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2463

STATE MEDICAL BOARD OF OHIO

77 South High Street, 17th Floor • Columbus, Ohio 43266-0315 • (614) 466-3934

APPLICATION FOR CERTIFICATE - MEDICINE OR OSTEOPATHIC MEDICINE

PLEASE TYPE OR PRINT CLEARLY

1. Social Security Number: Redacted - [redacted] [redacted]

2. Full Name (Use no initials):

LAST (Surname)	FIRST	MIDDLE	SUFFIX(Jr., II)
BEECH	AMY	LEIGH	

3. Name (As you prefer it inscribed on your Ohio license):

LAST (Surname)	FIRST	MIDDLE	SUFFIX(Jr., II)
BEECH	AMY	STEARNS	

4. Maiden Name Or Other Names Used (If none, enter "NONE"):

LAST (Surname)	FIRST	MIDDLE	SUFFIX(Jr., II)
STEARNS	AMY	LEIGH	

5. Current Address:

STREET & NUMBER [redacted] [redacted] Redacted

CITY [redacted] Redacted [redacted] ZIP CODE Redacted COUNTRY USA

6. Physical Description:

HEIGHT	WEIGHT	HAIR COLOR	EYE COLOR	IDENTIFYING MARKS
5'7"	125#	BROWN	HAZEL	

7. Sex: ☐ MALE ☒ FEMALE For statistics only (optional)

8. City In Ohio Where You Plan To Practice:

CITY COLUMBUS OR COUNTY

PLANS OF PRACTICE: Pediatrics

STATE MEDICAL BOARD OHIO
94 MAR 25 PM 2:55

9. Specialty Boards (U.S.A., Canada and foreign countries):

Name of Specialty Board	Board Certified Yes	Board Certified No	Year Certified	Country
	☐	☐		
	☐	☐		
	☐	☐		

FOR OFFICE USE ONLY ☐ 34 ☐ 35 ☐ Examination ☐ Endorsement

PAPERCLIP (DO NOT STAPLE) YOUR CHECK OR MONEY ORDER HERE

RESUME - MEDICINE OR OSTEOPATHIC MEDICINE

List **ALL** activities in chronological order from the date of medical school graduation to the present time using **MONTH** and **YEAR**. For any non-working time, you must state on the resume exactly what your activities were, such as "looking for residency program" or "vacation", as well as your permanent address for this period. If in private practice, indicate the hospitals where you hold or have held privileges and include complete dates and addresses. For any time in which you worked for an "emergency medical group" or did locum tenens, you must list all hospitals where you worked and include complete dates and addresses. If in private practice, indicate the hospitals where you hold or have held privileges and include complete dates and addresses. **DO NOT SUBSTITUTE ANY OTHER RESUME FOR THIS FORM.** Be sure to indicate the percentage of working time spent in clinical and administrative duties. If you require more space, attach separate sheets.

A.

month/year	Hospital, University or Other: / Complete Street Address: / Street & Number / City / State/Country / Zip	Position & Department	% Clinical / % Admin.
7 90	Albert Einstein College of Medicine Pediatrics Residency Jacobi Hospital Room 803 Pelham Parkway & East Chester Rd Bronx NY USA 10461	Pediatrics Resident (2 mos credit)	100% /
TO			
9 90			

B.

month/year	Hospital, University or Other: / Complete Street Address: / Street & Number / City / State/Country / Zip	Position & Department	% Clinical / % Admin.
9 90	Moving / Transfer (time to relocate) NYC → Columbus Ohio 373 S. Grant St (home) Columbus OH 43215		/
TO			
12 90			

C.

month/year	Hospital, University or Other: / Complete Street Address: / Street & Number / City / State/Country / Zip	Position & Department	% Clinical / % Admin.
12 90	Childrens Hospital 700 Childrens Drive Columbus OHIO 43205	Pediatrics Resident (7 mos credit)	100% /
TO			
6 91			

18 mos spent on voluntarily Maternity Leave (unpaid)

D.

month/year	Hospital, University or Other: / Complete Street Address: / Street & Number / City / State/Country / Zip	Position & Department	% Clinical / % Admin.
7 91	[redacted] Redacted [redacted] (home)	Maternity leave	/
TO			
1 92			

STATE MEDICAL BOARD OF OHIO 94 MAR 23 PM 2:55

RESUME- MEDICINE OR OSTEOPATHIC MEDICINE
PAGE TWO

Completion of internship

	month/year	TO	month/year	Hospital, University or Other:	Complete Street Address:	City	State/Country	Zip	Position & Department	% Clinical	% Admin.
E.	1 93	TO	6 93	Childrens Hospital	700 Childrens Drive Street & Number	Columbus	OH	43205	Pediatrics Resident (5 mos Credit)	100%	

Birth of 2nd Child - again on extended maternity leave (voluntary)

	month/year	TO	month/year	Hospital, University or Other:	Complete Street Address:	City	State/Country	Zip	Position & Department	% Clinical	% Admin.
F.	6 93	TO present		Part-time (10 hrs/week) research (no salaried employment presently) [HOME]	Redacted Street & Number	Redacted			Maternity leave		

- planning to work in pediatrics part-time when obtain license and continue CME
- will eventually complete Pediatrics Residency when son is a little older.

	month/year	TO	month/year	Hospital, University or Other:	Complete Street Address:	City	State/Country	Zip	Position & Department	% Clinical	% Admin.
G.		TO			Street & Number						

	month/year	TO	month/year	Hospital, University or Other:	Complete Street Address:	City	State/Country	Zip	Position & Department	% Clinical	% Admin.
H.		TO			Street & Number						

STATE MEDICAL BOARD OF OHIO

77 South High Street, 17th Floor • Columbus, Ohio 43266-0315 • (614) 466-3934

MEDICINE OR OSTEOPATHIC MEDICINE

FORM 1 - CERTIFICATE OF RECOMMENDATION

This form is to be completed by a physician fully licensed in the STATE IN WHICH THE FORM IS NOTARIZED. The recommending physician must be sufficiently acquainted with the applicant for at least **SIX** months. Relatives may not serve as recommending physicians. Recommending physicians are strongly urged to include additional comments. This form must be notarized. ALL questions must be answered. This form is not intended to standardize the recommendation or restrict it in any way. However, its form is designed to insure that certain information is included.

DO NOT COMPLETE UNLESS A *COLOR* PHOTO OF APPLICANT IS ATTACHED TO THE BACK OF THIS FORM

BLACK & WHITE PHOTOS ARE NOT ACCEPTABLE

I, MARY KAY KUZMA, a licensed and practicing physician in the state of
(recommending physician)

OHIO, affirm that AMY BEECH
(state of residence) (applicant)

has been known to me personally for 1/2 years and that he/she is of good moral character. Further, the photograph affixed hereto is a genuine likeness of the applicant. I offer the following in support of his/her application for full licensure:

*I rate his/her medical knowledge and technique as: GOOD

*His/her relationship with patients is: VERY GOOD

*I rate his/her ability to work well with peers and medical staff as: VERY GOOD

*His/her command of the English language is: EXCELLENT

*Additional comments: _____

I hereby recommend him/her for full licensure to practice in the State of Ohio.

OVER ⇨

FORM 1 - CERTIFICATE OF RECOMMENDATION - MEDICINE OR OSTEOPATHIC MEDICINE
PAGE TWO

MKKuzma MD
Signature of Recommending Physician
(name stamps not acceptable)

MARY KAY KUZMA, MD
Name of Recommending Physician
(please type or print clearly)

(216) 722-4414
Telephone Number
(include area code)

700 Childrens Dr. Columbus Oh 43205
Address of Recommending Physician
(include city, state and zip code)

Ohio 55412
State of Licensure & License Number of Recommending Physician
(please type or print clearly)

(NOTARY SEAL)

Subscribed and sworn to before me this 11th day of March, 1994.

Donna Bozman
Notary Public Signature

1/30/97 djb
Date Commission Expires

Donna J. Bozman
Notary Public, State of Ohio
My Commission Expires 1/20/97 djb

type
ant
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s

Signature of Applicant

Date Photo Taken: 3/94
Mo./Yr.

RETURN TO: STATE MEDICAL BOARD OF OHIO
77 SOUTH HIGH STREET, 17TH FLOOR
COLUMBUS, OH 43266-0315

Revised 05/26/92

STATE MEDICAL BOARD OF OHIO

77 South High Street, 17th Floor • Columbus, Ohio 43266-0315 • (614) 466-3934

MEDICINE OR OSTEOPATHIC MEDICINE

FORM 1 - CERTIFICATE OF RECOMMENDATION

This form is to be completed by a physician fully licensed in the STATE IN WHICH THE FORM IS NOTARIZED. The recommending physician must be sufficiently acquainted with the applicant for at least **SIX** months. Relatives may not serve as recommending physicians. Recommending physicians are strongly urged to include additional comments. This form must be notarized. ALL questions must be answered. This form is not intended to standardize the recommendation or restrict it in any way. However, its form is designed to insure that certain information is included.

DO NOT COMPLETE UNLESS A *COLOR* PHOTO OF APPLICANT IS ATTACHED TO THE BACK OF THIS FORM

BLACK & WHITE PHOTOS ARE NOT ACCEPTABLE

I, John D Mahan, MD, a licensed and practicing physician in the state of
(recommending physician)

Ohio, affirm that Amy L. Beech, MD
(state of residence) (applicant)

has been known to me personally for 2.5 years and that he/she is of good moral character. Further, the photograph affixed hereto is a genuine likeness of the applicant. I offer the following in support of his/her application for full licensure:

*I rate his/her medical knowledge and technique as: Excellent

*His/her relationship with patients is: Excellent

*I rate his/her ability to work well with peers and medical staff as: Good

*His/her command of the English language is: Excellent

*Additional comments: _____

I hereby recommend him/her for full licensure to practice in the State of Ohio.

OVER ⇨

FORM 1 - CERTIFICATE OF RECOMMENDATION - MEDICINE OR OSTEOPATHIC MEDICINE
PAGE TWO

John D Mahan MD
Signature of Recommending Physician
(name stamps not acceptable)

John D. Mahan, MD
Name of Recommending Physician
(please type or print clearly)

(614) 722-4419
Telephone Number
(include area code)

Columbus, Ohio 43205
700 Children's Drive
Address of Recommending Physician
(include city, state and zip code)

OHIO Lic.# 50467
State of Licensure & License Number of Recommending Physician
(please type or print clearly)

(NOTARY SEAL)

Subscribed and sworn to before me this 21st day of March, 1994.

