MEDICAL BOARD OF CALIFORNIA
LICENSE LOOKUP SYSTEM

License Information:

The following information is maintained by the Medical Board of California. For more information, click on the blue tabs above.

License:	**A 89646** Licensee may be a U.S. or Canadian medical school graduate whose pathway to licensure was based on the FLEX (Federation Licensing Exam), USMLE (United States Medical Licensing Exam) or LMCC (Licentiate of Medical Council of Canada) written examination and has been licensed less than four years in another state OR may be an International medical school graduate whose pathway to licensure was based on the above exams or approved combinations of the NBME (National Board Medical Exam), FLEX or USMLE.
License Type:	Physician and Surgeon
Name:	NICOLA LOUISE MOORE, M.D.
Address of Record:	**395 CONCORD AVENUE CAMBRIDGE, MA 02138**
Address of Record County:	OUT OF STATE
License Status:	**License Delinquent** License renewal fee has not been paid. No practice is permitted.
Public Record Action(s):	No Public Record Actions available
Original Issue Date:	December 17, 2004
Expiration Date:	December 31, 2010
School Name:	ALBERT EINSTEIN COLLEGE OF MEDICINE OF YESHIVA UNIVERSITY
Year Graduated:	1999

Public Record Action(s):

Please select the Public Record Documents tab to view the public document database. If information is posted in the Administrative Disciplinary Actions, Court Order, Administrative Citation Issued, or License Issued with Public Letter of Reprimand categories below, documents may be available for review. To find out what information is and is not available, please click here.

Administrative Disciplinary Actions:

The Medical Board's public disclosure screens are updated periodically as new information becomes available. Please contact the Central File Room at (916) 263-2525 or at 2005 Evergreen Street, Suite 1200, Sacramento, CA 95815, to obtain a copy of public documents at a minimal charge.

No Administrative Disciplinary Actions found.

Court Order:

This information would be provided if a physician's practice has been temporarily restricted or suspended pursuant to a court order. Please contact the Central File Room at (916) 263-2525 or at 2005 Evergreen Street, Suite 1200, Sacramento, CA 95815, to obtain a copy of the public documents.

No Court Orders found.

Administrative Action Taken by Other State or Federal Government:

This information is provided by another state/federal government agency. The Medical Board of California may take administrative action based on the action imposed by another state/federal government agency. For more information or verification, contact the agency listed below that imposed the action.

No Administrative Actions Taken by Other State or Federal Government found.

Felony Conviction:

The information provided only includes felony convictions that are known to the Board. All felony convictions known to the Board are reviewed and administrative action is taken only if it is determined that a violation of the Medical Practice Act occurred. For more information regarding felony convictions, contact the court of jurisdiction listed below.

No Felony Convictions found.

Misdemeanor Conviction:

California Business and Professions Code section 2027 (A)(7) states effective 1/1/07, any misdemeanor conviction that results in a disciplinary action or an accusation that is not subsequently withdrawn or dismissed shall be posted on the Internet. To see if a conviction has been expunged or dismissed, please contact the court below.

No Misdemeanor Convictions found.

Administrative Citation Issued:

A citation and/or fine has been issued for a minor violation of the law. This is not considered disciplinary action under California law but is an administrative action. Payment of the fine amount represents satisfactory resolution of this matter.

No Administrative Citations found.

License Issued with Public Letter of Reprimand:

The Medical Board of California has concurrently issued the applicant a medical license and a Public Letter of Reprimand for a minor violation that does not require probationary status or warrant denial. The issuance of a Public Letter of Reprimand is not considered disciplinary action and is not reported to the National Practitioner Databank or the Federation of State Medical Boards.

No License Issued with Public Letter of Reprimand found.

Hospital Disciplinary Action:

The action taken by this healthcare facility against this physician's staff privileges to provide health care services at this facility was for a medical disciplinary cause or reason. The Medical Board is authorized by law to disclose only revocations and terminations of staff privileges. The Medical Board is prohibited from releasing a copy of the actual report or any other information.

No Hospital Disciplinary Actions found.

Malpractice Judgment:

A malpractice judgment is a payment for damages and does not necessarily reflect that the physician's medical competence is below the standard of care. The Medical Board reviews all such reported judgments and action is taken only if it is determined that a violation of the Medical Practice Act occurred. The Medical Board is prohibited by law from releasing a copy of the judgment report or any other information concerning the judgment. For more information contact the court of jurisdiction listed below.

