UNT-TCU GME (PLANO) PROGRAM
<b>Specialty:</b>	TRANSITIONAL YEAR
<b>Training Type:</b>	SPECIALTY
<b>Dates:</b>	07/01/2023 - 06/30/2024
<b>Status:</b>	TRAINING IN PROGRESS

### Specialty board certification

NO DATA REPORTED AT THIS TIME

### Current and/or historical medical licensure

NO DATA REPORTED AT THIS TIME

### Action notifications reported to the AMA

**Medical Licensing Boards:** NO ACTIONS REPORTED AT THIS TIME



**Medicare/Medicaid Sanctions from DHHS: NO ACTIONS REPORTED AT THIS TIME**

**US DOJ Drug Enforcement Administration: NO ACTIONS REPORTED AT THIS TIME**

#### U.S. Drug Enforcement Administration (DEA)

NO DATA REPORTED AT THIS TIME

#### ECFMG certification

NOT APPLICABLE

#### Profile information

The content of the AMA Physician Profile is for credentialing use only. The content cannot be used or assembled for an employment purpose as defined under the Fair Credit Reporting Act. An organization's appropriate use of the data contained in the AMA Physician Professional Data™, formerly known as AMA Physician Masterfile, meets select primary source verification requirements of the Joint Commission, the Accreditation Association for Ambulatory Health Care (AAAHC) and the American Accreditation Health Care Commission (AAHCC)/ Utilization Review Accreditation Commission (URAC). The AMA Physician Professional Data is also an NCQA-approved source for verification of medical school, post-graduate medical training, ABMS Board Certification and federal DEA registration.

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

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



MAY 29 2024

OKLAHOMA STATE BOARD OF  
MEDICAL LICENSURE  
AND SUPERVISION

Email form to: [Licensing@okmedicalboard.org](mailto:Licensing@okmedicalboard.org)

**EVIDENCE OF STATUS – PART A**

Full Legal Name: Raza Ahmed Khan  
First Middle Last Maiden (if applicable)

Mailing Address: [REDACTED]  
City State Zip Code Telephone Number

Social Security #: [REDACTED]

**PRIMARY EVIDENCE OF CITIZENSHIP  
(FOR US CITIZENS, US NATIONALS, OR PERMANENT LEGAL RESIDENT ALIENS)**

If you are a U.S. citizen, U.S. national, or permanent legal resident alien, please attach a photocopy of one of the following documents to this form. Place a checkmark below to indicate the document that is attached.

- A birth certificate showing birth in one of the 50 States, the District of Columbia, Puerto Rico (on or after January 13, 1941), Guam, the U.S. Virgin Islands (on or after January 17, 1917), American Samoa, Swain's Island or the Northern Mariana Islands, unless the person was born to foreign diplomats residing in the U.S.
- United States passport** (except limited passports, which are issued for periods of less than five years)
- Report of birth abroad of a U.S. citizen (FS-240)** (issued by the Department of State to U.S. citizens)
- Certificate of birth (FS-545)** (issued by a foreign service post) or Certification of Report of Birth (DS1350) (issued by the Department of State), copies available from the Department of State
- Certificate of Naturalization (N-550 or N-570)** (issued by the INS through a Federal or State court, or through administrative naturalization after December 1990 to individuals who are individually naturalized; the N570 is a replacement certificate issued when the N-550 has been lost or mutilated or the individual's name has been changed)
- Certificate of Citizenship (N-560 or N-561)** (issued by the INS to individuals who derive U.S. citizenship through a parent; the N-561 is a replacement certificate issued when the N-560 has been lost or mutilated or the individual's name has been changed)
- United States Citizen Identification Card (I-197)** (issued by the INS until April 7, 1983 to U.S. citizens living near the Canadian or Mexican border who needed it for frequent border crossing) (formerly Form I-179, last issued in February 1974)
- Northern Mariana Identification Card** (issued by the INS to a collectively naturalized citizen of the U.S. who was born in the Northern Mariana Islands before November 3, 1986)
- Statement provided by a U.S. consular officer certifying that the individual is a U.S. citizen** (This is given to an individual born outside the U.S. who derives citizenship through a parent but does not have an FS-240, FS-545 or DS-1350);
- American Indian Card with a classification code "KIC" and a statement on the back** (identifying U.S. citizen members of the Texas Band of Kickapoos living near the U.S./Mexican border.)
- Alien Lawfully Admitted for Permanent Residence:**  
INS Form I-551 (Alien Registration Receipt Card, commonly known as a "green card")
- Alien Lawfully Admitted for Permanent Residence:**  
Unexpired Temporary I-551 stamp in foreign passport or on INS Form I-94

I declare under penalty of perjury, under the laws of the State of Oklahoma, that all information contained in this application and all accompanying documents provided to substantiate my Evidence of Status application are true and correct.