Donna J Bozman
Notary Public Signature
Donna J. Bozman State of Ohio

1/20/97
Date Commission Expires

Signature of Applicant

Date Photo Taken: 3/94
Mo./Yr.

RETURN TO: STATE MEDICAL BOARD OF OHIO
77 SOUTH HIGH STREET, 17TH FLOOR
COLUMBUS, OH 43266-0315

Revised 05/26/92

STATE MEDICAL BOARD OF OHIO

77 South High Street, 17th Floor • Columbus, Ohio 43266-0315 • (614) 466-3934

MEDICINE OR OSTEOPATHIC MEDICINE

FORM 2 - CERTIFICATE OF GRADUATE MEDICAL EDUCATION

MAIL TO HOSPITAL OR INSTITUTION OF GRADUATE MEDICAL EDUCATION IN THE U.S. OR CANADA

STATE MEDICAL BOARD OF OHIO
94 MAR 28 AM 8

Dear Sir:

I am applying for a license to practice in the State of Ohio. The State Medical Board of Ohio requires that my graduate medical education be certified. Please complete the form and return it directly to the State Medical Board of Ohio.

TO BE COMPLETED BY APPLICANT

BEECH, AMY LEIGH
Name in full (last, first, middle, suffix)

Redacted
Date of birth (mo/day/yr)

[redacted] Redacted [redacted]
Complete address (street, city, state & zip)

NEOUCOM
Medical school of graduation

I HEREBY AUTHORIZE MY HOSPITAL OR INSTITUTION OF GRADUATE MEDICAL EDUCATION TO FURNISH THE FOLLOWING INFORMATION TO THE STATE MEDICAL BOARD OF OHIO.

Amy Beech MD
Signature of applicant

3-7-94
Date

TO BE COMPLETED BY HOSPITAL OR TRAINING INSTITUTION

I offer the following in support of his/her application for full licensure:

I rate his/her medical knowledge and technique as: Excellent

His/her relationship with patients is: Excellent

I rate his/her ability to work well with peers and medical staff as: Good

His/her command of the English language is: Excellent

Additional comments: _____

OVER ⇨

FORM 2 - CERTIFICATE OF GRADUATE EDUCATION - MEDICINE OR OSTEOPATHIC MEDICINE
PAGE TWO

This certifies that Amy L. Beech, MD (name of applicant) has successfully completed

not less than 11 months of graduate medical education through the:
1 month of Graduate med. ed. through the second year

- ■ 1st year level
- ☐ 2nd year level
- ☐ 3rd year level or above

as a(n):
- ☐ intern
- ■ resident
- ☐ clinical fellow

in PEDIATRICS (department)

at Children's Hospital (name of hospital) 700 Children's Drive, Columbus, Ohio 43205 (complete street address of hospital)

from 01/01/93 through 04/30/93 (PL-1) 4 months beginning (mo/day/yr) to ending (mo/day/yr)
12-01-90 through 06/30/91 (PL-1) 7 months
05/01/93 through 05/27/93 (PL-2) one month

It is further certified that the above named:
- ☐ will be awarded a certificate on} _____ mo/day/yr
- ☐ was awarded a certificate on} _____ mo/day/yr
- ■ was not awarded a certificate
  please explain: training was not completed in a consecutive sequence, Part of her first year of training was completed at another institution.

and that the training:
- ■ was accredited by ACGME/AOA
- ☐ was not accredited by ACGME/AOA

I hereby recommend him/her for full licensure to practice in the State of Ohio.

(SEAL OF HOSPITAL)*

*If hospital has no seal, please indicate and have form notarized.

John D Mahaney MD
Signature of Medical Director or Program Director
(Original signature only, names stamps will not be accepted)

John. D. Mahaney, MD
Name (please print or type)

3/21/94
Date

RETURN TO: STATE MEDICAL BOARD OF OHIO
77 SOUTH HIGH STREET, 17TH FLOOR
COLUMBUS, OH 43266-0315

Revised 05/26/92

ADDITIONAL INFORMATION - MEDICINE OR OSTEOPATHIC MEDICINE

If you answer "YES" to any of the following questions, you are required to furnish complete details, including date, place, reason and disposition of the matter. All affirmative answers must be thoroughly explained on a separate sheet of paper.

(Please place a ✔ in the yes or no box)

		YES	NO
1.	Have you ever been denied staff membership at any hospital, nursing home, clinic, health maintenance organization, or similar institution?	☐	☒
2.	Have you ever been warned, censured, disciplined, had admissions monitored, had privileges limited, had privileges suspended or terminated, been put on probation, or been requested to withdraw from or resign privileges at any hospital, nursing home, clinic, health maintenance organization, or other similar institution in which you have trained, been a staff member, or held privileges, for reasons other than failure to maintain records on a timely basis, or failure to attend staff or section meetings?	☐	☒
3.	Have you ever resigned from, withdrawn from, or terminated, or have you ever been requested to resign from, withdraw from, or otherwise been terminated from, a position with a medical partnership, professional association, corporation, health maintenance organization, or other medical practice organization, either private or public?	☐	☒
4.	Have you ever resigned from, withdrawn from, or have you ever been warned by, censured by, disciplined by, been put on probation by, been requested to withdraw from, dismissed from, been refused renewal of a contract by, or expelled from, a medical school, clinical clerkship, externship, preceptorship, or graduate medical education?	☐	☒
5.	Have you ever transferred from one graduate medical education to another?	☒	☐
6.	Have you ever, for any reason, lost specialty board certification in the U.S. or elsewhere, or been denied such certification, or denied examination for such certification?	☐	☒
7.	Has any board, bureau, department, agency or other body, including those in Ohio, in any way limited, restricted, suspended, or revoked any professional license, certificate or registration granted to you; placed you on probation; or imposed a fine, censure or reprimand against you?	☐	☒

94 MAR 25 PM 2:55 STATE MEDICAL BOARD OF OHIO

OVER ⇨

ADDITIONAL INFORMATION - MEDICINE OR OSTEOPATHIC MEDICINE
PAGE TWO

		YES	NO
8.	Have you ever voluntarily surrendered, resigned, or otherwise forfeited any professional license, certificate or registration issued to you by any board, bureau, department, agency, or other body; or have you ever withdrawn any application for licensure, relicensure, or examination, in any state (including Ohio), territory, province, or country?	☐	☒
9.	Have you ever, for any reason, been denied licensure or relicensure, application for licensure or relicensure, or the privilege of taking an examination, in any state (including Ohio), territory, province, or country?	☐	☒
10.	Have you ever been requested to appear before any board, bureau, department, agency, or other body, including those in Ohio, concerning allegations against you?	☐	☒
11.	Have you ever entered into an agreement of any kind, whether oral or written, with respect to a professional license, in lieu of or in order to avoid formal disciplinary action, with any board, bureau, department, agency, or other body, including those in Ohio?	☐	☒
12.	Have you ever been notified of any investigation concerning you by, or have you ever been notified of, any charges, allegations, or complaints filed against you with, any board, bureau, department, agency, or other body, including those in Ohio, with respect to a professional license?	☐	☒
13.	Are you now or have you ever been, addicted to or excessively used alcohol, drugs, or other substances which may cause physical or psychological dependence, or impairment of the ability to practice?	☐	☒
14.	Have you ever been a patient (voluntary or otherwise) in any institution for the treatment of emotional or mental illness, drug addiction or abuse, or an alcohol problem? If yes, you must have your treating physician(s) submit a letter directly to the Board on your behalf summarizing dates of treatment, etc.	☐	☒
15.	Have you ever been treated but not hospitalized for emotional or mental illness, drug addiction or abuse, or an alcohol problem? If yes, you must have your treating physician(s) submit a letter directly to the Board on your behalf summarizing dates of treatment, etc.	☒	☐
16.	Have you ever been denied, or surrendered, a state or federal controlled substance or drug registration; had it revoked, terminated, or restricted in any way; or been warned, reprimanded, or fined by, or been requested to appear before, the responsible agency?	☐	☒

CONTINUED ⇨

ADDITIONAL INFORMATION - MEDICINE OR OSTEOPATHIC MEDICINE
PAGE THREE

		YES	NO
17.	Have you ever been convicted or found guilty of a violation of federal law, state law, or municipal ordinance other than a minor traffic violation?	☐	☒
18.	Have you ever forfeited collateral, bail, or bond for breach or violation of any law, police regulation, or ordinance other than for a minor traffic violation; been summoned into court as a defendant or had any lawsuit filed against you (other than a malpractice suit)?	☐	☒
19.	Have you been a defendant in a legal action involving professional liability (malpractice), or had a professional liability claim paid on your behalf, or paid such a claim yourself? If yes, include the case name, case number, court and address, date filed, and a summary of the underlying events. Indicate current status, including amount of settlement or judgment, if any.	☐	☒
20.	Have you ever been denied professional liability insurance or coverage, or had such insurance or coverage cancelled, limited, or restricted in any way?	☐	☒
21.	Have you ever been denied or relinquished participation in any third party reimbursement program, whether governmental or private, including Medicaid and Medicare; or had such participation limited, restricted, suspended, or revoked; or been warned, reprimanded, requested to appear before, or fined by the responsible body?	☐	☒
22.	Have you ever been denied privileges, or had privileges revoked, suspended, restricted, reduced, or terminated by the Department of Defense, the Veteran's Administration, or any of their respective components?	☐	☒

STATE MEDICAL BOARD OF OHIO
94 MAR 25 PM 2:55

Revised 05/26/92

AFFIDAVIT AND RELEASE OF APPLICANT

The affidavit and release below MUST be completed by **ALL** applicants. The form must be notarized. Failure of any applicant to submit the affidavit completed and notarized with the application will result in your application being considered as incomplete.

ss STATE OF OHIO

COUNTY OF FRANKLIN

I, AMY BEECH, hereby certify under oath that I am the person named in this application for a license to practice medicine or osteopathic medicine in the State of Ohio; 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 to this Board 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 respect.

I acknowledge that I have read the general information and instructions for all applicants and that I have answered all questions in compliance with these instructions and understand that the fee I submitted is not refundable nor transferable.

I further state that by filing this application for a license to practice medicine or osteopathic medicine in the State of Ohio, I hereby authorize and consent to have an investigation made as to my moral character, professional reputation and fitness for the practice of medicine or osteopathic medicine. I agree to give any further information which may be required in reference to my past record. I understand that I will not receive a copy of any reports or know their contents and I further understand that the contents of any investigative report will be privileged.

