PART 6

REFER TO ATTACHMENT #4
OF THE AGENDA

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

Type	Number	Name
MD	39602	LAXMI ALEKHYA MITTA

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:
496-23 Sri Ramachandra Med Coll, Dr M G R Med Univ, Madras, TN, India

Number of Licenses Previously Granted to Graduates of this Medical School:16

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	39602	LAXMI ALEKHYA MITTA

MEDICAL DOCTOR

Practice Address:

April 21, 2022

,

Endorsed By: USMLE

Status:
Res: TR
Received: 04/20/2022
Entered: 04/20/2022
Temp Issued:
Temp Expires:
Train Issued: 07/01/2022
Train Expires: 09/30/2024
Fed Rec: 05/08/2024
AMA Rec: 05/08/2024
Board Action:
License #: 39602
Sex: F
Ethnic Origin: 6

	Test	Score	Date Taken	Date Verified	Attempts
Test 1:	USMLE 3	PASS	04/21/23	5/8/23	1
Test 2:	USMLE 2CK	PASS	08/10/17	4/21/22	2
Test 3:	USMLE 1	PASS	09/12/16	4/21/22	1
	USMLE 2CS	PASS	10/29/14	4/21/22	1

Note: ***PASS*** means higher than 75

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

PRE-MED EDUCATION

School Name: HUDSON COLLAGE OF PUBLIC HEALTH
City: OKLAHOMA CITY **State:** OK **Country:** UNITED STATES
Degree: M.P.H. **From:** 9/2021 **To:** 4/ 2023 **Verified:**

School Name: KAKATIYA INTERMEDIATE COLLEGE
City: HYDERABAD **State:** **Country:** INDIA
Degree: HIGH SCHOOL **From:** 6/2004 **To:** 6/ 2006 **Verified:**

MEDICAL SCHOOL EDUCATION

Name: Sri Ramachandra Med Coll, Dr M G R Med Univ, Madras, TN, India
Foreign Name:
City: Madras **State/Country:** India
Degree: BACHELOR OF ME **From:** 6 / 2006 **To:** 2 / 2012 **Diploma Ver'd:** Y

Oklahoma State Board of Medical Licensure and Supervision
Application Summary

Type	Number	Name
MD	39602	LAXMI ALEKHYA MITTA

MEDICAL DOCTOR

POST GRADUATE EDUCATION

Facility: COLLEGE OF MEDICINE OKC — **Specialty:** INTERNAL MEDICINE
Res. Fellowship: Residency
City: OKLAHOMA CITY — **State:** OK — **Country:** UNITED STATES
Verified: — **From:** 7 / 2023 — **To:** /
ACGME Ver'd:
Comments:

Facility: COLLEGE OF MEDICINE OKC — **Specialty:** INTERNAL MEDICINE
Res. Fellowship: Residency
City: OKLAHOMA CITY — **State:** OK — **Country:** UNITED STATES OF AM
Verified: 07/11/2023 — **From:** 7 / 2022 — **To:** 6 / 2023
ACGME Ver'd: 07/11/2023
Comments:

Facility: CHALLA HSOPITALS — **Specialty:**
Res. Fellowship:
City: HYDERABAD — **State:** — **Country:** INDIA
Verified: Waived — **From:** 8 / 2012 — **To:** 5 / 2015
ACGME Ver'd: Waived
Comments:

Facility: APOLLO HOSPITALS — **Specialty:**
Res. Fellowship:
City: HYDERABAD — **State:** — **Country:** INDIA
Verified: Waived — **From:** 4 / 2012 — **To:** 7 / 2012
ACGME Ver'd: Waived
Comments:

Oklahoma State Board of Medical Licensure and Supervision
Application Summary

Type	Number	Name
MD	39602	LAXMI ALEKHYA MITTA

MEDICAL DOCTOR

PRACTICE HISTORY

Employed: NONE **Supervisor:**
City: OKLAHOMA CITIY **State:** OK **Country:**
Specialty: STAY AT HOME PARENT **From:** 6/ 2021 **To:** 9/ 2021 **Verified:**
Comments:

Employed: DAN L DUNCAN COMPREHENSIVE CANCER CENTER **Supervisor:**
City: HOUSTON **State:** TX **Country:** UNITED STATES
Specialty: RESEARCH QUALITY ANALYST & PATIENT SAFETY OFFI **From:** 10/ 2019 **To:** 6/ 2021 **Verified:**
Comments: REVIEWS AE (ADVERSE EVENT) REPORTS AND OBTAINS MORE DETAILED INFORMATION AS APPROPRIATE.

Employed: NONE **Supervisor:**
City: HOUSTON **State:** TX **Country:**
Specialty: STAY AT HOME PARENT **From:** 6/ 2018 **To:** 9/ 2019 **Verified:**
Comments:

Employed: NONE **Supervisor:**
City: OKLAHOMA CITY **State:** OK **Country:**
Specialty: STAY AT HOME PARENT **From:** 6/ 2015 **To:** 6/ 2018 **Verified:**
Comments:

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

RECEIVED
APR 13 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	Laxmi Alekhya	**LAST NAME**	Mitta
EMAIL ADDRESS	[redacted]		
LICENSE NUMBER	39602	**CELL PHONE**	[redacted]
HOME ADDRESS	[redacted]	**CITY/STATE ZIP CODE**	
PROGRAM ATTENDING	Dr. Christina Henson	**SPECIALTY**	Radiation Oncology

DOCUMENTATION TO ATTACH

PAYMENT COMPLETED			
☐	$150 payment made on Billpay for **RENEWAL** of training license	☒	$250 payment made on Billpay for **UPGRADE** of training license

DOCUMENTATION REQUIRED			
☐	Form 2 (must be received directly from program) ****ONLY FOR UPGRADE**	☐	Evaluation (must be received directly from program)
☐	USMLE Step 3 (must be received directly from USMLE)	☐	Answer confidential questions (on back of this form)

FOREIGN TRAINED STUDENTS			
☒	Current visa	☐	Social Security Number **if not provided at initial application
☐	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.

T39602
SJ

NAME Laxmi Alekhya Mitta

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)?	☐	☒
Have you been the subject of investigation or disciplinary action (including probation) by a hospital or training program?	☐	☒
Have you had any adverse judgment or settlement against you rising from a professional liability claim?	☐	☒
Have you been reported to the National Practitioner Data Bank (NPDB)?	☐	☒
Have you ever been denied, had removed, or suspended hospital privileges?	☐	☒
Have you surrendered hospital privileges while under investigation or to avoid investigation?	☐	☒
Have you entered into an Agreement with a Federal, State, or Local jurisdictional body to avoid formal action?	☐	☒
Has your application for licensure ever been denied?	☐	☒
Have you surrendered a license or had any disciplinary action taken on any license?	☐	☒
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)?	☐	☒
Have you obtained an assessment or been treated for use of any drug or chemical substance including alcohol?	☐	☒
Have you been arrested for, charged with, or convicted of a felony or misdemeanor other than a traffic violation?	☐	☒
Have you been arrested for, charged with, or convicted of a traffic violation involving the use of any drug or chemical substance?	☐	☒
Have you been addicted to or abused any drug or chemical substance including alcohol?	☐	☒
Have you been denied provider participation, terminated, sanctioned or penalized by any third-party payor including TRICARE, MEDICARE, or MEDICAID?	☐	☒
Have you surrendered or had any adverse action taken against any narcotic permit (State or Federal)?	☐	☒

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 04/01/2024

Laxmi Alekhya Mitta
As of April 19, 2022, 10:44 am

L.. Have you ever failed any part of a licensure/certification/registration examination?
Yes **No**

I have an attempt in Step 2 CK. I re-took the examination and cleared it in my second attempt.

Laxmi Alekhya Mitta
As of April 19, 2022, 10:44 am

State of: Oklahoma

County of: Oklahoma

The person or persons whose signature appears below personally appeared before the undersigned, a NOTARY PUBLIC, in and for the above named county and state, on the 20 day of April, 20 22, and acknowledged the execution of foregoing instrument to be the voluntary act and deed of the applicant therein named and for the purpose therein set forth, that they are duly authorized to execute the foregoing instrument, and that the statements and representations therein contained are true to the best of their knowledge and belief.

LINDA HUTTON NOTARY PUBLIC #21010530 EXP. 08/11/25 STATE OF OKLAHOMA

Signature of Applicant

Linda Hutton

Notary

8/11/2025

My Commission Expires

T-31602

Oklahoma State Board of Medical Licensure and Supervision

APPLICATION FOR OKLAHOMA MEDICAL DOCTOR LICENSE

Received:04/20/2022

Foreign Graduate

Applicant Name: MITTA, LAXMI ALEKHYA [redacted] **MD 39602**

[redacted]

Date Of Birth: [redacted] **Place Of Birth (City, State):** HYDERABAD, INDIA

Sex: F **Race:** Asian/Pacific Islander

Education

Type	Name	City	ST	Country	From	To	Degree	Comments	Veri
HS	KAKATIYA INTERMEDIATE COLLEGE	HYDERABAD		INDIA	6/2004	6/2006	HIGH SCHOOL		

Medical School Name	City	State Country	Comments	From	To
Sri Ramachandra Med Coll, Dr M G R Med Univ, Madras, TN, India	Madras	India		6/2006	3/2012

Post-Graduate

Facility	City	St	Country	Specialty	Comments	From	To
NONE			UNITED S			/	/

Practice History

Employer	Specialty	Supervisor	City	ST	Countr	From	To	Verif
DAN L DUNCAN COMPREHENSIVE CANCER CENTER	RESEARCH QUALITY ANALYST & PATIENT SAFETY OFFI		HOUSTON	TX		10/2019	6/2021	

Other/ Out-Of-State Licenses

State	License #	Profession	Status	Issue Date	Exp Date

$250.00

MD Exam

Exam	State	Score	Date Taken	#
USMLE				

Oklahoma State Board of Medical Licensure and Supervision

APPLICATION FOR OKLAHOMA MEDICAL DOCTOR LICENSE

Received:04/20/2022

Foreign Graduate

Questions Answered 04/19/2022		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?	Y
I have an attempt in Step 2 CK. I re-took the examination and cleared it in my second attempt.		
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:04/20/2022

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:

Oklahoma University College of Medicine

If so, Please identify with which category:

Residency

Name of Previous Carrier and Policy Holder

None

Name of Current Carrier and policy Holder

Oklahoma University Health Sciences Center
Oklahoma University 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 19, 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 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
APR 25 2022
OKLAHOMA STATE BOARD OF MEDICAL LICENSURE AND SUPERVISION

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

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

04 - 23 - 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 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 23 day of April, 2022

Notary Public Signature _____ My Notary Commission Expires 8-29-2024

T:39602

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: 05/12/2023

Examinee: Mitta, Laxmi Alekhya
Alt Name(s):

Examinee ID: 0-857-484-0
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
09/12/2016	Pass	204	(192)	

USMLE STEP 2

Clinical Knowledge (CK)

Test Date	Pass/Fail	Score	Minimum Pass	Comments
08/10/2017	Pass	211	(209)	
11/15/2013	Fail	202	(203)	

Clinical Skills (CS)

Test Date	Pass/Fail	Comments
10/29/2014	Pass	

USMLE STEP 3

Test Date	Pass/Fail	Score	Minimum Pass	Comments
04/21/2023	Pass	204	(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.

PRIMARY SOURCE

RECEIVED
MAY 15 2023
OKLAHOMA STATE BOARD OF MEDICAL LICENSURE AND SUPERVISION

T39602
SD

Rev 2018

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

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

Examinee: Mitta, Laxmi Alekhya

Examinee ID: 0-857-484-0
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.

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: Mitta Laxmi Alekhya

Institution: Sri Ramachandra Medical College & Research Institute City/State: Chennai, Tamil Nadu, India

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

From 06 / 28 / 2006 (Month / Day / Year) To 02 / 04 / 2012 (Month / Day / Year) and was awarded the degree M.B.B.S

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 S ANANDAN **Signature** S. Anandan

Title of Signatory: DEAN **Date of Signature** 30/04/2022

Tel: 091-44-24768027 **Fax:** 091-44-24765995 **E-Mail:** deansrmc@sriramachandra.edu.in

Sri Ramachandra Institute of Higher Education and Research (DU) School Seal CHENNAI-116

If no seal is available, this form must be notarized

Notary Public

Commission #

My commission expires:

Notary Seal

SRI RAMACHANDRA UNIVERSITY

(Declared under Section 3 of the UGC Act, 1956)

Porur, Chennai - 600 116.
Phone: 2476 8027, 31-33
Fax : 091-44-2476 5995
www.sriramachandra.edu.in

Sri Ramachandra Medical College and Research Institute

Date: 19.07.2012

TO WHOMSOEVER IT MAY CONCERN

This is to certify that **Dr. M L ALEKHYA** has passed the final MBBS Part II Examination conducted by Sri Ramachandra University during **DEC 2010** and she has completed one year Compulsory Rotatory Resident Internship on **DEC 2011.**

We also certify that the name **M L ALEKHYA** and **MITTA LAXMI ALEKHYA** refers to the same person.

DEAN OF FACULTIES
Sri Ramachandra University
Porur, Chennai-600 116.

RECEIVED
MAY 02 2022
OKLAHOMA STATE BOARD OF MEDICAL LICENSURE AND SUPERVISION

ATTESTED

Dr. S. ANANDAN
DEAN
SRI RAMACHANDRA
MEDICAL COLLEGE & RESEARCH INSTITUTE
Porur, Chennai - 600 116.

PRIMARY SOURCE

T 39602
VB

SRI RAMACHANDRA
INSTITUTE OF HIGHER EDUCATION AND RESEARCH
(Deemed to be University)

Porur, Chennai - 600 116
Phone : 091-44-2476 8027, 31-33
Fax : 091-44-2476 5995
www.sriramachandra.edu.in

Sri Ramachandra Medical College and Research Institute

Transcript of Curriculum

This is t certify that Dr. ALEKHYA M L (2006-2007) has attended four and a half years of medical college from June 2006 to December 2010 and has completed the one year compulsory internship from December 2010 to December 2011. He/She is hereby declared to have fulfilled the criteria for the Degree of Bachelor of Medicine and Bachelor of Surgery (MBBS) in Sri Ramachandra Medical College and Research Institute (Deemed University).

The course is structured so as to consist of two components – a study and training component, lasting for four and a half years, and a compulsory internship component lasting one year. The four and a half years of training are divided into three phases, as illustrated below.

<table>
<tr><td>Phase</td><td colspan="3"></td><td>Year</td></tr>
<tr><td rowspan="2">Phase I
(1 year)</td><td colspan="3">Preclinical</td><td rowspan="2">I : Anatomy, Physiology, Biochemistry</td></tr>
<tr><td colspan="2">Semester 1*</td><td>Semester 2</td></tr>
<tr><td rowspan="3">Phase II
(1.5 years)</td><td colspan="3">Paraclinical</td><td rowspan="3">II : Pathology, Pharmacology, Microbiology, Forensic Medicine</td></tr>
<tr><td colspan="3">Clinical</td></tr>
<tr><td>Semester 3</td><td>Semester 4</td><td>Semester 5</td></tr>
<tr><td rowspan="2">Phase III
(2 years)</td><td colspan="2">Semester 6</td><td>Semester 7</td><td>III : Ophthalmology, Otorhinolaryngology, Community Medicine</td></tr>
<tr><td colspan="2">Semester 8</td><td>Semester 9</td><td>IV : Medicine, Surgery, OBGYN, Pediatrics</td></tr>
</table>

* Each semester is of 6 months duration with 120 teaching days each, giving a total of 245 teaching days per year.

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During the first component, which consists of the three phases above, students are assessed by means of continuing assessment throughout the year by the various departments, as well as by final examinations, conducted by Sri Ramachandra Medical College and Research Institute (Deemed University). Internal assessments account for 20% of the final score, and the year end examinations account for 80% of the final score. Internal assessments include comprehensive student evaluation both formatively and sumatively. The final examinations consist of a written examination (with multiple choice questions, short answers and long answers), a clinical or practical examination (as dictated by the subject), and a viva voce. A minimum score of 50% independently in both the theory and practical exams is required for going on to the next year of study and internship.

SL No	Department	Teaching (in hours)			Clinical rotations (in days)	Clinical rotations (in weeks)
		Teaching other than clinical	Clinical	Total		
1.	Anatomy	650	-	650	-	-
2.	Physiology	480	-	480	-	-
3.	Biochemistry	240	-	240	-	-
4.	Pathology	300	-	300	-	-
5.	Microbiology	250	-	250	-	-
6.	Pharmacology	300	-	300	-	-
7.	Forensic Medicine	108	-	108	-	-
8.	Community Medicine	283	216	499	72	12
9.	Otorhinolaryngology	114	144	258	48	8
10.	Ophthalmology	114	144	258	48	8
11.	Medicine	300	486	786	162	27
12.	Surgery	300	486	786	162	27
13.	OBGYN	308	432	740	144	24
14.	Pediatrics	159	180	339	60	10
15.	Orthopedics	137	180	317	60	10

16.	Chest diseases and T.B.	33	36	69	12	2
17.	Psychiatry	33	36	69	12	2
18.	Radiology	30	36	66	12	2
19.	Anesthesiology	20	-	20	-	-
20.	Dentistry	33	36	69	12	2
21.	Accident and Emergency	16	36	52	12	2
22.	Dermatology and STD	45	72	117	24	4

Note - Calculations are for 245 working days per year, each semester consisting of 120 working days. Clinical sessions are for three hours a day, six days a week in the departments that the student is rotating in. The teaching other than clinical rotations includes lectures, and non lecturing sessions (seminars, symposium, integrated teaching, Tutorials & Self study.

The internship lasts for one year, and consists of rotations through various departments full-time, with an increase in the level of responsibility for patient care. There are no examinations during this period. However, each department assesses the interns on their knowledge, skills, responsibility, involvement in patient care, capacity for teamwork, participation in discussions and aptitude for research during the rotation.

During this period, there is a choice for two electives, lasting for a period of two weeks in any two of the following subjects –

1. Anesthesiology
2. Blood bank and transfusion medicine
3. Dermatology and sexually transmitted diseases
4. Forensic medicine and toxicology
5. Psychiatry
6. Physical medicine and rehabilitation
7. Radiodiagnosis
8. and respiratory diseases

DEAN - STUDENTS
SRI RAMACHANDRA
MEDICAL COLLEGE & RESEARCH INSTITUTE
(Deemed University)
Porur, Chennai-600 116

ATTESTED

Dr. S. ANANDAN
DEAN
SRI RAMACHANDRA
MEDICAL COLLEGE & RESEARCH INSTITUTE
Porur, Chennai - 600 116.

T 39602
KB

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 11 2023
OKLAHOMA STATE BOARD OF MEDICAL LICENSURE AND SUPERVISION

Verification of Graduate Medical Education

Applicant's Name: Laxmi Alekhya Nitta

Institution: University of Oklahoma, H.S.C City/State: Oklahoma City, Oklahom

Training Level (e.g. 1, 2, 3, etc.): 1 Specialty/Subspecialty: Internal Medicine From: 07/01/2020 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, MD

Title of Signatory: Program Director Date of Signature: 6/30/2023

Tel: 405 [illegible] 5963 Fax: 405-271-1476 E-Mail: Ajay-Nadig@ouhsc.edu

THE UNIVERSITY OF OKLAHOMA COLLEGE OF MEDICINE School Seal

PRIMARY SOURCE

If no seal is available, this form must be notarized

Notary Public ____

Commission # ____

My commission expires: ____

NOTARY SEAL

Updated 1/2023

T39602
UKC

ECFMG®
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: 19 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.

RECEIVED
APR 19 2022
OKLAHOMA STATE BOARD OF MEDICAL LICENSURE AND SUPERVISION

ECFMG® CERTIFICATION STATUS REPORT

USMLE®/ECFMG Identification Number: 0-857-484-0
Applicant's Name: Laxmi Alekhya Mitta
Applicant's Date of Birth: [redacted]
ECFMG Certified: Yes
Certificate Issue Date: 11 Sep 2017
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	12 Sep 2016	*	*
USMLE Step 2 CK	10 Aug 2017	*	*

Most Recent Passing Performance on Clinical Skills Examination:

Examination	Date
USMLE Step 2 CS	29 Oct 2014

Name of Medical School and Country: Sri Ramachandra Institute of Higher Education and Research (Deemed University), Chennai, INDIA
Degree Year: 2012
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: 6EQG2U5OUI

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.

AMA Physician Profile

PREPARED FOR

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

Name and Mailing Address

LAXMI ALEKHYA MITTA

[redacted]

Primary Office Address

PRIMARY SOURCE

Phone UNKNOWN

Birth date [redacted]

Physician's major professional activity HOSPITAL BASED RESIDENTS - ALL YEARS

AMA membership status MEMBER

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MAY 07 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: SRI RAMACHANDRA MEDICAL COLLEGE AND RESEARCH INSTITUTE

Degree Awarded:	YES	**Degree Type:**	MD
Enrollment Date:	NOT REPORTED	**Degree Date:**	2012

T39602 SJ

AMA
AMERICAN MEDICAL ASSOCIATION

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: 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 - 06/30/2023
Status: COMPLETED

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
39602	MD	OK	07/01/2022	09/30/2024		ACT	RES	05/06/2024	LAXMI ALEKHYA MITTA

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: 08574840

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.

OKLAHOMA STATE BOARD OF MEDICAL LICENSURE AND SUPERVISION
101 NE 51st STREET
OKLAHOMA CITY OK 73105

EVIDENCE OF STATUS – PART B

Full Legal Name: LAXMI (First) ALEKHYA (Middle) MITTA (Last) (Maiden (if applicable))

Mailing Address: [redacted] (Street Address or Post Office Box)

[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.

Immigrant or Non-Immigrant Visa Status:	
☑	**INS Form I-94**
☐	**INS Form I-688B**
Asylee:	
☐	**INS Form I-94** annotated with stamp showing grant of asylum under §208 of the INA
☐	**INS Form I-688B** (Employment Authorization Card) annotated "27a .12 (a) (5)"
☐	**INS Form I-766** (Employment Authorization Document) annotated "AS"
☐	**Grant letter** from the Asylum Office of INS
☐	**Order** of an immigration judge granting asylum
Refugee:	
☐	**INS Form I-94** annotated with stamp showing admission under §207 of the INA
☐	**INS Form I-688B** (Employment Authorization Card) annotated "274 a.12 (a) (3)"
☐	**INS Form I-766** (Employment Authorization Document) annotated "A3"
☐	**INS Form I-571** (RefugeeTravel Document)
Alien Paroled Into the U.S. for a least One Year:	
☐	**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.)
Alien Whose Deportation or Removal Was Withheld:	
☐	**INS Form I-688B** (Employment Authorization Card) annotated "274 a.12 (a) (10)"
☐	**INS Form I-766** (Employment Authorization Document) annotated "A10"
☐	**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
Alien Granted Conditional Entry:	
☐	**INS Form I-94** with stamp showing admission under §203 (a) (7) of the INA
☐	**INS Form I-688B** (Employment Authorization Card) annotated "274 a.12 (a) (3)"
☐	**INS Form I-766** (Employment Authorization Document) annotated "A3"
Cuban/Haitian Entrant:	
☐	**INS Form I-551** (Alien Registration Receipt Card, commonly known as a "green card") with the code CU6, CU7, or CH6
☐	**Unexpired temporary I-551** stamp in foreign passport or on INS Form I-94 with the code CU6 or CU7
☐	**INS Form I-94** with stamp showing parole as "Cuba/Haitian Entrant" under § 212 (d) (5) of the INA
Alien Who Has Been Battered or Subjected to Extreme Cruelty:	
☐	**INS petition** and appropriate supporting documentation
Other Document (please list)	
☐	

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APR 25 2022
OKLAHOMA STATE BOARD OF MEDICAL LICENSURE AND SUPERVISION

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 04/20/2022

Subscribed and sworn before me this 20 day of April, 20 22.

Notary Public Linda Hutton

Commission Number 21010530

My commission expires 8/11/25

LINDA HUTTON NOTARY PUBLIC STATE OF OKLAHOMA #21010530 EXP. 08/11/25 NOTARY SEAL

T39602

Name:	LAXMI ALEKHYA MITTA	Application #	39602

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
06	2006	03	2012	Sri Ramachandra university	Chennai	TN, INDIA	M.B.B.S
Sept 08	2021	04	2023	Hudson College of Public health	OKC	OK	M.P.H

EMPLOYMENT

Start Month	Start Year	End Month	End Year	Name of Employer	City	State	Job Title
Oct	2019	June	2021	Dan. L. Duncan Cancer center	Houston	TX	Research quality Analyst
April	2012	July	2012	Apollo Hospitals	Hyderabad	Telangana INDIA	Resident
Aug	2012	May	2015	Challa Hospitals	Hyderabad	Telangana INDIA	Resident

OTHER

Start Month	Start Year	End Month	End Year	Other (Unemployed, Stay at home parent, etc.)	City	State
June	2015	June	2018	Stay at home Parent	Okc	ok
June	2018	Sept	2019	Stay at home Parent	Houston	TX
June	2021	Sept	2021	Stay at home Parent	Okc	ok

3/2012-10/2019

6/2021- Present

T39602 Jan

Kenna L. Shaw

From: BillPay Webmaster <donotreply@www.ok.gov>
Sent: Saturday, April 13, 2024 9:45 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

LAXMI ALEKHYA MITTA has paid for a LICENSE - MD Training-to-Full License Fee 250.00 on 04/13/2024 09:04:45pm for $250.00.
OKLAHOMA MD LICENSE NUMBER 39602
To view all transactions please go to http://www.ok.gov/triton/ and login to your CMS account.

T 39602 VO

05/03/2022

LAXMI ALEKHYA MITTA
[redacted]

Check Your Application Status Online at:
http://www.okmedicalboard.org
***Username*:AP70606143**
***Password*:Last 4 SSN**

RE: MD Application #39602

Dear LAXMI ALEKHYA MITTA,

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 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:

Evidence of Status
Visa Type (if non-US citizen)
Visa Expiration Date (if non-US citizen)
OTHER DEFICIENCIES: RCVD EVD OF STATUS WAITING ON SAVE / *DO NOT NEED: FORM 2, STEP 3, AMA, FED, NPDB*
Exam verification date
US Customs and Immigration Service (USCIS)
Translations
MedSchool-Transcript Sri Ramachandra Med Coll, Dr M G R Med Univ, Madras, TN, India
MedSchool-Form 1 Sri Ramachandra Med Coll, Dr M G R Med Univ, Madras, TN, India
PostGrad - Form 2 COLLEGE OF MEDICINE OKC

If a "*Time Deficiency*" is listed, please e-mail 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). Your user name is AP70606143 (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 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	39602	LAXMI ALEKHYA MITTA

MEDICAL DOCTOR

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

OTHER DEFICIENCIES: *DO NOT NEED: FORM 2, STEP 3, AMA, FED, NPDB*
AMA Profile Not Received (to be completed by OSBMLS Staff)
Federation Clearance Not Received (to be completed by OSBMLS Staff)
NPDB Profile Not Received (to be completed by OSBMLS Staff)
Exam verification date
PostGrad - Form 2 COLLEGE OF MEDICINE OKC

Last Medical School Attended:
496-23 Sri Ramachandra Med Coll, Dr M G R Med Univ, Madras, TN, India

Number of Licenses Previously Granted to Graduates of this Medical School:15

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 _____** AJB 6-15-22

5) **REQUESTS SPECIFIC CONSIDERATION OF:**

_____

_____

_____

_____

_____

RETURN FORM TO:
OKLAHOMA STATE BOARD OF MEDICAL LICENSURE AND SUPERVISION
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	Laxmi Alekhya	**LAST NAME**	Mitta
EMAIL ADDRESS	[redacted]		
LICENSE NUMBER	39602	**CELL PHONE**	[redacted]
HOME ADDRESS	[redacted]	**CITY/STATE ZIP CODE**	
PROGRAM ATTENDING	Dr. Nadig	**SPECIALTY**	Prelim-Internal Medicine; Advanced-Radiation Oncology

DOCUMENTATION TO ATTACH

PAYMENT COMPLETED			
☒	$150 payment made on Billpay for **RENEWAL** of training license	☐	$250 payment made on Billpay for **UPGRADE** of training license

DOCUMENTATION REQUIRED			
☐	Form 2 (must be received directly from program) ****ONLY FOR UPGRADE** - ATTACHMENT 3	☐	Evaluation (must be received directly from program) - ATTACHMENT 4
☐	USMLE Step 3 (must be received directly from USMLE)	☐	Answer confidential questions (on back of this form)

FOREIGN TRAINED STUDENTS			
☒	Current visa	☐	Social Security Number **if not provided at initial application
☐	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 01-2023

RECEIVED
APR 26 2023
OKLAHOMA STATE BOARD OF MEDICAL LICENSURE AND SUPERVISION

T 39602 WB

RECEIVED

APR 2 6 2023

OKLAHOMA STATE BOARD OF MEDICAL LICENSURE AND SUPERVISION

NAME Laxmi Alekhya Mitta

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)?	☐	☒
Have you been the subject of investigation or disciplinary action (including probation) by a hospital or training program?	☐	☒
Have you had any adverse judgment or settlement against you rising from a professional liability claim?	☐	☒
Have you been reported to the National Practitioner Data Bank (NPDB)?	☐	☒
Have you ever been denied, had removed, or suspended hospital privileges?	☐	☒
Have you surrendered hospital privileges while under investigation or to avoid investigation?	☐	☒
Have you entered into an Agreement with a Federal, State, or Local jurisdictional body to avoid formal action?	☐	☒
Has your application for licensure ever been denied?	☐	☒
Have you surrendered a license or had any disciplinary action taken on any license?	☐	☒
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)?	☐	☒
Have you obtained an assessment or been treated for use of any drug or chemical substance including alcohol?	☐	☒
Have you been arrested for, charged with, or convicted of a felony or misdemeanor other than a traffic violation?	☐	☒
Have you been arrested for, charged with, or convicted of a traffic violation involving the use of any drug or chemical substance?	☐	☒
Have you been addicted to or abused any drug or chemical substance including alcohol?	☐	☒
Have you been denied provider participation, terminated, sanctioned or penalized by any third-party payor including TRICARE, MEDICARE, or MEDICAID?	☐	☒
Have you surrendered or had any adverse action taken against any narcotic permit (State or Federal)?	☐	☒

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 BVS 7-11-23

Signature _____ Date 04/25/2023

RENEWAL QUESTIONNAIRE UPDATED 01-2023

T 39602 VB

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

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

Name of Resident (please print) Laxmi Alekhya Nitta

License Number 396002 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	☐	☐	☐	☑	☐	☐
APPLICATION OF MEDICAL KNOWLEDGE	☐	☐	☐	☑	☐	☐
COMMUNICATION SKILLS	☐	☐	☐	☑	☐	☐
STABILITY IN WORKING RELATIONSHIP WITH OTHER PROFESSIONALS	☐	☐	☐	☑	☐	☐
THE INDIVIDUAL'S PERFORMANCE COMMENSURATE WITH PEER GROUP	☐	☐	☐	☑	☐	☐

REMARKS/COMMENTS

COMPLETED BY (please print) Ajay P. Nadig, M.D.

SIGNATURE Ajay P. Nadig, MD DATE 6/30/2023

Evaluation revised 1-2023

Oklahoma State Board of Medical Licensure and Supervision
Application Summary

Type	Number	Name
MD	39639	NIALL JAMES MOFFETT

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 SSM HEALTH

Last Medical School Attended:
661-02 Med Univ of the Americas

Number of Licenses Previously Granted to Graduates of this Medical School:76

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	39639	NIALL JAMES MOFFETT

MEDICAL DOCTOR

Practice Address:
April 24, 2022
SSM HEALTH MEDICAL GROUP- FAMILY MEDIC
608 NW 9TH SUITE 1100

OKLAHOMA CITY, OK 73102
OKLAHOMA

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: 05/07/2024
AMA Rec: 05/07/2024
Board Action:
License #: 39639
Sex: M
Ethnic Origin: 1

Endorsed By: USMLE

	Test	Score	Date Taken	Date Verified	Attempts
Test 1:	USMLE 1	PASS	06/03/20	5/10/22	1
Test 2:	USMLE 2	PASS	12/20/21	5/10/22	1
Test 3:	USMLE 3	PASS	12/20/22	6/16/23	1

Note: ***PASS*** means higher than 75

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

PRE-MED EDUCATION

School Name: UNIVERSITY OF ULSTER
City: JORDANSTOWN **State:** **Country:** IRELAND
Degree: BSC HONS DIAGNOSTIC RADIOGRAPHY **From:** 1/2005 **To:** 3/2010 **Verified:**

School Name: BELFAST INSTITUTE FOR HIGHER AND FURTHER EDUCATION
City: BELFAST **State:** **Country:** IRELAND
Degree: ACCESS TO UNIVERSITY COURSE, SCIENCE **From:** 10/2003 **To:** 12/2004 **Verified:**

School Name: BELFAST INSTITUTE FOR HIGHER AND FURTHER EDUCATION
City: BELFAST **State:** **Country:** IRELAND
Degree: GNVQ SCIENCE ADV **From:** 1/1999 **To:** 1/2001 **Verified:**

MEDICAL SCHOOL EDUCATION

Name: Med Univ of the Americas
Foreign Name:
City: Whitehall **State/Country:** Saint Kitts and Nevis
Degree: DOCTOR OF MEDI(**From:** 9 / 2017 **To:** 5 / 2022 **Diploma Ver'd:** Y

Oklahoma State Board of Medical Licensure and Supervision
Application Summary

Type	Number	Name
MD	39639	NIALL JAMES MOFFETT

MEDICAL DOCTOR

POST GRADUATE EDUCATION

Facility: SSM HEALTH **Specialty:** FAMILY MEDICINE

Res. Fellowship: Residency

City: OKLAHOMA CITY **State:** OK **Country:** UNITED STATES OF AM

Verified: **From:** 7 / 2022 **To:** /

ACGME Ver'd: 05/03/2022

Comments:

Oklahoma State Board of Medical Licensure and Supervision
Application Summary

Type	Number	Name
MD	39639	NIALL JAMES MOFFETT

MEDICAL DOCTOR

PRACTICE HISTORY

Employed: HOMEMAKER **Supervisor:**
City: GAINESVILLE **State:** FL **Country:** UNITED STATES
Specialty: LOOKED AFTER DAUGHTER WHILE WIFE WAS IN SCHOOL **From:** 1/ 2017 **To:** 8/ 2017 **Verified:**
Comments: LOOKED AFTER DAUGHTER WHILE WIFE WAS IN SCHOOL

Employed: FLORIDA CREDIT UNION **Supervisor:**
City: GAINESVILLE **State:** FL **Country:** UNITED STATES
Specialty: OUTBOUND CALL CENTER OPERATOR **From:** 10/ 2016 **To:** 1/ 2017 **Verified:**
Comments: OUTBOUND CALL CENTER OPERATOR

Employed: LIFESOUTH COMMUNITY BLOOD CENTERS **Supervisor:**
City: GAINESVILLE **State:** FL **Country:** UNITED STATES
Specialty: CALL CENTER FOR BLOOD DRIVES, PROMOTED TO CORD BLO **From:** 10/ 2014 **To:** 9/ 2016 **Verified:**
Comments: CALL CENTER FOR BLOOD DRIVES, PROMOTED TO CORD BLOOD PROCESSOR

Employed: NONE **Supervisor:**
City: GAINESVILLE **State:** FL **Country:** UNITED STATES
Specialty: SEARCHING FOR WORK **From:** 7/ 2014 **To:** 10/ 2014 **Verified:**
Comments: SEARCHING FOR WORK

Employed: LLOYDS BANK **Supervisor:**
City: BELFAST **State:** **Country:** IRELAND
Specialty: LLOYDS BANKING CALL CENTER, FRAUD DEPARTMENT. **From:** 4/ 2013 **To:** 7/ 2014 **Verified:**
Comments: LLOYDS BANKING CALL CENTER, FRAUD DEPARTMENT.

Employed: ANHUI POLYTECHNIC UNIVERSITY **Supervisor:**
City: WUHU **State:** **Country:** CHINA
Specialty: SPOKEN ENGLISH TEACHER, **From:** 1/ 2011 **To:** 1/ 2013 **Verified:**
Comments: SPOKEN ENGLISH TEACHER,

Employed: SANTANDER BANK **Supervisor:**
City: BELFAST **State:** **Country:** IRELAND
Specialty: BANKING CALL CENTER CUSTOMER SUPPORT. **From:** 5/ 2010 **To:** 12/ 2011 **Verified:**
Comments: BANKING CALL CENTER CUSTOMER SUPPORT.

Employed: THE CHURCH OF JESUS CHRIST OF LATTER-DAY SAINTS **Supervisor:**
City: SALT LAKE CITY **State:** UT **Country:** UNITED STATES
Specialty: 2 YEAR FULL TIME SERVICE MISSION, COMPLETED **From:** 8/ 2001 **To:** 8/ 2003 **Verified:**

Oklahoma State Board of Medical Licensure and Supervision
Application Summary

Type	Number	Name
MD	39639	NIALL JAMES MOFFETT

MEDICAL DOCTOR

Comments: 2 YEAR FULL TIME SERVICE MISSION, COMPLETED

Employed: NONE **Supervisor:**
City: BELFAST **State:** **Country:** IRELAND
Specialty: UNEMPLOYED **From:** 1/ 2001 **To:** 8/ 2001 **Verified:**
Comments:

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 SSM HEALTH

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

RECEIVED
APR 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	Niall	LAST NAME	Moffett
EMAIL ADDRESS	[redacted]		
LICENSE NUMBER	39639	CELL PHONE	[redacted]
HOME ADDRESS	[redacted]	CITY/STATE	
		ZIP CODE	
PROGRAM ATTENDING	Cheyn Onaredeer	SPECIALTY	Family Medicine

DOCUMENTATION TO ATTACH

PAYMENT COMPLETED			
☐	$150 payment made on Billpay for **RENEWAL** of training license	☑	$250 payment made on Billpay for **UPGRADE** of training license

DOCUMENTATION REQUIRED			
☐	Form 2 (must be received directly from program) **ONLY FOR UPGRADE	☐	Evaluation (must be received directly from program)
☐	USMLE Step 3 (must be received directly from USMLE)	☐	Answer confidential questions (on back of this form)

FOREIGN TRAINED STUDENTS			
☐	Current visa	☐	Social Security Number **if not provided at initial application
☐	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

T39639
SJ

RECEIVED
APR 02 2024
OKLAHOMA STATE BOARD OF MEDICAL LICENSURE AND SUPERVISION

NAME Niall Moffett

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)?	☐	☑
Have you been the subject of investigation or disciplinary action (including probation) by a hospital or training program?	☐	☑
Have you had any adverse judgment or settlement against you rising from a professional liability claim?	☐	☑
Have you been reported to the National Practitioner Data Bank (NPDB)?	☐	☑
Have you ever been denied, had removed, or suspended hospital privileges?	☐	☑
Have you surrendered hospital privileges while under investigation or to avoid investigation?	☐	☑
Have you entered into an Agreement with a Federal, State, or Local jurisdictional body to avoid formal action?	☐	☑
Has your application for licensure ever been denied?	☐	☑
Have you surrendered a license or had any disciplinary action taken on any license?	☐	☑
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)?	☐	☑
Have you obtained an assessment or been treated for use of any drug or chemical substance including alcohol?	☐	☑
Have you been arrested for, charged with, or convicted of a felony or misdemeanor other than a traffic violation?	☐	☑
Have you been arrested for, charged with, or convicted of a traffic violation involving the use of any drug or chemical substance?	☐	☑
Have you been addicted to or abused any drug or chemical substance including alcohol?	☐	☑
Have you been denied provider participation, terminated, sanctioned or penalized by any third-party payor including TRICARE, MEDICARE, or MEDICAID?	☐	☑
Have you surrendered or had any adverse action taken against any narcotic permit (State or Federal)?	☐	☑

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 Niall Moffett Date 04/01/24

Oklahoma State Board of Medical Licensure and Supervision

APPLICATION FOR OKLAHOMA MEDICAL DOCTOR LICENSE

Received:04/24/2022

Foreign Graduate

Applicant Name: MOFFETT, NIALL JAMES MR **MD 39639**

[redacted]

Date Of Birth: [redacted] **Place Of Birth (City, State):** BELFAST, UNITED KINGDOM

Sex: M **Race:** Caucasian

Education

Type	Name	City	ST	Country	From	To	Degree	Comments	Veri
GD	UNIVERSITY OF ULSTER	JORDANSTO'		IRELAND	1/2005	3/2010	BSC HONS DIAGNOSTIC RADIOGRAPHY		
HS	BELFAST INSTITUTE FOR HIGHER AND FURTHER EDUCATION	BELFAST		IRELAND	10/2003	12/2004	ACCESS TO UNIVERSITY COURSE, SCINECE		
HS	BELFAST INSTITUTE FOR HIGHER AND FURTHER EDUCATION	BELFAST		IRELAND	1/1999	1/2001	GNVQ SCIENCE ADV		

Medical School Name	City	State Country	Comments	From	To
Med Univ of the Americas	Whitehall	Saint Kitts and		9/2017	5/2022

Post-Graduate

Facility	City	St	Country	Specialty	Comments	From	To
MEDICAL UNIVERSITY OF THE AMERICAS	OKLAHOMA	OK	UNITED S'	UROLOGY		4/2022	5/2022
MEDICAL UNIVERSITY OF THE AMERICAS	OKLAHOMA	OK	UNITED S'	CARDIOLOGY		3/2022	4/2022
MEDICAL UNIVERSITY OF THE AMERICAS	OKLAHOMA	OK	UNITED S'	FAMILY MEDICINE		1/2022	3/2022
MEDICAL UNIVERSITY OF THE AMERICAS	OKLAHOMA	OK	UNITED S'	EMERGENCY MEDICINE		1/2022	1/2022
MEDICAL UNIVERSITY OF THE AMERICAS	OKLAHOMA	OK	UNITED S'	NEUROLOGY		11/2021	11/2021
MEDICAL UNIVERSITY OF THE AMERICAS	OKLAHOMA	OK	UNITED S'	NEPHROLOGY		11/2021	12/2021
MEDICAL UNIVERSITY OF THE AMERICAS	OKLAHOMA	OK	UNITED S'	PSYCHIATRY		10/2021	10/2021
MEDICAL UNIVERSITY OF THE AMERICAS	MIAMI	FL	UNITED S'	PEDIATRICS		7/2021	8/2021
MEDICAL UNIVERSITY OF THE AMERICAS	OKLAHOMA	OK	UNITED S'	OBSTETRICS AND GYNECOLOGY		5/2021	7/2021
MEDICAL UNIVERSITY OF THE AMERICAS	OKLAHOMA	OK	UNITED S'	SURGERY		3/2021	5/2021
MEDICAL UNIVERSITY OF THE AMERICAS	OKLAHOMA	OK	UNITED S'	PSYCHIATRY		1/2021	2/2022
MEDICAL UNIVERSITY OF THE AMERICAS	OKLAHOMA	OK	UNITED S'	INTERNAL MEDICINE		10/2020	1/2021

Oklahoma State Board of Medical Licensure and Supervision

APPLICATION FOR OKLAHOMA MEDICAL DOCTOR LICENSE

Received:04/24/2022

Foreign Graduate

MEDICAL UNIVERSITY OF THE AMERICAS	OKLAHOMA	OK UNITED S	INTERNAL MEDICINE	10/2020	1/2021
MEDICAL UNIVERSITY OF THE AMERICAS	OKLAHOMA	OK UNITED S	INTERNAL MEDICINE	10/2020	1/2021

Practice History

Employer	Specialty	Supervisor	City	ST	Countr	From	To	Verif
HOMEMAKER	NONE		GAINESVILLE	FL		1/2017	8/2017	
FLORIDA CREDIT UNION	NONE		GAINESVILLE	FL		10/2016	1/2017	
LIFESOUTH COMMUNITY BLOOD CENTERS	NONE		GAINESVILLE	FL		10/2014	9/2016	
SEARCHING FOR EMPLOYMENT	NONE		GAINESVILLE	FL		7/2014	10/2014	
LLOYDS BANK	NONE		BELFAST		IRELAND	4/2012	7/2014	
ANHUI POLYTECHNIC UNIVERSITY	NONE		WUHU		CHINA	1/2011	1/2012	
SANTANDER BANK	NONE		BELFAST		IRELAND	5/2010	12/2011	
THE CHURCH OF JESUS CHRIST OF LATTER-DAY SAINTS	NONE		SALT LAKE CITY	UT		8/2001	8/2003	

Other/ Out-Of-State Licenses

State	License #	Profession	Status	Issue Date	Exp Date

MD Exam

Exam	State	Score	Date Taken	#
NBME				

Oklahoma State Board of Medical Licensure and Supervision

APPLICATION FOR OKLAHOMA MEDICAL DOCTOR LICENSE

Received:04/24/2022

Foreign Graduate

Questions Answered 04/21/2022		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

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:
SSM Health Medical Group- Family Medicine Center

If so, Please identify with which category:
Residency

Name of Previous Carrier and Policy Holder
My medical school, covered my liability insurance. They did not name the Carrier of policy.

Name of Current Carrier and policy Holder
My medical school, covered my liability insurance. They did not name the Carrier of policy.

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
June 20th 2022

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 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.

Applicant Photograph

Securely tape or glue a recent front view 2"x2" passport-type color photo of yourself in this square

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

RECEIVED
MAY 10 2022
OKLAHOMA STATE BOARD OF MEDICAL LICENSURE

Moffett Niall James
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 Public seal should overlap the bottom of the photo to the left]

NOTARY

State of Oklahoma, County of Cleveland

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 6 day of May, 2022

Notary Public Signature [signature] Notary Public Commission Expires May 13, 2023

HAN HUYNH
NOTARY PUBLIC - STATE OF OKLAHOMA
MY COMMISSION EXPIRES MAY 13, 2023
COMMISSION # 11004448

T39639 MA

Oklahoma State Board of Medical Licensure and Supervision

MD 39639 MOFFETT, NIALL JAMES **Submitted:04/24/2022**

28543_12076.jpg

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: 06/16/2023

Examinee: Moffett, Niall James
Alt Name(s):

Examinee ID: 1-093-566-6
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
06/03/2020	Pass	224	(194)	

USMLE STEP 2

Clinical Knowledge (CK)

Test Date	Pass/Fail	Score	Minimum Pass	Comments
12/20/2021	Pass	238	(209)	

USMLE STEP 3

Test Date	Pass/Fail	Score	Minimum Pass	Comments
12/20/2022	Pass	220	(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.

Rev 2018

T 39639

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: Moffett, Niall James

Examinee ID: 1-093-566-6
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.

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: Niall James Moffett

Institution: Medical University of the Americas City/State: Charlestown, Nevis, West Indies

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

From 05 / 07 / 2018 (Month / Day / Year) To 05 / 20 / 2022 (Month / Day / Year) 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: Amy E. LeCain Signature: Amy E LeCain

Title of Signatory: University Registrar Date of Signature: June 16, 2022

Tel: 978-862-9500 Fax: 978-862-9599 E-Mail: registrar@mua.edu

MEDICAL UNIVERSITY OF THE AMERICAS • Nevis, West Indies •

If no seal is available, this form must be notarized

Notary Public

Commission #

My commission expires:

Notary Seal

T39639
LKC

Medical University of the Americas

in consideration of the satisfactory completion of all
requirements prescribed by the faculty
hereby confers upon

Niall James Moffett

the degree of

Doctor of Medicine

together with all the rights, privileges and responsibilities appertaining thereto.
In testimony whereof, the corporate seal and the signatures as authorized
by the Board of Trustees are hereunto affixed.

Given at Nevis, West Indies
this twentieth day of May, two thousand and twenty-two.

I certify that this is a true and exact copy of the diploma awarded to Medical University of the Americas graduate Niall James Moffett on May 20, 2022.

Amy E. LeCain
Amy E. LeCain — June 16, 2022
University Registrar

Executive Dean

MEDICAL UNIVERSITY OF THE AMERICAS
Nevis, West Indies

Chairman, Board of Trustees

T36039

TRANSCRIPT OF ACADEMIC RECORD

P.O. BOX 701, CHARLESTOWN, NEVIS

STUDENT NAME
Niall James Moffett

DEGREE(S) CONFERRED
Doctor of Medicine Degree 5/20/2022

STUDENT ID	PROGRAM	MATRICULATED AS OF	DATE ISSUE
8442	**Medical Doctor**	**5/7/2018**	**6/14/2022**

Fall 2017--MEDICAL UNIVERSITY OF THE AMERICAS
SESSION DATES 09/04/2017 -- 12/15/2017 Pre-Medicine

DESCRIPTION	GRADE	SCORE	QUAL. UNITS	SEM. PTS	WEEKS/ HOURS
PMED011 Principles of General Chemistry	B	85	3.50	17.50	5.00
PMED012 Medical Terminology	A	94	4.00	12.00	3.00
PMED013 Anatomy & Physiology I	B	87	3.70	22.20	6.00

	ATT	ERN	QPTS	GPA
CURRENT	14.00	14.00	51.70	3.69
CUMULATIVE	14.00	14.00	51.70	3.69

Spring 2018--MEDICAL UNIVERSITY OF THE AMERICAS
SESSION DATES 01/08/2018 -- 04/20/2018 Pre-Medicine

DESCRIPTION	GRADE	SCORE	QUAL. UNITS	SEM. PTS	WEEKS/ HOURS
PMED021 Advanced Organic Chemistry	C	70	2.00	10.00	5.00
PMED022 Introduction to Cell Biology	A	91	4.00	20.00	5.00
PMED023 Anatomy & Physiology II	B	85	3.50	21.00	6.00

	ATT	ERN	QPTS	GPA
CURRENT	16.00	16.00	51.00	3.18
CUMULATIVE	30.00	30.00	102.70	3.42

Summer 2018--MEDICAL UNIVERSITY OF THE AMERICAS
SESSION DATES 05/07/2018 -- 08/17/2018 Basic Science

DESCRIPTION	GRADE	SCORE	QUAL. UNITS	SEM. PTS	WEEKS/ HOURS
MED501 Scientific Foundations	A	95	4.00	20.00	5.00
MED502 Human Body Structure & Functio	A	96	4.00	60.00	15.00
MED503 Cell/Tissue Structure & Function	A	95	4.00	32.00	8.00
MED506 Clinical Skills I	B	88	3.80	7.60	2.00

	ATT	ERN	QPTS	GPA
CURRENT	30.00	30.00	119.60	3.98
CUMULATIVE	30.00	30.00	119.60	3.98

Fall 2018--MEDICAL UNIVERSITY OF THE AMERICAS
SESSION DATES 09/03/2018 -- 12/14/2018 Basic Science

DESCRIPTION	GRADE	SCORE	QUAL. UNITS	SEM. PTS	WEEKS/ HOURS
MED601 Metabolism & Nutrition	A	90	4.00	36.00	9.00
MED602 Genetics & Development	B	88	3.80	15.20	4.00
MED603 Infection/Defense/Response	B	88	3.80	45.60	12.00
MED606 Clinical Skills II	A	91	4.00	12.00	3.00
MED607 Foundational / Applied Clinical C	P				2.00
MED609 Research Curriculum - Evidence I	B	86	3.60	7.20	2.00

	ATT	ERN	QPTS	GPA
CURRENT	30.00	32.00	116.00	3.86
CUMULATIVE	60.00	62.00	235.60	3.92

T39639
UKC

Amy E. LeCain, University Registrar

MEDICAL UNIVERSITY OF THE AMERICAS

OFFICE OF THE REGISTRAR
27 Jackson Road
Suite 302
Devens, MA 01434
Phone (978) 862-9500 • Fax (978) 862-9599

CAMPUS SITE
P.O. Box 701
Charlestown, Nevis

TRANSCRIPT KEY

CALENDAR:
The Basic Science program operates on the tri-semester schedule: Fall (September-December); Winter/Spring (effective 2009) (January-April); Summer (May-August). The Clinical Medicine program operates under the calendar semester of 15 weeks in length. One credit represents one week of clinical rotations.

TRANSCRIPT SUMMARY:

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CUM ATT:	Cumulative number of credits attempted at MUA.
QPTS:	Quality points
GPA:	Grade Point Average: QPTS divided by CUM ERN. Grade Point Average is not included in third and fourth year of the M.D. program.
SCORE:	Percentage grade
WEEKS/HOURS:	Credit hours/weeks

GRADING SYSTEM: BASIC SCIENCE, CLINICAL MEDICINE, AND PSY.D. – M.D. PROGRAMS
The following grades are included in the calculation of GPA.

A	90-100%	(Superior Performance)
B	80-89%	(Good, Commendable Performance)
C	70-79%	(Satisfactory Performance)
F	Below 70%	(Unsatisfactory-Failing Performance)
WF		(Withdrawn/Failing) at the time of withdrawal

The following are not included in the calculation of the GPA.

H	(Honors)
P	(Pass)
E	(Unsatisfactory-Failing Performance)
I	(Incomplete)
W	(Withdrawal)
IP	(In progress)
WP	(Withdrawn/Pass) passing at the time of withdrawal
AU	(Audit)
T/C	(Transfer Credits) accepted
SCHEDULED	(Approved clerkship) no grade awarded
CURRENT	(Clerkship in progress) indicates weeks but not grade
PENDING	(Clerkship completed) awaiting grade
S	Satisfactory
U	Unsatisfactory

STATUS:

DEANS LIST:	Fall 2000 – Winter 2003, GPA of 3.75 or greater As of May 2003, GPA of 4.0
HONORS:	Fall 2000 – Winter 2003, GPA of 3.5 to 3.74 As of May 2003, GPA of 3.75 to 3.99

REQUIREMENTS FOR BACHELOR OF SCIENCE DEGREE:
Minimum of 120 semester hours required for degree. The 120 semester hours may combine pre-medical coursework and courses taken in the Doctor of Medicine program at MUA. The student must maintain an academic average of "C" or better during their enrollment at MUA.

REQUIREMENTS FOR THE DOCTOR OF MEDICINE DEGREE (M.D.):
For the M.D. degree each student must: (a) satisfactorily complete the Basic Sciences and Clinical Medicine curriculum, (b) pass the United States Medical Licensing Exam (USMLE) Step 1, (c) receive approval to graduate from the Board of Trustees and (d) complete such other requirements as may exist from time to time. For graduates on or after August 15, 2010, each student must also pass the USMLE Step 2 Clinical Knowledge and USMLE Step 2 Clinical Skills Exams.

REQUIREMENTS FOR THE PRE-MEDICAL PROGRAM:
For the Pre-Medical program, students must successfully complete the two-semester program in full except when a partial program is approved by the school and must maintain a "C" average or better.

COMPETENCIES:
Students beginning the first semester in Fall 2013 and thereafter must achieve grades of Satisfactory (S) in all assessed competencies in order to graduate and receive a final grade on their competency transcript. Such grades will be recorded on the transcript for Patient Care, Scientific & Medical Knowledge, Lifelong Learning, Scholarship & Collaboration, Professionalism, Communication & Interpersonal Skills and Social & Community Context of Healthcare.

CERTIFICATION OF OFFICIAL TRANSCRIPTS:
A transcript is official only when printed with a white signature on the Medical University of the Americas seal with a burgundy background.

RELEASE OF INFORMATION:
This transcript has been transmitted at the request of the named student in accordance with the Family Educational Rights and Privacy Act (FERPA) of 1974. This document cannot be released to a third party without the written consent of the student.

TRANSCRIPT OF ACADEMIC RECORD

P.O. BOX 701, CHARLESTOWN, NEVIS

STUDENT NAME

Niall James Moffett

DEGREE(S) CONFERRED

Doctor of Medicine Degree 5/20/2022

STUDENT ID	PROGRAM	MATRICULATED AS OF	DATE ISSUE
8442	**Medical Doctor**	**5/7/2018**	**6/14/2022**

Spring 2019--MEDICAL UNIVERSITY OF THE AMERICAS
SESSION DATES 01/07/2019 -- 04/19/2019 Basic Science

DESCRIPTION	GRADE	SCORE	QUAL. UNITS	SEM. PTS	WEEKS/ HOURS
MED701 Neuroscience, Mind & Behavior	B	88	3.80	45.60	12.00
MED702 Systems & Disease I (Introduction	B	88	3.80	38.00	10.00
MED703 Medical Ethics	B	83	3.30	6.60	2.00
MED706 Clinical Skills III	B	89	3.90	11.70	3.00
MED707 Epidemiology	A	96	4.00	8.00	2.00
MED708 Foundational/Applied Clinical Co	P				2.00

	ATT	ERN	QPTS	GPA
CURRENT	29.00	31.00	109.90	3.78
CUMULATIVE	89.00	93.00	345.50	3.88

Summer 2019--MEDICAL UNIVERSITY OF THE AMERICAS
SESSION DATES 05/06/2019 -- 08/16/2019 Basic Science

DESCRIPTION	GRADE	SCORE	QUAL. UNITS	SEM. PTS	WEEKS/ HOURS
MED801 Systems & Disease II (Repro/End	A	94	4.00	32.00	8.00
MED802 Systems & Disease III (CV/Resp/I	B	89	3.90	50.70	13.00
MED803 Systems & Disease IV (GI/Peds)	A	91	4.00	24.00	6.00
MED806 Clinical Skills IV	A	90	4.00	24.00	6.00

	ATT	ERN	QPTS	GPA
CURRENT	33.00	33.00	130.70	3.96
CUMULATIVE	122.00	126.00	476.20	3.90

Fall 2019--MEDICAL UNIVERSITY OF THE AMERICAS
SESSION DATES 09/02/2019 -- 12/13/2019 Basic Science

DESCRIPTION	GRADE	SCORE	QUAL. UNITS	SEM. PTS	WEEKS/ HOURS
MED901 Systems & Disease V (Heme/Imm	A	97	4.00	48.00	12.00
MED906 Clinical Skills V	A	97	4.00	12.00	3.00
MED908 Foundations of Clinical Medicine	P				16.00
MED909 Research Curriculum	P				1.00

	ATT	ERN	QPTS	GPA
CURRENT	15.00	32.00	60.00	4.00
CUMULATIVE	137.00	158.00	536.20	3.91

Third Year Clinical--MEDICAL UNIVERSITY OF THE AMERICAS

Psychiatry	A	6.00
Surgery	A	12.00
OBGYN	A	6.00
Internal Medicine	B	12.00
Pediatrics	A	6.00
Research: Literature Review and Analysis	B	8.00
Total Weeks/Hours		**50**

PRIMARY SOURCE

RECEIVED
JUN 21 2022
OKLAHOMA STATE BOARD OF MEDICAL LICENSURE AND SUPERVISION

T39639

Amy E. LeCain, University Registrar

MEDICAL UNIVERSITY OF THE AMERICAS

OFFICE OF THE REGISTRAR
27 Jackson Road
Suite 302
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Phone (978) 862-9500 • Fax (978) 862-9599

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E	(Unsatisfactory-Failing Performance)
I	(Incomplete)
W	(Withdrawal)
IP	(In progress)
WP	(Withdrawn/Pass) passing at the time of withdrawal
AU	(Audit)
T/C	(Transfer Credits) accepted
SCHEDULED	(Approved clerkship) no grade awarded
CURRENT	(Clerkship in progress) indicates weeks but not grade
PENDING	(Clerkship completed) awaiting grade
S	Satisfactory
U	Unsatisfactory

STATUS:

DEANS LIST:	Fall 2000 – Winter 2003, GPA of 3.75 or greater
	As of May 2003, GPA of 4.0
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STUDENT NAME

Niall James Moffett

DEGREE(S) CONFERRED

Doctor of Medicine Degree 5/20/2022

STUDENT ID	PROGRAM	MATRICULATED AS OF	DATE ISSUE
8442	**Medical Doctor**	**5/7/2018**	**6/14/2022**

DESCRIPTION	GRADE	SCORE	QUAL. UNITS	SEM. PTS	WEEKS/ HOURS
Fourth Year Clinical--MEDICAL UNIVERSITY OF THE AMERICAS					
Family Medicine	A				6.00
Emergency Medicine	A				4.00
Nephrology	A				4.00
Cardiology (Elective)	A				4.00
Urology	A				4.00
Neurology	A				4.00
Psychiatry Sub-I	A				4.00
Total Weeks/Hours					**30**

DESCRIPTION	GRADE	SCORE	QUAL. UNITS	SEM. PTS	WEEKS/ HOURS
**** End of Transcript ****					

Competency--MEDICAL UNIVERSITY OF THE AMERICAS

CARE	S
KNOWLEDGE	S
LIFELONG LEARNING	S
PROFESSIONALISM	S
INTERPERSONAL SKILLS	S
SOCIAL CONTEXT	S

T39639
UKC

Amy E. LeCain, University Registrar

MEDICAL UNIVERSITY OF THE AMERICAS

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Suite 302
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Phone (978) 862-9500 • Fax (978) 862-9599

CAMPUS SITE
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Charlestown, Nevis

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S	Satisfactory
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STATUS:

DEANS LIST:	Fall 2000 – Winter 2003, GPA of 3.75 or greater As of May 2003, GPA of 4.0
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RELEASE OF INFORMATION:
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FORM #4 (MD)

RECEIVED
MAY 25 2022
OKLAHOMA STATE BOARD OF MEDICAL LICENSURE AND SUPERVISION

Oklahoma State Board of Medical Licensure and Supervision
P.O. Box 18256, Oklahoma City, OK 73154-0256

VERIFICATION OF CLINICAL CLERKSHIP

In the event a foreign medical school utilized clerkships in the United States, its territories or possessions, and the applicant graduated from medical school after July 1, 2003, such clerkships shall have been performed in hospitals and schools that have programs accredited by the Accreditation Council for Graduate Medical Education (ACGME).

One form must be completed and mailed directly to the Board for each clerkship.

This is to certify that Niall Moffett (Student's Name); [redacted] (U.S. Social Security Number)

12/6/1981 (Date of Birth) a student of Medical University of the Americas (Medical School)

Completed a clerkship offered by Community Health of South Florida, Inc. (Name of Facility)

10300 SW 216 Street Miami, Fl 33190 (Address of Facility)

From 7 (Month) 12 (Day) 2021 (Year) through 8 (Month) 20 (Day) 2021 (Year) in the clinical area

Of Pediatrics (Clinical Area).

This facility has programs that are accredited by ACGME in the areas of Family Medicine and Psychiatry (Specialty).

I, Tanya Roman, swear or affirm that I am/was the individual facility program director or instructor for the student named above during the clerkship indicated and that I have carefully read and completed this form and that the statements made herein are accurate.

Institution Seal

Tanya Roman
Type or Print Name of Facility Program Director or Instructor

10300 SW 216 Street
Address

Miami (City) FL (State) 33190 (Zip Code)

305-253-5100
Telephone Number

Tanya Roman
Signature

In the absence of an official institution seal, the Facility Program Director or Instructor's signature must be notarized.

Signed and sworn before me this 19 day of May (Month) 2022 (Year).

Notary Seal

Notary Public State of Florida
Adlin S Correa
My Commission GG 959947
Expires 02/19/2024

Notary Public Signature

My Commission Expires: 2/19/2024

T 39639
NB

FORM #4 (MD)

Oklahoma State Board of Medical Licensure and Supervision
P.O. Box 18256, Oklahoma City, OK 73154-0256

VERIFICATION OF CLINICAL CLERKSHIP

In the event a foreign medical school utilized clerkships in the United States, its territories or possessions, and the applicant graduated from medical school after July 1, 2003, such clerkships shall have been performed in hospitals and schools that have programs accredited by the Accreditation Council for Graduate Medical Education (ACGME).

One form must be completed and mailed directly to the Board for each clerkship.

