THE NEW MEXICO MEDICAL SOCIETY

New Mexico Hospital Association

The New Mexico Statewide Application for Physician/Practitioner Appointment©

Physician (MD) Application

Rameet Harpal Singh MD

Other Names Used: _____

☐ Will you be applying by endorsement? Applying using: FCVS

Are you requesting to be credentialed as a PCP if Family Practice, Internal Medicine, or Pediatrics? ☐ Yes

Gender: F Citizenship: USA Place of Birth: Boston, MA

Immigration Status: Certification #:

Social Security Number: [redacted] Date of Birth: [redacted]/1970

State Tax ID#: ☐ Pending Fed. Tax ID#: ☐ Pending

Medicare #: H85520 ☐ Pending Medicaid #: 403641700 ☐ Pending

Unique Physician Identification Number (UPIN): H85520 ☐ Pending

National Provider Identifier Number (NPI): 1639171192 ☐ Applied

What are your immediate or future Practice Plans in New Mexico?

I plan to practice in the Department of Obstetrics and Gynecology at the University of New Mexico.

Current Mailing Address

[redacted]

Home address

[redacted]

Foreign Languages (spoken fluently by practititioner)

Punjabi

Hindi

Other Practice Locations

Practice Name: Johns Hopkins Womens Health Services at Odenton

1132 Annapolis Road

Odenton MD 21113

United States

Telephone Number: Facsimile: 410-874-1594

Answering Service: Effective Date: 08/01/2007

Office Manager or Contact Person:

Manager's Phone Number:

Practice Limited to: (Clinical Specialty):

Billing Address:

1132 Annapolis Road

MD 21113

United States

Telephone Number: Facsimile: 410-874-1594

Contact Person:

Practice Associates:

Roxanne Jamshidi	Call Coverage:	
Betty Chou	Call Coverage:	
Nell Molano	Call Coverage:	

What are the office hours for your Practice or Group Practice? (Provide days/hours):

M-F/8-5

What provisions have been made for after hours?:

Answering service. On call ob/gyn team at Johns Hopkins Bayview Medical Center.

Practice Name: Johns Hopkins Bayview Medical Center

4940 Eastern Avenue Room 121 A1C

Baltimore MD 21224

United States

Telephone Number: 410-550-0335 Facsimile: 410-550-0245

mailrameet@jhmi.edu

Answering Service: Effective Date: 07/01/2003

Office Manager or Contact Person: Victoria Wisniewski

Manager's Phone Number: 410-550-0337

Practice Limited to: (Clinical Specialty):

Billing Address:

4940 Eastern Avenue Room 121 A1C

MD 21224

United States

Telephone Number: 410-550-0335 Facsimile: 410-550-0245

Contact Person:

Practice Associates:

Anne Burke	Call Coverage:
Nancy Hueppchen	Call Coverage:
Roxanne Jamshidi	Call Coverage:

What are the office hours for your Practice or Group Practice? (Provide days/hours):

Mon-Friday 8-5

What provisions have been made for after hours?:

Ob/Gyn attending and residents on call.

Practice Name: Johns Hopkins Bayview Medical Center

4940 Eastern Avenue Room 121 A1C

Baltimore MD 21224

United States

Telephone Number: 410-550-0335 Facsimile: 410-550-0245

Answering Service: Effective Date: 07/01/2003

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Billing Address:

4940 Eastern Avenue Room 121 A1C

MD 21224

United States

Telephone Number: 410-550-0335 Facsimile: 410-550-0245

Contact Person:

Practice Associates:

Anne Burke	Call Coverage:
Nancy Hueppchen	Call Coverage:
Roxanne Jamshidi	Call Coverage:

What are the office hours for your Practice or Group Practice? (Provide days/hours):

Mon-Friday 8-5

What provisions have been made for after hours?:

Ob/Gyn attending and residents on call.

EDUCATION

Undergraduate Eductation

College or University: Brigham Young University

Department: CES Admissions A-41 ASB | Degree: Bachelor of Science

Address:

City: Provo | State/Province: UT | Zip Code: 84602

Telephone Number: | Facsimile: | Country: United States

Contact Person: | Title:

Email Address: | Specialty:

Dates Attended From: 08/92 To: 06/95 | Graduation Date: 1995

Graduate Education

College or University: University of UT School of Medicine (website)

Department: Attn: Erin Oh | Degree: Doctor of Medicine

Address: 50 North Medical Dr

City: Salt Lake City | State/Province: UT | Zip Code: 84132

Telephone Number: 801 581-2401 | Facsimile: 801 585-2507 | Country: United States

Contact Person: Karen Anastasopoulos | Title: Director of Student Affairs

Email Address: | Specialty:

Dates Attended From: 08/95 To: 06/99 | Graduation Date:

College or University: Johns Hopkins Bloomberg School of Public Health

Department: 615 N. Wolfe Street | Degree: Master of Public Health

Address:

City: Baltimore | State/Province: MD | Zip Code: 21205

Telephone Number: 410-955-3543 | Facsimile: | Country: United States

Contact Person: | Title:

Email Address: admiss@jhsph.edu | Specialty:

Dates Attended From: 07/03 To: 05/04 | Graduation Date: 2004

Residency/Fellowship

College or University: Medical College of Wisconsin

Department: Office of the Registrar | Degree: Obstetrics/Gynecology

Address: 8701 Watertown Plank Rd.

City: Milwaukee | State/Province: WI | Zip Code: 53226

Telephone Number: (414) 454-5660 | Facsimile: (414) 259-9012 | Country: United States

Contact Person: Thomas Hammeke | Title: Director

Email Address: thammeke@mcw.edu | Specialty: Obstetrics/Gynecology

Dates Attended From: 06/99 To: 06/03 | Graduation Date: 2003

Residency/Fellowship

College or University: Johns Hopkins Bayview Medical Center

Department: 4940 Eastern Avenue Degree:

Address:

City: Baltimore State/Province: MD Zip Code: 21224

Telephone Number: 410-550-0336 Facsimile: 410-550-0245 Country: United States

Contact Person: Title:

Email Address: Specialty:

Dates Attended From: 07/03 To: 06/05 Graduation Date:

WORK HISTORY

Please list all previous practice experience for the previous 15 years, including military or government service, listing the most recent first. If military service, state type of discharge and rank achieved and attach copy of discharge or separation documents. Please provide written explanation for any gaps in work history of 6 months or more.

Location: John Hopkins Univ School of Medicine From: 07/01/2003 To:

Department: Office of Registrar-Research Bldg

Street: 733 N BRdway #147 Phone Number: 410 955-3080

City: Baltimore State/Province: MD Zip Code: 21205-2196

Contact Person: Country: United States

Explanation of gap:

HOSPITAL AND HEALTHCARE AFFILIATIONS

☐ Are you a PCP? ☑ Do you deliver babies? ☑ Are you an MD, DO, or DPM?

If you answered yes to any question above, you must:

(a) Have admitting privileges at a hospital (list the affiliation in this section) OR
(b) Provide a written explanation as to the arrangements you have made with a physician to admit your patients along with a signed letter from that physician confirming the arrangements, and the name of the facility which your patients will be admitted.

Please list all hospital staff membership and/or healthcare organization affiliations in the past (5) years, and the status (active, courtesy, consulting, etc.). If an institution is no longer in existence, please provide an alternative source of verification. Use a separate page if necessary.

Facility Name

Name: Johns Hopkins Bayview Medical Center

Department: Medical Staff Office, GME

Street: 5501 Hopkins Bayview Cir

City: Baltimore State: MD Zip Code: 21224-2735

Province: Country: United States

Phone Number: 410 550-0506 Facsimile: 410 550-2612

Appointment Dates From: 07/03 To: Present

Type of Appointment: Active

☐ Check here if you have restrictions at this facility, and provide a written explanation below:

Privileges Assigned:

Check all that apply:

☐ If you have courtesy or consulting privileges at this facility.

☐ If these courtesy or consulting privileges allow you to admit patients.

If your courtesy or consulting privileges do not allow you to admit patients, please provide a written explanation as to the arrangements you have made with a physician to admit your patients, along with a signed letter from that physician confirming the arrangements, and the name of the facility where your patients will be admitted. The signed letter should be forwarded to HSC along with your signature pages and other accompanying documents.

Name: Johns Hopkins Hospital (Employment Verification)

Department: Human Resources

Street: 600 N Wolfe St

City: Baltimore State: MD Zip Code: 21289

Province: Country: United States

Phone Number: Facsimile:

Appointment Dates From: 07/03 To: Present

Type of Appointment: Active/Part-time

☐ Check here if you have restrictions at this facility, and provide a written explanation below:

Privileges Assigned:

Check all that apply:

☐ If you have courtesy or consulting privileges at this facility.

☐ If these courtesy or consulting privileges allow you to admit patients.

If your courtesy or consulting privileges do not allow you to admit patients, please provide a written explanation as to the arrangements you have made with a physician to admit your patients, along with a signed letter from that physician confirming the arrangements, and the name of the facility where your patients will be admitted. The signed letter should be forwarded to HSC along with your signature pages and other accompanying documents.

PROFESSIONAL REFERENCES

Please list three (3) professional peers familiar with your professional performance in the past five (5) years, (not including current or impending partners or associates in practice).