No Malpractice Judgments found.

Arbitration Award:

An arbitration award is a payment for damages and does not necessarily reflect that the physician's medical competence is below the standard of care. The Medical Board reviews all such reported arbitration awards and action is taken only if it is determined that a violation of the Medical Practice Act occurred. The Medical Board is prohibited by law from releasing a copy of the arbitration award report or any other information concerning the award.

No Arbitration Awards found.

Malpractice Settlements:

A settlement entered into by the licensee is a resolution of a claim for damages for death or personal injury caused by the licensee's negligence, error, or omission in practice, or by his or her rendering of unauthorized professional services. The Medical Board is required by law to disclose certain information related to the existence of multiple settlements made on or after January 1, 2003 in an amount of $30,000 or more.

No Malpractice Settlements found.

Note: "No information available from this agency" may not indicate none exists; but indicates no information has been reported to the Medical Board of California and/or that the Board is unable to post the information on the Web site by law.

Public Record Documents:

All imaged documents provided by the Medical Board are being made available to provide immediate access for the convenience of interested persons. While the Medical Board believes the information to be reliable, human or mechanical error remains a possibility, as does delay in the posting or updating of information. Therefore, the Medical Board makes no guarantee as to the accuracy, completeness, timeliness, currency, or correct sequencing of the information. The Medical Board shall not be responsible for any errors or omissions, or for the use or results obtained from the use of this information. The types of documents which are available include, but are not limited to, accusations, decisions, suspension/restriction orders, public letters of reprimand and citations.

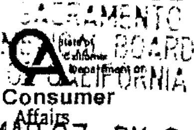
No documents found.

Please note that documents with an effective date prior to calendar year 2000 may not be available via the Web. To obtain a copy of the documents not posted on this site, please contact the Central File Room at (916) 263-2525 or click here for information on ordering public documents.

Disclaimer

All information provided by the Medical Board of California on this Web page, and on its other Web pages and Internet sites, is made available to provide immediate access for the convenience of interested persons. While the Board believes the information to be reliable, human or mechanical error remains a possibility, as does delay in the posting or updating of information. Therefore, the Board makes no guarantee as to the accuracy, completeness, timeliness, currency, or correct sequencing of the information. Neither the Board, nor any of the sources of the information, shall be responsible for any errors or omissions, or for the use or results obtained from the use of this information. Other specific cautionary notices may be included on other Web pages maintained by the Board. All access to and use of this Web page and any other Web page or Internet site of the Board is governed by the Disclaimers and Conditions for Access and Use as set forth at California Department of Consumer Affairs' Disclaimer Information and Use Information.

STATE OF CALIFORNIA - STATE AND CONSUMER SERVICES AGENCY GRAY DAVIS, Governor



MEDICAL BOARD OF CALIFORNIA

1426 Howe Avenue, Suite 54, Sacramento, CA 95825-3236
TEL: (916) 263-2499/FAX: (916) 263-2487 Internet: www.medbd.ca.gov

SACRAMENTO MEDICAL BOARD OF CALIFORNIA 03 MAR 27 PM 3:38

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APPLICATION FOR PHYSICIAN'S AND SURGEON'S LICENSE

009133

Please READ all instructions prior to completing this application. ALL questions on this application must be answered, and all supporting documents must be submitted as per instructions. Please type or print neatly. When space provided is insufficient, attach additional sheets of paper. All attachments are considered part of the application.

FALSIFICATION OR MISREPRESENTATION OF ANY ITEM OR RESPONSE ON THIS APPLICATION OR ANY ATTACHMENT HERETO IS A SUFFICIENT BASIS FOR DENYING OR REVOKING A LICENSE.

MBC USE ONLY — Personal Data

1. NAME: Last: MOORE First: NICOLA Middle: LOUISE

2. Other names you have used (include maiden name):

3. U.S. Social Security Number*: [redacted]

4A. (PUBLIC ADDRESS; will be released by the Board to the public): Number and Street/P.O. Box/Rural Route/Apartment Number, if any. [redacted]

City [redacted] State [redacted] Zip Code [redacted] Country US

4B. (CONFIDENTIAL ADDRESS): Number and Street/Rural Route/Apartment Number, if any. [Applicants must provide a confidential street address if a P. O. Box is used as the Public Address in #4A above.]