This is to certify that Niall Moffett (Student's Name); [redacted] (U.S. Social Security Number)

12/06/81 (Date of Birth) a student of Medical University of Americas (Medical School)

Completed a clerkship offered by Griffin Memorial Hospital (Name of Facility)

PO Box 151 Norman, OK 73070 (Address of Facility)

From 10/4/2021 (Month/Day/Year) through 10 29 2021 (Month Day Year) in the clinical area

Of Psychiatry (Clinical Area).

This facility has programs that are accredited by ACGME in the areas of Psychiatry (Specialty).

I, Clayton Morris, swear or affirm that I am/was the individual facility program director or instructor for the student named above during the clerkship indicated and that I have carefully read and completed this form and that the statements made herein are accurate.

Institution Seal

Clayton Morris, M.D.
Type or Print Name of Facility Program Director or Instructor

PO Box 151
Address

Norman OK 73070
City State Zip Code

4055736602
Telephone Number

Signature NOTA

In the absence of an official institution seal, the Facility Program Director or Instructor's signature must be notarized.

Signed and sworn before me this _____ day of _____(Month) _____(Year).

Notary Public Signature

Notary Seal

My Commission Expires: _____

RECEIVED
MAY 25 2022
OKLAHOMA STATE BOARD OF MEDICAL LICENSURE AND SUPERVISION

T39639 MB

FORM #4 (MD)

RECEIVED
MAY 13 2022
OKLAHOMA STATE BOARD OF MEDICAL LICENSURE AND SUPERVISION

Oklahoma State Board of Medical Licensure and Supervision
P.O. Box 18256, Oklahoma City, OK 73154-0256

VERIFICATION OF CLINICAL CLERKSHIP

In the event a foreign medical school utilized clerkships in the United States, its territories or possessions, and the applicant graduated from medical school after July 1, 2003, such clerkships shall have been performed in hospitals and schools that have programs accredited by the Accreditation Council for Graduate Medical Education (ACGME).

One form must be completed and mailed directly to the Board for each clerkship.

This is to certify that Nial Moffett (Student's Name); [redacted] (U.S. Social Security Number)

12/06/1981 (Date of Birth) a student of Medical University of the Americas (Medical School)

Completed a clerkship offered by St. Anthony Hospital (Name of Facility)

1000 N. Lee, Oklahoma City, Oklahoma 73102 (Address of Facility)

From 10 (Month) 26 (Day) 2020 (Year) through 01 (Month) 15 (Day) 2021 (Year) in the clinical area

Of Internal Medicine (Clinical Area).

This facility has programs that are accredited by ACGME in the areas of Family Medicine and OBGYN (Specialty).

I, Gregg Eichman, D.O., swear or affirm that I am/was the individual facility program director or instructor for the student named above during the clerkship indicated and that I have carefully read and completed this form and that the statements made herein are accurate.

Institution Seal

Gregg Eichman, D.O., Director of Graduate Medical Education
Type or Print Name of Facility Program Director or Instructor

1000 N. Lee
Address

Oklahoma City (City) OK (State) 73102 (Zip Code)

405-231-3798
Telephone Number

Gregg A. Eichman DO
Signature

In the absence of an official institution seal, the Facility Program Director or Instructor's signature must be notarized.

Signed and sworn before me this 13 day of May (Month) 2022 (Year).

Notary Seal — MELINDA GARZA NOTARY #11000509 EXP. 01/18/23 PUBLIC STATE OF OKLAHOMA

Notary Public Signature

My Commission Expires: 01-18-2023

PRIMARY SOURCE

T 39639 VB

FORM #4 (MD)

Oklahoma State Board of Medical Licensure and Supervision
P.O. Box 18256, Oklahoma City, OK 73154-0256

VERIFICATION OF CLINICAL CLERKSHIP

In the event a foreign medical school utilized clerkships in the United States, its territories or possessions, and the applicant graduated from medical school after July 1, 2003, such clerkships shall have been performed in hospitals and schools that have programs accredited by the Accreditation Council for Graduate Medical Education (ACGME).

One form must be completed and mailed directly to the Board for each clerkship.

This is to certify that Nial Moffett (Student's Name); [redacted] (U.S. Social Security Number)

12/06/1981 (Date of Birth) a student of Medical University of the Americas (Medical School)

Completed a clerkship offered by St. Anthony Hospital (Name of Facility)

1000 N. Lee, Oklahoma City, Oklahoma 73102 (Address of Facility)

From 01 (Month) 18 (Day) 2021 (Year) through 02 (Month) 26 (Day) 2021 (Year) in the clinical area

Of Psychiatry (Clinical Area).

This facility has programs that are accredited by ACGME in the areas of Family Medicine and OBGYN (Specialty).

I, Gregg Eichman, D.O., swear or affirm that I am/was the individual facility program director or instructor for the student named above during the clerkship indicated and that I have carefully read and completed this form and that the statements made herein are accurate.

Institution Seal

Gregg Eichman, D.O., Director of Graduate Medical Education
Type or Print Name of Facility Program Director or Instructor

1000 N. Lee
Address

Oklahoma City (City) OK (State) 73102 (Zip Code)

405-231-3798
Telephone Number

Signature

In the absence of an official institution seal, the Facility Program Director or Instructor's signature must be notarized.

Signed and sworn before me this 13 day of May (Month) 2022 (Year).

Notary Public Signature

Notary Seal — MELINDA GARZA NOTARY # 11000509 EXP. 01/18/23 PUBLIC STATE OF OKLAHOMA

My Commission Expires: 01-18-2023

PRIMARY SOURCE

T 39639 VB

RECEIVED
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Oklahoma State Board of Medical Licensure and Supervision
P.O. Box 18256, Oklahoma City, OK 73154-0256

VERIFICATION OF CLINICAL CLERKSHIP

In the event a foreign medical school utilized clerkships in the United States, its territories or possessions, and the applicant graduated from medical school after July 1, 2003, such clerkships shall have been performed in hospitals and schools that have programs accredited by the Accreditation Council for Graduate Medical Education (ACGME).

One form must be completed and mailed directly to the Board for each clerkship.

This is to certify that Nial Moffett (Student's Name); [redacted] (U.S. Social Security Number)

12/06/1981 (Date of Birth) a student of Medical University of the Americas (Medical School)

Completed a clerkship offered by St. Anthony Hospital (Name of Facility)

1000 N. Lee, Oklahoma City, Oklahoma 73102 (Address of Facility)

From 05 (Month) 24 (Day) 2021 (Year) through 07 (Month) 02 (Day) 2021 (Year) in the clinical area

Of OBGYN (Clinical Area).

This facility has programs that are accredited by ACGME in the areas of Family Medicine and OBGYN (Specialty).

I, Gregg Eichman, D.O., swear or affirm that I am/was the individual facility program director or instructor for the student named above during the clerkship indicated and that I have carefully read and completed this form and that the statements made herein are accurate.

Institution Seal

Gregg Eichman, D.O., Director of Graduate Medical Education
Type or Print Name of Facility Program Director or Instructor

1000 N. Lee
Address

Oklahoma City (City) OK (State) 73102 (Zip Code)

405-231-3798
Telephone Number

Signature

In the absence of an official institution seal, the Facility Program Director or Instructor's signature must be notarized.

Signed and sworn before me this 13 day of May (Month) 2022 (Year).

Notary Public Signature

Notary Seal — MELINDA GARZA NOTARY # 11000509 EXP. 01/18/23 PUBLIC STATE OF OKLAHOMA

My Commission Expires: 01-18-2023

PRIMARY SOURCE

T39639 MB

RECEIVED
MAY 13 2022
OKLAHOMA STATE BOARD OF MEDICAL LICENSURE AND SUPERVISION

FORM #4 (MD)

Oklahoma State Board of Medical Licensure and Supervision
P.O. Box 18256, Oklahoma City, OK 73154-0256

VERIFICATION OF CLINICAL CLERKSHIP

In the event a foreign medical school utilized clerkships in the United States, its territories or possessions, and the applicant graduated from medical school after July 1, 2003, such clerkships shall have been performed in hospitals and schools that have programs accredited by the Accreditation Council for Graduate Medical Education (ACGME).

One form must be completed and mailed directly to the Board for each clerkship.

This is to certify that Nial Moffett (Student's Name); [redacted] (U.S. Social Security Number)

12/06/1981 (Date of Birth) a student of Medical University of the Americas (Medical School)

Completed a clerkship offered by St. Anthony Hospital (Name of Facility)

1000 N. Lee, Oklahoma City, Oklahoma 73102 (Address of Facility)

From 03 (Month) 01 (Day) 2021 (Year) through 05 (Month) 21 (Day) 2021 (Year) in the clinical area

Of Surgery (Clinical Area).

This facility has programs that are accredited by ACGME in the areas of Family Medicine and OBGYN (Specialty).

I, Gregg Eichman, D.O., swear or affirm that I am/was the individual facility program director or instructor for the student named above during the clerkship indicated and that I have carefully read and completed this form and that the statements made herein are accurate.

Institution Seal

Gregg Eichman, D.O., Director of Graduate Medical Education
Type or Print Name of Facility Program Director or Instructor

1000 N. Lee
Address

Oklahoma City (City) OK (State) 73102 (Zip Code)

405-231-3798
Telephone Number

Signature

In the absence of an official institution seal, the Facility Program Director or Instructor's signature must be notarized.

Signed and sworn before me this 13 day of May (Month) 2022 (Year).

Notary Public Signature

Notary Seal — BRENDA GARZA NOTARY # 11000509 EXP. 01/18/23 PUBLIC STATE OF OKLAHOMA

My Commission Expires: 01-18-2023

PRIMARY SOURCE

T 39639 VB

RECEIVED
MAY 13 2022
OKLAHOMA STATE BOARD OF MEDICAL LICENSURE AND SUPERVISION

FORM #4 (MD)

Oklahoma State Board of Medical Licensure and Supervision
P.O. Box 18256, Oklahoma City, OK 73154-0256

VERIFICATION OF CLINICAL CLERKSHIP

In the event a foreign medical school utilized clerkships in the United States, its territories or possessions, and the applicant graduated from medical school after July 1, 2003, such clerkships shall have been performed in hospitals and schools that have programs accredited by the Accreditation Council for Graduate Medical Education (ACGME).

One form must be completed and mailed directly to the Board for each clerkship.

This is to certify that Nial Moffett (Student's Name); [redacted] (U.S. Social Security Number)

12/06/1981 (Date of Birth) a student of Medical University of the Americas (Medical School)

Completed a clerkship offered by St. Anthony Hospital (Name of Facility)

1000 N. Lee, Oklahoma City, Oklahoma 73102 (Address of Facility)

From 11 (Month) 29 (Day) 2021 (Year) through 12 (Month) 24 (Day) 2021 (Year) in the clinical area

Of Nephrology (Clinical Area).

This facility has programs that are accredited by ACGME in the areas of Family Medicine and OBGYN (Specialty).

I, Gregg Eichman, D.O., swear or affirm that I am/was the individual facility program director or instructor for the student named above during the clerkship indicated and that I have carefully read and completed this form and that the statements made herein are accurate.

Institution Seal

Gregg Eichman, D.O., Director of Graduate Medical Education
Type or Print Name of Facility Program Director or Instructor

1000 N. Lee
Address

Oklahoma City (City) OK (State) 73102 (Zip Code)

405-231-3798
Telephone Number

Signature

In the absence of an official institution seal, the Facility Program Director or Instructor's signature must be notarized.

Signed and sworn before me this 13 day of May (Month) 2022 (Year).

Notary Public Signature

Notary Seal — MELINDA GARZA NOTARY #11000509 EXP. 01/18/23 PUBLIC STATE OF OKLAHOMA

My Commission Expires: 01-18-2023

PRIMARY SOURCE

T 39639 VB

FORM #4 (MD)

Oklahoma State Board of Medical Licensure and Supervision
P.O. Box 18256, Oklahoma City, OK 73154-0256

VERIFICATION OF CLINICAL CLERKSHIP

In the event a foreign medical school utilized clerkships in the United States, its territories or possessions, and the applicant graduated from medical school after July 1, 2003, such clerkships shall have been performed in hospitals and schools that have programs accredited by the Accreditation Council for Graduate Medical Education (ACGME).

One form must be completed and mailed directly to the Board for each clerkship.

This is to certify that Nial Moffett (Student's Name); [redacted] (U.S. Social Security Number)

12/06/1981 (Date of Birth) a student of Medical University of the Americas (Medical School)

Completed a clerkship offered by St. Anthony Hospital (Name of Facility)

1000 N. Lee, Oklahoma City, Oklahoma 73102 (Address of Facility)

From 11 (Month) 01 (Day) 2021 (Year) through 11 (Month) 26 (Day) 2021 (Year) in the clinical area

Of Neurology (Clinical Area).

This facility has programs that are accredited by ACGME in the areas of Family Medicine and OBGYN (Specialty).

I, Gregg Eichman, D.O., swear or affirm that I am/was the individual facility program director or instructor for the student named above during the clerkship indicated and that I have carefully read and completed this form and that the statements made herein are accurate.

Institution Seal

Gregg Eichman, D.O., Director of Graduate Medical Education
Type or Print Name of Facility Program Director or Instructor

1000 N. Lee
Address

Oklahoma City (City) OK (State) 73102 (Zip Code)

405-231-3798
Telephone Number

Signature

In the absence of an official institution seal, the Facility Program Director or Instructor's signature must be notarized.

Signed and sworn before me this 13 day of May (Month) 2022 (Year).

Notary Public Signature

Notary Seal — MELINDA GARZA NOTARY #11000509 EXP. 01/18/23 PUBLIC STATE OF OKLAHOMA

My Commission Expires: 01-18-2023

T 39639 VG

FORM #4 (MD)

RECEIVED
MAY 13 2022
OKLAHOMA STATE BOARD OF MEDICAL LICENSURE AND SUPERVISION

Oklahoma State Board of Medical Licensure and Supervision
P.O. Box 18256, Oklahoma City, OK 73154-0256

VERIFICATION OF CLINICAL CLERKSHIP

In the event a foreign medical school utilized clerkships in the United States, its territories or possessions, and the applicant graduated from medical school after July 1, 2003, such clerkships shall have been performed in hospitals and schools that have programs accredited by the Accreditation Council for Graduate Medical Education (ACGME).

One form must be completed and mailed directly to the Board for each clerkship.

This is to certify that Nial Moffett (Student's Name); [redacted] (U.S. Social Security Number)

12/06/1981 (Date of Birth) a student of Medical University of the Americas (Medical School)

Completed a clerkship offered by St. Anthony Hospital (Name of Facility)

1000 N. Lee, Oklahoma City, Oklahoma 73102 (Address of Facility)

From 01 (Month) 01 (Day) 2022 (Year) through 01 (Month) 28 (Day) 2022 (Year) in the clinical area

Of Emergency Medicine (Clinical Area).

This facility has programs that are accredited by ACGME in the areas of Family Medicine and OBGYN (Specialty).

I, Gregg Eichman, D.O., swear or affirm that I am/was the individual facility program director or instructor for the student named above during the clerkship indicated and that I have carefully read and completed this form and that the statements made herein are accurate.

Institution Seal

Gregg Eichman, D.O., Director of Graduate Medical Education
Type or Print Name of Facility Program Director or Instructor

1000 N. Lee
Address

Oklahoma City (City) OK (State) 73102 (Zip Code)

405-231-3798
Telephone Number

Signature

In the absence of an official institution seal, the Facility Program Director or Instructor's signature must be notarized.

Signed and sworn before me this 13 day of May (Month) 2022 (Year).

Notary Public Signature

Notary Seal — MELINDA GARZA NOTARY #11000509 EXP. 01/18/23 PUBLIC STATE OF OKLAHOMA

My Commission Expires: 01-18-2023

PRIMARY SOURCE

T39639 VB

FORM #4 (MD)

RECEIVED
MAY 13 2022
OKLAHOMA STATE BOARD OF MEDICAL LICENSURE AND SUPERVISION

Oklahoma State Board of Medical Licensure and Supervision
P.O. Box 18256, Oklahoma City, OK 73154-0256

VERIFICATION OF CLINICAL CLERKSHIP

In the event a foreign medical school utilized clerkships in the United States, its territories or possessions, and the applicant graduated from medical school after July 1, 2003, such clerkships shall have been performed in hospitals and schools that have programs accredited by the Accreditation Council for Graduate Medical Education (ACGME).

One form must be completed and mailed directly to the Board for each clerkship.

This is to certify that Nial Moffett (Student's Name); [redacted] (U.S. Social Security Number)

12/06/1981 (Date of Birth) a student of Medical University of the Americas (Medical School)

Completed a clerkship offered by St. Anthony Hospital (Name of Facility)

1000 N. Lee, Oklahoma City, Oklahoma 73102 (Address of Facility)

From 01 (Month) 31 (Day) 2022 (Year) through 03 (Month) 11 (Day) 2022 (Year) in the clinical area

Of Family Medicine (Clinical Area).

This facility has programs that are accredited by ACGME in the areas of Family Medicine and OBGYN (Specialty).

I, Gregg Eichman, D.O., swear or affirm that I am/was the individual facility program director or instructor for the student named above during the clerkship indicated and that I have carefully read and completed this form and that the statements made herein are accurate.

Institution Seal

Gregg Eichman, D.O., Director of Graduate Medical Education
Type or Print Name of Facility Program Director or Instructor

1000 N. Lee
Address

Oklahoma City (City) OK (State) 73102 (Zip Code)

405-231-3798
Telephone Number

Signature

In the absence of an official institution seal, the Facility Program Director or Instructor's signature must be notarized.

Signed and sworn before me this 13 day of May (Month) 2022 (Year).

Notary Public Signature

Notary Seal

MELINDA GARZA NOTARY #11000509 EXP. 01/18/23 PUBLIC STATE OF OKLAHOMA

My Commission Expires: 01-18-2023

PRIMARY SOURCE

T39639 VB

FORM #4 (MD)

Oklahoma State Board of Medical Licensure and Supervision
P.O. Box 18256, Oklahoma City, OK 73154-0256

VERIFICATION OF CLINICAL CLERKSHIP

In the event a foreign medical school utilized clerkships in the United States, its territories or possessions, and the applicant graduated from medical school after July 1, 2003, such clerkships shall have been performed in hospitals and schools that have programs accredited by the Accreditation Council for Graduate Medical Education (ACGME).

One form must be completed and mailed directly to the Board for each clerkship.

This is to certify that Nial Moffett (Student's Name); [redacted] (U.S. Social Security Number)

12/06/1981 (Date of Birth) a student of Medical University of the Americas (Medical School)

Completed a clerkship offered by St. Anthony Hospital (Name of Facility)

1000 N. Lee, Oklahoma City, Oklahoma 73102 (Address of Facility)

From 04 (Month) 11 (Day) 2022 (Year) through 05 (Month) 06 (Day) 2022 (Year) in the clinical area

Of Urology (Clinical Area).

This facility has programs that are accredited by ACGME in the areas of Family Medicine and OBGYN (Specialty).

I, Gregg Eichman, D.O., swear or affirm that I am/was the individual facility program director or instructor for the student named above during the clerkship indicated and that I have carefully read and completed this form and that the statements made herein are accurate.

Institution Seal

Gregg Eichman, D.O., Director of Graduate Medical Education
Type or Print Name of Facility Program Director or Instructor

1000 N. Lee
Address

Oklahoma City (City) OK (State) 73102 (Zip Code)

405-231-3798
Telephone Number

Signature

In the absence of an official institution seal, the Facility Program Director or Instructor's signature must be notarized.

Signed and sworn before me this 13 day of May (Month) 2022 (Year).

Notary Public Signature

Notary Seal

MELINDA GARZA NOTARY # 11000509 EXP. 01/18/23 PUBLIC STATE OF OKLAHOMA

My Commission Expires: 01-18-2023

T 39639 NB

RECEIVED
MAY 13 2022
OKLAHOMA STATE BOARD OF MEDICAL LICENSURE AND SUPERVISION

FORM #4 (MD)

Oklahoma State Board of Medical Licensure and Supervision
P.O. Box 18256, Oklahoma City, OK 73154-0256

VERIFICATION OF CLINICAL CLERKSHIP

In the event a foreign medical school utilized clerkships in the United States, its territories or possessions, and the applicant graduated from medical school after July 1, 2003, such clerkships shall have been performed in hospitals and schools that have programs accredited by the Accreditation Council for Graduate Medical Education (ACGME).

One form must be completed and mailed directly to the Board for each clerkship.

This is to certify that Nial Moffett (Student's Name); [redacted] (U.S. Social Security Number)

12/06/1981 (Date of Birth) a student of Medical University of the Americas (Medical School)

Completed a clerkship offered by St. Anthony Hospital (Name of Facility)

1000 N. Lee, Oklahoma City, Oklahoma 73102 (Address of Facility)

From 03 (Month) 14 (Day) 2022 (Year) through 04 (Month) 08 (Day) 2022 (Year) in the clinical area

of Cardiology (Clinical Area).

This facility has programs that are accredited by ACGME in the areas of Family Medicine and OBGYN (Specialty).

I, Gregg Eichman, D.O., swear or affirm that I am/was the individual facility program director or instructor for the student named above during the clerkship indicated and that I have carefully read and completed this form and that the statements made herein are accurate.

Institution Seal

Gregg Eichman, D.O., Director of Graduate Medical Education
Type or Print Name of Facility Program Director or Instructor

1000 N. Lee
Address

Oklahoma City (City) OK (State) 73102 (Zip Code)

405-231-3798
Telephone Number

Signature

In the absence of an official institution seal, the Facility Program Director or Instructor's signature must be notarized.

Signed and sworn before me this 13 day of May (Month) 2022 (Year).

Notary Public Signature

Notary Seal

MELINDA GARZA NOTARY PUBLIC STATE OF OKLAHOMA # 11000509 EXP. 01/18/23

My Commission Expires: 01-19-2023

PRIMARY SOURCE

T 39639 VB

ECFMG®
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: 23 Jun 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
JUN 29 2022
OKLAHOMA STATE BOARD OF MEDICAL LICENSURE AND SUPERVISION

USMLE®/ECFMG Identification Number: 1-093-566-6
Applicant's Name: Niall James Moffett
Applicant's Date of Birth: [redacted]
ECFMG Certified: Yes
Certificate Issue Date: 16 Jun 2022
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	03 Jun 2020	*	*
USMLE Step 2 CK	20 Dec 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: Medical University of the Americas (Nevis), Charlestown, SAINT KITTS AND NEVIS
Degree Year: 2022
Medical Education Credentials Status†: 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.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: Q3AJH7UWBL

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.

T39639 IKC

AMA Physician Profile

PREPARED FOR

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

PRIMARY SOURCE

Name and Mailing Address

NIALL J MOFFETT
ST ANTHONY HOSP
STE 1000
608 NW 9TH ST
OKLAHOMA CITY, OK 73102-1014

Primary Office Address

SAME AS MAILING ADDRESS

Phone UNKNOWN

RECEIVED
MAY 07 2024
OKLAHOMA STATE BOARD OF MEDICAL LICENSURE AND SUPERVISION

Birth date [redacted]

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: MEDICAL UNIVERSITY OF THE AMERICAS (NEVIS)

Degree Awarded:	YES	**Degree Type:**	MD
Enrollment Date:	NOT REPORTED	**Degree Date:**	2022

T39639
57

AMA AMERICAN MEDICAL ASSOCIATION

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:	ST ANTHONY HOSPITAL
Sponsoring State:	OKLAHOMA
Program name:	SSM HEALTH ST ANTHONY HOSPITAL PROGRAM
Specialty:	FAMILY MEDICINE
Training Type:	SPECIALTY
Dates:	06/30/2022 - 06/30/2025
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

Applicant Number: 10935666

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.

OKLAHOMA STATE BOARD OF MEDICAL LICENSURE AND SUPERVISION
101 NE 51st STREET
OKLAHOMA CITY OK 73105

EVIDENCE OF STATUS – PART A

Full Legal Name: Niall (First) James (Middle) McFfett (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 Niall McFfett Date 5/6/22

Subscribed and sworn before me this 6 day of May, 20 22.

Notary Public [signature]

Commission Number 11004448

My commission expires 11004448 / May 13, 2023

HAN HUYNH
NOTARY PUBLIC - STATE OF OKLAHOMA
MY COMMISSION EXPIRES MAY 13, 2023
SEAL
COMMISSION # 11004448

T 39639 MA

OKLAHOMA STATE BOARD OF MEDICAL LICENSURE AND SUPERVISION
101 NE 51ST 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 Wiser 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 i 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.

Niall Moffett — Name of Applicant (type or print)
Niall Moffett — Signature of Applicant
05/06/2022 — 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.

T39639 MA

TIME DEFICIENCY

Name:	Niall Moffett	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
1 ✓	01	1999	01	2001	Belfast Institute for Higher and Further Education	Belfast	Ireland	GNVQ Science Adv
5 ✓	10	2003	12	2004	Belfast Institute for Higher and Further Education	Belfast	Ireland	Access to University course
6 ✓	01	2005	12	2010	University of Ulster	Jordanstown	Ireland	Bsc Hons Diagnostic Radiography
17 ✓	09	2017	05	2022	Medical University of the Americas	Potworks	Nevis	Doctor of Medicine

EMPLOYMENT

	Start Month	Start Year	End Month	End Year	Name of Employer	City	State	Job Title
3 ✓	08	2001	08	2003	The Church of Jesus Christ of Latter-day Saints	Winnipeg	Canada	Service Missionary
7 ✓	01	2011	11	2011	Santander Bank	Belfast	Ireland	call center customer support
9 ✓	01	2012	01	2013	Anhui Polytechnic University	Wuhu	China	Spoken English teacher
11 ✓	04	2013	07	2014	Lloyd's Bank	Belfast	Ireland	call center customer support
13 ✓	10	2014	09	2016	Lifesouth Community Blood Centers	Gainesville	FL	call center/cord blood processor
15 ✓	10	2016	01	2017	Florida Credit Union	Gainesville	FL	call center customer support

OTHER

	Start Month	Start Year	End Month	End Year	Other (Unemployed, Stay at home parent, etc.)	City	State
2	01	2001	08	2001	Unemployed	Belfast	Ireland
4	08	2003	10	2003	unemployed	Belfast	Ireland
8	11	2011	01	2012	unemployed	Belfast	Ireland
10	01	2013	04	2013	unemployed	Belfast	Ireland
12 ✓	07	2014	10	2014	unemployed	Gainesville	FL
14	09	2016	10	2016	unemployed	Gainesville	FL
16 ✓	01	2017	08	2017	homemaker/stay at home parent	Gainesville	FL

1) 2001-10/2003
3/2010 - 9/2017

T 39639

Kenna L. Shaw

From: BillPay Webmaster <donotreply@www.ok.gov>
Sent: Tuesday, April 2, 2024 9:50 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

TIANA ISLEY has paid for a LICENSE - MD Training-to-Full License Fee 250.00
on 04/02/2024 09:04:50am for $250.00.
OKLAHOMA MD LICENSE NUMBER 39639
To view all transactions please go to http://www.ok.gov/triton/ and
login to your CMS account.

Niall Moffett
T 39639
VO

05/03/2022

NIALL JAMES MOFFETT
[redacted]

Check Your Application Status Online at:
http://www.okmedicalboard.org
***Username*:AP39900338**
***Password*:Last 4 SSN**

RE: MD Application #39639

Dear NIALL MOFFETT,

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 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:

Evidence of Status
Visa Type (if non-US citizen)
Visa Expiration Date (if non-US citizen)
INSTRUCTION SHEET
OATH
Extended Background Check
Time DEFICIENCIES: 1/2001-10/2003, 3/2010-9/2017 (PLEASE USE TIME DEFICIENCY FORM FOR EXPLANATIONS)
OTHER DEFICIENCIES: NEED CHRONOLOGICAL LIST OF US ROTATIONS AND FORM 4 *OR* EVAL FOR EACH/ ***DO NOT NEED FORM2, STEP3, FED, AMA OR NPDB***
Exam verification date
US Customs and Immigration Service (USCIS)
Translations
ECFMG
ECFMG Date
MedSchool-Transcript Med Univ of the Americas
MedSchool-Form 1 Med Univ of the Americas
PostGrad - Form 2 ST ANTHONY HOSPITAL
USMLE Exams Incomplete

If a "*Time Deficiency*" is listed, please e-mail 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). Your user name is AP39900338 (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 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	39639	NIALL JAMES MOFFETT

MEDICAL DOCTOR

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

Exam verification date
PostGrad - Form 2 ST ANTHONY HOSPITAL
USMLE Exams Incomplete
OTHER DEFICIENCIES: ***DO NOT NEED FORM2, STEP3, FED, AMA OR NPDB***
AMA Profile Not Received (to be completed by OSBMLS Staff)
Federation Clearance Not Received (to be completed by OSBMLS Staff)
NPDB Profile Not Received (to be completed by OSBMLS Staff)

Last Medical School Attended:
661-02 Med Univ of the Americas

Number of Licenses Previously Granted to Graduates of this Medical School:66

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** BJK 6-29-22

5) **REQUESTS SPECIFIC CONSIDERATION OF:**

_____

_____

_____

_____

_____

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

RECEIVED
JUN 16 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	Niall	**LAST NAME**	Moffett
EMAIL ADDRESS	[redacted]		
LICENSE NUMBER	39639	**CELL PHONE**	[redacted]
HOME ADDRESS	[redacted]	**CITY/STATE ZIP CODE**	
PROGRAM ATTENDING	Cheyn Onarecker	**SPECIALTY**	Family Medicine

DOCUMENTATION TO ATTACH

PAYMENT COMPLETED			
☐	$150 payment made on Billpay for **RENEWAL** of training license	☐	$250 payment made on Billpay for **UPGRADE** of training license

DOCUMENTATION REQUIRED			
☐	Form 2 (must be received directly from program) ****ONLY FOR UPGRADE** - **ATTACHMENT 3**	☐	Evaluation (must be received directly from program) - **ATTACHMENT 4**
☑	USMLE Step 3 (must be received directly from USMLE)	☐	Answer confidential questions (on back of this form)

FOREIGN TRAINED STUDENTS			
☐	Current visa	☐	Social Security Number **if not provided at initial application
☐	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.

T39639 VD

NAME Niall Moffett

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)?	☐	☑
Have you been the subject of investigation or disciplinary action (including probation) by a hospital or training program?	☐	☑
Have you had any adverse judgment or settlement against you rising from a professional liability claim?	☐	☑
Have you been reported to the National Practitioner Data Bank (NPDB)?	☐	☑
Have you ever been denied, had removed, or suspended hospital privileges?	☐	☑
Have you surrendered hospital privileges while under investigation or to avoid investigation?	☐	☑
Have you entered into an Agreement with a Federal, State, or Local jurisdictional body to avoid formal action?	☐	☑
Has your application for licensure ever been denied?	☐	☑
Have you surrendered a license or had any disciplinary action taken on any license?	☐	☑
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)?	☐	☑
Have you obtained an assessment or been treated for use of any drug or chemical substance including alcohol?	☐	☑
Have you been arrested for, charged with, or convicted of a felony or misdemeanor other than a traffic violation?	☐	☑
Have you been arrested for, charged with, or convicted of a traffic violation involving the use of any drug or chemical substance?	☐	☑
Have you been addicted to or abused any drug or chemical substance including alcohol?	☐	☑
Have you been denied provider participation, terminated, sanctioned or penalized by any third-party payor including TRICARE, MEDICARE, or MEDICAID?	☐	☑
Have you surrendered or had any adverse action taken against any narcotic permit (State or Federal)?	☐	☑

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.

RECEIVED
JUN 16 2023
OKLAHOMA STATE BOARD OF MEDICAL LICENSURE AND SUPERVISION

Signature Niall Moffett Date 06/12/23

T39639 OIC 7-5-23

RENEWAL QUESTIONNAIRE UPDATED 01-2023

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

PRIMARY SOURCE

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) Niall J Moffett

License Number 39639 Specialty Family Medicine

Institution Name St. Anthony Hospital

Program Director (please print) Cheyn Onarecker, M.D.

Program Director Email cheyn.onarecker@ssmhealth.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	☐	☐	☐	☐	☑	☐
APPLICATION OF MEDICAL KNOWLEDGE	☐	☐	☐	☐	☑	☐
COMMUNICATION SKILLS	☐	☐	☐	☐	☑	☐
STABILITY IN WORKING RELATIONSHIP WITH OTHER PROFESSIONALS	☐	☐	☐	☐	☑	☐
THE INDIVIDUAL'S PERFORMANCE COMMENSURATE WITH PEER GROUP	☐	☐	☐	☐	☑	☐

REMARKS/COMMENTS

COMPLETED BY (please print) Cheyn Onarecker, M.D.

SIGNATURE Cheyn Onarecker DATE 06/30/2023

Evaluation revised 1-2023

TMD 39639
RCVD 7-3-23
LKC

Oklahoma State Board of Medical Licensure and Supervision
Application Summary

Type	Number	Name
MD	39459	AHMED MOHAMMED

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 GRIFFIN MEMORIAL HOSPITAL

Last Medical School Attended:
690-11 Bayero Univ, Fac Of Med, Kano, Nigeria

Number of Licenses Previously Granted to Graduates of this Medical School:0

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: Bayero University Faculty of Medicine
LOCATION: Kano ,Nigeria

ALTERNATE NAMES

SCHOOL DETAILS

School type: Federal
Year instruction started: 1984
Operational status: Currently operational
Additional information:

PROGRAM DETAILS

Year instruction began: 1984
Curriculum duration: 5 years
Language(s) of instruction: English
Entrance exam: ○ IS REQUIRED ○ IS NOT REQUIRED ◉ INFORMATION NOT PROVIDED
Additional information:

SPONSOR NOTES

Graduation Years: to ; to ; 1988 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	39459	AHMED MOHAMMED

MEDICAL DOCTOR

Practice Address:

April 06, 2022

Endorsed By: USMLE

Status:
Res: TR
Received: 04/03/2022
Entered: 04/03/2022
Temp Issued:
Temp Expires:
Train Issued: 07/01/2022
Train Expires: 09/30/2024
Fed Rec: 05/10/2024
AMA Rec: 05/10/2024
Board Action:
License #: 39459
Sex: M
Ethnic Origin: 2

	Test	Score	Date Taken	Date Verified	Attempts
Test 1:	USMLE 3	PASS	11/22/21	4/5/22	1
Test 2:	USMLE 1	PASS	3/17/20	4/5/22	1
Test 3:	USMLE 2	PASS	3/20/21	4/5/22	1

Note: ***PASS*** means higher than 75

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

PRE-MED EDUCATION

School Name: BAYERO UNIVERSITY KANO
City: KANO **State:** **Country:** NIGERIA
Degree: MICROBIOLOGY **From:** 1/2001 **To:** 3/ 2005 **Verified:**

School Name: BAYERO UNIVERSITY KANO FACULTY OF SCIENCE
City: KANO **State:** **Country:** NIGERIA
Degree: **From:** 8/2000 **To:** 1/ 2001 **Verified:**

MEDICAL SCHOOL EDUCATION

Name: Bayero Univ, Fac Of Med, Kano, Nigeria
Foreign Name:
City: Kano **State/Country:** Nigeria
Degree: MBBS **From:** 1 / 2006 **To:** 12 / 2011 **Diploma Ver'd:** Y

Oklahoma State Board of Medical Licensure and Supervision
Application Summary

Type	Number	Name
MD	39459	AHMED MOHAMMED

MEDICAL DOCTOR

POST GRADUATE EDUCATION

Facility: GRIFFIN MEMORIAL HOSPITAL **Specialty:** PSYCHIATRY
Res. Fellowship: Residency
City: NORMAN **State:** OK **Country:** USA
Verified: **From:** 7 / 2022 **To:** /
ACGME Ver'd: 04/10/2022
Comments:

Facility: AMINU KANO TEACHING HOSPITAL **Specialty:** INTERNAL MEDICINE, SURGERY, PEDIATRICS AND OBGYN
Res. Fellowship:
City: KANO **State:** **Country:** NIGERIA
Verified: Waived **From:** 3 / 2012 **To:** 3 / 2013
ACGME Ver'd:
Comments:

Oklahoma State Board of Medical Licensure and Supervision
Application Summary

Type	Number	Name
MD	39459	AHMED MOHAMMED

MEDICAL DOCTOR

PRACTICE HISTORY

Employed: CEDAR RIDGE BEHAVIORAL HOSPITAL **Supervisor:**
City: OKLAHOMA CITY **State:** OK **Country:** UNITED STATES
Specialty: MENTAL HEALTH TECHNICIAN II **From:** 1/ 2019 **To:** 7/ 2022 **Verified:**
Comments:

Employed: OKLAHOMA ISLAMIC ACADEMY **Supervisor:**
City: OKLAHOMA CITY **State:** OK **Country:** UNITED STATES
Specialty: VOLUNTEER **From:** 1/ 2017 **To:** 1/ 2019 **Verified:**
Comments: SCIENCE AND SOCIAL STUDIES TEACHER AT PRIVATE SCHOOL (OKLAHOMA ISLAMIC ACADEMY).

Employed: NONE **Supervisor:**
City: OKLAHOMA CITY **State:** OK **Country:** UNITED STATES
Specialty: TRANSITION TO THE UNITED STATES. **From:** 9/ 2016 **To:** 1/ 2017 **Verified:**
Comments: TRANSITION TO THE UNITED STATES.

Employed: NAMERAH GENERAL HOSPITAL **Supervisor:**
City: NAMERAH **State:** **Country:** SAUDI ARABIA
Specialty: MEDICAL OFFICER **From:** 10/ 2015 **To:** 9/ 2016 **Verified:**
Comments:

Employed: AMINU KANO TEACHING HOSPITAL **Supervisor:**
City: KANO **State:** **Country:** NIGERIA
Specialty: MEDICAL OFFICER **From:** 4/ 2013 **To:** 9/ 2015 **Verified:**
Comments:

Employed: NONE **Supervisor:**
City: KANO **State:** **Country:** NIGERIA
Specialty: TRANSITION FROM MED SCHOOL TO INTERNSHIP **From:** 12/ 2011 **To:** 3/ 2012 **Verified:**
Comments:

Employed: NONE **Supervisor:**
City: KANO **State:** **Country:** NIGERIA
Specialty: TRANSITION FROM PRED MED TO MEDICAL SCHOOL **From:** 3/ 2005 **To:** 1/ 2006 **Verified:**
Comments:

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	39459	AHMED MOHAMMED

MEDICAL DOCTOR

DEFICIENCIES

OTHER DEFICIENCIES: NEED FORM 2 AND EVAL UPON COMPLETION OF TRAINING, MUST COME DIRECTLY FROM YOUR PROGRAM
PostGrad - Form 2 GRIFFIN MEMORIAL HOSPITAL

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

RECEIVED
APR 09 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	AHMED	**LAST NAME**	MOHAMMED
EMAIL ADDRESS	[redacted]		
LICENSE NUMBER	39459	**CELL PHONE**	[redacted]
HOME ADDRESS	[redacted]	**CITY/STATE ZIP CODE**	
PROGRAM ATTENDING	Dr Clayton Morris	**SPECIALTY**	Psychiatry

DOCUMENTATION TO ATTACH

PAYMENT COMPLETED			
☐	$150 payment made on Billpay for **RENEWAL** of training license	☒	$250 payment made on Billpay for **UPGRADE** of training license

DOCUMENTATION REQUIRED			
☐	Form 2 (must be received directly from program) ****ONLY FOR UPGRADE**	☐	Evaluation (must be received directly from program)
☐	USMLE Step 3 (must be received directly from USMLE)	☒	Answer confidential questions (on back of this form)

FOREIGN TRAINED STUDENTS			
☒	Current visa	☒	Social Security Number **if not provided at initial application
☐	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

T39459 SJ

NAME AHMED MOHAMMED

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)?	☐	☒
Have you been the subject of investigation or disciplinary action (including probation) by a hospital or training program?	☐	☒
Have you had any adverse judgment or settlement against you rising from a professional liability claim?	☐	☒
Have you been reported to the National Practitioner Data Bank (NPDB)?	☐	☒
Have you ever been denied, had removed, or suspended hospital privileges?	☐	☒
Have you surrendered hospital privileges while under investigation or to avoid investigation?	☐	☒
Have you entered into an Agreement with a Federal, State, or Local jurisdictional body to avoid formal action?	☐	☒
Has your application for licensure ever been denied?	☐	☒
Have you surrendered a license or had any disciplinary action taken on any license?	☐	☒
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)?	☐	☒
Have you obtained an assessment or been treated for use of any drug or chemical substance including alcohol?	☐	☒
Have you been arrested for, charged with, or convicted of a felony or misdemeanor other than a traffic violation?	☐	☒
Have you been arrested for, charged with, or convicted of a traffic violation involving the use of any drug or chemical substance?	☐	☒
Have you been addicted to or abused any drug or chemical substance including alcohol?	☐	☒
Have you been denied provider participation, terminated, sanctioned or penalized by any third-party payor including TRICARE, MEDICARE, or MEDICAID?	☐	☒
Have you surrendered or had any adverse action taken against any narcotic permit (State or Federal)?	☐	☒

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 Ahmed Mohammed Date 4/09/24

Oklahoma State Board of Medical Licensure and Supervision

APPLICATION FOR OKLAHOMA MEDICAL DOCTOR LICENSE

Received:04/03/2022

Foreign Graduate

Applicant Name: MOHAMMED, AHMED [redacted] **MD 39459**

[redacted]

Date Of Birth: [redacted] **Place Of Birth (City, State):** KANO, NIGERIA

Sex: M **Race:** Black

Education

Type	Name	City	ST	Country	From	To	Degree	Comments	Veri
UG	BAYERO UNIVERSITY KANO	KANO		NIGERIA	1/2001	3/2005	MICROBIOLOGY		

Medical School Name	City	State	Country	Comments	From	To
Bayero Univ, Fac Of Med, Kano, Nigeria	Kano		Nigeria		1/2006	12/2011
Bayero Univ, Fac of Med, Kano, Nigeria	Kano		Nigeria		1/2006	12/2011

Post-Graduate

Facility	City	St	Country	Specialty	Comments	From	To
AMINU KANO TEACHING HOSPITAL	KANO		NIGERIA	INTERNAL MEDICINE, SURGERY, PEDIATRICS AND OBGYN		3/2012	3/2013

Practice History

Employer	Specialty	Supervisor	City	ST	Countr	From	To	Verif
CEDAR RIDGE BEHAVIORAL HOSPITAL	MENTAL HEALTH TECHNICIAN II		OKLAHOMA CITY	OK		1/2019		
OKLAHOMA ISLAMIC ACADEMY	VOLUNTEER		OKLAHOMA CITY	OK		1/2017	1/2019	
NONE	NONE		OKLAHOMA CITY	OK		9/2016	1/2017	
NAMERAH GENERAL HOSPITAL	MEDICAL OFFICER		NAMERAH		SAUDI ARABIA	10/2015	9/2016	
AMINU KANO TEACHING HOSPITAL	MEDICAL OFFICER		KANO		NIGERIA	4/2013	9/2015	

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

Received:04/03/2022

Foreign Graduate

Questions Answered 04/02/2022		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

Oklahoma State Board of Medical Licensure and Supervision

APPLICATION FOR OKLAHOMA MEDICAL DOCTOR LICENSE

Received:04/03/2022

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:

Griffin Memorial Hospital

If so, Please identify with which category:

Mental Health Facility

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 02, 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 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
APR 04 2022
OKLAHOMA STATE BOARD OF MEDICAL LICENSURE AND SUPERVISION

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

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

4/3/2022
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 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 3 day of April, 2022

Notary Public Signature _____ My Notary Commission Expires August 27, 2025

T39459

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.

RECEIVED
APR 07 2022
OKLAHOMA STATE BOARD OF MEDICAL LICENSURE AND SUPERVISION

Applicant's Name: Ahmed Mohammed

Institution: Bayero University Kano Medical School City/State: Kano, Nigeria

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

From Jan / 05 / 2006 (Month / Day / Year) To Dec / 06 / 2011 (Month / Day / Year) and was awarded the degree Bachelor of Medicine, Bachelor of Surgery (MBBS)

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: Yusuf Yauza Ibrahim Signature: [signature]

Title of Signatory: Assistant Registrar (Records) Date of Signature: 7/4/2022

Tel: 2348066886054 Fax: — E-Mail: yyibrahim.reg@buk.edu.ng

OFFICE OF THE REGISTRAR • P.M.B 3011 • School Seal • 07/04/22 • BAYERO UNIVERSITY, KANO.

If no seal is available, this form must be notarized

Notary Public

Commission #

My commission expires:

PRIMARY SOURCE

Notary Seal

MD39459
SD

BAYERO UNIVERSITY, KANO

KANO-NIGERIA

ACADEMIC TRANSCRIPT

FACULTY OF MEDICINE

OFFICIAL COPY

SERIAL NO: 0066112013

QUALIFICATION OBTAINED: MBBS	DEGREE CLASS: UNCLASSIFIED
REASON FOR LEAVING: GRADUATED	

NAME	AHMED MOHAMMED	DATE OF BIRTH:	[redacted]
NUMBER	MED/05/MBBS/00804	SEX	MALE
DATE OF ENTRY:	2005/2006	DATE OF LEAVING:	2011/2012

YEAR ONE

SESSION 2005/2006 LEVEL 200

DEPARTMENT: DEPARTMENT OF MEDICINE

CODE	COURSE NAME	CV	LG	GP
	ANATOMY		C	
	BIOCHEMISTRY		C	
	COMMUNITY BASED MEDICAL EDUCATION AND SERVICE PROGRAMME		C	
	PHYSIOLOGY		C	

YEAR TWO

SESSION : 2006/2007 LEVEL 300

DEPARTMENT: DEPARTMENT OF MEDICINE

CODE	COURSE NAME	CV	LG	GP
	ANATOMY		B	
	BIOCHEMISTRY		C	
	COMMUNITY BASED MEDICAL EDUCATION AND SERVICE PROGRAMME		C	
	PHYSIOLOGY		C	

YEAR THREE

SESSION 2007/2008 LEVEL 400

DEPARTMENT: DEPARTMENT OF MEDICINE

CODE	COURSE NAME	CV	LG	GP
	PATHOLOGY		C	
	PHARMACOLOGY		C	

YEAR FOUR

SESSION : 2009/2010 LEVEL 500

DEPARTMENT: DEPARTMENT OF MEDICINE

CODE	COURSE NAME	CV	LG	GP
	OBSTETRICS AND GYNAECOLOGY		C	
	PAEDIATRICS		C	

Director
Mgt. Information System
Bayero University, Kano

Prepared by M.I.S Unit and Issued by the Registrar's Office at 11:57 PM on 03/12/2013

MD39459
SJ

YEAR FIVE

SESSION : 2010/2011	LEVEL 600			
DEPARTMENT	DEPARTMENT OF MEDICINE			
CODE	COURSE NAME	CV	LG	GP
	COMMUNITY MEDICINE		C	
	MEDICINE		C	
	SURGERY		C	

DEAN
FACULTY OF MEDICINE

DIRECTOR
ACADEMIC AFFAIRS

.....END OF TRANSCRIPT.....

8-12-2013

10/12/13

DEAN'S OFFICE
FACULTY OF MEDICINE
BAYERO UNIVERSITY
KANO.

Director
Directorate Of Academic Affair.
Bayero University, Kano

RECEIVED
APR 07 2022
OKLAHOMA STATE BOARD OF MEDICAL LICENSURE AND SUPERVISION

PRIMARY SOURCE

Director
Mgt. Information System
Bayero University, Kano.

BAYERO UNIVERSITY, KANO

ABOUT THE GRADING SYSTEM

Bayero University, Kano, operates the Course Unit System. Consequently, the University uses the GPA/CGPA grading system. The following are some of the important features of the system.

1. **Letter Grades**: Each course is assessed by a letter grade using the letters **A, B, C, D, E, F** and **I**. Each letter, except **I**, corresponds to a range of marks as follows: **A** for 70-100%; **B** for 60-69%; **C** for 50-59%; **D** for 45-49; **E** for 40- 44% and for 0-39%. The grades **A** to **E** denote pass, with grade **A** being the best; the grade **F** denotes failure in the course while the grade **I** is explained below.

2. **Incomplete Grade**: The Incomplete grade 'I' is awarded to a student who has completed all aspect of a course except the end-of-semester examination, and Senate has accepted as valid his/her reason(s) for not sitting the examination. The student would not carry over the course. Rather, he/she will only sit for the examination when it is offered next. His/Her continuous assessment is carried forward and added to the examination marks.

3. **Grade Points (GP)**: Each letter grade, except **I**, is assigned a Grade Point as follows: **A=5, B=4, C=3, D=2, E=1** and **F=0**. A grade "**ABS**" of point **0** is assigned to a course which the student failed to sit for its examination without valid reasons. No grade point is assigned to **I**.

4. **Points**: The points obtained in a course are the product of the credit value of the course and the grade point obtained in the course. Thus, if a student obtains a 'B' grade in a 3-credit course, the points are **4x3=12.**

5. **Grade Point Average (GPA)**: The semester Grade Point Average (GPA) is defined as the weighted average of all the grade points obtained in the semester, with the credits as the weights. It is an indication of student's (average) performance in the semester. In computing the GPA, credit values of course(s) graded incomplete are not counted. Thus

$$GPA = \frac{Total\ Semester\ Points}{Total\ Semester\ Credits}$$

Where credits for incomplete course(s) are not counted in totaling the credits.

6. **Cumulative Grade Point Average (CGPA)**: The Cumulative Grade Point Average (CGPA) is defined as the weighted of all the grade points obtained by the student from the time he\she joined the program of study up to the time of computation. Thus, the CGPA gives an indication of the student's overall performance in the program of study. The CGPA is computed as follows;

$$CGPA = \frac{Total\ Semester\ Points\ for\ ALL\ Semesters}{Total\ Semester\ Credits\ for\ ALL\ Semesters}$$

Where credits for incomplete course(s) are not counted in totaling the credits.
Roughly, the GPA/CGPA values are interpreted as follow:

GPA / CGPA	INTERPRETATION	
	For Degree Students	For Diploma Students
4.50-5.00	First Class Honours (Excellent)	Distinction
3.50-4.49	Upper Second Class Honours (Very Good)	Credit
2.40-3.49	Lower Second Class Honours (Good)	Merit
1.50-2.39	Third Class Honours (Fair)	Pass
1.00-1.49	Pass Degree Honours (Satisfactory)	
0.00-0.99	Fail	Fail

WORLD EDUCATION SERVICES

WWW.WES.ORG

P.O. Box 5087, Bowling Green Station
New York, NY 10274-5087
U.S.A
Tel: +1 212-966-6311 Fax: +1 212-739-6100
Email: www.wes.org/contact-us

05-Apr-2022

Oklahoma state medical board
Licensure and Supervision
Licensure and Supervision
101 NE 51st Street
Oklahoma City, OK 73105-

Reference#: 2529768/ssb
MOHAMMED, Ahmed

The enclosed evaluation report is sent to you at the request of the applicant named above.

WES is prepared to answer any questions that you may have regarding the evaluation. Please contact our Academic Services staff by e-mail at www.wes.org/contact-us or by phone at +1 212-966-6311

WES evaluations can be accessed online via *AccessWES*. Please visit <https://applications.wes.org/accesswes/Pages/Logon.aspx> for more information.

Sincerely,

World Education Services

Cc: Ahmed MOHAMMED
[redacted]

Attachments

* 2 1 8 0 7 7 4 4 *

TMD39459

WORLD EDUCATION SERVICES (WES) EVALUATION TERMS

Evaluation Scope: World Education Services (WES) evaluates formal educational credentials. WES does not evaluate trade, occupational, or professional experience. WES evaluations are based upon the best information and resources available to professional evaluators. WES evaluations are offered as non-binding advisory opinions.

Accredited Institution or Program: The status of a nationally recognized institution or program in another country is comparable to that of a regionally accredited institution in the United States.

Credential Authentication: Evaluations prepared by WES specify the manner in which each document was authenticated. The WES method used to authenticate academic documents depends on what is appropriate for the specific country and level of education. WES authenticates academic documents using one of the following methods:

- We require that official transcripts be sent to WES directly by the issuing institutions or examination bodies.

OR

- We require that relevant government authorities (for example, Ministry of Education) authenticate official transcripts and send them directly to WES.

OR

- We send documents submitted by individuals back to the issuing institution/examination bodies for verification and obtaining a written confirmation of authenticity.

Detailed document requirements can be viewed at **wes.org/required**.

Grades/Quality Points: WES uses an alphabetic system to identify grades. The standard WES conversion of letter grades into a numerical scale/quality points is as follows: A = 4.00; A-=3.67; B+ = 3.33; B = 3.00; B- = 2.67; C+ = 2.33; C = 2.00; C- = 1.67; D+ = 1.33; D = 1.00; D- = .67; F = 0; F*= (see below); R*= (see below).

- "F*" indicates a course that was failed initially, but passed on a subsequent attempt. It is not included in the GPA calculation.
- "R*" indicates a course that was passed initially, but was retaken for grade improvement. It is not included in the GPA calculation.
- "Pass" is not included in the cumulative GPA. For study completed at the undergraduate level, it corresponds to at least a "C" in the United States. For graduate and professional study, "Pass" corresponds to at least a "B."

Grade Point Average (GPA) is calculated by multiplying the number of course credits for each course by the quality points for the grade received in that course. The calculation is repeated for each course. The total of the credit hour quality points are then divided by the total number of course credits.

Course Level Designation: The designation "U" (upper) or "L" (lower) for a course at the undergraduate level is an indication of its level.

Credit Recognition and Transfer: The Course-by-Course analysis represents a breakdown of post-secondary study in terms of U.S. semester credit and grade equivalents. The number of credits accepted for transfer to a degree program or towards a professional license in the U.S. may vary from those listed in this report in accordance with the policies of the receiving educational institution or professional licensing body.

Evaluations for Professional Licensing/Certification: Only authorities qualified in the profession can determine whether an individual meets the requirements for licensing or to practice the profession in the U.S.

For questions or comments about this evaluation report, please visit **wes.org/contact**

WORLD EDUCATION SERVICES

CREDENTIAL EVALUATION AND AUTHENTICATION REPORT

Name: MOHAMMED, Ahmed
Date of Birth: [redacted]

Date : April 05, 2022
Ref#: 2529768/ssb

U.S. EQUIVALENCY SUMMARY

Bachelor's degree and first professional degree in medicine (Doctor of Medicine) from a regionally accredited institution

Duplicate Evaluation Report (original completed on May 05, 2014)

CREDENTIAL ANALYSIS

1. ***Credential Authentication:*** *Documents were verified by the institution*

Country or Territory:	Nigeria
Credential:	Bachelor of Science
Year:	2005
Awarded By:	Bayero University
Status:	Accredited Institution
Admission Requirements:	West African School Certificate
Length of Program:	Four years
Major:	Microbiology
U.S. Equivalency:	Bachelor's degree

WORLD EDUCATION SERVICES (WES) EVALUATION TERMS

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OR

- We require that relevant government authorities (for example, Ministry of Education) authenticate official transcripts and send them directly to WES.

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WES WORLD EDUCATION SERVICES

CREDENTIAL EVALUATION AND AUTHENTICATION REPORT

Name: MOHAMMED, Ahmed
Date of Birth: [redacted]

Date : April 05, 2022
Ref#: 2529768/ssb

2.	***Credential Authentication:***	*Documents were verified by the institution*
	Country or Territory:	Nigeria
	Credential:	Bachelor of Medicine, Bachelor of Surgery
	Year:	2011
	Awarded By:	Bayero University
	Status:	Accredited Institution
	Admission Requirements:	West African School Certificate
	Length of Program:	Six years
	Major:	Medicine
	U.S. Equivalency:	First professional degree in medicine (Doctor of Medicine)
	Remarks:	Mr. Mohammed was exempted from part of the program on the basis of study previously completed (see # 1, above). The Bachelor of Medicine, Bachelor of Surgery is the first professional degree in medicine in Nigeria and entitles the holder to practice.

PRIMARY SOURCE

RECEIVED
APR 07 2022
OKLAHOMA STATE BOARD OF MEDICAL LICENSURE AND SUPERVISION

WES WORLD EDUCATION SERVICES
Founded in 1974

WORLD EDUCATION SERVICES (WES) EVALUATION TERMS

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WES WORLD EDUCATION SERVICES

COURSE-BY-COURSE ANALYSIS

Name: MOHAMMED, Ahmed
Date of Birth: [redacted]

Date : April 05, 2022
Ref#: 2529768/ssb
Page: 3 of 5

INSTITUTIONS - DATES - SUBJECTS	U.S. Semester Credits	U.S. Grades
Bayero University		
2000-2001		
(L) General Biology III	2.0	B
(L) Organic Chemistry	2.0	C
(L) General Biology I	2.0	A
(L) Practical Physics	1.0	B+
(L) Mechanics	2.0	B+
(L) Electricity and Magnetism	2.0	B+
(L) Elementary Mathematics I	3.0	B+
(L) Study Skills	2.0	A
(L) Practical Chemistry	2.0	C
(L) Elementary Mathematics III	3.0	B
(L) Practical Physics	1.0	A
(L) General Biology IV	2.0	B+
(L) General Biology II	2.0	A
(L) Inorganic Chemistry	2.0	A
(L) Behavior of Matter	2.0	B+
2001-2002		
(L) General Microbiology I	2.0	B
(L) General Biochemistry	3.0	B+
(L) Introduction to Computer Science	2.0	A
(L) Organic Chemistry	2.0	B
(L) Genetics	2.0	B+
(L) Nigerian Government and Economy	2.0	B+
(L) General Physiology	2.0	B+
(L) Invertebrata	3.0	B
(L) General Microbiology II	2.0	A
(L) Biological Techniques	2.0	B
(L) Biostatistics	2.0	B+
(L) General Biochemistry II	3.0	C
(L) Inorganic Chemistry	2.0	B+
(L) Physical Chemistry	2.0	A
(L) Foundations of Nigerian Culture	2.0	A

(Continued on next page)

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WES WORLD EDUCATION SERVICES

COURSE-BY-COURSE ANALYSIS

Name: MOHAMMED, Ahmed
Date of Birth: [redacted]

Date : April 05, 2022
Ref#: 2529768/ssb
Page: 4 of 5

INSTITUTIONS - DATES - SUBJECTS	U.S. Semester Credits	U.S. Grades
2002-2003		
(U) Protozoology	3.0	B+
(U) Microbial, Physiology and Metabolism	3.0	B+
(U) Pathogenic Bacteriology	3.0	B+
(U) Microbial Genetics and Molecular Biology	3.0	B+
(U) Biosystematics	2.0	B
(U) Food Microbiology	2.0	B+
(U) Environmental Microbiology	2.0	C+
(U) SIWES	3.0	B+
(U) Immunology and Chemotherapy	3.0	B
(U) Molecular Biology	2.0	B+
(U) Field Course I	1.0	B+
(U) Pathogenic Mycology	2.0	B+
2004-2005		
(U) Field Course II	2.0	A
(U) Review Essay	2.0	A
(U) Analytical Microbiology	2.0	B
(U) Microbial Ecology	3.0	B
(U) Parasitology	3.0	A
(U) Industrial Microbiology	2.0	B
(U) Principles of Epidemiology	3.0	C+
(U) Project	6.0	A
(U) Plant Pathology	3.0	B+
(U) Virology	2.0	B+
Bayero University		
2005-2006		
Anatomy	10.0	B
Biochemistry	10.0	B
Community Based Medical Education and Service Program	10.0	B
Physiology	10.0	B
2006-2007		
Anatomy	10.0	B+
Biochemistry	10.0	B
Community Based Medical Education and Service Program	10.0	B

(Continued on next page)

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WES WORLD EDUCATION SERVICES

COURSE-BY-COURSE ANALYSIS

Name: MOHAMMED, Ahmed
Date of Birth: [redacted]

Date : April 05, 2022
Ref#: 2529768/ssb
Page: 5 of 5

INSTITUTIONS - DATES - SUBJECTS	U.S. Semester Credits	U.S. Grades
Physiology	10.0	B
2008-2009		
Pathology	10.0	B
Pharmacology	10.0	B
2009-2010		
Obstetrics and Gynecology	10.0	B
Pediatrics	10.0	B
2010-2011		
Community Medicine	10.0	B
Medicine	10.0	B
Surgery	10.0	B

SUMMARY

Total Undergraduate Semester Credits: 120.0 GPA: 3.31
Total Professional Semester Credits: 150.0 GPA: 3.02

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Founded in 1974

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ECFMG®
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: 02 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: 0-856-491-6
Applicant's Name: Ahmed Mohammed
Applicant's Date of Birth: [redacted]
ECFMG Certified: Yes
Certificate Issue Date: 03 Aug 2021
English Test Valid Through: 31 Dec 2024
Clinical Skills Assessment Valid Through: 31 Dec 2024

RECEIVED
APR 04 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	17 Mar 2020	*	*
USMLE Step 2 CK	20 Mar 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: Bayero University Faculty of Medicine, Kano, NIGERIA
Degree Year: 2011
Medical Education Credentials Status†: 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.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: F4J92FFNKH

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.

TMD39459
SJ

AMA Physician Profile

PREPARED FOR

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

Name and Mailing Address

AHMED MOHAMMED
[redacted]

Primary Office Address

3918 NW 58TH TER
OKLAHOMA CITY, OK 73112-1613

Phone UNKNOWN

Birth date [redacted]

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

NPI Number	Enumeration Date	Deactivation Date	Reactivation Date	Replacement Number	Last Reported Date
1649913401	04/19/2022	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: BAYERO UNIVERSITY FACULTY OF MEDICINE

Degree Awarded: YES **Degree Type:** MD

AMA AMERICAN MEDICAL ASSOCIATION

Enrollment Date: NOT REPORTED **Degree Date:** 2011

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: OKLAHOMA STATE UNIVERSITY CENTER FOR HEALTH SCIENCES
Sponsoring State: OKLAHOMA
Program name: OSTEOPATHIC MEDICAL EDUCATION CONSORTIUM OF OKLAHOMA INC (OMECO) PROGRAM
Specialty: PSYCHIATRY
Training Type: SPECIALTY
Dates: 07/01/2022 - 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
39459	MD	OK	07/01/2022	09/30/2024		ACT	RES	05/06/2024	AHMED MOHAMMED

AMA
AMERICAN MEDICAL ASSOCIATION

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: 08564916

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.

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

EVIDENCE OF STATUS – PART A

Full Legal Name: Ahmed (First) Mohammed (Middle) [redacted] (Last) [redacted] (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 Mohammed Date 4/3/2022

Subscribed and sworn before me this 3 day of April, 2022.

Notary Public Justice Smith

Commission Number 21011368

My commission expires August 27, 2025

NOTARY SEAL

JUSTICE SMITH NOTARY #21011368 EXP. 08/27/25 STATE OF OKLAHOMA

T.39459 cah

OKLAHOMA STATE BOARD OF MEDICAL LICENSURE AND SUPERVISION
101 NE 51ST 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 Wiser 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.

Ahmed Mohammed	Mohammed	4/03/2022
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-39459

Kenna L. Shaw

From: BillPay Webmaster <donotreply@www.ok.gov>
Sent: Tuesday, April 9, 2024 3:01 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

AHMED MOHAMMED has paid for a LICENSE - MD Training-to-Full License Fee 250.00 on 04/09/2024 03:04:00pm for $250.00.