Name: Nancy Hueppchen MD Specialty: Maternal Fetal Medicine

Address1: Phipps 228

Address2: 600 North Wolfe Street

City: Baltimore State/Province: MD Zip Code: 21287

Email: nhueppc1@jhmi.edu Country: United States

Phone Number: 410-955-8496 Facsimile: 410-614-8305

Name: Cynthia Argani MD Specialty: Obstetrics and Gynecology

Address1:

Address2: 4940 Eastern Avenue Room 121 A1C

City: Baltimore State/Province: MD Zip Code: 21231

Email: aburke1@jhmi.edu Country: United States

Phone Number: 410-550-0335 Facsimile: 410-550-0245

Name: Roxanne Jamshidi MD Specialty: Obstetrics and Gynecology

Address1:

Address2: 4940 Eastern Avenue Room 121 A1C

City: Baltimore State/Province: MD Zip Code: 21224

Email: rjamshi1@jhmi.edu Country: United States

Phone Number: 410-550-0336 Facsimile: 410-550-0245

Military Service

Branch: ☐ Current

Dates: From: To:

Rank: Type of Discharge:

Immigration

Status: Certification Number:

CLIA

Number (if applicable): Approval Level: Expiration Date:

Certifications

ACLS Certified? Yes Expires: 08/31/2010

ATLS Certified? Expires:

PALS Certified? Expires:

ECFMG (Educational Commission for Foreign Medical Graduates)

Number (if applicable): Date Issued:

STATE PROFESSIONAL LICENSE/CERTIFICATION NUMBERS

State: MD Number: D0060365 Issue Date: 05/22/2003 Expiration Date: 09/30/2011 ☐ Pending

FEDERAL DRUG ENFORCEMENT ADMINISTRATION (DEA) REGISTRATION

Number: [redacted] Expiration: 02/28/2010 ☐ Pending

STATE CONTROLLED SUBSTANCE REGISTRATION (CSR)

Number: M54233 State: MD Expiration: 03/31/2011 ☐ Pending

BOARD/SUBSPECIALTY BOARD CERTIFICATIONS

Are you Board Certified? ☐ **Yes** ☐ **No** ☐ **N/A**

Certified/Recertified by the Board/Subspecialty Board of: Obstetrics and Gynecology

Date Certified: 12/09/2005 Date Last Recertified: Expiration Date: 12/31/2011

Certification Number: 9007101

☐ Accepted for Examination?

☐ If not accepted, have you made application?

If no, provide an explanation:

If you are not Board certified by a Board recognized by the American Board of Medical Specialties, the American Osteopathic Association, the National Commission on Certification of Physician Assistants, the American Nurses' Credentialing Center, or the National Certification Commission, or accepted for examination in your specialty, please give a brief explanation. Explain any gaps or delays in achieving Board certification by the recognized Board in your specialty area.

PROFESSIONAL MEDICAL MALPRACTICE INSURANCE

☐ Do you have current medical malpractice insurance?

(Please list medical malpractice insurance carriers for the past 5 years.)

Carrier

Name: MCIC Vermont Inc

Department: Claims Department - Attn Patricia Keene

Street: 76 St Paul St Ste 500

City: Burlington State: VT Zip Code: 85402-1530

Province: Country: United States

Policy #: Limits Per-claim: $ 0 Aggregate: $ 0

Dates Insured From: To:

LICENSING EXAM: Please check all that apply:

☐ State Board Exam Which State? _____ Date(s) passed? _____

☐ **FLEX**	☐ **National Board (NMBE)**	☑ **USMLE**
Date Passed: /	Part/Step 1 Date Passed	Part/Step 1 Date Passed 06/97
	Part/Step 2 Date Passed	Part/Step 2 Date Passed 08/98
☐ **LMCC**	Part/Step 3 Date Passed	Part/Step 3 Date Passed 12/00
Date Passed:		

PROFESSIONAL PRACTICE QUESTIONS

Please answer the following Yes or No questions. If you answer Yes to any question, you must give details including name, address, and telephone number of significant parties. You must respond to each question.

1.	Has your professional liability coverage ever been terminated by action of the insurance company except as a result of teh company ceasing to offer insurance to physicians?	No
2.	Have you ever been denied professional liability insurance coverage? If yes, explain below.	No
3.	Has your professional liability carrier ever excluded any specific procedures from your coverage? If yes, explain below.	No
4.	Have you ever been denied membership or renewal thereof, or been subject to disciplinary action in any professional organization? If yes, explain below.	No
5.	Have you ever had any sanctions imposed by Medicare and/or Medicaid?	No
6.	Have you ever been arrested? If so, explain the circumstance, regardless of the outcome (i.e. expunged, dismissed, sealed, vacated).	No

7.	Have you ever been named as a defendant in any criminal proceedings?	No
8.	Have you ever been subject to investigation by a governmental entity or Board that either could have resulted or did result in licensure sanction or other adverse actions, irrespective of the outcome?	No
9.	Have you ever been named in any formal requests for corrective actions filed by any healthcare entity where you have had an appointment (a request which could result in either formal or informal proceedings)? If yes, explain below.	No
10.	Have your privileges at any healthcare entity ever been voluntarily or involuntarily suspended, restricted, diminished, revoked, surrendered, or not renewed, except for medical records delinquency?	No
	b.) Have you ever agreed not to exercise your clinical privileges while under investigation?	No
11.	Have you ever resigned from a healthcare entity to avoid modification, suspension, or termination of privileges, or while under investigation?	No
12.	a.) Has your application for licensure or license to practice in any jurisdiction ever been investigated, voluntarily or involuntarily limited, suspended, revoked, surrendered or denied?	No
	b.) Are any currently held licenses pending investigation or being challenged?	No
13.	Have you ever been notified to appear before any licensing agency for a hearing or complaint of any nature? If yes, explain below.	No
14.	Has your federal or state narcotics registration certificate in any jurisdiction ever been voluntarily or involuntarily limited (stipulations), suspended, revoked, restricted, or are there currently challenges to any of these items?	No
15.	Have you ever been involved in a settlement, medical malpractice claim or suit, or have you ever received written notice of intent to file such a suit? If yes, please provide the following information for each claim or suit. • Name, age, sex of patient/claimant. • Date(s) and type of treatment and/or surgery that led to the allegations against you. • Nature of allegations in claims/suits. Specify whether a suit was ever filed. • Names of other practitioners and hospital, if any, involved in claims or suit. • Disposition or current status of claim or suit (be specific). • Name of insurance carrier defending you. • Name of defense attorney.	No
16.	Have you ever been reported to the National Practitioner Data Bank?	No
17.	Are you now, or were you in the past, addicted to, abusive of, or in treatments for abuse of any controlled substances, habit-forming drugs, illegal drugs, prescription medication or alcohol?	No
18.	In the five (5) years prior to this application, have you had any physical injury or disease, or mental illness or impairment, which either has affected or could reasonably be expected to affect your on-going ability to practice medicine safely and competently? If yes, please have your treating physician send the NM Medical Board a letter regarding your diagnosis and treatment.	No
19.	Have you ever, for any reason:	
	a) Resigned from a medical school or postgraduate training (PGT) program?	No
	b) Withdrawn from a medical school or postgraduate training program?	No
	c) Been suspended, dismissed, or expelled from a medical school or PGT program?	No
	d) Been placed on probation or remediation, including academic probation or remediation, by a medical school or PGT program?	No
	e) Taken a leave of absence or break from, or had any interruptions or extensions in, a medical school or PGT program for any reason, personal or professional (include illness, pregnancy, academic, etc)?	No

Explanations:

Rameet Harpal Singh, MD

Licensed Physician #MD2010-0125

Issue Date	Expiration Date
03/17/2010	07/01/2010

Signature of Holder

The bearer is prohibited by law from using this identification card to give the impression that they are in any way connected with a governmental agency.

New Mexico Medical Board

Triennial Renewal Certificate

This is to certify that

Rameet Harpal Singh, MD

License Number: MD2010-0125

Having complied with the provisions of the Medical Practice Act is hereby granted a license to practice in the State of New Mexico as a Physician.

Issue Date: 03/17/2010 Date Expires: 07/01/2010*

**A New Mexico medical license that has not been renewed by July 1 of the renewal year will remain temporarily active with respect to medical practice until September 30 of the renewal year at which time, the status will be changed to lapsed. A lapsed license is not valid for practice in New Mexico.*

This License Must Be Conspicuously Posted In Each Practice Location

MARYLAND BOARD OF PHYSICIANS
P.O. Box 2571
4201 Patterson Avenue
Baltimore, MD 21215-0095
(410) 764-4777
Fax (410) 358-2252

January 27, 2010

Requested by: Medical Board of New Mexico

The following is available under the Maryland Public Information Act, State Government Article, Section 10-617(h), regarding the following practitioner:

SINGH, RAMEET HARPAL
2220 GOUGH STREET
BALTIMORE, MD 21231-3426

License Number: D0060365

Date Issued: May 22, 2003

Current Status: Active

Expiration Date: September 30, 2011

Medical School: UNIV OF UT SCH OF MED

Licensed By: USMLE Steps 1, 2, and 3

Specialty:

Charges:

Disciplinary Actions: NONE

No Maryland Health Claims Arbitration Office malpractice claims filed since July 1, 1986

Suzanne Cox

Verification Clerk

01/27/2010

Date

This is a computer generated form which is acceptable by other states.
Licensing examination scores should be requested directly from the examining authority.

State of Wisconsin Department of Regulation & Licensing
Online Applications: Credential Lookup

Wisconsin Credential Lookup

location: DRL -> Credential Lookup -> Credential Summary

Credential Summary - Details

Credential Summary for 43408-20

Name:	Singh, Rameet H
Credential Type:	Medicine and Surgery (20)
Credential Number:	43408-20
Location:	BALTIMORE, MD
License Type:	regular
Status	credential license is not current (expired)
Eligible To Practice:	Not Eligible to Practice
First Fee Received:	NO

Details Requirements Payments Orders Relationships

Details

License current through:	10/31/2003
Granted date:	06/14/2001
Multi-state:	N
Orders:	NONE
Specialties:	OBSTETRICS AND GYNECOLOGY
Other Names:	Rameet H Singh

Consistent with JCAHO and NCQA standards for primary source verification.
Data on this page is refreshed hourly.

Questions?
Send an e-mail, or call (608) 266-2112 between 7:45 a.m. and 2:00 p.m., Central Time.

New Mexico Medical Board
2055 S. Pacheco St.
Building 400
Santa Fe, NM 87505
(505) 476-7220

WORK EXPERIENCE VERIFICATION

I am applying for a medical license in the State of New Mexico. The New Mexico Medical Board requires this form to be completed by the Chief of Staff or facility's administrative staff. I hereby authorize release of all information in your files, favorable or otherwise, DIRECTLY to the NMMB, **2055 S. Pacheco St., Bldg. 400, Santa Fe, NM 87505.**

RAMEET SINGH
Applicant Name

[redacted]
Address

[redacted]
City/State/Zip

Applicant Signature

07/2003 – 02/2010
*Dates of Privilege/Employment (must be provided)

[redacted]
Telephone

The section below should be completed by the chief of staff or facility's administrative staff.
Letters of Recommendation are ***NOT*** accepted in lieu of this form.