City State Zip Code Country

5. Telephone Number: Home: [redacted] Work: [redacted]

6. California Driver's License Number (optional): NUMBER EXPIRATION

7. Date of Birth (Month/Day/Year) and Place of Birth: [redacted] U.K

8. Sex: ☐ Male ☒ Female

9. Are you a U.S. citizen? ☒ Yes ☐ No

10. Have you ever filed an application for Physician's and Surgeon's examination or licensure in California? ☐ Yes ☒ No

IF YES, PLEASE GIVE DATE PREVIOUS APPLICATION WAS SUBMITTED. ____________

11. List the names and locations of all colleges or universities attended where pre-professional, postsecondary instruction was received. Please submit official transcripts with the school seal affixed for each school attended. Transcripts will not be returned.

Pre-Medical Education

Name	City, State, Country	Dates of Attendance
Yale University	New Haven, Ct US	9/1972 - 12/76
Columbia University	New York, NY US	5/1994 - 5/1995

12. List the names and locations of all schools where professional medical instruction was received, and, where applicable, the degree awarded.
PLEASE SUBMIT: 1) an original Certificate of Medical Education (Form L2) and official transcripts with the signature of the dean or registrar and the school seal affixed from each school attended; and,
2) an original medical diploma and a 8 1/2" x 11" photocopy (original diploma will be returned).

Medical Education — L2 Trans

School Name	City, State, Country	Dates of Attendance	Degree Awarded
Albert Einstein	Bronx, NY US	8/95 - 6/99	MD

DOCTOR OF MEDICINE DEGREE, as referenced above.

Name of Medical School	Address of Medical School	Exact Date of Issuance
Albert Einstein College of Medicin	1300 Morris Park Ave Bronx, NY 10461	6/3/1999

* MANDATORY DISCLOSURE OF U.S. SOCIAL SECURITY NUMBERS

Disclosure of your U.S. social security number is mandatory. Section 30 of the Business and Professions Code and Public Law 94-455 (42 USCA 405(c)(2)(C)) authorize collection of your social security number. Your social security number will be used exclusively for tax enforcement purposes, for purposes of compliance with any judgment or order for family support in accordance with Section 17520 of the Family Code, or for verification of licensure or examination status by a licensing or examination entity which utilizes a national examination and where licensure is reciprocal with the requesting state. If you fail to disclose your social security number your application for initial licensure will not be processed AND you will be reported to the Franchise Tax Board, which may assess a $100 penalty against you.

MBC USE ONLY: NY04 School Code

L1A

X new address only

07A-100 (Rev. 3/01)

MBC USE ONLY

13. Have you taken any of the following written examinations: National Boards, other state boards, USMLE, SPEX, FLEX, ECFMG or LMCC? ☒ Yes ☐ No

Written Examination

IF YES, LIST NAME, LOCATION, DATE AND RESULT OF EACH EXAMINATION; FAILURES MUST ALSO BE DISCLOSED. EACH EXAMINATION AGENCY MUST SUBMIT AN ORIGINAL OFFICIAL EXAMINATION HISTORY REPORT DIRECTLY TO THE MEDICAL BOARD OF CALIFORNIA. THESE REPORTS WILL NOT BE RETURNED.

Examination	Date	Result (Pass/Fail)
USMLE Step 1	06/1997	[redacted]
USMLE Step 2	08/1998	[redacted]
USMLE Step 3	07/2000	[redacted]

14. Have you ever been licensed to practice medicine in any state, territory, province, country, or U.S. federal jurisdiction? ☒ Yes ☐ No

License Data

IF YES, LIST THE JURISDICTION, LICENSE NUMBER, DATE ISSUED AND DATES OF PRACTICE IN THAT JURISDICTION. PLEASE INCLUDE PERMANENT, TEMPORARY, TRAINING, PROVISIONAL, LIMITED LICENSE, OR PERMIT. AN ORIGINAL OFFICIAL LETTER OF GOOD STANDING (LGS), OR COMPARABLE LICENSE HISTORY CERTIFICATION, IS REQUIRED FOR EACH PERMANENT, TEMPORARY, TRAINING, PROVISIONAL, LIMITED LICENSE, OR PERMIT OBTAINED IN ANY U.S. STATE, U.S. OR CANADIAN TERRITORY, CANADIAN PROVINCE, OR U.S. FEDERAL JURISDICTION. EACH LGS, OR COMPARABLE CERTIFICATION, SHOULD BE MAILED BY THE ISSUING AUTHORITY DIRECTLY TO THE MEDICAL BOARD OF CALIFORNIA.