OKLAHOMA MD LICENSE NUMBER 39459

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

X 39459 VS

TIME DEFICIENCY

Name:	AHMED MOHAMMED	Application #	39459

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
August	2000	Jan	2001	Bayero University Kano Faculty of Science	Kano	Nigeria	Pre degree

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
March	2005	Jan	2006	Transition from Pre med to medical school	Kano	Nigeria
Dec	2011	March	2012	Transition from medical school to internship	Kano	Nigeria

8/2000 - 1/2001

3/2005 - 1/2006

12/2011 - 3/2012

RECEIVED

MAY 19 2022

OKLAHOMA STATE BOARD OF MEDICAL LICENSURE AND SUPERVISION

39459 MA

04/14/2022

AHMED MOHAMMED
[redacted]

RE: MD Application #39459

Check Your Application Status Online at:
http://www.okmedicalboard.org
***Username*:AP21886879**
***Password*:Last 4 SSN**

Dear AHMED MOHAMMED,

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 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:

Extended Background Check
Time DEFICIENCIES: 8/2000-1/2001, 3/2005-1/2006, 12/2011-3/2012(PLEASE USE TIME DEFICIENCY FORM FOR EXPLANATIONS)
OTHER DEFICIENCIES: ***DO NOT NEED FORM2, USMLE STEP3, FED, AMA OR NPDB***
PostGrad - Form 2 GRIFFIN MEMORIAL HOSPITAL

If a "*Time Deficiency*" is listed, please e-mail 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). Your user name is AP21886879 (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 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	39459	AHMED MOHAMMED

MEDICAL DOCTOR

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

OTHER DEFICIENCIES: ***DO NOT NEED FORM2, USMLE STEP3, FED, AMA OR NPDB***
AMA Profile Not Received (to be completed by OSBMLS Staff)
Federation Clearance Not Received (to be completed by OSBMLS Staff)
NPDB Profile Not Received (to be completed by OSBMLS Staff)
PostGrad - Form 2 GRIFFIN MEMORIAL HOSPITAL

Last Medical School Attended:
690-11 Bayero Univ, Fac Of Med, Kano, Nigeria

Number of Licenses Previously Granted to Graduates of this Medical School:0

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** _____ 5-26-22

5) **REQUESTS SPECIFIC CONSIDERATION OF:**

_____

_____

_____

_____

_____

ATTACHMENT 1

RECEIVED
JUN 06 2023
OKLAHOMA STATE BOARD OF MEDICAL LICENSURE AND SUPERVISION

RETURN FORM TO:
OKLAHOMA STATE BOARD OF MEDICAL LICENSURE AND SUPERVISION
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	AHMED	**LAST NAME**	MOHAMMED
EMAIL ADDRESS	[redacted]		
LICENSE NUMBER	39459	**CELL PHONE**	[redacted]
HOME ADDRESS	[redacted]	**CITY/STATE ZIP CODE**	
PROGRAM ATTENDING	Clayton Morris, MD	**SPECIALTY**	Psychiatry

DOCUMENTATION TO ATTACH

PAYMENT COMPLETED			
☒	$150 payment made on Billpay for **RENEWAL** of training license	☐	$250 payment made on Billpay for **UPGRADE** of training license

DOCUMENTATION REQUIRED			
☐	Form 2 (must be received directly from program) ****ONLY FOR UPGRADE** - ATTACHMENT 3	☐	Evaluation (must be received directly from program) - ATTACHMENT 4
☒	USMLE Step 3 (must be received directly from USMLE)	☐	Answer confidential questions (on back of this form)

FOREIGN TRAINED STUDENTS			
☐	Current visa	☒	Social Security Number **if not provided at initial application
☐	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.

T39459
SJ

RECEIVED

JUN 06 2023

OKLAHOMA STATE BOARD OF
MEDICAL LICENSURE
AND SUPERVISION

NAME AHMED MOHAMMED

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)?	☐	☒
Have you been the subject of investigation or disciplinary action (including probation) by a hospital or training program?	☐	☒
Have you had any adverse judgment or settlement against you rising from a professional liability claim?	☐	☒
Have you been reported to the National Practitioner Data Bank (NPDB)?	☐	☒
Have you ever been denied, had removed, or suspended hospital privileges?	☐	☒
Have you surrendered hospital privileges while under investigation or to avoid investigation?	☐	☒
Have you entered into an Agreement with a Federal, State, or Local jurisdictional body to avoid formal action?	☐	☒
Has your application for licensure ever been denied?	☐	☒
Have you surrendered a license or had any disciplinary action taken on any license?	☐	☒
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)?	☐	☒
Have you obtained an assessment or been treated for use of any drug or chemical substance including alcohol?	☐	☒
Have you been arrested for, charged with, or convicted of a felony or misdemeanor other than a traffic violation?	☐	☒
Have you been arrested for, charged with, or convicted of a traffic violation involving the use of any drug or chemical substance?	☐	☒
Have you been addicted to or abused any drug or chemical substance including alcohol?	☐	☒
Have you been denied provider participation, terminated, sanctioned or penalized by any third-party payor including TRICARE, MEDICARE, or MEDICAID?	☐	☒
Have you surrendered or had any adverse action taken against any narcotic permit (State or Federal)?	☐	☒

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 6/5/23

OK 6-23-23

RENEWAL QUESTIONNAIRE UPDATED 01-2023

RETURN FORM TO:
OKLAHOMA STATE BOARD OF MEDICAL LICENSURE AND SUPERVISION
oktraining@okmedicalboard.org
FORM *MUST BE* RETURNED BY THE PROGRAM, NOT THE APPLICANT

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

Name of Resident (please print) Ahmed Mohammed

License Number 39459 Specialty Psychiatry

Institution Name Griffin Memorial Hospital

Program Director (please print) Clayton Morris

Program Director Email cdmorris@odmhsas.org

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	☐	☐	☐	☐	☒	☐
APPLICATION OF MEDICAL KNOWLEDGE	☐	☐	☐	☐	☒	☐
COMMUNICATION SKILLS	☐	☐	☐	☐	☒	☐
STABILITY IN WORKING RELATIONSHIP WITH OTHER PROFESSIONALS	☐	☐	☐	☐	☒	☐
THE INDIVIDUAL'S PERFORMANCE COMMENSURATE WITH PEER GROUP	☐	☐	☐	☐	☒	☐

REMARKS/COMMENTS

COMPLETED BY (please print) Clayton Morris

SIGNATURE [signature] DATE 05/17/23

Evaluation revised 1-2023

T39459
UKC

Oklahoma State Board of Medical Licensure and Supervision
Application Summary

Type	Number	Name
MD	41660	MARA ROSE LANGAMIN MONTENEGRO

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 SSM HEALTH

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	41660	MARA ROSE LANGAMIN MONTENEGRO

MEDICAL DOCTOR

Practice Address:
April 28, 2023
SSM HEALTH MEDICAL GROUP- FAMILY MEDIC
1110 N LEE AVE, 300,

OKLAHOMA CITY, OK 73103
OKLAHOMA

Status:
Res: MD
Received: 04/28/2023
Entered: 04/28/2023
Temp Issued:
Temp Expires:
Train Issued: 07/01/2023
Train Expires: 09/30/2024
Fed Rec: 06/04/2024
AMA Rec: 06/04/2024
Board Action:
License #: 41660
Sex: F
Ethnic Origin: 6

Endorsed By: USMLE

	Test	Score	Date Taken	Date Verified	Attempts
Test 1:	USMLE 3	PASS	01/26/24	6/6/24	1
Test 2:	USMLE 1	PASS	6/17/21	5/2/23	1
Test 3:	USMLE 2	PASS	7/29/22	5/2/23	1

Note: ***PASS*** means higher than 75

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

PRE-MED EDUCATION

School Name: THE UNIVERSITY OF OKLAHOMA
City: NORMAN **State:** OK **Country:** UNITED STATES
Degree: **From:** 8/2014 **To:** 5/ 2018 **Verified:**

School Name: VALLIANT HIGHSCHOOL
City: VALLIANT **State:** OK **Country:** UNITED STATES
Degree: **From:** 8/2010 **To:** 5/ 2014 **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: **From:** 8 / 2019 **To:** 5 / 2023 **Diploma Ver'd:** Y

Oklahoma State Board of Medical Licensure and Supervision
Application Summary

Type	Number	Name
MD	41660	MARA ROSE LANGAMIN MONTENEGRO

MEDICAL DOCTOR

POST GRADUATE EDUCATION

Facility: SSM HEALTH **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: OU COLLEGE OF MEDICINE DEPARTMENT OF ANESTHESIOLOG **Supervisor:**
City: OKLAHOMA CITY **State:** OK **Country:** UNITED STATES
Specialty: ANESTHESIOLOGY EXTERN **From:** 7 / 2021 **To:** 11 / 2022 **Verified:**
Comments: FUNCTION AS PART OF THE ANESTHESIOLOGY TEAM TO GAIN EXPERIENCE IN OPERATING ROOM

Employed: TRAVEL **Supervisor:**
City: OKLAHOMA CITY **State:** OK **Country:** UNITED STATES
Specialty: TRAVEL **From:** 7 / 2019 **To:** 8 / 2019 **Verified:**
Comments: HOMEMAKER

Employed: MIDFIRST BANK **Supervisor:**
City: OKLAHOMA CITY **State:** OK **Country:** UNITED STATES
Specialty: BANK TELLER **From:** 11 / 2018 **To:** 7 / 2019 **Verified:**
Comments: PROCESSING CUSTOMER TRANSACTIONS, MAINTAINING A CASH DRAWER,CROSS-SELLING BANK PRODUCT AND SERVICES

Employed: TRAVEL **Supervisor:**
City: NORMAN **State:** OK **Country:** UNITED STATES
Specialty: TRAVEL **From:** 8 / 2018 **To:** 11 / 2018 **Verified:**
Comments: TRAVELED

Employed: UNIVERSITY OF OKLAHOMA **Supervisor:**
City: NORMAN **State:** OK **Country:** UNITED STATES
Specialty: STUDENT PEER LEARNING ASSISTANT TUTOR **From:** 8 / 2016 **To:** 8 / 2018 **Verified:**
Comments: PROVIDE ACADEMIC ASSISTANCE FOR STUDENTS ENROLLED IN COURSES, MANAGED TUTORING SESSIONS.

Employed: UNIVERSITY OF OKLAHOMA **Supervisor:**
City: NORMAN **State:** OK **Country:** UNITED STATES
Specialty: STUDENT TOUR GUIDE **From:** 3 / 2015 **To:** 8 / 2018 **Verified:**
Comments: LEAD PROSPECTIVE STUDENTS AND THEIR FAMILIES ON CAMPUS TOURS AND ENTER STUDENT RECORDS INTO COMPUTER

Employed: SUMMER BREAK **Supervisor:**
City: VALLIANT **State:** OK **Country:** UNITED STATES
Specialty: SUMMER BREAK **From:** 5 / 2014 **To:** 8 / 2014 **Verified:**
Comments:

Oklahoma State Board of Medical Licensure and Supervision
Application Summary

Type	Number	Name
MD	41660	MARA ROSE LANGAMIN MONTENEGRO

MEDICAL DOCTOR

Other Licenses

State	Lic Type and Number	Status	Issued	Exp	Verif

DEFICIENCIES

OTHER DEFICIENCIES: NEED EVALUATION
PostGrad - Form 2 SSM HEALTH

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

FIRST NAME	Mara Rose	**LAST NAME**	Montenegro
EMAIL ADDRESS	[redacted]		
LICENSE NUMBER	41660	**CELL PHONE**	[redacted]
HOME ADDRESS	[redacted]	**CITY/STATE**	
		ZIP CODE	
PROGRAM ATTENDING	SSM St. Anthony Family Medicine	**SPECIALTY**	Family Medicine

DOCUMENTATION TO ATTACH

PAYMENT COMPLETED			
☐	$150 payment made on Billpay for **RENEWAL** of training license	☒	$250 payment made on Billpay for **UPGRADE** of training license

DOCUMENTATION REQUIRED			
☐	Form 2 (must be received directly from program) ****ONLY FOR UPGRADE**	☐	Evaluation (must be received directly from program)
☐	USMLE Step 3 (must be received directly from USMLE)	☐	Answer confidential questions (on back of this form)

FOREIGN TRAINED STUDENTS			
☐	Current visa	☐	Social Security Number **if not provided at initial application
☐	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

RECEIVED 6/5/2024
T41660
SJ

NAME Mara Rose Montenegro

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)?	☐	☒
Have you been the subject of investigation or disciplinary action (including probation) by a hospital or training program?	☐	☒
Have you had any adverse judgment or settlement against you rising from a professional liability claim?	☐	☒
Have you been reported to the National Practitioner Data Bank (NPDB)?	☐	☒
Have you ever been denied, had removed, or suspended hospital privileges?	☐	☒
Have you surrendered hospital privileges while under investigation or to avoid investigation?	☐	☒
Have you entered into an Agreement with a Federal, State, or Local jurisdictional body to avoid formal action?	☐	☒
Has your application for licensure ever been denied?	☐	☒
Have you surrendered a license or had any disciplinary action taken on any license?	☐	☒
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)?	☐	☒
Have you obtained an assessment or been treated for use of any drug or chemical substance including alcohol?	☐	☒
Have you been arrested for, charged with, or convicted of a felony or misdemeanor other than a traffic violation?	☐	☒
Have you been arrested for, charged with, or convicted of a traffic violation involving the use of any drug or chemical substance?	☐	☒
Have you been addicted to or abused any drug or chemical substance including alcohol?	☐	☒
Have you been denied provider participation, terminated, sanctioned or penalized by any third-party payor including TRICARE, MEDICARE, or MEDICAID?	☐	☒
Have you surrendered or had any adverse action taken against any narcotic permit (State or Federal)?	☐	☒

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 Mara Rose Montenegro Date 6-5-24

Oklahoma State Board of Medical Licensure and Supervision

APPLICATION FOR OKLAHOMA MEDICAL DOCTOR LICENSE

Received: 04/28/2023

Applicant Name: MONTENEGRO, MARA ROSE [redacted] **MD 41660**

[redacted]

Date Of Birth: [redacted] **Place Of Birth (City, State):** IDABEL, OK

Sex: F **Race:** Asian/Pacific Islander

Education

Type	Name	City	ST	Country	From	To	Degree	Comments	Veri
UG	THE UNIVERSITY OF OKLAHOMA	NORMAN	OK		8/2014	5/2018			
HS	VALLIANT HIGHSCHOOL	VALLIANT	OK		8/2010	5/2014			

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
OU COLLEGE OF MEDICINE DEPARTMENT OF ANESTHESIOLOG	ANESTHESIOLOGY EXTERN		OKLAHOMA CITY	OK		7/2021	11/2022	
NONE	TRAVEL		OKLAHOMA CITY	OK		7/2019	8/2019	
MIDFIRST BANK	BANK TELLER		OKLAHOMA CITY	OK		11/2018	7/2019	
NONE	TRAVEL		NORMAN	OK		8/2018	11/2018	
UNIVERSITY OF OKLAHOMA	STUDENT PEER LEARNING ASSISTANT TUTOR		NORMAN	OK		8/2016	8/2018	
UNIVERSITY OF OKLAHOMA	STUDENT TOUR GUIDE		NORMAN	OK		3/2015	8/2018	

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

Received:04/28/2023

Questions Answered 04/26/2023		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:04/28/2023

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?

No

If 'Yes', Name of practice:

If so, Please identify with which category:

Name of Previous Carrier and Policy Holder

Not applicable

Name of Current Carrier and policy Holder

SSM St Anthony

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 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

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 29 2023
OKLAHOMA STATE BOARD OF MEDICAL LICENSURE AND SUPERVISION

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

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

April 27, 2023
Date of signature (must correspond to the date of notarization)

NOTARY

SAMANTHA WOLF
Notary Public - State of Oklahoma
Commission Number 20009422
My Commission Expires Aug 5, 2024

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 27th day of April, 20 23

Notary Public Signature Samantha Wolf My Notary Commission Expires 8/5/2024

NOTARY SEAL

T41660 HS

US·MLE
United States
Medical
Licensing
Examination

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: 06/05/2024

Examinee: Montenegro, Mara Rose Langamin
Alt Name(s): Langamin Montenegro, Mara Rose

Examinee ID: 5-476-328-9
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
06/17/2021	Pass	205	(194)	

USMLE STEP 2

Clinical Knowledge (CK)

Test Date	Pass/Fail	Score	Minimum Pass	Comments
07/29/2022	Pass	226	(214)	

USMLE STEP 3

Test Date	Pass/Fail	Score	Minimum Pass	Comments
01/26/2024	Pass	218	(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.

Rev 2018

T41660 SJ

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

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Examinee: Montenegro, Mara Rose Langamin

Examinee ID: 5-476-328-9
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

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

Applicant's Name: Mara Rose Montenegro

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 (Month / Day / Year) To 5 / 20 / 2023 (Month / Day / Year) 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** Teresa Scordino

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: Edith Torres

Commission #: 21004896

My commission expires: 4/9/2025

EDITH TORRES NOTARY # 21004896 EXP. 04/09/25 PUBLIC STATE OF OKLAHOMA Notary Seal

RECEIVED
JUN 08 2023
OKLAHOMA STATE BOARD OF MEDICAL LICENSURE AND SUPERVISION

PRIMARY SOURCE

T41660
SJ

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JUN 08 2023
OKLAHOMA STATE BOARD OF MEDICAL LICENSURE AND SUPERVISION

Official Transcript

Printed: 07-JUN-2023
Page No. 1

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

Name : Mara Rose Montenegro
Student ID: 1798905
Birthdate : [redacted]

PRIMARY SOURCE

Degrees Awarded

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

External Degrees

University of Oklahoma
2018-05-11 Bachelor of Science
Field of Study : Biology

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	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): Storytelling in Medicine Storytelling 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

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

T41660

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 informaiton without the student's written consent.

Lori Klein

REGISTRAR, OUHSC

Registrar's Office
1105 N. Stonewall Avenue
LIB 121
Oklahoma City, OK 73117-1221

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

PHONE (405) 271-2359
FAX (405) 271-2480
www.ouhsc.edu

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.

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.

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.

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 : Mara Rose Montenegro
Student ID: 1798905
Birthdate : [redacted]

Summer II 2021

Course		Description	Attempted	Earned	Grade	Points
INDT	9301	Clinical Transitions	40.00	40.00	S	
PSBS	9520	Psychiatry Clerkshp	240.00	240.00	B	720.000
EM	9101	EM Selective	80.00	80.00	S	
TERM GPA :	3.000	GPH: 240.00	TOTALS :	360.00	360.00	720.000
OUHSC GPA :	3.000	GPH: 240.00	TOTALS :	1882.50	1882.50	720.000

Fall 2021

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
TERM GPA :	3.000	GPH: 640.00	TOTALS :	640.00	640.00	1920.000
OUHSC GPA :	3.000	GPH: 880.00	TOTALS :	2522.50	2522.50	2640.000

Spring 2022

Course		Description	Attempted	Earned	Grade	Points
PEDI	9650	Pediatric Clerkship	240.00	240.00	B	720.000
OBGY	9210	Obstet & Gyn Clerkship	240.00	240.00	B	720.000
ANES	9110	Anesthesiology Selective	80.00	80.00	S	
OPHT	9101	Ophthalmology Selective	80.00	80.00	S	
FM	9540	Fam Med Clerkship	160.00	160.00	B	480.000
NEUR	9370	Neurology Clerkship	160.00	160.00	A	640.000
TERM GPA :	3.200	GPH: 800.00	TOTALS :	960.00	960.00	2560.000
OUHSC GPA :	3.095	GPH: 1680.00	TOTALS :	3482.50	3482.50	5200.000

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				
TERM GPA :	4.000	GPH: 160.00	TOTALS :	320.00	320.00	640.000
OUHSC GPA :	3.174	GPH: 1840.00	TOTALS :	3802.50	3802.50	5840.000

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	9406	Special Studies Elective	160.00	160.00	S	
		Course Topic(s): FM Special Studies Elective				
INDT	9407	Fourth Year Selective	160.00	160.00	S	
		Course Topic(s): Pharmacology Readings Pharmacology Readings				
TERM GPA :	4.000	GPH: 160.00	TOTALS :	480.00	480.00	640.000
OUHSC GPA :	3.240	GPH: 2000.00	TOTALS :	4282.50	4282.50	6480.000

Spring 2023

Course		Description	Attempted	Earned	Grade	Points
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): RADI Mixed In/Outpatient Elect				
INDT	9407	Fourth Year Selective	80.00	80.00	S	
FM	9569	CH I	80.00	80.00	S	
FM	9572	CH II	80.00	80.00	S	

RECEIVED
JUN 08 2023
OKLAHOMA STATE BOARD OF MEDICAL LICENSURE AND SUPERVISION

Lou Klein

REGISTRAR, OUHSC

Registrar's Office
1105 N. Stonewall Avenue
LIB 121
Oklahoma City, OK 73117-1221

EXPLANATION OF RECORD
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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.

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.

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.

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 : Mara Rose Montenegro
Student ID: 1798905
Birthdate : [redacted]

Spring 2023 (cont.)

TERM GPA :	0.000	GPH: 0.00	TOTALS :	560.00	560.00	0.000
OUHSC GPA :	3.240	GPH: 2000.00	TOTALS :	4842.50	4842.50	6480.000

Medicine Career Totals

OUHSC GPA :	3.240	GPH: 2000.00	TOTALS :	4842.50	4842.50	6480.000

Post-Baccalaureate Career Totals

OUHSC GPA :	3.240	GPH: 125.00	TOTALS :	302.65	302.65	405.000

- - - - - End Of Career (1 of 1) - - - - -
- - - - - End Of Transcript - - - - -

RECEIVED
JUN 08 2023
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 informaiton without the student's written consent.

PRIMARY SOURCE

Lou Klein

REGISTRAR, OUHSC

Registrar's Office
1105 N. Stonewall Avenue
LIB 121
Oklahoma City, OK 73117-1221

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

PHONE (405) 271-2359
FAX (405) 271-2480
www.ouhsc.edu

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
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Fall (Graduate)	= 9 semester hours
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TERM DEFINITIONS:

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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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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!

AMA Physician Profile

PREPARED FOR

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

Name and Mailing Address

MARA ROSE LANGAMIN MONTENEGRO

[redacted]

Birth date [redacted]

Primary Office Address

Phone UNKNOWN

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: UNIVERSITY OF OKLAHOMA COLLEGE OF MEDICINE

Degree Awarded:	YES	**Degree Type:**	MD
Enrollment Date:	08/2019	**Degree Date:**	05/2023

T41660
SD

AMA AMERICAN MEDICAL ASSOCIATION

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:	ST ANTHONY HOSPITAL
Sponsoring State:	OKLAHOMA
Program name:	SSM HEALTH ST ANTHONY HOSPITAL PROGRAM
Specialty:	FAMILY MEDICINE
Training Type:	SPECIALTY
Dates:	06/23/2023 - 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.

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: Mara Rose (First) Langamin (Middle) Montenegro (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 Mara Rose Montenegro Date 4-27-23

Subscribed and sworn before me this 27 day of April, 20 23.

Notary Public Samantha Wolf

Commission Number 20009422

My commission expires 8/5/2024

NOTARY SEAL
SAMANTHA WOLF
Notary Public - State of Oklahoma
Commission Number 20009422
My Commission Expires Aug 5, 2024

T 41 of 0 HS

OKLAHOMA STATE BOARD OF MEDICAL LICENSURE AND SUPERVISION
101 NE 51ST 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

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.

Mara Rose Langamin Montenegro — Name of Applicant (type or print)
Mara Rose Montenegro — Signature of Applicant
4-26-23 — 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 29 2023
OKLAHOMA STATE BOARD OF MEDICAL LICENSURE AND SUPERVISION

T 41660 HS

05/11/2023

MARA ROSE MONTENEGRO
[redacted]

Check Your Application Status Online at:
http://www.okmedicalboard.org
***Username*:AP17598483**
***Password*:Last 4 SSN**

RE: MD Application #41660

Dear MARA ROSE MONTENEGRO,

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

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

OTHER DEFICIENCIES: WHAT IS FULL LEGAL NAME?
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 ST ANTHONY HOSPITAL
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 AP17598483 (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

Sincerely,

Seema Jayachand

Seema Jayachand

Dept. of Licensing

Encl

Oklahoma State Board of Medical Licensure and Supervision
Application Summary

Type	Number	Name
MD	41660	MARA ROSE LANGAMIN MONTENEGRO

MEDICAL DOCTOR

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

Exam verification date
PostGrad - Form 2 ST ANTHONY HOSPITAL
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** _____ 6-12-23

5) **REQUESTS SPECIFIC CONSIDERATION OF:**

_____

_____

_____

_____

_____

Lisa Cullen

From: OK Training
Sent: Thursday, May 18, 2023 7:44 AM
To: [redacted]
Subject: RE: [EXTERNAL] Deficiencies Inquiry MD Application #41660 Mara Rose Montenegro

No you don't need to fill out a separate form. Everything you have provided is correct.

Please be advised, due to high volumes of emails and documents received, processing time is approximately 30 days.

Lisa K. Cullen, Director of Licensing
Oklahoma State Board of Medical Licensure and Supervision
101 NE 51st Street
Oklahoma City, OK 73105
Licensing (405) 962-1470
licensing@okmedicalboard.org
Direct (405) 962-1453
Visit our website www.okmedicalboard.org

From: Mara Montenegro [redacted]
Sent: Monday, May 15, 2023 2:27 PM
To: OK Training <OKTraining@okmedicalboard.org>
Subject: [EXTERNAL] Deficiencies Inquiry MD Application #41660 Mara Rose Montenegro

To Whom It May Concern:

I am emailing to inquire about my incomplete application. The specific deficiencies I have questions regarding are as follows "OTHER DEFICIENCIES: WHAT IS FULL LEGAL NAME? , Exam verification date, USMLE Exams Incomplete."

My full legal name is Mara Rose (first name), Langamin (middle name), Montenegro (last name). I have attached a copy of my birth certificate.

I looked on the website to find a form to complete for these and was unable to find the document. I have previously submitted my USMLE transcript and the website shows they were delivered on (Delivered 05/01/2023).

I have a screenshot of my USMLE transcript order that shows it was delivered.

Is there a separate form I need to fill out?

I appreciate your assistance in this matter.

Thank you,

T 41666
SJ

TIME DEFICIENCY FORM

Name:	Mara Rose Langamin Montenegro	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
August	2010	May	2014	Valliant Highschool	Valliant	OK	
August	2014	May	2018	The University of Oklahoma	Norman	OK	Bachelor of Science
August	2019	May	2023	The University of Oklahoma College of Medicine	Oklahoma City	OK	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
March	2015	August	2018	The University of Oklahoma	Norman	OK	Tour Guide
November	2018	July	2019	MidFirst Bank	Oklahoma City	OK	Bank Teller

OTHER - UNEMPLOYED, STAY AT HOME PARENT, SUMMER BREAK, TRAVELING

Start Month	Start Year	End Month	End Year	Other	City	State
May	2014	August	2014	Summer break	Valliant	OK
August	2018	November	2018	Traveling	Norman	OK
July	2019	August	2019	Unemployed	Oklahoma City	OK

RECEIVED
APR 29 2023
OKLAHOMA STATE BOARD OF MEDICAL LICENSURE AND SUPERVISION

T41660 #5

Kenna L. Shaw

From: BillPay Webmaster <donotreply@www.ok.gov>
Sent: Wednesday, June 5, 2024 11:22 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

MARA ROSE LANGAMIN MONTENEGRO has paid for a LICENSE - MD Training-to-Full License Fee 250.00 on 06/05/2024 11:06:21am for $250.00.

OKLAHOMA MD LICENSE NUMBER 41660

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

Oklahoma State Board of Medical Licensure and Supervision
Application Summary

Type	Number	Name
MD	41629	CADE AUSTIN MORRIS

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:
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	41629	CADE AUSTIN MORRIS

MEDICAL DOCTOR

Practice Address:

May 03, 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: 05/24/2024
AMA Rec: 05/24/2024
Board Action:
License #: 41629
Sex: M
Ethnic Origin: 1

Endorsed By: USMLE

	Test	Score	Date Taken	Date Verified	Attempts
Test 1:	USMLE 3	PASS	01/26/24	5/20/24	1
Test 2:	USMLE 1	PASS	07/07/20	4/27/23	1
Test 3:	USMLE 2	PASS	07/30/21	4/27/23	1

Note: ***PASS*** means higher than 75

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

PRE-MED EDUCATION

School Name: OKLAHOMA STATE UNIVERSITY
City: STILLWATER **State:** OK **Country:** UNITED STATES
Degree: NUTRITIONAL SCIENCES **From:** 8/2014 **To:** 5/ 2018 **Verified:**

School Name: CHICKASHA HIGH SCHOOL
City: CHICKASHA **State:** OK **Country:** UNITED STATES
Degree: **From:** 8/2010 **To:** 5/ 2014 **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: **From:** 8 / 2018 **To:** 5 / 2023 **Diploma Ver'd:** Y

Oklahoma State Board of Medical Licensure and Supervision
Application Summary

Type	Number	Name
MD	41629	CADE AUSTIN MORRIS

MEDICAL DOCTOR

POST GRADUATE EDUCATION

Facility: COLLEGE OF MEDICINE OKC **Specialty:** ORTHOPAEDIC SURGERY
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: VANDERBILT UNIVERSITY MEDICAL CENTER **Supervisor:**
City: NASHVILLE **State:** TN **Country:** UNITED STATES
Specialty: ORTHOPAEDIC TRAUMA RESEARCH **From:** 6 / 2022 **To:** / **Verified:**
Comments: RESEARCH FELLOW AT VANDERBILT UNIVERSITY MEDICAL CENTER

Employed: SELF-EMPLOYED **Supervisor:**
City: OKLAHOMA CITY **State:** OK **Country:** UNITED STATES
Specialty: WELDING AND FABRICATION **From:** 1 / 2022 **To:** 4 / 2022 **Verified:**
Comments: SELF-EMPLOYED, CONTRACTED WORKER

Employed: NONE **Supervisor:**
City: OKLAHOMA CITY **State:** OK **Country:** UNITED STATES
Specialty: SUMMER BETWEEN UNDERGRADUATE SCHOOL AND MEDICAL SC **From:** 5 / 2018 **To:** 7 / 2018 **Verified:**
Comments:

Other Licenses

State	Lic Type and Number	Status	Issued	Exp	Verif

DEFICIENCIES

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

RECEIVED
MAY 19 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	Cade	**LAST NAME**	Morris
EMAIL ADDRESS	[redacted]		
LICENSE NUMBER	41629	**CELL PHONE**	[redacted]
HOME ADDRESS	[redacted]	**CITY/STATE ZIP CODE**	
PROGRAM ATTENDING	Charles Pasque, MD	**SPECIALTY**	Orthopedic Surgery

DOCUMENTATION TO ATTACH

PAYMENT COMPLETED			
☐	$150 payment made on Billpay for **RENEWAL** of training license	☑	$250 payment made on Billpay for **UPGRADE** of training license

DOCUMENTATION REQUIRED			
☐	Form 2 (must be received directly from program) ****ONLY FOR UPGRADE**	☐	Evaluation (must be received directly from program)
☑	USMLE Step 3 (must be received directly from USMLE)	☑	Answer confidential questions (on back of this form)

FOREIGN TRAINED STUDENTS			
☐	Current visa	☐	Social Security Number **if not provided at initial application
☐	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

T41629
SJ

NAME Cade Morris

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)?	☐	☑
Have you been the subject of investigation or disciplinary action (including probation) by a hospital or training program?	☐	☑
Have you had any adverse judgment or settlement against you rising from a professional liability claim?	☐	☑
Have you been reported to the National Practitioner Data Bank (NPDB)?	☐	☑
Have you ever been denied, had removed, or suspended hospital privileges?	☐	☑
Have you surrendered hospital privileges while under investigation or to avoid investigation?	☐	☑
Have you entered into an Agreement with a Federal, State, or Local jurisdictional body to avoid formal action?	☐	☑
Has your application for licensure ever been denied?	☐	☑
Have you surrendered a license or had any disciplinary action taken on any license?	☐	☑
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)?	☐	☑
Have you obtained an assessment or been treated for use of any drug or chemical substance including alcohol?	☐	☑
Have you been arrested for, charged with, or convicted of a felony or misdemeanor other than a traffic violation?	☐	☑
Have you been arrested for, charged with, or convicted of a traffic violation involving the use of any drug or chemical substance?	☐	☑
Have you been addicted to or abused any drug or chemical substance including alcohol?	☐	☑
Have you been denied provider participation, terminated, sanctioned or penalized by any third-party payor including TRICARE, MEDICARE, or MEDICAID?	☐	☑
Have you surrendered or had any adverse action taken against any narcotic permit (State or Federal)?	☐	☑

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 Cade Morris MD Date 4/29/24

Oklahoma State Board of Medical Licensure and Supervision

APPLICATION FOR OKLAHOMA MEDICAL DOCTOR LICENSE

Received:04/26/2023

Applicant Name: MORRIS, CADE AUSTIN [redacted]

MD 41629

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
UG	OKLAHOMA STATE UNIVERSITY	STILLWATER	OK		8/2014	5/2018	NUTRITIONAL SCIENCES		
HS	CHICKASHA HIGH SCHOOL	CHICKASHA	OK		8/2010	5/2014			

Medical School Name	City	State	Country	Comments	From	To
Univ Of Ok Coll Of Med, Oklahoma City Ok 73190	Oklahoma City	OK	United States		8/2018	5/2023

Post-Graduate

Facility	City	St	Country	Specialty	Comments	From	To
COLLEGE OF MEDICINE OKC	OKLAHOMA CITY	OK	UNITED S	ORTHOPAEDIC SURGERY		7/2023	/

Practice History

Employer	Specialty	Supervisor	City	ST	Countr	From	To	Verif
VANDERBILT UNIVERSITY MEDICAL CENTER	ORTHOPAEDIC TRAUMA RESEARCH		NASHVILLE	TN		6/2022	0/0	
SELF-EMPLOYED	WELDING AND FABRICATION		OKLAHOMA CITY	OK		1/2022	4/2022	
NONE	SUMMER BETWEEN UNDERGRADUATE SCHOOL AND MEDICAL SC		OKLAHOMA CITY	OK		5/2018	7/2018	

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

Received:04/26/2023

Questions Answered 04/25/2023		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:04/26/2023

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?

Yes

If 'Yes', Name of practice:

University of Oklahoma Health Sciences Center

If so, Please identify with which category:

Residency

Name of Previous Carrier and Policy Holder

As student, provided by University of Oklahoma College of Medicine

Name of Current Carrier and policy Holder

Malpractice insurance provided by 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 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
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
APR 27 2023
OKLAHOMA STATE BOARD OF MEDICAL LICENSURE AND SUPERVISION

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

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

April 27th, 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

TENNESSEE NOTARY PUBLIC SUMNER COUNTY

State of Tennessee, County of Sumner

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 27 day of April, 2023

Notary Public Signature _____ My Notary Commission Expires March 25, 2025

T 4/16/09 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

Recipient: OKLAHOMA STATE BOARD OF MEDICAL LICENSURE & SUPERVISION

Date: 05/19/2024

Examinee: Morris, Cade Austin
Alt Name(s):

Examinee ID: 5-451-479-9
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
07/07/2020	Pass	238	(194)	

USMLE STEP 2

Clinical Knowledge (CK)

Test Date	Pass/Fail	Score	Minimum Pass	Comments
07/30/2021	Pass	261	(209)	

USMLE STEP 3

Test Date	Pass/Fail	Score	Minimum Pass	Comments
01/26/2024	Pass	210	(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.

Rev 2018

T41629
SD

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: Morris, Cade Austin

Examinee ID: 5-451-479-9
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

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

Applicant's Name: Cade Morris

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 / 7 / 2018 (Month / Day / Year) To May / 20 / 2023 (Month / Day / Year) 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: Cade took a leave of absence to conduct a research fellowship in orthopedic surgery at Vanderbilt University.

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** Teresa Scordino

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: Edith Torres

Commission #: 21004896

My commission expires: 4/9/2025

RECEIVED
JUN 08 2023
OKLAHOMA STATE BOARD OF MEDICAL LICENSURE AND SUPERVISION

PRIMARY SOURCE

EDITH TORRES NOTARY PUBLIC STATE OF OKLAHOMA Notary Seal # 21004896 EXP. 04/09/25

T41629
SJ

Official Transcript

Printed: 07-JUN-2023
Page No. 1

CS 6-9-23

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

Name : Cade Morris
Student ID: 1790331
Birthdate : [redacted]

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 : Nutritional Sciences

Academic Program History

Program : Medicine MD
2018-07-09 : Active in Program
2018-07-09 : Medicine - MD Major
2022-05-13 : Leave of Absence
2022-08-02 : Active in Program
2022-12-16 : Leave of Absence
2023-01-13 : Active in Program
2023-05-20 : Completed Program

Beginning of Medicine Record

Fall 2018

Course		Description	Attempted	Earned	Grade	Points
INDT	8108	Molec & Cellular Systems	100.00	100.00	S	
INDT	8110	Design/Analysis Clin Res	16.00	16.00	S	
INDT	8116	Princ Phys, Pharm & Path	76.00	76.00	S	
INDT	8122	Clinical Medicine I	111.50	111.50	S	
INDT	8124	The Human Structure	105.00	105.00	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	

Fall 2018 (cont.)

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 2019

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 2019

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	8556	Req Orientation Documents II		0.00	CE	
INDT	8301	Enrichment Program: Humanities	16.00	16.00	S	

Course Topic(s): On the Wards: Hands on Hum
On the Wards: Hands on Hum

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	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	

Lori Klein

REGISTRAR, OUHSC

Registrar's Office
1105 N. Stonewall Avenue
LIB 121
Oklahoma City, OK 73117-1221

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

PHONE (405) 271-2359
FAX (405) 271-2480
www.ouhsc.edu

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.

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:

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Transfer statistics (if posted)
OUHSC statistics
Combined statistics

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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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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 : Cade Morris
Student ID: 1790331
Birthdate : [redacted]

Spring 2020 (cont.)

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 2020

Course		Description	Attempted	Earned	Grade	Points
INDT	9301	Clinical Transitions	40.00	40.00	S	
INDT	9407	Fourth Year Selective	80.00	80.00	S	
Course Topic(s):		Prin of Internal Med & Surg I				
		Prin of Internal Med & Surg I				

Course		Description	Attempted	Earned	Grade	Points
INDT	9407	Fourth Year Selective	80.00	80.00	S	
Course Topic(s):		Prin of Internal Med & Surg II				
		Prin of Internal Med & Surg II				

Course		Description	Attempted	Earned	Grade	Points
ANES	9110	Anesthesiology Selective	80.00	80.00	S	

TERM GPA :	0.000	GPH: 0.00	TOTALS :	280.00	280.00	0.000
OUHSC GPA :	0.000	GPH: 0.00	TOTALS :	1802.50	1802.50	0.000

Fall 2020

Course		Description	Attempted	Earned	Grade	Points
NEUR	9370	Neurology Clerkship	160.00	160.00	A	640.000
PEDI	9650	Pediatric Clerkship	240.00	240.00	A	960.000
OBGY	9210	OB/Gyn & Gynecology Clerkship	240.00	240.00	B	720.000
NRSG	9101	Neurosurgery	80.00	80.00	S	

TERM GPA :	3.625	GPH: 640.00	TOTALS :	720.00	720.00	2320.000
OUHSC GPA :	3.625	GPH: 640.00	TOTALS :	2522.50	2522.50	2320.000

Spring 2021

Course		Description	Attempted	Earned	Grade	Points
SURG	9760	Surgery Clerkship	240.00	240.00	B	720.000
PSBS	9520	Psychiatry Clerkshp	240.00	240.00	A	960.000
MED	9250	Medicine Clerkship	240.00	240.00	B	720.000
ORSG	9101	Orthopedic Selective	80.00	80.00	S	
FM	9540	Family Medicine Clerkship	160.00	160.00	B	480.000

TERM GPA :	3.273	GPH: 880.00	TOTALS :	960.00	960.00	2880.000
OUHSC GPA :	3.421	GPH: 1520.00	TOTALS :	3482.50	3482.50	5200.000

Summer II 2021

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):		ORSG Subinternship Elective				

TERM GPA :	4.000	GPH: 160.00	TOTALS :	320.00	320.00	640.000
OUHSC GPA :	3.476	GPH: 1680.00	TOTALS :	3802.50	3802.50	5840.000

Fall 2021

Course		Description	Attempted	Earned	Grade	Points
INDT	9405	Off-Campus Elective	160.00	160.00	S	
Course Topic(s):		ORSG Off-Campus Elective				
INDT	9405	Off-Campus Elective	160.00	160.00	S	
Course Topic(s):		SURG Off-Campus Elective				
INDT	9407	Fourth Year Selective	80.00	80.00	S	
Course Topic(s):		Essentials of the Phys Exam 1				
		Essentials of the Phys Exam 1				

Course		Description	Attempted	Earned	Grade	Points
INDT	9407	Fourth Year Selective	80.00	80.00	S	
Course Topic(s):		Essentials of the Phys Exam 2				
		Essentials of the Phys Exam 2				

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Lori Klein

REGISTRAR, OUHSC

Registrar's Office
1105 N. Stonewall Avenue
LIB 121
Oklahoma City, OK 73117-1221

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

PHONE (405) 271-2359
FAX (405) 271-2480
www.ouhsc.edu

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)
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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.

TERM DEFINITIONS:

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

Name : Cade Morris
Student ID: 1790331
Birthdate : [redacted]

Fall 2021 (cont.)

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

OUHSC GPA : 3.476 GPH: 1680.00 TOTALS : 4282.50 4282.50 5840.000

Spring 2022

Course	Description	Attempted	Earned	Grade	Points
INDT 9407	Fourth Year Selective	160.00	160.00	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 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 : 400.00 400.00 0.000

OUHSC GPA : 3.476 GPH: 1680.00 TOTALS : 4682.50 4682.50 5840.000

Interprofessional Education Tier I-Completed

Fall 2022

Course	Description	Attempted	Earned	Grade	Points
INDT 9405	Off-Campus Elective	160.00	160.00	S	
Course Topic(s): ORSG Off-Campus Elective					

TERM GPA : 0.000 GPH: 0.00 TOTALS : 160.00 160.00 0.000

OUHSC GPA : 3.476 GPH: 1680.00 TOTALS : 4842.50 4842.50 5840.000

Medicine Career Totals

OUHSC GPA : 3.476 GPH: 1680.00 TOTALS : 4842.50 4842.50 5840.000

Post-Baccalaureate Career Totals

OUHSC GPA : 3.476 GPH: 105.00 TOTALS : 302.65 302.65 365.000

- - - - - End Of Career (1 of 1) - - - - -

- - - - - End Of Transcript - - - - -

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AMA Physician Profile

PREPARED FOR

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

PRIMARY SOURCE

Name and Mailing Address

CADE AUSTIN MORRIS
[redacted]

Primary Office Address

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

Birth date [redacted]

Physician's major professional activity HOSPITAL BASED RESIDENTS - ALL YEARS

RECEIVED
MAY 24 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

NPI Number	Enumeration Date	Deactivation Date	Reactivation Date	Replacement Number	Last Reported Date
1912594409	12/30/2020	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 OKLAHOMA COLLEGE OF MEDICINE

Degree Awarded: YES **Degree Type:** MD

T41629
SJ

AMA AMERICAN MEDICAL ASSOCIATION

Enrollment Date: 08/2018 **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: ORTHOPAEDIC 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
41629	MD	OK	07/01/2023	09/30/2024		ACT	RES	05/06/2024	CADE AUSTIN MORRIS

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
APR 27 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: Cade (First) Austin (Middle) Morris (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 April 27th, 2023

Subscribed and sworn before me this 27 day of April, 20 23.

Notary Public [signature]

Commission Number NA

My commission expires _____

My Commission Expires
March 25, 2025

DIANA ARCURI
NOTARY
SEAL
STATE OF TENNESSEE
NOTARY PUBLIC
SUMNER COUNTY

T41629 HS

OKLAHOMA STATE BOARD OF MEDICAL LICENSURE AND SUPERVISION
101 NE 51ST 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 Wiser 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.

Cade Austin Morris		4/27/23
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.

RECEIVED
APR 27 2023
OKLAHOMA STATE BOARD OF MEDICAL LICENSURE AND SUPERVISION

+4116 29 HS

Kenna L. Shaw

From: BillPay Webmaster <donotreply@www.ok.gov>
Sent: Sunday, May 19, 2024 10:39 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

CADE AUSTIN MORRIS has paid for a LICENSE - MD Training-to-Full License Fee 250.00 on 05/19/2024 10:05:38am for $250.00.

OKLAHOMA MD LICENSE NUMBER 41629

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

T 41629 W

05/03/2023

CADE AUSTIN MORRIS
[redacted]

Check Your Application Status Online at:
http://www.okmedicalboard.org
***Username*:AP28212065**
***Password*:Last 4 SSN**

RE: MD Application #41629

Dear CADE MORRIS,

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

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

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 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 AP28212065 (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

Sincerely,

Seema Jayachand

Seema Jayachand

Dept. of Licensing

Encl

Oklahoma State Board of Medical Licensure and Supervision
Application Summary

Type	Number	Name
MD	41629	CADE AUSTIN MORRIS

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** ___/___/___

4) **HAS ISSUED A SPECIAL PGY-1 TRAINING LICENSE** BVS 6-12-23

5) **REQUESTS SPECIFIC CONSIDERATION OF:**

_____

_____

_____

_____

_____

Oklahoma State Board of Medical Licensure and Supervision
Application Summary

Type	Number	Name
MD	41511	NICHOLAS STEVEN MORSE

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 FORM 2 AND EVAL UPON COMPLETION OF TRAINING, MUST COME DIRECTLY FROM YOUR PROGRAM

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	41511	NICHOLAS STEVEN MORSE

MEDICAL DOCTOR

Practice Address:
May 03, 2023

Status:
Res: TR
Received: 04/13/2023
Entered: 04/13/2023
Temp Issued:
Temp Expires:
Train Issued: 07/05/2023
Train Expires: 09/30/2024
Fed Rec: 05/10/2024
AMA Rec: 05/10/2024
Board Action:
License #: 41511
Sex: M
Ethnic Origin: 1

Endorsed By: USMLE

	Test	Score	Date Taken	Date Verified	Attempts
Test 1:	USMLE 3	PASS	01/19/24	4/19/24	1
Test 2:	USMLE 1	PASS	5/19/21	7/3/23	1
Test 3:	USMLE 2	PASS	6/25/22	7/3/23	1

Note: ***PASS*** means higher than 75

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

PRE-MED EDUCATION

School Name: WASHBURN UNIVERSITY
City: TOPEKA **State:** KS **Country:** UNITED STATES
Degree: ASSOCIATE OF SCIENCE IN RADIOLOGIC TECHNOLOGY **From:** 8/2011 **To:** 5/2013 **Verified:**

School Name: WASHBURN UNIVERSITY
City: TOPEKA **State:** KS **Country:** UNITED STATES
Degree: BACHELOR OF HEALTH SCIENCE IN HEALTH ADMINISTRATION **From:** 8/2011 **To:** 8/2016 **Verified:**

School Name: ALLEN COUNTY COMMUNITY COLLEGE
City: IOLA **State:** KS **Country:** UNITED STATES
Degree: ASSOCIATE OF SCIENCE **From:** 8/2009 **To:** 5/2011 **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: DOCTOR OF MEDI(**From:** 7 / 2019 **To:** 5 / 2023 **Diploma Ver'd:** Y

Oklahoma State Board of Medical Licensure and Supervision
Application Summary

Type	Number	Name
MD	41511	NICHOLAS STEVEN MORSE

MEDICAL DOCTOR

POST GRADUATE EDUCATION

Facility: COLLEGE OF MEDICINE TULSA **Specialty:** EMERGENCY MEDICINE
Res. Fellowship: Residency
City: TULSA **State:** OK **Country:** UNITED STATES OF AM
Verified: **From:** 7 / 2023 **To:** /
ACGME Ver'd:
Comments:

PRACTICE HISTORY

Employed: UNIVERSITY OF KANSAS MEDICAL CENTER **Supervisor:**
City: KANSAS CITY **State:** KS **Country:** UNITED STATES
Specialty: RADIOLOGIC TECHNOLOGY **From:** 7 / 2017 **To:** 12 / 2021 **Verified:**
Comments: WORKED AS A RADIOLOGIC TECHNOLOGIST

Employed: UNIVERSITY OF KANSAS HEALTH SYSTEM ST. FRANCIS CAM **Supervisor:**
City: TOPEKA **State:** KS **Country:** UNITED STATES
Specialty: RADIOLOGY TECHNOGIST **From:** 4 / 2013 **To:** 11 / 2020 **Verified:**
Comments: WORKED AS A RADIOLOGIC TECHNOLOGIST

Other Licenses

State	Lic Type and Number	Status	Issued	Exp	Verif

DEFICIENCIES

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

RECEIVED
APR 24 2024
OKLAHOMA STATE BOARD OF MEDICAL LICENSURE AND SUPERVISION

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

FIRST NAME	Nicholas	**LAST NAME**	Morse
EMAIL ADDRESS	[redacted]		
LICENSE NUMBER	41511	**CELL PHONE**	[redacted]
HOME ADDRESS	[redacted]	**ZIP CODE**	[redacted]
PROGRAM ATTENDING	The University of Oklahoma - Tulsa	**SPECIALTY**	Emergency Medicine

DOCUMENTATION TO ATTACH

PAYMENT COMPLETED			
☐	$150 payment made on Billpay for **RENEWAL** of training license	☐	$250 payment made on Billpay for **UPGRADE** of training license

DOCUMENTATION REQUIRED			
☐	Form 2 (must be received directly from program) ****ONLY FOR UPGRADE**	☐	Evaluation (must be received directly from program)
☐	USMLE Step 3 (must be received directly from USMLE)	☐	Answer confidential questions (on back of this form)

FOREIGN TRAINED STUDENTS			
☐	Current visa	☐	Social Security Number ****if not provided at initial application**
☐	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

T41511
SJ

RECEIVED
APR 24 2024
OKLAHOMA STATE BOARD OF MEDICAL LICENSURE AND SUPERVISION

NAME Nicholas Morse

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)?	☐	☑
Have you been the subject of investigation or disciplinary action (including probation) by a hospital or training program?	☐	☑
Have you had any adverse judgment or settlement against you rising from a professional liability claim?	☐	☑
Have you been reported to the National Practitioner Data Bank (NPDB)?	☐	☑
Have you ever been denied, had removed, or suspended hospital privileges?	☐	☑
Have you surrendered hospital privileges while under investigation or to avoid investigation?	☐	☑
Have you entered into an Agreement with a Federal, State, or Local jurisdictional body to avoid formal action?	☐	☑
Has your application for licensure ever been denied?	☐	☑
Have you surrendered a license or had any disciplinary action taken on any license?	☐	☑
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)?	☐	☑
Have you obtained an assessment or been treated for use of any drug or chemical substance including alcohol?	☐	☑
Have you been arrested for, charged with, or convicted of a felony or misdemeanor other than a traffic violation?	☐	☑
Have you been arrested for, charged with, or convicted of a traffic violation involving the use of any drug or chemical substance?	☐	☑
Have you been addicted to or abused any drug or chemical substance including alcohol?	☐	☑
Have you been denied provider participation, terminated, sanctioned or penalized by any third-party payor including TRICARE, MEDICARE, or MEDICAID?	☐	☑
Have you surrendered or had any adverse action taken against any narcotic permit (State or Federal)?	☐	☑

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 4/24/24

Oklahoma State Board of Medical Licensure and Supervision

APPLICATION FOR OKLAHOMA MEDICAL DOCTOR LICENSE

Received:04/13/2023

Applicant Name: MORSE, NICHOLAS STEVEN [redacted] **MD 41511**

Date Of Birth: [redacted] **Place Of Birth (City, State):** PARSONS, KS

Sex: M **Race:** Caucasian

Education

Type	Name	City	ST	Country	From	To	Degree	Comments	Veri
UG	WASHBURN UNIVERSITY	TOPEKA	KS		8/2011	5/2013	ASSOCIATE OF SCIENCE IN RADIOLOGIC TECHNOLOGY		
UG	WASHBURN UNIVERSITY	TOPEKA	KS		8/2011	8/2016	BACHELOR OF HEALTH SCIENCE IN HEALTH ADMINISTRATION		
UG	ALLEN COUNTY COMMUNITY COLLEGE	IOLA	KS		8/2009	5/2011	ASSOCIATE 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
UNIVERSITY OF OKLAHOMA	TULSA	OK	UNITED S	EMERGENCY MEDICINE		/	/

Practice History

Employer	Specialty	Supervisor	City	ST	Countr	From	To	Verif
UNIVERSITY OF KANSAS MEDICAL CENTER	RADIOLOGIC TECHNOLOGY		KANSAS CITY	KS		7/2017	12/2021	
UNIVERSITY OF KANSAS HEALTH SYSTEM ST. FRANCIS CAM	RADIOLOGY TECHNOGIST		TOPEKA	KS		4/2013	11/2020	

Other/ Out-Of-State Licenses

State	License #	Profession	Status	Issue Date	Exp Date
KS	Radiologic Techn	Radiologic Technology	U	6/28/13	9/30/22

MD Exam

Exam	State	Score	Date Taken	#
USMLE				

$250 ✓ SJ

Oklahoma State Board of Medical Licensure and Supervision

APPLICATION FOR OKLAHOMA MEDICAL DOCTOR LICENSE

Received:04/13/2023

Questions Answered 04/08/2023		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?

Yes

If 'Yes', Name of practice:

University of Oklahoma

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 will have insurance provided by my residency 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 12, 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.

RECEIVED
JUN 07 2023
OKLAHOMA STATE BOARD OF MEDICAL LICENSURE AND SUPERVISION

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

Morse, Nicholas Steven

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

4/28/23

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 Kansas **, County of** Johnson

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 April, 20 23

Notary Public Signature Misty Ballantyne My Notary Commission Expires 4-26-26

MISTY BALLANTYNE
Notary Public - State of Kansas
My Appointment Expires 4-26-26

T4151
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

Recipient: OKLAHOMA STATE BOARD OF MEDICAL LICENSURE & SUPERVISION

Date: 04/19/2024

Examinee: Morse, Nicholas Steven
Alt Name(s):

Examinee ID: 5-465-669-9
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
05/19/2021	Pass	213	(194)	

USMLE STEP 2

Clinical Knowledge (CK)

Test Date	Pass/Fail	Score	Minimum Pass	Comments
06/25/2022	Pass	255	(209)	

USMLE STEP 3

Test Date	Pass/Fail	Score	Minimum Pass	Comments
01/19/2024	Pass	224	(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.

Rev 2018

TH1511 SD

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: Morse, Nicholas Steven

Examinee ID: 5-465-669-9
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.

FCVS | FEDERATION CREDENTIALS VERIFICATION SERVICE

PRIMARY SOURCE

Medical Professional Information Profile

This report provides credentialing information for:

Name:	**Morse, Nicholas Steven**
Social Security Number:	[redacted]
Date of Birth:	[redacted]
FID#:	**304796907**
Recipient:	**OK - Oklahoma State Board of Medical Licensure & Supervision**
Delivery Date:	**06/29/2023**

RECEIVED 7/3/2023

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.

TMD41511
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.

Notary:
Your seal (or stamp) must be partly upon the photo and partly upon the signature of the applicant.

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.

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

Morse
Applicant's Printed Last Name

Nicholas S
Applicant's Printed First Name, Middle Initial, and Suffix (e.g., Jr.)

6/6/23
Date of Signature (must correspond to date of notarization)

TAMRA A RAMIREZ
NOTARY PUBLIC
No. 22010102
Exp. 07/26/26
IN AND FOR
STATE OF OKLAHOMA

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 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 6th day of June, 2023.

Notary Public Signature: Tamra A. Ramirez

My Notary Commission Expires: 07/26/2026

400 FULLER WISER ROAD | EULESS, TX 76039 | TEL (817) 868-5000

FID Number
304796907

CERTIFICATION OF IDENTIFICATION

Certification by Notary Public Is Required

Applicant Full Legal Name: Morse (Last) Nicholas (First) Steven (Middle)

Applicant:

1. **COMPLETE** this document in the presence of a Notary.
2. **SELECT** the identity document used:
   - ☐ Birth Certificate
   - ☒ Passport
3. **ATTACH** a photocopy of the identity document presented to the Notary.

Notary Public: Please complete the section below.

Notary Exception – A notary public or other officer completing this certificate verifies only the identity of the individual who signed the document to which this certificate is attached, and not the truthfulness, accuracy, or validity of that document.

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 presented one of the following forms of identification as proof of his/her identity (Birth Certificate or Valid 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.

(Day) 6th, of (Month) June, (Year) 2023.

Notary Public Signature: Tamra A. Ramirez

Commission Expiration Date* (Month) July / (Day) 26th / (Year) 2026

***The notary's commission expiration date must be current and legible. If no expiration date, such as 'lifetime', and explanation must be provided. If you are in California, the notary may attach an California All-Purpose Acknowledgement form to this document.**

Notary Stamp Here

TAMRA A RAMIREZ
NOTARY PUBLIC
No. 22010102
Exp. 07/26/26
IN AND FOR
STATE OF OKLAHOMA

FID Number

304796907

FCVS FEDERATION CREDENTIALS VERIFICATION SERVICE

Identity

fsmb

Biographic Information

Medical professional Name(s): **Morse, Nicholas Steven**

Date of Birth: [redacted]

Place of Birth: Parsons, Kansas, UNITED STATES

Contact Information

Home Address: [redacted]
UNITED STATES

Mobile Phone: [redacted]

Email: [redacted]

Credentials Analysis Information for Identity

There is no Omission/Discrepancy/Miscellaneous information identified.

FCVS FEDERATION CREDENTIALS VERIFICATION SERVICE

Chronology of Activities

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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
07/22/2019	05/14/2023	Medical Education	University of Kansas School of Medicine Kansas City Kansas UNITED STATES

End of Chronology of Activities report for: Morse, Nicholas Steven

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Medical Education

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Medical Education

Medical School: **University of Kansas School of Medicine**

Location: Kansas City, KS
UNITED STATES

Credentials Analysis Information for Medical Education

There is no Omission/Discrepancy/Miscellaneous information identified.

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Institution Name: University of Kansas School of Medicine

City: Kansas City **State/Province:** Kansas **Country:** UNITED STATES

Premedical Education:

Years of education required for admission to your medical school: 4

Credential/degree presented by the applicant for admission to your medical school: Baccalaureate

Enrollment and Participation:

Our records indicate that Morse, Nicholas Steven

attended our medical school for a total of 144 weeks of medical education on the following dates: From MM/DD/YYYY: 07/29/2019 To MM/DD/YYYY: 05/12/2023

This individual was awarded the degree of Doctor of Medicine on 05/14/2023

DS CS

Unusual circumstances

1. Do this individual's official records reflect (an) interruption(s) in his/her medical education? YES NO X N/A

If 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.

			From MM/DD/YYYY:	To MM/DD/YYYY:
Personal/Family	Applicable	N/A	/ /	/ /
Academic remediation	Applicable	N/A	/ /	/ /
Health	Applicable	N/A	/ /	/ /
Financial	Applicable	N/A	/ /	/ /
Participation in joint degree program (e.g., MD/PhD)	Applicable	N/A	/ /	/ /
Other	Applicable	N/A	/ /	/ /

Other Explanation:

2. Do this individual's official records reflect that he/she was ever placed on academic or disciplinary probation during his/her medical education? YES NO X N/A

If YES, please select the reason(s) for the probation and indicate the date(s) of placement on and removal from probation.

			From MM/DD/YYYY:	To MM/DD/YYYY:
Academic Probation	Applicable	N/A	/ /	/ /
Probation for unprofessional conduct/behavior	Applicable	N/A	/ /	/ /
Probation for other reason	Applicable	N/A	/ /	/ /

Other Reason Explanation:

3. Do this individual's official records reflect that he/she was ever disciplined for unprofessional conduct/behavioral reasons by the medical school or parent university? YES NO X N/A

If YES, please provide detailed information about the circumstances and outcome(s):

4. Do this individual's official records reflect that he/she was ever the subject of negative reports for behavioral reasons or an investigation by the medical school or parent university? YES NO X N/A

If YES, please provide detailed information about the circumstances and outcome(s):

5. Do this individual's official records 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 N/A

If YES, please provide detailed information about the nature of the limitations or special requirements:

6. Attach Transcript **7. Attach Diploma** **8. Do you have a Dean's Letter to Attach?** YES X NO **9. Would you like to upload an additional attachment?** YES NO X

Attestation of Person completing Verification of Medical Education document: I hereby attest that the information contained herein accurately reflects the training records of the above-named physician.

ELECTRONIC SEAL VERIFIED	Name: Caroline Scala Title: Campus Registrar Signature: DocuSigned by: Caroline Scala 24357DD89BF141B... Date of Signature: 6/26/2023 Email: eraab@kumc.edu

The University of Kansas

By the authority of the Board of Regents of the State of Kansas
and upon the recommendation of the faculty of the

SCHOOL OF MEDICINE

confers upon

Nicholas S Morse

the degree of

DOCTOR OF MEDICINE

with all its rights, privileges, and responsibilities.
Given under the seal of the University of Kansas this
fourteenth day of May, two thousand and twenty-three.

Chancellor

Kansas Board of Regents

Chair, Kansas Board of Regents

Caroline Scala
Campus Registrar
May 15, 2023

I certify this to be a true and accurate copy of the original diploma awarded to Nicholas S Morse for the Doctor of Medicine degree by The University of Kansas on May 14, 2023.

ELECTRONIC SEAL VERIFIED

University of Kansas
Lawrence, KS

Official KU Academic Record

Name: Nicholas Morse
Student ID: 2268372

Institution Info: University of Kansas
Lawrence, KS 66045
CEEB: 06871 ACT: 1470

SSN: ***-**-2248
Birthdate: Aug 01

Print Date: 06/26/2023

To: FCVS

Beginning of Medicine Record

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

			Attempted	Earned	GPA Units	Points
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

			Attempted	Earned	GPA Units	Points
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	2.000	2.000	P	0.000

			Attempted	Earned	GPA Units	Points
Term GPA	0.000	Term Totals	2.000	2.000	0.000	0.000
Cum GPA	0.000	Cum Totals	37.000	37.000	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., Develpmnt & Sexuality	0.000	0.000	IP	0.000
GSMC	502	Interprofessional Collab II	0.000	0.000	NE	0.000

			Attempted	Earned	GPA Units	Points
Term GPA	0.000	Term Totals	16.000	16.000	0.000	0.000
Cum GPA	0.000	Cum Totals	53.000	53.000	0.000	0.000

2021 Spring

Program: Medicine Professional

Course		Description	Attempted	Earned	Grade	Points
ACED	835	Reprod., Develpmnt & Sexuality	8.000	8.000	P	0.000
ACED	840	Medicine Capstone	8.000	8.000	P	0.000
IDSP	806	Prsnl Prfessonl Development	0.000	0.000	NE	0.000

			Attempted	Earned	GPA Units	Points
Term GPA	0.000	Term Totals	16.000	16.000	0.000	0.000
Cum GPA	0.000	Cum Totals	69.000	69.000	0.000	0.000

ELECTRONIC SEAL VERIFIED

Casey L. Wallace
University Registrar

RAISED SEAL NOT REQUIRED

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Official KU Academic Record

University of Kansas
Lawrence, KS

Name: Nicholas Morse
Student ID: 2268372

2021 Fall

Program: Medicine Professional

Course		Description	Attempted	Earned	Grade	Points
GYNO	900	Obstetric/Gynecology Clerkship	0.000	0.000	IP	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

			Attempted	Earned	GPA Units	Points
Term GPA	3.000	Term Totals	24.000	24.000	24.000	72.000
Cum GPA	3.000	Cum Totals	93.000	93.000	24.000	72.000

2022 Spring

Program: Medicine Professional

Course		Description	Attempted	Earned	Grade	Points
FAPR	955	Family Medicine Clerkship	8.000	8.000	P	24.000
GSMC	503	Interprofessional Collab III	0.000	0.000	NE	0.000
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

			Attempted	Earned	GPA Units	Points
Term GPA	3.000	Term Totals	24.000	24.000	24.000	72.000
Cum GPA	3.000	Cum Totals	117.000	117.000	48.000	144.000

2022 Fall

Program: Medicine Professional

Course		Description	Attempted	Earned	Grade	Points
ERMD	919	Clinical Clerkship Emerg. Med	4.000	4.000	P	0.000
ERMD	921	Emergency Ultrasound	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
NEUR	931	Clinical Neurology Elective	4.000	4.000	P	0.000

			Attempted	Earned	GPA Units	Points
Term GPA	0.000	Term Totals	16.000	16.000	0.000	0.000
Cum GPA	3.000	Cum Totals	133.000	133.000	48.000	144.000

2023 Spring

Program: Medicine Professional

Course		Description	Attempted	Earned	Grade	Points
FAPR	900	Rural Preceptorship	4.000	4.000	P	0.000
FAPR	901	Fam Med Subinterns	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
MED	907	Amb Spec in Dermat	2.000	2.000	P	0.000
SURG	929	Crit Care Surg ICU	4.000	4.000	P	0.000

			Attempted	Earned	GPA Units	Points
Term GPA	0.000	Term Totals	14.000	14.000	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

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: 07/13/2022
Date Attempted: 07/13/2022 Completed

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: Doctor of Medicine
Confer Date: 05/14/2023
Plan: Doctor of Medicine

Casey L. Wallace
University Registrar

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University of Kansas
Lawrence, KS

Official KU Academic Record
Name: Nicholas Morse
Student ID: 2268372

End of Official KU Academic Record

Casey L. Wallace
University Registrar

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THE UNIVERSITY OF KANSAS

Medical Student Performance Evaluation

for

Nicholas "Nick" Morse

September 28, 2022

Identifying Information

Nicholas "Nick" Morse is a fourth-year student at the University of Kansas School of Medicine in Kansas City, Kansas.