I further understand that my application for a license to practice medicine or osteopathic medicine in the State of Ohio is an ongoing process. I will immediately notify the State Medical Board of Ohio in writing of any changes to the answers to any of the questions contained in the ADDITIONAL INFORMATION section of the application if such a change in an answer is warranted at any time prior to licensure being granted to me by the State Medical Board of Ohio. I further understand that failure to complete this application as requested by the Board within six months can be considered abandonment of any request for licensure and that any fee I submitted is not refundable nor transferable.

I authorize and request every person, hospital, clinic, governmental agency (local, state, federal or foreign), court, association, institution, or law enforcement agency having control of any documents, records and other information pertaining to me to furnish to the State Medical Board of Ohio 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 State Medical Board of Ohio or any of its agents or representatives to inspect and make copies of such documents, records, and other information in connection with this application, subsequent licensure or practice thereunder.

I hereby release, discharge, and exonerate the State Medical Board of Ohio, 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 State Medical Board of Ohio. I authorize the State Medical Board of Ohio to release information, material, documents, orders or the like relating to me or to this application to any other governmental agency (local, state, federal or foreign), or to any hospital, nursing home, clinic, health maintenance organization or similar institution; or to any professional association.

I further understand that issuance of a certificate to practice medicine or osteopathic medicine in Ohio will be considered on the truth of the statements and documents contained herein or to be furnished, which if false, can subject me to denial of said certificate.

(NOTARY SEAL)

Amy Beech MD

Signature of Applicant

Subscribed and sworn to before me this 23rd day of March 1994.

Patty J. Grierson

Notary Public Signature

June 17, 1997

Date Commission Expires

PATTY J. GRIERSON
Notary Public - State of Ohio
My Commission Expires June 17, 1997

Revised 05/26/92

4/1.23

MEDICINE OR OSTEOPATHIC PRELIMINARY EDUCATION FORM

NAME:

LAST (Surname)	FIRST	MIDDLE	SUFFIX(Jr., II)
BEECH	AMY	~~MARIE~~ STEARNS	

HIGH SCHOOL OR EQUIVALENT:

SCHOOL NAME	CITY	STATE	COUNTRY
Liberty High School	Youngstown	Ohio	U.S.

DATES ATTENDED: FROM: MO/DAY/YR 9/ /80 TO: MO/DAY/YR 5/ /84

UNDERGRADUATE COLLEGE OR EQUIVALENT:

SCHOOL NAME	CITY	STATE	COUNTRY
Youngstown State University	Youngstown	OH	

DATES ATTENDED: FROM: MO/DAY/YR 7/ /84 TO: MO/DAY/YR 5/ /90 DEGREE RECEIVED: BS

RJBab

* combined BSMD 6 year program

SCHOOL NAME	CITY	STATE	COUNTRY

DATES ATTENDED: FROM: MO/DAY/YR / / TO: MO/DAY/YR / / DEGREE RECEIVED:

MEDICAL OR OSTEOPATHIC SCHOOL OF GRADUATION:

SCHOOL NAME	CITY	STATE	COUNTRY
Northeastern Ohio Universities College of Medicine	Rootstown	OH	

DATES ATTENDED: FROM: MO/DAY/YR 7/ /86 TO: MO/DAY/YR 5/ /90 DEGREE RECEIVED: MD

FOR BOARD USE ONLY

CERTIFICATE OF PRELIMINARY EDUCATION

NO: 84212 DATE ISSUED: 4-12-94

This is to certify that this applicant has met the preliminary education requirements for study in conformity with the statutes of Ohio and the regulations of the State Medical Board of Ohio.

Ray 2. Bumgarner
Entrance Examiner

[illegible] M.D.
Secretary

Revised 05/28/93

STATE MEDICAL BOARD OF OHIO

77 South High Street, 17th Floor • Columbus, Ohio 43266-0315 • (614) 466-3934

MEDICINE OR OSTEOPATHIC MEDICINE

FORM 2 - CERTIFICATE OF GRADUATE MEDICAL EDUCATION

MAIL TO HOSPITAL OR INSTITUTION OF GRADUATE MEDICAL EDUCATION IN THE U.S. OR CANADA

Dear Sir:

I am applying for a license to practice in the State of Ohio. The State Medical Board of Ohio requires that my graduate medical education be certified. Please complete the form and return it directly to the State Medical Board of Ohio.

TO BE COMPLETED BY APPLICANT

BEECH, AMY LEIGH
Name in full (last, first, middle, suffix)

Redacted
Date of birth (mo/day/yr)

[redacted] Redacted [redacted]
Complete address (street, city, state & zip)

NEOUCOM
Medical school of graduation

I HEREBY AUTHORIZE MY HOSPITAL OR INSTITUTION OF GRADUATE MEDICAL EDUCATION TO FURNISH THE FOLLOWING INFORMATION TO THE STATE MEDICAL BOARD OF OHIO.

Amy Beech MD
Signature of applicant

3-7-94
Date

TO BE COMPLETED BY HOSPITAL OR TRAINING INSTITUTION

I offer the following in support of his/her application for full licensure:

I rate his/her medical knowledge and technique as: INSUFFICIENT

His/her relationship with patients is: GOOD.

I rate his/her ability to work well with peers and medical staff as: GOOD

His/her command of the English language is: EXCELLENT

Additional comments: ONLY SUPERVISED FOR 4 MOS

OVER ⇨

FORM 2 - CERTIFICATE OF GRADUATE EDUCATION - MEDICINE OR OSTEOPATHIC MEDICINE
PAGE TWO

This certifies that Amy Beech (name of applicant) has successfully completed

not less than 4 (4 OR more) months of graduate medical education through the:
- ☑ 1st year level
- ☐ 2nd year level
- ☐ 3rd year level or above

as a(n):
- ☑ intern
- ☐ resident
- ☐ clinical fellow

in Pediatrics (department)

at Albert Einstein College of Medicine and Montefiore Medical Center (name of hospital) 111 E. 210th St., Bronx, NY 10467 (complete street address of hospital)

from July 1, 1990 (beginning (mo/day/yr)) to October 31, 1990 (ending (mo/day/yr)).

It is further certified that the above named:
- ☐ will be awarded a certificate on} _____ mo/day/yr
- ☐ was awarded a certificate on} _____ mo/day/yr
- ☒ was not awarded a certificate
  please explain: left the program

and that the training:
- ☑ was accredited by ACGME/AOA
- ☐ was not accredited by ACGME/AOA

I hereby recommend him/her for full licensure to practice in the State of Ohio.

(SEAL OF HOSPITAL)* _____

Steven P. Shelov.

Signature of Medical Director or Program Director
(Original signature only, names stamps will not be accepted)

*If hospital has no seal, please indicate and have form notarized.

Steven P. Shelov, MD
Name (please print or type)

5/5/94
Date

RETURN TO: STATE MEDICAL BOARD OF OHIO
77 SOUTH HIGH STREET, 17TH FLOOR
COLUMBUS, OH 43266-0315

Revised 05/26/92

Northeastern Ohio Universities College of Medicine

Upon recommendation of the Faculty
and the Board of Trustees
Northeastern Ohio Universities College of Medicine
acting in concert with
The University of Akron, Kent State University and Youngstown State University
hereby confers upon

Amy Stearns Beech

the degree of

Doctor of Medicine

with all the rights and privileges pertaining thereto

Given this twenty-sixth day of May, Nineteen hundred ninety.

President, The University of Akron

President, Kent State University

Neil D Humphrey
President, Youngstown State University

Chairman, Board of Trustees
Northeastern Ohio Universities College of Medicine

Provost and Dean
Northeastern Ohio Universities College of Medicine

PATTY J. GRIERSON
Notary Public - State of Ohio
My Commission Expires June 17, 1997

NATIONAL BOARD OF MEDICAL EXAMINERS®

ENDORSEMENT OF CERTIFICATION

Note: The embossed seal of the National Board of Medical Examiners (NBME®) in the lower left corner certifies the authenticity of this document.

Diplomate Name: Amy Leigh Stearns Beech, MD

Date of Birth: Redacted

Certification Date: 06/01/1993

Certificate #: 384636

It is certified that the physician named above has successfully completed the examination, education, and training requirements for certification by the NBME as of the certification date shown above.

Exam	Test Date	Total Test	Min. Pass	Pass/ Fail	Anat	Phys	Bioc	Path	Micr	Phar	Beh Sci
NBME PART I	Sep 1988	445 77	380 75	PASS	420 75	415 75	480 79	370 72	545 83	435 76	545 83

Exam	Test Date	Total Test	Min. Pass	Pass/ Fail	Med	Surg	Ob/Gyn	PM/PH	Ped	Psych
NBME PART II	Sep 1989	520 82	290 75	PASS	515 82	435 79	545 83	440 79	535 83	635 87

Exam	Test Date	Total Test	Min. Pass	Pass/ Fail
NBME PART III	Mar 1991	400 78	290 75	PASS

STATE MEDICAL BOARD OF OHIO
94 MAY 17 PM 3:15

DATE: 05/13/1994

SEE OTHER SIDE FOR SCORE INFORMATION

OH0383

AMA-APP-SENT 2/23/94

STATE MEDICAL BOARD OF OHIO

77 South High Street, 17th Floor • Columbus, Ohio 43266-0315 • (614) 466-3934

STATE MEDICAL BOARD OF OHIO 94 FEB 18 PM 4:10

REQUEST FOR APPLICATION FORMS
(MEDICAL OR OSTEOPATHIC)

PLEASE TYPE OR PRINT CLEARLY

I hereby submit the following information in order to receive an application:

NAME: LAST (Surname): BEECH | FIRST: AMY | MIDDLE: STEARNS | SUFFIX (Jr., II):

ADDRESS: STREET NUMBER: Redacted [redacted] | Redacted [redacted]

CITY: Redacted [redacted] | STATE: Redacted | ZIP CODE: Redacted [redacted] | COUNTRY: US

TELEPHONE: BUSINESS: AREA CODE & NUMBER ( ) | HOME: AREA CODE & NUMBER [redacted] Redacted

BIRTH DATE: MO/DAY/YR Redacted [redacted] | BIRTHPLACE: CITY Redacted [redacted] | STATE Redacted | COUNTRY US

MEDICAL OR OSTEOPATHIC EDUCATION

MEDICAL SCHOOL OF GRADUATION: SCHOOL NAME: Northeastern Ohio Universities College of Medicine (NEOUCOM)