Harold E. Fox, M.D.
Type or Print Name of person completing this form

Professor and Director
Title

Johns Hopkins University, Johns Hopkins Hospital and Women's Health at Odenton
Name of Institution

600 N.Wolfe Street Phipps 264
Address

Baltimore, Maryland 21287
City / State / Zip

1. This evaluation is based on: ✓ Observation of applicant ___ Review of personnel file
2. In your estimation, is there any reason why this applicant should not be licensed to practice? ___ Yes ✓ No
3. To your knowledge, is there any mental or physical reason why this applicant should not be licensed? ___ Yes ✓ No
4. To your knowledge, is there any derogatory/disciplinary information regarding this applicant? ___ Yes ✓ No
5. Are the dates of privilege/employment provided by the applicant on this form accurate? * ✓ Yes ___ No

If not, please provide correct dates: Beginning _____ (Month/Year) Ending _____ (Month/Year)

If you answered "YES" to questions 2, 3, and/or 4, please provide a written explanation and/or any supporting documentation that may be relevant.

DIANE H. WHEELER
NOTARY PUBLIC
BALTIMORE COUNTY
MY COMMISSION EXPIRES
JUN 1 2010
Please affix hospital or notary seal here

HAROLD E FOX M.D. 1/28/10
Printed name of person completing this form — Signature — Date

Diane H. Wheeler 1/28/10
Signature of Notary (if applicable) — Date

My commission expires: 6/1/2010

Please note on this form if there is no hospital or notary seal available.
Please return this form directly to the address above
Thank you for your cooperation.

Revised 10/04

New Mexico Medical Board
2055 S. Pacheco St.
Building 400
Santa Fe, NM 87505
(505) 476-7220

RECEIVED
JAN 21 2010
NM MEDICAL BOARD

WORK EXPERIENCE VERIFICATION

I am applying for a medical license in the State of New Mexico. The New Mexico Medical Board requires this form to be completed by the Chief of Staff or facility's administrative staff. I hereby authorize release of all information in your files, favorable or otherwise, DIRECTLY to the NMMB, **2055 S. Pacheco St., Bldg. 400, Santa Fe, NM 87505.**

RANEET H. SINGH
Applicant Name

[redacted]

Applicant Signature

07/2003 - PRESENT
*Dates of Privilege/Employment mm/yy to mm/yy (must be provided)

[redacted]
Telephone Number

The section below should be completed by the chief of staff or facility's administrative staff.
Letters of Recommendation are ***NOT*** accepted in lieu of this form.

Jennifer Terry
Type or Print Name of person completing this form

Administrator
Title

Johns Hopkins Bayview Medical Center
Name of Institution

4940 Eastern Ave A 121
Address

Baltimore, MD 21224
City / State / Zip

1. This evaluation is based on: ___Observation of applicant X Review of personnel file
2. In your estimation, is there any reason why this applicant should not be licensed to practice? ___Yes X No
3. To your knowledge, is there any mental or physical reason why this applicant should not be licensed? ___Yes X No
4. To your knowledge, is there any derogatory/disciplinary information regarding this applicant? ___Yes X No
5. Are the dates of privilege/employment provided by the applicant on this form accurate?* X Yes ___No

If not, please provide correct dates: Beginning _____ (Month/Year) Ending _____ (Month/Year)

If you answered "YES" to questions 2, 3, and/or 4, please provide a written explanation and/or any supporting documentation that may be relevant.

Please affix hospital or notary seal here

Jennifer J. Terry — Printed name of person completing this form
Signature
1/14/10 — Date

Linda C. Gorman — Signature of Notary (if applicable)
1-14-10 — Date
Linda C. Gorman

My commission expires: 11/24/2012

Please note on this form if there is no hospital or notary seal available.
Please return this form directly to the address above
Thank you for your cooperation.

Revised 8/08

The Federation of State Medical Boards of the United States, Inc.
Federation Credentials Verification Service
P.O. Box 619850
Dallas, Texas 75261-9850
Telephone: (817) 868-4000
Fax: (817) 868-4099

Physician Information Profile

This report is compiled exclusively for:

Name:	**Rameet Harpal Singh**
SSN:	[redacted]
DOB:	[redacted]/1970
Packet ID:	**112325**
Recipient:	**New Mexico Medical Board**

NOTICE:

The Federation Credentials Verification Service (FCVS) was retained by the above referenced physician 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. All documents bearing the 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.

Physician Information Profile is compiled and published by the Federation of State Medical Boards of the United States, Inc. as a reference source for its member boards and other authorized entities. Physician Information Profile may not be republished, sold, resold or duplicated, in whole or in part, for commercial or any other purposes, or for purposes of compiling lists or files without the express written consent of the Federation's Executive Vice President as authorized by its Board Of Directors. The use of this Physician Information Profile to establish independent data files or compendiums or information is strictly prohibited.

Table of Contents

Section I

FCVS Reports

FEDERATION CREDENTIALS VERIFICATION SERVICE

Physician Information Report

Identity:

Name:	**Rameet Harpal Singh**	
Other Name Used:	**Rameet Kaur**	
Gender:	**Female**	
Date of Birth:	[redacted]**1970**	
Place of Birth:	**MA USA**	
SSN:	[redacted]	
Current Address:	[redacted]	
Permanent Address:	**Same**	
Telephone Numbers:	Bus:	[redacted]
	Fax:	**N/A**
	Home:	**410-332-4653**
	Other:	**N/A**
Physical Description:	Height:	**5' 06"**
	Weight:	**128 lbs**
	Eye Color:	**Brown**
	Hair Color:	**Brown**
Physical Marks:	Description:	**Scar**
	Location:	**Head**
	Description:	**Scar**
	Location:	**Head**

Premedical Education (Reported by physician. Not verified by FCVS):

Institution:	**Brigham Young University, Provo, UT 84602**
Dates of Attendance:	**09/1992 - 06/1995**
Degree Conferred/Issued:	**Bachelor of Science**

Medical Education:

Medical School:	**University of Utah School of Medicine** **201 S 1460 E RM 250 N** **Salt Lake City, UT 84112-9056**
Dates of Attendance:	**09/27/1995 - 05/22/1999**
Date Degree Conferred/Issued:	**05/22/1999**
Degree Conferred/Issued:	**Doctor of Medicine**
Unusual Circumstance:	**None**

Graduate Medical Education:

Institution:	**Medical College of Wisconsin** **Dept of Obstetrics Gynecology** **9200 West Wisconsin Avenue** **Milwaukee, WI 53226**
Training Level:	**1**
Program Type:	**Internship**
Specialty/Subspecialty:	**Obstetrics and Gynecology**
Dates of Attendance:	**07/01/1999 - 06/30/2000**
Completion:	**Yes**
Accreditation:	**ACGME**
Training Level:	**2-4**
Program Type:	**Residency**
Specialty/Subspecialty:	**Obstetrics and Gynecology**
Dates of Attendance:	**07/01/2000 - 06/30/2003**
Completion:	**Yes**
Accreditation:	**ACGME**
Unusual Circumstance:	**None**

Fifth Pathway:

N/A

Examination History:

Licensure Examinations:	**USMLE Step 1** **USMLE Step 2** **USMLE Step 3**

Board Action:

A Report of the results from a search of the Board Action Data Bank is enclosed.

Credentials Analysis Report

The Credentials Analysis Report is a comparative report of a physician's credentials as reported to FCVS by the physician applicant and the primary source (Medical School, PGT program, etc.). It will also list particular missing documentation, if any, as outlined in the FCVS Policies and Procedures.

Physician Identification:

Name:	Rameet Harpal Singh
DOB:	[redacted]
SSN:	
Packet ID:	112325
Request ID:	21692217

OMISSIONS

Omission 1:

Section of Profile:	**Medical Education**
Omission:	Univ Of Utah Sch Med did not certify the medical school diploma.
Follow-Up:	FCVS has contacted the institution and requested a seal or notarization be affixed to the diploma.

DISCREPANCIES

Discrepancy 1:

Section of Profile:	**Examination History**
Discrepancy:	The applicant reports sitting for USMLE Steps 1, 2 and 3 as `Dates Unknown`. The USMLE transcript reports the examination dates were 06/11/1997, 08/26/1998 and 12/8/2000, respectively.
Follow-Up:	Left to Recipient's discretion.

MISCELLANEOUS INFORMATION

Miscellaneous 1:

Section of Profile:	**Identity**
Issue:	The applicant did not provide a photocopy of a birth certificate, passport, court order, baptismal certificate, naturalization certificate, marriage certificate or divorce decree to support alternate names, as requested by FCVS.
Follow-Up:	In lieu of the requested documents, please see the Name Explanation Form.

End of report for Rameet Harpal Singh

Board Action Databank Search

State Queried For:	**New Mexico Medical Board**
Physician's Name	**Singh, Rameet Harpal**
Date of Birth:	[redacted]/1970
Medical School:	**045010 - University of Utah School of Medicine**
Year of Graduation:	**1999**
Social Security Number:	[redacted]
ECFMG Number:	**N/A**

Results:

WE HAVE NO UNFAVORABLE INFORMATION REGARDING THE ABOVE NAMED PHYSICIAN

MAR 0 1 2010

Humayun J. Chaudhry, D.O., FACP
President and CEO

AMERICAN BOARD OF MEDICAL SPECIALTIES
VERIFICATION OF CERTIFICATION

As of: 3/2/2010

State Queried For:	New Mexico Medical Board
Physician Name:	Rameet Harpal Singh
Date of Birth:	[redacted]1970
Year of Graduation:	1999 (Doctor of Medicine)
Social Security Number:	[redacted]
ABMSU ID:	829179

Certification:

Board:	Obstetrics and Gynecology
Specialty:	Obstetrics and Gynecology
Status:	ACTIVE
Initial Certification:	12/09/2005

Section II

Identity

Federation of STATE MEDICAL BOARDS

Affidavit and Release and Authorization for Release of Information, Documents and Records

I, the undersigned, being duly sworn, 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 read and understand the "Instructions for Completing the FCVS 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 waive confidentiality, 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 (FCVS) any such information, including documents, records regarding charges or complaints filed against me, formal or informal, pending or closed, my examination grades, or any other pertinent data and to permit FCVS or any of its agents or representatives to inspect and make copies of such documents, records, and other information in connection with this application that can subsequently be provided to professional licensing boards, hospitals and other entities when I apply for licensure, staff membership, employment or other privileges.