Noteworthy Characteristics

- Nick continued to work as a radiologic technologist during his first two years of medical school including during the pandemic.
- Nick was one of the first members of the Socially Responsible Surgery chapter at KU and was elected to the executive board.
- Nick partook in a program that partnered him with an individual in the early stages of dementia to allow him to gain perspective as to what it is like living with dementia.

Academic Progress

Professional Performance

Nicholas has met all objectives of the University of Kansas School of Medicine graduation competencies, including the core tenets of professionalism: altruism, accountability, excellence, duty, service, honor, integrity, and respect for others.

Academic History

Nicholas's academic experience was briefly affected by the COVID-19 pandemic: for three months during the second semester of first year, classes were predominately virtual.

Date of Initial Matriculation in Medical School: July 29, 2019
Date of Expected Graduation from Medical School: May 14, 2023

Preclerkship Curriculum

The University of Kansas School of Medicine has a modular, systems-based curriculum in years one and two. The course blocks are developed and delivered by interdisciplinary teams composed of foundational scientists, behavioral scientists, and clinical faculty from the pertinent departments. Large group interactive sessions, small group case-based and problem-based learning, standardized patients and simulation are the instructional methods utilized in the delivery of the curriculum. Students also participate in specific interprofessional learning experiences. Grading in the course blocks is Pass/Fail. Students must receive a grade of "Pass" in each block prior to beginning clerkships.

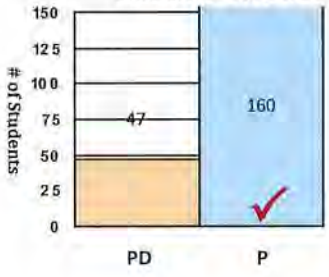
Clerkship Curriculum

Year three consists of seven required clerkships in core clinical disciplines (Family Medicine, Internal Medicine, Neurology, Psychiatry, Obstetrics and Gynecology, Pediatrics, and Surgery) and the Issues in Clinical Medicine course. Grading in the clerkships is Pass with Distinction/Pass/Fail and passing a clinical skills assessment at the end of the third year is required for promotion to the fourth year. During year four, students complete additional required courses (Rural Preceptorship, Critical Care, Subinternship) and electives. Grading in year four is Pass/Fail. The Medical Student Performance Evaluation (MSPE) includes the student's quartile ranking based upon year-three grades and comments obtained from the student's preceptors after completion of required courses. The School of Medicine has an end of third year clinical skills assessment that students are required to pass for graduation. Historically, passing this exam correlated to over a 99% likelihood of passing USMLE Step 2 CS on first attempt.

Core Clinical Clerkships

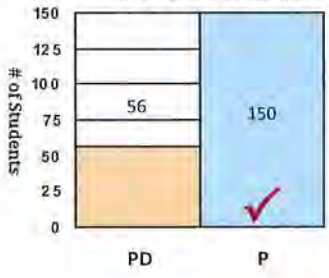
Clerkships are listed in chronological order.

05/31/21-07/24/21 **Surgery** **P**



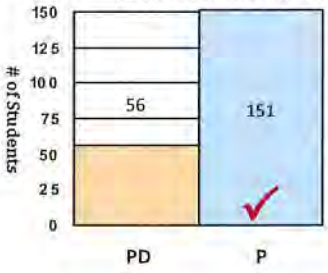
Nick did a great job on service. He was an active participant on rounds and came prepared for cases in the operating room. Nick's outstanding efforts on service made all of his patient encounters well above average. He had an excellent work ethic, wanted to learn, learned quickly, did neuro exams on morning rounds, with excellent progression of skills. His willingness to accept feedback and do anything to facilitate progress (even cleaning) was noticed, appreciated, and ultimately helped the service run more efficiently - again all of this effort makes his interactions with the team and patients well above average.

07/26/21-09/18/21 **Pediatrics** **P**



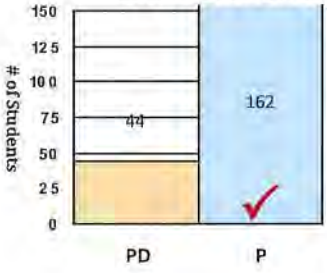
In outpatient clinic, Nick was able to multitask and divide attention appropriately to make observations about development and behavior with active siblings. He was able to see a family who he had taken care of in the nursery. He appreciated the continuity and so did the family, who remarked on it. On the inpatient floor, in a patient with a true ALTE, Nick was able to establish trust with the parent/grandparent and furthered that trust with daily post round follow ups, making the ongoing evaluation easier. Nick did a good job in same day sick clinic. He was eager to see patients, and he worked through each differential well.

09/27/21-11/20/21 **Internal Medicine** **P**



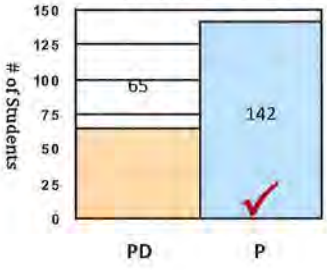
Nick is very personable, developed great rapport with patients, and delivered solid presentations on rounds. Every day, Nick would circle back to see his patients in the afternoon and see how they were doing and give the team updates on them. Nick was always prepared, his presentations were succinct, however, thorough, even with two very complicated/challenging neurological patients. Nick has good social skills and makes patients feel comfortable. He was actively engaged with his patients and eager to take on new patients. Nick was eager to learn new information and collaborate with resident team; it was clear collaboration was occurring pre-rounding.

01/03/22-01/29/22 **Obstetrics and Gynecology** **P**



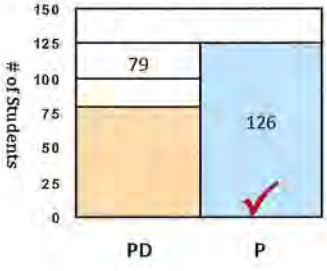
Nick was flexible in clinic and eager to learn. His pelvic exam skills improved, and he removed 2 IUDs without incident. Nick had a great awareness of the surgical setting. He was able to communicate well with patients. Nick is thoughtful and deliberate in his approach to patient care. He was very thoughtful about a patient's safety and support at home in clinic. On a slow clinic day, Nick was attentive and respectful and was able to learn from the sonographers performing ultrasound, as well as observing an embryo transfer. Nick was able to hone in to complaints on many new patients to the system and did not get bogged down in extra information.

01/31/22-02/26/22 **Psychiatry** **P**

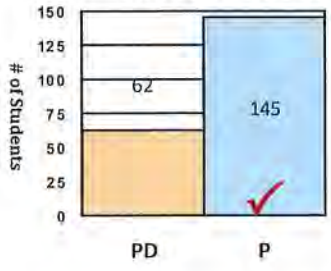


Nick did superior work during his child and adolescent psychiatry rotation. He demonstrated great interview skills and was able to obtain a thorough history after establishing rapport with some of our really challenging patients. He did extra research to help care for a patient with Myelin Oligodendrocyte Glycoprotein Antibody Associated Disease (MOGAD). Nick is an outstanding medical student-personable and easily integrates into the team setting.

02/28/22-03/26/22 **Neurology** **P**



Nick performed well with regards to clinical care and patient interaction. He did well with picking up complex patients on a very busy service.



04/04/22-05/28/22 **Family Medicine** **P**

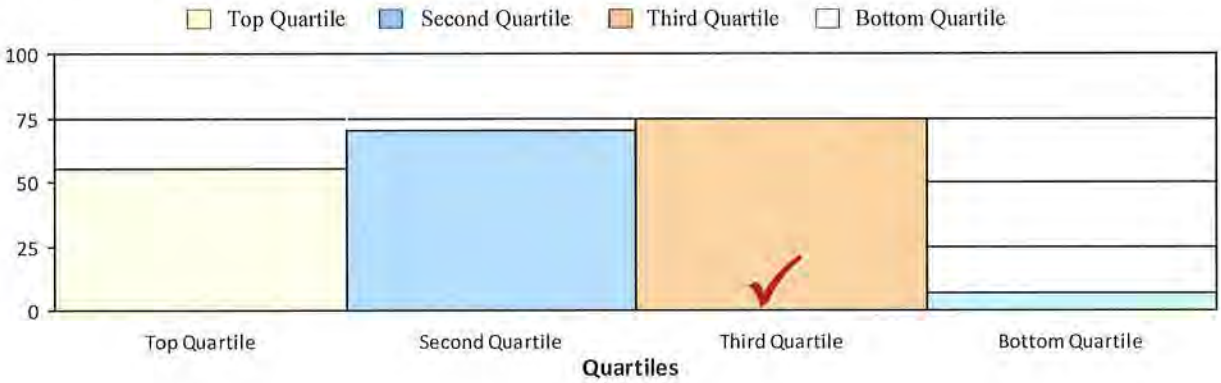
Nick was very engaged with his patient and his team and did well coming up with his own assessments and plans for his patients. Preceptors observed his thoughtful, thorough approach to complex patients and noted that he knew the patients well. Even on a rotation not fully aligned with his specialty of interest, Nick had a great attitude and eagerly participated in patient care. Another recalled an instance when they had a patient with high blood pressure due to non-adherence with medication. Nick directly discussed possible negative outcomes of her uncontrolled blood pressure. The patient became tearful at the thought of having a stoke or worse. For the first time the patient recognized the importance of taking her medication as prescribed. Her physician reported she later called to say she needed a refill of her medication and said she was taking it daily.

* Students were allowed to complete two away rotations.

* The University of Kansas School of Medicine selects students for AΩA based solely on the criteria of scholastic excellence, leadership, professionalism, a firm sense of ethics, promise of future success, and a commitment to service. Consequently, there may be a discrepancy between class rank and AΩA status.

Overall Comparative Performance in Third Year Clerkships

Nicholas Morse



Summary

Nicholas "Nick" Morse's third year clerkship performance places him in the third quartile of his class. The University of Kansas School of Medicine is pleased to recommend Nicholas "Nick" Morse for residency training. (The MSPE process at the University of Kansas School of Medicine assigns an evaluation level to each student based on quartiles, and this process was unaffected by the COVID-19 pandemic.)

Sincerely,

Mark C. Meyer, M.D.
Senior Associate Dean for Student Affairs
Alice M. Patterson, M.D. and Harold L. Patterson, M.D. Professor, Department of Family Medicine

University of Kansas School of Medicine

The Medical Student Performance Evaluation (MSPE) includes the student's quartile ranking based upon year-three grades and comments obtained from the student's preceptors. The quartile ranking reflects all students in the graduating class of 2023.

The University of Kansas School of Medicine transcript legend is as follows:

ACE Curriculum

- PD: Pass with Distinction (4 points) - Successfully completed all course requirements and met defined criteria for distinction. (Only applicable for M3 grading)
- P: Pass (3 points) - successfully completed/met all course requirements.
- F: Fail (0 points) - work less than acceptable quality.
- I: Incomplete - work required for the course not completed, but the student is otherwise passing the course.
- CR: Credit Received - student receives credit for the course, but no grade given.
- W: Withdrew Passing - not calculated into the student's grade point average.
- WF: Withdrew Failing - calculated into the student's grade point average.
- WG: Withheld Grade - grade was not finalized by the Course Director in time for posting on the student's transcript but may be noted in the student's Medical Student Performance Evaluation and calculated into the student's overall grade point average.
- NE: Not Evaluated - non-credit course, transcript notation only.

FCVS FEDERATION CREDENTIALS VERIFICATION SERVICE

Applicant Reported Unusual Circumstances

fsmb

Medical School

Medical Professional Name: Morse, Nicholas Steven

University of Kansas School of Medicine

Unusual Circumstances

Did you have any interruption(s) or extension(s) in your medical education?	**No**
Were you ever placed on probation?	**No**
Were you ever disciplined or placed under investigation?	**No**
Were any negative reports for behavioral reasons ever filed by instructors?	**No**
Were any limitations or special requirements imposed on you because of academic performance, incompetence, disciplinary problems or for any other reason?	**No**

End of Applicant Reported Unusual Circumstances report for: Morse, Nicholas Steven

FCVS FEDERATION CREDENTIALS VERIFICATION SERVICE

Postgraduate Training

fsmb

Postgraduate Training

No training reported by applicant

Credentials Analysis Information for Postgraduate Training

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

fsmb

Licensure / Examinations

Exam: USMLE

Credential Analysis Information for Licensure / Examinations

There is no Omission/Discrepancy/Miscellaneous information identified.

AMA Physician Profile

PREPARED FOR

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

Name and Mailing Address

NICHOLAS MORSE

[redacted]

PRIMARY SOURCE

Birth date [redacted]

Primary Office Address

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MAY 10 2024
OKLAHOMA STATE BOARD OF MEDICAL LICENSURE AND SUPERVISION

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 KANSAS SCHOOL OF MEDICINE

Degree Awarded:	YES	**Degree Type:**	MD
Enrollment Date:	07/2019	**Degree Date:**	05/2023

T41511 SJ

AMA AMERICAN MEDICAL ASSOCIATION

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: EMERGENCY 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
41511	MD	OK	07/05/2023	09/30/2024		ACT	RES	05/06/2024	NICHOLAS STEVEN MORSE

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
JUN 07 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: Nicholas (First) Steven (Middle) Morse (Last) ____ 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 [signature] Date 4/28/23

Subscribed and sworn before me this 28 day of April, 20 23.

Notary Public Misty Ballantyne

Commission Number NA

My commission expires 4.26.26

NOTARY SEAL
MISTY BALLANTYNE
Notary Public - State of Kansas
My Appointment Expires 4.26.26

T41511
SJ

OKLAHOMA STATE BOARD OF MEDICAL LICENSURE AND SUPERVISION
101 NE 51ST 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 Wiser 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.

Nicholas Morse — Name of Applicant (type or print)

Signature of Applicant

4/28/23 — 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

JUN 07 2023

OKLAHOMA STATE BOARD OF MEDICAL LICENSURE AND SUPERVISION

T4151C
SJ

Kenna L. Shaw

From: BillPay Webmaster <donotreply@www.ok.gov>
Sent: Wednesday, April 24, 2024 4:34 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

NICHOLAS STEVEN MORSE has paid for a LICENSE - MD Training-to-Full License Fee 250.00 on 04/24/2024 04:04:34pm for $250.00.
OKLAHOMA MD LICENSE NUMBER 41511
To view all transactions please go to http://www.ok.gov/triton/ and login to your CMS account.

05/03/2023

NICHOLAS STEVEN MORSE
[redacted]

Check Your Application Status Online at:
http://www.okmedicalboard.org
***Username*:AP20755293**
***Password*:Last 4 SSN**

RE: MD Application #41511

Dear NICHOLAS MORSE,

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

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

Evidence of Status
Application Instructions
OATH
Extended Background Check
OTHER DEFICIENCIES: FCVS
Exam verification date
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 TULSA
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 AP20755293 (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

Sincerely,

Seema Jayachand

Seema Jayachand

Dept. of Licensing

Encl

Oklahoma State Board of Medical Licensure and Supervision
Application Summary

Type	Number	Name
MD	41511	NICHOLAS STEVEN MORSE

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 TULSA
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:670

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** _____ 7-5-23

5) **REQUESTS SPECIFIC CONSIDERATION OF:**

_____

_____

_____

_____

_____

Oklahoma State Board of Medical Licensure and Supervision
Application Summary

Type	Number	Name
MD	41458	KAREN HAN NGUYEN

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:
048-16 TX A & M UNIV SYS HSC, COLL OF MED, COLLEGE STATION TX 77843

Number of Licenses Previously Granted to Graduates of this Medical School:183

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	41458	KAREN HAN NGUYEN

MEDICAL DOCTOR

Practice Address:
May 03, 2023

Status:
Res: TR
Received: 04/08/2023
Entered: 04/08/2023
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 #: 41458
Sex: F
Ethnic Origin: 6

Endorsed By: USMLE

	Test	Score	Date Taken	Date Verified	Attempts
Test 1:	USMLE 2	PASS	05/08/22	4/11/23	1
Test 2:	USMLE 1	PASS	06/30/21	4/11/23	1
Test 3:	USMLE 3	PASS	12/7/23	4/11/24	1

Note: ***PASS*** means higher than 75

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

PRE-MED EDUCATION

School Name: UNIVERSITY OF HOUSTON
City: HOUSTON **State:** TX **Country:** UNITED STATES
Degree: BIOLOGY, B.S. **From:** 8/2013 **To:** 5/ 2017 **Verified:**

School Name: JERSEY VILLAGE HIGH SCHOOL
City: JERSEY VILLAGE **State:** TX **Country:** UNITED STATES
Degree: **From:** 8/2009 **To:** 5/ 2013 **Verified:**

MEDICAL SCHOOL EDUCATION

Name: TX A & M UNIV SYS HSC, COLL OF MED, COLLEGE STATION TX 77843
Foreign Name:
City: College Sta **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

Type	Number	Name
MD	41458	KAREN HAN NGUYEN

MEDICAL DOCTOR

POST GRADUATE EDUCATION

Facility: COLLEGE OF MEDICINE OKC **Specialty:** PSYCHIATRY
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: NONE **Supervisor:**
City: LOS ANGELES **State:** CA **Country:** UNITED STATES
Specialty: TRAVELING **From:** 4 / 2019 **To:** 5 / 2019 **Verified:**
Comments:

Employed: TEXAS DERMATOLOGY **Supervisor:**
City: HOUSTON **State:** TX **Country:** UNITED STATES
Specialty: MEDICAL ASSISTANT **From:** 1 / 2018 **To:** 3 / 2019 **Verified:**
Comments:

Employed: SCRIBEAMERICA **Supervisor:**
City: HOUSTON **State:** TX **Country:** UNITED STATES
Specialty: MEDICAL SCRIBE **From:** 8 / 2016 **To:** 12 / 2017 **Verified:**
Comments:

Employed: KUMON (SUE MCLEAN) **Supervisor:**
City: HOUSTON **State:** TX **Country:** UNITED STATES
Specialty: KUMON INSTRUCTOR **From:** 7 / 2009 **To:** 10 / 2015 **Verified:**
Comments:

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

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	Karen	**LAST NAME**	Nguyen
EMAIL ADDRESS	[redacted]		
NUMBER	41458	**PHONE**	[redacted]
HOME ADDRESS	[redacted]	**CITY/STATE ZIP CODE**	[redacted]
PROGRAM ATTENDING	Dr. Christopher Czapla	**SPECIALTY**	Psychiatry

DOCUMENTATION TO ATTACH

PAYMENT COMPLETED			
☐	$150 payment made on Billpay for **RENEWAL** of training license	☐	$250 payment made on Billpay for **UPGRADE** of training license

DOCUMENTATION REQUIRED			
☐	Form 2 (must be received directly from program) ****ONLY FOR UPGRADE**	☐	Evaluation (must be received directly from program)
☐	USMLE Step 3 (must be received directly from USMLE)	☐	Answer confidential questions (on back of this form)

FOREIGN TRAINED STUDENTS			
☐	Current visa	☐	Social Security Number **if not provided at initial application
☐	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

T41458
SJ

NAME Karen Nguyen

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)?	☐	☒
Have you been the subject of investigation or disciplinary action (including probation) by a hospital or training program?	☐	☒
Have you had any adverse judgment or settlement against you rising from a professional liability claim?	☐	☒
Have you been reported to the National Practitioner Data Bank (NPDB)?	☐	☒
Have you ever been denied, had removed, or suspended hospital privileges?	☐	☒
Have you surrendered hospital privileges while under investigation or to avoid investigation?	☐	☒
Have you entered into an Agreement with a Federal, State, or Local jurisdictional body to avoid formal action?	☐	☒
Has your application for licensure ever been denied?	☐	☒
Have you surrendered a license or had any disciplinary action taken on any license?	☐	☒
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)?	☐	☒
Have you obtained an assessment or been treated for use of any drug or chemical substance including alcohol?	☐	☒
Have you been arrested for, charged with, or convicted of a felony or misdemeanor other than a traffic violation?	☐	☒
Have you been arrested for, charged with, or convicted of a traffic violation involving the use of any drug or chemical substance?	☐	☒
Have you been addicted to or abused any drug or chemical substance including alcohol?	☐	☒
Have you been denied provider participation, terminated, sanctioned or penalized by any third-party payor including TRICARE, MEDICARE, or MEDICAID?	☐	☒
Have you surrendered or had any adverse action taken against any narcotic permit (State or Federal)?	☐	☒

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 Karen Nguyen Date 04/12/2024

RENEWAL QUESTIONNAIRE
UPDATED 03/2024

RECEIVED
APR 12 2024
OKLAHOMA STATE BOARD OF MEDICAL LICENSURE AND SUPERVISION

Oklahoma State Board of Medical Licensure and Supervision

APPLICATION FOR OKLAHOMA MEDICAL DOCTOR LICENSE

Received: 04/08/2023

Applicant Name: NGUYEN, KAREN HAN [redacted]

MD 41458

[redacted]

Date Of Birth: [redacted] **Place Of Birth (City, State):** HOUSTON, TX

Sex: F **Race:** Asian/Pacific Islander

Education

Type	Name	City	ST	Country	From	To	Degree	Comments	Veri
UG	UNIVERSITY OF HOUSTON	HOUSTON	TX		8/2013	5/2017	BIOLOGY, B.S.		
HS	JERSEY VILLAGE HIGH SCHOOL	JERSEY VILL	TX		8/2009	5/2013			

Medical School Name	City	State	Country	Comments	From	To
TX A & M UNIV SYS HSC, COLL OF MED, COLLEGE STATION TX 77843	College Sta	TX	United States		7/2019	5/2023

Post-Graduate

Facility	City	St	Country	Specialty	Comments	From	To
			UNITED S			/	/
			UNITED S			/	/

Practice History

Employer	Specialty	Supervisor	City	ST	Countr	From	To	Verif
TEXAS DERMATOLOGY	MEDICAL ASSISTANT		HOUSTON	TX		1/2018	3/2019	
SCRIBEAMERICA	MEDICAL SCRIBE		HOUSTON	TX		8/2016	12/2017	
KUMON (SUE MCLEAN)	KUMON INSTRUCTOR		HOUSTON	TX		7/2009	10/2015	

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

Received:04/08/2023

	Questions Answered 04/07/2023	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

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, Department of Psychiatry and Behavioral Sciences

If so, Please identify with which category:

Hospital

Name of Previous Carrier and Policy Holder

Anco Insurance-Connie Grocholski
TAMHSC Office of Risk; BSW Medical Education; Cristie Columbus MD

Name of Current Carrier and policy Holder

Malpractice insurance will be provided by the training program (OUHSC-Psychiatry Residency 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 07, 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

RECEIVED
APR 17 2023
OKLAHOMA STATE BOARD OF MEDICAL LICENSURE AND SUPERVISION

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

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

04/14/2023
Date of signature (must correspond to the date of notarization)

NOTARY

State of Texas **, County of** Harris

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 14th day of April, 2023

Notary Public Signature _____ My Notary Commission Expires 09/15/2025

NOTARY SEAL

AUTUMN WRIGHT
Notary ID #133334131
My Commission Expires
September 15, 2025

T 41458
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, Euless, TX 76039-3856 - Telephone (817) 868-4000

Recipient: OKLAHOMA STATE BOARD OF MEDICAL LICENSURE & SUPERVISION

Date: 04/11/2024

Examinee: Nguyen, Karen
Alt Name(s):

Examinee ID: 5-467-440-3
Date of Birth: [redacted]

Results for Steps taken by this examinee (and for which results have been reported to date) are shown below. For Steps that span more than one day, the test date reflects the day on which the examination began. 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
06/30/2021	Pass	225	(194)	

USMLE STEP 2

Clinical Knowledge (CK)

Test Date	Pass/Fail	Score	Minimum Pass	Comments
05/08/2022	Pass	243	(209)	

USMLE STEP 3

Test Date	Pass/Fail	Score	Minimum Pass	Comments
12/07/2023	Pass	217	(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.

Rev 2018

T41458 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: Nguyen, Karen

Examinee ID: 5-467-440-3
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.

Attachment 6

Form 1 (MD)

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

RECEIVED
MAY 31 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: Karen Nguyen

Institution: Texas A&M School of Medicine City/State: Bryan, Texas

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

From 07 / 29 / 2019 (Month / Day / Year) To 05 / 20 / 2023 (Month / Day / Year) and was awarded the degree Doctor of Medicine 05/20/2023

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: Wei-Jung Chen, PhD **Signature**

Title of Signatory: Associate Dean for Student Affairs **Date of Signature** 05/22/2023

Tel: 979-436-0245 **Fax:** 979-436-0097 **E-Mail:** wjchen@tamu.edu

School Seal
TEXAS A&M UNIVERSITY
SCHOOL OF MEDICINE

If no seal is available, this form must be notarized

Notary Public

Commission #

My commission expires:

Notary Seal

PRIMARY SOURCE

T41458
UKC

TEXAS A&M UNIVERSITY

College Station, Texas 77843

OFFICIAL ACADEMIC RECORD

24-MAY-2023

Name: Karen Han Nguyen

Date of Birth: [redacted]

SID: [redacted]

Course Level: Professional Medicine

Degree Awarded Doctor of Medicine 20-MAY-2023
Major : Medicine

SUBJ NO.	COURSE TITLE	CRED GRD	PTS R
INSTITUTION CREDIT:			
Fall 2019 - Half Year Term			
Semester			
MEID 605	FOUNDATIONS OF MEDICINE I	5.00 P	15.00
MEID 606	FOUNDATIONS OF MEDICINE II	3.00 P	9.00
MEID 607	MEDICAL GROSS ANATOMY	5.00 P	15.00
MEID 619	PRACTICE OF MEDICINE I	8.00 H	32.00
Ehrs: 21.00 GPA-Hrs: 21.00 QPts:		71.00 GPA:	3.38
Spring 2020 - Half Year Term			
Semester			
MEID 608	NEUROSCIENCE	5.00 P	15.00
MEID 609	INTRODUCTION TO DISEASE	9.00 S	0.00
MEID 616	CARDIOVASCULAR	5.00 P	15.00
MEID 617	RESPIRATORY	3.00 P	9.00
MEID 618	MEDICAL STUDENT GRAND ROUNDS	2.00 P	6.00
MEID 620	PRACTICE OF MEDICINE II	8.00 H	32.00
Ehrs: 32.00 GPA-Hrs: 23.00 QPts:		77.00 GPA:	3.34
Fall 2020 - Half Year Term			
Semester			
MEID 701	HEMATOLOGY/ONCOLOGY	4.00 P	12.00
MEID 704	RENAL GENITOURINARY	4.00 P	12.00
MEID 706	METABOLISM, GI, NUTRITION	5.00 P	15.00
MEID 707	ENDO REPRO SCI HUM SEXUALITY	5.00 P	15.00
MEID 708	INTEGUMENT MUSCULOSKELETAL	2.00 H	8.00
MEID 711	EVIDENCE BASED MED S&R	1.00 S	0.00
MEID 712	POM III	6.00 H	24.00
********** CONTINUED ON NEXT COLUMN **********			

PRIMARY SOURCE

SUBJ NO.	COURSE TITLE	CRED GRD	PTS R
Institution Information continued:			
Ehrs: 27.00 GPA-Hrs: 26.00 QPts:		86.00 GPA:	3.30
Spring 2021 - Half Year Term			
Semester			
IMED 999	ON CAMPUS SIE:IN-AB	2.50 S	0.00
MEID 685	DIRECTED STUDIES:IN AB	5.00 S	0.00
MRAD 800	RADIOLOGY CLERKSHIP	2.00 H	8.00
SURG 800	SURGERY CLERKSHIP	10.00 P	30.00
Ehrs: 19.50 GPA-Hrs: 12.00 QPts:		38.00 GPA:	3.16
Fall 2021 - Half Year Term			
Semester			
MFCM 800	FAMILY MEDICINE CLERKSHIP	7.50 P	22.50
MPED 800	PEDIATRICS CLERKSHIP	7.50 P	22.50
MPSY 800	PSYCHIATRY CLERKSHIP	7.50 P	22.50
OBGY 800	OBSTETRICS & GYNCLGY CLERKSHIP	7.50 P	22.50
Ehrs: 30.00 GPA-Hrs: 30.00 QPts:		90.00 GPA:	3.00
Spring 2022 - Half Year Term			
Semester			
ANES 802	ANESTHESIOLOGY	2.50 S	0.00
EMED 807	TOXICOLOGY	2.50 S	0.00
IMED 800	INTERNAL MEDICINE CLERKSHIP	10.00 P	30.00
MEID 805	COMPUTER RESOURCES PROF DEV	2.50 S	0.00
MEID 823	POM VI INTERPROF SOC & ETH DIL	1.00 S	0.00
MHUM 807	FELLOWSHIPS IN LEADERSHIP	0.00 S	0.00
MHUM 815	ESSENTIALS OF LEADERSHIP:IN-AB	2.50 H	10.00
MPSY 809	ADV INPATIENT PSYCH	5.00 S	0.00
MPSY 810	CONSULTATION//LIAISON PSYCH	0.00 S	0.00
MPSY 999	ON CAMPUS SIE:IN-AB	2.50 S	0.00
MRAD 801	DIAGNOSTIC RADIOLOGY	2.50 S	0.00
Ehrs: 31.00 GPA-Hrs: 12.50 QPts:		40.00 GPA:	3.20
Fall 2022 - Half Year Term			
Semester			
EMED 800	EMERGENCY MEDICINE CLERKSHIP	5.00 S	0.00
********** CONTINUED ON PAGE 2 **********			

RECEIVED

MAY 25 2023

OKLAHOMA STATE BOARD OF MEDICAL LICENSURE AND SUPERVISION

Transcript is official with digitized seal and signature of the Registrar.

Oklahoma State Board of Medical Licensure and Supe

T41458 UKC

Venesa A. Heidick

Venesa A. Heidick
Registrar

TEXAS A&M UNIVERSITY

College Station, Texas 77843

OFFICIAL ACADEMIC RECORD

24-MAY-2023

Name: Karen Han Nguyen

Date of Birth: [redacted]

SID: [redacted]

Level: Professional Medicine

SUBJ	NO.	COURSE TITLE	CRED	GRD	PTS	R
Institution Information continued:						
IMED	824	NEUROLOGY	2.50	S	0.00	
IMED	825	PALLIATIVE MED & END-OF-LIFE	2.50	S	0.00	
IMED	831	MEDICAL ICU	5.00	S	0.00	
IMED	891	PULMONARY & SLEEP MED ELECTIVE	2.50	S	0.00	
MPSY	802	CHILD & ADOLESCENT PSYCHIATRY	2.50	S	0.00	
MPSY	810	CONSULTATION//LIAISON PSYCH	5.00	S	0.00	
Ehrs: 25.00 GPA-Hrs: 0.00 QPts: 0.00 GPA: 0.00						
Spring 2023 - Half Year Term						
Semester						
ANES	801	CLINICAL ANESTHESIOLOGY	2.50	S	0.00	
IMED	896	INTERNAL MEDICINE AI	5.00	S	0.00	
MEID	850	POM CAPSTONE	2.50	S	0.00	
MRAD	801	DIAGNOSTIC RADIOLOGY	2.50	S	0.00	
MRAD	811	PEDIATRIC IMAGING	2.50	S	0.00	
Ehrs: 15.00 GPA-Hrs: 0.00 QPts: 0.00 GPA: 0.00						

********** TRANSCRIPT TOTALS **********

	Earned Hrs	GPA Hrs	Points	GPA
TOTAL INSTITUTION	200.50	124.50	402.00	3.22
TOTAL TRANSFER	0.00	0.00	0.00	0.00
OVERALL	200.50	124.50	402.00	3.22

********** END OF TRANSCRIPT **********

RECEIVED

MAY 25 2023

OKLAHOMA STATE BOARD OF MEDICAL LICENSURE AND SUPERVISION

PRIMARY SOURCE

Transcript is official with digitized seal and signature of the Registrar.

Venesa A. Heidick

Venesa A. Heidick
Registrar

THE UNIVERSITY
Texas A&M University is comprised of sixteen colleges and two branch campuses in Galveston and Qatar. Texas A&M University offers undergraduate, graduate and professional programs. In 1963 the name was changed from the Agricultural and Mechanical College of Texas to Texas A&M University. In 2013, Texas A&M University officially added the Texas A&M University Health Science Center (TAMUHSC) under its administration and acquired the Texas A&M University School of Law from Texas Wesleyan University.

ACCREDITATION
Texas A&M University is accredited by the Southern Association of Colleges and Schools Commission on Colleges. Additional information about accreditation for individual colleges and programs is listed in the University catalogs.

CALENDAR
The academic year for undergraduate and graduate students consists of 15-week fall and spring semesters and the summer terms, which are two 5-week terms and a 10-week semester. The academic year for students in professional programs varies and is detailed in the University catalogs.

TRANSCRIPTS
Official transcripts are prepared in accordance with the policies of Texas A&M University, the Southern Association of Colleges and Schools Commission on Colleges and the American Association of Collegiate Registrars and Admissions Officers. All official transcripts are produced by the Office of the Registrar, Texas A&M University. This transcript is provided with the understanding it will not be released or transferred to any other person, agency or party without the consent of the student, pursuant to the Family Educational Rights and Privacy Act of 1974.

ACADEMIC CREDIT
The unit of credit is the semester hour. Each semester hour represents a class meeting 1 hour per week or a laboratory of 2 to 4 hours per week for 15 weeks. An equivalent amount of work is required for semesters of fewer than 15 weeks. Each course listing on the front of this transcript includes: Subject area and course number, course title, credit hours, grade earned, and grade points earned.

COURSE NUMBERING

100-199	Freshman courses	200-299	Sophomore courses	300-399	Junior courses
400-499	Senior courses	600-799	Graduate courses	900+	Professional courses

GRADING SYSTEM

Letter Grade	Description	Grade Points	Hrs included in GPA?	Texas A&M University (All, Specific Unit, College, or Level)
A+		4.01	Yes	School of Law-Doctor of Jurisprudence
A	Excellent	4.00	Yes	All
H	Honors (Effective June 1, 2014)	4.00	Yes	College of Medicine
A-		3.67	Yes	School of Law-Doctor of Jurisprudence
B+	Good	3.50	Yes	College of Dentistry-Doctor of Dental Surgery
		3.33	Yes	School of Law-Doctor of Jurisprudence
B	Good	3.00	Yes	All
P	Pass (Effective June 1, 2014)	3.00	Yes	College of Medicine
B-		2.67	Yes	School of Law-Doctor of Jurisprudence
C+	Satisfactory	2.50	Yes	College of Dentistry – Doctor of Dental Surgery
		2.33	Yes	School of Law-Doctor of Jurisprudence
C	Satisfactory	2.00	Yes	All
C-		1.67	Yes	School of Law-Doctor of Jurisprudence
D+		1.33	Yes	School of Law-Doctor of Jurisprudence
D	Passing	1.00	Yes	All (excluding Graduate and College of Pharmacy)
F/P	Fail, but satisfactorily remediated (Effective June 1, 2014)	1.00	Yes	College of Medicine
F/C	Fail, but course remediated (prior to June 1, 2014)	1.00	Yes	College of Medicine
D-		0.67	Yes	School of Law-Doctor of Jurisprudence
F	Fail	0.00	Yes	All
I	Incomplete	0.00	No	All
NR	No grade reported (historical)	0.00	No	Colleges and Schools of TAMUHSC
NG	No grade drop, course dropped by student's dean	0.00	No	All
P	Satisfactory, D- or above.	0.00	No	School of Law-Doctor of Jurisprudence
S	Satisfactory, C or above.	0.00	No	Undergraduate & Professional
	Satisfactory, B or above.	0.00	No	Graduate
U	Unsatisfactory, D or F.	0.00	Yes	Undergraduate & Professional
	Unsatisfactory, D or F.	0.00	No	College of Dentistry – Doctor of Dental Surgery
	Unsatisfactory, F.	0.00	Yes	School of Law-Doctor of Jurisprudence
	Unsatisfactory, C or below.	0.00	No	Graduate
U/S	Unsatisfactory, but course satisfactorily remediated.	0.00	No	Colleges and Schools of TAMUHSC
Q	Dropped course with no penalty	0.00	No	All
X	No grade submitted	0.00	No	All
W	Withdraw	0.00	No	All
WP	Withdrew Passing	0.00	No	All
WF	Withdrew Failing	0.00	Yes	All

GRADE STANDARD – SCHOOL OF LAW-DOCTOR OF JURISPRUDENCE:

3.0	All lockstep and non-lockstep courses with an enrollment over twenty
0	All non-lockstep, non-seminar courses with an enrollment fewer than twenty and
3.33	all seminar courses

Minimum GPA for good standing at the School of Law- Doctor of Jurisprudence is a 2.33 GPA or higher.

EXPLANATION OF SYMBOLS

IP	Indicates a course in progress. Found in the hours column.
HNR	Indicates an honors course. Appears before the course title.
*	Aggie Honor Code Violation. Appears after the grade as F* or U*
#	Grade Exclusion Policy, credit hour(s) and grade excluded from GPA calculation. Appears after the grade as F#, D#, or U#.
E	Indicates a course taken as part of the TAMU System Course Exchange Program. Appears before the grade. See http://cep.tamus.edu for more information

TRANSFER WORK
Transfer work displayed on the transcript is noted on the transcript with grades of

TA	Transfer grade of 'A'	TCR	Transfer of credit (e.g., AP credit by exam) Transfer
TB	Transfer grade of 'B'	TR	of credit (e.g. credit by exam – TAMUHSC)
TC	Transfer grade of 'C'		

REPEAT CODES

A	Indicates a course has been repeated. Hours are included in the GPA, but are not included in cumulative totals. The symbol appears next to the hours column.
E	Indicates a course has been repeated. Hours are excluded from the GPA and cumulative totals. The symbol appears next to the hours column.
I	Indicates a course has been repeated. Hours are included in the GPA and cumulative totals. The symbol appears next to the hours column.

SPECIAL GRADUATION REQUIREMENTS – COLLEGE OF MEDICINE
Passage of USMLE Step 1 and Step 2-CK is required for graduation. Students must pass USMLE Step 1 for promotion to the 4th year. Students must take Step 2-CS prior to graduation.

ACADEMIC HONORS FOR UNDERGRADUATE PROGRAMS
Students completing the required number of undergraduate semester hours preceding graduation at Texas A&M University may qualify to graduate Summa Cum Laude by holding a final grade point average of 3.90 or above, Magna Cum Laude with a grade point average of 3.70 through 3.899 and Cum Laude with a grade point average of 3.50 through 3.699. Information regarding other designations may be found at http://honorsprograms.tamu.edu/Home. Undergraduate Research Scholar recognizes graduates who participated in a select program of independent research leading to a senior thesis (http://hur.tamu.edu/Undergraduate-Research/Undergraduate-Research-Scholars). Honors Fellow recognizes graduates who completed the University Honors curriculum (30 credit hours of honors coursework and a capstone experience; http://hur.tamu.edu/Honors/University-Honors-Distinction).

ACADEMIC HONORS FOR FIRST-PROFESSIONAL PROGRAMS
Students who complete their entire course of study at the TAMUHSC College of Medicine are eligible for academic honors. College of Medicine students must obtain a grade point average of 3.50 or greater to graduate with honors. In the College of Dentistry, only those students in the top 1st to 4th positions in the class are eligible for academic honors. Rangel College of Pharmacy, students are eligible for Latin Honors as follows: Summa Cum Laude (4.0-3.90), Magna Cum Laude (3.89-3.75), and Cum Laude (3.74-3.50). Through May 2019, School of Law-Doctor of Jurisprudence graduates may qualify to graduate as Summa Cum Laude if in the top 2% of the graduating class; Magna Cum Laude if in the top 5% of the graduating class but not in the top 2%; and Cum Laude if graduates in the top 10% of the graduating class but not in the top 5%. Beginning May 2019, School of Law-Doctor of Jurisprudence graduates may qualify to graduate with Latin Honors as follows: Summa Cum Laude (3.8 or above cumulative grade point average); Magna Cum Laude (3.60-3.79 cumulative grade point average), and Cum Laude (3.40-3.59 cumulative grade point average). A first-professional student in the College of Veterinary Medicine may qualify to graduate Summa Cum Laude by holding a final grade point average of 3.90 or above, Magna Cum Laude with a grade point average of 3.70 through 3.899 and Cum Laude with a grade point average of 3.50 through 3.699.

CONSORTIUM AGREEMENTS – TEXAS A&M UNIVERSITY HEALTH SCIENCE CENTER (Effective Fall 1999)- The TAMUHSC Institute of Biotechnology participates in the Gulf Coast Consortia. Prior to the merger, the TAMUHSC participated in a consortium agreement with Texas A&M University.

AMA Physician Profile

PREPARED FOR

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

Name and Mailing Address

KAREN HAN NGUYEN
UNIV OF OKLAHOMA HEALTH SCIENCES CTR
DEPT OF PSYCHIATRY & BEHAVIORAL SCIENCES
PO BOX 26901
OKLAHOMA CITY, OK 73126-0901

Primary Office Address

Phone [redacted]

Birth date [redacted]

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: TEXAS A&M UNIVERSITY SYSTEM HEALTH SCIENCE CENTER COLLEGE OF MEDICINE

Degree Awarded: YES **Degree Type:** MD

T14458

AMA AMERICAN MEDICAL ASSOCIATION

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: PSYCHIATRY
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
41458	MD	OK	07/01/2023	09/30/2024		ACT	RES	05/06/2024	KAREN HAN NGUYEN

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: Karen Han Nguyen
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 Karen Nguyen Date 04/14/2023

Subscribed and sworn before me this 14th day of April, 2023.

Notary Public Rebecca Sepulveda

Commission Number 7133158

My commission expires October 20, 2026

NOTARY SEAL

REBECCA SEPULVEDA
Notary ID #7133158
My Commission Expires
October 20, 2026

RECEIVED
APR 17 2023
OKLAHOMA STATE BOARD OF MEDICAL LICENSURE AND SUPERVISION

T 41458

OKLAHOMA STATE BOARD OF MEDICAL LICENSURE AND SUPERVISION
101 NE 51ST 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	For FLEX or USMLE Scores
National Board of Medical Examiners	Federation of State Medical Boards
PO Box 48014	400 Fuller Wiser Road
Newark, NJ 07101-4814	Euless, TX 76039-3855
(215) 590-9500	(817) 868-4000
www.NBME.org	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.

Karen Nguyen — Name of Applicant (type or print)
Karen Nguyen — Signature of Applicant
04/10/2023 — 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.

RECEIVED
APR 17 2023
OKLAHOMA STATE BOARD OF MEDICAL LICENSURE AND SUPERVISION

T 41458
KB

Kenna L. Shaw

From: BillPay Webmaster <donotreply@www.ok.gov>
Sent: Thursday, April 11, 2024 7:58 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

KAREN HAN NGUYEN has paid for a LICENSE - MD Training-to-Full License Fee 250.00
on 04/11/2024 07:04:58pm for $250.00.
OKLAHOMA MD LICENSE NUMBER 41458
To view all transactions please go to http://www.ok.gov/triton/ and
login to your CMS account.

ATTACHMENT 5

TIME DEFICIENCY FORM

Name:	Karen Nguyen	Application #	41458

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	2009	May	2013	Jersey Village High School	Jersey Village	TX	
Aug	2013	May	2017	University of Houston	Houston	TX	BS (Biology)
July	2019	May	2023	Texas A&M School of Medicine	College Station & Dallas	TX	MD

EMPLOYMENT IF NEEDED TO FILL TIME GAP

Start Month	Start Year	End Month	End Year	Name of Employer	City	State	Job Title
July	2009	Oct	2015	Kumon	Houston	TX	Instructor
Aug	2016	Dec	2017	Scribe America	Houston	TX	medical scribe
Jan	2018	March	2019	Texas Dermatology	Houston	TX	medical assistant

OTHER - UNEMPLOYED, STAY AT HOME PARENT, SUMMER BREAK, TRAVELING

Start Month	Start Year	End Month	End Year	Other	City	State
April	2019	May	2019	traveling	Los Angeles	CA
June	2019	June	2019	Med Camp at Texas A&M School of Medicine	College Station	TX

3/19 - 7/19

T 41458 VD

05/03/2023

KAREN HAN NGUYEN
[redacted]

Check Your Application Status Online at:
http://www.okmedicalboard.org
Username:AP92127974
Password:Last 4 SSN

RE: MD Application #41458

Dear KAREN NGUYEN,

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

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

Application Instructions
PostGrad - Form 2 COLLEGE OF MEDICINE OKC
USMLE Exams Incomplete
Evidence of Status
MedSchool-Transcript TX A & M UNIV SYS HSC, COLL OF MED, COLLEGE STATION TX 77843
OATH
Extended Background Check
Time Deficiency Form for: 3/2019-7/2019
Exam verification date
MedSchool-Form 1 TX A & M UNIV SYS HSC, COLL OF MED, COLLEGE STATION TX 77843

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 AP92127974 (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

Sincerely,

Seema Jayachand

Seema Jayachand

Dept. of Licensing

Encl

Oklahoma State Board of Medical Licensure and Supervision
Application Summary

Type	Number	Name
MD	41458	KAREN HAN NGUYEN

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:
048-16 TX A & M UNIV SYS HSC, COLL OF MED, COLLEGE STATION TX 77843

Number of Licenses Previously Granted to Graduates of this Medical School:177

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** _____ 6-1-23

5) **REQUESTS SPECIFIC CONSIDERATION OF:**

_____

_____

_____

_____

_____

Oklahoma State Board of Medical Licensure and Supervision
Application Summary

Type	Number	Name
MD	41700	REBECCA MICHELLE NUSS

MEDICAL DOCTOR

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

OTHER DEFICIENCIES: NEED USMLE STEP 3 / QUESTIONNAIRE / $250 UPGRADE FEE / EVALUATION
Exam verification date
PostGrad - Form 2 COLLEGE OF MEDICINE TULSA
USMLE Exams Incomplete

Last Medical School Attended:
021-05 LSU Sch Of Med in New Orleans, New Orleans La 70112

Number of Licenses Previously Granted to Graduates of this Medical School:191

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	41700	REBECCA MICHELLE NUSS

MEDICAL DOCTOR

Practice Address:

May 05, 2023

Status:
Res: TR
Received: 06/04/2024
Entered: 06/04/2024
Temp Issued:
Temp Expires:
Train Issued: 07/01/2023
Train Expires: 09/30/2024
Fed Rec: 06/04/2024
AMA Rec: 06/04/2024
Board Action:
License #: 41700
Sex: F
Ethnic Origin: 1

Endorsed By: USMLE

	Test	Score	Date Taken	Date Verified	Attempts
Test 1:	USMLE 1	PASS	7/22/21	5/25/23	1
Test 2:	USMLE 2CK	PASS	9/16/22	5/25/23	1
Test 3:	Note: ***PASS*** means higher than 75				

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

PRE-MED EDUCATION

School Name: DELGADO COMMUNITY COLLEGE
City: NEW ORLEANS **State:** LA **Country:** UNITED STATES
Degree: CERTIFICATE OF EMERGENCY MEDICAL TECHNICIAN **From:** 5/2016 **To:** 7/ 2016 **Verified:**

School Name: SOUTHEASTERN LOUISIANA UNIVERSITY
City: HAMMOND **State:** LA **Country:** UNITED STATES
Degree: BIOLOGICAL SCIENCES **From:** 8/2015 **To:** 5/ 2019 **Verified:**

MEDICAL SCHOOL EDUCATION

Name: LSU Sch Of Med in New Orleans, New Orleans La 70112
Foreign Name:
City: New Orleans **State/Country:** United States of America
Degree: DOCTOR OF MEDIC **From:** 7 / 2019 **To:** 5 / 2023 **Diploma Ver'd:** Y

Oklahoma State Board of Medical Licensure and Supervision
Application Summary

Type	Number	Name
MD	41700	REBECCA MICHELLE NUSS

MEDICAL DOCTOR

POST GRADUATE EDUCATION

Facility: COLLEGE OF MEDICINE TULSA **Specialty:** OBSTETRICS/GYNECOLOGY
Res. Fellowship: Residency
City: TULSA **State:** OK **Country:** UNITED STATES OF AM
Verified: **From:** 7 / 2023 **To:** /
ACGME Ver'd:
Comments:

PRACTICE HISTORY

Employed: **Supervisor:**
City: **State:** **Country:**
Specialty: **From:** / **To:** / **Verified:**
Comments:

Other Licenses

State	Lic Type and Number	Status	Issued	Exp	Verif

DEFICIENCIES

OTHER DEFICIENCIES: NEED USMLE STEP 3 / QUESTIONNAIRE / $250 UPGRADE FEE / EVALUATION
Exam verification date
PostGrad - Form 2 COLLEGE OF MEDICINE TULSA
USMLE Exams Incomplete

Oklahoma State Board of Medical Licensure and Supervision

APPLICATION FOR OKLAHOMA MEDICAL DOCTOR LICENSE

Received:05/03/2023

Applicant Name: NUSS, REBECCA MICHELLE [redacted]

MD 41700

Date Of Birth: [redacted] **Place Of Birth (City, State):** NEW ORLEANS, LA

Sex: F **Race:** Caucasian

Education

Type	Name	City	ST	Country	From	To	Degree	Comments	Veri
UG	DELGADO COMMUNITY COLLEGE	NEW ORLEAI	LA		5/2016	7/2016	CERTIFICATE OF EMERGENCY MEDICAL TECHNICIAN		
UG	SOUTHEASTERN LOUISIANA UNIVERSITY	HAMMOND	LA		8/2015	5/2019	BIOLOGICAL SCIENCES		

Medical School Name	City	State	Country	Comments	From	To
LSU Sch Of Med in New Orleans, New Orleans La 70112	New Orleans	LA	United States		7/2019	5/2023

Post-Graduate

Facility	City	St	Country	Specialty	Comments	From	To
COLLEGE OF MEDICINE TULSA	TULSA	OK	UNITED S	OBSTETRICS/GYNECOLOGY		7/2023	/

Practice History

Employer	Specialty	Supervisor	City	ST	Countr	From	To	Verif
						/		

Other/ Out-Of-State Licenses

State	License #	Profession	Status	Issue Date	Exp Date

$250.00

MD Exam

Exam	State	Score	Date Taken	#
USMLE				

Oklahoma State Board of Medical Licensure and Supervision

APPLICATION FOR OKLAHOMA MEDICAL DOCTOR LICENSE

Received:05/03/2023

Questions Answered 04/25/2023		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

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 School of Community Medicine Dept of OBGYN

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
Resident

I attest that all the above information is accurate as of May 02, 2023: (Signed Online)

[illegible]

Applicant [illegible]

Send this form to [illegible]

oktraining@okmedicalboard.org

I, the undersigned, being duly sworn, hereby certify under oath that I am the person named in this application [illegible] that make with respect thereto are true; that I am the original and lawful possessor of and person named in the [illegible] furnished with respect to my application, and that all documents [illegible] application are strictly true in every aspect.

I acknowledge that I have read and understand the application and have answered all questions [illegible] completely. I further acknowledge that failure on my part to answer questions truthfully and completely [illegible] appropriate federal and state laws.

I authorize and request every person, hospital, clinic, government agency (local, state, federal [illegible]) enforcement agency having custody or control of any documents, records, and other information pertaining [illegible] information, including documents, records regarding charges or complaints filed against me, formal or informal, pending [illegible] 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.

Rebecca M. Nuss
Applicant's signature (must be signed in the presence of a notary)

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

05 | 08 | 2023
Date of signature (must correspond to the date of notarization)

RECEIVED
MAY 24 2023
OKLAHOMA STATE BOARD OF MEDICAL LICENSURE AND SUPERVISION

NOTARY

State of Louisiana, County of Orleans

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 8 day of May, 2023

Notary Public Signature [signature] Notary Commission Expires for life

SARAH ELAYNE COHEN NOTARY PUBLIC #161633 MY COMMISSION IS FOR LIFE ORLEANS PARISH, LA

T 41700

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: 05/24/2023

Examinee: Nuss, Rebecca Michelle
Alt Name(s):

Examinee ID: 5-460-572-0
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
07/22/2021	Pass	205	(194)	

USMLE STEP 2

Clinical Knowledge (CK)

Test Date	Pass/Fail	Score	Minimum Pass	Comments
09/16/2022	Pass	236	(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.

Rev 2018

T41700
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 Wiser Road, Euless, TX 76039-3856 - Telephone (817) 868-4000

Examinee: Nuss, Rebecca Michelle

Examinee ID: 5-460-572-0
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.

Attachment 6

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 Rebecca Nuss

Institution: LSU SOM New Orleans City/State New Orleans, LA

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

From 08/01/2019 (Month Day Year) To 05/18/2023 (Month Day Year) and was awarded the degree doctor of medicine (MD)

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: Cathy J. Lazenby Signature Cathy J Lazenby

Title of Signatory: Assoc. Dean, Student Affairs Date of Signature May 19, 2023

Tel: 504-568-4874 Fax: 504-568-6534 E-Mail: slerrye1@lsuhsc.edu

School Seal

RECEIVED
MAY 23 2023
OKLAHOMA STATE BOARD OF MEDICAL LICENSURE AND SUPERVISION

If no seal is available, this form must be notarized

Notary Public

Commission #

My commission expires:

Notary Seal

PRIMARY SOURCE

T41700

LOUISIANA STATE UNIVERSITY
HEALTH SCIENCES CENTER AT NEW ORLEANS
Office of the Registrar
433 Bolivar Street
New Orleans, LA 70112-2223

OFFICIAL TRANSCRIPT

Name : Nuss,Rebecca Michelle
Emplid : 5034002
SSN : [redacted]
Birthdate : [redacted]

Print Date: 2023-05-24

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

Degree: Doctor of Medicine
Confer Date: 2023-05-18
Plan: DOCTOR OF MEDICINE

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

SOUTHEASTERN LOUISIANA UNIVERSITY
2019-05-17 Bachelor of Science

----- Beginning of Medicine, New Orleans Record -----

Fall 2019
Program: Medicine (MD), New Orleans
Plan: DOCTOR OF MEDICINE Specialization

Course		Description	Attempted	Earned	Grade	Honors Hours
ANAT	100	GROSS & DEVELOPMENTAL ANATOMY	203.000	203.000	P	0.000
BIOCH	100	BIOCHEMISTRY	70.000	70.000	P	0.000
MCLIN	101	CLINICAL SKILLS INTEGRATION	78.000	78.000	HP	0.000
		Term Totals:	351.000	351.000		0.000
		Cum Totals:	351.000	351.000		0.000

Spring 2020
Program: Medicine (MD), New Orleans
Plan: DOCTOR OF MEDICINE Specialization

Course		Description	Attempted	Earned	Grade	Honors Hours
ANAT	110	CELL BIOLOGY & MICROANATOMY	86.000	86.000	HP	0.000
GENET	100	MEDICAL GENETICS	15.000	15.000	H	15.000
MCLIN	102	CLINICAL SKILLS INTEGRATION	60.000	60.000	H	60.000
MCLIN	110	POPULATION MEDICINE	40.000	40.000	H	40.000
MICRO	100	IMMUNOLOGY	30.000	30.000	HP	0.000
PHYSIO	100	PHYSIOLOGY	86.000	86.000	HP	0.000
PSYC	100	HUMAN BEHAVIOR	18.000	18.000	H	18.000
		Term Totals:	335.000	335.000		133.000
		Cum Totals:	686.000	686.000		133.000

Summer 2020
Program: Medicine (MD), New Orleans
Plan: DOCTOR OF MEDICINE Specialization

Course		Description	Attempted	Earned	Grade	Honors Hours
MCLIN	198	L1 RESEARCH ELECTIVE	30.000	30.000	P	0.000
		Term Totals:	30.000	30.000		0.000
		Cum Totals:	716.000	716.000		133.000

Fall 2020
Program: Medicine (MD), New Orleans
Plan: DOCTOR OF MEDICINE Specialization

Course		Description	Attempted	Earned	Grade	Honors Hours
MCLIN	201	CLINICAL SKILLS 1 (PASS/FAIL)	33.000	33.000	P	0.000
MCLIN	230	FOUNDATIONS DISEASE & THERAPY	72.000	72.000	P	0.000
MCLIN	232	DISEASE AND THERAPY NEUROPSYCH	144.000	144.000	HP	0.000
MCLIN	234	DISEASE AND THERAPY CARDIOVASC	54.000	54.000	HP	0.000
MCLIN	236	DISEASE AND THERAPY RENAL	60.000	60.000	HP	0.000
		Term Totals:	363.000	363.000		0.000
		Cum Totals:	1079.000	1079.000		133.000

Spring 2021
Program: Medicine (MD), New Orleans
Plan: DOCTOR OF MEDICINE Specialization

Course		Description	Attempted	Earned	Grade	Honors Hours
MCLIN	202	CLINICAL SKILLS 2 (PASS/FAIL)	33.000	33.000	P	0.000
MCLIN	231	DISEASE AND THERAPY HEME	38.000	38.000	H	38.000
MCLIN	233	DISEASE AND THERAPY MUSC DERM	34.000	34.000	HP	0.000
MCLIN	235	DISEASE AND THERAPY PULMONARY	54.000	54.000	HP	0.000
MCLIN	237	DISEASE AND THERAPY GASTRO	60.000	60.000	HP	0.000
MCLIN	238	DISEASE AND THERAPY ENDO REPRO	60.000	60.000	H	60.000
		Term Totals:	279.000	279.000		98.000
		Cum Totals:	1358.000	1358.000		231.000

Fall 2021
Program: Medicine (MD), New Orleans
Plan: DOCTOR OF MEDICINE Specialization

Course		Description	Attempted	Earned	Grade	Honors Hours
MCLIN	310	CLERKSHIP PREP (PASS/FAIL)	24.000	24.000	P	0.000
PEDI	300	PEDIATRICS	304.000	304.000	HP	0.000
SPTP	500	SPEC TOPICS-USMLE (PASS/FAIL)	266.000	266.000	P	0.000
SURG	300	SURGERY	342.000	342.000	P	0.000
		Term Totals:	936.000	936.000		0.000
		Cum Totals:	2294.000	2294.000		231.000

Spring 2022
Program: Medicine (MD), New Orleans
Plan: DOCTOR OF MEDICINE Specialization

Course		Description	Attempted	Earned	Grade	Honors Hours
MCLIN	300	CLIN CARE PLAN ELE (PASS/FAIL)	76.000	76.000	P	0.000
MED	300	MEDICINE	380.000	380.000	HP	0.000
OBGYN	300	OB/GYN	228.000	228.000	H	228.000
PSYC	300	PSYCHIATRY	228.000	228.000	H	228.000
		Term Totals:	912.000	912.000		456.000
		Cum Totals:	3206.000	3206.000		687.000

Fall-New Orleans 2022
Program: Medicine (MD), New Orleans
Plan: DOCTOR OF MEDICINE Specialization

Course		Description	Attempted	Earned	Grade	Honors Hours
FMMD	300	FAMILY MEDICINE	152.000	152.000	HP	0.000
MCLIN	498	SENIOR RESEARCH ELECTIVE	152.000	152.000	H	152.000
NEURO	300	NEUROLOGY	114.000	114.000	HP	0.000
OBGYN	418	OBGYN SEC ACT INTER	152.000	152.000	H	152.000
OBGYN	419	OBGYN ACTING INTERNSHIP	152.000	152.000	H	152.000

Send To: OKLAHOMA STATE BOARD OF MEDICAL LIC
OKTRAINING@OKMEDICALBOARD.ORG

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PRIMARY SOURCE

Alicia Price Edwards
University Registrar, LSUHSC

T 41700

LOUISIANA STATE UNIVERSITY
HEALTH SCIENCES CENTER AT NEW ORLEANS
Office of the Registrar
433 Bolivar Street
New Orleans, LA 70112-2223

OFFICIAL TRANSCRIPT

Name : Nuss,Rebecca Michelle
Emplid : 5034002
SSN : [redacted]
Birthdate : [redacted]

Course		Description		Attempted	Earned	Grade	Honors Hours
OBGYN	499	OBGYN OUT-STATE ELEC		152.000	152.000	HP	0.000
			Term Totals:	874.000	874.000		456.000
			Cum Totals:	4080.000	4080.000		1143.000

Spring-New Orleans 2023
Program: Medicine (MD), New Orleans
Plan: DOCTOR OF MEDICINE Specialization

Course		Description		Attempted	Earned	Grade	Honors Hours
MCLIN	400	CRITICAL CONCEPTS		152.000	152.000	HP	0.000
MCLIN	420	HUMANITIES IN MED 420 (P/F)		152.000	152.000	P	0.000
OBGYN	420	OBGYN CLINICAL		152.000	152.000	H	152.000
SPTP	400	SPECIAL TOPICS (PASS/FAIL)		38.000	38.000	P	0.000
			Term Totals:	494.000	494.000		152.000
			Cum Totals:	4574.000	4574.000		1295.000

Medicine, New Orleans Career Totals

			Cum Totals:	4574.000	4574.000		1295.000

Effective June 1988, all medical students are required to pass USMLE Step 1 prior to enrollment in 300 level courses. Effective May 1995, all medical students are required to pass USMLE Step 2 CK prior to graduation. Effective December 2007, all medical students are required to pass USMLE Step 2 CK and Step 2 CS prior to graduation.

----- End of Transcript -----

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OKTRAINING@OKMEDICALBOARD.ORG

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PRIMARY SOURCE

Alicia Price Edwards
University Registrar, LSUHSC

Louisiana State University
Health Sciences Center at New Orleans
Office of the Registrar
433 Bolivar Street
New Orleans, LA 70112-2223
(504) 568-4829 FAX: (504) 568-5545
registrar@lsuhsc.edu

ACCREDITATION

Louisiana State University Health Sciences Center at New Orleans is accredited by the Southern Association of Colleges and Schools Commission on Colleges (SACSCOC) to award associate degrees, baccalaureate degrees, master's degrees, doctoral degrees and professional certificates. Contact SACSCOC at 1866 Southern Lane, Decatur, Georgia 30033-4097 or call 404-679-4500 for questions about the accreditation of Louisiana State University Health Sciences Center at New Orleans.