Signature [Signature] Date 05/29/2024

Subscribed and sworn before me this 29<sup>th</sup> day of May, 2024

Notary Public Shaniquea Patrice  
Commission Number 132610959  
My commission expires 8/7/2024

NOTARY SEAL



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57



Name:	Raza Khan	Application #	43872
-------	-----------	---------------	-------

We must account **for any/all time from your 18th birthday to present.** Please complete this form to the best of your recollection for the times indicated.

EDUCATION							
Start Month	Start Year	End Month	End Year	Name of Institution	City	State	Degree
8	2014	5	2018	University of Rochester	Rochester	NY	B.S. neuroscience
8	2019	5	2023	University of Oklahoma College of	Oklahoma Ci	OK	M.D.

WORK HISTORY							
Start Month	Start Year	End Month	End Year	Name of Employer	City	State	Job Title
10	2018	7	2019	Envision	Oklahoma Ci	OK	Medical Scribe
7	2023	6	2024	HCA Healthcare	Plano	TX	Transtional year

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 MAY 29 2024  
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 MEDICAL LICENSURE  
 AND SUPERVISION

OTHER ACTIVITY							
Start Month	Start Year	End Month	End Year	Other Activity (example: Unemployed, Summer Break, Stay at home parent, etc.)	City	State	
5	2014	8	2014	Summer break			
5	2018	10	2018	Unemployed, break			

*Need city & state*

*T43872  
SD*



05/24/2024

RAZA KHAN  
[REDACTED]

RE: MD Application #43872

**Check Your Application  
Status Online at:**  
<http://www.okmedicalboard.org>  
**Username:AP18612412**  
**Password:Last 4 SSN**

Dear RAZA KHAN,

## **YOU CANNOT PRACTICE YOUR PROFESSION IN THE STATE OF OKLAHOMA UNTIL A VALID LICENSE HAS BEEN ISSUED.**

Your training application has been processed and the current deficiencies are listed below. Please be advised, these may not be the only deficiencies. You will be advised if any other deficiencies are added. You may check your application status online by logging in with the username and password provided above.

If you have further questions please email  
[oktraining@okmedicalboard.org](mailto:oktraining@okmedicalboard.org)

If a "Time Deficiency" is listed, please complete a time deficiency form and e-mail the document to  
[oktraining@okmedicalboard.org](mailto:oktraining@okmedicalboard.org)  
 with your activities during the specified time frame.

OTHER DEFICIENCIES: FCVS/NEED FORM 2 UPON COMPLETION OF TRAINING, MUST COME DIRECTLY FROM YOUR PROGRAM  
 MedSchool-Transcript Univ Of Ok Coll Of Med, Oklahoma City Ok 73190  
 MedSchool-Form 1 Univ Of Ok Coll Of Med, Oklahoma City Ok 73190  
 PostGrad - Form 2 MEDICAL CITY HEALTHCARE UNT-TCU GME PROGRAM  
 USMLE Exams Incomplete  
 Evidence of Status  
 Visa Type (if non-US citizen)  
 Exam verification date  
 Visa Expiration Date (if non-US citizen)  
 Application Instructions  
 OATH  
 Extended Background Check  
 Time Deficiency Form for: 5/2018-10/2018 MUST USE TIME DEFICIENCY FORM FOR EXPLANATIONS

Any of the required forms in the list above may be downloaded from our website:

<http://www.okmedicalboard.org/resources>

In order to check on the status of your application, please log on to our web site:

<https://secure.okmedicalboard.org/applicant/signin>

Your user name is AP18612412 (all caps and no spaces) and your password is the last 4 digits of your social security number.

If you did not provide a social security number with your application, your password will be your 4-digit year of birth in the form "YYYY".

If we may be of further assistance, please email.

[oktraining@okmedicalboard.org](mailto:oktraining@okmedicalboard.org)

Sincerely,

*Seema Jayachand*

Seema Jayachand

Dept. of Licensing

Encl