STREET ADDRESS: P.O. Box 95

CITY: Rootstown | STATE: OH. | 44425 | COUNTRY: US

DATES ATTENDED: FROM: MO/DAY/YR 9 / 1 / 86 | TO: MO/DAY/YR 5 / 1 / 90

DEGREE RECEIVED: BSMD | DATE RECEIVED: MO/DAY/YR 5 / 26 / 90

Revised 01/11/93

OVER

OTHER MEDICAL SCHOOLS ATTENDED: (IF NONE, ENTER "NONE")

SCHOOL NAME: NONE

STREET ADDRESS:

CITY | STATE | COUNTRY

DATES ATTENDED: FROM: MO/DAY/YR / / TO: MO/DAY/YR / /

REASON DEGREE NOT RECEIVED AT THIS SCHOOL:

SCHOOL NAME:

STREET ADDRESS:

CITY | STATE | COUNTRY

DATES ATTENDED: FROM: MO/DAY/YR / / TO: MO/DAY/YR / /

REASON DEGREE NOT RECEIVED AT THIS SCHOOL:

FIFTH PATHWAY

FIFTH PATHWAY PROGRAM AT: (IF NONE, ENTER "NONE")

HOSPITAL OR INSTITUTION: NONE

AFFILIATED WITH: NAME OF MEDICAL SCHOOL

ADDRESS: STREET & NUMBER

CITY | STATE | ZIP CODE

DATES ATTENDED: FROM: MO/DAY/YR / / TO: MO/DAY/YR / /

QUALIFYING EXAM TAKEN: DATE TAKEN: MO/DAY/YR / /

CONTINUED ⇨

GRADUATE MEDICAL EDUCATION

List ALL graduate medical education (internship, residency, or clinical fellowship), undertaken in the U.S. or Canada. If additional space is needed, please attach an extra sheet. If none, enter "NONE")

month/year	Hospital, University or Other / Complete Street Address / Street & Number / City / State/Country / Zip	Position & Department	Level of Training (check one only)
7 90 – 10 90	Albert Einstein College of Medicine Jacobi Hospital Room 803 Pelham Parkway + Eastchester Rd Bronx NY 10461	Pediatrics	☒ 1st year ☐ 2nd year ☐ 3rd year or above
12 90 – 7 91	Childrens Hospital (Columbus) 700 Childrens Drive Columbus OH 43205	Pediatrics	☒ 1st year ☐ 2nd year ☐ 3rd year or above
1 93 – 3 93	* Childrens Hospital 700 Childrens Drive Columbus OH 43205	Pediatrics	☒ 1st year ☒ 2nd year ☐ 3rd year or above
4 93 – 6 93	* Childrens Hospital same as above	Pediatrics	☐ 1st year ☒ 2nd year ☐ 3rd year or above

extended maternity leave 7/91 - 1/93

Currently on maternity leave

RECEIVED 1996 FEB 16 PM 4:39 STATE MEDICAL BOARD OF OHIO

OVER ⇨

WRITTEN EXAMINATIONS TAKEN

List each and every written (FLEX or State Board except National Boards) exam taken whether in Ohio or any other state, territory or province. If additional space is needed, please attach an extra sheet. (If none, enter "NONE") Refer to the "Additional Eligibility Information" section for National Board information. Do not list National Board exam information in this section.

STATE	DATE TAKEN	WRITTEN EXAM TAKEN	FINAL RESULTS	TYPE OF EXAM
	MO/YR /	❑ FLEX ❑ STATE BOARD	❑ PASS ❑ FAIL	❑ FULL ❑ PARTIAL
	/	❑ FLEX ❑ STATE BOARD	❑ PASS ❑ FAIL	❑ FULL ❑ PARTIAL
	/	❑ FLEX ❑ STATE BOARD	❑ PASS ❑ FAIL	❑ FULL ❑ PARTIAL
	/	❑ FLEX ❑ STATE BOARD	❑ PASS ❑ FAIL	❑ FULL ❑ PARTIAL

LICENSES IN THE UNITED STATES & CANADA

List **ALL** states/provinces **whether the license is current or not** in which you are or have been licensed to practice medicine and surgery or osteopathic medicine and surgery. Indicate the license number, date of issuance, and the basis of licensure (e.g., FLEX, state board exam, endorsement of another state license, endorsement of diplomate status, etc.). If additional space is needed, please attach an extra sheet (If none, enter "NONE").

STATE	ISSUE DATE	LICENSE #	BASIS OF LICENSE	LICENSE CURRENT
	MO/YR /			❑ YES ❑ NO
	/			❑ YES ❑ NO
	/			❑ YES ❑ NO
	/			❑ YES ❑ NO

AMERICAN MEDICAL ASSOCIATION NATIONAL PHYSICIAN CREDENTIALS VERIFICATION SERVICE

The American Medical Association (AMA) has recently implemented a National Physician Credentials Verification Service (NPCVS), which for a fee will verify a physician's possessive credentials.

Are you currently a member of the AMA'S NPCVS? ❑ YES ☒ NO

For further information contact the AMA at the address below:

AMERICAN MEDICAL ASSOCIATION
NATIONAL PHYSICIAN CREDENTIALS VERIFICATION SERVICE
515 N. STATE STREET, 4TH FLOOR
CHICAGO, IL 60610
(312)464-5000

CONTINUED ⇨

ADDITIONAL ELIGIBILITY INFORMATION - ANSWER ALL QUESTIONS

Are you a diplomate of the National Board of Medical Examiners?
❑ PENDING ☒ YES ❑ NO DATE: 3 / 91
MO/YR

Are you a diplomate of the National Board of Osteopathic Medical Examiners?
❑ PENDING ❑ YES ☒ NO DATE: /
MO/YR

Are you a licentiate of the Medical Council of Canada? ❑ YES ☒ NO

Are you applying to sit for the FLEX exam in Ohio?
❑ YES ☒ NO IF YES, ❑ JUNE OR ❑ DECEMBER YEAR: 199___

Do you have a valid ECFMG Certificate?
❑ YES ☒ NO NUMBER:_____ DATE ISSUED: /
MO/YR

STATE MEDICAL BOARD OF OHIO
94 FEB 18 PM 4:30

If you are a graduate of a Mexican Medical School indicate degree: (CHECK ONLY ONE)
❑ ACTA ❑ TITULO ❑ MEDICO CIRUJANO

During the five (5) years immediately preceding the date of your application have you held an unrestricted license in the US? (Refer to the TSE section in the Eligibility Packet for more information) ☒ YES ❑ NO temporary license through residency

During the five (5) years immediately preceding the date of your application have you been actively practicing medicine and surgery or osteopathic medicine and surgery in the US? (Refer to the TSE section in the Eligibility Packet for more information) ☒ YES ❑ NO during residency years

Have you applied for or taken the Test of Spoken English (TSE)* of the Educational Testing Service (ETS)?
❑ YES ☒ NO LAST DATE TAKEN OR SCHEDULED /
MO/YR

Have you achieved a score of at least two hundred ten (210) on TSE* of the ETS?
❑ YES ☒ NO SCORE:_____ DATE TAKEN: /
MO/YR

* (THE TOEFL, ECFMG EXAM, ETC., ARE NOT EQUIVALENT AND CANNOT BE SUBSTITUTED FOR THE TEST OF SPOKEN ENGLISH (TSE)

CERTIFICATION

I HEREBY CERTIFY THAT I AM THE PERSON REFERRED TO IN THE FOREGOING REQUEST FOR APPLICATION FORMS AND THAT THE STATEMENTS HEREIN ARE STRICTLY TRUE IN EVERY RESPECT.

Mary Stearns Beech — SIGNATURE

2/15/94 — DATE

RETURN TO: STATE MEDICAL BOARD OF OHIO
77 SOUTH HIGH STREET, 17TH FLOOR
COLUMBUS, OH 43266-0315

Revised 05/26/93

CONTINUED ⇨

DETACH HERE AND REMIT THIS PORTION WITH FEE

STATE MEDICAL BOARD OF OHIO
77 SOUTH HIGH STREET, 17TH FLOOR, COLUMBUS, OHIO 43266 - 0315

CERTIFICATION

I CERTIFY, UNDER PENALTY OF LOSS OF MY RIGHT TO PRACTICE IN THE STATE OF OHIO, THAT I HAVE COMPLETED OR WILL HAVE COMPLETED DURING THE 1994-1996 BIENNIUM THE REQUISITE HOURS OF CONTINUING MEDICAL EDUCATION CERTIFIED BY THE OHIO STATE MEDICAL ASSOCIATION AND APPROVED BY THE STATE MEDICAL BOARD, AND THAT THE INFORMATION PROVIDED ON THIS APPLICATION FOR RENEWAL IS TRUE AND CORRECT IN EVERY RESPECT.

X Amy Beech MD 8/26/96
(SIGNATURE OF APPLICANT) (DATE)

IDENTIFICATION NUMBER	AMOUNT DUE	DATE DUE
35-06-6895	~~$250.00~~ 275.00	05/01/96

AMY STEARNS BEECH,M.D.
Redacted

77-13
#1014
$ 275.00
9-1-96

MD & DO SPECIALTY CODES CURRENTLY ON RECORD

PD PEDIATRICS (Public Health)

☐ SPECIALTY CODE(S) CORRECT AS LISTED

IF CORRECTIONS ARE NECESSARY, PLEASE ENTER ALL SPECIALTY CODES. CODE1: PH CODE2: CODE3:

REPORT ANY CHANGE OF ADDRESS

Redacted

COUNTY

30 AM 10:21

OF OHIO
MEDICAL BOARD

:96969696 2: 0935066895 :00000 25000:

PRINCIPAL PRACTICE ADDRESS - IF DIFFERENT FROM THE ADDRESS SHOWN ON FRONT:

Street

Street

City | State | Zip Code

County

AT ANY TIME SINCE SIGNING YOUR LAST APPLICATION FOR RENEWAL OF YOUR CERTIFICATE HAVE YOU :

YES ☐ NO ☑ 1.) Been found guilty of, or pled guilty or no contest to a felony or misdemeanor.

YES ☐ NO ☑ 2.) Been found guilty of, or pled guilty or no contest to a federal or state law regulating the possession, distribution or use of any drug?

YES ☐ NO ☑ 3.) Been addicted to or dependent upon alcohol or any chemical substance; or been treated for, or been diagnosed as suffering from, drug or alcohol dependency or abuse? You may answer "no" to this question if you have successfully completed treatment at a program approved by this board and have subsequently adhered to all statutory requirements as contained in sections 4731.224 and 4731.25 O.R.C., and related provisions, or you are currently enrolled in a board approved program. Any questions concerning approval can be directed to the board offices.