GRADING SYSTEM

HONORS GRADING SYSTEM

School of Medicine

H	Honors
HP	High Pass
P	Pass
F	Fail
I	Incomplete
W	Withdrawn

LETTER GRADING SYSTEM

Schools of Allied Health Professions, Dentistry, Graduate Studies, Nursing and Public Health

Grade	Quality Points
A	4
B	3
C	2
D	1
F	0
I	Incomplete
P	Pass
S	Satisfactory
U	Unsatisfactory
W	Withdrawn
AU	Audit

DEGREES WITH HONORS

Honors are awarded in conjunction with the undergraduate degrees as follows:

Summa cum laude	3.960 to 4.000
Magna cum laude	3.860 to 3.959
Cum laude	3.760 to 3.859

More detailed academic program and course information may be found at www.lsuhsc.edu.

This transcript is official only if it carries the following on the reverse:

- a stamped seal with the facsimile signature of the Registrar
- the image of LSU Health Sciences Center seal in the center of the page

AMA Physician Profile

PREPARED FOR

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

Name and Mailing Address

REBECCA MICHELLE NUSS
[redacted]

Birth date [redacted]

Primary Office Address

UNIV OK DEPT IM
4502 E 41ST ST
TULSA, OK 74135-2553
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

NPI Number	Enumeration Date	Deactivation Date	Reactivation Date	Replacement Number	Last Reported Date
1871281154	04/25/2023	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: LOUISIANA STATE UNIVERSITY SCHOOL OF MEDICINE IN NEW ORLEANS

Degree Awarded: YES **Degree Type:** MD

T4879

AMA AMERICAN MEDICAL ASSOCIATION

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 SCHOOL OF COMMUNITY MEDICINE-TULSA
Sponsoring State: OKLAHOMA
Program name: UNIVERSITY OF OKLAHOMA SCHOOL OF COMMUNITY MEDICINE (TULSA) PROGRAM
Specialty: OBSTETRICS & GYNECOLOGY
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
41700	MD	OK	07/01/2023	09/30/2024		ACT	RES	05/06/2024	REBECCA MICHELLE NUSS

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
MAY 24 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 [illegible] Michelle Nuss ______ Maiden (if applicable)

Mailing Address [redacted] Social Security #: [redacted]

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 Rebecca M. Nuss Date 5/8/23

Subscribed and sworn before me this 8 day of May 2023

Notary Public Sarah Bayne Cohen

Commission Number 161653

My commission expires for life

T41700
VD

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.

Rebecca Nuss — Name of Applicant (Type or print)

Rebecca Nuss — Signature of Applicant

5/9/23 — 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 41700
M

ATTACHMENT 5

TIME DEFICIENCY FORM

Name [redacted] Application # 41700

Use this chart as a tool to help you complete your application.
Please note: all time is required from 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	2016	New Orleans Center for Creative Arts	New Orleans	LA	[redacted] Certificate
08	2011	05	2012	Virtual Academy	New Orleans	LA	N/A
08	2012	05	2014	International HS of New Orleans	New Orleans	LA	N/A
08	2014	05	2015	Grace King HS	Metairie	LA	HS Diploma
08	2015	05	2019	Southeastern LA University	Hammond	LA	Biological Sciences

EMPLOYMENT IF NEEDED TO FILL TIME GAP

Start Month	Start Year	End Month	End Year	Name of Employer	City	State	Job Title
07	2019	05	2023	Louisiana State University School of Medicine	New Orleans	LA	7017

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	New Orleans	LA
05	2016	08	2016	Delgado Community College	New Orleans	LA
05	2017	08	2017	Summer Break	New Orleans	LA
05	2018	08	2018	Summer Break	New Orleans	LA
05	2019	08	2019	Summer Break	New Orleans	LA
05	2020	07	2020	Summer Break	New Orleans	LA
05	2021	07	2021	Summer Break	New Orleans	LA

RECEIVED
MAY 24 2023
OKLAHOMA STATE BOARD OF MEDICAL LICENSURE AND SUPERVISION

Ø need
T 41700

05/12/2023

REBECCA MICHELLE NUSS
[redacted]

Check Your Application Status Online at:
http://www.okmedicalboard.org
***Username*:AP30751473**
***Password*:Last 4 SSN**

RE: MD Application #41700

Dear REBECCA NUSS,

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

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

Evidence of Status
Application Instructions
OATH
Exam verification date
MedSchool-Transcript LSU Sch Of Med in New Orleans, New Orleans La 70112
MedSchool-Form 1 LSU Sch Of Med in New Orleans, New Orleans La 70112
PostGrad - Form 2 COLLEGE OF MEDICINE TULSA
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 AP30751473 (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

Sincerely,

Kenna Shaw

Kenna Shaw

Dept. of Licensing

Encl

Oklahoma State Board of Medical Licensure and Supervision
Application Summary

Type	Number	Name
MD	41700	REBECCA MICHELLE NUSS

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 TULSA
USMLE Exams Incomplete

Last Medical School Attended:
021-05 LSU Sch Of Med in New Orleans, New Orleans La 70112

Number of Licenses Previously Granted to Graduates of this Medical School:186

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** _____ 6-1-23

5) **REQUESTS SPECIFIC CONSIDERATION OF:**

_____

_____

_____

_____

_____

Oklahoma State Board of Medical Licensure and Supervision
Application Summary

Type	Number	Name
MD	41643	AMNA OBAID

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
OTHER DEFICIENCIES: NEED USMLE STEP 3 / QUESTIONNAIRE / $250 UPGRADE FEE / EVALUATION
Exam verification date

Last Medical School Attended:
048-17 Paul L Foster Sch of Med, TX Tech Univ, El Paso, TX

Number of Licenses Previously Granted to Graduates of this Medical School:24

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	41643	AMNA OBAID

MEDICAL DOCTOR

Practice Address:

May 03, 2023

Status:
Res: TR
Received: 04/27/2023
Entered: 04/27/2023
Temp Issued:
Temp Expires:
Train Issued: 07/01/2023
Train Expires: 09/30/2024
Fed Rec: 06/04/2024
AMA Rec: 06/04/2024
Board Action:
License #: 41643
Sex: F
Ethnic Origin: 6

Endorsed By: USMLE

	Test	Score	Date Taken	Date Verified	Attempts
Test 1:	USMLE 2	PASS	5/28/22	4/28/23	1
Test 2:	USMLE 1	PASS	7/9/20	4/28/23	1
Test 3:	Note: ***PASS*** means higher than 75				

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

PRE-MED EDUCATION

School Name: TULANE UNIVERSITY
City: NEW ORLEANS **State:** LA **Country:** UNITED STATES
Degree: M.S. BIOCHEMISTRY **From:** 7/2016 **To:** 5/ 2017 **Verified:**

School Name: UNIVERSITY OF TEXAS AT DALLAS
City: RICHARDSON **State:** TX **Country:** UNITED STATES
Degree: B.S. BIOLOGY **From:** 7/2012 **To:** 5/ 2016 **Verified:**

School Name: PLANO SENIOR HIGH SCHOOL
City: PLANO **State:** TX **Country:** UNITED STATES
Degree: HIGH SCHOOL DIPLOMA **From:** 8/2008 **To:** 5/ 2012 **Verified:**

MEDICAL SCHOOL EDUCATION

Name: Paul L Foster Sch of Med, TX Tech Univ, El Paso, TX
Foreign Name:
City: El Paso **State/Country:** United States of America
Degree: DOCTOR OF MEDIC **From:** 7 / 2018 **To:** 5 / 2023 **Diploma Ver'd:** Y

Oklahoma State Board of Medical Licensure and Supervision
Application Summary

Type	Number	Name
MD	41643	AMNA OBAID

MEDICAL DOCTOR

POST GRADUATE EDUCATION

Facility: COLLEGE OF MEDICINE TULSA **Specialty:** PEDIATRICS
Res. Fellowship: Residency
City: TULSA **State:** OK **Country:** UNITED STATES OF AM
Verified: **From:** 7 / 2023 **To:** /
ACGME Ver'd:
Comments:

PRACTICE HISTORY

Employed: NONE **Supervisor:**
City: PLANO **State:** TX **Country:** UNITED STATES
Specialty: LEAVE OF ABSENCE FROM MEDICAL SCHOOL **From:** 7 / 2021 **To:** 5 / 2022 **Verified:**
Comments: LEAVE OF ABSENCE FROM MEDICAL SCHOOL

Employed: NONE **Supervisor:**
City: PLANO **State:** TX **Country:** UNITED STATES
Specialty: UNEMPLOYED **From:** 4 / 2018 **To:** 6 / 2018 **Verified:**
Comments: AT HOME

Employed: NAVAZ JHA **Supervisor:**
City: MCKINNEY **State:** TX **Country:** UNITED STATES
Specialty: KUMON MATH AND READING CENTER ADMINISTRATIVE ASSIS **From:** 12 / 2017 **To:** 3 / 2018 **Verified:**
Comments: ADMINISTRATIVE ASSISTANT

Employed: NONE **Supervisor:**
City: PLANO **State:** TX **Country:** UNITED STATES
Specialty: UNEMPLOYED **From:** 6 / 2017 **To:** 11 / 2017 **Verified:**
Comments: AT HOME/TRAVEL

Employed: NONE **Supervisor:**
City: PLANO **State:** TX **Country:** UNITED STATES
Specialty: SUMMER VACATION **From:** 5 / 2016 **To:** 7 / 2016 **Verified:**
Comments: SUMMER VACATION

Employed: NONE **Supervisor:**
City: PLANO **State:** TX **Country:** UNITED STATES
Specialty: SUMMER VACATION **From:** 6 / 2015 **To:** 7 / 2015 **Verified:**
Comments: SUMMER VACATION

Employed: NONE **Supervisor:**
City: PLANO **State:** TX **Country:** UNITED STATES
Specialty: SUMMER VACATION **From:** 6 / 2014 **To:** 7 / 2014 **Verified:**
Comments: SUMMER VACATION

Employed: NONE **Supervisor:**
City: PLANO **State:** TX **Country:** UNITED STATES
Specialty: SUMMER VACATION **From:** 6 / 2013 **To:** 7 / 2013 **Verified:**
Comments: SUMMER VACATION

Oklahoma State Board of Medical Licensure and Supervision
Application Summary

Type	Number	Name
MD	41643	AMNA OBAID

MEDICAL DOCTOR

Other Licenses

State	Lic Type and Number	Status	Issued	Exp	Verif

DEFICIENCIES

PostGrad - Form 2 COLLEGE OF MEDICINE TULSA
USMLE Exams Incomplete
OTHER DEFICIENCIES: NEED USMLE STEP 3 / QUESTIONNAIRE / $250 UPGRADE FEE / EVALUATION
Exam verification date

Oklahoma State Board of Medical Licensure and Supervision

APPLICATION FOR OKLAHOMA MEDICAL DOCTOR LICENSE

Received:04/27/2023

Applicant Name: OBAID, AMNA [redacted] **MD 41643**

[redacted]

Date Of Birth: [redacted] **Place Of Birth (City, State):** VALHALLA, NY

Sex: F **Race:** Asian/Pacific Islander

Education

Type	Name	City	ST	Country	From	To	Degree	Comments	Veri
GD	TULANE UNIVERSITY	NEW ORLEAI	LA		7/2016	5/2017	M.S. BIOCHEMISTRY		
UG	UNIVERSITY OF TEXAS AT DALLAS	RICHARDSOI	TX		7/2012	5/2016	B.S. BIOLOGY		
HS	PLANO SENIOR HIGH SCHOOL	PLANO	TX		8/2008	5/2012	HIGH SCHOOL DIPLOMA		

Medical School Name	City	State	Country	Comments	From	To
Paul L Foster Sch of Med, TX Tech Univ, El Paso, TX	El Paso	TX	United States		7/2018	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
NONE	UNEMPLOYED		PLANO	TX		7/2021	5/2022	
NONE	UNEMPLOYED		PLANO	TX		4/2018	6/2018	
NAVAZ JHA	KUMON MATH AND READING CENTER		MCKINNEY	TX		12/2017	3/2018	
NONE	UNEMPLOYED		PLANO	TX		6/2017	11/2017	
NONE	SUMMER VACATION		PLANO	TX		5/2016	7/2016	
NONE	SUMMER VACATION		PLANO	TX		6/2015	7/2015	
NONE	SUMMER VACATION		PLANO	TX		6/2014	7/2014	
NONE	SUMMER VACATION		PLANO	TX		6/2013	7/2013	

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

Received:04/27/2023

Questions Answered 04/25/2023		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:04/27/2023

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-TU School of Community 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

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 26, 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.

RECEIVED

APR 27 2023

OKLAHOMA STATE BOARD OF MEDICAL LICENSURE AND SUPERVISION

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

Obaid, Amna

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

04/26/23

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

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 26th day of April 2023

Notary Public Signature S. H

My Notary Commission Expires 11/13/2025

NOTARY SEAL

T 411643 HS

US·MLE
United States
Medical
Licensing
Examination

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: 04/27/2023

Examinee: Obaid, Amna
Alt Name(s):

Examinee ID: 5-439-536-3
Date of Birth: [redacted]

Results for Steps taken by this examinee (and for which results have been reported to date) are shown below. For Steps that span more than one day, the test date reflects the day on which the examination began. 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
07/09/2020	Pass	204	(194)	

USMLE STEP 2

Clinical Knowledge (CK)

Test Date	Pass/Fail	Score	Minimum Pass	Comments
05/28/2022	Pass	233	(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.

Rev 2018

T 41643 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 Wiser Road, Euless, TX 76039-3856 - Telephone (817) 868-4000

Examinee: Obaid, Amna

Examinee ID: 5-439-536-3
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.

Attachment 6

Form 1 (MD)

RECEIVED
MAY 31 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
OKTRAINING@OKMEDICALBOARD.ORG

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

Applicant's Name Amna Obaid

Institution: Paul L Foster School of Medicine City/State El Paso, TX

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

From 07/09/2018 (Month Day Year) To 05/19/2023 (Month Day Year) and was awarded the degree M.D.

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: Starting June 2021 through May 2022, the student took a one year leave of absence for personal reasons after completing her third year of medical school. Personal reason, marital seperation.

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: Charmaine A. Martin, M.D. Signature Charmaine Martin

Title of Signatory: Interim Associate Dean Date of Signature 5.3.2023

Tel: 915-215-4010 Fax: — E-Mail: Charmaine.Martin@ttuhsc.edu

School Seal

If no seal is available, this form must be notarized

PRIMARY SOURCE

Notary Public _____

Commission # _____

My commission expires: _____

Notary Seal

T 41643 D

Texas Tech University Health Sciences Center El Paso

SSN: [redacted] Date of Birth: 19-AUG-1994

Date Issued: 30-MAY-2023
HSC ELP Graduate Prof Ofcl

Page: 1

Record of: Amna Obaid
Current Name: Amna Obaid
Issued To: OKLAHOMA STATE BOARD OF MEDICA
OKTRAINING@OKMEDICALBOARD.ORG

Course Level: Medicine

Current Program
Doctor of Medicine
Program : Medicine - El Paso
College : Paul L Foster SOM in El Paso
Campus : El Paso HSC
Major : Medicine

Awarded Degree Doctor of Medicine 19-MAY-2023
Primary Degree
Program : Medicine - El Paso
College : Paul L Foster SOM in El Paso
Campus : El Paso HSC
Major : Medicine

SUBJ	NO.	COURSE TITLE	CREDGRD	PTS	R	C
INSTITUTION CREDIT:						
Fall 2018 Medicine - El Paso						
PMAS	5101	Masters' Colloquim I	2.000	PA	.00	
PMSK	5301	Medical Skills I	2.000	PA	.00	
PSCI	5221	Soc. Comm & Individual I	8.000	PA	.00	
PSPM	5021	Scient Princ of Medicine I	14.00	PA	.00	

	AHRS	EHRS	QHRS	QPTS	GPA
Current	26.000	26.000	0.000	.00	.00
Cumulative	26.000	26.000	0.000	.00	.00

********** CONTINUED ON NEXT COLUMN **********

SUBJ	NO.	COURSE TITLE	CREDGRD	PTS	R	C
Institution Information continued:						
Spring 2019 Medicine - El Paso						
PMAS	5112	Masters Colloquium II	1.000	PA	.00	
PMSK	5302	Medical Skills II	2.000	PA	.00	
PSAP	5401	Scholarly Activity Project I	1.000	PA	.00	
PSCI	5212	Society Comm Individual II	2.000	PA	.00	
PSPM	5012	Scient Princ of Medicine II	12.00	PA	.00	

	AHRS	EHRS	QHRS	QPTS	GPA
Current	18.000	18.000	0.000	.00	.00
Cumulative	44.000	44.000	0.000	.00	.00

Fall 2019 Medicine - El Paso						
PMAS	6111	Masters Colloquium III	2.000	PA	.00	
PMSK	6311	Medical Skills III	2.000	PA	.00	
PSCI	6211	Society Comm Individual III	2.000	PA	.00	
PSPM	6011	Scient Princ of Medicine III	12.00	PA	.00	

	AHRS	EHRS	QHRS	QPTS	GPA
Current	18.000	18.000	0.000	.00	.00
Cumulative	62.000	62.000	0.000	.00	.00

********** CONTINUED ON PAGE 2 **********

Diana Andrade, Registrar

T41643
LLC

Texas Tech University Health Sciences Center El Paso

SSN: [redacted]

Date of Birth: 19-AUG-1994

Date Issued: 30-MAY-2023
HSC ELP Graduate Prof Ofcl

Record of: Amna Obaid
Level: Medicine

Institution Information continued:

SUBJ	NO.	COURSE TITLE	CREDGRD	PTS	R	C
Spring 2020 Medicine - El Paso						
PMAS	6112	Masters Colloquium IV	1.000	.00	PA	
PMSK	6302	Medical Skills IV	1.000	.00	PA	
PSCI	6212	Society Comm Individual IV	1.000	.00	PA	
PSPM	6022	Scient Princ of Medicine IV	4.000	.00	PA	

	AHRS	EHRS	QHRS	QPTS	GPA
Current	7.000	7.000	0.000	.00	.00
Cumulative	69.000	69.000	0.000	.00	.00

SUBJ	NO.	COURSE TITLE	CREDGRD	PTS	R	C
Fall 2020 Medicine - El Paso						
PFAM	7001	Family Medicine Clerkship	7.000	.00	PA	
PICE	7002	Clerkship Intersession	2.000	.00	PA	
PINT	7001	Internal Medicine Clerkship	10.00	.00	PA	
PPSY	7001	Psychiatry Clerkship	7.000	.00	PA	

	AHRS	EHRS	QHRS	QPTS	GPA
Current	26.000	26.000	0.000	.00	.00
Cumulative	95.000	95.000	0.000	.00	.00

SUBJ	NO.	COURSE TITLE	CREDGRD	PTS	R	C
Spring 2021 Medicine - El Paso						
POBG	7001	Ob/Gyn Clerkship	8.000	.00	PA	
PPED	7001	Pediatrics Clerkship	8.000	.00	PA	
PSUR	7001	Surgery Clerkship	10.00	.00	PA	

	AHRS	EHRS	QHRS	QPTS	GPA
Current	26.000	26.000	0.000	.00	.00
Cumulative	121.000	121.000	0.000	.00	.00

********** CONTINUED ON NEXT COLUMN **********

Institution Information continued:

SUBJ	NO.	COURSE TITLE	CREDGRD	PTS	R	C
Fall 2021 Medicine - El Paso						
Leave of Absence Effective 06/06/2021						
Spring 2022 Medicine - El Paso						
Leave of Absence Effective 06/06/2021						
Fall 2022 Medicine - El Paso						
PEDI	8100	Medical Educ Research	2.000	.00	PA	
PEME	8016	Pediatric Environmental Health	4.000	.00	HO	
PINT	8025	Nutrition Support Elective	2.000	.00	HO	
PNEU	8001	Clinical Neurosciences	4.000	.00	PA	
PPED	8001	Pediatric Subinternship	4.000	.00	HO	
PPED	8022	Care of Well Newborn (Nursery)	2.000	.00	HO	
PRAD	8010	Radiology Elective	4.000	.00	PA	
PSAP	6401	Scholarly Activity Project II	1.000	.00	PA	

	AHRS	EHRS	QHRS	QPTS	GPA
Current	23.000	23.000	0.000	.00	.00
Cumulative	144.000	144.000	0.000	.00	.00

SUBJ	NO.	COURSE TITLE	CREDGRD	PTS	R	C
Spring 2023 Medicine - El Paso						
PEME	8001	Emergency Medicine	4.000	.00	PA	
PFAM	8011	Family Med. Sr. Rotation	2.000	.00	PA	
PICE	8001	Bootcamp	2.000	.00	PA	
PPED	8003	NICU	4.000	.00	PA	
PSAP	7401	Scholarly Activity Project III	1.000	.00	PA	

********** CONTINUED ON PAGE 3 **********

Diana Andrade, Registrar

Texas Tech University Health Sciences Center El Paso

SSN: [redacted]

Date of Birth: 19-AUG-1994

Date Issued: 30-MAY-2023
HSC ELP Graduate Prof Ofcl

Record of: Amna Obaid
Level: Medicine

SUBJ	NO.	COURSE TITLE	CREDGRD	PTS	R	C

Institution Information continued:

	AHRS	EHRS	QHRS	QPTS	GPA
Current	13.000	13.000	0.000	.00	.00
Cumulative	157.000	157.000	0.000	.00	.00

********** TRANSCRIPT TOTALS **********

INSTITUTION	Ehrs:	157.000	QPts:	0.00
	GPA-Hrs:	0.000	GPA:	0.00
TRANSFER	Ehrs:	0.000	QPts:	0.00
	GPA-Hrs:	0.000	GPA:	0.00
OVERALL	Ehrs:	157.000	QPts:	0.00
	GPA-Hrs:	0.000	GPA:	0.00

********** END OF TRANSCRIPT **********

Diana Andrade, Registrar

TEXAS TECH UNIVERSITY HEALTH SCIENCES CENTER EL PASO

Office of the Registrar – 5001 El Paso Drive – El Paso, TX 79905 - 915-215-4370 – Fax 915-783-5145

Official Transcripts: The officially sealed and signed transcript is printed on secured paper and does not require a raised seal. Transcripts issued directly to students are stamped "Issued to Student."

Confidentiality of Records: This transcript must not be released to a third party without the written authorization of the student (in accordance with the Family Educational Rights and Privacy Act of 1974, Federal Law 93-380).

Accreditation: Texas Tech University Health Sciences Center El Paso is accredited by Southern Association of Colleges and Schools Commission on Colleges to award baccalaureate, master's, doctoral, and professional degrees. Contact Southern Association of Colleges and Schools Commission on Colleges at 1866 Southern Lane, Decatur, GA 30033-4097 or call 404-679-4500 for questions about the accreditation of Texas Tech University Health Sciences Center El Paso. Individual school programs are accredited by appropriate professional organizations. Information about school level accreditation is located in the corresponding school catalog.

Course Numbers: TTUHSC El Paso uses a 4-digit course numbering system. The first digit indicates the general level of the course. The second digit specifies the number of semester credit hours (a 0 indicated a variable credit course) for all schools but the Paul L. Foster School of Medicine.

Grade Point Average (GPA): Grade point average is computed by multiplying the credit hours for each course attempted by the grade points earned in the particular course and then dividing the total grade points by the total number of credit hours attempted, excluding those hours for which non-computed grades are recorded (see grade point tables). Abbreviations: AHRS = Attempted Hours, EHRS = Earned Hours, QHRS = Quality Hours (included in GPA), QPTS = Quality Points (included in GPA).

Grading System Used in Common by All Schools

Grade	*Description*	*Grade Points Per Semester Hour*
CR	Credit	NA*
DE	Deferred**	NA*
DG	Dropped (drop limit)	NA*
DW	Drop with no limit	NA*
DX	Drop – state limit exception	NA*
HO	Honors	NA*
I	Incomplete**	NA*
NC	No credit	0.00
NR	Grade not returned	NA*
PR	In progress**	NA*
RP	Repeat	NA*
W	Withdrawal	NA*
WF	Withdraw failing	0.00
X	Grade not submitted**	NA*

*Not included in GPA calculation
**Temporary grade

Graduate School of Biomedical Sciences Grading System

Grade	*Description*	*Grade Points Per Semester Hour*
A	Well above passing standard	4.0
B	Above the passing standard	3.0
C	Passing standard	2.0
D	Below the passing standard	1.0
F	Well below the passing standard	0.0

School of Nursing Grading System

Grade	*Description*	*Grade Points Per Semester Hour*
A	Well above passing standard	4.0
B	Above the passing standard	3.0
C	Passing standard	2.0
D	Below the passing standard	1.0
F	Well below the passing standard	0.0

School of Medicine Grading System

Credit Units: The unit of measure of the valuation of courses is the medical school credit unit and should not be confused with traditional credit hours. One unit in the pre-clerkship phase is equal to 20 contact hours and one unit in the clerkship phase is equal to one week of clinical contact experience

Grading Convention: Pass/Fail (PA/FA) grading is used in the pre-clerkship phase of the M.D. program. Honors/Pass/Fail (HO/PA/FA) is used only in the clerkship phase of the M.D. program.

Grade	*Description*	*Grade Points Per Semester Hour*
FA	Below the passing standard	NA
HO	Well above the passing standard	NA
PA	Meets the passing standard	NA
FA/PA	Initial fail – remediation pass	NA

AMA Physician Profile

PREPARED FOR

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

Name and Mailing Address

AMNA OBAID

[redacted]

Primary Office Address

Phone [redacted]

Birth date [redacted]

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: PAUL L FOSTER SCHOOL OF MEDICINE TEXAS TECH UNIVERSITY HEALTH SCIENCES CTR

Degree Awarded:	YES	**Degree Type:**	MD
Enrollment Date:	07/2018	**Degree Date:**	05/2023

TH1643

AMA
AMERICAN MEDICAL ASSOCIATION

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

NO DATA REPORTED AT THIS TIME

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

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
APR 27 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: Amna Obaid
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 Amna Obaid Date 04/26/23

Subscribed and sworn before me this 26th day of April, 2023.

Notary Public S. VA

Commission Number 131349192

My commission expires 11/13/2025

NOTARY SEAL

NEERAJA SANNIDHANAM
Notary Public, State of Texas
Comm. Expires 11-13-2025
Notary ID 131349192

T 41643 #5

ATTACHMENT 5

TIME DEFICIENCY FORM

Name:	Amna Obaid	Application #	First Year Post-Grad Training

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	08	05	12	Plano Senior High School	Plano	TX	HS Diploma
07	12	05	16	Univ of Texas at Dallas	Richardson	TX	BS
07	16	05	17	Tulane University	New Orleans	LA	MS
07	18	05	23	Paul L Foster Sch TTUHSC	El Paso	TX	MD

EMPLOYMENT IF NEEDED TO FILL TIME GAP

Start Month	Start Year	End Month	End Year	Name of Employer	City	State	Job Title
12	17	03	18	Never Jhaw	Mckinney	TX	Admin Assistant

OTHER - UNEMPLOYED, STAY AT HOME PARENT, SUMMER BREAK, TRAVELING

Start Month	Start Year	End Month	End Year	Other	City	State
06	13	07	13	Summer Break	Plano	TX
06	14	07	14	Summer Break	Plano	TX
06	15	07	15	Summer Break	Plano	TX
05	16	07	16	Summer Break	Plano	TX
06	17	11	17	Unemployed	Plano	TX
04	18	04	18	Unemployed	Plano	TX
07	21	05	22	Leave of Absence	Plano	TX

RECEIVED
APR 27 2023
OKLAHOMA STATE BOARD OF MEDICAL LICENSURE AND SUPERVISION

T 41643 HS

05/10/2023

AMNA OBAID
[redacted]

Check Your Application Status Online at:
http://www.okmedicalboard.org
***Username*:AP85825796**
***Password*:Last 4 SSN**

RE: MD Application #41643

Dear AMNA OBAID,

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

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

Application Instructions
Extended Background Check
OTHER DEFICIENCIES: WHY DID YOU TAKE 1 YEAR LEAVE FROM MED SCHOOL? RECEIVED FORM 1 FROM MED SCHOOL PRIOR TO GRADUATION - PLEASE HAVE SCHOOL RESEND AFTER GRADUATION /
Exam verification date
MedSchool-Transcript Paul L Foster Sch of Med, TX Tech Univ, El Paso, TX
MedSchool-Form 1 Paul L Foster Sch of Med, TX Tech Univ, El Paso, TX
PostGrad - Form 2 COLLEGE OF MEDICINE TULSA
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 AP85825796 (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

Sincerely,

Seema Jayachand

Seema Jayachand

Dept. of Licensing

Encl

Oklahoma State Board of Medical Licensure and Supervision
Application Summary

Type	Number	Name
MD	41643	AMNA OBAID

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 TULSA
USMLE Exams Incomplete

Last Medical School Attended:
048-17 Paul L Foster Sch of Med, TX Tech Univ, El Paso, TX

Number of Licenses Previously Granted to Graduates of this Medical School:21

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** MLV 6.6.23

5) **REQUESTS SPECIFIC CONSIDERATION OF:**

_____

_____

_____

_____

_____

Oklahoma State Board of Medical Licensure and Supervision
Application Summary

Type	Number	Name
MD	41576	EMILY MARIE OGG

MEDICAL DOCTOR

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

OTHER DEFICIENCIES: NEED QUESTIONNAIRE / EVALUATION
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:52

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	41576	EMILY MARIE OGG

MEDICAL DOCTOR

Practice Address:

May 03, 2023

Status:
Res: MD
Received: 04/20/2023
Entered: 04/20/2023
Temp Issued:
Temp Expires:
Train Issued: 07/01/2023
Train Expires: 09/30/2024
Fed Rec: 05/09/2024
AMA Rec: 05/09/2024
Board Action:
License #: 41576
Sex: F
Ethnic Origin: 1

Endorsed By: USMLE

	Test	Score	Date Taken	Date Verified	Attempts
Test 1:	USMLE 1	PASS	06/04/21	4/20/23	1
Test 2:	USMLE 2	PASS	07/29/22	4/20/23	1
Test 3:	USMLE 3	PASS	08/30/23	4/1/24	1

Note: ***PASS*** means higher than 75

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

PRE-MED EDUCATION

School Name: OKLAHOMA STATE UNIVERSITY
City: STILLWATER **State:** OK **Country:** UNITED STATES
Degree: BACHELOR OF SCIENCE IN MICROBIOLOGY AND MOLECULAR GENETICS AND PSYCHOLOGY **From:** 8/2015 **To:** 5/ 2019 **Verified:**

School Name: PRYOR HIGH SCHOOL
City: PRYOR **State:** OK **Country:** UNITED STATES
Degree: **From:** 4/2015 **To:** 5/ 2015 **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

Oklahoma State Board of Medical Licensure and Supervision
Application Summary

Type	Number	Name
MD	41576	EMILY MARIE OGG

MEDICAL DOCTOR

POST GRADUATE EDUCATION

Facility: COLLEGE OF MEDICINE TULSA **Specialty:** PEDIATRICS
Res. Fellowship: Residency
City: TULSA **State:** OK **Country:** UNITED STATES OF AM
Verified: **From:** 7 / 2023 **To:** /
ACGME Ver'd:
Comments:

PRACTICE HISTORY

Employed: **Supervisor:**
City: **State:** **Country:**
Specialty: **From:** / **To:** / **Verified:**
Comments:

Other Licenses

State	Lic Type and Number	Status	Issued	Exp	Verif

DEFICIENCIES

OTHER DEFICIENCIES: NEED QUESTIONNAIRE / EVALUATION
PostGrad - Form 2 COLLEGE OF MEDICINE TULSA

Oklahoma State Board of Medical Licensure and Supervision

APPLICATION FOR OKLAHOMA MEDICAL DOCTOR LICENSE

Received:04/20/2023

Applicant Name: OGG, EMILY MARIE "Gietzen" [redacted] **MD 41576**

[redacted]

Date Of Birth: [redacted] **Place Of Birth (City, State):** TULSA, OK

Sex: F **Race:** Caucasian

Education

Type	Name	City	ST	Country	From	To	Degree	Comments	Veri
UG	OKLAHOMA STATE UNIVERSITY	STILLWATER	OK		8/2015	5/2019	BACHELOR OF SCIENCE IN MICROBIOLOGY AND MOLECULAR GENETICS AND PSYCHOLOGY		
HS	PRYOR HIGH SCHOOL	PRYOR	OK		4/2015	5/2015			

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
COLLEGE OF MEDICINE TULSA	TULSA	OK	UNITED S	PEDIATRICS		7/2023	/

Practice History

Employer	Specialty	Supervisor	City	ST	Countr	From	To	Verif
						/		

Other/ Out-Of-State Licenses

State	License #	Profession	Status	Issue Date	Exp Date

MD Exam

Exam	State	Score	Date Taken	#
USMLE				

$250✓

Oklahoma State Board of Medical Licensure and Supervision

APPLICATION FOR OKLAHOMA MEDICAL DOCTOR LICENSE

Received:04/20/2023

Questions Answered 04/06/2023		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:04/20/2023

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

Will be provided by 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, 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.

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

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

05/09/23
Date of signature (must correspond to the date of notarization)

RECEIVED
MAY 10 2023
OKLAHOMA STATE BOARD OF MEDICAL LICENSURE AND SUPERVISION

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 9 day of May, 2023

Notary Public Signature Allison Ervin My Notary Commission Expires 12/18/23

ALLISON ERVIN NOTARY PUBLIC STATE OF OKLAHOMA #19014711 EXP. 12/18/23 NOTARY SEAL

T41576

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: 03/30/2024

Examinee: Ogg, Emily Marie
Alt Name(s): Gietzen, Emily Marie

Examinee ID: 5-476-357-8
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
06/04/2021	Pass	203	(194)	

USMLE STEP 2

Clinical Knowledge (CK)

Test Date	Pass/Fail	Score	Minimum Pass	Comments
07/29/2022	Pass	225	(214)	

USMLE STEP 3

Test Date	Pass/Fail	Score	Minimum Pass	Comments
08/30/2023	Pass	217	(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.

Rev 2018

T4576 SD

US·MLE
United States
Medical
Licensing
Examination

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: Ogg, Emily Marie

Examinee ID: 5-476-357-8
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.

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 Emily Ogg

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 (Month Day Year) To 05 / 19 / 2023 (Month Day Year) 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.	☐ 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

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

T41576
SJ

The Oklahoma State Regents for Higher Education

acting through

The University of Oklahoma

have admitted

Emily Marie Ogg

to the degree of

Doctor of Medicine

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

Chairman

Secretary

Chancellor

For the University

Chairman, Board of Regents

President of the University

Academic Dean

OKLAHOMA STATE REGENTS FOR HIGHER EDUCATION
VITA ABUNDANTIOR
1941

ALVMNVS CIVI ET REIPUBLICAE

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

Name : Emily Ogg
Student ID: 1798976
Birthdate : [redacted]

CS 9151

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

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

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

Oklahoma St Univ-Stillwater
2019-05-11 Bachelor of Science
Field of Study : Microbio/Cell & Molecular Bio

----- 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

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 :			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

Lori Klein
OUHSC Registrar

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

Name : Emily Ogg
Student ID: 1798976
Birthdate : [redacted]

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	
PSBS	9520	Psychiatry Clerkshp	226.00	226.00	B	678.000
DERM	9101	Dermatology Selective	80.00	80.00	S	
TERM GPA :	3.000	GPH: 226.00	TOTALS :	530.00	530.00	678.000
OUHSC GPA :	3.000	GPH: 226.00	TOTALS :	2068.50	2068.50	678.000

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 :	3.363	GPH: 822.00	TOTALS :	2664.50	2664.50	2764.000

Spring 2022

Course		Description	Attempted	Earned	Grade	Points
OBGY	9210	Obstet & Gyn Clerkship	226.00	226.00	A	904.000
PATH	9101	Pathology and Lab Med	80.00	80.00	S	
NEUR	9370	Neurology Clerkship	155.00	155.00	A	620.000
FM	9540	Fam Med Clerkship	155.00	155.00	A	620.000
EM	9101	EM Selective	80.00	80.00	S	
PEDI	9650	Pediatric Clerkship	226.00	226.00	A	904.000
TERM GPA :	4.000	GPH: 762.00	TOTALS :	922.00	922.00	3048.000
OUHSC GPA :	3.669	GPH: 1584.00	TOTALS :	3586.50	3586.50	5812.000

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 :	3.669	GPH: 1584.00	TOTALS :	3906.50	3906.50	5812.000

Fall 2022

Course		Description	Attempted	Earned	Grade	Points
INDT	9401	Outpatient Elective	160.00	160.00	S	
		Course Topic(s): PEDI Outpatient Elective				
INDT	9400	Inpatient Elective	160.00	160.00	S	
		Course Topic(s): PEDI Inpatient Elective				
INDT	9404	Research/Scholarship Elective	160.00	160.00	S	
		Course Topic(s): PEDI Res/Scholarship Elective				
INDT	9403	Subinternship Elective	80.00	80.00	A	320.000
		Course Topic(s): PEDI Subinternship Elective				
TERM GPA :	4.000	GPH: 80.00	TOTALS :	560.00	560.00	320.000
OUHSC GPA :	3.685	GPH: 1664.00	TOTALS :	4466.50	4466.50	6132.000

Spring 2023

Course		Description	Attempted	Earned	Grade	Points
FM	9569	CH I	80.00	80.00	S	
INDT	9406	Special Studies Elective	80.00	80.00	S	
		Course Topic(s): PEDI Special Studies Elective				
INDT	9400	Inpatient Elective	160.00	160.00	S	
		Course Topic(s): PEDI Inpatient Elective				
INDT	9406	Special Studies Elective	80.00	80.00	S	
		Course Topic(s): PEDI Special Studies Elective				
INDT	9406	Special Studies Elective	80.00	80.00	S	
		Course Topic(s): PEDI Special Studies Elective				
INDT	9406	Special Studies Elective	80.00	80.00	S	
		Course Topic(s): PEDI Special Studies Elective				

Lori Klein
OUHSC Registrar

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

Name : Emily Ogg
Student ID: 1798976
Birthdate : [redacted]

Spring 2023 (cont.)

Course	Description	Attempted	Earned	Grade	Points
FM 9572	CH II	80.00	80.00	S	

TERM GPA : 0.000 GPH: 0.00 TOTALS : 640.00 640.00 0.000

OUHSC GPA : 3.685 GPH: 1664.00 TOTALS : 5106.50 5106.50 6132.000

Medicine Career Totals

OUHSC GPA : 3.685 GPH: 1664.00 TOTALS : 5106.50 5106.50 6132.000

Post-Baccalaureate Career Totals

OUHSC GPA : 3.685 GPH: 104.00 TOTALS : 319.15 319.15 383.250

- - - - - End Of Career (1 of 1) - - - - -
- - - - - End Of Transcript - - - - -

Lori Klein
OUHSC Registrar

AMA Physician Profile

PREPARED FOR

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

Name and Mailing Address

EMILY MARIE GIETZEN

[redacted]

Primary Office Address

Phone UNKNOWN

Birth date [redacted]

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

T41576 51

AMA
AMERICAN MEDICAL ASSOCIATION

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:	PEDIATRICS
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.

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: Emily Marie Ogg Gietzen (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 Emily Marie Ogg Date 05/09/23

Subscribed and sworn before me this 9 day of May, 20 23.

Notary Public Allison Ervin Allison Ervin

Commission Number 19012563

My commission expires 12/18/23

ALLISON ERVIN NOTARY # 19012563 EXP. 12/18/23 PUBLIC STATE OF OKLAHOMA

NOTARY SEAL

RECEIVED
MAY 10 2023
OKLAHOMA STATE BOARD OF MEDICAL LICENSURE AND SUPERVISION

T 4/15/76 WS

OKLAHOMA STATE BOARD OF MEDICAL LICENSURE AND SUPERVISION
101 NE 51ST 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

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.

Emily Marie Ogg — Name of Applicant (type or print)
Emily Marie Ogg — Signature of Applicant
05/09/23 — 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
MAY 10 2023
OKLAHOMA STATE BOARD OF MEDICAL LICENSURE AND SUPERVISION

T 41576 WB

TIME DEFICIENCY FORM

Name:	Emily Marie Ogg	Application #	41576

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
04	2015	05	2015	Pryor High School	Pryor	OK	High School Diploma
08	2015	05	2019	Oklahoma State University	Stillwater	OK	BS of Microbiology + Molecular Genetics Psychology
08	2019	05	2023	OU-TU School of Community Medicine	Tulsa	OK	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
05	2015	08	2015	Summer Break	Pryor	OK
05	2019	08	2019	Summer Break	Pryor	OK

RECEIVED
MAY 10 2023
OKLAHOMA STATE BOARD OF MEDICAL LICENSURE AND SUPERVISION

T41576
VB

05/03/2023

EMILY MARIE OGG
[redacted]

RE: MD Application #41576

Check Your Application Status Online at:
http://www.okmedicalboard.org
***Username*:AP17997370**
***Password*:Last 4 SSN**

Dear EMILY OGG,

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

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

Evidence of Status
Application Instructions
OATH
Extended Background Check
OTHER DEFICIENCIES: COPY OF LEGAL NAME CHANGE DOCUMENT REQUIRED
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

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 AP17997370 (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

Sincerely,

Seema Jayachand

Seema Jayachand

Dept. of Licensing

Encl

Kenna L. Shaw

From: BillPay Webmaster <donotreply@www.ok.gov>
Sent: Saturday, March 23, 2024 1:25 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

EMILY MARIE OGG has paid for a LICENSE - MD Training-to-Full License Fee 250.00
on 03/23/2024 01:03:25am for $250.00.
OKLAHOMA MD LICENSE NUMBER 41576
To view all transactions please go to http://www.ok.gov/triton/ and
login to your CMS account.

T41576

Oklahoma State Board of Medical Licensure and Supervision
Application Summary

Type	Number	Name
MD	41576	EMILY MARIE OGG

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 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: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 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** MH 6-20-23

5) **REQUESTS SPECIFIC CONSIDERATION OF:**

_____

_____

_____

_____

_____

Oklahoma State Board of Medical Licensure and Supervision
Application Summary

Type	Number	Name
MD	41680	KWAME KUSI OPOKU

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:

048-15 Tx Tech Univ Hlth Sci Ctr Sch Of Med, Lubbock Tx 79430

Number of Licenses Previously Granted to Graduates of this Medical School:352

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	41680	KWAME KUSI OPOKU

MEDICAL DOCTOR

Practice Address:

May 03, 2023

,

Status:
Res: TR
Received: 05/01/2023
Entered: 05/01/2023
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 #: 41680
Sex: M
Ethnic Origin: 2

Endorsed By: USMLE

	Test	Score	Date Taken	Date Verified	Attempts
Test 1:	USMLE 3	PASS	12/11/23	5/1/24	1
Test 2:	USMLE 1	PASS	6/29/21	5/2/23	1
Test 3:	USMLE 2	PASS	7/25/22	5/2/23	1

Note: ***PASS*** means higher than 75

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

PRE-MED EDUCATION

School Name: TEXAS TECH UNIVERSITY
City: LUBBOCK **State:** TX **Country:** UNITED STATES
Degree: BACHELOR OF SCIENCE **From:** 8/2015 **To:** 5/2019 **Verified:**

School Name: JAMES E. TAYLOR HIGH SCHOOL
City: KATY **State:** TX **Country:** UNITED STATES
Degree: HIGH SCHOOL DIPLOMA **From:** 8/2013 **To:** 6/2015 **Verified:**

MEDICAL SCHOOL EDUCATION

Name: Tx Tech Univ Hlth Sci Ctr Sch Of Med, Lubbock Tx 79430
Foreign Name:
City: Lubbock **State/Country:** United States of America
Degree: DOCTORATE OF MEI **From:** 8 / 2019 **To:** 5 / 2023 **Diploma Ver'd:** Y

Oklahoma State Board of Medical Licensure and Supervision
Application Summary

Type	Number	Name
MD	41680	KWAME KUSI OPOKU

MEDICAL DOCTOR

POST GRADUATE EDUCATION

Facility: COLLEGE OF MEDICINE OKC **Specialty:** ANESTHESIOLOGY

Res. Fellowship: Residency

City: OKLAHOMA CITY **State:** OK **Country:** UNITED STATES OF AMER

Verified: **From:** 7 / 2023 **To:** /

ACGME Ver'd:

Comments:

PRACTICE HISTORY

Employed: **Supervisor:**

City: **State:** **Country:**

Specialty: **From:** / **To:** / **Verified:**

Comments:

Other Licenses

State	Lic Type and Number	Status	Issued	Exp	Verif

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

RECEIVED
MAY 01 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	Kwame	**LAST NAME**	Opoku
EMAIL ADDRESS	[redacted]		
LICENSE NUMBER	41680	**CELL PHONE**	[redacted]
HOME ADDRESS	[redacted]	**CITY/STATE ZIP CODE**	
PROGRAM ATTENDING	Pramod Chetty, MD	**SPECIALTY**	Anesthesiology

DOCUMENTATION TO ATTACH

PAYMENT COMPLETED			
☐	$150 payment made on Billpay for **RENEWAL** of training license	☑	$250 payment made on Billpay for **UPGRADE** of training license

DOCUMENTATION REQUIRED			
☐	Form 2 (must be received directly from program) ****ONLY FOR UPGRADE** - ATTACHMENT 3	☐	Evaluation (must be received directly from program) - ATTACHMENT 4
☐	USMLE Step 3 (must be received directly from USMLE)	☐	Answer confidential questions (on back of this form)

FOREIGN TRAINED STUDENTS			
☐	Current visa	☐	Social Security Number **if not provided at initial application
☐	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.

T41680 CS

NAME Kwame Opoku

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)?	☐	☑
Have you been the subject of investigation or disciplinary action (including probation) by a hospital or training program?	☐	☑
Have you had any adverse judgment or settlement against you rising from a professional liability claim?	☐	☑
Have you been reported to the National Practitioner Data Bank (NPDB)?	☐	☑
Have you ever been denied, had removed, or suspended hospital privileges?	☐	☑
Have you surrendered hospital privileges while under investigation or to avoid investigation?	☐	☑
Have you entered into an Agreement with a Federal, State, or Local jurisdictional body to avoid formal action?	☐	☑
Has your application for licensure ever been denied?	☐	☑
Have you surrendered a license or had any disciplinary action taken on any license?	☐	☑
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)?	☐	☑
Have you obtained an assessment or been treated for use of any drug or chemical substance including alcohol?	☐	☑
Have you been arrested for, charged with, or convicted of a felony or misdemeanor other than a traffic violation?	☐	☑
Have you been arrested for, charged with, or convicted of a traffic violation involving the use of any drug or chemical substance?	☐	☑
Have you been addicted to or abused any drug or chemical substance including alcohol?	☐	☑
Have you been denied provider participation, terminated, sanctioned or penalized by any third-party payor including TRICARE, MEDICARE, or MEDICAID?	☐	☑
Have you surrendered or had any adverse action taken against any narcotic permit (State or Federal)?	☐	☑

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 4/29/2024

Oklahoma State Board of Medical Licensure and Supervision

APPLICATION FOR OKLAHOMA MEDICAL DOCTOR LICENSE

Received: 05/01/2023

Applicant Name: OPOKU, KWAME KUSI [redacted] **MD 41680**

[redacted]

Date Of Birth: [redacted] **Place Of Birth (City, State):** BURLINGTON, IA

Sex: M **Race:** Black

Education

Type	Name	City	ST	Country	From	To	Degree	Comments	Veri
UG	TEXAS TECH UNIVERSITY	LUBBOCK	TX		8/2015	5/2019	BACHELOR OF SCIENCE		
HS	JAMES E. TAYLOR HIGH SCHOOL	KATY	TX		8/2013	6/2015	HIGH SCHOOL DIPLOMA		

Medical School Name	City	State	Country	Comments	From	To
Tx Tech Univ Hlth Sci Ctr Sch Of Med, Lubbock Tx 79430	Lubbock	TX	United States		7/2019	5/2023

Post-Graduate

Facility	City	St	Country	Specialty	Comments	From	To
COLLEGE OF MEDICINE OKC	OKLAHOMA CITY	OK	UNITED S	ANESTHESIOLOGY		7/2023	/

Practice History

Employer	Specialty	Supervisor	City	ST	Countr	From	To	Verif
						/		

Other/ Out-Of-State Licenses

State	License #	Profession	Status	Issue Date	Exp Date

MD Exam

Exam	State	Score	Date Taken	#
USMLE				

$250

53

Oklahoma State Board of Medical Licensure and Supervision

APPLICATION FOR OKLAHOMA MEDICAL DOCTOR LICENSE

Received:05/01/2023

Questions Answered 04/29/2023		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:05/01/2023

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 Sciences Center

If so, Please identify with which category:

Residency

Name of Previous Carrier and Policy Holder

Texas Tech University Health Sciences Center School of Medicine in Lubbock, TX

Name of Current Carrier and policy Holder

APIC

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 30, 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.

RECEIVED

MAY 0 1 2023

OKLAHOMA STATE BOARD OF MEDICAL LICENSURE AND SUPERVISION

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

Opoku, Kwame, K

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

04/21/2023

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 21 day of April, 2023

Notary Public Signature Deborah K. Stuart My Notary Commission Expires Dec 5, 2024

DEBORAH K. STUART NOTARY PUBLIC STATE OF OKLAHOMA NOTARY SEAL 16016909 EXP. 12/05/24

T 41680 #5

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: 05/01/2024

Examinee: Opoku, Kwame Kusi
Alt Name(s):

Examinee ID: 5-472-304-4
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
06/29/2021	Pass	219	(194)	

USMLE STEP 2

Clinical Knowledge (CK)

Test Date	Pass/Fail	Score	Minimum Pass	Comments
07/25/2022	Pass	229	(214)	

USMLE STEP 3

Test Date	Pass/Fail	Score	Minimum Pass	Comments
12/11/2023	Pass	215	(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.

Rev 2018

T41680 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: Opoku, Kwame Kusi

Examinee ID: 5-472-304-4
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.

Attachment 6

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: Kwame Kusi Opoku

Institution: Texas Tech University Health Sciences Center School of Medicine City/State: Lubbock, TX

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

From 08 / 05 / 2019 (Month / Day / Year) To 05 / 19 / 2023 (Month / Day / Year) and was awarded the degree Doctorate of Medicine

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: Kristin Stutz Signature: Kristin A. Stutz

Title of Signatory: Assistant Regional Dean for Medical Education Date of Signature: 06/15/2023

Tel: (806) 414-9666 Fax: (806) 351-3787 E-Mail: kristin.stutz@ttuhsc.edu

School Seal

If no seal is available, this form must be notarized

Notary Public

Commission #

My commission expires:

Notary Seal

RECEIVED
JUN 20 2023
OKLAHOMA STATE BOARD OF MEDICAL LICENSURE AND SUPERVISION

PRIMARY SOURCE

T 41680 VB

Texas Tech University Health Sciences Center

Office of the Registrar, Lubbock, Texas 79430

SSN: [redacted]

Date of Birth: [redacted]

Date Issued: 14-JUN-2023
HSC Graduate Professional Ofcl

Page: 1

Record of: Kwame Kusi Opoku
Current Name: Kwame Kusi Opoku
Issued To: ~~OKLAHOMA~~ STATE BOARD OF MEDICA
OKTRAINING@OKMEDICALBOARD.ORG

Course Level: Medicine

Current Program
Doctor of Medicine
Program : Medicine
College : School of Medicine
Campus : Amarillo HSC
Major : Medicine

Comments:
Interprofessional(IPE) Rqmnt Complete:

Awarded Degree Doctor of Medicine 19-MAY-2023
Primary Degree
Program : Medicine
College : School of Medicine
Campus : Amarillo HSC
Major : Medicine

SUBJ	NO.	COURSE TITLE	CREDGRD		PTS	R	C
INSTITUTION CREDIT:							
Fall 2019 Lubbock Medicine							
IPMD	5101	Interprof Collab Practice	0.000	PA	.000		
MSCI	5101	Clinically Oriented Anatomy	9.000	PA	.000		
MSCI	5102	Biology of Cells and Tissues	6.000	PA	.000		
MSCI	5106	P3/DOCS 1	3.000	CR	.000		

	AHRS	EHRS	QHRS	QPTS	GPA
Current	18.000	18.000	0.000	.000	.000
Cumulative	18.000	18.000	0.000	.000	.000

********** CONTINUED ON NEXT COLUMN **********

SUBJ	NO.	COURSE TITLE	CREDGRD		PTS	R	C
Institution Information continued:							
Spring 2020 Lubbock Medicine							
MSCI	5103	Structure & Funct Maj Organ Sy	6.000	HP	.000		
MSCI	5106	P3/DOCS 1	3.000	HO	.000		
MSCI	5107	Gen Prin & Infectious Diseases	8.000	PA	.000		

	AHRS	EHRS	QHRS	QPTS	GPA
Current	17.000	17.000	0.000	.000	.000
Cumulative	35.000	35.000	0.000	.000	.000

Fall 2020 Lubbock Medicine							
MSCI	6106	Basic Medical Spanish	0.000	PA	.000		
MSCI	6108	Integrated Neurosciences	9.000	PA	.000		
MSCI	6109	P3/DOCS 2	2.000	CR	.000		
MSCI	6110	Multi-Sys Disorders	6.000	PA	.000		

	AHRS	EHRS	QHRS	QPTS	GPA
Current	17.000	17.000	0.000	.000	.000
Cumulative	52.000	52.000	0.000	.000	.000

Spring 2021 Lubbock Medicine							
MSCI	6106	Basic Medical Spanish	0.000	PA	.000		
MSCI	6109	P3/DOCS 2	2.000	HO	.000		
MSCI	6111	Step 1 Enhancement	3.000	PA	.000		
MSCI	6112	System Disorders	12.00	PA	.000		

	AHRS	EHRS	QHRS	QPTS	GPA
Current	17.000	17.000	0.000	.000	.000
Cumulative	69.000	69.000	0.000	.000	.000

********** CONTINUED ON PAGE 2 **********

Amanda McSween

Amanda McSween, Registrar

Texas Tech University Health Sciences Center

Office of the Registrar, Lubbock, Texas 79430

SSN: [redacted] Date of Birth: [redacted]

Date Issued: 14-JUN-2023
HSC Graduate Professional Ofcl

Page: 2

Record of: Kwame Kusi Opoku
Level: Medicine

SUBJ	NO.	COURSE TITLE	CREDGRD	PTS	R	C
Institution Information continued:						
Fall 2021 Lubbock Medicine						
MINT	7101	Internal Medicine Jr. Clerkshi	8.000	PA	.000	
MOBG	7101	OB/GYN JR Clerkship	8.000	PA	.000	
MPSY	7101	Psychiatry JR Clerkship	8.000	HP	.000	

	AHRS	EHRS	QHRS	QPTS	GPA
Current	24.000	24.000	0.000	.000	.000
Cumulative	93.000	93.000	0.000	.000	.000

Spring 2022 Lubbock Medicine						
MFAM	7101	Family Medicine Jr. Clerkship	8.000	HP	.000	
MPED	7101	Pediatric JR Clerkship	8.000	HP	.000	
MSCI	7102	Integration Seminar-SGR	0.000	PA	.000	
MSUR	7101	General Surgery JR Clerkship	8.000	HP	.000	

	AHRS	EHRS	QHRS	QPTS	GPA
Current	24.000	24.000	0.000	.000	.000
Cumulative	117.000	117.000	0.000	.000	.000

Fall 2022 Lubbock Medicine						
MANE	8401	Anesthesiology Elective	4.000	PA	.000	
MANE	8401	Anesthesiology Elective	4.000	PA	.000	
MINT	8102	Internal Med Ambulatory Rotati	2.000	PA	.000	
MINT	8201	MICU/CCU Elective	2.000	PA	.000	
MINT	8404	Gastroenterology Elective	2.000	PA	.000	

********** CONTINUED ON NEXT COLUMN **********

SUBJ	NO.	COURSE TITLE	CREDGRD	PTS	R	C
Institution Information continued:						

	AHRS	EHRS	QHRS	QPTS	GPA
Current	14.000	14.000	0.000	.000	.000
Cumulative	131.000	131.000	0.000	.000	.000

Spring 2023 Lubbock Medicine						
MIDS	8403	Clinical Research Elective	4.000	PA	.000	
MIDS	8419	Transition to Residency	4.000	PA	.000	
MINT	8301	Internal Medicine Sub-Internsh	4.000	PA	.000	
MINT	8413	Hospice Elective	2.000	PA	.000	
MRAD	8401	Radiology Elective	4.000	PA	.000	

	AHRS	EHRS	QHRS	QPTS	GPA
Current	18.000	18.000	0.000	.000	.000
Cumulative	149.000	149.000	0.000	.000	.000

********** TRANSCRIPT TOTALS **********

INSTITUTION	Ehrs:	149.000	QPts:	0.000	
	GPA-Hrs:	0.000	GPA:	0.000	
TRANSFER	Ehrs:	0.000	QPts:	0.000	
	GPA-Hrs:	0.000	GPA:	0.000	
OVERALL	Ehrs:	149.000	QPts:	0.000	
	GPA-Hrs:	0.000	GPA:	0.000	

********** END OF TRANSCRIPT **********

Amanda McSween

Amanda McSween, Registrar

TEXAS TECH UNIVERSITY HEALTH SCIENCES CENTER

Office of the Registrar - 3601 4th Street - Lubbock, TX 79430 - Telephone (806) 743-2300 - Fax (806) 743-3027

Official Transcripts: The officially sealed and signed transcript is printed on secured paper and does not require a raised seal. Transcripts issued directly to students are stamped "Issued to Student."

Confidentiality of Records: This transcript must not be released to a third party without the written authorization of the student (in accordance with the Family Educational Rights and Privacy Act of 1974, Federal Law 93-380).

Accreditation: The Texas Tech University Health Sciences Center is accredited by the Commission on Colleges of the Southern Association of Colleges and Schools to award Bachelor's, Master's, and Doctor's Degrees. Individual school programs are accredited by appropriate professional organizations. Information about accreditation is listed in each school's catalog.

Course Numbers: TTUHSC utilizes a 4-digit course numbering system. The first digit indicates the general level of the course. The second digit specifies the number of semester credit hours (a 0 indicates variable credit); for all schools but the School of Medicine.

Grade Point Average (GPA): Grade point average is computed by multiplying the credit hours for each course attempted by the grade points earned in the particular course and then dividing the total number of grade points by the total number of credit hours attempted, excluding those hours for which non-computed grades are recorded (see grade point tables). Abbreviations: AHRS=Attempted Hours, EHRS=Earned Hours, QHRS=Quality Hours (included in GPA), QPTS=Quality Points (included in GPA).

Concurrent Enrollment: Concurrent enrollment means that students may be enrolled in coursework at Texas Tech University Health Sciences Center and Texas Tech University during any one semester.

Grading Symbols Used in Common by All Schools:

Symbols	*Description*
++	Denotes the inclusion of initial academic statistics
*	Course not applicable to current program

Grades	*Description*	*Grade Points Per Semester Hour*
I	Incomplete	N/A*
W	Withdrawal	N/A*
WF	Withdraw Failing	0.00
NC	No Credit	0.00
CR	Credit	N/A*
DG	Dropped (drop limit)	N/A*
DW	Dropped (no drop limit)	N/A*
DX	Dropped (limit w/except)	N/A*
PR	In Progress	N/A*
X	Grade Not Submitted	N/A*
NR	Grade Not Recorded	N/A*

*Not included in the calculation of grade point average

School of Health Professions (Formerly School of Allied Health Sciences)

Grading & Grade Point System:

Grades	*Description*	*Grade Points Per Semester Hour*
A	Excellent	4.0
B	Good	3.0
C	Average	2.0
D	Poor	1.0
F	Fail	0.0
P	Pass	N/A*

*Not included in the calculation of grade point average.

School of Nursing

Grading & Grade Point System:

Grades	*Description*	*Grade Points Per Semester Hour*
A	Excellent	4.0
B	Good	3.0
C	Average	2.0
D	Poor	1.0
F	Fail	0.0
P	Pass	N/A*
RP	Repeat	N/A*

*Not included in the calculation of grade point average.

Graduate School of Biomedical Sciences

Grading & Grade Point System:

Grades	*Description*	*Grade Points Per Semester Hour*
A	Excellent	4.0
B	Good	3.0
C	Average	2.0
D	Poor	1.0
F	Fail	N/A*
P	Pass	N/A*

*Not included in the calculation of grade point average.

School of Medicine

Academic Calendar: The School of Medicine maintains a classical four-year curriculum, with each year ranging in length from 32 to 47 weeks. The first two years are devoted principally to the basic sciences while the last two years offer intense clinical experiences and direct patient care.

Credit Units: The unit of measure for the valuation of courses is the medical credit unit which should not be confused with traditional credit hours. One unit is approximately 100 contact hours.

Grading & Grade Point System:

Grades	*Description*
90-100	Excellent
80-89	Good
70-79	Satisfactory
0-69	Unsatisfactory
F/FA	Fail
H	Honors
HO	Honors
HP	High Pass
LP	Low Pass
MA	Marginal
P	Pass
PA	Pass
S	Satisfactory
U	Unsatisfactory

School of Pharmacy

Grading & Grade Point System:

Grades	*Description*
90-100	Excellent
80-89	Good
70-79	Satisfactory
0-69	Unsatisfactory
F	Fail
P	Pass
RP	Repeat

This Academic Transcript from Texas Tech University Health Sciences Center located in Lubbock, TX is being provided to you by Parchment, Inc. Under provisions of, and subject to, the Family Educational Rights and Privacy Act of 1974, Parchment, Inc. is acting on behalf of TTUHSC in facilitating the delivery of academic transcripts from TTUHSC to other colleges, universities and third parties.

This secure transcript has been delivered electronically by Parchment, Inc. in a Portable Document Format (PDF) file. Please be aware that this layout may be slightly different in look than TTUHSC's printed/mailed copy, however it will contain the identical academic information. Depending on the school and your capabilities, we also can deliver this file as an XML document or an EDI document. Any questions regarding the validity of the information you are receiving should be directed to: Office of the Registrar, Texas Tech University Health Sciences Center, 3601 4th Street, Lubbock, TX 79430, Tel: (806) 743-2300.

AMA Physician Profile

PREPARED FOR

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

Name and Mailing Address

KWAME KUSI OPOKU
[redacted]

Primary Office Address

UNIV OK HLTH SCI CTR
920 STANTON L YOUNG BLVD
OKLAHOMA CITY, OK 73104-5020

Phone UNKNOWN

Birth date [redacted]

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
1134818651	05/01/2023	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: TEXAS TECH UNIVERSITY HEALTH SCIENCE CENTER SCHOOL OF MEDICINE

T41680
SD

AMA AMERICAN MEDICAL ASSOCIATION

Degree Awarded:	YES	**Degree Type:**	MD
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 COLLEGE OF MEDICINE
Sponsoring State:	OKLAHOMA
Program name:	UNIVERSITY OF OKLAHOMA HEALTH SCIENCES CENTER PROGRAM
Specialty:	ANESTHESIOLOGY
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

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
MAY 01 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: Kwame (First) Kusi (Middle) Opoku (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 _____ Date 04/21/2023

Subscribed and sworn before me this 21 day of April, 20 23.