I hereby release, discharge and exonerate FCVS, 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 FCVS.

I will immediately notify FCVS in writing of any changes to the answers to any questions contained in this application if such a change occurs at any time prior to my FCVS Physician Information Profile being mailed.

P Singh

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

SINGH

Applicant's Printed Last Name

RAMEET H.

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

12-10-2009

Date of Signature

[redacted]-1970

Date of Birth

[redacted]

Applicant SSN

NOTARY

Your seal or stamp must be partly upon the photograph.

State of Maryland County of Baltimore

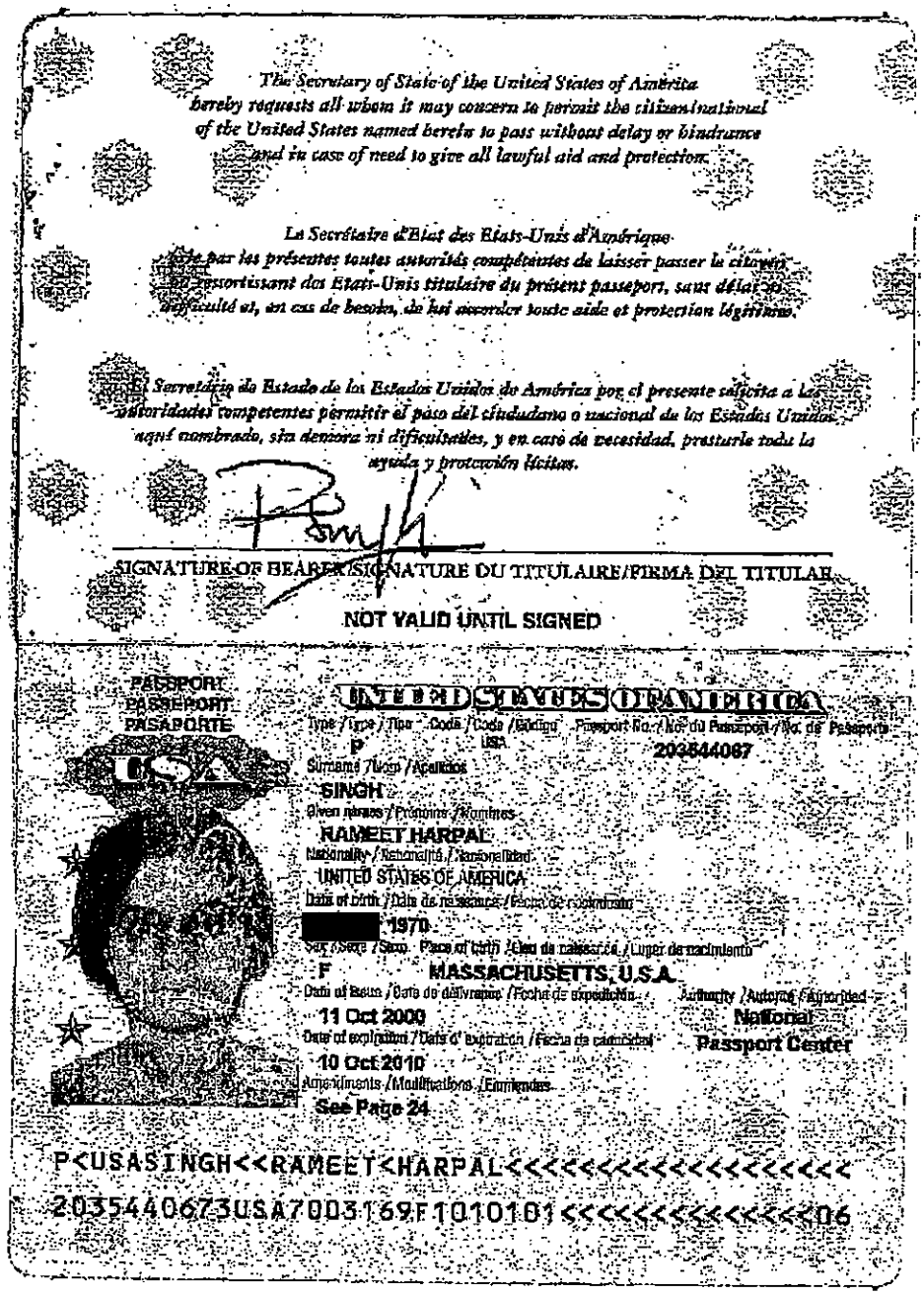
SUBSCRIBED AND SWORN TO before me this 10 day of December 20 09

My commission expires: 11/04/2012

(NOTARY PUBLIC SIGNATURE & SEAL)

Notary Public signature: Linda C. Hoenar Linda C. Gormen

I certify that on the date set forth above 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 Secretary of State of the United States of America
hereby requests all whom it may concern to permit the citizen/national
of the United States named herein to pass without delay or hindrance
and in case of need to give all lawful aid and protection.

La Secrétaire d'Etat des Etats-Unis d'Amérique
prie par les présentes toutes autorités compétentes de laisser passer le citoyen/
ressortissant des Etats-Unis titulaire du présent passeport, sans délai ni
difficulté et, en cas de besoin, de lui accorder toute aide et protection légitimes.

El Secretario de Estado de los Estados Unidos de América por el presente solicita a las
autoridades competentes permitir el paso del ciudadano o nacional de los Estados Unidos
aquí nombrado, sin demora ni dificultades, y en caso de necesidad, prestarle toda la
ayuda y protección lícitas.

SIGNATURE OF BEARER/SIGNATURE DU TITULAIRE/FIRMA DEL TITULAR

NOT VALID UNTIL SIGNED

PASSPORT
PASSEPORT
PASAPORTE

USA

UNITED STATES OF AMERICA

Type / Type / Tipo: P
Code / Code / Código: USA
Passport No. / No du Passeport / No. de Pasaporte: 203544067

Surname / Nom / Apellidos: SINGH

Given names / Prénoms / Nombres: RAMEET HARPAL

Nationality / Nationalité / Nacionalidad: UNITED STATES OF AMERICA

Date of birth / Date de naissance / Fecha de nacimiento: [redacted] 1970

Sex / Sexe / Sexo: F

Place of birth / Lieu de naissance / Lugar de nacimiento: MASSACHUSETTS, U.S.A.

Date of issue / Date de délivrance / Fecha de expedición: 11 Oct 2000

Authority / Autorité / Autoridad: National Passport Center

Date of expiration / Date d'expiration / Fecha de caducidad: 10 Oct 2010

Amendments / Modifications / Enmiendas: See Page 24

P<USASINGH<<RAMEET<HARPAL<<<<<<<<<<<<<<<<<<<<

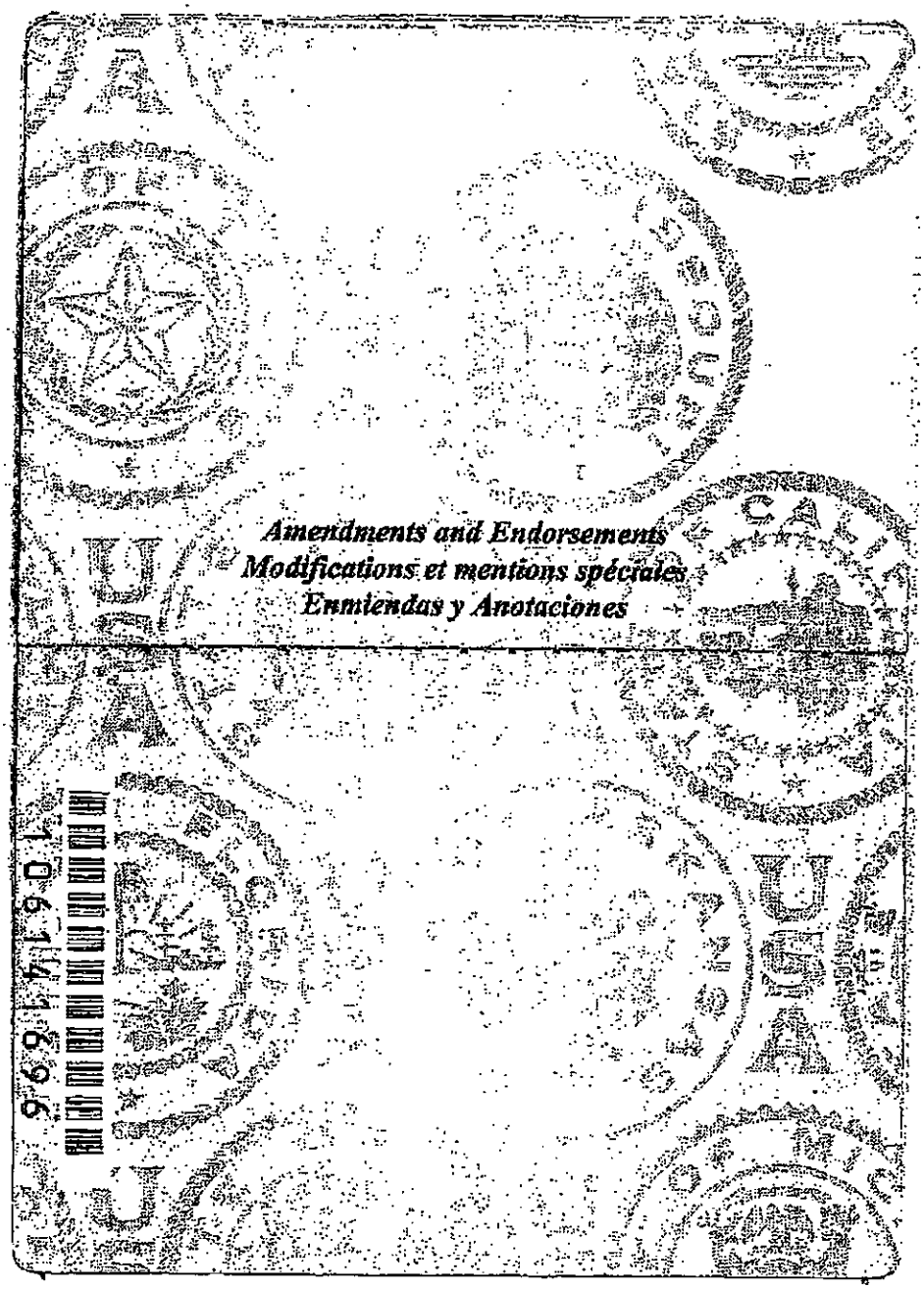
2035440673USA7003169F1010101<<<<<<<<<<<<<<06

The Federation Credentials Verification Service certifies that this page was copied directly from the original document.