YES ☐ NO ☑ 4.) Had malpractice insurance cancelled or limited for other than failure to pay premiums?

YES ☐ NO ☑ 5.) Had any disciplinary action taken or initiated against you by any state licensing board other than the State Medical Board of Ohio?

YES ☐ NO ☑ 6.) Surrendered, or consented to limitation upon: a) A license to practice medicine; OR b) State or federal privileges to prescribe controlled substances?

YES ☐ NO ☑ 7.) Had any clinical privileges suspended, restricted or revoked for reasons other than failure to maintain records or attend staff meetings?

YES ☐ NO ☑ 8.) Referred a patient, or participated in an arrangement or scheme for referral of a patient, for clinical laboratory services to a person or facility in which either you or a member of your immediate family has an ownership or investment interest, or any compensation arrangement?

[redacted] REDACTED

SOCIAL SECURITY NUMBER
(Optional for purposes of identification)

DETACH HERE AND REMIT THIS PORTION WITH FEE

STATE MEDICAL BOARD OF OHIO
77 SOUTH HIGH STREET, 17TH FLOOR, COLUMBUS, OHIO 43266 - 0315

CERTIFICATION

I CERTIFY, UNDER PENALTY OF LOSS OF MY RIGHT TO PRACTICE IN THE STATE OF OHIO, THAT I HAVE COMPLETED OR WILL HAVE COMPLETED DURING THE 1996-1998 BIENNIUM THE REQUISITE HOURS OF CONTINUING MEDICAL EDUCATION CERTIFIED BY THE OHIO STATE MEDICAL ASSOCIATION AND APPROVED BY THE STATE MEDICAL BOARD, AND THAT THE INFORMATION PROVIDED ON THIS APPLICATION FOR RENEWAL IS TRUE AND CORRECT IN EVERY RESPECT.

X _____ 4/23/98
(SIGNATURE OF APPLICANT) (DATE)

IDENTIFICATION NUMBER	AMOUNT DUE	DATE DUE
35-06-6895-B	$371.00	05/01/98

Redacted

MD & DO SPECIALTY CODES CURRENTLY ON RECORD

PH PUBLIC HEALTH & GENERAL PREVENTIVE

☐ SPECIALTY CODE(S) CORRECT AS LISTED

IF CORRECTIONS ARE NECESSARY, PLEASE ENTER ALL SPECIALTY CODES. CODE1 CODE2 CODE3

REPORT ANY CHANGE OF ADDRESS

STREET

STREET

CITY STATE ZIP CODE

COUNTY

:96969696 2: 0935066895" "0000037100"

PRINCIPAL PRACTICE ADDRESS - IF DIFFERENT FROM THE ADDRESS SHOWN ON FRONT:

Street

Street

City State Zip Code

County

AT ANY TIME SINCE SIGNING YOUR LAST APPLICATION FOR RENEWAL OF YOUR CERTIFICATE HAVE YOU :

YES NO ☐ ☒ 1.) Been found guilty of, or pled guilty or no contest to a felony or misdemeanor.

YES NO ☐ ☒ 2.) Been found guilty of, or pled guilty or no contest to a federal or state law regulating the possession, distribution or use of any drug?

YES NO ☐ ☒ 3.) Been addicted to or dependent upon alcohol or any chemical substance; or been treated for, or been diagnosed as suffering from, drug or alcohol dependency or abuse? You may answer "no" to this question if you have successfully completed treatment at a program approved by this board and have subsequently adhered to all statutory requirements as contained in sections 4731.224 and 4731.25 O.R.C., and related provisions, or you are currently enrolled in a board approved program. Any questions concerning approval can be directed to the board offices.

YES NO ☐ ☒ 4.) Had malpractice insurance cancelled or limited for other than failure to pay premiums?

YES NO ☐ ☒ 5.) Had any disciplinary action taken or initiated against you by any state licensing board other than the State Medical Board of Ohio?

YES NO ☐ ☒ 6.) Surrendered, or consented to limitation upon: a) A license to practice medicine; OR b) State or federal privileges to prescribe controlled substances?

YES NO ☐ ☒ 7.) Had any clinical privileges suspended, restricted or revoked for reasons other than failure to maintain records or attend staff meetings?

YES NO ☐ ☒ 8.) Referred a patient, or participated in an arrangement or scheme for referral of a patient, for clinical laboratory services to a person or facility in which either you or a member of your immediate family has an ownership or investment interest, or any compensation arrangement?

SOCIAL SECURITY NUMBER
(Optional for purposes of identification)

DETACH HERE AND REMIT THIS PORTION WITH FEE

STATE MEDICAL BOARD OF OHIO
77 SOUTH HIGH STREET, 17TH FLOOR, COLUMBUS, OHIO 43266 - 0315

CERTIFICATION

I CERTIFY, UNDER PENALTY OF LOSS OF MY RIGHT TO PRACTICE IN THE STATE OF OHIO, THAT I HAVE COMPLETED OR WILL HAVE COMPLETED DURING THE 1998-2001 REGISTRATION PERIOD THE REQUISITE HOURS OF CONTINUING MEDICAL EDUCATION CERTIFIED BY THE OHIO STATE MEDICAL ASSOCIATION AND APPROVED BY THE STATE MEDICAL BOARD, AND THAT THE INFORMATION PROVIDED ON THIS APPLICATION FOR RENEWAL IS TRUE AND CORRECT IN EVERY RESPECT.

X [signature] MD MPH 3/27/01
(SIGNATURE OF APPLICANT) (DATE)

IDENTIFICATION NUMBER	AMOUNT DUE	DATE DUE
35-06-6895-B	$305.00	04/01/2001

Redacted

MD & DO SPECIALTY CODES CURRENTLY ON RECORD

MPH PUBLIC HEALTH & GEN PREVENTIVE MED

☑ SPECIALTY CODE(S) CORRECT AS LISTED

IF CORRECTIONS ARE NECESSARY, PLEASE ENTER ALL SPECIALTY CODES. CODE1 CODE2 CODE3

RESIDENCE ADDRESS-THIS MUST BE ENTERED AT EACH RENEWAL

Redacted

:96969696 2: 0935066895" "0000030500"

PRINCIPAL PRACTICE ADDRESS - THIS ADDRESS MUST BE ENTERED AT EACH RENEWAL.

[redacted]

County

AT ANY TIME SINCE SIGNING YOUR LAST APPLICATION FOR RENEWAL OF YOUR CERTIFICATE :

YES ☐ NO ☑ 1.) Have you been found guilty of, or pled guilty or no contest to, or received treatment or intervention in lieu of conviction of, a misdemeanor or felony?

YES ☐ NO ☑ 2.) Have you been addicted to or dependent upon alcohol or any chemical substance; or been treated for, or been diagnosed as suffering from, drug or alcohol dependency or abuse? **You may answer "NO" to this question if** you have successfully completed treatment at a program approved by this board and have subsequently adhered to all statutory requirements as contained in sections 4731.224 and 4731.25 O.R.C., and related provisions, or you are currently enrolled in a board approved program. Any questions concerning approval can be directed to the board offices.

YES ☐ NO ☑ 3.) Have any malpractice awards been paid by you or on your behalf for acts occurring in any state other than Ohio?

YES ☐ NO ☑ 4.) Has any board, bureau, department, agency, or other body, including those in Ohio, **other than this board,** filed any charges, allegations or complaints against you?

YES ☐ NO ☑ 5.) Have you surrendered, or consented to limitation of a license to practice any healthcare profession or state or federal privileges to prescribe controlled substances in any jurisdiction? You may answer "NO" to this question if the only such surrender or consent was given to this board.

YES ☐ NO ☑ 6.) Have you had any clinical privileges or other similar institutional authority suspended, restricted or revoked for reasons **other than failure to maintain records on a timely basis or to attend staff meetings?**

REQUIRED: [redacted]

SOCIAL SECURITY NUMBER

DETACH HERE AND REMIT THIS PORTION WITH FEE

STATE MEDICAL BOARD OF OHIO
77 SOUTH HIGH STREET, 17TH FLOOR, COLUMBUS, OHIO 43215 - 6127

CERTIFICATION

I CERTIFY, UNDER PENALTY OF LOSS OF MY RIGHT TO PRACTICE IN THE STATE OF OHIO, THAT I HAVE COMPLETED OR WILL HAVE COMPLETED DURING THE 2001 - 2003 REGISTRATION PERIOD THE REQUISITE HOURS OF CONTINUING MEDICAL EDUCATION CERTIFIED BY THE
OHIO STATE MEDICAL ASSOCIATION
AND APPROVED BY THE STATE MEDICAL BOARD, AND THAT THE INFORMATION PROVIDED ON THIS APPLICATION FOR RENEWAL IS TRUE AND CORRECT IN EVERY RESPECT.

X [signature] MD MPH 3-28-03
(SIGNATURE OF APPLICANT) (DATE)

IDENTIFICATION NUMBER	AMOUNT DUE	DATE DUE	$50 Late Fee Due After
35-06-6895-B	$305.00	04/01/03	07/01/03

Redacted

MD & DO SPECIALTY CODES CURRENTLY ON RECORD
MPH PUBLIC HEALTH & GEN PREVENTIVE MED

☒ SPECIALTY CODE(S) CORRECT AS LISTED

IF CORRECTIONS ARE NECESSARY, PLEASE ENTER ALL SPECIALTY CODES. CODE1 CODE2 CODE3

RESIDENCE ADDRESS-THIS MUST BE ENTERED AT EACH RENEWAL

Redacted

0935066895 30500

AT ANY TIME SINCE SIGNING YOUR LAS
APPLICATION FOR RENEWAL OF YOU
CERTIFICATE :

YES ☐ NO ☒ *1.) Have you been found guilty of, or pled guilty or no contest to, or received treatment or intervention in lieu of conviction of, a misdemeanor or felony?*

YES ☐ NO ☒ *2.) Have you been addicted to or dependent upon alcohol or any chemical substance; or been treated for, or been diagnosed as suffering from, drug or alcohol dependency or abuse? **You may answer "NO" to this question** if you have successfully completed treatment at, or are currently enrolled in, a program approved by this Board and have adhered to all statutory requirements during and subsequent to treatment. You must answer "YES" if you have ever relapsed. Any questions concerning program approval or concerning this question can be directed to the board offices.*

YES ☐ NO ☒ *3.) Have any malpractice awards been paid by you or on your behalf for acts occurring in any state other than Ohio?*

YES ☐ NO ☒ *4.) Has any board, bureau, department, agency, or other body, including those in Ohio, **other than this board**, filed any charges, allegations or complaints against you?*

YES ☐ NO ☒ *5.) Have you surrendered, or consented to limitation of, or to reprimand or probation concerning, a license to practice any healthcare profession or state or federal privileges to prescribe controlled substances in any jurisdiction? You may answer "NO" to this question if the only such surrender or consent was given to this board.*

YES ☐ NO ☒ *6.) Have you had any clinical privileges or other similar institutional authority suspended, restricted or revoked for reasons **other than failure to maintain records on a timely basis or to attend staff meetings?***

PRINCIPAL PRACTICE ADDRESS - THIS ADDRESS MUST BE ENTERED AT EACH RENEWAL.