Notary Public Deborah K. Stuart

Commission Number 00019909

My commission expires December 5, 2024

DEBORAH K. STUART NOTARY PUBLIC STATE OF OKLAHOMA COMM. # 00019909 EXP. 12/05/24 SEAL

T 41680 #5

OKLAHOMA STATE BOARD OF MEDICAL LICENSURE AND SUPERVISION
101 NE 51ST STREET
OKLAHOMA CITY OK 73105
Phone: (405)962-1400 Fax: (405)962-1440 email: oktraining@okmedicalboard.org

RECEIVED
MAY 0 1 2023
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 Wiser 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.

Kwame Opoku		04/21/2023
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 41680 HS

Kenna L. Shaw

From: BillPay Webmaster <donotreply@www.ok.gov>
Sent: Tuesday, April 30, 2024 10:59 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

KWAME KUSI OPOKU has paid for a LICENSE - MD Training-to-Full License Fee 250.00 on 04/30/2024 10:04:59pm for $250.00.
OKLAHOMA MD LICENSE NUMBER 41680
To view all transactions please go to http://www.ok.gov/triton/ and login to your CMS account.

T 41680 V

ATTACHMENT 5

TIME DEFICIENCY FORM

Name:	Kwame Opoku	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	06	2015	James E. Taylor High School	Katy	TX	High School
08	2015	05	2019	Texas Tech University	Lubbock	TX	Bachelors
07	2019	05	2023	TTUHSC School of Medicine	Lubbock	TX	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
06	2015	08	2015	Summer Break	Richmond	TX
05	2019	07	2019	Summer Break	Richmond	TX

RECEIVED
MAY 01 2023
OKLAHOMA STATE BOARD OF MEDICAL LICENSURE AND SUPERVISION

T41680 #5

05/12/2023

KWAME KUSI OPOKU

[redacted]

RE: MD Application #41680

Check Your Application Status Online at:
http://www.okmedicalboard.org
***Username*:AP14886625**
***Password*:Last 4 SSN**

Dear KWAME OPOKU,

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

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

USMLE Exams Incomplete
MedSchool-Form 1 Tx Tech Univ Hlth Sci Ctr Sch Of Med, Lubbock Tx 79430
PostGrad - Form 2 COLLEGE OF MEDICINE OKC
Extended Background Check
Exam verification date
MedSchool-Transcript Tx Tech Univ Hlth Sci Ctr Sch Of Med, Lubbock Tx 79430

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 AP14886625 (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

Sincerely,

Seema Jayachand

Seema Jayachand

Dept. of Licensing

Encl

Oklahoma State Board of Medical Licensure and Supervision
Application Summary

Type	Number	Name
MD	41680	KWAME KUSI OPOKU

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:
048-15 Tx Tech Univ Hlth Sci Ctr Sch Of Med, Lubbock Tx 79430

Number of Licenses Previously Granted to Graduates of this Medical School:343

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** _____ 6-28-23

5) **REQUESTS SPECIFIC CONSIDERATION OF:**

_____

_____

_____

_____

_____

Oklahoma State Board of Medical Licensure and Supervision
Application Summary

Type	Number	Name
MD	39698	AKEEM OLAREWAJU OSENI

MEDICAL DOCTOR

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

OTHER DEFICIENCIES: NEED QUESTIONNAIRE / $250 UPGRADE FEE / EVALUATION
PostGrad - Form 2 SSM HEALTH

Last Medical School Attended:
665-03 St. James School of Medicine, St James, Netherland Antilles (moved in 2015)

Number of Licenses Previously Granted to Graduates of this Medical School:9

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	39698	AKEEM OLAREWAJU OSENI

MEDICAL DOCTOR

Practice Address:

May 04, 2022

,

Endorsed By: USMLE

Status:
Res: MD
Received: 04/29/2022
Entered: 04/29/2022
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 #: 39698
Sex: M
Ethnic Origin: 2

	Test	Score	Date Taken	Date Verified	Attempts
Test 1:	USMLE 3	PASS	05/12/23	6/28/23	2
Test 2:	USMLE 2	PASS	10/2/20	4/29/22	1
Test 3:	USMLE 1	PASS	9/14/18	4/29/22	1

Note: ***PASS*** means higher than 75

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

PRE-MED EDUCATION

School Name: UNIVERSITY OF OKLAHOMA HEALTH SCIENCE CENTER
City: OKLAHOMA **State:** OK **Country:** UNITED STATES
Degree: B.S. NURSING **From:** 8/2005 **To:** 5/2007 **Verified:**

School Name: UNIVERSITY OF OKLAHOMA
City: NORMAN **State:** OK **Country:** UNITED STATES
Degree: B.S. BIOCHEMISTRY **From:** 1/2000 **To:** 5/2002 **Verified:**

School Name: OKLAHOMA COMMUNITY COLLEGE
City: OKLAHOMA **State:** OK **Country:** UNITED STATES
Degree: ASSOCIATE OF SCIENCE **From:** 8/1997 **To:** 5/2000 **Verified:**

School Name: KADUNA POLYTHECNIC
City: ZARIA **State:** **Country:** NIGERIA
Degree: **From:** 8/1994 **To:** 7/1996 **Verified:**

Oklahoma State Board of Medical Licensure and Supervision
Application Summary

Type	Number	Name
MD	39698	AKEEM OLAREWAJU OSENI

MEDICAL DOCTOR

MEDICAL SCHOOL EDUCATION

Name: St. James School of Medicine, St James, Netherland Antilles (moved in 2015)
Foreign Name:
City: St James **State/Country:** Netherlands Antilles
Degree: MD **From:** 1 / 2019 **To:** 9 / 2021 **Diploma Ver'd:** Y

Name: St. James School of Medicine, St James, Netherland Antilles (moved in 2015)
Foreign Name:
City: St James **State/Country:** Netherlands Antilles
Degree: APPROVED LEAVE O **From:** 9 / 2014 **To:** 8 / 2016 **Diploma Ver'd:** Y

POST GRADUATE EDUCATION

Facility: SSM HEALTH **Specialty:** FAMILY MEDICINE
Res. Fellowship: Residency
City: OKLAHOMA **State:** OK **Country:** UNITED STATES OF AMER
Verified: **From:** 7 / 2022 **To:** /
ACGME Ver'd: 05/09/2022
Comments: RCVD EVAL 7/27/23 (LKC)

Oklahoma State Board of Medical Licensure and Supervision
Application Summary

Type	Number	Name
MD	39698	AKEEM OLAREWAJU OSENI

MEDICAL DOCTOR

PRACTICE HISTORY

Employed: FAMILY DOCTOR URGENT CARE **Supervisor:**
City: CHICAGO **State:** IL **Country:** UNITED STATES
Specialty: GRADUATE MEDICAL STUDENT **From:** 8 / 2021 **To:** / **Verified:**
Comments: I TAKE PATIENT HISTORY, PERFORM PHYSICAL EXAMS, PATIENT EDUCATION AND SUPERVISING MEDICAL STUDENTS.

Employed: SELF EMPLOYED **Supervisor:**
City: CHICAGO **State:** IL **Country:** UNITED STATES
Specialty: DROPSHIPPING ONLINE BUSINESS **From:** 8 / 2016 **To:** 12 / 2018 **Verified:**
Comments: I PURCHASED CHEAP GOODS ONLINE, LIST THEM ON EBAY AND AMAZON FOR HIGHER PROFIT TO FINANCE MY SCHOOL

Employed: UNIVERSITY OF OKLAHOMA MEDICAL CENTER **Supervisor:**
City: OKLAHOMA CITY **State:** OK **Country:** UNITED STATES
Specialty: REGISTERED NURSE **From:** 6 / 2007 **To:** 8 / 2014 **Verified:**
Comments: I ASSISTED PATIENTS WITH THEIR CARE, MONITORING VITAL SIGNS, AND RECOVERY PROGRESS.

Employed: BOB HOWARD AUTO GROUP **Supervisor:**
City: OKLAHOMA CITY **State:** OK **Country:** UNITED STATES
Specialty: SALES CONSULTANT **From:** 9 / 2001 **To:** 1 / 2008 **Verified:**
Comments: I SOLD BOTH NEW AND USED CARS.

Employed: MCDONALD COPORATION **Supervisor:**
City: OKLAHOMA CITY **State:** OK **Country:** UNITED STATES
Specialty: COOK **From:** 9 / 1996 **To:** 8 / 1997 **Verified:**
Comments: I WORKED IN THE GRILL SECTION, MAKING HAMBURGER MEAT

Other Licenses

State	Lic Type and Number	Status	Issued	Exp	Verif
OK	RN RN R0089729	I	7/16/07	9/30/18	5/9/22
IL	RN 041447121	A	10/13/16	8/31/22	5/9/22

DEFICIENCIES

OTHER DEFICIENCIES: NEED QUESTIONNAIRE / $250 UPGRADE FEE / EVALUATION
PostGrad - Form 2 SSM HEALTH

Oklahoma State Board of Medical Licensure and Supervision

APPLICATION FOR OKLAHOMA MEDICAL DOCTOR LICENSE

Received:04/29/2022

Foreign Graduate

Applicant Name: OSENI, AKEEM OLAREWAJU [redacted] **MD 39698**

[redacted]

Date Of Birth: [redacted] **Place Of Birth (City, State):** ILORIN, NIGERIA

Sex: M **Race:** Black

Education

Type	Name	City	ST	Country	From	To	Degree	Comments	Veri
UG	UNIVERSITY OF OKLAHOMA HEALTH SCIENCE CENTER	OKLAHOMA	OK		8/2005	5/2007	B.S. NURSING		
UG	UNIVERSITY OF OKLAHOMA	NORMAN	OK		1/2000	5/2002	B.S. BIOCHEMISTRY		
UG	OKLAHOMA COMMUNITY COLLEGE	OKLAHOMA	OK		8/1997	5/2000	ASSOCIATE OF SCIENCE		

Medical School Name	City	State	Country	Comments	From	To
St. James School of Medicine (Anguilla or St. Vincent Campus) frmly 665-03	Arnos Vale		St. Vincent an		9/2014	8/2016
St. James School of Medicine (Anguilla or St. Vincent Campus) frmly 665-03	Arnos Vale		St. Vincent an		1/2019	9/2021

Post-Graduate

Facility	City	St	Country	Specialty	Comments	From	To
ST. ANTHONY HOSPITAL	OKLAHOMA	OK	UNITED S	M.D.		/	/

Practice History

Employer	Specialty	Supervisor	City	ST	Countr	From	To	Verif
FAMILY DOCTOR URGENT CARE	FAMILY MEDICINE		CHICAGO	IL		8/2021	0/0	
SELF EMPLOYED	DROPSHIPPING ONLINE BUSINESS		CHICAGO	IL		8/2016	12/2018	
UNIVERSITY OF OKLAHOMA MEDICAL CENTER	REGISTERED NURSE		OKLAHOMA CITY	OK		6/2007	8/2014	
BOB HOWARD AUTO GROUP	SALES CONSULTANT		OKLAHOMA CITY	OK		9/2001	1/2008	
MCDONALD COPORATION	COOK		OKLAHOMA CITY	OK		9/1996	8/1997	

Other/ Out-Of-State Licenses

State	License #	Profession	Status	Issue Date	Exp Date
OK	RN R0089729	RN	U	7/16/07	9/30/18
IL	041447121		U	10/13/16	5/31/22

$250.00

Oklahoma State Board of Medical Licensure and Supervision

APPLICATION FOR OKLAHOMA MEDICAL DOCTOR LICENSE

Received:04/29/2022

Foreign Graduate

MD Exam

Exam	State	Score	Date Taken	#
USMLE				

Oklahoma State Board of Medical Licensure and Supervision

APPLICATION FOR OKLAHOMA MEDICAL DOCTOR LICENSE

Received:04/29/2022

Foreign Graduate

Questions Answered 04/28/2022		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

Oklahoma State Board of Medical Licensure and Supervision

APPLICATION FOR OKLAHOMA MEDICAL DOCTOR LICENSE

Received:04/29/2022

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:

St. Anthony Hospital

If so, Please identify with which category:

Primary Care Or Specialty Care Clinic

Name of Previous Carrier and Policy Holder

NONE. St. Anthony Hospital will provide my professional liability insurance by July 1, 2022.

Name of Current Carrier and policy Holder

NONE. St. Anthony Hospital will provide my professional liability insurance by July 1, 2022.

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

JULY 1, 2022

I attest that all the above information is accurate as of April 28, 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 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
MAY 02 [illegible]
OKLAHOMA [illegible] BOARD OF

Notary Public - State of Illinois
My Commission Expires August 16, 2025

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

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

4-26-2022
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 Illinois, County of COOK

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 26th day of April, 2022

Notary Public Signature [signature] My Notary Commission Expires August 16, 2025

T39695 MA

US·MLE
United States
Medical
Licensing
Examination

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: 06/28/2023

Examinee: Oseni, Akeem Olarewaju
Alt Name(s):

Examinee ID: 1-036-771-2
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
09/14/2018	Pass	226	(194)	

USMLE STEP 2

Clinical Knowledge (CK)

Test Date	Pass/Fail	Score	Minimum Pass	Comments
10/02/2020	Pass	226	(209)	

USMLE STEP 3

Test Date	Pass/Fail	Score	Minimum Pass	Comments
05/12/2023	Pass	199	(198)	
03/23/2023	Fail	187	(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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JUN 28 2023
OKLAHOMA STATE BOARD OF MEDICAL LICENSURE AND SUPERVISION

Rev 2018

T39698
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: Oseni, Akeem Olarewaju

Examinee ID: 1-036-771-2
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
This form must be completed by the institution and mailed directly from the institution.

Applicant's Name: Akeem Olarewaju Oseni

Institution: Saint James School of Medicine City/State: Park Ridge IL

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

From 09 / 03 / 2014 (Month / Day / Year) To 09 / 22 / 2021 (Month / Day / Year) and was awarded the degree Doctor of Medicine (M.D)

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: Approved Leave of Absence- Financial

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PRIMARY SOURCE

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: Naim Lokhandwala **Signature** NLokhandwala

Title of Signatory: Associate Registrar Services **Date of Signature** 04/27/2022

Tel: 847-375-0543 **Fax:** 847-298-2375 **E-Mail:** records@mail.sjsm.org

SAINT JAMES SCHOOL OF MEDICINE · EST. 1999 ·

If no seal is available, this form must be notarized

Notary Public _____

Commission # _____

My commission expires: _____

Notary Seal

T 39698
VB

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Registrar Services
1480 Renaissance Dr, Ste 300
Park Ridge, IL. 60068

Reprinted originally received on 4/26/22

How to Authenticate This Official Transcript from Saint James School of Medicine

This official transcript has been delivered to the recipient, and is intended solely for use by that recipient. It is not permissible to replicate this document or forward it to any person or organization other than the identified recipient. Release of this record or disclosure of its contents to any third party without written consent of the record owner is prohibited.

Printed Transcript:
If you have received this transcript as a printed document, you may verify it's authenticity by testing the security features noted on the document.

Electronic Transcript:
This document is official when downloaded by a Parchment Receive member from their inbox.
If receiving via email, this official transcript has been digitally signed and therefore contains special characteristics. This document will reveal a digital certificate that has been applied to the transcript, and for optimal results, we recommend that this document is viewed with the latest version of Adobe® Acrobat or Adobe® Reader. This digital certificate will appear in a pop-up screen or status bar on the document, display a blue ribbon, and declare that the document was certified by Parchment, with a valid certificate issued by GlobalSign CA for Adobe®. This document certification can be validated by clicking on the Signature Properties of the document.

The Blue Ribbon Symbol: The blue ribbon is your assurance that the digital certificate is valid, the document is authentic, and the contents of the transcript have not been altered.

Invalid: If the transcript does not display a valid certification and signature message, reject this transcript immediately. An invalid digital certificate display means either the digital signature is not authentic, or the document has been altered. The digital signature can also be revoked bythe transcript office if there is cause, and digital signatures can expire. A document with an invalid digital signature display should be rejected.

Author Unknown: Lastly, one other possible message, Author Unknown, can have two possible meanings: The certificate is a self-signed certificate or has been issued by an unknown or untrusted certificate authority and therefore has not been trusted, or the revocation check could not complete. If you receive this message make sure you are properly connected to the internet. If you have a connection and you still cannot validate the digital certificate on-line, reject this document.

The transcript key is the last page of this document.

The current version of Adobe® Reader is free of charge, and available for immediate download at http://www.adobe.com.

If you require further information regarding the authenticity of this transcript, you may email the Registrar's Office at Saint James School of Medicine at records@mail.sjsm.org

TMD 39698
SJ

Saint James School of Medicine

Graduated - MD Conferred Date: Sep 22, 2021

Student: Oseni, Akeem Olarewaju
Student Id: 117155
Date of Birth: [redacted]
OFFICIAL TRANSCRIPT OF GRADES
Printed on April 26, 2022

Key

A – 90-100% **B** – 80-89% **C** – 70-79% **F** – <70%
TC – Transfer Credit **W** – Withdrawn **I** – Incomplete **IP** – In Progress
*Credit = Weeks (Rotations Only)

Cum GPA Weighted 2.94

Basic Sciences - Fall - 2014/2015				
Course	**Hospital Name**	**Start Date**	**Grade**	**Credits***
CCBS I (Clinical Correlation of Basic Science)		09/03/2014	C	1.00
Embryology		09/03/2014	C	6.00
Gross Anatomy		09/03/2014	C	14.00
Histology		09/03/2014	C	11.00
Medical and Legal Ethics		09/03/2014	C	4.00
Basic Sciences - Spring - 2014/2015				
Course	**Hospital Name**	**Start Date**	**Grade**	**Credits***
Biochemistry		01/11/2015	B	10.00
CCBS II (Clinical Correlation of Basic Science)		01/11/2015	B	1.00
Genetics		01/11/2015	A	4.00
Neurosciences		01/11/2015	B	6.00
Physiology		01/11/2015	B	10.00
RHM I (Research in Health and Medicine)		01/11/2015	Cr	1.00
Basic Sciences - Summer - 2014/2015				
Course	**Hospital Name**	**Start Date**	**Grade**	**Credits***
CCBS III (Clinical Correlation of Basic Science)		05/07/2015	B	1.00
Medical Psychology		05/07/2015	B	4.00
Microbiology		05/07/2015	B	10.00
Pathology I		05/07/2015	C	11.00
Pharmacology		05/07/2015	B	10.00
RHM II (Research in Health and Medicine)		05/07/2015	Cr	1.00
Basic Sciences - Fall - 2015/2016				
Course	**Hospital Name**	**Start Date**	**Grade**	**Credits***
CCBS IV (Clinical Correlation of Basic Science)		09/04/2015	C	1.00
Epidemiology		09/04/2015	C	4.00
Pathology II		09/04/2015	C	11.00
Physical Diagnosis		09/04/2015	C	10.00
RHM III (Research in Health and Medicine)		09/04/2015	B	1.00

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Saint James School of Medicine

Graduated - MD Conferred Date: Sep 22, 2021

Student: Oseni, Akeem Olarewaju
Student Id: 117155
Date of Birth: [redacted]
OFFICIAL TRANSCRIPT OF GRADES
Printed on April 26, 2022

Key

A – 90-100% **B** – 80-89% **C** – 70-79% **F** – <70%
TC – Transfer Credit **W** – Withdrawn **I** – Incomplete **IP** – In Progress
*Credit = Weeks (Rotations Only)

Basic Sciences - 2015/2016				
Course	**Hospital Name**	**Start Date**	**Grade**	**Credits***
Adv Pre Clin Rev	Jackson Park Hospital	03/07/2016	B	8.00
Adv Intro Clin Med	Jackson Park Hospital	05/02/2016	B	8.00
Clinical Core Rotations - 2018/2019				
Course	**Hospital Name**	**Start Date**	**Grade**	**Credits***
Psychiatry	Jackson Park Hospital	01/07/2019	B	6.00
Internal Medicine	Mercy Hospital	03/25/2019	B	12.00
Family Medicine	Jackson Park Hospital	06/24/2019	A	6.00
OB-GYN	Jackson Park Hospital	08/05/2019	A	6.00
Clinical Core Rotations - 2019/2020				
Course	**Hospital Name**	**Start Date**	**Grade**	**Credits***
Pediatrics	Jackson Park Hospital	09/16/2019	A	6.00
Surgery	Weiss Memorial Hospital	10/28/2019	A	12.00
Radiology	Weiss Memorial Hospital	06/15/2020	A	4.00
Internal Medicine	Weiss Memorial Hospital	07/27/2020	A	4.00
Clinical Elective Rotations - 2020/2021				
Course	**Hospital Name**	**Start Date**	**Grade**	**Credits***
Urgent Care	West Suburban	11/23/2020	A	4.00
Neurology	West Suburban Medical Center	12/21/2020	A	4.00
Infectious Disease	West Suburban Medical Center	01/18/2021	A	4.00
Internal Medicine	West Suburban Medical Center	02/15/2021	A	4.00
Family Medicine	External site (Urgent Care)	03/15/2021	A	4.00
Pediatrics	West Suburban Medical Center	04/26/2021	A	4.00

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Legend:

Academic Calendar

The School Calendar is based on a three-semester system: Spring, Summer and Fall. A Standard semester contains approximately 16 weeks of instruction, including final examinations.

Grading system and Credits

The following letter grades and symbols are included in our transcripts:

Grade	Definition	GPA Value
A	90 – 100 %	4.00
B	80 – 89 %	3.00
C	70 – 79 %	2.00
F	Below 70	1.00
TC*	Transfer Credit	-
W*	Withdrawn	-
I*	Incomplete	-
IP*	In Progress	-
Cr*	Earned credit for pass/fail course	-

**Grades not Included in GPA*

The credit hour calculation is primarily based on the length of time students spend attending classroom lectures, and the school reserves the right to determine the exact credit hour value of each component. For Clinicals, all credit obtained by students of this school is reported in terms of weeks.

Release of Information

This Transcript has been transmitted at the request of the named student. Further transmission of this record is not authorized.

My Profile My Admissions

Student Portal Login Student Dashboard Clinical Schedule
GRADE KEY
I = Incomplete (missing logs and/or cases)
IP = In Progress (evaluation and/or exam pending)

- Emergency Contacts
- Request Forms
- My Finances
- Statement
- Clinical Schedule
- Policies
- Need Assistance?
- Contracts

Student Id	Student First Name	Student Last Name	External Course	Course Name	Hospital Name	Course Start Date	Course End Date	Weeks	Teacher First Name	Teacher Last Name
117155	Akeem	Oseni	0	Pediatrics	West Suburban Medical Center	4/26/2021 12:00:00 AM	5/21/2021 12:00:00 AM	4	Dr. Mohamed	Jabri
117155	Akeem	Oseni	0	Family Medicine	External site (Urgent Care)	3/15/2021 12:00:00 AM	4/9/2021 12:00:00 AM	4	Dr. Adebayo	Badamosi
117155	Akeem	Oseni	0	Internal Medicine	West Suburban Medical Center	2/15/2021 12:00:00 AM	3/12/2021 12:00:00 AM	4	Dr. Krishdeep	Khosla
117155	Akeem	Oseni	0	Infectious Disease	West Suburban Medical Center	1/18/2021 12:00:00 AM	2/12/2021 12:00:00 AM	4	Dr. Tasheen	Siddiqui
117155	Akeem	Oseni	0	Neurology	West Suburban Medical Center	12/21/2020 12:00:00 AM	1/15/2021 12:00:00 AM	4	Dr. Jason	Parikh
117155	Akeem	Oseni	0	Urgent Care	West Suburban	11/23/2020 12:00:00 AM	12/18/2020 12:00:00 AM	4	Dr. Iftikhar	Khan
117155	Akeem	Oseni	0	Internal Medicine	Weiss Memorial Hospital	7/27/2020 12:00:00 AM	8/21/2020 12:00:00 AM	4	Dr. Eric	Mizuno
117155	Akeem	Oseni	0	Radiology	Weiss Memorial Hospital	6/15/2020 12:00:00 AM	7/10/2020 12:00:00 AM	4	Dr. Avnit	Kapur
117155	Akeem	Oseni	0	Surgery	Weiss Memorial Hospital	10/28/2019 12:00:00 AM	1/17/2020 12:00:00 AM	12	Dr. Philip	Zaret
117155	Akeem	Oseni	0	Pediatrics	Jackson Park Hospital	9/16/2019 12:00:00 AM	10/25/2019 12:00:00 AM	6	Dr. Shirley	Montgom

1 2

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My Profile My Admissions

Student Portal Login Student Dashboard Clinical Schedule
GRADE KEY
I = Incomplete (missing logs and/or cases)
IP = In Progress (evaluation and/or exam pending)

- Emergency Contacts
- Request Forms
- My Finances
- Statement
- Clinical Schedule
- Policies
- Need Assistance?
- Contracts

Student Id	Student First Name	Student Last Name	External Course	Course Name	Hospital Name	Course Start Date	Course End Date	Weeks	Teacher First Name	Teacher Last Name
117155	Akeem	Oseni	0	OB-GYN	Jackson Park Hospital	8/5/2019 12:00:00 AM	9/13/2019 12:00:00 AM	6	Dr. Angela	Walker
117155	Akeem	Oseni	0	Family Medicine	Jackson Park Hospital	6/24/2019 12:00:00 AM	8/2/2019 12:00:00 AM	6	Dr. Okechukwu	Okolo
117155	Akeem	Oseni	0	Internal Medicine	Mercy Hospital	3/25/2019 12:00:00 AM	6/14/2019 12:00:00 AM	12	Dr. Rizwana	Syed
117155	Akeem	Oseni	0	Psychiatry	Jackson Park Hospital	1/7/2019 12:00:00 AM	2/15/2019 12:00:00 AM	6	Dr. Thodur	Ranganatha

1 2

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PRIMARY SOURCE

FORM #4 (MD)

RECEIVED
MAY 02 2022
OKLAHOMA STATE BOARD OF MEDICAL LICENSURE AND SUPERVISION

Oklahoma State Board of Medical Licensure and Supervision
P.O. Box 18256, Oklahoma City, OK 73154-0256

VERIFICATION OF CLINICAL CLERKSHIP

In the event a foreign medical school utilized clerkships in the United States, its territories or possessions, and the applicant graduated from medical school after July 1, 2003, such clerkships shall have been performed in hospitals and schools that have programs accredited by the Accreditation Council for Graduate Medical Education (ACGME).

One form must be completed and mailed directly to the Board for each clerkship.

This is to certify that Akeem Oseni (Student's Name); [redacted] (U.S. Social Security Number)

[redacted] (Date of Birth) a student of St. James School of Medicine (Medical School)

Completed a clerkship offered by Family Doctor Medical Center (Name of Facility)

1918 W. Irving park Rd Chicago IL 60613 (Address of Facility)

From 03 - 15 - 2021 (Month Day Year) through 04 - 09 - 2021 (Month Day Year) in the clinical area

of Family Medicine (Clinical Area).

This facility has programs that are accredited by ACGME in the areas of Family Medicine (Specialty).

I, Adebayo Bademosi, swear or affirm that I am/was the individual facility program director or instructor for the student named above during the clerkship indicated and that I have carefully read and completed this form and that the statements made herein are accurate.

Institution Seal

Adebayo Bademosi
Type or Print Name of Facility Program Director or Instructor

1918 W. Irving Park Rd
Address

Chicago IL 60613
City State Zip Code

773-360-1438
Telephone Number

Bademosi MD
Signature

FAMILY DOCTOR MEDICAL CENTER
1918 W. IRVING PARK RD
CHICAGO, IL 60613
Ph:(773) 360-1438
Fax: (773) 698-8562

In the absence of an official institution seal, the Facility Program Director or Instructor's signature must be notarized.

Signed and sworn before me this _____ day of _____(Month) _____(Year).

_____
Notary Public Signature

Notary Seal

My Commission Expires:_____

T 39698 VB

FORM #4 (MD) RECEIVED MAY 05 2022 OKLAHOMA STATE BOARD OF MEDICAL LICENSURE AND SUPERVISION PRIMARY SOURCE

Oklahoma State Board of Medical Licensure and Supervision
P.O. Box 18256, Oklahoma City, OK 73154-0256

VERIFICATION OF CLINICAL CLERKSHIP

In the event a foreign medical school utilized clerkships in the United States, its territories or possessions, and the applicant graduated from medical school after July 1, 2003, such clerkships shall have been performed in hospitals and schools that have programs accredited by the Accreditation Council for Graduate Medical Education (ACGME).

One form must be completed and mailed directly to the Board for each clerkship.

This is to certify that Akeem Oseni (Student's Name); [redacted] (U.S. Social Security Number)

[redacted] (Date of Birth) a student of Saint James School of medicine (Medical School)

Completed a clerkship offered by Mercy Hospital & Medical Center (Name of Facility)

2525 South Michigan Avenue Chicago, IL 60616 (Address of Facility)

From 03 (Month) 25 (Day) 2019 (Year) through 06 (Month) 14 (Day) 2019 (Year) in the clinical area

Of Internal Medicine (Clinical Area).

This facility has programs that are accredited by ACGME in the areas of Internal Medicine (Specialty).

I, KATHLEEN VANDIRK, swear or affirm that I am/was the individual facility program director or instructor for the student named above during the clerkship indicated and that I have carefully read and completed this form and that the statements made herein are accurate.

Institution Seal: FOSTER G. McGAW HOSPITAL LOYOLA UNIVERSITY MEDICAL CENTER SEAL MAYWOOD, ILLINOIS

NOT AVAILABLE - PLEASE REFER TO DIO LETTER INCLUDED
Type or Print Name of Facility Program Director or Instructor

KATHLEEN VANDIRK - INSTITUTIONAL COORDINATOR - GME

Address: 2160 S. FIRST AVE MAYWOOD, IL 60153

City State Zip Code

708-216-4533 (Telephone Number) KathleenVandirk (Signature)

In the absence of an official institution seal, the Facility Program Director or Instructor's signature must be notarized.

Signed and sworn before me this _____ day of _____(Month) _____(Year).

Notary Public Signature

Notary Seal

My Commission Expires: _____

T 3 of 8 VO

LOYOLA MEDICINE
Loyola University Health System

October 6, 2021

Federation Credentials Verification Services400
Fuller Wiser Road, Suite 300
Euless TX 76039

To whom this may concern:

Due to the closure of Mercy Hospital and Medical Center on June 30, 2021 a Program Director is not available for MHMC Internal Medicine, Obstetrics and Gynecology and Podiatric Medicine residency programs. The people below are authorized to complete and sign verifications in lieu of a Program Director for the Mercy programs:

Kathleen Vandlik, Institutional Coordinator
Ann Baker, Institutional Coordinator
Jory Eaton, Operations Manager
Anne Hartford, Administrative Director/DIO

Anne Hartford, Administrative Director and Designated Institutional Official is responsible for completion, review and certification of all GME verifications and is the highest administrative office in the GME office at Loyola Medicine. The above signors are not M.D./D.O.s and there is not one available.

Anne Hartford, MBA
Administrative Director & Designated Institutional Official
Loyola Medicine
2160 S. First Ave.
Maywood, IL 60153

FORM #4 (MD)

Oklahoma State Board of Medical Licensure and Supervision
P.O. Box 18256, Oklahoma City, OK 73154-0256

VERIFICATION OF CLINICAL CLERKSHIP

In the event a foreign medical school utilized clerkships in the United States, its territories or possessions, and the applicant graduated from medical school after July 1, 2003, such clerkships shall have been performed in hospitals and schools that have programs accredited by the Accreditation Council for Graduate Medical Education (ACGME).

One form must be completed and mailed directly to the Board for each clerkship.

This is to certify that AKEEM OSENI; [redacted]
Student's Name — U.S. Social Security Number

[redacted] a student of Saint James School of Medicine
Date of Birth — Medical School

Completed a clerkship offered by JACKSON PARK HOSPITAL
Name of Facility

7531 S. STONY ISLAND AVE, CHICAGO, IL. 60649
Address of Facility

From 06 (Month) 24 (Day) 2019 (Year) through 08 (Month) 02 (Day) 2019 (Year) in the clinical area

Of Family Medicine.
Clinical Area

This facility has programs that are accredited by ACGME in the areas of FAMILY MEDICINE.
Specialty

I, Ruksana Nazneen, M.D, swear or affirm that I am/was the individual facility program director or instructor for the student named above during the clerkship indicated and that I have carefully read and completed this form and that the statements made herein are accurate.

Institution Seal

Ruksana Nazneen, MD
Type or Print Name of Facility Program Director or Instructor

7531 S. STONY ISLAND AVE
Address

CHICAGO — IL — 60649
City — State — Zip Code

773-947-7500
Telephone Number

Signature

In the absence of an official institution seal, the Facility Program Director or Instructor's signature must be notarized.

Signed and sworn before me this _____ day of _____(Month) _____(Year).

Notary Public Signature

Notary Seal

My Commission Expires: _____

T39698

SAINT JAMES
SCHOOL OF MEDICINE
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End of Clinical Rotation Evaluation Form

Rotation: FAMILY MEDICINE Student Name: AKEEM OSENI

Start Date: 06/24/19 End Date: 08/2/19 No. of Weeks 6

Preceptor: O. OKOLO, M.D. Hospital/ Site: JACKSON PARK HOSPITAL

Address/ City/State/Zip: 7531 S. STONY ISLAND AVE., CHICAGO IL. 60649

Contact Phone: 773-947-7500 Email:

Student Evaluation Scores

Please rate the student's achievement of each competency below on a scale of 0-10:

10 = Outstanding, 9 = Advanced, 8 = Proficient, 7 = Needs Remediation, 0-6 = Poor/Failing

Detailed information about SJSM intended learning outcomes is available on the website: https://www.sjsm.org/resources/downloads/

10 Patient Care (Integration of clinical knowledge and skills in patient care)
10 Medical Knowledge (Integration of basic science in medicine)
9 Practice-Based Learning and Improvement (Life-long learning and self-improvement)
9 Systems Based Practice (Organization and system-based approach to medicine)
10 Professionalism
10 Interpersonal and Communication Skills

58 **TOTAL FOR SIX COMPETENCIES**
A **FINAL GRADE AWARDED** (A = 54-60, B = 48-53, C = 42-47, F = 0-41)

FOR CORE ROTATIONS ONLY - Logbook Entries: Check the box as verification that all logbook entries for this rotation have been reviewed and verified. ☑

I certify, that I have not been involved in providing health care to the student. ☑

Comments for Dean's Letter: *Please note **all** comments will be used in student's performance review for residency applications. Please write legibly.*

Hand workup and relationship. Will be a good doctor.

Preceptor's Signature: VJ **Date:** 8/2/19

Please return this form by mail to: Saint James School of Medicine, 1480 Renaissance Dr. Suite 300, Park Ridge, IL 60068. Phone: 847-375-0543 Fax: 847-298-2375

THANK YOU!

FORM #4 (MD)

Oklahoma State Board of Medical Licensure and Supervision
P.O. Box 18256, Oklahoma City, OK 73154-0256

VERIFICATION OF CLINICAL CLERKSHIP

In the event a foreign medical school utilized clerkships in the United States, its territories or possessions, and the applicant graduated from medical school after July 1, 2003, such clerkships shall have been performed in hospitals and schools that have programs accredited by the Accreditation Council for Graduate Medical Education (ACGME).

One form must be completed and mailed directly to the Board for each clerkship.

This is to certify that AKEEM OSENI ; [redacted]
Student's Name U.S. Social Security Number

[redacted] a student of Saint James School of Medicine
Date of Birth Medical School

Completed a clerkship offered by JACKSON PARK HOSPITAL
Name of Facility

7531 S. STONY ISLAND AVE, CHICAGO, IL. 60649
Address of Facility

From 08 05 2019 through 09 13 2019 in the clinical area
Month Day Year Month Day Year

Of OBSTETRICS/GYNECOLOGY.
Clinical Area

This facility has programs that are accredited by ACGME in the areas of FAMILY MEDICINE.
Specialty

I, Ruksana Nazneen, MD, swear or affirm that I am/was the individual facility program director or instructor for the student named above during the clerkship indicated and that I have carefully read and completed this form and that the statements made herein are accurate.

Institution Seal

Ruksana Nazneen, MD
Type or Print Name of Facility Program Director or Instructor

7531 S. STONY ISLAND AVE
Address

CHICAGO IL 60649
City State Zip Code

773-947-7500
Telephone Number

Signature

In the absence of an official institution seal, the Facility Program Director or Instructor's signature must be notarized.

Signed and sworn before me this _____ day of _____(Month) _____(Year).

Notary Public Signature

Notary Seal

RECEIVED
MAY 13 2022
OKLAHOMA STATE BOARD OF MEDICAL LICENSURE AND SUPERVISION

My Commission Expires: _____

PRIMARY SOURCE

T39698
57

SAINT JAMES
SCHOOL OF MEDICINE
Your Future. Our Promise.

End of Clinical Rotation Evaluation Form

Rotation: OB/GYN Student Name: AKEEM OSENI

Start Date: 08/05/19 End Date: 09/13/19 No. of Weeks 6

Preceptor: A. WALKER, M M.D. Hospital/ Site: JACKSON PARK HOSPITAL

Address/ City/State/Zip: 7531 S. STONY ISLAND AVE., CHICAGO IL. 60649

Contact Phone: 773-947-7500 Email:

Student Evaluation Scores

Please rate the student's achievement of each competency below on a scale of 0-10:

10 = Outstanding, 9 = Advanced, 8 = Proficient, 7 = Needs Remediation, 0-6 = Poor/Failing

Detailed information about SJSM intended learning outcomes is available on the website:
https://www.sjsm.org/resources/downloads/

10 Patient Care (Integration of clinical knowledge and skills in patient care)
10 Medical Knowledge (Integration of basic science in medicine)
10 Practice-Based Learning and Improvement (Life-long learning and self-improvement)
10 Systems Based Practice (Organization and system-based approach to medicine)
10 Professionalism
10 Interpersonal and Communication Skills

60 **TOTAL FOR SIX COMPETENCIES**
A **FINAL GRADE AWARDED** (A = 54-60, B = 48-53, C = 42-47, F = 0-41)

FOR CORE ROTATIONS ONLY - Logbook Entries: Check the box as verification that all logbook entries for this rotation have been reviewed and verified. ☐

I certify, that I have not been involved in providing health care to the student. ☐

Comments for Dean's Letter: *Please note **all** comments will be used in student's performance review for residency applications. Please write legibly.*

Great Job

Preceptor's Signature: [signature] **Date:** 9/11/19

Please return this form by mail to: Saint James School of Medicine, 1480 Renaissance Dr. Suite 300, Park Ridge, IL 60068. Phone: 847-375-0543 Fax: 847-298-2375

THANK YOU!

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MAY 13 2022
OKLAHOMA STATE BOARD OF MEDICAL LICENSURE AND SUPERVISION

PRIMARY SOURCE

FORM #4 (MD)

Oklahoma State Board of Medical Licensure and Supervision
P.O. Box 18256, Oklahoma City, OK 73154-0256

VERIFICATION OF CLINICAL CLERKSHIP

In the event a foreign medical school utilized clerkships in the United States, its territories or possessions, and the applicant graduated from medical school after July 1, 2003, such clerkships shall have been performed in hospitals and schools that have programs accredited by the Accreditation Council for Graduate Medical Education (ACGME).

One form must be completed and mailed directly to the Board for each clerkship.

This is to certify that AKEEM OSENI (Student's Name); [redacted] (U.S. Social Security Number)

[redacted] (Date of Birth) a student of Saint James School of Medicine (Medical School)

Completed a clerkship offered by JACKSON PARK HOSPITAL (Name of Facility)

7531 S. STONY ISLAND AVE, CHICAGO, IL. 60649 (Address of Facility)

From 09 (Month) 16 (Day) 2019 (Year) through 10 (Month) 25 (Day) 2019 (Year) in the clinical area

Of PEDIATRICS (Clinical Area).

This facility has programs that are accredited by ACGME in the areas of FAMILY MEDICINE (Specialty).

I, Ruksana Nazneen, MD, swear or affirm that I am/was the individual facility program director or instructor for the student named above during the clerkship indicated and that I have carefully read and completed this form and that the statements made herein are accurate.

Institution Seal

Ruksana Nazneen, MD
Type or Print Name of Facility Program Director or Instructor

7531 S. STONY ISLAND AVE
Address

CHICAGO (City) IL (State) 60649 (Zip Code)

773-947-7500
Telephone Number

Signature

In the absence of an official institution seal, the Facility Program Director or Instructor's signature must be notarized.

Signed and sworn before me this _____ day of _____(Month) _____(Year).

Notary Public Signature

Notary Seal

RECEIVED
MAY 13 2022
OKLAHOMA STATE BOARD OF MEDICAL LICENSURE AND SUPERVISION

My Commission Expires: _____

PRIMARY SOURCE

T39698

SAINT JAMES
SCHOOL OF MEDICINE
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End of Clinical Rotation Evaluation Form

Rotation: PEDIATRICS Student Name: AKEEM OSENI

Start Date: 09/16/19 End Date: 10/25/19 No. of Weeks 6

Preceptor: Shirley Montgomery, M.D. Hospital/ Site: JACKSON PARK HOSPITAL

Address/ City/State/Zip: 7531 S. STONY ISLAND AVE., CHICAGO IL. 60649

Contact Phone: 773-947-7500 Email:

Student Evaluation Scores

Please rate the student's achievement of each competency below on a scale of 0-10:

10 = Outstanding, 9 = Advanced, 8 = Proficient, 7 = Needs Remediation, 0-6 = Poor/Failing

Detailed information about SJSM intended learning outcomes is available on the website:
https://www.sjsm.org/resources/downloads/

9 Patient Care (Integration of clinical knowledge and skills in patient care)
10 Medical Knowledge (Integration of basic science in medicine)
10 Practice-Based Learning and Improvement (Life-long learning and self-improvement)
9 Systems Based Practice (Organization and system-based approach to medicine)
10 Professionalism
10 Interpersonal and Communication Skills

58 **TOTAL FOR SIX COMPETENCIES**
A **FINAL GRADE AWARDED** (A = 54-60, B = 48-53, C = 42-47, F = 0-41)

FOR CORE ROTATIONS ONLY - Logbook Entries: Check the box as verification that all logbook entries for this rotation have been reviewed and verified. ☑

I certify, that I have not been involved in providing health care to the student. ☑

Comments for Dean's Letter: *Please note **all** comments will be used in student's performance review for residency applications. Please write legibly.*

Very mature and focused. Asked questions that evidenced his studying and medical curiosity. Speaks up and interacts on a professional level.

Preceptor's Signature: S. Montgomery MD **Date:** 10/28/2019

Please return this form by mail to: Saint James School of Medicine, 1480 Renaissance Dr, Suite 300, Park Ridge, IL 60068. Phone: 847-375-0543 Fax: 847-298-2375

THANK YOU!

FORM #4 (MD)

Oklahoma State Board of Medical Licensure and Supervision
P.O. Box 18256, Oklahoma City, OK 73154-0256

VERIFICATION OF CLINICAL CLERKSHIP

In the event a foreign medical school utilized clerkships in the United States, its territories or possessions, and the applicant graduated from medical school after July 1, 2003, such clerkships shall have been performed in hospitals and schools that have programs accredited by the Accreditation Council for Graduate Medical Education (ACGME).

One form must be completed and mailed directly to the Board for each clerkship.

This is to certify that AKEEM OSENI; [redacted]
Student's Name — U.S. Social Security Number

[redacted] a student of Saint James School of Medicine
Date of Birth — Medical School

Completed a clerkship offered by JACKSON PARK HOSPITAL
Name of Facility

7531 S. STONY ISLAND AVE, CHICAGO, IL. 60649
Address of Facility

From 01 07 2019 through 02 15 2019 in the clinical area
Month Day Year — Month Day Year

Of PSYCHIATRY.
Clinical Area

This facility has programs that are accredited by ACGME in the areas of FAMILY MEDICINE.
Specialty

I, Ruksana Nazneen, MD, swear or affirm that I am/was the individual facility program director or instructor for the student named above during the clerkship indicated and that I have carefully read and completed this form and that the statements made herein are accurate.

Institution Seal

Ruksana Nazneen, MD
Type or Print Name of Facility Program Director or Instructor

7531 S. STONY ISLAND AVE
Address

CHICAGO — IL — 60649
City — State — Zip Code

773-947-7500
Telephone Number

RN
Signature

In the absence of an official institution seal, the Facility Program Director or Instructor's signature must be notarized.

Signed and sworn before me this _____ day of _____(Month) _____(Year).

Notary Seal

RECEIVED
MAY 13 2022
OKLAHOMA STATE BOARD OF MEDICAL LICENSURE AND SUPERVISION

Notary Public Signature

My Commission Expires: _____

PRIMARY SOURCE

T39698

SAINT JAMES
SCHOOL OF MEDICINE
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End of Clinical Rotation Evaluation Form

Rotation: PSYCHIATRY Student Name: AKEEM OSENI

Start Date: 01/07/19 End Date: 02/15/19 No. of Weeks 6

Preceptor: T. RANGANATHAN, M.D. Hospital/ Site: JACKSON PARK HOSPITAL

Address/ City/State/Zip: 7531 S. STONY ISLAND AVE., CHICAGO IL. 60649

Contact Phone: 773-947-7500 Email:

Student Evaluation Scores

Please rate the student's achievement of each competency below on a scale of 0-10:

10 = Outstanding, 9 = Advanced, 8 = Proficient, 7 = Needs Remediation, 0-6 = Poor/Failing

Detailed information about SJSM intended learning outcomes is available on the website: https://www.sjsm.org/resources/downloads/

9 Patient Care (Integration of clinical knowledge and skills in patient care)
9 Medical Knowledge (Integration of basic science in medicine)
9 Practice-Based Learning and Improvement (Life-long learning and self-improvement)
9 Systems Based Practice (Organization and system-based approach to medicine)
9 Professionalism
9 Interpersonal and Communication Skills

54 **TOTAL FOR SIX COMPETENCIES**
A **FINAL GRADE AWARDED** (A = 54-60, B = 48-53, C = 42-47, F = 0-41)

FOR CORE ROTATIONS ONLY - Logbook Entries: Check the box as verification that all logbook entries for this rotation have been reviewed and verified. ☑

I certify, that I have not been involved in providing health care to the student. ☑

Comments for Dean's Letter: *Please note **all** comments will be used in student's performance review for residency applications. Please write legibly.*

Preceptor's Signature: [signature] **Date:** 3.3.19

Please return this form by mail to: Saint James School of Medicine, 1480 Renaissance Dr. Suite 300, Park Ridge, IL 60068. Phone: 847-375-0543 Fax: 847-298-2375

THANK YOU!

FORM #4 (MD)

Oklahoma State Board of Medical Licensure and Supervision
P.O. Box 18256, Oklahoma City, OK 73154-0256

VERIFICATION OF CLINICAL CLERKSHIP

In the event a foreign medical school utilized clerkships in the United States, its territories or possessions, and the applicant graduated from medical school after July 1, 2003, such clerkships shall have been performed in hospitals and schools that have programs accredited by the Accreditation Council for Graduate Medical Education (ACGME).

One form must be completed and mailed directly to the Board for each clerkship.

This is to certify that Akeem Oseni (Student's Name); [redacted] (U.S. Social Security Number)

[redacted] (Date of Birth) a student of Saint James School of Medicine (Medical School)

Completed a clerkship offered by West Suburban Medical Center (Name of Facility)

3 Erie St. Oak Park, IL 60302 (Address of Facility)

From April (Month) 26 (Day) 2021 (Year) through May (Month) 21 (Day) 2021 (Year) in the clinical area

Of Pediatrics (Clinical Area).

This facility has programs that are accredited by ACGME in the areas of Pediatrics (Specialty).

I, D. Nikki Bekteshi, swear or affirm that I am/was the individual facility program director or instructor for the student named above during the clerkship indicated and that I have carefully read and completed this form and that the statements made herein are accurate.

Institution Seal

D. Nikki Bekteshi, MD, MHS
Type or Print Name of Facility Program Director or Instructor

West Suburban Medical Center
Address

3 Erie Oak Park IL 60302
City State Zip Code

708-567-2099
Telephone Number

D Nikki Bekteshi
Signature

In the absence of an official institution seal, the Facility Program Director or Instructor's signature must be notarized.

Signed and sworn before me this 28th day of April (Month) 2022 (Year).

WALID SAYYED
OFFICIAL SEAL
Notary Public, State of Illinois
My Commission Expires
May 24, 2023
Notary Seal

W Sayyed
Notary Public Signature

My Commission Expires: May 24, 2023

T 39698
VB

FORM #4 (MD)

Oklahoma State Board of Medical Licensure and Supervision
P.O. Box 18256, Oklahoma City, OK 73154-0256

VERIFICATION OF CLINICAL CLERKSHIP

In the event a foreign medical school utilized clerkships in the United States, its territories or possessions, and the applicant graduated from medical school after July 1, 2003, such clerkships shall have been performed in hospitals and schools that have programs accredited by the Accreditation Council for Graduate Medical Education (ACGME).

One form must be completed and mailed directly to the Board for each clerkship.

This is to certify that Akeem Oseni (Student's Name); [redacted] (U.S. Social Security Number)

[redacted] (Date of Birth) a student of Saint James School of Medicine (Medical School)

Completed a clerkship offered by West Suburban Medical Center (Name of Facility)

3 Erie St. Oak Park, IL 60302 (Address of Facility)

From February (Month) 15 (Day) 2021 (Year) through March (Month) 12 (Day) 2021 (Year) in the clinical area

Of Internal Medicine (Clinical Area).

This facility has programs that are accredited by ACGME in the areas of Internal Medicine (Specialty).

I, D. Nikki Bektteshi, swear or affirm that I am/was the individual facility program director or instructor for the student named above during the clerkship indicated and that I have carefully read and completed this form and that the statements made herein are accurate.

Institution Seal

D. Nikki Bektteshi, MD, MHS
Type or Print Name of Facility Program Director or Instructor

West Suburban Medical Cente
Address

3 Erie Oak Park, IL 60302
City State Zip Code

708-567-2099
Telephone Number

Signature

In the absence of an official institution seal, the Facility Program Director or Instructor's signature must be notarized.

Signed and sworn before me this 28th day of April (Month) 2022 (Year).

Notary Public Signature

WALID SAYYED
OFFICIAL SEAL
Notary Public, State of Illinois
My Commission Expires
May 24, 2023

My Commission Expires: May 24, 2023.

T39698
VD

FORM #4 (MD)

Oklahoma State Board of Medical Licensure and Supervision
P.O. Box 18256, Oklahoma City, OK 73154-0256

VERIFICATION OF CLINICAL CLERKSHIP

In the event a foreign medical school utilized clerkships in the United States, its territories or possessions, and the applicant graduated from medical school after July 1, 2003, such clerkships shall have been performed in hospitals and schools that have programs accredited by the Accreditation Council for Graduate Medical Education (ACGME).

One form must be completed and mailed directly to the Board for each clerkship.

This is to certify that Akeem Oseni (Student's Name); [redacted] (U.S. Social Security Number)

[redacted] (Date of Birth) a student of Saint James School of Medicine (Medical School)

Completed a clerkship offered by West Suburban Medical Center (Name of Facility)

3 Erie St. Oak Park, IL 60302 (Address of Facility)

From January (Month) 18 (Day) 2021 (Year) through February (Month) 12 (Day) 2021 (Year) in the clinical area

Of Infectious Disease (Clinical Area).

This facility has programs that are accredited by ACGME in the areas of Infectious Disease (Specialty).

I, D. Nikki Bekteshi, swear or affirm that I am/was the individual facility program director or instructor for the student named above during the clerkship indicated and that I have carefully read and completed this form and that the statements made herein are accurate.

Institution Seal

D. Nikki Bekteshi, MD MHS
Type or Print Name of Facility Program Director or Instructor

West Suburban Medical Center
Address

3 Erie Oak Park IL 60302
City State Zip Code

708-567-2099
Telephone Number

D. Nikki Bekteshi
Signature

In the absence of an official institution seal, the Facility Program Director or Instructor's signature must be notarized.

Signed and sworn before me this 28th day of April (Month) 2022 (Year).

WALID SAYYED
OFFICIAL SEAL
Notary Public, State of Illinois
My Commission Expires
May 24, 2023

Notary Public Signature

My Commission Expires: May 24, 2023

T39698
VB

FORM #4 (MD)

Oklahoma State Board of Medical Licensure and Supervision
P.O. Box 18256, Oklahoma City, OK 73154-0256

VERIFICATION OF CLINICAL CLERKSHIP

In the event a foreign medical school utilized clerkships in the United States, its territories or possessions, and the applicant graduated from medical school after July 1, 2003, such clerkships shall have been performed in hospitals and schools that have programs accredited by the Accreditation Council for Graduate Medical Education (ACGME).

One form must be completed and mailed directly to the Board for each clerkship.

This is to certify that Akeem Oseni (Student's Name); [redacted] (U.S. Social Security Number)

[redacted] (Date of Birth) a student of Saint James School of medicine (Medical School)

Completed a clerkship offered by Weiss Memorial Hospital (Name of Facility)

4646 N. Marine Dr. Suite A4950 Chicago, IL 60640 (Address of Facility)

From 10 (Month) 28 (Day) 2019 (Year) through 01 (Month) 17 (Day) 2020 (Year) in the clinical area

Of General Surgery (Clinical Area).

This facility has programs that are accredited by ACGME in the areas of Internal Medicine and Transitional Surgery Program (Specialty).

I, Eric Mizuno MD, swear or affirm that I am/was the individual facility program director or instructor for the student named above during the clerkship indicated and that I have carefully read and completed this form and that the statements made herein are accurate.

Institution Seal

Eric Mizuno MD
Type or Print Name of Facility Program Director or Instructor

4646 N. Marine Drive Suite A4950
Address

Chicago IL 60640
City State Zip Code

773 564 5437
Telephone Number

Signature

In the absence of an official institution seal, the Facility Program Director or Instructor's signature must be notarized.

Signed and sworn before me this _____ day of _____(Month) _____(Year).

Notary Public Signature

Notary Seal

My Commission Expires: _____

MD39698

SAINT JAMES SCHOOL OF MEDICINE
Your Future Our Promise

End of Clinical Rotation Assessment Form

Rotation: Ortho Surgery Student Name: Akeem Oseni
Start Date: 11-25-19 End Date: 12-20-19 No. of Weeks 4

Preceptor: Dr. Mitchell Goldflies Hospital/ Site Weiss Memorial Hospital
Address/ City/State/Zip: 4646 N. Marine Dr.
Contact Phone: 773-564-6183 Email mgmdsc@gmail.com

Student Assessment Scores

Please rate the student's achievement of each competency below on a scale of 0-10:
10 = Outstanding, 9 = Advanced, 8 = Proficient, 7 = Needs Remediation, 0-6 = Poor/Failing

Detailed information about SJSM intended learning outcomes is available on the website:
[illegible]

10 Patient Care (Integration of clinical knowledge and skills in patient care)
9 Medical Knowledge (Integration of basic science in medicine)
9 Practice-Based Learning and Improvement (Life-long learning and self-improvement)
10 Systems Based Practice (Organization and system based practice in medicine)
10 Professionalism
10 Interpersonal and Communication Skills

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MAY 16 2022
OKLAHOMA STATE BOARD OF MEDICAL LICENSURE AND SUPERVISION

58 TOTAL FOR SIX COMPETENCIES
A FINAL GRADE AWARDED (A = 54-60, B = 48-53, C = 42-47, F = 0-41)

FOR CORE ROTATIONS ONLY - Logbook Entries: Check the box as verification that all logbook entries for this rotation have been reviewed and verified. ☑

I certify, that I have not been involved in providing health care to the student ☑

Comments for Dean's Letter: *Please provide comments on the student's performance review for use in the Dean's letter. Please write legibly.*

Good patient physical Exams

Preceptor's Signature: [signature] Date: 12-20-19

Please return this form by mail to: Saint James School of Medicine, 1480 Renaissance Dr, Suite 300, Park Ridge, IL 60068 Phone: 847-375-[illegible] Fax: [illegible]

Weiss Hospital
4646 N. Marine Drive
Chicago, IL 60640

THANK YOU!

SAINT JAMES
SCHOOL OF MEDICINE
Your Future. Our Promise.

End of Clinical Rotation Assessment Form

Rotation: Plastic Surgery Student Name: Akeem Oseni

Start Date: 12-22-19 End Date: 1-17-20 No. of Weeks 4

Preceptor: Dr. Lawrence Zachary Hospital/ Site: Weiss Memorial Hospital

Address/ City/State/Zip: 4646 N Marine Dr

Contact Phone: 773-564-6133 Email: lszachary@gmail.com

Student Assessment Scores

Please rate the student's achievement of each competency below on a scale of 0-10:

10 = Outstanding, 9 = Advanced, 8 = Proficient, 7 = Needs Remediation, 0-6 = Poor/Failing

Detailed information about SJSM intended learning outcomes is available on the website:
https://www.sjsm.org/resources/downloads/

9 Patient Care (Integration of clinical knowledge and skills in patient care)
10 Medical Knowledge (Integration of basic science in medicine)
10 Practice-Based Learning and Improvement (Life-long learning and self-improvement)
10 Systems Based Practice (Organization and system-based approach to medicine)
10 Professionalism
10 Interpersonal and Communication Skills

59 **TOTAL FOR SIX COMPETENCIES**
A **FINAL GRADE AWARDED** (A = 54-60, B = 48-53, C = 42-47, F = 0-41)

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MAY 16 2022
OKLAHOMA STATE BOARD OF MEDICAL LICENSURE AND SUPERVISION

FOR CORE ROTATIONS ONLY - Logbook Entries: Check the box as verification that all logbook entries for this rotation have been reviewed and verified. ☐

I certify, that I have not been involved in providing health care to the student. ☑

Comments for Dean's Letter: *Please note **all** comments will be used in student's performance review for residency applications. Please write legibly.*

KNOWLEDGEABLE & ENGAGED IN CASES

Preceptor's Signature: _____ **Date:** 1/17/20

Please return this form by mail to:
Weiss Hospital
4646 N. Marine Drive
Chicago, IL 60640

Saint James School of Medicine
1480 Renaissance Dr. Suite 300,
Park Ridge, IL 60068.

Phone: 847-375-0543
Fax: 847-298-2375
sjsmclinical@mail.sjsm.org

THANK YOU!

SAINT JAMES
SCHOOL OF MEDICINE
Your Future, Our Promise.

Mid-Rotation Assessment Form

To be used for assessment purposes only. Do not use for billing.

Rotation: General Surg Student Name: Akeem Oseni

Start Date: 10/28/19 End Date: 1/17/20 No. of Weeks 12

Preceptor: DR Philip Zarbt Hospital/ Site: WEISS Mem Hospital

Address/ City/State/Zip: 4646 N. Marine dr Chicago IL 60640

Contact Phone: 773-564-6133 Email: _____

Student Assessment Scores

Please rate the student's achievement of each competency below on a scale of 0-10:

10 = Outstanding, 9 = Advanced, 8 = Proficient, 7 = Needs Remediation, 0-6 = Poor/Failing

Detailed information about SJSM intended learning outcomes is available on the website:
https://www.sjsm.org/resources/downloads/

- 10 Patient Care (Integration of clinical knowledge and skills in patient care)
- 10 Medical Knowledge (Integration of basic science in medicine)
- 10 Practice-Based Learning and Improvement (Life-long learning and self-improvement)
- 9 Systems Based Practice (Organization and system-based approach to medicine)
- 10 Professionalism
- 10 Interpersonal and Communication Skills

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MAY 16 2022
OKLAHOMA STATE BOARD OF MEDICAL LICENSURE AND SUPERVISION

- 59 **TOTAL FOR SIX COMPETENCIES**
- 59 **FINAL GRADE AWARDED** (A = 54-60, B = 48-53, C = 42-47, F = 0-41)

FOR CORE ROTATIONS ONLY - Logbook Entries: Check the box as verification that all logbook entries for this rotation have been reviewed and verified. ☑

I certify, that I have not been involved in providing health care to the student. ☑

How the student can **improve performance for the remainder of the rotation:**

Excellent student

Preceptor's Signature: _____ **Date:** 1/17/20

Please return this form by mail to:
Weiss Hospital
4646 N. Marine Drive
Chicago, IL 60640

Saint James School of Medicine
1480 Renaissance Dr. Suite 300,
Park Ridge, IL 60068.

Phone: 847-375-0543
Fax: 847-298-2375
sjsmclinical@mail.sjsm.org

THANK YOU!

SAINT JAMES
SCHOOL OF MEDICINE
Your Future. Our Promise.

End of Clinical Rotation Assessment Form

Rotation: General Surgery Student Name: Akeem Osemi

Start Date: 10-28-19 End Date: 11-22-19 No. of Weeks 4

Preceptor: Dr. Phillip Zaret Hospital/ Site: Weiss Memorial Hospital

Address/ City/State/Zip: 4646 N. Marine Dr

Contact Phone: 773-564-6133 Email: zaretmd@gmail.com

Student Assessment Scores

Please rate the student's achievement of each competency below on a scale of 0-10:

10 = Outstanding, 9 = Advanced, 8 = Proficient, 7 = Needs Remediation, 0-6 = Poor/Failing

Detailed information about SJSM intended learning outcomes is available on the website:
https://www.sjsm.org/resources/downloads/

10 Patient Care (Integration of clinical knowledge and skills in patient care)
9 Medical Knowledge (Integration of basic science in medicine)
10 Practice-Based Learning and Improvement (Life-long learning and self-improvement)
9 Systems Based Practice (Organization and system-based approach to medicine)
10 Professionalism
9 Interpersonal and Communication Skills

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OKLAHOMA STATE BOARD OF MEDICAL LICENSURE AND SUPERVISION

57 **TOTAL FOR SIX COMPETENCIES**

A 57 **FINAL GRADE AWARDED** (A = 54-60, B = 48-53, C = 42-47, F = 0-41)

FOR CORE ROTATIONS ONLY - Logbook Entries: Check the box as verification that all logbook entries for this rotation have been reviewed and verified. ☒

I certify, that I have not been involved in providing health care to the student. ☐

Comments for Dean's Letter: *Please note **all** comments will be used in student's performance review for residency applications. Please write legibly.*

Great student. A pleasure to have on the rotation.

Preceptor's Signature: _____ **Date:** 12/6/19

Please return this form by mail to: Saint James School of Medicine, 1480 Renaissance Dr. Suite 300, Park Ridge, IL 60068.

Phone: 847-375-0543
Fax: 847-298-2375
sjsmclinical@mail.sjsm.org

THANK YOU!

Weiss Hospital
4646 N. Marine Drive
Chicago, IL 60640

SAINT JAMES
SCHOOL OF MEDICINE
Your Future, Our Promise.

End ~~Mid~~ Rotation Assessment Form

To be used for assessment purposes only. Do not use for billing.

Rotation: General Surg Student Name: Akeem Oseni

Start Date: 10/28/19 End Date: 1/17/20 No. of Weeks 12

Preceptor: DR Philip Zarbt Hospital/ Site: Weiss Mem Hospital

Address/ City/State/Zip: 4646 N. Marine dr Chicago IL 60640

Contact Phone: _____ Email: _____

Student Assessment Scores

Please rate the student's achievement of each competency below on a scale of 0-10:

10 = Outstanding, 9 = Advanced, 8 = Proficient, 7 = Needs Remediation, 0-6 = Poor/Failing

Detailed information about SJSM intended learning outcomes is available on the website:
https://www.sjsm.org/resources/downloads/

10 Patient Care (Integration of clinical knowledge and skills in patient care)
10 Medical Knowledge (Integration of basic science in medicine)
10 Practice-Based Learning and Improvement (Life-long learning and self-improvement)
9 Systems Based Practice (Organization and system-based approach to medicine)
10 Professionalism
10 Interpersonal and Communication Skills

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OKLAHOMA STATE BOARD OF MEDICAL LICENSURE AND SUPERVISION

59 **TOTAL FOR SIX COMPETENCIES**
59 **FINAL GRADE AWARDED** (A = 54-60, B = 48-53, C = 42-47, F = 0-41)

FOR CORE ROTATIONS ONLY - Logbook Entries: Check the box as verification that all logbook entries for this rotation have been reviewed and verified. ☑

I certify, that I have not been involved in providing health care to the student. ☑

How the student can **improve performance for the remainder of the rotation:**

Excellent student

Preceptor's Signature: _____ **Date:** _____

Please return this form by mail to: Saint James School of Medicine
1480 Renaissance Dr. Suite 300,
Park Ridge, IL 60068.