Kevin Caldwell
Federation Credentials Verification Service

December 30, 2009

Date



The Federation Credentials Verification Service certifies that this page was copied directly from the original document.

Kevin Caldwell
Federation Credentials Verification Service

December 30, 2009

Date

EXPLANATION OF ALTERNATE NAME FORM

Use this form to explain the use of any name(s) not supported by the identity document(s) submitted with your application. Do not write on the back of this form. If additional space is required, please make a photocopy(ies). Be certain to sign the form in the space provided at the bottom of the page.

Documented Name

The name reported here must be the name on your identity document.

SINGH
Last Name (Surname) and Generational Suffix

RANEET HARPAL
First and Middle Name(s)

KAUR
Last Name (Surname) and Generational Suffix

RAMEET
First and Middle Name(s)

Explanation of Use of Name

In my religion (Sikhism) all women have KAUR as their last name. My birth certificate has my father's name listed after mine. Once I got my US passport around age 12 I started using my legal name.

Last Name (Surname) and Generational Suffix

First and Middle Name(s)

Explanation of Use of Name

Last Name (Surname) and Generational Suffix

First and Middle Name(s)

Explanation of Use of Name

Signature
(Required)

Signature

12-10-2009
Date

Section III

Medical Education

FEDERATION CREDENTIALS VERIFICATION SERVICE (FCVS)

VERIFICATION OF MEDICAL EDUCATION

(This form must be completed by the medical school)

INSTRUCTIONS TO THE DEAN

The individual identified on the attached Authorization For Release of Information, Documents and Records form has authorized your medical school to provide to the Federation Credentials Verification Service (FCVS) any and all information pertaining to their education at your institution. **Please complete this form and forward it to FCVS in the enclosed postage-paid, self-addressed envelope.**

Please note: If your institution processes transcript requests through another office, FCVS has likely made such a request under separate cover. **If your office also processes transcript requests, please attach the individual's official transcript (which indicates courses taken, dates and hours of attendance, and scores, grades, or evaluation).**

VERIFICATION OF MEDICAL EDUCATION

Name of Institution: University of Utah School of Medicine

Complete Address: Deans Office

Street Address: School of Medicine

City: University of Utah 30 North 1900 East **ZIP Code (Postal Code):** Salt Lake City, UT 84132-2101

If name of institution was different when individual attended, please note this name below:

Premedical Education:

Years of education required for admission to your medical school: 4 with a bachelors degree

Credential/degree presented by the applicant for admission to your medical school: BA Economics. BA Psychology, BS Zoology

Enrollment and Participation: Our records indicate that Singh, Ramneet Harpal (type/print individual's name: Last, First, Middle, Suffix)

attended our medical school for total of 158 weeks of medical education on the following dates (mm/dd/yy):

From 9 / 27 / 95 (Month / Date / Year) **To** 5 / 22 / 99 (Month / Date / Year)

This individual (check one):

Was awarded the degree of M.D. on 5 / 22 / 99 (Month / Date / Year)

Was NOT awarded a degree because: _____
(please explain - attach additional pages if necessary)

Certification: By my signature, I, EDWARD P. JUNKINS, M.D., M.P.H. (type/print name), certify that the above information is an accurate account of the above named individual's official records maintained in this and is true and correct to my knowledge.

Affix Institutional Seal Here. If no seal is available, this form must be notarized.

SEAL VERIFIED

Signature: [signature]

Title: Associate Dean for Student Affairs

Date of Signature: 1-29-10

Phone: (801) 581-7201 **Fax:** (801) 585-3300

Email:

VERIFICATION OF MEDICAL EDUCATION

Unusual Circumstances: The following questions apply to unusual circumstances that occurred during any part of the individual's medical education. Please check the appropriate response and provide dates and requested information. "Yes" responses to any of these questions require a copy of explanatory records or a written explanation (attach additional pages as necessary).

1. Do this individual's official records reflect (an) interruption(s) or extension(s) in his/her medical education?
   Response YES ☐ NO ☑

   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 Mo/Yr	To Mo/Yr	Approved	Unapproved
Personal/Family			☐	☐
Academic remediation			☐	☐
Health			☐	☐
Financial			☐	☐
Participation in joint degree Program (e.g., MD/PhD)			☐	☐
Participation in non-research special study (e.g., fellowship, international experience)			☐	☐
Participation in non-degree research			☐	☐
Other			☐	☐

   Please Specify: _____

2. Do this individual's official records reflect that he/she was ever placed on academic or disciplinary probation during his/her medical education? Response YES ☐ NO ☑

   If YES, please select the reason(s) for the probation, indicate the date(s) of placement on and removal from probation and attach additional documentation to this report.

	From Mo/Yr	To Mo/Yr
Academic Probation		
Probation for unprofessional conduct/behavioral		
Probation for other reason		

   Please specify reason: _____

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? Response YES ☐ NO ☑

   If YES, please provide detailed documentation/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? Response YES ☐ NO ☑

   If YES, please provide detailed documentation/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?
   Response YES ☐ NO ☑

   If YES, please provide detailed documentation/information about the nature of the limitations or special requirements.

   _____

   _____

Medical Education

School	045010 - University of Utah School of Medicine		
Address	50 North Medical Drive		
	Salt Lake City, UT 84132		
	USA		
Phone			
Dates	08/1995 - 05/1999	**Grad Date**	05/22/1999
Degree	MD - Doctor of Medicine		
Program 6+ years:	N		
Completed clinical clerkship in a country other than where my medical school was located:	Y		
Clinical Training			
Unusual Circumstances			
Leaves/Extensions	N		
Probation	N		
Disciplined	N		
Negative Reports	N		
Limitations	N		

PROVIDED BY APPLICANT

THE UNIVERSITY OF UTAH®
SALT LAKE CITY, UTAH 84112

Official Transcript

Name: SINGH, RAMEET HARPAL
Student ID: 00057945
SSN: XXX-XX-7870
Birthdate: XXXX-03-16

UNIVERSITY OF UTAH DEGREES
Doctor of Medicine
Major in Medicine
Confer Date: May 22, 1999

DEGREES AWARDED BY OTHER INSTITUTIONS
BRIGHAM YOUNG UNIVERSITY
PROVO, UT
Bachelor of Science
August 01, 1995

BEGINNING OF MEDICINE QUARTER CAREER

Course		Description	Units Enrolled	Units Earned	Grade
Autumn 1995					
ANAT	601	Gross Anatomy Human	11.00	11.00	P
ANAT	603	Histology	7.00	7.00	P
ANAT	606	Embryology	3.00	3.00	P
BIO C	608	Medical Biochemistry	5.00	5.00	P
FP MD	617	Ambulatory Care Homelss	1.00	1.00	P
Term GPA: 0.000			27.000	27.000	
Winter 1996					
BIO C	609	Medical Biochemistry	4.00	4.00	P
FP MD	617	Ambulatory Care Homelss	1.00	1.00	P
FP MD	634	Medicine & Society	3.00	3.00	P
PHYSL	603	Medical Physiology	12.00	12.00	P
PSYCT	601	Basic Sci Foundation	4.00	4.00	P
Term GPA: 0.000			24.000	24.000	
Spring 1996					
ANAT	605	Neuroanatomy	5.00	5.00	P
BIO C	610	Medical Biochemistry	2.00	2.00	P
FP MD	617	Ambulatory Care Homelss	1.00	1.00	P
H GEN	610	Genetics In Medicine	2.00	2.00	P

Continued Next Column

Course		Description	Units Enrolled	Units Earned	Grade
Spring 1996 (Continued)					
INTMD	701	Intro To Medicine	5.00	5.00	P
PED	602	Clinical Correlation	2.00	2.00	P
PHYSL	604	Endocrinology	2.00	2.00	P
Term GPA: 0.000			19.000	19.000	
Autumn 1996					
FP MD	617	Ambulatory Care Homelss	1.00	1.00	P
INTMD	702	Intro To Medicine	6.00	6.00	P
PATH	600	Medical Immunology	3.00	3.00	
PATH	601	General Pathology	5.00	5.00	
PATH	604	Medical Microbiology	6.00	6.00	P
PH TX	601	Pharmacology Therapy	7.00	7.00	P
Term GPA: 0.000			28.000	28.000	
Winter 1997					
FP MD	617	Ambulatory Care Homelss	1.00	1.00	P
MD ID	602	Organ Systems	14.00	14.00	P
PATH	602	Systemic Pathology	5.00	5.00	P
PH TX	604	Pharmacology	4.00	4.00	P
Term GPA: 0.000			24.000	24.000	
Spring 1997					
INTMD	704	Foundations Geriatrics	1.00	1.00	P
MD ID	603	Organ Systems	13.00	13.00	P
PATH	603	Systemic Pathology	5.00	5.00	P
PSYCT	610	Intro Clinicl Psychiatr	2.00	2.00	P
Term GPA: 0.000			21.000	21.000	
Autumn 1997					
OBST	701	Clerkship Ob Gyn Clinic	12.00	12.00	P
PED	701	Pediatric Clerkship	12.00	12.00	P
Term GPA: 0.000			24.000	24.000	