☒ *Check this Box if you have NO principal Practice address.*

Street

Street

City *State* *Zip Code*

County

REQUIRED: [redacted] REDACTED

SOCIAL SECURITY NUMBER

Date Posted: 3/27/2005 1:41:27 PM

Please review all information you have provided. Click on the "Review" button to change any information given or click on the "I Agree" button to verify that all information posted below is correct and to proceed to payment options.

Please note that knowingly providing false information may result in denial of registration.

License Information

License Number	35.066895
License Name	AMY BEECH
Email Address	

Fees

Relicensure Fee	$305.00
	========
Total Fees	**$305.00**

Specialty Codes

1. Please select one specialty from the field below
   . . . . . PUBLIC HEALTH & GEN PREVENTIVE MED
2. Please select one specialty from the field below, if applicable.
   . . . . . PEDIATRICS
3. Please select one specialty from the field below, if applicable.
   . . . . . *{not Answered}*

CME

1. Have you met the above CME requirements for your license?
   . . . . . YES

Discipline

1. Have you been found guilty of, or pled guilty or no contest to, or received treatment or intervention in lieu of conviction of, a misdemeanor or felony?
   . . . . . NO
2. Have you surrendered, consented to limitation of, or to suspension, reprimand or probation concerning, a license to practice any healthcare profession or state or federal privileges to prescribe controlled substances in any jurisdiction other than Ohio?
   . . . . . NO
3. Have any malpractice awards been paid by you or on your behalf for acts occurring in any state other than Ohio?
   . . . . . NO
4. Has any board, bureau, department, agency, or any other body, including those in Ohio **other than this board,** filed any charges, allegations or complaints against you?

. . . . . NO

5. Have you had any clinical privileges or other similar institutional authority suspended, restricted or revoked for reasons **other than failure to maintain records on a timely basis or to attend staff meetings?**

. . . . . NO

6. Have you been addicted to or dependent upon alcohol or any chemical substance; or been treated for, or been diagnosed as suffering from, drug or alcohol dependency or abuse?

. . . . . NO

Social Security Number

1.

. . . . . REDACTED

Nurse Collaboration Info

1. Are you currently in a collaboration agreement with any Clinical Nurse Specialists, Certified Nurse-Midwives or Certified Nurse Practitioners?

. . . . . NO

2. List the name/names and type of licensure for each nurse with whom you are collaborating. **For example: Jane Doe, CNP; Mary Smith, CNS.**

. . . . . *{not Answered}*

I understand that submitting a false, fraudulent, or forged statement or document or omitting a material fact in obtaining licensure may be grounds for disciplinary action against my license.

Under penalty of law, I hereby swear or affirm that the information I have provided in the application is complete and correct, and that I have complied with all criteria for applying on line.

Date Posted: 3/30/2007 3:50:36 PM

Please review all information you have provided. Click on the "Review" button to change any information given or click on the "I Agree" button to verify that all information posted below is correct and to proceed to payment options.

Please note that knowingly providing false information may result in denial of registration.

License Information

License Number	35.066895
License Name	AMY BEECH
Email Address	Redacted

Fees

Relicensure Fee	$305.00
	========
Total Fees	**$305.00**

Specialty Codes

1. Please select one specialty from the field below
   . . . . . PUBLIC HEALTH & GEN PREVENTIVE MED
2. Please select one specialty from the field below, if applicable.
   . . . . . *{not Answered}*
3. Please select one specialty from the field below, if applicable.
   . . . . . *{not Answered}*

CME-Physicians

1. Have you met the above CME requirements for your license?
   . . . . . YES

Discipline

1. Have you been found guilty of, or pled guilty or no contest to, or received treatment or intervention in lieu of conviction of, a misdemeanor or felony?
   . . . . . NO
2. Have you surrendered, consented to limitation of, or to suspension, reprimand or probation concerning, a license to practice any healthcare profession or state or federal privileges to prescribe controlled substances in any jurisdiction other than Ohio?
   . . . . . NO
3. Have any malpractice awards been paid by you or on your behalf for acts occurring in any state other than Ohio?
   . . . . . NO
4. Has any board, bureau, department, agency, or any other body, including those in Ohio **other than this board,** filed any charges, allegations or complaints against you?

. . . . . NO

5. Have you had any clinical privileges or other similar institutional authority suspended, restricted or revoked for reasons **other than failure to maintain records on a timely basis or to attend staff meetings?**

. . . . . NO

6. Have you been addicted to or dependent upon alcohol or any chemical substance; or been treated for, or been diagnosed as suffering from, drug or alcohol dependency or abuse?

. . . . . NO

Social Security Number

1.

. . . . . REDACTED

Nurse CollaborationInfo

1. Are you currently in a collaboration agreement with any Clinical Nurse Specialists, Certified Nurse-Midwives or Certified Nurse Practitioners?

. . . . . NO

2. List the name/names and type of licensure for each nurse with whom you are collaborating. **For example: Jane Doe, CNP; Mary Smith, CNS.**

. . . . . *{not Answered}*

I understand that submitting a false, fraudulent, or forged statement or document or omitting a material fact in obtaining licensure may be grounds for disciplinary action against my license.

Under penalty of law, I hereby swear or affirm that the information I have provided in the application is complete and correct, and that I have complied with all criteria for applying on line.

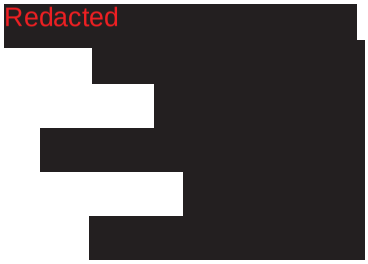
Date Posted: 3/30/2009 9:24:15 AM

Please review all information you have provided. Click on the "Review" button to change any information given or click on the "I Agree" button to verify that all information posted below is correct and to proceed to payment options.

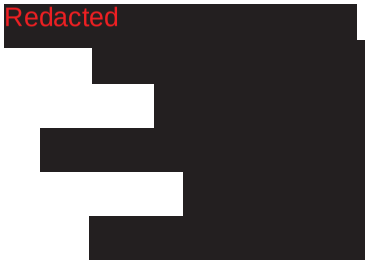
Please note that knowingly providing false information may result in denial of registration.

Address Information

CREDENTIAL MAIL ADDRESS



MAIN



License Information

License Number 35.066895

License Name AMY BEECH

Fees

Relicensure Fee $305.00

========

Total Fees **$305.00**

Specialty Codes

1. Please select one specialty from the field below

. . . . . PUBLIC HEALTH & GEN PREVENTIVE MED

2. Please select one specialty from the field below, if applicable.

. . . . . *{not Answered}*

3. Please select one specialty from the field below, if applicable.

. . . . . *{not Answered}*

CME-Physicians

1. Have you met the above CME requirements for your license?

. . . . . YES

Discipline

1. Have you been found guilty of, or pled guilty or no contest to, or received treatment or intervention in lieu of conviction of, a misdemeanor or felony?

. . . . . NO

2. Have you surrendered, consented to limitation of, or to suspension, reprimand or probation concerning, a license to practice any healthcare profession or state or federal privileges to prescribe controlled substances in any jurisdiction other than Ohio?

. . . . . NO

3. Have any malpractice awards been paid by you or on your behalf for acts occurring in any state other than Ohio?

. . . . . NO

4. Has any board, bureau, department, agency, or any other body, including those in Ohio **other than this board,** filed any charges, allegations or complaints against you?

. . . . . NO

5. Have you had any clinical privileges or other similar institutional authority suspended, restricted, revoked or placed on probation for reasons **other than failure to maintain records on a timely basis or to attend staff meetings?**

. . . . . NO

6. Have you been addicted to or dependent upon alcohol or any chemical substance; or been treated for, or been diagnosed as suffering from, drug or alcohol dependency or abuse?

. . . . . NO

Social Security Number

1.

. . . . . REDACTED

Nurse Collaboration Info

1. Are you currently in a collaboration agreement with any Clinical Nurse Specialists, Certified Nurse-Midwives or Certified Nurse Practitioners?

. . . . . NO

2. List the name/names and type of licensure for each nurse with whom you are collaborating. **For example: Jane Doe, CNP; Mary Smith, CNS.**

. . . . . *{not Answered}*

I understand that submitting a false, fraudulent, or forged statement or document or omitting a material fact in obtaining licensure may be grounds for disciplinary action against my license.

Under penalty of law, I hereby swear or affirm that the information I have provided in the application is complete and correct, and that I have complied with all criteria for applying on line.

Date Posted: 3/31/2011 10:31:23 AM

Please review all information you have provided. Click on the "Review" button to change any information given or click on the "I Agree" button to verify that all information posted below is correct and to proceed to payment options.

Please note that knowingly providing false information may result in denial of registration.

Address Information

CREDENTIAL MAIL ADDRESS

MAIN

License Information

License Number 35.066895

License Name AMY BEECH

Fees

Relicensure Fee $305.00

========

Total Fees **$305.00**

Medical Board Correspondence Email

1. **Did you provide a Credential email address? Please note this information is a public record.**

. . . . . YES

Specialty Codes

1. Please select one specialty from the field below

. . . . . PUBLIC HEALTH & GEN PREVENTIVE MED

2. Please select one specialty from the field below, if applicable.

. . . . . *{not Answered}*

3. Please select one specialty from the field below, if applicable.

. . . . . *{not Answered}*

CME-Physicians

1. Have you met the above CME requirements for your license?

. . . . . YES

Discipline

1. Have you been found guilty of, or pled guilty or no contest to, or received treatment or intervention in lieu of conviction of, a misdemeanor or felony?