Phone: 847-375-0543
Fax: 847-298-2375
sjsmclinical@mail.sjsm.org

THANK YOU!

FORM #4 (MD)

Oklahoma State Board of Medical Licensure and Supervision
P.O. Box 18256, Oklahoma City, OK 73154-0256

VERIFICATION OF CLINICAL CLERKSHIP

In the event a foreign medical school utilized clerkships in the United States, its territories or possessions, and the applicant graduated from medical school after July 1, 2003, such clerkships shall have been performed in hospitals and schools that have programs accredited by the Accreditation Council for Graduate Medical Education (ACGME).

One form must be completed and mailed directly to the Board for each clerkship.

This is to certify that Akeem Oseni; [redacted]
Student's Name — U.S. Social Security Number

[redacted] a student of Saint James school of Medicine
Date of Birth — Medical School

Completed a clerkship offered by Weiss Memorial Hospital
Name of Facility

RECEIVED
MAY 16 2022
OKLAHOMA STATE BOARD OF MEDICAL LICENSURE AND SUPERVISION

4646 N. Marine Dr. Suite A4950 Chicago, IL 60640
Address of Facility

From 07 (Month) 27 (Day) 2020 (Year) through 08 (Month) 21 (Day) 2020 (Year) in the clinical area

Of Internal Medicine.
Clinical Area

This facility has programs that are accredited by ACGME in the areas of Internal Medicine + Transitional.
Specialty — Program

I, Epic Hizono MD, swear or affirm that I am/was the individual facility program director or instructor for the student named above during the clerkship indicated and that I have carefully read and completed this form and that the statements made herein are accurate.

Institution Seal

Epic Hizono MD
Type or Print Name of Facility Program Director or Instructor

4646 N. Marine Drive Suite A4950
Address

Chicago — IL — 60640
City — State — Zip Code

773-564-5437
Telephone Number

Signature

In the absence of an official institution seal, the Facility Program Director or Instructor's signature must be notarized.

Signed and sworn before me this _____ day of _____(Month) _____(Year).

Notary Public Signature

Notary Seal

My Commission Expires:_____

SAINT JAMES
SCHOOL OF MEDICINE
Your Future, Our Promise

End of Clinical Rotation Assessment Form

Rotation: Internal Medicine Student Name: Akeem Oseni

Start Date: 7.20.20 End Date: 8.14.20 No. of Weeks 4

Preceptor: Dr. Eric Mizuno Hospital/ Site: Weiss Memorial Hospital

Address/ City/State/Zip: 4646 N. Marine Drive

Contact Phone: 312.859.4518 Email: ericmizuno@yahoo.com

Student Assessment Scores

Please rate the student's achievement of each competency below on a scale of 0-10:

10 = Outstanding, 9 = Advanced, 8 = Proficient, 7 = Needs Remediation, 0-6 = Poor/Failing

Detailed information about SJSM intended learning outcomes is available on the website:
https://www.sjsm.org/resources/downloads/

10 Patient Care (Integration of clinical knowledge and skills in patient care)
10 Medical Knowledge (Integration of basic science in medicine)
10 Practice-Based Learning and Improvement (Life-long learning and self-improvement)
9 Systems Based Practice (Organization and system-based approach to medicine)
9 Professionalism
10 Interpersonal and Communication Skills

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MAY 16 2022
OKLAHOMA STATE BOARD OF MEDICAL LICENSURE AND SUPERVISION

A **TOTAL FOR SIX COMPETENCIES**
SY **FINAL GRADE AWARDED** (A = 54-60, B = 48-53, C = 42-47, F = 0-41)

FOR CORE ROTATIONS ONLY - Logbook Entries: Check the box as verification that all logbook entries for this rotation have been reviewed and verified. ☐

I certify, that I have not been involved in providing health care to the student. ☑

Comments for Dean's Letter: *Please note **all** comments will be used in student's performance review for residency applications. Please write legibly.*

Preceptor's Signature: _____ **Date:** 9/23/20

Please return this form by mail to: Saint James School of Medicine, 1480 Renaissance Dr. Suite 300, Park Ridge, IL 60068.

Phone: 847-375-0543
Fax: 847-298-2375
sjsmclinical@mail.sjsm.org

Weiss Hospital
4646 N. Marine Drive
Chicago, IL 60640

THANK YOU!

SAINT JAMES
SCHOOL OF MEDICINE
Your Future. Our Promise.

End of Clinical Rotation Assessment Form

Rotation: Internal Medicine Student Name: Akeem Osani

Start Date: 7.27.20 End Date: 8.21.20 No. of Weeks 4

Preceptor: Dr. Eric Miwood Hospital/ Site: Weiss Memorial Hospital

Address/ City/State/Zip: 4646 N. Marine Drive

Contact Phone: 773 564. 6183 Email: ericmiwood@yahoo.com

Student Assessment Scores

Please rate the student's achievement of each competency below on a scale of 0-10:

10 = Outstanding, 9 = Advanced, 8 = Proficient, 7 = Needs Remediation, 0-6 = Poor/Failing

Detailed information about SJSM intended learning outcomes is available on the website:
https://www.sjsm.org/resources/downloads/

4 Patient Care (Integration of clinical knowledge and skills in patient care)
4 Medical Knowledge (Integration of basic science in medicine)
4 Practice-Based Learning and Improvement (Life-long learning and self-improvement)
4 Systems Based Practice (Organization and system-based approach to medicine)
4 Professionalism
4 Interpersonal and Communication Skills

24 **TOTAL FOR SIX COMPETENCIES**
A **FINAL GRADE AWARDED** (A = 54-60, B = 48-53, C = 42-47, F = 0-41)

FOR CORE ROTATIONS ONLY - Logbook Entries: Check the box as verification that all logbook entries for this rotation have been reviewed and verified. ☐

I certify, that I have not been involved in providing health care to the student. ☑

Comments for Dean's Letter: *Please note **all** comments will be used in student's performance review for residency applications. Please write legibly.*

Preceptor's Signature: _____ **Date:** 8/29/20

Please return this form by mail to: Saint James School of Medicine, 1480 Renaissance Dr. Suite 300, Park Ridge, IL 60068. Phone: 847-375-0543, Fax: 847-298-2375, sjsmclinical@mail.sjsm.org

THANK YOU!

Weiss Hospital
4646 N. Marine Drive
Chicago, IL

FORM #4 (MD)

Oklahoma State Board of Medical Licensure and Supervision
P.O. Box 18256, Oklahoma City, OK 73154-0256

VERIFICATION OF CLINICAL CLERKSHIP

In the event a foreign medical school utilized clerkships in the United States, its territories or possessions, and the applicant graduated from medical school after July 1, 2003, such clerkships shall have been performed in hospitals and schools that have programs accredited by the Accreditation Council for Graduate Medical Education (ACGME).

One form must be completed and mailed directly to the Board for each clerkship.

This is to certify that Akeem Oseni (Student's Name); [redacted] (U.S. Social Security Number)

[redacted] (Date of Birth) a student of Saint James School of medicine (Medical School)

RECEIVED
MAY 16 2022
OKLAHOMA STATE BOARD OF MEDICAL LICENSURE AND SUPERVISION

Completed a clerkship offered by Weiss Memorial Hospital (Name of Facility)

4646 N. Marine Dr. Suite A4950 Chicago, IL 60640 (Address of Facility)

From 06 (Month) 15 (Day) 2020 (Year) through 07 (Month) 10 (Day) 2020 (Year) in the clinical area

Of Radiology (Clinical Area).

This facility has programs that are accredited by ACGME in the areas of Internal Medicine + Transitional (Specialty) Program.

I, Eric Hizuno MD, swear or affirm that I am/was the individual facility program director or instructor for the student named above during the clerkship indicated and that I have carefully read and completed this form and that the statements made herein are accurate.

Institution Seal

Eric Hizuno MD
Type or Print Name of Facility Program Director or Instructor

4646 N. Marine Drive Suite A4950
Address

Chicago (City) ILL (State) 60640 (Zip Code)

773-564-5431
Telephone Number

Signature

In the absence of an official institution seal, the Facility Program Director or Instructor's signature must be notarized.

Signed and sworn before me this _____ day of _____(Month) _____(Year).

Notary Public Signature

Notary Seal

My Commission Expires:_____

SAINT JAMES
SCHOOL OF MEDICINE
Your Future. Our Promise.

End of Clinical Rotation Assessment Form

Rotation: Radiology Student Name: Akeem Oseni

Start Date: 6.15.20 End Date: 7.10.20 No. of Weeks 4

Preceptor: Dr. Arnit Kapur Hospital/ Site: Weiss Memorial Hospital

Address/ City/State/Zip: 4646 N. Marine Dr.

Contact Phone: 773-564-6153 Email: arnitkapur@gmail.com

Student Assessment Scores

Please rate the student's achievement of each competency below on a scale of 0-10:
10 = Outstanding, 9 = Advanced, 8 = Proficient, 7 = Needs Remediation, 0-6 = Poor/Failing

Detailed information about SJSM intended learning outcomes is available on the website:
https://www.sjsm.org/resources/downloads/

10 Patient Care (Integration of clinical knowledge and skills in patient care)
10 Medical Knowledge (Integration of basic science in medicine)
10 Practice-Based Learning and Improvement (Life-long learning and self-improvement)
10 Systems Based Practice (Organization and system-based approach to medicine)
10 Professionalism
10 Interpersonal and Communication Skills

60 TOTAL FOR SIX COMPETENCIES
A FINAL GRADE AWARDED (A = 54-60, B = 48-53, C = 42-47, F = 0-41)

FOR CORE ROTATIONS ONLY - Logbook Entries: Check the box as verification that all logbook entries for this rotation have been reviewed and verified. ☐

I certify, that I have not been involved in providing health care to the student. ☐

Comments for Dean's Letter: *Please note all comments will be used in student's performance review for residency applications. Please write legibly.*

MR Oseni WILL BE AN ASSET TO THE MEDICAL COMMUNITY.

Preceptor's Signature: [signature] **Date:** 7/13/20

Please return this form by mail to: Saint James School of Medicine, 1480 Renaissance Dr. Suite 300, Park Ridge, IL 60068.
Phone: 847-375-0543
Fax: 847-298-2375
sjsmclinical@mail.sjsm.org

THANK YOU!

FORM #4 (MD)

Oklahoma State Board of Medical Licensure and Supervision
P.O. Box 18256, Oklahoma City, OK 73154-0256

VERIFICATION OF CLINICAL CLERKSHIP

In the event a foreign medical school utilized clerkships in the United States, its territories or possessions, and the applicant graduated from medical school after July 1, 2003, such clerkships shall have been performed in hospitals and schools that have programs accredited by the Accreditation Council for Graduate Medical Education (ACGME).

One form must be completed and mailed directly to the Board for each clerkship.

This is to certify that Akeem Oseni (Student's Name); [redacted] (U.S. Social Security Number)

[redacted] (Date of Birth) a student of Saint James School of Medicine (Medical School)

Completed a clerkship offered by South Loop Urgent Care (Name of Facility)

1430 S. Michigan Ave. Chicago, IL 60605 (Address of Facility)

From November (Month) 23 (Day) 2020 (Year) through December (Month) 18 (Day) 2020 (Year) in the clinical area

Of Urgent Care (Clinical Area).

This facility has programs that are accredited by ACGME in the areas of Urgent Care (Specialty).

I, Leonard Levites, MD, swear or affirm that I am/was the individual facility program director or instructor for the student named above during the clerkship indicated and that I have carefully read and completed this form and that the statements made herein are accurate.

Institution Seal

South Loop Urgent Care
Type or Print Name of Facility Program Director or Instructor

1430 S Michigan Ave
Address

Chicago IL 60605
City State Zip Code

3126633522
Telephone Number

Signature

In the absence of an official institution seal, the Facility Program Director or Instructor's signature must be notarized.

Signed and sworn before me this 12th day of May (Month) 2022 (Year).

DASHURIJE BEKTESHI
OFFICIAL SEAL
Notary Public, State of Illinois
My Commission Expires
March 29, 2023

Notary Public Signature

My Commission Expires: March 29, 2023.

MD39698
SJ

FORM #4 (MD)

RECEIVED
MAY 20 2022
OKLAHOMA STATE BOARD OF MEDICAL LICENSURE AND SUPERVISION

Oklahoma State Board of Medical Licensure and Supervision
P.O. Box 18256, Oklahoma City, OK 73154-0256

VERIFICATION OF CLINICAL CLERKSHIP

In the event a foreign medical school utilized clerkships in the United States, its territories or possessions, and the applicant graduated from medical school after July 1, 2003, such clerkships shall have been performed in hospitals and schools that have programs accredited by the Accreditation Council for Graduate Medical Education (ACGME).

One form must be completed and mailed directly to the Board for each clerkship.

This is to certify that Akeem Oseni (Student's Name); [redacted] (U.S. Social Security Number)

[redacted] (Date of Birth) a student of Saint James School of Medicine (Medical School)

Completed a clerkship offered by Neurological Care Specialists (Name of Facility)

908 N. Elm St. Hinsdale, IL 60521 (Address of Facility)

From December (Month) 21 (Day) 2020 (Year) through January (Month) 15 (Day) 2021 (Year) in the clinical area

Of Neurology (Clinical Area).

This facility has programs that are accredited by ACGME in the areas of Neurology (Specialty).

I, Jason Parikh, swear or affirm that I am/was the individual facility program director or instructor for the student named above during the clerkship indicated and that I have carefully read and completed this form and that the statements made herein are accurate.

Institution Seal

Jason Parikh MD
Type or Print Name of Facility Program Director or Instructor

908 N. Elm St. Suite 110
Address

Hinsdale IL 60521
City State Zip Code

630-986-8770
Telephone Number

Signature

In the absence of an official institution seal, the Facility Program Director or Instructor's signature must be notarized.

Signed and sworn before me this 12th day of May (Month) 2022 (Year).

Notary Public Signature

Notary Seal

DASHURIJE BEKTESHI
OFFICIAL SEAL
Notary Public, State of Illinois
My Commission Expires
March 29, 2023

My Commission Expires: March 29, 2023

MD39698
87

ECFMG®
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: 26 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.

RECEIVED
APR 26 2022
OKLAHOMA STATE BOARD OF MEDICAL LICENSURE

ECFMG® CERTIFICATION STATUS REPORT

PRIMARY SOURCE

USMLE®/ECFMG Identification Number: 1-036-771-2
Applicant's Name: Akeem Olarewaju Oseni
Applicant's Date of Birth: [redacted]
ECFMG Certified: Yes
Certificate Issue Date: 15 Mar 2022
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	14 Sep 2018	*	*
USMLE Step 2 CK	02 Oct 2020	*	*

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: Saint James School of Medicine Anguilla, The Quarter, ANGUILLA
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.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: YVCOA857P7

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.

TMD39698
SD

AMA Physician Profile

PREPARED FOR

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

Name and Mailing Address

AKEEM OLAREWAJU OSENI
[redacted]

Primary Office Address

ST ANTHONY HOSP
STE 1000
608 NW 9TH ST
OKLAHOMA CITY, OK 73102-1014
Phone UNKNOWN

Birth date [redacted]

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: SAINT JAMES SCHOOL OF MEDICINE ANGUILLA

Degree Awarded:	YES	**Degree Type:**	MD
Enrollment Date:	NOT REPORTED	**Degree Date:**	2020

T39698

AMA
AMERICAN MEDICAL ASSOCIATION

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: ST ANTHONY HOSPITAL
Sponsoring State: OKLAHOMA
Program name: SSM HEALTH ST ANTHONY HOSPITAL PROGRAM
Specialty: FAMILY MEDICINE
Training Type: SPECIALTY
Dates: 06/20/2022 - 09/24/2025
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
39698	MD	OK	07/01/2022	09/30/2024		ACT	RES	05/06/2024	AKEEM OLAREWAJU OSENI

AMA
AMERICAN MEDICAL ASSOCIATION

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: 10367712

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.

Illinois Department of Financial and Professional Regulation

PRIMARY SOURCE

Lookup Detail View

Contact

Contact Information

Name	City/State/Zip	DBA / AKA
AKEEM OLAREWAJU OSENI	Chicago, IL 60649	

License

License Information

License Number	Description	Status	First Effective Date	Effective Date	Expiration Date	Ever Disciplined
041447121	REGISTERED PROFESSIONAL NURSE	ACTIVE	10/13/2016	08/10/2020	08/31/2022	N

Generated on: 5/9/2022 4:02:20 PM

OKLAHOMA BOARD OF NURSING
Primary Source License Verification

Verification Report

Primary Source Board of Nursing Report Summary for

AKEEM OLAREWAJU OSENI

Monday, May 09 2022 04:04:19 PM

For a more accurate search, select "Search by License Number" or "Search by NCSBN ID" above.Partial name searches are accepted

For nurses (RNs and LPNs) this report is not sufficient as primary license verification when applying to another board of nursing for licensure. For primary verification to transfer/endorse to another state, use the Nurse License Verification (https://www.nursys.com/) service to request the required verification of licensure.

Temporary and Permanent (Post Exam) License(s)/Certificate(s)

Name on License	License/Certificate Type	License/Certificate Number	License Status	Original Issue Date	Current Expiration Date	Compact Status	Discipline
OSENI, AKEEM OLAREWAJU	RN	R0089729	Lapsed	07/16/2007	09/30/2018	N/A	NO

License type information

- **RN:** Registered Nurse
- **PN:** Practical Nurse (aka Licensed Practical Nurse (LPN), Vocational Nurse (VN), Licensed Vocational Nurse (LVN))
- **CNP:** Certified Nurse Practitioner
- **CNS:** Clinical Nurse Specialist
- **CNM:** Certified Nurse Midwife
- **CRNA:** Certified Registered Nurse Anesthetist

Nurse Licensure Compact (NLC) information

- **Multistate licensure privilege:** Authority to practice as a licensed nurse in a remote state under the current license issued by the individual's home state provided both states are party to the Nurse Licensure Compact and the privilege is not otherwise restricted.
- **Single state license:** A license issued by a state board of nursing that authorizes practice only in the state of issuance.
- More information about the Nurse Licensure Compact (NLC) (https://www.ncsbn.org/nurse-licensure-compact.htm)

OKLAHOMA STATE BOARD OF MEDICAL LICENSURE AND SUPERVISION
101 NE 51st STREET
OKLAHOMA CITY OK 73105

EVIDENCE OF STATUS – PART A

Full Legal Name: AKEEM OLAREWAJU OSENI
First Middle Last Maiden (if applicable)

Mailing Address: [redacted]

[redacted] **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 4-26-2022

Subscribed and sworn before me this 26th day of April, 2022.

Notary Public Ceonna Martin

Commission Number 937270

My commission expires August 16, 2025

NOTARY SEAL

"OFFICIAL SEAL"
CEONNA A MARTIN
Notary Public - State of Illinois
My Commission Expires August 16, 2025

T 314 98 MA

DEFICIENCY UPDATED

1. Exam verification date..... N/A (Cleared over the phone).

2. Translations..... N/A (Cleared over the phone).

3. PostGrad - Form 2 ST ANTHONY HOSPITAL.... N/A (1ST year training, cleared over the phone)

4. USMLE Exams Incomplete..... N/A (Cleared over the phone).

5. An extended Background Check was completed and the link to the result was emailed to me on May 2, 2022. I will attach a copy to this email.

   I have lived in Oklahoma City, Oklahoma, and Chicago, IL only in the United States. I have never visited or resided in New Orleans and the Florida States.

6. Time DEFICIENCIES: 9/95 - 9/96 (PLEASE USE TIME DEFICENCY FORM) .... I emailed an updated copy on May 2, 2022. I will attach a copy to this mail.

7. OTHER DEFICIENCIES: NEED EVAL OF US ROTATIONS *OR* FORM 4 FOR EACH:

   I have contacted all the institutions, some have mailed the forms, and others promised that they would be mailed out this week.

8. WHAT IS YOUR JOB TITLE AT FAMILY DR URGENT CARE IN CHICAGO?

   Graduate medical student assistance. I do not have any job title; I do the same work as a medical student.

   In August 2021, I applied to Family medicine urgent care as a medical student and after I graduated in September 2021, I was no longer a medical student and became a graduate medical student assistant. I am continuing to do the same job that I was doing as a medical student, responsible for taking patient history, physical examination, and patient education, and now am mentoring other medical students. I worked under the supervision of my attending physician, and the main purpose of this job is to prepare for the residency program. The job does not require any license, because I was only allowed to do the work I was doing as a medical student.

T39498

9. ADDRESS ON APPLICATION DOES NOT MATCH ADDRESS ON BACKGROUND CHECK NEED CURRENT MAILING ADDRESS REQUIRED/
I moved from Oklahoma City, Oklahoma to Chicago IL for school, and I am moving back to Oklahoma on May 31st, 2022.

My current address from now – May 31, 2022.

[redacted]

I will be moving back to my house in Oklahoma City, Oklahoma on June 1st, 2022. My address in Oklahoma is as follows:

Mailing address is

[redacted]

Permanent address is

[redacted]

*DO NOT NEED:

Verify License from OK RN R0089729.....Done
Verify License from IL 041447121.....Done

RECEIVED
MAY 13 2022
OKLAHOMA STATE BOARD OF MEDICAL LICENSURE AND SUPERVISION

T39698 nah

Name:	AKEEM OSENI	Application #	

We have to 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
08	1994	07	1996	Kaduna Polythecnic	ZARIA	NIGERIA	Left for USA
08	1997	05	2000	Oklahoma City Community College	Oklahoma City	OK	Associate of Science
01	2000	05	2002	University of Oklahoma	Norman	OK	B.S. Biochemistry
08	2005	05	2007	University of Oklahoma Health Science	Oklahoma City	OK	B.S Nursing

WORK HISTORY

Start Month	Start Year	End Month	End Year	Name of Employer	City	State	Job Title
09	1996	08	1997	McDonald Coporation	Oklahoma City	Ok	Cook
09	01	01	2008	Bob Howard Auto Group	Oklahoma City	OK	Auto Sales consultant
06	2007	08	2014	University of Oklahoma Medical Center	Oklahoma City	OK	Registered nurse
08	2016	12	2018	Buying/Selling goods to finance my school/ Study for STEPS Exams.	Chicago	IL	Sales
08	2001	Till date	Till date	Family Doctor Urgent Care	Chicago	IL	Medical graduate Assistance

OTHER ACTIVITY

Start Month	Start Year	End Month	End Year	Other Activity (example: Unemployed, Stay at home parent, etc.)	City	State
08	2014	12	2015	Saint James School of Medicine	Anguilla	Anguila
01	2016	01	2016	School break for transistion from Aguilla to USA	Kwara	Nigeria
01	2016	02	2016	School break for Transition from Aguilla to USA	Oklahoma Ci	Oklahoma
03	2016	08	2016	Saint James School of Medicine	Chicago	IL
08	2016	12	2018	Leave of absence due to financial difficulty	Chicago	IL
01	2019	09	2021	Saint James School of Medicine	Chicago	IL

9/1995-9/1996

RECEIVED
MAY 13 2022
OKLAHOMA STATE BOARD OF MEDICAL LICENSURE AND SUPERVISION

T39698

OKLAHOMA STATE BOARD OF MEDICAL LICENSURE AND SUPERVISION
101 NE 51ST 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 Wiser 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.

Akeem Olarewaju Gbeni — Name of Applicant (type or print)

Signature of Applicant

4-26-2022 — 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.

T396 CB MA

To Whom It May Concern:

In August 2016, I took a leave of absence to save money for my education, while also preparing for my Step 1 exam. I started an online business during this time, and I stopped in December 2018. I would search for the products I wanted to sell from a big company and then list these products for a higher price on website like eBay and Amazon. Once a customer purchases a product from me, I will order it from the big company and shipped directly to the customers, saving the profits to finance my education and other expenses because I could not get a loan and my school does not offer guaranteed student loans.

Akeem Oseni

Notarized by Ceonna Martin

"OFFICIAL SEAL"
CEONNA A MARTIN
Notary Public - State of Illinois
My Commission Expires August 16, 2025

T39698
MA

05/09/2022

AKEEM OLAREWAJU OSENI

[redacted]

Check Your Application Status Online at:
http://www.okmedicalboard.org
***Username*:AP21992151**
***Password*:Last 4 SSN**

RE: MD Application #39698

Dear AKEEM OSENI,

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 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
Translations
PostGrad - Form 2 ST ANTHONY HOSPITAL
USMLE Exams Incomplete
Extended Background Check
Time DEFICIENCIES: 9/95 - 9/96 (PLEASE USE TIME DEFICENCY FORM)
OTHER DEFICIENCIES: NEED EVAL OF US ROTATIONS *OR* FORM 4 FOR EACH / WHAT IS YOUR JOB TITLE AT FAMILY DR URGENT CARE IN CHICAGO? / ADDRESS ON APPLICATION DOES NOT MATCH ADDRESS ON BACKGROUND CHECK NEED CURRENT MAILING ADDRESS REQUIRED/ *DO NOT NEED:
Verify License from OK RN R0089729
Verify License from IL 041447121

If a "*Time Deficiency*" is listed, please e-mail 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). Your user name is AP21992151 (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 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	39698	AKEEM OLAREWAJU OSENI

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 ST ANTHONY HOSPITAL
USMLE Exams Incomplete
OTHER DEFICIENCIES: *DO NOT NEED: FORM 2, STEP 3, AMA, FED, NPDB*
AMA Profile Not Received (to be completed by OSBMLS Staff)
Federation Clearance Not Received (to be completed by OSBMLS Staff)

Last Medical School Attended:
793-02 St. James School of Medicine (Anguilla or St. Vincent Campus) frmly 665-03

Number of Licenses Previously Granted to Graduates of this Medical School:1

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** _____ MG 6-2-22

5) **REQUESTS SPECIFIC CONSIDERATION OF:**

_____

_____

_____

_____

_____

ATTACHMENT 1

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

RECEIVED
JUN 30 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	AKEEM	**LAST NAME**	OSENI
EMAIL ADDRESS	[redacted]		
LICENSE NUMBER	39698	**CELL PHONE**	[redacted]
HOME ADDRESS	[redacted]	**CITY/STATE**	
		ZIP CODE	
PROGRAM ATTENDING	Cheyn Onarecker, MD	**SPECIALTY**	Family medicine

DOCUMENTATION TO ATTACH

PAYMENT COMPLETED			
☒	$150 payment made on Billpay for **RENEWAL** of training license	☐	$250 payment made on Billpay for **UPGRADE** of training license

DOCUMENTATION REQUIRED			
☐	Form 2 (must be received directly from program) ****ONLY FOR UPGRADE** - ATTACHMENT 3	☐	Evaluation (must be received directly from program) - ATTACHMENT 4
☒	USMLE Step 3 (must be received directly from USMLE)	☒	Answer confidential questions (on back of this form)

FOREIGN TRAINED STUDENTS			
☐	Current visa	☐	Social Security Number **if not provided at initial application
☐	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.

T39698
LKC

RECEIVED

JUN 30 2023

OKLAHOMA STATE BOARD OF MEDICAL LICENSURE AND SUPERVISION

NAME Akeem Oseni, MD

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)?	☒	☐
Have you been the subject of investigation or disciplinary action (including probation) by a hospital or training program?	☒	☐
Have you had any adverse judgment or settlement against you rising from a professional liability claim?	☐	☒
Have you been reported to the National Practitioner Data Bank (NPDB)?	☐	☒
Have you ever been denied, had removed, or suspended hospital privileges?	☐	☒
Have you surrendered hospital privileges while under investigation or to avoid investigation?	☐	☒
Have you entered into an Agreement with a Federal, State, or Local jurisdictional body to avoid formal action?	☐	☒
Has your application for licensure ever been denied?	☐	☒
Have you surrendered a license or had any disciplinary action taken on any license?	☐	☒
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)?	☐	☒
Have you obtained an assessment or been treated for use of any drug or chemical substance including alcohol?	☐	☒
Have you been arrested for, charged with, or convicted of a felony or misdemeanor other than a traffic violation?	☐	☒
Have you been arrested for, charged with, or convicted of a traffic violation involving the use of any drug or chemical substance?	☐	☒
Have you been addicted to or abused any drug or chemical substance including alcohol?	☐	☒
Have you been denied provider participation, terminated, sanctioned or penalized by any third-party payor including TRICARE, MEDICARE, or MEDICAID?	☐	☒
Have you surrendered or had any adverse action taken against any narcotic permit (State or Federal)?	☐	☒

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.

6/c (MM 6-28-23

Signature [signature]

Date 6/26/23

RENEWAL QUESTIONNAIRE UPDATED 01-2023

T39698
UKL

Name: Akeem Oseni
LIC ID: 39698

To Whom It May Concern

This letter is written to notify Oklahoma Medical Board that I failed on my first attempt of Steps 3 exam which was written on March 23 & 25, 2023. It was retake, and passed on the second attempt which was written on May 12 & 13, 2023. On June 16, 23 I was placed on probation for clinical competence and I will be reassessed on September 24th, 2023.

Thank you
Oseni, Akeem MD

Akeem Oseni -

07/27/2023
Exp: 04/20/2026

SKYLAR SMITH
NOTARY
22005571
EXP. 04/20/26
PUBLIC
STATE OF OKLAHOMA

T39698
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

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

Name of Resident (please print) Akeem Olarewaju Oseni

License Number 39698 Specialty Family Medicine

Institution Name St. Anthony Hospital

Program Director (please print) Cheyn Onarecker, M.D.

Program Director Email cheyn.onarecker@ssmhealth.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	☐	☐	☑	☐	☐	☐
APPLICATION OF MEDICAL KNOWLEDGE	☐	☐	☐	☑	☐	☐
COMMUNICATION SKILLS	☐	☐	☐	☑	☐	☐
STABILITY IN WORKING RELATIONSHIP WITH OTHER PROFESSIONALS	☐	☐	☐	☐	☑	☐
THE INDIVIDUAL'S PERFORMANCE COMMENSURATE WITH PEER GROUP	☐	☐	☑	☐	☐	☐

REMARKS/COMMENTS Resident Oseni's Training Medical License needs to be extended until September 24, 2023. Dr. Oseni was placed on academic probation and is undergoing remediation. We expect him to meet probation requirements and be ready for promotion

COMPLETED BY (please print) Cheyn Onarecker, M.D.

SIGNATURE Cheyn Onarecker DATE 7/17/2023

Evaluation revised 1-2023

T39698
UKC

Oklahoma State Board of Medical Licensure and Supervision
Application Summary

Type	Number	Name
MD	41337	RACHEL ANNE OURSBOURN

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:
028-46 UNIV OF MO-KANSAS CITY SCH OF MED, KANSAS CITY MO 64108

Number of Licenses Previously Granted to Graduates of this Medical School:174

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	41337	RACHEL ANNE OURSBOURN

MEDICAL DOCTOR

Practice Address:

April 19, 2023

Status:
Res: TR
Received: 03/29/2023
Entered: 03/29/2023
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 #: 41337
Sex: F
Ethnic Origin: 1

Endorsed By: USMLE

	Test	Score	Date Taken	Date Verified	Attempts
Test 1:	USMLE 3	PASS	03/18/24	4/12/24	1
Test 2:	USMLE 1	PASS	06/17/21	4/3/23	1
Test 3:	USMLE 2	PASS	08/29/22	4/3/23	1

Note: ***PASS*** means higher than 75

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

PRE-MED EDUCATION

School Name: UNIVERSITY OF MISSOURI - KANSAS CITY
City: KANSAS CITY **State:** MO **Country:** UNITED STATES
Degree: BACHELOR OF ARTS - BIOLOGY **From:** 8/2015 **To:** 5/2022 **Verified:**

School Name: LEBANON HIGH SCHOOL
City: LEBANON **State:** MO **Country:** UNITED STATES
Degree: DIPLOMA **From:** 8/2011 **To:** 5/2015 **Verified:**

MEDICAL SCHOOL EDUCATION

Name: UNIV OF MO-KANSAS CITY SCH OF MED, KANSAS CITY MO 64108
Foreign Name:
City: Kansas City **State/Country:** United States of America
Degree: MEDICINE - MD **From:** 5 / 2019 **To:** 5 / 2023 **Diploma Ver'd:** Y

Oklahoma State Board of Medical Licensure and Supervision
Application Summary

Type	Number	Name
MD	41337	RACHEL ANNE OURSBOURN

MEDICAL DOCTOR

POST GRADUATE EDUCATION

Facility: COLLEGE OF MEDICINE OKC **Specialty:** PEDIATRICS
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: **Supervisor:**
City: **State:** **Country:**
Specialty: **From:** / **To:** / **Verified:**
Comments:

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

RECEIVED
APR 14 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	Rachel	**LAST NAME**	Oursbourn
EMAIL ADDRESS	[redacted]		
LICENSE NUMBER	41337	**CELL PHONE**	[redacted]
HOME ADDRESS	[redacted]	**CITY/STATE ZIP CODE**	[redacted]
PROGRAM ATTENDING	University of Oklahoma	**SPECIALTY**	Pediatrics

DOCUMENTATION TO ATTACH

PAYMENT COMPLETED			
☐	$150 payment made on Billpay for **RENEWAL** of training license	☒	$250 payment made on Billpay for **UPGRADE** of training license Paid 4/11/2024

DOCUMENTATION REQUIRED			
☐	Form 2 (must be received directly from program) ****ONLY FOR UPGRADE** Will be sent 6/30/2024	☐	Evaluation (must be received directly from program)
☒	USMLE Step 3 (must be received directly from USMLE) Sent 4/11/2024	☒	Answer confidential questions (on back of this form)

FOREIGN TRAINED STUDENTS			
☐	Current visa	☐	Social Security Number **if not provided at initial application
☐	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.

41337
SJ

RECEIVED
APR 14 2024
OKLAHOMA STATE BOARD OF MEDICAL LICENSURE AND SUPERVISION

NAME Rachel Oursbourn

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)?	☐	☒
Have you been the subject of investigation or disciplinary action (including probation) by a hospital or training program?	☐	☒
Have you had any adverse judgment or settlement against you rising from a professional liability claim?	☐	☒
Have you been reported to the National Practitioner Data Bank (NPDB)?	☐	☒
Have you ever been denied, had removed, or suspended hospital privileges?	☐	☒
Have you surrendered hospital privileges while under investigation or to avoid investigation?	☐	☒
Have you entered into an Agreement with a Federal, State, or Local jurisdictional body to avoid formal action?	☐	☒
Has your application for licensure ever been denied?	☐	☒
Have you surrendered a license or had any disciplinary action taken on any license?	☐	☒
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)?	☐	☒
Have you obtained an assessment or been treated for use of any drug or chemical substance including alcohol?	☐	☒
Have you been arrested for, charged with, or convicted of a felony or misdemeanor other than a traffic violation?	☐	☒
Have you been arrested for, charged with, or convicted of a traffic violation involving the use of any drug or chemical substance?	☐	☒
Have you been addicted to or abused any drug or chemical substance including alcohol?	☐	☒
Have you been denied provider participation, terminated, sanctioned or penalized by any third-party payor including TRICARE, MEDICARE, or MEDICAID?	☐	☒
Have you surrendered or had any adverse action taken against any narcotic permit (State or Federal)?	☐	☒

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 [signature] Date 4/11/2024

RENEWAL QUESTIONNAIRE
UPDATED 03/2024

Lisa Cullen

From: Rachel Wright-Oursbourn [redacted]
Sent: Thursday, June 8, 2023 4:01 PM
To: OK Training
Subject: [EXTERNAL] Oklahoma MD Application #41337

To Whom It May Concern,

I noticed a deficiency on my MD license application (#41337) regarding academic probation. To clarify, I was placed on academic probation for failure to complete one undergraduate course. My probation period was approximately one and a half years before meeting criteria to be released. If I had marked "no" on my application, it was an oversight and I apologize for the confusion. Please let me know if you require any additional information to resolve this issue.

Thank you in advance,
Rachel Oursbourn

T41337
UCL

Oklahoma State Board of Medical Licensure and Supervision

APPLICATION FOR OKLAHOMA MEDICAL DOCTOR LICENSE

Received:03/29/2023

Applicant Name: OURSBOURN, RACHEL ANNE "Alexander" "Wright" **MD 41337**

[redacted]

Date Of Birth: [redacted] **Place Of Birth (City, State):** LEBANON, MO

Sex: F **Race:** Caucasian

Education

Type	Name	City	ST	Country	From	To	Degree	Comments	Veri
UG	UNIVERSITY OF MISSOURI - KANSAS CITY	KANSAS CITY	MO		8/2015	5/2022	BACHELOR OF ARTS - BIOLOGY		

Medical School Name	City	State	Country	Comments	From	To
UNIV OF MO-KANSAS CITY SCH OF MED, KANSAS CITY MO 64108	Kansas City	MO	United States		5/2019	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				

$250 ✓ SJ

Oklahoma State Board of Medical Licensure and Supervision

APPLICATION FOR OKLAHOMA MEDICAL DOCTOR LICENSE

Received:03/29/2023

	Questions Answered 03/27/2023	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: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:

University of Oklahoma

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

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.

RECEIVED
MAR 30 2023
OKLAHOMA STATE BOARD OF MEDICAL LICENSURE AND SUPERVISION

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

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

3/28/2023
Date of signature (must correspond to the date of notarization)

NOTARY

State of Missouri **, County of** Jackson

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 28th day of March, 2023

Notary Public Signature Cheri Burton My Notary Commission Expires 12/16/2023

NOTARY SEAL

T41337 SD

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: 04/11/2024

Examinee: Oursbourn, Rachel Anne
Alt Name(s): Wright, Rachel Anne

Examinee ID: 4-166-071-3
Date of Birth: [redacted]

Results for Steps taken by this examinee (and for which results have been reported to date) are shown below. For Steps that span more than one day, the test date reflects the day on which the examination began. 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
06/17/2021	Pass	209	(194)	

USMLE STEP 2

Clinical Knowledge (CK)

Test Date	Pass/Fail	Score	Minimum Pass	Comments
08/29/2022	Pass	237	(214)	

USMLE STEP 3

Test Date	Pass/Fail	Score	Minimum Pass	Comments
03/18/2024	Pass	219	(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.

Rev 2018

T41337 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: Oursbourn, Rachel Anne

Examinee ID: 4-166-071-3
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: Rachel A. Oursbourn (Wright)

Institution: University of Missouri-Kansas City City/State: Kansas City, MO

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

From 08 / 22 / 2016 (Month Day Year) To 05 / 26 / 2023 (Month Day Year) and was awarded the degree Doctor of Medicine

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: #1 - Extension time 6/1/2018-5/31/2019 due to academic probation

#2 Academic probation - Spring 2018 D in Human Structure Function III resultedin placement on academic probation effective 5/31/2018-5/31/2019. That probation end date was extended to January 5, 2021 following a repeat C+ in a required science course (Human Biochemistry I).

Verifying Official

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: Kimberlee Kalaiwaa **Signature** Kimberlee Kalaiwaa

Title of Signatory: Verifying Official **Date of Signature** 05/26/2023

Tel: 816-235-1900 **Fax:** 816-235-5593 **E-Mail:** umkcsomcareerservices@umkc.edu

If no seal is available, this form must be notarized

Notary Public

Commission #

My commission expires:

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

PRIMARY SOURCE

Notary Seal

T41337

The Curators of the University of Missouri

To all whom it may concern
Greeting:

Be it known that the Curators, having been advised by the Faculty that

Rachel Anne Oursbourn

has completed the Course of Study required of candidates for the degree of

Doctor of Medicine

and is qualified to receive the same, do confer said degree
with all the honors and privileges appertaining thereto.
In testimony whereof the signatures of the proper officials and the
seal of the University are affixed.

Done at the

University of Missouri-Kansas City

in the City of Kansas City, State of Missouri,
this twenty-sixth day of May, in the year two thousand and twenty-three.

Chair of the Board of Curators

President of the University

Chancellor

Dean

University of Missouri – Kansas City

Official Transcript

Name: **Oursbourn,Rachel Anne**
Student ID: 16198649
Date of Birth: [redacted]
Soc. Sec. Number: [redacted]

This transcript has been produced for:

UMKC School of Medicine

Course Number	Course Title	Grade	Hours	Remarks
Degrees Awarded				
University of Missouri - Kansas City				
Medicine-Md MD		05-26-2023		
Biology BA		05-13-2022		
Chemistry Minor		05-13-2022		
	Engl Prof/Writ & Read Assmnt			
01 RW	RW Roo Writer (E)			08/02/2016
FALL 2013	**Drury University**			
Hist 101	Survey of U.S. History I	A	3.0	
SPNG 2014	**Drury University**			
Hist 102	Survey U.S. History II	A	3.0	
SPNG 2015	**Drury University**			
Math 109	College Algebra	A-	3.0	
Plsc 101	US Political System	A	3.0	
FALL 2015	**Univ of MO-KC** Ugrd	Biol-BS		
Anch 106	Money/Med/Morals	A	3.0	
Biology 108	General Biology I	B	3.0	
Biology 108L	General Biology I Lab	A	1.0	
Chem 211	General Chemistry I	B	4.0	
Chem 211L	Exper General Chem I	B	1.0	
Disc 100	Discourse I	A	3.0	

	GPA Hrs Att	Hrs Ern	Qual Pt	GPA
UGRD Term:	15.0	15.0	52.00	3.467
UGRD CUM:	15.0	27.0	52.00	3.467

Course Number	Course Title	Grade	Hours	Remarks
SPNG 2016	**Univ of MO-KC** Ugrd	Biol-BS		
Anch 214	European Cultures, Hist & Idea - Nazi Occupied Europe	A	3.0	
Biology 109	General Biology II	A	3.0	
Biology 109L	General Biology II Lab	A	1.0	
Chem 212LR	Exper General Chem II	B	1.0	
Chem 212R	General Chemistry II	B	4.0	
Disc 200	Discourse II	A	3.0	

	GPA Hrs Att	Hrs Ern	Qual Pt	GPA
UGRD Term:	15.0	15.0	55.00	3.667
UGRD CUM:	30.0	42.0	107.00	3.567

FALL 2016	**Univ of MO-KC** Ugrd	Med-Undec		
Ls Anato 218L	Intro Anatomy Laboratory	A	2.0	
Ls Anato 219	Functional Anatomy I	B+	3.0	
Medicine 9110	Fundamtl Med Practice I	H	5.0	
Medicine 9115	Medical Terminology	CR	1.0	
Medicine 9119	Learn Basic Med Sciences	A	1.0	
Psych 210	General Psychology	A	3.0	
Stat 235	Elementary Statistics	A	3.0	

	GPA Hrs Att	Hrs Ern	Qual Pt	GPA
UGRD Term:	12.0	18.0	45.90	3.825
UGRD CUM:	42.0	60.0	152.90	3.640

SPNG 2017	**Univ of MO-KC** Ugrd	Med-Undec		
Chem 320	Elementary Organic Chem	A	4.0	
Chem 320L	Exper Organic Chem	A	1.0	
Ls Mcr 121	Human Biology III (Micro)	B	3.0	
Ls Mcr 121L	Hum Bio III(Micbio) Lab	A	1.0	
Medicine 9120	Fundamntl Med Pract II	HP	5.0	
Sociol 101	Sociology: An Introductn	A	3.0	

	GPA Hrs Att	Hrs Ern	Qual Pt	GPA
UGRD Term:	12.0	17.0	45.00	3.750
UGRD CUM:	54.0	77.0	197.90	3.665

SUM 2017	**Univ of MO-KC** Ugrd	Med-Undec		
Anch 307	Arch: Frauds & Myths	A	3.0	
Biology 202	Cell Biology	A	3.0	
Disc 300	Discourse III	A	3.0	
Medicine 9221	Hospital Team Exp	CR	1.0	

	GPA Hrs Att	Hrs Ern	Qual Pt	GPA
UGRD Term:	9.0	10.0	36.00	4.000
UGRD CUM:	63.0	87.0	233.90	3.713

FALL 2017	**Univ of MO-KC** Ugrd	Med-Undec		
Biology 206	Genetics	A	3.0	
Bms 9265	Human Biochemistry-I-Med	C	5.0	
Cnsvty 125	Hist & Dev Rock & Roll	A	3.0	
Medicine 9210	Fund of Medical Practice III	H	5.0	
Sociol 211	Soc&Psych Dev Thro Lifcy	A	3.0	

	GPA Hrs Att	Hrs Ern	Qual Pt	GPA
UGRD Term:	14.0	19.0	46.00	3.286
UGRD CUM:	77.0	106.0	279.90	3.635

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JUN 09 2023
OKLAHOMA STATE BOARD OF MEDICAL LICENSURE AND SUPERVISION

PRIMARY SOURCE

Amy Cole
Registrar, Amy Cole

I41335 SJ

University of Missouri – Kansas City

Official Transcript

Name: **Oursbourn,Rachel Anne**
Student ID: 16198649
Date of Birth: [redacted]
Soc. Sec. Number: [redacted]

This transcript has been produced for:

UMKC School of Medicine

Course Number		Course Title	Grade	Hours	Remarks
SPNG 2018	**Univ of MO-KC**	Ugrd	Med-Undec		
Bms	9296	Human Structure Func I	C+	7.0	
Bms	9297	Human Structure Func II	C	6.0	
Bms	9298	Human Structure Func III	D+	5.0	
Medicine	9220	Fundamntl Med Pract IV	H	5.0	

	GPA Hrs Att	Hrs Ern	Qual Pt	GPA
UGRD Term:	18.0	23.0	34.60	1.922
UGRD CUM:	95.0	129.0	314.50	3.311

SUM 2018	**Univ of MO-KC**	Ugrd	Med-Undec		
Biology	498WI	Crtcl Anlys of Bio Iss	A	3.0	
Chem	206	Human Nutrition	A	3.0	
Chem	311	Lab Safety & Health I	A	1.0	

	GPA Hrs Att	Hrs Ern	Qual Pt	GPA
UGRD Term:	7.0	7.0	28.00	4.000
UGRD CUM:	102.0	136.0	342.50	3.358

FALL 2018	**Univ of MO-KC**	Ugrd	Med-Undec		
Biology	409	Developmental Biology	B	3.0	
Bms	9265	Human Biochemistry-I-Med	C+	5.0	
Ls Phs	316	Principles of Physiology	B	3.0	
Medicine	9224	Ambulatory Care I	H	2.0	
Phys Ed	106	Badminton	A	1.0	
Phys Ed	189BE	Special Topics: Activity - Beginning Equestrian	A	1.0	
Phys Ed	206	First Aid and Safety	A	1.0	

	GPA Hrs Att	Hrs Ern	Qual Pt	GPA
UGRD Term:	14.0	16.0	41.50	2.964
UGRD CUM:	116.0	152.0	384.00	3.310

Course Number		Course Title	Grade	Hours	Remarks
SPNG 2019	**Univ of MO-KC**	Ugrd	Med-Undec		
Bms	9296	Human Structure Func I	B	6.0	
Bms	9297	Human Structure Func II	B-	5.0	
Bms	9298	Human Structure Func III	B+	5.0	
Medicine	9226	Ambulatory Care II	H	2.0	

	GPA Hrs Att	Hrs Ern	Qual Pt	GPA
UGRD Term:	16.0	18.0	48.00	3.000
UGRD CUM:	132.0	170.0	432.00	3.273

SUM 2019	**Univ of MO-KC**	Meds	Med-Md		
Bms	9399	Human Structure Funct IV	C+	6.0	
Medicine	9310	History of Medicine	A	1.0	
Medicine	9390	Clinical Correlations	B+	5.0	

	GPA Hrs Att	Hrs Ern	Qual Pt	GPA
MEDS Term:	12.0	12.0	34.30	2.858
MEDS CUM:	12.0	12.0	34.30	2.858

FALL 2019	**Univ of MO-KC**	Meds	Med-Md		
Bms	9310	Medical Neurosciences	B	9.0	
Medicine	9308	Clinical Practice of Med I	H	3.0	
Medicine	9312	Pathology I	B	10.0	
Medicine	9383	Continuing Care Clinic	AT	0.0	
Medicine	9385	Intro Pharmacology	A	2.0	

	GPA Hrs Att	Hrs Ern	Qual Pt	GPA
MEDS Term:	21.0	24.0	65.00	3.095
MEDS CUM:	33.0	36.0	99.30	3.009

SPNG 2020	**Univ of MO-KC**	Meds	Med-Md		
Bms	9311	Medical Microbiology	B-	5.0	
Medicine	9309	Clinical Practice of Med II	HP	5.0	
Medicine	9313	Pathology II	B	11.0	
Medicine	9383	Continuing Care Clinic	H	5.0	

	GPA Hrs Att	Hrs Ern	Qual Pt	GPA
MEDS Term:	16.0	26.0	46.50	2.906
MEDS CUM:	49.0	62.0	145.80	2.976

SUM 2020	**Univ of MO-KC**	Meds	Med-Md		
Medicine	9408	Pharmacology	B	10.0	
Medicine	9483	Continuing Care Clinic	H	1.0	

	GPA Hrs Att	Hrs Ern	Qual Pt	GPA
MEDS Term:	10.0	11.0	30.00	3.000
MEDS CUM:	59.0	73.0	175.80	2.980

Amy Cole
Registrar, Amy Cole

University of Missouri – Kansas City

Official Transcript

Name: **Oursbourn,Rachel Anne**
Student ID: 16198649
Date of Birth: [redacted]
Soc. Sec. Number: [redacted]

This transcript has been produced for:

UMKC School of Medicine

Course Number		Course Title		Grade	Hours	Remarks
FALL 2020	**Univ of MO-KC**		Meds	Med-Md		
Medicine	9401	Int Med/Doc Inst Yr 4		H	10.0	
Medicine	9471	Family Medicine		HP	5.0	
Medicine	9472	Behavioral Sci in Med		SP	5.0	
Medicine	9482	Patient Phys Society I		B	2.0	
Medicine	9483	Continuing Care Clinic		H	2.0	
Medicine	9885C51	Path Anatomic&Cli-Genera		H	5.0	
		GPA Hrs Att	Hrs Ern	Qual Pt		GPA
MEDS Term:		2.0	29.0	6.00		3.000
MEDS CUM:		61.0	102.0	181.80		2.980
SPNG 2021	**Univ of MO-KC**		Meds	Med-Md		
Medicine	9483	Continuing Care Clinic		H	2.0	
Medicine	9484	Patient Phys Society II		CR	2.0	
Medicine	9485	Ambulatory Care Pharmacl		A	2.0	
Medicine	9714A	Academic General		CR	5.0	
Medicine	9714A	Academic General		CR	5.0	
Medicine	9716A1	Independent Study Month		CR	5.0	
Medicine	9716A1	Independent Study Month		CR	5.0	
Medicine	9818-C91	Special Topics - Miscellaneous - Spec Top-Clinical Encounters		H	5.0	
Medicine	9818-C91	Special Topics - Miscellaneous - Spec Top-Clinical Encounters		H	5.0	
		GPA Hrs Att	Hrs Ern	Qual Pt		GPA
MEDS Term:		2.0	36.0	8.00		4.000
MEDS CUM:		63.0	138.0	189.80		3.013
SUM 2021	**Univ of MO-KC**		Meds	Med-Md		
Medicine	9506	Obstet-Gynecol Rotation		HP	10.0	
Medicine	9578	Medicine and Art		A	5.0	
Medicine	9583	Continuing Care Clinic		AT	0.0	
		GPA Hrs Att	Hrs Ern	Qual Pt		GPA
MEDS Term:		5.0	15.0	20.00		4.000
MEDS CUM:		68.0	153.0	209.80		3.085

Course Number		Course Title		Grade	Hours	Remarks
FALL 2021	**Univ of MO-KC**		Meds	Med-Md		
Medicine	9501	Int Med/Doc Inst Yr 5		HP	10.0	
Medicine	9505	Gen Surgery Rotation		SP	10.0	
Medicine	9583	Continuing Care Clinic		AT	0.0	
		GPA Hrs Att	Hrs Ern	Qual Pt		GPA
MEDS Term:		0.0	20.0	0.00		
MEDS CUM:		68.0	173.0	209.80		3.085
SPNG 2022	**Univ of MO-KC**		Meds	Med-Md		
Medicine	9503	Peds Rotation		HP	10.0	
Medicine	9571	Psychiatry Rotation		HP	5.0	
Medicine	9583	Continuing Care Clinic		H	5.0	
Medicine	9716A1	Independent Study Month		CR	5.0	
Medicine	9910C61	Pediatrics-Generl		H	5.0	
		GPA Hrs Att	Hrs Ern	Qual Pt		GPA
MEDS Term:		0.0	30.0	0.00		
MEDS CUM:		68.0	203.0	209.80		3.085
SUM 2022	**Univ of MO-KC**		Meds	Med-Md		
Medicine	9585	Prescb Special Popultns		A	2.0	
Medicine	9683	Continuing Care Clinic		AT	0.0	
Medicine	9716A1	Independent Study Month		CR	5.0	
Medicine	9906C61	Ped Critical Care Med		H	5.0	
		GPA Hrs Att	Hrs Ern	Qual Pt		GPA
MEDS Term:		2.0	12.0	8.00		4.000
MEDS CUM:		70.0	215.0	217.80		3.111
FALL 2022	**Univ of MO-KC**		Meds	Med-Md		
Medicine	9678	Emergency Medicine		HP	5.0	
Medicine	9683	Continuing Care Clinic		AT	0.0	
Medicine	9685	Rational & Safe Prescrb		B+	2.0	
Medicine	9703R1	Academic Research		H	5.0	
Medicine	9703R3	Academic Research		H	5.0	
		GPA Hrs Att	Hrs Ern	Qual Pt		GPA
MEDS Term:		2.0	17.0	6.60		3.300
MEDS CUM:		72.0	232.0	224.40		3.117
SPNG 2023	**Univ of MO-KC**		Meds	Med-Md		
Medicine	9601	Int Med/Doc Inst Yr 6		H	10.0	
Medicine	9683	Continuing Care Clinic		CR	5.0	
Medicine	9714A	Academic General		CR	5.0	
Medicine	9714A	Academic General		CR	5.0	
Medicine	9714A	Academic General		CR	5.0	
		GPA Hrs Att	Hrs Ern	Qual Pt		GPA
MEDS Term:		0.0	30.0	0.00		
MEDS CUM:		72.0	262.0	224.40		3.117
Combined Undergraduate/Professional						
Ugrd/Prof CUM		204.0	432.0	656.40		3.218

Amy Cole
Registrar, Amy Cole

AMA Physician Profile

PREPARED FOR

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

Name and Mailing Address

RACHEL ANNE WRIGHT
UMKC SCHOOL OF MEDICINE 2411 HOLMES ST
2411 HOLMES ST
KANSAS CITY, MO 64108-2741

Primary Office Address

Phone UNKNOWN

Birth date [redacted]

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 MISSOURI-KANSAS CITY SCHOOL OF MEDICINE

Degree Awarded:	YES	**Degree Type:**	MD
Enrollment Date:	05/2019	**Degree Date:**	05/2023

T41337

AMA AMERICAN MEDICAL ASSOCIATION

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:	PEDIATRICS
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.

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: Rachel (First) Anne (Middle) Oursbourn (Last) Alexander Wright (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 Cheri Burton Date 3-28-23

Subscribed and sworn before me this 28th day of March, 20 23.

Notary Public Cheri Burton

Commission Number 19226501

My commission expires 12/16/2023

RECEIVED
MAR 30 2023
OKLAHOMA STATE BOARD OF MEDICAL LICENSURE AND SUPERVISION

NOTARY SEAL

T41337

OKLAHOMA STATE BOARD OF MEDICAL LICENSURE AND SUPERVISION
101 NE 51ST 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

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.

Rachel A. Oursbourn — Name of Applicant (type or print)
[signature] — Signature of Applicant
3/27/23 — 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
MAR 30 2023
OKLAHOMA STATE BOARD OF MEDICAL LICENSURE AND SUPERVISION

T41337 D

Kenna L. Shaw

From: BillPay Webmaster <donotreply@www.ok.gov>
Sent: Thursday, April 11, 2024 11:41 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

RACHEL ANNE OURSBOURN has paid for a LICENSE - MD Training-to-Full License Fee 250.00 on 04/11/2024 11:04:40am for $250.00.
OKLAHOMA MD LICENSE NUMBER 41337
To view all transactions please go to http://www.ok.gov/triton/ and login to your CMS account.

T 41337 MD

TIME DEFICIENCY FORM

Name:	Rachel A. Oursbourn	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	-11	05	-15	Lebanon High School	Lebanon	MO	—
08	-15	05	-22	Uni of MO - Kansas City	KC	MO	BA - Biology
* 01	-19	05	-23	Uni of MO - Kansas City	KC	MO	MD

EMPLOYMENT IF NEEDED TO FILL TIME GAP

Start Month	Start Year	End Month	End Year	Name of Employer	City	State	Job Title
				N/A			

OTHER - UNEMPLOYED, STAY AT HOME PARENT, SUMMER BREAK, TRAVELING

Start Month	Start Year	End Month	End Year	Other	City	State
				N/A		

* Of note, I earned my undergraduate degree + graduate degree in a combined BA/MD medical program. Thus, the dates of these two degrees overlap.

RECEIVED
MAR 30 2023
OKLAHOMA STATE BOARD OF

TH1337

05/03/2023

RACHEL ANNE OURSBOURN
[redacted]

Check Your Application Status Online at:
http://www.okmedicalboard.org
***Username*:AP43735221**
***Password*:Last 4 SSN**

RE: MD Application #41337

Dear RACHEL OURSBOURN,

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

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

Exam verification date
MedSchool-Transcript UNIV OF MO-KANSAS CITY SCH OF MED, KANSAS CITY MO 64108
MedSchool-Form 1 UNIV OF MO-KANSAS CITY SCH OF MED, KANSAS CITY MO 64108
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 AP43735221 (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

Sincerely,

Seema Jayachand

Seema Jayachand

Dept. of Licensing

Encl

Oklahoma State Board of Medical Licensure and Supervision
Application Summary

Type	Number	Name
MD	41337	RACHEL ANNE OURSBOURN

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:
028-46 UNIV OF MO-KANSAS CITY SCH OF MED, KANSAS CITY MO 64108

Number of Licenses Previously Granted to Graduates of this Medical School:167

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** 5 yr

3) **HAS ISSUED A TEMPORARY LICENSE THROUGH** ___/___/___

4) **HAS ISSUED A SPECIAL PGY-1 TRAINING LICENSE** BH 6.22.22

5) **REQUESTS SPECIFIC CONSIDERATION OF:**

_____

_____

_____

_____

_____

Oklahoma State Board of Medical Licensure and Supervision
Application Summary

Type	Number	Name
MD	41628	BRIAN PADILLA

MEDICAL DOCTOR

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

OTHER DEFICIENCIES: NEED USMLE STEP 3 / QUESTIONNAIRE / $250 UPGRADE FEE / 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:7,359

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	41628	BRIAN PADILLA

MEDICAL DOCTOR

Practice Address:

May 04, 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: 06/04/2024
AMA Rec: 06/04/2024
Board Action:
License #: 41628
Sex: M
Ethnic Origin: 4

Endorsed By: USMLE

	Test	Score	Date Taken	Date Verified	Attempts
Test 1:	USMLE 2	PASS	01/06/23	6/12/23	1
Test 2:	USMLE 1	PASS	06/19/21	6/12/23	1
Test 3:	Note: ***PASS*** means higher than 75				

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

PRE-MED EDUCATION

School Name: UNIVERSITY OF OKLAHOMA
City: NORMAN **State:** OK **Country:** UNITED STATES
Degree: BACHELOR IN SCIENCE **From:** 8/2009 **To:** 5/ 2014 **Verified:**

School Name: MUSTANG HIGH SCHOOL
City: MUSTANG **State:** OK **Country:** UNITED STATES
Degree: DIPLOMA **From:** 3/2009 **To:** 5/ 2009 **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: DOCTOR OF MEDIC **From:** 8 / 2019 **To:** 5 / 2023 **Diploma Ver'd:** Y

Oklahoma State Board of Medical Licensure and Supervision
Application Summary

Type	Number	Name
MD	41628	BRIAN PADILLA

MEDICAL DOCTOR

POST GRADUATE EDUCATION

Facility: INTEGRIS BAPTIST MEDICAL CENTER **Specialty:** RADIOLOGY
Res. Fellowship: Residency
City: OKLAHOMA CITY **State:** OK **Country:** UNITED STATES
Verified: Waived **From:** 7 / 2024 **To:** /
ACGME Ver'd: Waived
Comments: ELIGIBLE FOR UPGRADE (LKC)

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:

PRACTICE HISTORY

Employed: OSOI **Supervisor:**
City: OKLAHOMA CITY **State:** OK **Country:** UNITED STATES
Specialty: MEDICAL SCRIBE **From:** 6 / 2017 **To:** 8 / 2019 **Verified:**
Comments: DOCUMENT PHYSICIAN'S CLINIC NOTES

Employed: NONE **Supervisor:**
City: MUSTANG **State:** OK **Country:** UNITED STATES
Specialty: UNEMPLOYED **From:** 1 / 2017 **To:** 6 / 2017 **Verified:**
Comments:

Employed: CSL PLASMA **Supervisor:**
City: OKLAHOMA CITY **State:** OK **Country:** UNITED STATES
Specialty: PHLEBOTOMIST **From:** 12 / 2015 **To:** 1 / 2017 **Verified:**
Comments: PHLEBOTOMIST: PERFORMED VENIPUNCTURE ON DONORS TO BEGIN PHERESIS PROCESS

Employed: NONE **Supervisor:**
City: MUSTANG **State:** OK **Country:** UNITED STATES
Specialty: UNEMPLOYED **From:** 5 / 2014 **To:** 12 / 2015 **Verified:**
Comments:

Other Licenses

State	Lic Type and Number	Status	Issued	Exp	Verif

DEFICIENCIES

OTHER DEFICIENCIES: NEED USMLE STEP 3 / QUESTIONNAIRE / $250 UPGRADE FEE / EVALUATION
Exam verification date
PostGrad - Form 2 COLLEGE OF MEDICINE OKC
USMLE Exams Incomplete

Oklahoma State Board of Medical Licensure and Supervision

APPLICATION FOR OKLAHOMA MEDICAL DOCTOR LICENSE

Received: 04/26/2023

Applicant Name: PADILLA, BRIAN [redacted] **MD 41628**

Date Of Birth: [redacted] **Place Of Birth (City, State):** PASADENA, CA

Sex: M **Race:** Hispanic

Education

Type	Name	City	ST Country	From	To	Degree	Comments	Veri
UG	UNIVERSITY OF OKLAHOMA	NORMAN	OK	8/2009	5/2014	BACHELOR IN SCIENCE		

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
COLLEGE OF MEDICINE OKC	OKLAHOMA CITY	OK	UNITED S	INTERNAL MEDICINE		7/2023	/

Practice History

Employer	Specialty	Supervisor	City	ST	Countr	From	To	Verif
OSOI	MEDICAL SCRIBE		OKLAHOMA CITY	OK		6/2017	8/2019	
CSL PLASMA	PHLEBOTOMIST		OKLAHOMA CITY	OK		12/2015	1/2017	

Other/ Out-Of-State Licenses

State	License #	Profession	Status	Issue Date	Exp Date

MD Exam

Exam	State	Score	Date Taken	#
USMLE				

$250

SJ

Oklahoma State Board of Medical Licensure and Supervision

APPLICATION FOR OKLAHOMA MEDICAL DOCTOR LICENSE

Received:04/26/2023

Questions Answered 04/25/2023		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

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 College of 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
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 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
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
JUN 02 2023
OKLAHOMA STATE BOARD OF MEDICAL LICENSURE AND SUPERVISION

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

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

5-24-23
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 Canadian

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 24th day of May, 2023

HALEE DELANO
NOTARY PUBLIC
STATE OF OKLAHOMA
IN AND FOR
#22005473

Notary Public Signature Halee Delano My Notary Commission Expires 4-18-26

T 41628 D

USMLE United States Medical Licensing Examination®

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: 06/09/2023

Examinee: Padilla, Brian Angel
Alt Name(s):

Examinee ID: 5-476-290-1
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
06/19/2021	Pass	241	(194)	

USMLE STEP 2

Clinical Knowledge (CK)

Test Date	Pass/Fail	Score	Minimum Pass	Comments
01/06/2023	Pass	241	(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

Rev 2018

T41628 SJ

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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: Brian Padilla

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 (Month / Day / Year) To 5 / 20 / 2023 (Month / Day / Year) 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** Teresa Scordino

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: Edith Torres

Commission #: 21004896

My commission expires: 4/9/2025

EDITH TORRES NOTARY # 21004896 EXP. 04/09/25 STATE OF OKLAHOMA

Notary Seal

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TH1628 SJ

Printed: 07-JUN-2023
Page No. 1

Official Transcript

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

Name : Brian Padilla
Student ID: 1781054
Birthdate : [redacted]

Degrees Awarded

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

External Degrees

University of Oklahoma
2014-05-09 Bachelor of Science
Field of Study : Microbiology

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	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						
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

Lori Klein

REGISTRAR, OUHSC

Registrar's Office
1105 N. Stonewall Avenue
LIB 121
Oklahoma City, OK 73117-1221

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

PHONE (405) 271-2359
FAX (405) 271-2480
www.ouhsc.edu

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)
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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.