Winter 1998
Continued Page 2

FEDERATION CREDENTIALS VERIFICATION SERVICE
FEDERATION OF STATE MEDICAL BOARDS
PO BOX 619850
DALLAS, TX 75261-9850

SEAL VERIFIED

Timothy J. Ebner
University Registrar

THE UNIVERSITY OF UTAH®
SALT LAKE CITY, UTAH 84112

Official Transcript

Name: SINGH, RAMEET HARPAL
Student ID: 00057945
SSN: XXX-XX-7870
Birthdate: XXXX-03-16

Course		Description	Units Enrolled	Units Earned	Grade
		Winter 1998 (Continued)			
INTMD	720	Clinical Clerkship	24.00	24.00	P
MD ID	714	Topics In Medicine	3.00	3.00	P
PSYCT	720	Psychiatric Clin Clkshp	12.00	12.00	P
Term GPA: 0.000			39.000	39.000	
		Spring 1998			
FP MD	718	Family Practice Clkshp	8.00	8.00	P
MD ID	715	Topics In Medicine	3.00	3.00	P
SURG	702	Junior Clinical Clkshp	16.00	16.00	P
Term GPA: 0.000			27.000	27.000	
		CAREER SUMMARY			
Cumulative GPA:		0.000			
Cumulative GPA Units:		0.000			
Units Enrolled:		233.000			
U of U Units Earned:				233.000	
Total Transfer Units:				0.000	
Total Test Credit:				0.000	
Total Other Credit:				0.000	
Cumulative Units				233.000	
		END OF MEDICINE QUARTER CAREER			
		BEGINNING OF MEDICINE SEMESTER CAREER			
		Quarter to Semester Cum Stats			
GPA: 0.000			155.330	155.330	
		Fall 1998			
INTMD	7590	Hemostasis	2.00	2.00	P
NEURO	7910	Clin Clerkship - V.A.	4.00	4.00	P
OBST	7050	Subinternship	4.00	4.00	P
OBST	7090	Honors Program	4.00	4.00	P
SURG	7300	Surgical ICU	4.00	4.00	P

Continued Next Column

Course		Description	Units Enrolled	Units Earned	Grade
		Fall 1998 (Continued)			
Term GPA: 0.000			18.000	18.000	
		Spring 1999			
ANES	7040	Clerkship	2.00	2.00	P
INTMD	7560	Medical Ethics	2.00	2.00	P
OBST	7090	Honors Program	6.00	6.00	P
PATH	7140	Clin Diagnosis & Mgt	4.00	4.00	P
PED	7050	Preceptorship	4.00	4.00	P
Term GPA: 0.000			18.000	18.000	
		CAREER SUMMARY			
Cumulative GPA:		0.000			
Cumulative GPA Units:		0.000			
Units Enrolled:		191.330			
U of U Units Earned:				191.330	
Total Transfer Units:				0.000	
Total Test Credit:				0.000	
Total Other Credit:				0.000	
Cumulative Units				191.330	
		END OF MEDICINE SEMESTER CAREER			
		End of Transcript			

Timothy J. Ebner
University Registrar

THE UNIVERSITY OF UTAH
OFFICE OF THE REGISTRAR
TRANSCRIPT INFORMATION
FICE CODE: 003675
www.sa.utah.edu/regist

ACCREDITATION - Northwest Association of Schools and Colleges. See the general catalog for other accreditations.

CREDIT HOURS - Unless otherwise noted, all credit hours on the U of U transcript through summer quarter 1998 are quarter hours except that Law courses with a # sign in the Units column indicates semester hours. All credit hours beginning with fall semester 1998 are semester hours. The University converted to a semester calendar fall 1998.

GRADING SYSTEM

GRADE		GRADE POINTS PER UNIT
A	Excellent	4.0
A-	Excellent	3.7
B+	Good	3.3
B	Good	3.0
B-	Good	2.7
C+	Standard	2.3
C	Standard	2.0
C-	Standard	1.7
D+	Substandard	1.3
D	Substandard	1.0
D-	Substandard	0.7
E	Failure	0.0
X	Condition	0.0
WF	Withdrawn Failing	0.0
EW	Withdrawn for Nonperformance	0.0
EU	Unofficial Withdrawal	0.0
F	Fail	0.0
P	Pass	
I	Incomplete	
T	Work in Progress	
CR	Credit (Work at a U.S. Level or above)	
NC	No Credit	
W	Withdrawn	
WP	Withdrawn Passing	
V	Visitor (Audit)	
***	Grade has not been submitted by the instructor.	

ACADEMIC RENEWAL - Grade not computed in GPA
COURSE REPEATED - Grade not computed in GPA
NONDEGREE CREDIT - Not computed in GPA
CONTINUING EDUCATION UNIT - One CEU is awarded for each 10 contact hours. Not computed in GPA or hours passed.

COURSE NUMBERING
Through summer quarter 1969
1 - 99 Lower Division
100 - 199 Upper Division. Recognized as graduate credit if baccalaureate degree has been awarded.
200 and above: Graduate Courses

Beginning fall quarter 1969
1- 99 Noncredit
100 - 199 Lower Division (Freshman & Sophomore Courses)
201 - 299 Honors - Lower Division
301 - 399 Upper Division (Junior & Senior Courses)
401 - 499 Honors - Upper Division
501 - 599 Upper Division and Graduate Courses
601 - 799 Graduate Courses

Beginning fall quarter 1971
001 - 099 Noncredit & CEU
100 - 299 Lower Division (Freshman & Sophomore Courses)
300 - 499 Upper Division (Junior & Senior Courses)
500 - 599 Upper Division & Graduate Courses (Graduate credit permitted for departmental majors)
600 - 799 Graduate Courses

Beginning fall semester 1998
0001 - 0999 Noncredit
1000 - 2999 Lower Division (Freshman & Sophomore Courses)
3000 - 4999 Upper Division (Junior & Senior Courses)
5000 - 5999 Upper Division & Graduate Courses (Graduate credit permitted for departmental majors)
6000 - 6999 Masters Level
7000 - 7999 Doctoral Level

GENERAL EDUCATION CODES
Courses which fulfill General Education requirements prior to fall quarter 1977 are identified as follows:

AI	American Institutions
EN	English
FA	Fine Arts
LS	Life Science
PS	Physical Science
SS	Social And Behavioral Science
WC	Western Civilization

LIBERAL EDUCATION CODES
Courses which fulfill the Liberal Education requirements beginning fall quarter 1977 through summer quarter 1998 are identified as follows:

BC	Social and Behavioral Science Core
BD	Social and Behavioral Science Distribution
FC	Fine Arts Core
FD	Fine Arts Distribution
HC	Humanities Core
HD	Humanities Distribution
SC	Science Core
SD	Science Distribution
AI	American Institutions
EN	English
WR	Writing

GENERAL EDUCATION DESCRIPTIONS
Courses which fulfill General Education requirements beginning fall semester 1998 have a message printed below each applicable course.

MESSAGE BELOW A COURSE
Additional information pertaining to that particular course (i.e. General Education, Honors, Correspondence, etc.).

COURSE DESCRIPTION PREFIX - Prior to fall 1998
SL - When preceding course description designates course as "SERVICE LEARNING."

WE - When preceding course description designates course as "WRITING EMPHASIS."

WI - When preceding course description designates course as "WRITING INTENSIVE."

AUTHENTICATION OF RECORD
A transcript is official when it bears the facsimile signature of the University Registrar, the University of Utah seal, and the date. The background of this transcript is light gray and red, the signature is white.

ADDITIONAL TESTS: When photocopied, a latent image containing the words COPY VOID will appear. This paper has a tamper resistant background to prevent altering. A DNA marker has been added to the paper. Further authentification can be obtained by calling (801) 581-8965. ANY ATTEMPT TO ALTER OR TAMPER WITH THIS TRANSCRIPT IS PUNISHABLE BY STATE AND FEDERAL LAWS.

THIS TRANSCRIPT CANNOT BE RELEASED TO A THIRD PARTY WITHOUT WRITTEN CONSENT FROM THE STUDENT. THIS IS IN ACCORDANCE WITH THE FAMILY EDUCATIONAL RIGHTS AND PRIVACY ACT OF 1974.

The University of Utah

upon the recommendation of the Faculty of

The School of Medicine

has conferred upon

Rameet R Singh

the Degree of

Doctor of Medicine

with all its Rights, Honors and Responsibilities

In Witness Thereof we have caused the Seal of the University to be affixed this

Twenty-second day of May, One Thousand Nine Hundred Ninety-nine.

Commissioner of Higher Education

Chair, Utah State Board of Regents

President of the University

Chair, Board of Trustees

Senior Vice President for Health Sciences

Section IV

Graduate Medical Education Training

Federation of STATE MEDICAL BOARDS

[redacted]ration Credentials Verification Service (FC[redacted])

Federation Place, P.O. Box 619850, Dallas, TX 75261-9850
Tel: (817) 868-5000 Fax: (817) 868-5098

Verification of Postgraduate Medical Education

Institution: **Medical College of Wisconsin**

Address: **Department of Obstetrics Gynecology**
Milwaukee, WI 53226

Attention: **Program Director**

Affiliated University: Medical College of Wisconsin

Verification For:

Name: **Singh, Rameet Harpal**

DOB: [redacted]/1970

Individual's Name on Record (if different from above): ____

Program Participation:

Important:
Report incomplete postgraduate years (PGY) separate from those that were successfully completed.

If the postgraduate year is currently in progress report the expected completion date in the "To" field.

Report Internships, Residencies and Fellowships separately.

Use one section per Department/Specialty. If the Department/Specialty is rotating or transitional, please provide a schedule of rotations.