. . . . . NO

2. Have you surrendered, consented to limitation of, or to suspension, reprimand or probation concerning, a license to practice any healthcare profession or state or federal privileges to prescribe controlled substances in any jurisdiction other than Ohio?

. . . . . NO

3. Have any malpractice awards been paid by you or on your behalf for acts occurring in any state other than Ohio?

. . . . . NO

4. Has any board, bureau, department, agency, or any other body, including those in Ohio **other than this board,** filed any charges, allegations or complaints against you?

. . . . . NO

5. Have you had any clinical privileges or other similar institutional authority suspended, restricted, revoked or placed on probation for reasons **other than failure to maintain records on a timely basis or to attend staff meetings?**

. . . . . NO

6. Have you been addicted to or dependent upon alcohol or any chemical substance; or been treated for, or been diagnosed as suffering from, drug or alcohol dependency or abuse?

. . . . . NO

Social Security Number

1.

. . . . . REDACTED

Nurse Collaboration Info

1. Are you currently in a collaboration agreement with any Clinical Nurse Specialists, Certified Nurse-Midwives or Certified Nurse Practitioners?

. . . . . NO

2. List the name/names and type of licensure for each nurse with whom you are collaborating. **For example: Jane Doe, CNP; Mary Smith, CNS.**

. . . . . *{not Answered}*

Ohio Employment

1. Do you practice in Ohio?

. . . . . YES

Ohio Workforce Questions

1. "Clinical" - direct patient care

. 0

2. "Research" - study of a treatment, procedure or medication done in a medical setting or for a medical purpose

. 0

3. "Administration" - activities related generally to patient care other than direct contact with a patient (e.g. recordkeeping, clerical tasks, chart review, prior authorizations with insurers, claims, billing issues, etc.)

. 0

4. "Education" - preceptor, mentor, etc.

. 25-29

5. "Volunteering" - providing medical and medical-related services at no cost

. 5-9

6. "Other" - medical professional activities not included in above categories

. 1-4

Workforce Counties

1. Enter the first zip code:

. 43209

2. Enter the first county:

. . . . . Franklin

3. Enter the second zip code:

. . . . . *{not Answered}*

4. Enter the second county:

. . . . . *{not Answered}*

5. Enter the third zip code:

. . . . . *{not Answered}*

6. Enter the third county:

. . . . . *{not Answered}*

Practice Arrangement (size)

1. Solo practitioner

. . . . . YES

2. Single-specialty Group

. . . . . N/A

3. Multi-specialty Group

. . . . . N/A

4. Employee of a clinical facility or hospital? (Clinical facility is an urgent care, industrial clinic or similar entity)

. . . . . NO

Workforce Language Question

1. Do practitioners or staff in your practice communicate in sign language or in a language other than spoken English?

. . . . . NO

ABMS Certified

1. Are you certified by an ABMS Board?

. . . . . NO

I understand that submitting a false, fraudulent, or forged statement or document or omitting a material fact in obtaining licensure may be grounds for disciplinary action against my license.

Under penalty of law, I hereby swear or affirm that the information I have provided in the application is complete and correct, and that I have complied with all criteria for applying on line.

Date Posted: 3/31/2013 12:03:03 PM

Please review all information you have provided. Click on the "Review" button to change any information given or click on the "I Agree" button to verify that all information posted below is correct and to proceed to payment options.

Please note that knowingly providing false information may result in denial of registration.

Address Information

CREDENTIAL MAIL ADDRESS Redacted

License Information

License Number 35.066895

License Name AMY ACTON

Fees

Relicensure Fee $305.00

========

Total Fees **$305.00**

Medical Board Correspondence Email

1. **Did you provide a Credential email address? Please note this information is a public record.**

. . . . . YES

Specialty Codes

1. Please select one specialty from the field below

. . . . . PUBLIC HEALTH & GEN PREVENTIVE MED

2. Please select one specialty from the field below, if applicable.

. . . . . EPIDEMIOLOGY

3. Please select one specialty from the field below, if applicable.

. . . . . *{not Answered}*

CME-Physicians

1. Have you met the above CME requirements for your license?

. . . . . YES

Discipline

1. Have you been found guilty of, or pled guilty or no contest to, or received treatment or intervention in lieu of conviction of, a misdemeanor or felony?

. . . . . NO

2. Have you surrendered, consented to limitation of, or to suspension, reprimand or probation concerning, a license to practice any healthcare profession or state or federal privileges to prescribe controlled substances in any jurisdiction other than Ohio?

. . . . . NO

3. Have any malpractice awards been paid by you or on your behalf for acts occurring in any state other than Ohio?

. . . . . NO

4. Has any board, bureau, department, agency, or any other body, including those in Ohio **other than this board,** filed any charges, allegations or complaints against you?

. . . . . NO

5. Have you had any clinical privileges or other similar institutional authority suspended, restricted, revoked or placed on probation for reasons **other than failure to maintain records on a timely basis or to attend staff meetings?**

. . . . . NO

6. Have you been addicted to or dependent upon alcohol or any chemical substance; or been treated for, or been diagnosed as suffering from, drug or alcohol dependency or abuse?

. . . . . NO

Social Security Number

1.

. . . . . REDACTED

Nurse Collaboration Info

1. Are you currently in a collaboration agreement with any Clinical Nurse Specialists, Certified Nurse-Midwives or Certified Nurse Practitioners?

. . . . . NO

2. List the name/names and type of licensure for each nurse with whom you are collaborating. **For example: Jane Doe, CNP; Mary Smith, CNS.**

. . . . . *{not Answered}*

Ohio Employment

1. Do you practice in Ohio?

. . . . . YES

Ohio Workforce Questions

1. "Clinical" - direct patient care

. 0

2. "Research" - study of a treatment, procedure or medication done in a medical setting or for a medical purpose

. 1-4

3. "Administration" - activities related generally to patient care other than direct contact with a patient (e.g. recordkeeping, clerical tasks, chart review, prior authorizations with insurers, claims, billing issues, etc.)

. 5-9

4. "Education" - preceptor, mentor, etc.

. 40-44

5. "Volunteering" - providing medical and medical-related services at no cost

. 1-4

6. "Other" - medical professional activities not included in above categories

. 0

Workforce Counties

1. Enter the first zip code:

. . . . . Redacted

2. Enter the first county:

. . . . . Redacted

3. Enter the second zip code:

. . . . . *{not Answered}*

4. Enter the second county:

. . . . . *{not Answered}*

5. Enter the third zip code:

. . . . . *{not Answered}*

6. Enter the third county:

. . . . . *{not Answered}*

7. Do you have more than one practice location?

. . . . . NO

Practice Arrangement (size)

1. Solo practitioner

. . . . . NO

2. Single-specialty Group

. . . . . N/A

3. Multi-specialty Group

. . . . . N/A

4. Employee of a clinical facility or hospital? (Clinical facility is an urgent care, industrial clinic or similar entity)

. . . . . YES

Workforce Language Question

1. Do practitioners or staff in your practice communicate in sign language or in a language other than spoken English?

. . . . . NO

ABMS Certified

1. Are you certified by an ABMS Board?

. . . . . NO

I understand that submitting a false, fraudulent, or forged statement or document or omitting a material fact in obtaining licensure may be grounds for disciplinary action against my license.

Under penalty of law, I hereby swear or affirm that the information I have provided in the application is complete and correct, and that I have complied with all criteria for applying on line.

Date Posted: 3/22/2015 10:57:19 AM

Please review all information you have provided. Click on the "Review" button to change any information given or click on the "I Agree" button to verify that all information posted below is correct and to proceed to payment options.

Please note that knowingly providing false information may result in denial of registration.

License Information

License Number 35.066895

License Name AMY ACTON

Fees

Relicensure Fee $305.00

========

Total Fees **$305.00**

Medical Board Correspondence Email

1. **Did you provide a Credential email address? Please note this information is a public record.**

. . . . . YES

Specialty Codes

1. Please select one specialty from the field below

. . . . . PUBLIC HEALTH & GEN PREVENTIVE MED

2. Please select one specialty from the field below, if applicable.

. . . . . *{not Answered}*

3. Please select one specialty from the field below, if applicable.

. . . . . *{not Answered}*

CME-Physicians

1. Have you met the above CME requirements for your license?

. . . . . YES

Discipline

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

. . . . . NO

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

. . . . . NO

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

. . . . . NO

4. **At any time since signing your last application for renewal of your certificate** has any board, bureau, department, agency, or any other body, including those in Ohio **other than this board,** filed any charges, allegations or complaints against you?

. . . . . NO

5. **At any time since signing your last application for renewal of your certificate** have you had any clinical privileges or other similar institutional authority suspended, restricted, revoked or placed on probation for reasons **other than failure to maintain records on a timely basis or to attend staff meetings?**

. . . . . NO

6. **At any time since signing your last application for renewal of your certificate** have you been addicted to or dependent upon alcohol or any chemical substance; relapsed, been treated for, or been diagnosed as suffering from, drug or alcohol dependency or abuse?

. . . . . NO

Social Security Number

1.

. . . . . REDACTED

Nurse Collaboration Info

1. Are you currently in a collaboration agreement with any Clinical Nurse Specialists, Certified Nurse-Midwives or Certified Nurse Practitioners?

. . . . . NO

2. List the name/names and type of licensure for each nurse with whom you are collaborating. **For example: Jane Doe, CNP; Mary Smith, CNS.**

. . . . . *{not Answered}*

Ohio Employment

1. Do you practice in Ohio?

. . . . . YES

Ohio Workforce Questions

1. "Clinical" - direct patient care

. 0

2. "Research" - study of a treatment, procedure or medication done in a medical setting or for a medical purpose

. 1-4

3. "Administration" - activities related generally to patient care other than direct contact with a patient (e.g. recordkeeping, clerical tasks, chart review, prior authorizations with insurers, claims, billing issues, etc.)

. 1-4

4. "Education" - preceptor, mentor, etc.

. 50-54

5. "Volunteering" - providing medical and medical-related services at no cost

. 1-4

6. "Other" - medical professional activities not included in above categories

. 0

Workforce Counties

1. Enter the first zip code:

. . . . . Redacted

2. Enter the first county:

. . . . . Redacted

3. Enter the second zip code:

. . . . . *{not Answered}*

4. Enter the second county:

. . . . . *{not Answered}*

5. Enter the third zip code:

. . . . . *{not Answered}*

6. Enter the third county:

. . . . . *{not Answered}*

7. Do you have more than one practice location?

. . . . . NO

Practice Arrangement (size)

1. Solo practitioner

. . . . . NO

2. Single-specialty Group

. . . . . N/A

3. Multi-specialty Group

. . . . . N/A

4. Employee of a clinical facility or hospital? (Clinical facility is an urgent care, industrial clinic or similar entity)

. . . . . YES

Workforce Language Question

1. Do practitioners or staff in your practice communicate in sign language or in a

language other than spoken English?