TERM DEFINITIONS:

Summer	= 8 weeks in length
Summer I	= 8 weeks in length
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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

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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 : Brian Padilla
Student ID: 1781054
Birthdate : [redacted]

Summer II 2021

Course		Description	Attempted	Earned	Grade	Points
INDT	9301	Clinical Transitions	40.00	40.00	S	
PSBS	9520	Psychiatry Clerkshp	240.00	240.00	B	720.000
TERM GPA :	3.000	GPH: 240.00	TOTALS :	280.00	280.00	720.000
OUHSC GPA :	3.000	GPH: 240.00	TOTALS :	1802.50	1802.50	720.000

Fall 2021

Course		Description	Attempted	Earned	Grade	Points
NEUR	9370	Neurology Clerkship	160.00	160.00	B	480.000
FM	9540	Fam Med Clerkship	160.00	160.00	B	480.000
PEDI	9650	Pediatric Clerkship	240.00	240.00	A	960.000
RADI	9101	RADI Selective	80.00	80.00	S	
ANES	9110	Anesthesiology Selective	80.00	80.00	S	
TERM GPA :	3.429	GPH: 560.00	TOTALS :	720.00	720.00	1920.000
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
OPHT	9101	Ophthalmology 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

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): RADI 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	9406	Special Studies Elective	160.00	160.00	S	
		Course Topic(s): FM Special Studies Elective				
INDT	9406	Special Studies Elective	160.00	160.00	S	
		Course Topic(s): RADI Special Studies Elective				
TERM GPA :	0.000	GPH: 0.00	TOTALS :	320.00	320.00	0.000
OUHSC GPA :	3.217	GPH: 1840.00	TOTALS :	4122.50	4122.50	5920.000

Spring 2023

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): Directed Readings in PHARM Directed Readings in PHARM				

Course		Description	Attempted	Earned	Grade	Points
INDT	9407	Fourth Year Selective	80.00	80.00	S	
INDT	9406	Special Studies Elective	80.00	80.00	S	
		Course Topic(s): INDT Special Studies Elective				
INDT	9401	Outpatient Elective	160.00	160.00	S	
		Course Topic(s): RADI Outpatient Elective				
INDT	9407	Fourth Year Selective	80.00	80.00	S	
		Course Topic(s): Directed Readings in PHARM				

Lori Klein

REGISTRAR, OUHSC

THE UNIVERSITY OF OKLAHOMA HEALTH SCIENCES CENTER
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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 : Brian Padilla
Student ID: 1781054
Birthdate : [redacted]

Spring 2023 (cont.)

Course	Description	Attempted	Earned	Grade	Points
	Directed Readings in PHARM				
TERM GPA : 4.000	GPH: 160.00 TOTALS :	720.00	720.00		640.000
OUHSC GPA : 3.280	GPH: 2000.00 TOTALS :	4842.50	4842.50		6560.000
Medicine Career Totals					
OUHSC GPA : 3.280	GPH: 2000.00 TOTALS :	4842.50	4842.50		6560.000
Post-Baccalaureate Career Totals					
OUHSC GPA : 3.280	GPH: 125.00 TOTALS :	302.65	302.65		410.000

- - - - - End Of Career (1 of 1) - - - - -
- - - - - End Of Transcript - - - - -

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JUN 08 2023
OKLAHOMA STATE BOARD OF MEDICAL LICENSURE AND SUPERVISION

PRIMARY SOURCE

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 informaiton without the student's written consent.

Lori Klein

REGISTRAR, OUHSC

THE UNIVERSITY OF OKLAHOMA HEALTH SCIENCES CENTER
THE UNIVERSITY OF OKLAHOMA HEALTH SCIENCES CENTER

Registrar's Office
1105 N. Stonewall Avenue
LIB 121
Oklahoma City, OK 73117-1221

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

PHONE (405) 271-2359
FAX (405) 271-2480
www.ouhsc.edu

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.

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.

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.

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AMA Physician Profile

PREPARED FOR

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

Name and Mailing Address

BRIAN ANGEL PADILLA

[redacted]

Primary Office Address

Phone UNKNOWN

Birth date [redacted]

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

T41629

AMA
AMERICAN MEDICAL ASSOCIATION

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 - 06/30/2024
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.

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OKLAHOMA STATE BOARD OF MEDICAL LICENSURE AND SUPERVISION
101 NE 51st STREET
OKLAHOMA CITY OK 73105

EVIDENCE OF STATUS – PART A

Full Legal Name: Brian (First) Angel (Middle) Padilla (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 5-24-23

Subscribed and sworn before me this 24 day of May, 2023.

Notary Public Halee Delano

Commission Number 22005473

My commission expires 4-18-26

HALEE DELANO NOTARY PUBLIC IN AND FOR SEAL #22005473 STATE OF OKLAHOMA NOTARY PUBLIC

T 11628

Name:	Brian Padilla	Application #	41628

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 (example: Unemployed, Summer Break, Stay at home parent, etc.)	City	State
3	2009	8	2009	Still in High School from March - May 2009 when I graduated High School , then summer break from May-August 2009	Mustang	Oklahoma
5	2014	12	2015	Unemployed	Mustang	Oklahoma
1	2017	6	2017	Unemployed	Mustang	Oklahoma

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Tulle 28 D

OKLAHOMA STATE BOARD OF MEDICAL LICENSURE AND SUPERVISION
101 NE 51ST 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 Wiser 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.

Brian Padilla		6-2-23
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.

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OKLAHOMA STATE BOARD OF MEDICAL LICENSURE AND SUPERVISION

T4166S
ID

05/04/2023

BRIAN PADILLA
[redacted]

RE: MD Application #41628

Check Your Application Status Online at:
http://www.okmedicalboard.org
***Username*:AP10638644**
***Password*:Last 4 SSN**

Dear BRIAN PADILLA,

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

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

Evidence of Status
Application Instructions
OATH
Extended Background Check
Time Deficiency Form for: 3/2009-8/2009, 5/2014-12/2015, 1/2017-6/2017
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

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 AP10638644 (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

Sincerely,

Seema Jayachand

Seema Jayachand

Dept. of Licensing

Encl

Oklahoma State Board of Medical Licensure and Supervision
Application Summary

Type	Number	Name
MD	41628	BRIAN PADILLA

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:7,276

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** _____ MH 6-20-23

5) **REQUESTS SPECIFIC CONSIDERATION OF:**

_____

_____

_____

_____

_____

Oklahoma State Board of Medical Licensure and Supervision
Application Summary

Type	Number	Name
MD	41678	JAROD JOHN PAMATMAT

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:
048-12 Univ Of TX Southwestern Med Sch At Dallas SW Med Sch, Dallas Tx 75235

Number of Licenses Previously Granted to Graduates of this Medical School:613

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	41678	JAROD JOHN PAMATMAT

MEDICAL DOCTOR

Practice Address:

May 12, 2023

Status:
Res: TR
Received: 05/01/2023
Entered: 05/01/2023
Temp Issued:
Temp Expires:
Train Issued: 07/01/2023
Train Expires: 09/30/2024
Fed Rec: 06/04/2024
AMA Rec: 06/04/2024
Board Action:
License #: 41678
Sex: M
Ethnic Origin: 6

Endorsed By: USMLE

	Test	Score	Date Taken	Date Verified	Attempts
Test 1:	USMLE 1	PASS	7/10/20	6/8/23	1
Test 2:	USMLE 2	PASS	9/9/22	6/8/23	1
Test 3:	Note: ***PASS*** means higher than 75				

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

PRE-MED EDUCATION

School Name: THE UNIVERSITY OF TEXAS AT DALLAS
City: RICHARDSON, TX **State:** TX **Country:** UNITED STATES
Degree: **From:** 8/2015 **To:** 5/ 2018 **Verified:**

MEDICAL SCHOOL EDUCATION

Name: Univ Of TX Southwestern Med Sch At Dallas SW Med Sch, Dallas Tx 75235
Foreign Name:
City: Dallas **State/Country:** United States of America
Degree: MD **From:** 8 / 2018 **To:** 5 / 2023 **Diploma Ver'd:** Y

POST GRADUATE EDUCATION

Facility: COLLEGE OF MEDICINE OKC **Specialty:** PEDIATRICS
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	41678	JAROD JOHN PAMATMAT

MEDICAL DOCTOR

PRACTICE HISTORY

Employed: NONE **Supervisor:**
City: TYLER **State:** TX **Country:** UNITED STATES
Specialty: SUMMER BREAK **From:** 5 / 2015 **To:** 8 / 2015 **Verified:**
Comments:

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

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MAY 26 2024
OKLAHOMA STATE BOARD OF MEDICAL LICENSURE AND SUPERVISION

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

FIRST NAME	Jarod John	**LAST NAME**	Pamatmat
EMAIL ADDRESS	[redacted]		
LICENSE NUMBER	1508540584	**CELL PHONE**	[redacted]
HOME ADDRESS	[redacted]	**CITY/STATE ZIP CODE**	
PROGRAM ATTENDING	University of Oklahoma Health Sciences Center	**SPECIALTY**	Pediatrics

DOCUMENTATION TO ATTACH

PAYMENT COMPLETED			
☐	$150 payment made on Billpay for **RENEWAL** of training license	☑	$250 payment made on Billpay for **UPGRADE** of training license

DOCUMENTATION REQUIRED			
☐	Form 2 (must be received directly from program) ****ONLY FOR UPGRADE**	☐	Evaluation (must be received directly from program)
☐	USMLE Step 3 (must be received directly from USMLE)	☐	Answer confidential questions (on back of this form)

FOREIGN TRAINED STUDENTS			
☐	Current visa	☐	Social Security Number **if not provided at initial application
☐	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.

T41678
SJ

NAME Jarod John Pamatmat

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)?	☐	☑
Have you been the subject of investigation or disciplinary action (including probation) by a hospital or training program?	☐	☑
Have you had any adverse judgment or settlement against you rising from a professional liability claim?	☐	☑
Have you been reported to the National Practitioner Data Bank (NPDB)?	☐	☑
Have you ever been denied, had removed, or suspended hospital privileges?	☐	☑
Have you surrendered hospital privileges while under investigation or to avoid investigation?	☐	☑
Have you entered into an Agreement with a Federal, State, or Local jurisdictional body to avoid formal action?	☐	☑
Has your application for licensure ever been denied?	☐	☑
Have you surrendered a license or had any disciplinary action taken on any license?	☐	☑
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)?	☐	☑
Have you obtained an assessment or been treated for use of any drug or chemical substance including alcohol?	☐	☑
Have you been arrested for, charged with, or convicted of a felony or misdemeanor other than a traffic violation?	☐	☑
Have you been arrested for, charged with, or convicted of a traffic violation involving the use of any drug or chemical substance?	☐	☑
Have you been addicted to or abused any drug or chemical substance including alcohol?	☐	☑
Have you been denied provider participation, terminated, sanctioned or penalized by any third-party payor including TRICARE, MEDICARE, or MEDICAID?	☐	☑
Have you surrendered or had any adverse action taken against any narcotic permit (State or Federal)?	☐	☑

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 May 26, 2024

Oklahoma State Board of Medical Licensure and Supervision

APPLICATION FOR OKLAHOMA MEDICAL DOCTOR LICENSE

Received:05/01/2023

Applicant Name: PAMATMAT, JAROD JOHN [redacted] **MD 41678**

[redacted]

Date Of Birth: [redacted] **Place Of Birth (City, State):** DEFIANCE, OH

Sex: M **Race:** Asian/Pacific Islander

Education

Type	Name	City	ST	Country	From	To	Degree	Comments	Veri
UG	THE UNIVERSITY OF TEXAS AT DALLAS	RICHARDSOI	TX		8/2015	5/2018			

Medical School Name	City	State	Country	Comments	From	To
Univ Of TX Southwestern Med Sch At Dallas SW Med Sch, Dallas Tx 75235	Dallas	TX	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	PEDIATRICS		7/2023	/

Practice History

Employer	Specialty	Supervisor	City	ST	Countr	From	To	Verif
						/		

Other/ Out-Of-State Licenses

State	License #	Profession	Status	Issue Date	Exp Date

MD Exam

Exam	State	Score	Date Taken	#
USMLE				

$250

SJ

Oklahoma State Board of Medical Licensure and Supervision

APPLICATION FOR OKLAHOMA MEDICAL DOCTOR LICENSE

Received:05/01/2023

Questions Answered 04/30/2023		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? Failed internal medicine and OBGYN shelf exams largely in part due to untreated [redacted]), which made it difficult to study during clerkship year. Placed on academic probation and repeated clerkship year. After appropriate diagnosis and treatment, was able to successfully remediate without further concerns.	Y
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? [redacted]	Y
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:05/01/2023

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 Sciences Center

If so, Please identify with which category:

Residency

Name of Previous Carrier and Policy Holder

The University of Texas System
Professional Medical Liability Benefit Plan

Name of Current Carrier and policy Holder

The University of Texas System
Professional Medical Liability Benefit Plan

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 (7/1/2023)

I attest that all the above information is accurate as of April 30, 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.

RECEIVED
JUN 16 2023
OKLAHOMA STATE BOARD OF MEDICAL LICENSURE AND SUPERVISION

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

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

6-16-2023
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 Texas, County of Smith

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 16 day of June, 2023

Notary Public Signature _____ My Notary Commission Expires 02-04-2027

SHANNON DEWALCH
Notary ID #131880393
My Commission Expires
February 4, 2027

T4116 28

USMLE United States Medical Licensing Examination

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: 06/08/2023

Examinee: Pamatmat, Jarod John Munda
Alt Name(s): Munda Pamatmat, Jarod John

Examinee ID: 5-453-167-8
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
07/10/2020	Pass	207	(194)	

USMLE STEP 2

Clinical Knowledge (CK)

Test Date	Pass/Fail	Score	Minimum Pass	Comments
09/09/2022	Pass	225	(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 08 2023
OKLAHOMA STATE BOARD OF MEDICAL LICENSURE AND SUPERVISION

T 41678 VD

Rev 2018

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

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

Examinee: Pamatmat, Jarod John Munda

Examinee ID: 5-453-167-8
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.

RECEIVED
JUN 29 2023
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 Jarod Pamatmat

Institution: UT Southwestern Medical Center City/State Dallas/Texas

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

From 08 / 06 / 2018 (Month Day Year) To 05 / 05 / 2023 (Month Day Year) 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: see attached letter

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: Blake Barker, M.D. **Signature** BMM

Title of Signatory: Assoc. Dean for Student Affairs **Date of Signature** 6/14/23

Tel: 214-648-2168 **Fax:** 214-648-7517 **E-Mail:** Blake.Barker@utsouthwestern.edu

PRIMARY SOURCE

School Seal

If no seal is available, this form must be notarized

Notary Public _____

Commission # _____

My commission expires: _____

Notary Seal

Angela Peterman Mihalic, M.D.
Dean of Medical Students and Associate Dean for Student Affairs
Professor, Department of Pediatrics
Distinguished Teaching Professor

UT Southwestern Medical Center

September 28, 2022

IDENTIFYING INFORMATION

Jarod John Munda Pamatmat is a fourth-year student at the University of Texas Southwestern Medical School in Dallas, Texas.

NOTEWORTHY CHARACTERISTICS

- As evidence of his passion for leadership and interprofessional teamwork, Jarod was elected as one of the interprofessional education representatives for student government and was a member of the Interprofessional Student Collaborative. His responsibilities included helping organize Convergence Day, a yearly event highlighting the importance of interprofessional education.
- Jarod's commitment to service and clinical improvement is exemplified by his work at various clinics, including the Agape Pediatrics Free Clinic for uninsured patients. During his first and second year of medical school, he attended a weekly clinic and spent his summer off completing pediatrics and internal medicine preceptorships.
- Jarod has conducted research with Dr. Heather Goff focusing on the impact of microstomia on scleroderma patients and the safety and efficacy of dermal fillers in patients with connective tissue diseases. He has published three co-first author papers during his time in medical school.

ACADEMIC HISTORY

Date of Expected Graduation from Medical School: 05/05/2023
Date of Initial Matriculation in Medical School: 08/06/2018
Please explain any extension(s), leave(s) of absence, gap(s), or break(s) in the student's educational program.
See below.
☐ Not applicable

For dual/joint/combined degree students:
Date of Expected Graduation from Other Degree Program:
Date of Initial Matriculation in Other Degree Program:
Type of Other Degree Program:
☑ Not applicable

Was this student required to repeat or otherwise remediate any coursework during their medical education?
☐ No
☑ Yes - Please explain:

During his third year of medical school, Jarod experienced deficiencies on his Internal Medicine and Obstetrics and Gynecology clerkship shelf exams. As a result, he was required to repeat the clerkship year during which he was diagnosed with [redacted]. After receiving appropriate treatment, he successfully repeated these clerkships as well as Surgery and Family Medicine without further academic difficulty.

Was this student the recipient of any adverse action(s) by the medical school or its parent institution?
☑ No
☐ Yes - Please explain:

5323 Harry Hines Blvd., Dallas, Texas 75390-9006 Phone: 214-648-2168 Fax: 214-648-7517

COVID-19 STATEMENT

Due to the impact of the pandemic, the clerkship length for Surgery was decreased from eight to six weeks. Pre-COVID, all students were required to complete four weeks of Family Medicine and six weeks of Ambulatory Medicine clerkships. Post-COVID, students who completed one of the two clerkships could waive the other and achieve outpatient competencies via approved elective experience. Students who completed neither were enrolled in a new combined Outpatient Care clerkship. Based on the variations among clerkships longitudinally, UT Southwestern has suspended ranking students into quartiles this year.

ACADEMIC PROGRESS

Professional Performance

Jarod John Munda Pamatmat has met all the stated objectives for professionalism at UT Southwestern Medical School. We have assessed all students' communication skills, adaptability, respect for patients and the health care team, cultural competency, accountability, initiative, and composure under stress.

Preclinical Coursework

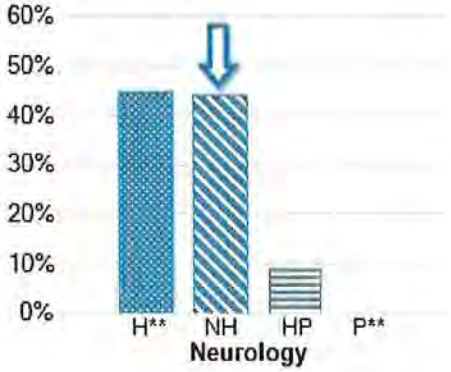
Jarod John Munda Pamatmat successfully completed the preclinical curriculum, which was graded pass/fail.

Clerkships (in chronological order)

Neurology (12/30/2019 - 1/24/2020) Grade: NH

Overall grade based on: Clinical - 60%; Exam - 30%; Observed Neurological Exam - 10%

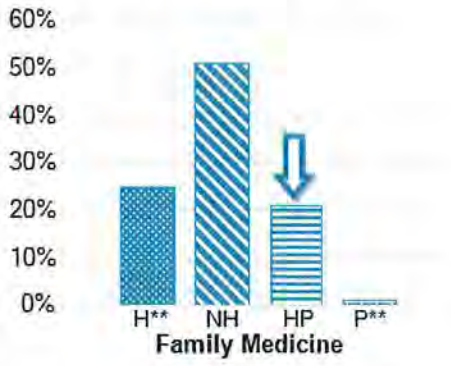
"Jarod has a good fund of knowledge, and it was a pleasure working with him." "Jarod did a great job on his first clinical rotation! This was a challenging two weeks with an unusual cluster of complex neurological diagnoses, and Jarod handled them very well. He was eager to learn, had a great attitude, and came well prepared to rounds. He was kind, courteous, and a valuable member to our team. His neurological exam skills improved throughout the rotation, and his presentations became more fluid. He is humble and took constructive feedback well. He is going to have a very successful training career and will be an asset to any training program he joins."



Family Medicine (1/27/2020 - 2/21/2020) Grade: HP

Overall grade based on: Clinical - 50%; Exam - 30%; Project Presentation - 10%; Coursework - 10%

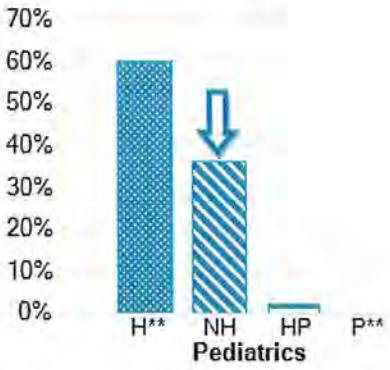
"Jarod did great and performed above his level of training," "I worked with Jarod during his second year of medical school, and he did an exceptional job. He is a team player and had immediate rapport with patients." "Jarod did an outstanding job in my experience with him on his family medicine rotation. He is exceptionally bright and well fluent at this point in his training. Since he was so very early on in his clinical training, I feel hard pressed to give an honors grade, but he is certainly deserving and is one of the better students I have had in the past two years." "Jarod is an excellent student who showed medical knowledge and management plans that were above his level of training. He has a



very good bedside manner that helped put patients at ease during their visits. He will be an outstanding physician in whichever specialty he chooses. It was a pleasure to have him in Tyler for his FM rotation." "Jarod is a great student with a great personality. He will serve his community and his patients incredibly and graciously in the future."

Pediatrics (1/4/2021 - 2/12/2021) Grade: NH

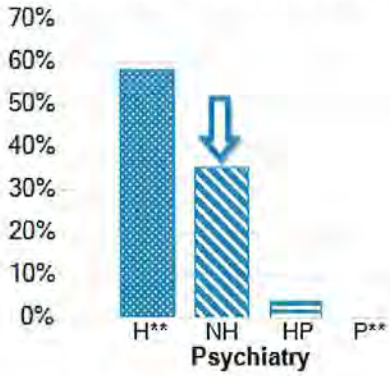
Overall grade based on: Clinical - 50%; Exam - 30%; Case Exam, TBL, CLIPP Cases - 20%



"Jarod was enthusiastic, knowledgeable, and very comfortable interacting with patients and the team. He gave crisp presentations, demonstrating an excellent sense of the important parts of the history and physical, an ability to synthesize the details into an assessment of the patient's status that day, and a clear understanding of the plan. I was impressed with his sensitivity to a patient who was transgender. He was eager for all learning opportunities, and the residents reported he was very helpful." "Jarod was engaged throughout the rotation. He asked very good questions, looked up literature, and solicited feedback on his performance." "Jarod was eager to learn and exceeded all requirements of the rotation." "Jarod was a welcome presence on our team. He was well prepared for rounds each and every day. His presentations made it clear that he had taken the extra steps to read literature and develop well-thought-out differential diagnoses and plans of care for each of his patients. He was able to utilize family appropriate terminology on rounds to explain diagnoses and plans to the families and patients." "I enjoyed having Jarod on our inpatient pediatrics team. He is very hardworking and enthusiastic. He related very well to families, and it was obvious he enjoyed interacting with and caring for children. His positive attitude was greatly appreciated."

Psychiatry (4/12/2021 - 5/21/2021) Grade: NH

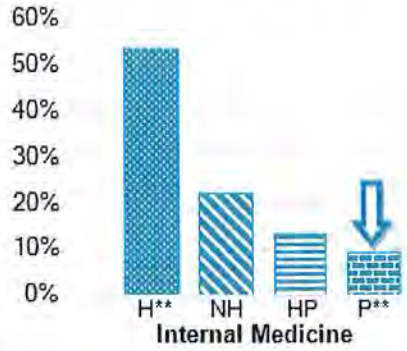
Overall grade based on: Clinical - 50%; Exam - 30%; Write-Up - 8%; Presentation - 8%; TBL - 4%



"I enjoyed working with Jarod. The census on the unit was low, but he did his fair share of inpatient consults and outpatient evaluations. He is a very empathetic and hardworking student who excelled in a plethora of areas. He was very reliable and highly ethical. He is a fast learner and adapted his interview style to suit elderly patients with cognitive deficits. He enjoyed working with geriatric patients and felt at ease and very comfortable with this patient population. He learned quickly about cognitive screenings and cognitive profiles of various neurocognitive disorders. It was a pleasure to have Jarod on our service, and we wish him the very best." "Jarod did a very good job. He quickly became comfortable interviewing patients with addiction. He wrote good notes and worked very well with the team. He is professional and courteous. He could benefit from continuing to read up on DSM diagnoses and psychopharmacology."

Internal Medicine (8/16/2021 - 10/8/2021) Grade: P**

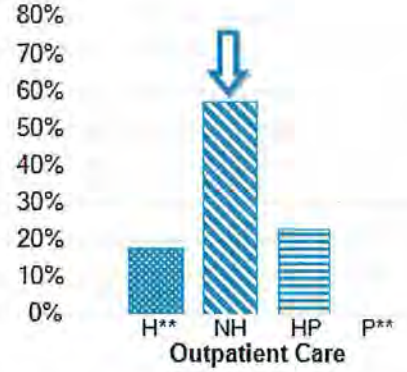
Overall grade based on: Clinical - 60%; Exam - 30%; Completion of Aquifer Modules, EMR H&P Feedback Form, Comprehensive H&P Write-Up, Reflective Writing Exercise - 10%



"I worked with Jarod for the second two weeks of his general internal medicine ward rotation at CUH. He performed well, and his oral presentations were organized and generally complete with regard to the information I wanted. His written H&P was fair but not as complete as needed. He was open to feedback and suggestions, and his second H&P was much better. He showed initiative in obtaining information from one 15 year old patient admitted with acute liver injury and went above and beyond in extending the history from the patient. He was liked and respected by the team, and I enjoyed working with him." "Jarod was always prepared for rounds, communicated his responsibilities maturely, and engaged in the learning environment. I saw him complete bedside rounds on a challenging and complex patient with many medical problems, and he had good rapport with the patient. I also observed him perform a history on a patient with GBM admitted for acute PE who had many family members in the room. Jarod did an excellent job gathering history on the primary problem. We discussed the challenge of interviewing a patient admitted to the hospital with many involved family members in the midst of tragic circumstances and ways to address the emotion in the room before delving into the business at hand. During my one week with Jarod, he cared for a very complicated woman who was admitted with hemolytic anemia and puzzling post-prandial N/V after a TEE. He did an excellent job presenting her subjective and objective information and needed little assistance ordering her problem list and honing in on a problem representation given the myriad number of disparate yet active problems. For his patient with GBM and PE, he was able to discuss the treatment for PE given the underlying cancer. His next steps should be to create differentials for the entire problem list (constipation, mouth ulcers, etc.) and to consider monitoring for our treatments (glucose for steroids)." "Jarod did great work during our two weeks together. He was able to elicit important histories from his patients and gained their trust. He was gaining proficiency in his physical exams and was eager to learn more. His notes and H&Ps were complete and well researched. He routinely used the literature to inform his patient care. His verbal presentations on rounds were well organized and complete. I enjoyed working with him."

Outpatient Care (11/8/2021 - 12/17/2021) Grade: NH

Overall grade based on: Clinical - 50%; Exam - 30%; Coursework - 20%



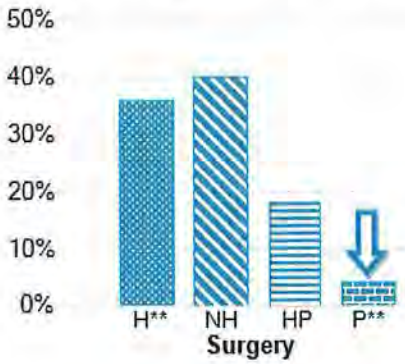
"Jarod performed amazingly well from the first half day I worked with him in my clinic. He was immediately happy to see a variety of patients and was appropriately prepared for each visit. He chart checked and gathered initial information thoroughly, and I was surprised to find my clinic ran efficiently while he and I alternated seeing patents. I enjoyed working with him, as it was like having a team member or colleague rather than a clerkship student. He performed well above his level of training, and I would feel comfortable having him see any of my patients. I encouraged him to consider a career in primary care." "Jarod is organized, thorough, and was able to ask pertinent questions based on the appropriate differential when performing a history and physical. He was able to interpret data collected and formulate a well-reasoned and prioritized differential diagnosis on straightforward patients. He

utilized motivational interviewing or similar communication skills to counsel patients and was able to make most patients feel comfortable. He especially excelled in the pediatrics clinic, where he was able to obtain a focused pediatric history, develop a differential diagnosis, and establish rapport with a caregiver on the first visit." "We had very limited time working together in clinic, but Jarod did a solid job. As he continues to read and learn clinical medicine, I anticipate he will become a very capable physician."

Surgery (1/3/2022 - 2/11/2022) Grade: P**

Overall grade based on: Clinical - 50%; Exam - 30%; Consent Exam - 10%; Suturing Exam - 10%

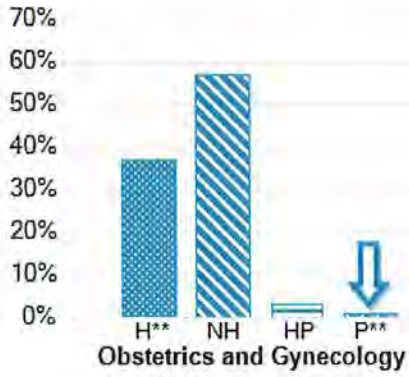
"Jarod performed with distinction on the pediatric surgical rotation. He was professional, pleasant to work with, interested, and involved. He has a good bedside manner and got along well with patients, other medical students, residents, and staff. He is dedicated to learning and asked appropriate questions. He was responsive to feedback, and his fund of knowledge is appropriate for his level. With continued reading and clinical exposure, he will make an excellent physician." "Jarod participated in all aspects of clinical care during the vascular surgery rotation and was well prepared for presentations."



Obstetrics and Gynecology (2/14/2022 - 3/25/2022) Grade: P**

Overall grade based on: Clinical - 50%; Exam - 30%; OSCE - 20%

"Jarod gave a great presentation to the group on postpartum hemorrhage." "Jarod gathered a complete history and was learning how to perform a sensitive exam." "Jarod was a delight to work with. He integrated into our team very well and will be an asset to any residency program." "Jarod demonstrated good history-taking skills that were well focused and thorough. He had good exam skills and concise documentation of care that improved with repetition."

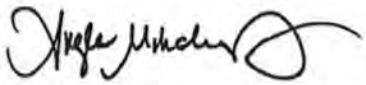


SUMMARY

In reviewing several years of Jarod John Munda Pamatmat's accomplishments, several patterns become apparent. Despite struggling initially on the clerkship exams due in part to a previously undiagnosed medical condition, Jarod demonstrated resilience and grit, receiving consistent praise for his strong clinical skills, diligent work ethic, and dedication to his patients. His attendings were impressed with his eagerness to learn and quickly incorporate feedback, his initiative in patient care tasks, and his helpful contribution to the work of the team. His evaluators also complimented his professionalism, dependability, compassion, empathy, and ease at establishing rapport with patients and families. Jarod has demonstrated a commitment to improving access to care for the underserved community as well as to improving team skills through interprofessional education initiatives. His determination to overcome obstacles, along with his dedication to patients will ensure that he is a welcome addition to any postgraduate residency training program and future health care team.

I hope these observations are of assistance in the consideration of Jarod's application for residency.

Respectfully submitted,



Angela Peterman Mihalic, M.D.
Dean of Medical Students and Associate Dean for Student Affairs

MEDICAL SCHOOL INFORMATION

For additional information about the University of Texas Southwestern Medical School please see:
https://www.utsouthwestern.edu/education/medical-school/curriculum/class-2023.pdf

Official UT Southwestern Medical School Record

Name: Jarod John Munda Pamatmat

Student ID: 168410

SSN: [redacted]

Other Institutions Attended
University of Texas/Dallas
Tyler Junior College
Middlebury College
Northeast Texas Community College

Print Date: Jun 16, 2023

---------- **Beginning of Medical School Record** ----------

Medical Year 2018-2019

Program: School of Medicine
Plan: General Medicine Major

Course		Description	Attempted	Earned	Grade	Points
BSF	1000	MICROANATOMY	0.50	0.50	P	0.00
BSF	1001	HUMAN STRUCTURE	2.50	2.50	P	0.00
COLL	1301	ACADEMIC COLL: PRE-CLRK I	1.00	1.00	P	0.00
COLL	1302	ACADEMIC COLL: PRE-CLRK II	1.00	1.00	P	0.00
ENRH	118	SIAP: SPANISH INTERPRETER PGM	0.00	0.00	P	0.00
ENRH	148	CULINARY MEDICINE	0.00	0.00	P	0.00
FBS	1101	MACROMOLECULES	0.50	0.50	P	0.00
FBS	1102	CELLS	1.00	1.00	P	0.00
FBS	1103	TISSUES	1.00	1.00	P	0.00
FBS	1104	GENETICS	1.00	1.00	P	0.00
FBS	1105	ORGANISMS AND HOST	2.00	2.00	P	0.00
FBS	1106	INTRO TO PHARMACOLOGY	0.50	0.50	P	0.00
FCR	1401	FNDN FOR CLINICAL REASONING	0.50	0.50	P	0.00
IM	1201	MUSCULOSKELETAL AND SKIN	2.00	2.00	P	0.00
IM	1202	HEMATOPOIETIC SYSTEM	2.00	2.00	P	0.00
IM	1203	CARDIOVASCULAR	2.00	2.00	P	0.00
IM	1204	RESPIRATORY SYSTEM	2.00	2.00	P	0.00
IM	1205	RENAL AND GENITOURINARY	2.00	2.00	P	0.00
STRV	501	STRIVE: PERSONAL & PROF DEV I	0.00	0.00	P	0.00
STRV	502	STRIVE: PERSONAL & PROF DEV II	0.00	0.00	P	0.00

			Attempted	Earned	GPA Units	Points
Term GPA:	0.00	Term Totals:	21.50	21.50	0.00	0.00
Cum GPA:	0.00	Cum Totals:	21.50	21.50	0.00	0.00

Medical Year 2019-2020

Program: School of Medicine
Plan: General Medicine Major

Course		Description	Attempted	Earned	Grade	Points
COLL	1303	ACADEMIC COLL: PRE-CLRK III	1.00	1.00	P	0.00
COLL	1304	ACADEMIC COLL: CLERKSHIP I	0.50	0.50	P	0.00
ENRH	139	LOOC PROGRAM	0.00	0.00	P	0.00
ENRH	156	MEDICAL SIMULATIONS	0.00	0.00	P	0.00
FAM	1802	FAMILY MEDICINE CORE CLERKSHIP	4.00	4.00	HP	12.00
FCR	1401	FNDN FOR CLINICAL REASONING	0.50	0.50	P	0.00
IM	1206	GASTROINTESTINAL SYSTEM	2.00	2.00	P	0.00
IM	1207	ENDO ENGY HOMEO & REPROD HLTH	2.50	2.50	P	0.00
IM	1208	BRAIN AND BEHAVIOR	3.00	3.00	P	0.00
NEUR	1805	NEUROLOGY CORE CLERKSHIP	4.00	4.00	NH	14.00
STRV	1703	SCH ACT-CLIN & TRANSL RESEARCH	6.00	6.00	P	0.00
STP	1601	USMLE STEP 1 PREPARATION	3.00	3.00	P	0.00
STRV	503	STRIVE: PERSONAL& PROF DEV III	0.50	0.50	P	0.00
TTC	1501	TRANSITION TO CLERKSHIPS	0.50	0.50	P	0.00

			Attempted	Earned	GPA Units	Points
Term GPA:	3.25	Term Totals:	27.50	27.50	8.00	26.00
Cum GPA:	3.25	Cum Totals:	49.00	49.00	8.00	26.00

Medical Year 2020-2021

Program: School of Medicine
Plan: General Medicine Major

Course		Description	Attempted	Earned	Grade	Points
ANES	2001	EXPLORATION ANESTHESIA	1.00	1.00	P	0.00
COLL	1305	ACADEMIC COLL: CLERKSHIP II	0.50	0.50	P	0.00
COLL	1306	ACADEMIC COLL: CLERKSHIP III	0.50	0.50	P	0.00
GEN	2008W	PLAN YOUR OWN ADVENTURE	1.00	1.00	P	0.00
MED	1801	INTERNAL MEDICINE CORE CLKSHIP Repeat (Excluded from GPA)	8.00	0.00	F	0.00
OBG	1807	OB/GYN CORE CLERKSHIP Repeat (Excluded from GPA)	6.00	0.00	F	0.00
PED	1803	PEDIATRICS CORE CLERKSHIP	6.00	6.00	NH	21.00
PED	2021	ADOLESCENT TRANSGENDER CARE	1.00	1.00	P	0.00
PSY	1806	PSYCHIATRY CORE CLERKSHIP	6.00	6.00	NH	21.00
STP	2001	STEP 1 SELF-DIRECTED STUDY	1.00	1.00	P	0.00
SUR	1808	SURGERY CORE CLERKSHIP	6.00	6.00	HP	18.00

			Attempted	Earned	GPA Units	Points
Term GPA:	3.33	Term Totals:	37.00	23.00	18.00	60.00
Cum GPA:	3.31	Cum Totals:	86.00	72.00	26.00	86.00

Medical Year 2021-2022

Program: School of Medicine
Plan: General Medicine Major

Course		Description	Attempted	Earned	Grade	Points
COLL	1305	ACADEMIC COLL: CLERKSHIP II	0.50	0.50	P	0.00
COLL	1306	ACADEMIC COLL: CLERKSHIP III	0.50	0.50	P	0.00
FAMB	1809	OUTPATIENT CARE CLERKSHIP	6.00	6.00	NH	21.00
MED	1801	INTERNAL MEDICINE CORE CLKSHIP First Attempt: F Second Attempt: NH Final Grade: P** Med School Repeat (Max grade of P**)	8.00	8.00	P**	16.00
OBG	1807	OB/GYN CORE CLERKSHIP First Attempt: F Second Attempt: HP Final Grade: P** Med School Repeat (Max grade of P**)	6.00	6.00	P**	12.00
PATH	2104	HEMATOPATHOLOGY	2.00	2.00	P	0.00
PED	1906	SEL- ACUTE NEONATAL ICU (CMC)	2.00	2.00	H	0.00
PED	2106	PEDI CL GASTROENTEROLOGY	2.00	2.00	P	0.00
PMED	2001	EXPLORE PM&R	1.00	1.00	P	0.00
PMED	2004	ADVANCED PM&R- PED REHAB MED	1.00	1.00	P	0.00
PSY	2016	EXPLORE MINDFULNESS FOR MED ST	1.00	1.00	P	0.00

Registrar

7/16/23

Official UT Southwestern Medical School Record

Name: Jarod John Munda Pamatmat

Student ID: 168410

Course		Description	Attempted	Earned	Grade	Points
RAD	2001	EXPLORE RADIOLOGY	1.00	1.00	P	0.00
SUR	1808	SURGERY CORE CLERKSHIP	6.00	6.00	P**	12.00

			Attempted	Earned	GPA Units	Points
Term GPA:	2.35	Term Totals:	37.00	37.00	26.00	61.00
Cum GPA:	2.83	Cum Totals:	123.00	109.00	52.00	147.00

Attempted:

Clerkship Objective Structured Clinical Exam
Status: Completed
Program: School of Medicine
Date Completed: 2021-04-18
Milestone Level: Exam
Date Attempted: 2021-04-18 Completed

Medical Year 2022-2023

Program: School of Medicine
Plan: General Medicine Major

Course		Description	Attempted	Earned	Grade	Points
COLL	1307	ACADEMIC COLL: POST CLRK I	1.00	1.00	P	0.00
COLL	1308	ACADEMIC COLL: POST CLRK II	1.00	1.00	P	0.00
EMED	2102	CLINCAL TOXICOLOGY	2.00	2.00	P	0.00
FIM	2207	FIM- RESUSCITATION MEDICINE	2.00	2.00	P	0.00
GEN	2101	BIOSTATISTICS	2.00	2.00	P	0.00
PAS	2301	PHYSICIANS & SOCIETY	2.00	2.00	P	0.00
PED	1901	SEL - ACUTE PEDI EMERG ROOM	2.00	2.00	HP*	0.00
PED	1904	SEL - PEDIATRIC SUBINTERNSHIP	2.00	2.00	H	0.00
PED	2199	SPECIAL TOPICS	2.00	2.00	P	0.00
		Course Topic: SPECIAL TOPICS IN PEDIATRICS				
RES	2401	RESIDENCY ESSENTIALS	2.00	2.00	P	0.00

			Attempted	Earned	GPA Units	Points
Term GPA:	0.00	Term Totals:	18.00	18.00	0.00	0.00
Cum GPA:	2.83	Cum Totals:	141.00	127.00	52.00	147.00

--------- End of Official UT Southwestern Medical School Record ---------

Degrees Awarded

Degree: Doctor of Medicine
Confer Date: May 5, 2023
Plan: General Medicine
INTERNSHIP:
University of Oklahoma College of Medicine
Oklahoma City, Oklahoma
Pediatrics

Non-Course Milestones

Basic Life Support Certification
Status: Completed
Program: School of Medicine
Date Completed: 2018-08-08
Date Attempted: 2018-08-08 Completed
Exam Taken
Course Grade: P

PreClerkship Objective Structured Clinical Exam
Status: Completed
Program: School of Medicine
Date Completed: 2019-11-16
Milestone Level: Exam
Date Attempted: 2019-11-16 Completed

Registrar

AMA Physician Profile

PREPARED FOR

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

Name and Mailing Address

JAROD PAMATMAT
OU CHILDREN'S HOSP
A2 14000
1200 CHILDRENS AVE
OKLAHOMA CITY, OK 73104-4637

Primary Office Address

SAME AS MAILING ADDRESS

Phone [redacted]

Birth date [redacted]

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 TEXAS SOUTHWESTERN MEDICAL SCHOOL

Degree Awarded:	YES	**Degree Type:**	MD
Enrollment Date:	08/2018	**Degree Date:**	05/2022

T41678

AMA
AMERICAN MEDICAL ASSOCIATION

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:	PEDIATRICS
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.

OKLAHOMA STATE BOARD OF MEDICAL LICENSURE AND SUPERVISION
101 NE 51st STREET
OKLAHOMA CITY OK 73105

RECEIVED
JUN 16 2023
OKLAHOMA STATE BOARD OF MEDICAL LICENSURE AND SUPERVISION

EVIDENCE OF STATUS – PART A

Full Legal Name: Jarod (First) John (Middle) Munda (Last) Pamatmat (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 Jarod Pamatmat Date 6-16-23

Subscribed and sworn before me this 16th day of June, 2023.

Notary Public (Shannon DeWalch)

Commission Number 131880393

My commission expires 02-04-2027

NOTARY SEAL

SHANNON DEWALCH
Notary ID #131880393
My Commission Expires
February 4, 2027

TULSA OK

Jarod John Pamatmat
As of April 30, 2023, 3:44 pm

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?
Yes No

Failed internal medicine and OBGYN shelf exams largely in part due to [redacted], which made it difficult to study during clerkship year. Placed on academic probation and repeated clerkship year. After appropriate diagnosis and treatment, was able to successfully remediate without further concerns.

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?
Yes No

[redacted].

Jarod John Pamatmat
As of April 30, 2023, 3:44 pm

State of: Texas

County of: Smith

The person or persons whose signature appears below personally appeared before the undersigned, a NOTARY PUBLIC, in and for the above named county and state, on the 16th day of June, 2023, and acknowledged the execution of foregoing instrument to be the voluntary act and deed of the applicant therein named and for the purpose therein set forth, that they are duly authorized to execute the foregoing instrument, and that the statements and representations therein contained are true to the best of their knowledge and belief.

Seal

NOTARY PUBLIC STATE OF TEXAS
SHANNON DEWALCH
Notary ID #131880393
My Commission Expires
February 4, 2027

Jarod Pamatmat
Signature of Applicant

Notary

02-04-2027
My Commission Expires

RECEIVED
JUN 16 2023
OKLAHOMA STATE BOARD OF MEDICAL LICENSURE AND SUPERVISION

T 41678 V

OKLAHOMA STATE BOARD OF MEDICAL LICENSURE AND SUPERVISION
101 NE 51ST 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 Wiser 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.

Jarod John Pamatmat		6/17/2023
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.

RECEIVED
JUN 16 2023
OKLAHOMA STATE BOARD OF MEDICAL LICENSURE AND SUPERVISION

T 4/16/78 VS

Name:	Jarod John Pamatmat	Application #	41678

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
April	2015	May	2015	All Saints Episcopal School	Tyler	TX	High School
August	2015	May	2018	The University of Texas at Dallas	Richardson	TX	Biology, BA
August	2018	May	2023	UT Southwestern Medical School	Dallas	TX	MD

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
May	2015	August	2015	Summer Break	Tyler	TX
May	2018	August	2018	Summer Break	Tyler	TX

RECEIVED
JUN 16 2023
OKLAHOMA STATE BOARD OF MEDICAL LICENSURE AND SUPERVISION

T 41678 V

05/12/2023

JAROD JOHN PAMATMAT
[redacted]

Check Your Application Status Online at:
http://www.okmedicalboard.org
***Username*:AP56762978**
***Password*:Last 4 SSN**

RE: MD Application #41678

Dear JAROD JOHN PAMATMAT,

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

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

Evidence of Status
Affidavit DEFICIENCIES: NOTARIZED STATEMENT RE:YES ANSWERS
Application Instructions
OATH
Extended Background Check
Time Deficiency Form for: 4/2015-8/2015
OTHER DEFICIENCIES: FCVS/ WHY DID MED SCHOOL TAKE 5 YEARS?
Exam verification date
MedSchool-Transcript Univ Of TX Southwestern Med Sch At Dallas SW Med Sch, Dallas Tx 75235
MedSchool-Form 1 Univ Of TX Southwestern Med Sch At Dallas SW Med Sch, Dallas Tx 75235
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 AP56762978 (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

Sincerely,

Seema Jayachand

Seema Jayachand

Dept. of Licensing

Encl

Kenna L. Shaw

From: BillPay Webmaster <donotreply@www.ok.gov>
Sent: Sunday, May 26, 2024 6:33 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

JAROD JOHN PAMATMAT has paid for a LICENSE - MD Training-to-Full License Fee 250.00 on 05/26/2024 06:05:33pm for $250.00.
OKLAHOMA MD LICENSE NUMBER 41678
To view all transactions please go to http://www.ok.gov/triton/ and login to your CMS account.

T 41678 VD

Oklahoma State Board of Medical Licensure and Supervision
Application Summary

Type	Number	Name
MD	41678	JAROD JOHN PAMATMAT

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:
048-12 Univ Of TX Southwestern Med Sch At Dallas SW Med Sch, Dallas Tx 75235

Number of Licenses Previously Granted to Graduates of this Medical School:599

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** BM 6-29-23

5) **REQUESTS SPECIFIC CONSIDERATION OF:**

_____

_____

_____

_____

_____

Oklahoma State Board of Medical Licensure and Supervision
Application Summary

Type	Number	Name
MD	41332	DANIEL OLIVER PANKRATZ

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	41332	DANIEL OLIVER PANKRATZ

MEDICAL DOCTOR

Practice Address:

April 19, 2023

Status:
Res: TR
Received: 03/29/2023
Entered: 03/29/2023
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 #: 41332
Sex: M
Ethnic Origin: 1

Endorsed By: USMLE

	Test	Score	Date Taken	Date Verified	Attempts
Test 1:	USMLE 1	PASS	05/16/21	3/28/23	1
Test 2:	USMLE 2	PASS	06/11/22	3/28/23	1
Test 3:	USMLE 3	PASS	9/11/23	1/19/24	1

Note: ***PASS*** means higher than 75

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

PRE-MED EDUCATION

School Name: KANSAS STATE UNIVERSITY
City: MANHATTAN **State:** KS **Country:** UNITED STATES
Degree: BACHELOR OF SCIENCE **From:** 8/2014 **To:** 5/ 2018 **Verified:**

School Name: BLUE VALLEY WEST HIGH SCHOOL
City: OVERLAND PARK **State:** KS **Country:** UNITED STATES
Degree: **From:** 8/2010 **To:** 5/ 2014 **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: **From:** 7 / 2019 **To:** 5 / 2023 **Diploma Ver'd:** Y

Oklahoma State Board of Medical Licensure and Supervision
Application Summary

Type	Number	Name
MD	41332	DANIEL OLIVER PANKRATZ

MEDICAL DOCTOR

POST GRADUATE EDUCATION

Facility: COLLEGE OF MEDICINE OKC **Specialty:** ORTHOPEDIC SURGERY
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: COLLEGE PARK FAMILY CARE CENTER **Supervisor:**
City: OVERLAND PARK **State:** KS **Country:** UNITED STATES
Specialty: MEDICAL ASSISTANT **From:** 5 / 2018 **To:** 5 / 2019 **Verified:**
Comments:

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

RECEIVED
APR 16 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** Text 1
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	Daniel 2	**LAST NAME** 5	Pankratz 3 4
EMAIL ADDRESS	[redacted]		7
LICENSE NUMBER	41332 8	**CELL PHONE** 10	[redacted] 11
HOME ADDRESS	[redacted]	**CITY/STATE** 14 **ZIP CODE**	15
PROGRAM ATTENDING	The University of Oklahoma 16	**SPECIALTY** 18	Orthopedic Surgery 17 19

DOCUMENTATION TO ATTACH

20

PAYMENT 22 NT COMPLETED			21
☐	$150 payment made on Billpay for **RENEWAL** of training license	☐	$250 payment made on Billpay for **UPGRADE** of training license

DOCUMENTATION REQUIRED			
☐	Form 2 (must be received directly from program) **ONLY FOR UPGRADE	☐	Evaluation (must be received directly from program)
☐	USMLE Step 3 (must be received directly from USMLE)	☐	Answer confidential questions (on back of this form)

FOREIGN TRAINED STUDENTS			
☐	Current visa	☐	Social Security Number **if not provided at initial application
☐	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

T41332
SJ

NAME Daniel Pankratz [1]

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)?	☐	☒ [2]
Have you been the subject of investigation or disciplinary action (including probation) by a hospital or training program?	☐	☒ [3]
Have you had any adverse judgment or settlement against you rising from a professional liability claim?	☐	☒ [4]
Have you been reported to the National Practitioner Data Bank (NPDB)?	☐	☒ [5]
Have you ever been denied, had removed, or suspended hospital privileges?	☐	☒ [6]
Have you surrendered hospital privileges while under investigation or to avoid investigation?	☐	☒ [7]
Have you entered into an Agreement with a Federal, State, or Local jurisdictional body to avoid formal action?	☐	☒ [8]
Has your application for licensure ever been denied?	☐	☒ [9]
Have you surrendered a license or had any disciplinary action taken on any license?	☐	☒ [10]
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)?	☐	☒ [11]
Have you obtained an assessment or been treated for use of any drug or chemical substance including alcohol?	☐	☒ [12]
Have you been arrested for, charged with, or convicted of a felony or misdemeanor other than a traffic violation?	☐	☒ [13]
Have you been arrested for, charged with, or convicted of a traffic violation involving the use of any drug or chemical substance?	☐	☒ [14]
Have you been addicted to or abused any drug or chemical substance including alcohol?	☐	☒ [15]
Have you been denied provider participation, terminated, sanctioned or penalized by any third-party payor including TRICARE, MEDICARE, or MEDICAID?	☐	☒ [16]
Have you surrendered or had any adverse action taken against any narcotic permit (State or Federal)?	☐	☒ [17]

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 Daniel Pankratz

Date 4/16/24 [18]

Oklahoma State Board of Medical Licensure and Supervision

APPLICATION FOR OKLAHOMA MEDICAL DOCTOR LICENSE

Received: 03/29/2023

Applicant Name: PANKRATZ, DANIEL OLIVER [redacted] **MD 41332**

Date Of Birth: [redacted] **Place Of Birth (City, State):** OVERLAND PARK, KS

Sex: M **Race:** Caucasian

Education

Type	Name	City	ST	Country	From	To	Degree	Comments	Veri
UG	KANSAS STATE UNIVERSITY	MANHATTAN	KS		8/2014	5/2018	BACHELOR OF SCIENCE		
HS	BLUE VALLEY WEST HIGH SCHOOL	OVERLAND F	KS		8/2010	5/2014			

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
COLLEGE PARK FAMILY CARE CENTER	MEDICAL ASSISTANT		OVERLAND PARK	KS		5/2018	5/2019	

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

Received:03/29/2023

	Questions Answered 03/24/2023	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: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:

The University of Oklahoma

If so, Please identify with which category:

Teaching Facility

Name of Previous Carrier and Policy Holder

Covered by KU School of Medicine during medical school.

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 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
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.

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

RECEIVED
MAR 28 2023
OKLAHOMA STATE BOARD OF MEDICAL LICENSURE AND SUPERVISION

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

3/28/2023
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 Kansas, County of Johnson

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 _____ My Notary Commission Expires 7-6-26

REGAN VAN WYHE
Notary Public-State of Kansas
My Appt. Expires 7-6-26

T41332
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

Recipient: OKLAHOMA STATE BOARD OF MEDICAL LICENSURE & SUPERVISION

Date: 01/19/2024

Examinee: Pankratz, Daniel Oliver
Alt Name(s):

Examinee ID: 5-465-701-0
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
05/16/2021	Pass	258	(194)	

USMLE STEP 2

Clinical Knowledge (CK)

Test Date	Pass/Fail	Score	Minimum Pass	Comments
06/11/2022	Pass	263	(209)	

USMLE STEP 3

Test Date	Pass/Fail	Score	Minimum Pass	Comments
09/11/2023	Pass	235	(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.

Rev 2018

T 41532 MA

USMLE
United States
Medical
Licensing
Examination

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: Pankratz, Daniel Oliver

Examinee ID: 5-465-701-0
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.

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.

RECEIVED
MAY 25 2023
OKLAHOMA STATE BOARD OF MEDICAL LICENSURE AND SUPERVISION

Applicant's Name Daniel Oliver Pankratz

Institution: University of Kansas School of Medicine City/State Kansas City, KS

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

From 07 / 29 / 2019 (Month Day Year) To 05 / 12 / 2023 (Month Day Year) and was awarded the degree Doctor of Medicine 05/14/2023

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: Caroline Seals Signature

Title of Signatory: Campus Registrar Date of Signature 05/16/2023

Tel: 913-588-7055 Fax: 913-588-8841 E-Mail: Kumcreg.staff@kumc.edu

School Seal

If no seal is available, this form must be notarized

Notary Public

Commission #

My commission expires:

PRIMARY SOURCE

Notary Seal

T41332
LKC

University of Kansas
Lawrence, KS

Official KU Academic Record

Name: Daniel Pankratz
Student ID: 2956369

Institution Info: University of Kansas
Lawrence, KS 66045
CEEB: 06871 ACT: 1470

SSN: ***-**-8199
Birthdate: Jul 01

Print Date: 05/24/2023

To: OK Board

Beginning of Medicine Record

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

			Attempted	Earned	GPA Units	Points
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

			Attempted	Earned	GPA Units	Points
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 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., Develpmnt & Sexuality	0.000	0.000	IP	0.000
GSMC	502	Interprofessional Collab II	0.000	0.000	NE	0.000

			Attempted	Earned	GPA Units	Points
Term GPA	0.000	Term Totals	16.000	16.000	0.000	0.000
Cum GPA	0.000	Cum Totals	51.000	51.000	0.000	0.000

2021 Spring

Program: Medicine Professional

Course		Description	Attempted	Earned	Grade	Points
ACED	835	Reprod., Develpmnt & Sexuality	8.000	8.000	P	0.000
ACED	840	Medicine Capstone	8.000	8.000	P	0.000
IDSP	806	Prsnl Prfessonl Development	0.000	0.000	NE	0.000

			Attempted	Earned	GPA Units	Points
Term GPA	0.000	Term Totals	16.000	16.000	0.000	0.000
Cum GPA	0.000	Cum Totals	67.000	67.000	0.000	0.000

2021 Fall

Program: Medicine Professional

Course		Description	Attempted	Earned	Grade	Points
FAPR	955	Family Medicine Clerkship	0.000	0.000	IP	0.000
ICM	900	Issues Clin Med	0.000	0.000	P	0.000
MED	900	Internal Medicine Clerkship	8.000	8.000	PD	32.000
NEUR	900	Neurology Clerkship	4.000	4.000	PD	16.000
PYCH	955	Psychiatry Clerkship	4.000	4.000	PD	16.000
SURG	900	Surgery Clerkship	8.000	8.000	PD	32.000

			Attempted	Earned	GPA Units	Points
Term GPA	4.000	Term Totals	24.000	24.000	24.000	96.000
Cum GPA	4.000	Cum Totals	91.000	91.000	24.000	96.000

Casey L. Wallace
Interim University Registrar

RAISED SEAL NOT REQUIRED

This Official Transcript is printed on tamper-proof security paper and does not require a raised seal. To confirm authenticity, see instructions on reverse side.

TU1332
UKC

Official KU Academic Record

University of Kansas
Lawrence, KS

Name: Daniel Pankratz
Student ID: 2956369

2022 Spring

Program: Medicine Professional

Course		Description	Attempted	Earned	Grade	Points
FAPR	955	Family Medicine Clerkship	8.000	8.000	PD	32.000
GSMC	503	Interprofessional Collab III	0.000	0.000	NE	0.000
GYNO	900	Obstetric/Gynecology Clerkship	8.000	8.000	P	24.000
ICM	900	Issues Clin Med	0.000	0.000	P	0.000
PED	900	Pediatrics Clerkship	8.000	8.000	P	24.000

			Attempted	Earned	GPA Units	Points
Term GPA	3.330	Term Totals	24.000	24.000	24.000	80.000
Cum GPA	3.670	Cum Totals	115.000	115.000	48.000	176.000

2022 Fall

Program: Medicine Professional

Course		Description	Attempted	Earned	Grade	Points
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
IDSP	900	Special Program	4.000	4.000	P	0.000
IDSP	900	Special Program	4.000	4.000	P	0.000
SURG	915	Sub-I-Ortho Surg	4.000	4.000	P	0.000
SURG	929	Crit Care Surg ICU	4.000	4.000	P	0.000

			Attempted	Earned	GPA Units	Points
Term GPA	0.000	Term Totals	20.000	20.000	0.000	0.000
Cum GPA	3.670	Cum Totals	135.000	135.000	48.000	176.000

2023 Spring

Program: Medicine Professional

Course		Description	Attempted	Earned	Grade	Points
ANES	910	Anesthesiology	4.000	4.000	P	0.000
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	900	Special Program	2.000	2.000	P	0.000
Transcript Note: PHRM	911	Emerg Tox Rdg in Pharmacolgy	2.000	2.000	P	0.000

			Attempted	Earned	GPA Units	Points
Term GPA	0.000	Term Totals	12.000	12.000	0.000	0.000
Cum GPA	3.670	Cum Totals	147.000	147.000	48.000	176.000

Medicine Career Totals

Cum GPA:	3.670	Cum Totals	147.000	147.000	48.000	176.000

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

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: Doctor of Medicine
Confer Date: 05/14/2023
Plan: Doctor of Medicine

End of Official KU Academic Record

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MAY 25 2023
OKLAHOMA STATE BOARD OF MEDICAL LICENSURE AND SUPERVISION

PRIMARY SOURCE

Casey L. Wallace
Interim University Registrar

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T41332
LKC

AMA Physician Profile

PREPARED FOR

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

PRIMARY SOURCE

Name and Mailing Address

DANIEL OLIVER PANKRATZ
UNIV OF OKLAHOMA HEALTH SCIENCES CTR
PO BOX 26901
800 STANTON L YOUNG BLVD
OKLAHOMA CITY, OK 73104-5018

Primary Office Address

Phone UNKNOWN

RECEIVED
MAY 10 2024
OKLAHOMA STATE BOARD OF MEDICAL LICENSURE AND SUPERVISION

Birth date [redacted]

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 KANSAS SCHOOL OF MEDICINE

Degree Awarded:	YES	**Degree Type:**	MD
Enrollment Date:	07/2019	**Degree Date:**	05/2023

T41332

AMA AMERICAN MEDICAL ASSOCIATION

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:	ORTHOPAEDIC 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

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 28 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: Daniel (First) Oliver (Middle) Pankratz (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 3/28/2023

Subscribed and sworn before me this 28 day of March, 20 23.

Notary Public Regan VanWyhe

Commission Number 1199178

My commission expires 7-6-2026

NOTARY SEAL

REGAN VAN WYHE
Notary Public-State of Kansas
My Appt. Expires 7-6-26

T41332
SD

OKLAHOMA STATE BOARD OF MEDICAL LICENSURE AND SUPERVISION
101 NE 51ST 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 Wiser 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.

Daniel Pawkratz — Name of Applicant (type or print)
Signature of Applicant
3/28/2023 — 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.

T41332
SD

Kenna L. Shaw

From: BillPay Webmaster <donotreply@www.ok.gov>
Sent: Tuesday, April 16, 2024 1:35 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

DANIEL PANKRATZ has paid for a LICENSE - MD Training-to-Full License Fee 250.00 on 04/16/2024 01:04:35am for $250.00.

OKLAHOMA MD LICENSE NUMBER 41332

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

T 41332 D

05/04/2023

DANIEL OLIVER PANKRATZ
[redacted]

Check Your Application Status Online at:
http://www.okmedicalboard.org
***Username*:AP91311826**
***Password*:Last 4 SSN**

RE: MD Application #41332

Dear DANIEL PANKRATZ,

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

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

Exam verification date
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 AP91311826 (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

Sincerely,

Seema Jayachand

Seema Jayachand

Dept. of Licensing

Encl

Oklahoma State Board of Medical Licensure and Supervision
Application Summary

Type	Number	Name
MD	41332	DANIEL OLIVER PANKRATZ

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** _____ 6-1-23

5) **REQUESTS SPECIFIC CONSIDERATION OF:**

_____

_____

_____

_____

_____