PGY: 1

☒ Internship
☐ Residency
☐ Chief Residency
☐ Fellowship
☐ Research

Specialty/Subspecialty: Obstetrics and Gynecology

From: 7/1/1999 To: 6/30/2000

Successfully Completed?: ☒ Yes ☐ No ☐ In Progress

Accredited by: ☒ ACGME ☐ AOA ☐ LCGME ☐ RSC ☐ CFPC ☐ RCPSC ☐ APPAP ☐ None of these

PGY: 2-4

☐ Internship
☒ Residency
☐ Chief Residency
☐ Fellowship
☐ Research

Specialty/Subspecialty: Obstetrics and Gynecology

From: 7/1/2000 To: 6/30/2003

Successfully Completed?: ☒ Yes ☐ No ☐ In Progress

Accredited by: ☒ ACGME ☐ AOA ☐ LCGME ☐ RSC ☐ CFPC ☐ RCPSC ☐ APPAP ☐ None of these

PGY: ____

☐ Internship
☐ Residency
☐ Chief Residency
☐ Fellowship
☐ Research

Specialty/Subspecialty: ____

From: / / To: / /

Successfully Completed?: ☐ Yes ☐ No ☐ In Progress

Accredited by: ☐ ACGME ☐ AOA ☐ LCGME ☐ RSC ☐ CFPC ☐ RCPSC ☐ APPAP ☐ None of these

Unusual Circumstances:

Check the correct responses. Omitted responses require written explanation.

If necessary, you may continue your explanation on a seperate sheet of paper.

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 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:

____

____

ELECTRONIC SEAL VERIFIED

Completion of the following is certification that the information above is an accurate account of this individual's records and is true and correct. The signature line must contain the original signature, or the electronic typed signature, of the program director (M.D./D.O. only).

Name: Paul Lemen Signature: *Paul M. Lemen, MD*

Title: Residency Director Date of Signature: 1/21/10

Tel: 414-805-6607 Fax 414-805-6622 E-Mail: plemen@mcw.edu

Postgraduate Medical Education

Hospital	Medical College of Wisconsin
Affiliated School	
	8701 Watertown Plank Road
	Milwaukee, WI 53226

Year(s)	1-4	**Program Type**	Residency
Complete?	Yes	**Specialty/Subspecialty**	Obstetrics and Gynecology
Dates	07/1999 - 06/2003		

Unusual Circumstances

Leaves/Extensions	N
Probation	N
Disciplined	N
Negative Reports	N
Limits	N

PROVIDED BY APPLICANT

Section V

Examination History/Score Transcripts

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

USMLE United States Medical Licensing Examination™

This document was prepared by the
Federation of State Medical Boards of the United States, Inc.
Federation Place, PO Box 619850, Dallas, TX 75261-9850 -- Telephone (817) 868-4041

Date : 01/21/2010

Recipient:
Federation Credentials Verification Service
ATTN: FCVS

Packet ID: 112325

Examinee: Singh, Rameet Harpal
Alt Name(s):

Examinee ID#: 5-016-673-5
Date of Birth: [redacted]1970

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. Where numeric scores are reported, there are two scales used and the recommended minimum passing score ("MP") on each scale is shown in parentheses.

USMLE STEP 1

		Three-Digit Score		Two-Digit Score		
Test Date	Pass/Fail	Total	MP	Total	MP	Comments
06/10/1997	Pass	186	176	77	75	

USMLE STEP 2

Clinical Knowledge (CK)

		Three-Digit Score		Two-Digit Score		
Test Date	Pass/Fail	Total	MP	Total	MP	Comments
08/25/1998	Pass	199	170	81	75	

USMLE STEP 3

		Three-Digit Score		Two-Digit Score		
Test Date	Pass/Fail	Total	MP	Total	MP	Comments
WISCONSIN 12/07/2000	Pass	205	177	83	75	

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

MD2010-0125

Quintana, Amanda L., BME

From: Rameet Singh [redacted]@salud.unm.edu]
Sent: Thursday, July 01, 2010 11:22 AM
To: explain, med, BME
Subject: RE: Medical License Renewal NM Licence- MD2010-0125
Attachments: Letter.pdf

To whom it may concern,

For my license renewal (NM Licence- MD2010-0125) I am attaching an explanation for Question 15 on the survey form. If you have any additional questions please do not hesitate to contact me.

GOODELL, DEVRIES, LEECH & DANN, LLP

ATTORNEYS AT LAW
ONE SOUTH STREET, 20TH FLOOR
BALTIMORE, MARYLAND 21202
http://www.gdldlaw.com

TELEPHONE (410) 783-4000

FACSIMILE (410) 783-4040

MARIANNE DEPAULO PLANT
MDP@GDLDLAW.COM
WRITER'S DIRECT NUMBER
410-783-4059

657-63

June 30, 2010

CONFIDENTIAL, FOR PURPOSES OF CREDENTIALING ONLY

RE: [redacted] ***et al v. Johns Hopkins Bayview Medical Center, Inc., et al***

To Whom It May Concern:

I am writing to provide information requested for credentialing purposes regarding my client, Dr. Rameet Singh. I am representing Dr. Singh in the above-referenced matter, currently pending in the Health Care Alternative Resolution Office of Maryland (HCADRO), Case No. 2010-153. Regarding the venue, it is expected that Claimants will seek to transfer the case to the Circuit Court for Baltimore City. This case is in its infancy, and Claimants have not yet filed the requisite Certificate of Merit by a qualified expert.

The Claimant in this case is a female, who was 23 years old at the time of treatment in April of 2007. Dr. Singh saw her for post C-section wound care. Other health care providers named in the suit are Johns Hopkins Bayview Medical Center, Inc. and Johns Hopkins Community Physicians, Inc. The allegation is that her wound care was not appropriate, and that she experienced delayed healing.

Dr. Singh's insurance coverage applicable to this claim is with MCIC Vermont, through Johns Hopkins University.

Should you require further information, please feel free to contact me.

Yours very truly,

Marianne D. Plant

Marianne DePaulo Plant

MDP/slt
4844-0388-6342

Application Questions

Please answer the following question(s) by choosing the respective answer(s) from the drop-down menu(s). Click the **submit button** when you have answered the question(s).

Question	Answer
1. Since your last renewal has your professional liability coverage been terminated by action of the insurance company except as a result of the company ceasing to offer insurance to physicians?	No
2. Since your last renewal have you been denied professional liability insurance coverage?	No
3. Since your last renewal has your professional liability carrier excluded any specific procedures from your coverage?	No
4. Since your last renewal have you been denied membership or renewal thereof, or been subject to disciplinary action in any professional organization?	No
5. Since your last renewal have you been excluded from or sanctioned by Medicare and/or Medicaid?	No
6. Have you ever been arrested? If so explain the circumstance, regardless of the outcome (i.e. expunged, dismissed, sealed, vacated).	No
7. Have you ever been named as a defendant in any criminal proceedings?	No
8. Have you ever been subject to investigation by a governmental entity or Board that either could have resulted or did result in licensure sanction or other adverse actions, irrespective of the outcome?	No
9. Since your last renewal have you been named in any formal requests for corrective actions filed by any healthcare entity where you have had an appointment (a request which could result in either formal or informal proceedings).	No
10. a. Since your last renewal have your privileges at any healthcare entity been voluntarily or involuntarily suspended, restricted, diminished, revoked, surrendered, or not renewed, except for medical records delinquency?	No
10. b. Since your last renewal have you agreed not to exercise your clinical privileges while under investigation?	No
11. Since your last renewal have you resigned from a healthcare entity to avoid modification, suspension, or termination of privileges, or while under investigation?	No
12. a. Since your last renewal has your application for licensure or license to practice in any jurisdiction been investigated, voluntarily or involuntarily limited, suspended, revoked, surrendered or denied?	No
12. b. Are any currently held licenses pending investigation or being challenged?	No
13. Since your last renewal have you been notified to appear before any licensing agency for a hearing or complaint of any nature?	No
14. Since your last renewal has your federal or state narcotics registration certificate in any jurisdiction been voluntarily or involuntarily limited (stipulations), suspended, revoked, restricted, or are there currently challenges to any of these items?	No
15. Since your last renewal have you been involved in a settlement, medical malpractice claim or suit, or have you ever received written notice of intent to file such a suit? If yes, please provide the following information for each claim or suit. Please type on a separate sheet of paper for each case. . Name, age, sex of patient/claimant. . Date(s) and type of treatment and/or surgery, which led to the allegations against you. . Nature of allegations in claims/suits. Specify whether a suit was ever filed. . Names of other practitioners and hospital, if any, involved in claims or suit. . Disposition or current status of claim or suit (be specific). . Name of insurance carrier defending you. . Name of defense attorney.	~~No~~ Yes, see attached letter from counsel.
16. Since your last renewal have you been reported to the National Practitioner Data Bank?	No
17. Are you now, or were you in the past, addicted to, abusive of, or in treatment for abuse of any controlled substances, habit-forming drugs, illegal drugs, prescription medication or alcohol?	No
18. In the five (5) years prior to this application, have you had any physical injury or disease, or mental illness or impairment, which you are currently under treatment for or could reasonably be expected to affect your on-going ability to practice medicine safely and competently? If yes, please have your treating physician send the NM Medical Board a letter regarding your diagnosis and treatment.	No
19. I certify that I have completed a minimum of 75 AMA Category I hours of Continuing Medical Education as required by 16.10.4 NMAC?	Yes
20. Are you ABMS (American Board of Medical Specialties) Board Certified?	~~Yes~~ NO
21. If yes do you hold Lifetime Certification?	No
22 . If yes do you hold Time Limited Certification?	~~Yes~~

Attestation

By clicking the **submit button** you hereby swear or affirm under the penalties of perjury that you understand and have answered the questions truthfully to the best of your knowledge.

If you have answered yes to questions 1-18 above please click **HERE** and provide a written explanation of your yes answer (s) and indicate if you will be providing any additional information by mail. Board staff will review the explanations provided. This may delay the processing of your renewal application as further information may be required.

If you have answered "No" to question #19, please click **here** for information about an Emergency Deferral.

To request an Emergency Deferral, click **here**.