. . . . . NO

ABMS Certified

1. Are you certified by an ABMS Board?

. . . . . NO

NPI number

1. Please enter your current NPI number

. . . . . *{not Answered}*

DEA number

1. Please enter your DEA number. Only enter one, or the primary DEA number.

. . . . . *{not Answered}*

I understand that submitting a false, fraudulent, or forged statement or document or omitting a material fact in obtaining licensure may be grounds for disciplinary action against my license.

Under penalty of law, I hereby swear or affirm that the information I have provided in the application is complete and correct, and that I have complied with all criteria for applying on line.

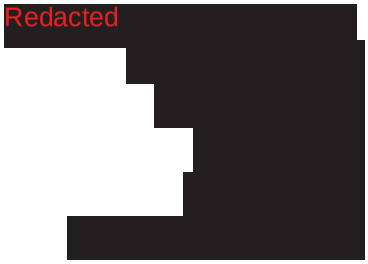
Date Posted: 3/21/2017 11:02:49 AM

Please review all information you have provided. Click on the "Review" button to change any information given or click on the "I Agree" button to verify that all information posted below is correct and to proceed to payment options.

Please note that knowingly providing false information may result in denial of registration.

Address Information

CREDENTIAL MAIL ADDRESS



License Information

License Number 35.066895

License Name AMY ACTON

Fees

Relicensure Fee $305.00

========

Total Fees **$305.00**

Medical Board Correspondence Email

1. **Did you provide a Credential email address? Please note this information is a public record.**

. . . . . YES

Specialty Codes

1. Please select one specialty from the field below

. . . . . PUBLIC HEALTH & GEN PREVENTIVE MED

2. Please select one specialty from the field below, if applicable.

. . . . . *{not Answered}*

3. Please select one specialty from the field below, if applicable.

. . . . . *{not Answered}*

CME-Physicians

1. Have you met the above CME requirements for your license?

. . . . . YES

Discipline

1. **At any time since signing your last application for renewal of your**

certificate have you been found guilty of, or pled guilty or no contest to, or received treatment or intervention in lieu of conviction of, a misdemeanor or felony?

. . . . . NO

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

. . . . . NO

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

. . . . . NO

4. **At any time since signing your last application for renewal of your certificate** has any board, bureau, department, agency, or any other body, including those in Ohio **other than this board,** filed any charges, allegations or complaints against you?

. . . . . NO

5. **At any time since signing your last application for renewal of your certificate** have you had any clinical privileges or other similar institutional authority suspended, restricted, revoked or placed on probation for reasons **other than failure to maintain records on a timely basis or to attend staff meetings?**

. . . . . NO

6. **At any time since signing your last application for renewal of your certificate** have you been addicted to or dependent upon alcohol or any chemical substance; relapsed, been treated for, or been diagnosed as suffering from, drug or alcohol dependency or abuse?

. . . . . NO

Social Security Number

1.

. . . . . REDACTED

Nurse Collaboration Info

1. Are you currently in a collaboration agreement with any Clinical Nurse Specialists, Certified Nurse-Midwives or Certified Nurse Practitioners?

. . . . . NO

2. List the name/names and type of licensure for each nurse with whom you are collaborating. **For example: Jane Doe, CNP; Mary Smith, CNS.**

. . . . . *{not Answered}*

Ohio Employment

1. Do you practice in Ohio?

. . . . . YES

Ohio Workforce Questions

1. "Clinical" - direct patient care

. 0

2. "Research" - study of a treatment, procedure or medication done in a medical setting or for a medical purpose

. 0

3. "Administration" - activities related generally to patient care other than direct contact with a patient (e.g. recordkeeping, clerical tasks, chart review, prior authorizations with insurers, claims, billing issues, etc.)

. 10-14

4. "Education" - preceptor, mentor, etc.

. 40-44

5. "Volunteering" - providing medical and medical-related services at no cost

. 1-4

6. "Other" - medical professional activities not included in above categories

. 1-4

Workforce Counties

1. Enter the first zip code:

. . . . . Redacted

2. Enter the first county:

. . . . . Redacted

3. Enter the second zip code:

. . . . . *{not Answered}*

4. Enter the second county:

. . . . . *{not Answered}*

5. Enter the third zip code:

. . . . . *{not Answered}*

6. Enter the third county:

. . . . . *{not Answered}*

7. Do you have more than one practice location?

. . . . . NO

Practice Arrangement (size)

1. Solo practitioner

. . . . . YES

2. Single-specialty Group

. . . . . N/A

3. Multi-specialty Group

. . . . . N/A

4. Employee of a clinical facility or hospital? (Clinical facility is an urgent care, industrial clinic or similar entity)

. . . . . NO

Workforce Language Question

1. Do practitioners or staff in your practice communicate in sign language or in a language other than spoken English?

. . . . . NO

ABMS Certified

1. Are you certified by an ABMS Board?

. . . . . NO

NPI number

1. Please enter your current NPI number

. . . . . *{not Answered}*

DEA number

1. Please enter your DEA number. Only enter one, or the primary DEA number.

. . . . . *{not Answered}*

OARRS Registration

1. Since signing your last renewal have you prescribed or personally furnished opioid analgesics or benzondiazepines while practicing in Ohio?

. . . . . NO

2. Are you registered with the Ohio Automated Rx Reporting System (OARRS)?

. . . . . NO

I understand that submitting a false, fraudulent, or forged statement or document or omitting a material fact in obtaining licensure may be grounds for disciplinary action against my license.

Under penalty of law, I hereby swear or affirm that the information I have provided in the application is complete and correct, and that I have complied with all criteria for applying on line.

Submission Date and Time: 5/26/2019 2:01 PM

License Renewal Application

License Type - Doctor of Medicine (MD)

Personal Information

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

Title
Dr.
First Name
Amy
Middle Name
Stearns
Last Name
Acton
Maiden Name
Stearns
Social Security Number
REDACTE
Date of Birth
Redacted
Email Address
Redacted
Phone Number
Redacted
Other Phone Number
No Response
What is your U.S. Residency status related to your employment?
United States Citizen
Do you consider yourself Hispanic, Latino/a or of Spanish origin?
No
What do you consider your race?
White
List languages you personally use to communicate with patients excluding an interpreter or software
English
Other Language
No Response
Individual National Provider Identifier - if N/A enter all zeroes
0000000000
Enter home US zip-code. Enter NA if unavailable
43209

Additional Information

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

Do you have other aliases?
BEECH AMY STEARNS
What is your gender?
Female
In which country were you born?
United States
In which state were you born (if United States)?
Ohio
In which city were you born?
YOUNGSTOWN

Employment Status

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

What is your primary employment status
Actively working in a position(s) that requires this license
Which of the following best describes your five-year employment plan?
Maintain practice hours as is

License Mailing Address

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

Redacted
United States

License Public Address

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

Redacted

United States

Military Service

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

Have you served in the military?
No
If you answered "Yes", are you currently serving in the military?
No Response
Has your spouse served in the military?
No
If you answered "Yes", are they currently serving in the military?
No Response
I declined to answer these questions

Secondary Email Recipient

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

Secondary Email Address:

Specialty Tracking Component

Please list any American Board of Medical Specialties, American Osteopathic Association, or Council on Podiatric Medical Education specialty and/or subspecialty certifications that you currently hold.

Current Employment Location(s)

Please provide the following information for all practice sites where you use this license, beginning with the locations in which you spend most of your time. If you are not actively working or volunteering in a position that requires this license (e.g. student or recent graduate) employment location information is optional.

Employment location information helps improve the accuracy and efficiency of Health Professional Shortage Area Designations and enables Ohio to identify healthcare workforce distribution.

Name of Practice Site - Redacted
Practice Settings - Federal/State/Community Health Center(s)
Street Address - Redacted
City - Redacted
[redacted]
Major Area of Focus or Specialty - Preventive Medicine-Public Health
Total Hours Worked at this practice site, per Week - 60

Percent of time spent per week in each of the following at this practice site:
Direct Patient Care - 0
Teaching/Academic - 0
Research - 0
Professional Services - 0
Administrative Activities - 100
Other - 0
Total Hours- 100

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

Questions

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

Question - At any time since signing your last application for renewal of your certificate have you had any clinical privileges or other similar institutional authority suspended, restricted, revoked or placed on probation for reasons other than failure to maintain records on a timely basis or to attend staff meetings?
Answer - No

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

Question - At any time since signing your last application for renewal of your certificate have any malpractice awards been paid by you or on your behalf for acts occurring in any state other than Ohio?
Answer - No

Question - Since signing your last renewal have you prescribed opioid analgesics or benzondiazepines while practicing in Ohio?
Answer - No

Question - Are you registered with the Ohio Automated Rx Reporting System (OARRS)?
Answer - No

Question - Are you currently in a collaboration agreement with any Clinical Nurse Specialists, Certified Nurse-Midwives or Certified Nurse Practitioners?
Answer - No

Question - At any time since signing your last application for renewal of your certificate has any board, bureau, department, agency, or any other body, including those in Ohio other than this board, filed any charges, allegations or complaints against you?
Answer - No

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

Question - At any time since signing your last application for renewal of your certificate have you surrendered, consented to limitation of, or to suspension, reprimand or probation concerning, a license to practice any healthcare profession or state or federal privileges to prescribe controlled substances in any jurisdiction other than Ohio?
Answer - No

Question - Do you currently supervise one or more Physician Assistants?
Answer - No

Question - Do you prescribe controlled substances?
Answer - No

Attachments

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

Review + Submit

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

Application Review - Completed

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

Consent to Electronic Signature - **Consented**
Date/Time Stamp - 5/26/2019 2:01 PM
Type your First Name and Last Name as they appear on the application to sign electronically.
Amy Acton
Submit your Application -After clicking the 'Submit' button below, you will no longer be able to change this application. **PLEASE DO NOT USE THE BROWSER'S BACK BUTTON AS THAT MAY OVERWRITE YOUR DATA.** If you want to return to your application, simply log out and log back in.
If this application requires payment you will be prompted to begin the payment process. You must complete the payment process before the board will review your application. If this application does not require payment, you will be navigated back to the eLicense home page and the board will review your application.