Singh, Rameet Harpal **Medical Doctor** **MD2010-0125**

11. Since your last renewal have you resigned from a healthcare entity to avoid modification, suspension, or termination of privileges, or while under investigation?	N	06/29/2010
10. b. Since your last renewal have you agreed not to exercise your clinical privileges while under investigation?	N	06/29/2010
12. b. Are any currently held licenses pending investigation or being challenged?	N	06/29/2010
6. Have you ever been arrested? If so explain the circumstance, regardless of the outcome (i.e. expunged, dismissed, sealed, vacated).	N	06/29/2010
13. Since your last renewal have you been notified to appear before any licensing agency for a hearing or complaint of any nature?	N	06/29/2010
15. Since your last renewal have you been involved in a settlement, medical malpractice claim or suit, or have you ever received written notice of intent to file such a suit? If yes, please provide the following information for each claim or suit. Please type on a separate sheet	Y	07/01/2010
14. Since your last renewal has your federal or state narcotics registration certificate in any jurisdiction been voluntarily or involuntarily limited (stipulations), suspended, revoked, restricted, or are there currently challenges to any of these items?	N	06/29/2010
16. Since your last renewal have you been reported to the National Practitioner Data Bank?	N	06/29/2010
17. Are you now, or were you in the past, addicted to, abusive of, or in treatment for abuse of any controlled substances, habit-forming drugs, illegal drugs, prescription medication or alcohol?	N	06/29/2010
18. In the five (5) years prior to this application, have you had any physical injury or disease, or mental illness or impairment, which you are currently under treatment for or could reasonably be expected to affect your on -going ability to practice medicine safely and	N	06/29/2010
1. Since your last renewal has your professional liability coverage been terminated by action of the insurance company except as a result of the company ceasing to offer insurance to physicians ?	N	06/29/2010
2. Since your last renewal have you been denied professional liability insurance coverage?	N	06/29/2010
3. Since your last renewal has your professional liability carrier excluded any specific procedures from your coverage?	N	06/29/2010
4. Since your last renewal have you been denied membership or renewal thereof, or been subject to disciplinary action in any professional organization?	N	06/29/2010
5. Since your last renewal have you been excluded from or sanctioned by Medicare and/or Medicaid?	N	06/29/2010
7. Have you ever been named as a defendant in any criminal proceedings?	N	06/29/2010
19. I certify that I have completed a minimum of 75 AMA Category I hours of Continuing Medical Education as required by 16.10.4 NMAC?	Y	06/29/2010
20. Are you ABMS (American Board of Medical Specialties) Board Certified?	N	07/01/2010
21. If yes do you hold Lifetime Certification?	N	06/29/2010
22 . If yes do you hold Time Limited Certification?	N	07/01/2010
8. Have you ever been subject to investigation by a governmental entity or Board that either could have resulted or did result in licensure sanction or other adverse actions, irrespective of the outcome?	N	06/29/2010
9. Since your last renewal have you been named in any formal requests for corrective actions filed by any healthcare entity where you have had an appointment (a request which could result in either formal or informal proceedings).	N	06/29/2010
10. a. Since your last renewal have your privileges at any healthcare entity been voluntarily or involuntarily suspended, restricted, diminished, revoked, surrendered, or not renewed, except for medical records delinquency?	N	06/29/2010
12. a. Since your last renewal has your application for licensure or license to practice in any jurisdiction been investigated, voluntarily or involuntarily limited, suspended, revoked, surrendered or denied?	N	06/29/2010

Singh, Rameet Harpal **Medical Doctor** **MD2010-0125**

1. Since your last renewal has your professional liability coverage been terminated by action of the insurance company except as a result of the company ceasing to offer insurance to physicians ?	N	04/17/2013
2. Since your last renewal have you been denied professional liability insurance coverage?	N	04/17/2013
3. Since your last renewal has your professional liability carrier excluded any specific procedures from your coverage?	N	04/17/2013
4. Since your last renewal have you been denied membership or renewal thereof, or been subject to disciplinary action in any professional organization?	N	04/17/2013
5. Since your last renewal have you been excluded from or sanctioned by Medicare and/or Medicaid?	N	04/17/2013
6. Since your last renewal, have you been arrested? If so explain the circumstance, regardless of the outcome (i.e. expunged, dismissed, sealed, vacated).	N	04/17/2013
7. Since your last renewal, have you been named as a defendant in any criminal proceedings?	N	04/17/2013
8. Since your last renewal, have you been subject to investigation by a governmental entity or Board that either could have resulted or did result in licensure sanction or other adverse actions, irrespective of the outcome?	N	04/17/2013
9. Since your last renewal have you been named in any formal requests for corrective actions filed by any healthcare entity where you have had an appointment (a request which could result in either formal or informal proceedings).	N	04/17/2013
10. a. Since your last renewal have your privileges at any healthcare entity been voluntarily or involuntarily suspended, restricted, diminished, revoked, surrendered, or not renewed, except for medical records delinquency?	N	04/17/2013
10. b. Since your last renewal have you agreed not to exercise your clinical privileges while under investigation?	N	04/17/2013
11. Since your last renewal have you resigned from a healthcare entity to avoid modification, suspension, or termination of privileges, or while under investigation?	N	04/17/2013
12. a. Since your last renewal has your application for licensure or license to practice in any jurisdiction been investigated, voluntarily or involuntarily limited, suspended, revoked, surrendered or denied?	N	04/17/2013
12. b. Are any currently held licenses pending investigation or being challenged?	N	04/17/2013
13. Since your last renewal have you been notified to appear before any licensing agency for a hearing or complaint of any nature?	N	04/17/2013
14. Since your last renewal has your federal or state narcotics registration certificate in any jurisdiction been voluntarily or involuntarily limited (stipulations), suspended, revoked, restricted, or are there currently challenges to any of these items?	N	04/17/2013
15. Since your last renewal have you been involved in a settlement, medical malpractice claim or suit, or have you ever received written notice of intent to file such a suit? If yes, please provide the following information for each claim or suit. Please type on a separate sheet	N	04/17/2013
16. Since your last renewal have you been reported to the National Practitioner Data Bank?	N	04/17/2013
17. Are you now, or were you in the past, addicted to, abusive of, or in treatment for abuse of any controlled substances, habit-forming drugs, illegal drugs, prescription medication or alcohol?	N	04/17/2013
18. In the five (5) years prior to this application, have you had any physical injury or disease, or mental illness or impairment, which you are currently under treatment for or could reasonably be expected to affect your on -going ability to practice medicine safely and	N	04/17/2013
19. I certify that I have completed a minimum of 75 AMA Category I hours of Continuing Medical Education as required by 16.10.4 NMAC?	Y	04/17/2013
20. Are you ABMS (American Board of Medical Specialties) Board Certified?	N	04/17/2013
21. If yes do you hold Lifetime Certification?	N	04/17/2013
22 . If yes do you hold Time Limited Certification?	N	04/17/2013

Singh, Rameet Harpal **Medical Doctor** **MD2010-0125**

1. Since your last renewal has your professional liability coverage been terminated by action of the insurance company except as a result of the company ceasing to offer insurance to physicians ?	N	05/13/2016
2. Since your last renewal have you been denied professional liability insurance coverage?	N	05/13/2016
3. Since your last renewal has your professional liability carrier excluded any specific procedures from your coverage?	N	05/13/2016
4. Since your last renewal have you been denied membership or renewal thereof, or been subject to disciplinary action in any professional organization?	N	05/13/2016
5. Since your last renewal have you been excluded from or sanctioned by Medicare and/or Medicaid?	N	05/13/2016
6. Since your last renewal, have you been arrested? If so explain the circumstance, regardless of the outcome (i.e. expunged, dismissed, sealed, vacated).	N	05/13/2016
7. Since your last renewal, have you been named as a defendant in any criminal proceedings?	N	05/13/2016
8. Since your last renewal, have you been subject to investigation by a governmental entity or Board that either could have resulted or did result in licensure sanction or other adverse actions, irrespective of the outcome?	N	05/13/2016
9. Since your last renewal have you been named in any formal requests for corrective actions filed by any healthcare entity where you have had an appointment (a request which could result in either formal or informal proceedings).	N	05/13/2016
10. a. Since your last renewal have your privileges at any healthcare entity been voluntarily or involuntarily suspended, restricted, diminished, revoked, surrendered, or not renewed, except for medical records delinquency?	N	05/13/2016
10. b. Since your last renewal have you agreed not to exercise your clinical privileges while under investigation?	N	05/13/2016
11. Since your last renewal have you resigned from a healthcare entity to avoid modification, suspension, or termination of privileges, or while under investigation?	N	05/13/2016
12. a. Since your last renewal has your application for licensure or license to practice in any jurisdiction been investigated, voluntarily or involuntarily limited, suspended, revoked, surrendered or denied?	N	05/13/2016
12. b. Are any currently held licenses pending investigation or being challenged?	N	05/13/2016
13. Since your last renewal have you been notified to appear before any licensing agency for a hearing or complaint of any nature?	N	05/13/2016
14. Since your last renewal has your federal or state narcotics registration certificate in any jurisdiction ever been investigated, voluntarily or involuntarily limited, suspended, revoked, or restricted?	N	05/13/2016
15. Since your last renewal have you been involved in a settlement, medical malpractice claim or suit, or have you ever received written notice of intent to file such a suit? If yes, please provide the following information for each claim or suit. Please type on a separate sheet	N	05/13/2016
16. Since your last renewal have you been reported to the National Practitioner Data Bank?	N	05/13/2016
17. Are you now, or were you in the past, addicted to, abusive of, or in treatment for abuse of any controlled substances, habit-forming drugs, illegal drugs, prescription medication or alcohol?	N	05/13/2016
18. In the five (5) years prior to this application, have you had any physical injury or disease, or mental illness or impairment, which you are currently under treatment for or could reasonably be expected to affect your on -going ability to practice medicine safely and	N	05/13/2016
19. I certify that I have completed a minimum of 75 AMA Category I hours of Continuing Medical Education as required by 16.10.4 NMAC	N	05/13/2016
19a. I certify that 5 hours of the required 75 hours of CME are in Pain Management, as required by 16.10.14. 11 NMAC OR I certify that I do NOT hold a NM Controlled Substance Registration.	N	05/13/2016
20. I attest that I will limit my practice to areas in which I am competent to practice.	N	05/13/2016
21. Are you currently in arrears in payments of amounts required to be paid pursuant to an outstanding judgement and order for child support in New Mexico or in any other state?	N	05/13/2016