LGS

Jurisdiction	License Number	Date of Issuance	Dates of Practice in that Jurisdiction
New York	219226	9/14/2000	7/99 - present

15. Do you hold any other professional license in any state, territory, province, country, or U.S. federal jurisdiction? ☐ Yes ☒ No

IF YES: PROFESSION: ________, LICENSE NO.: ________, JURISDICTION: ________.

Other Professional Licenses

HAS THIS LICENSE EVER BEEN REVOKED, OR SUBJECT TO DISCIPLINE? IF YES, PLEASE PROVIDE ALL OFFICIAL DOCUMENTATION REGARDING THE MATTER IN ADDITION TO A WRITTEN EXPLANATION. YOU ARE ALSO REQUIRED TO REPORT ANY MATTER THAT IS PENDING OR IN WHICH CHARGES HAVE BEEN DROPPED OR EXPUNGED. ☐ Yes ☒ No

16A. Are you currently, or have you ever been, a participant in a postgraduate training program in a facility in the U.S. or Canada? (You must include every residency, internship, and fellowship, whether or not completed.) ☒ Yes ☐ No

Postgraduate Training

IF YES, LIST NAMES AND ADDRESSES OF ALL FACILITIES. SUBMIT AN ORIGINAL CERTIFICATE OF COMPLETION OF ACGME/RCPSC POSTGRADUATE TRAINING (FORM L3A) FROM EACH FACILITY. (DO NOT COMPLETE FORM L3As TO DOCUMENT TRAINING RECEIVED IN RESEARCH FELLOWSHIP PROGRAMS.) ALL TRAINING MUST BE LISTED, REGARDLESS OF WHETHER IT WAS SATISFACTORILY COMPLETED OR WILL BE USED TO MEET LICENSING REQUIREMENTS.

Facility Name	Address	Categorial Specialty Area	Dates of Attendance
Highland Hospital	1000 South Ave, Roch. NY	Family Med	6/99 - 9/02
Repro Health, Fam Med	1000 South Ave, Roch NY	Reproductive Health	9/02 - 6/03

QUESTIONS 16B through 23:
If you answer YES to any of the following questions, please provide ALL official documentation regarding the matter in addition to your written personal explanations. An applicant must provide official hearing/court documents and original letters of explanation from medical schools or training program directors. If these documents are not provided with the application, they will be requested before review of the application can proceed. APPLICANTS ARE REQUIRED TO REPORT ANY MATTER THAT IS PENDING OR IN WHICH CHARGES HAVE BEEN DROPPED OR EXPUNGED.

16B. Have you ever withdrawn from, or been suspended, dismissed or expelled from a medical school or postgraduate training program OR have you ever taken a leave of absence from such a school or program? [redacted] Yes [redacted] No

IF YOU ANSWERED YES, BOTH APPLICANT AND SCHOOL/PROGRAM MUST PROVIDE DETAILS ON A SEPARATE ATTACHMENT.

NAME OF APPLICANT: NICOLA LOUISE MOORE

DATE OF BIRTH: [redacted]

MBC USE ONLY

License Data

For all of the below, also include any disciplinary actions by the U.S. Military, U.S. Public Health Service, or other U.S. federal governmental entity.

17A. Have you ever been charged with, or been found to have committed, unprofessional conduct, professional incompetence, gross negligence, or repeated negligent acts or malpractice by any medical licensing board, other agency, or hospital?

17B. Has any disciplinary action ever been filed or taken, including but not limited to, informal or confidential discipline, consent orders, or letters of warning, regarding any healing arts license which you now hold or have ever held?

17C. Is any such action as described above pending?

17(A) Yes No

17(B) Yes No

17(C) Yes No

IF YOU ANSWERED YES TO 17A, 17B OR 17C, PROVIDE DETAILS ON A SEPARATE ATTACHMENT.

18. Has a claim or action for damages ever been filed against you in the course of the practice of medicine or any other healing art which resulted in a malpractice settlement, judgement, or arbitration award of over $30,000.00?

Yes No

IF YOU ANSWERED YES, PROVIDE DETAILS ON A SEPARATE ATTACHMENT.

19. Have you ever been denied a license, permission to practice medicine or any other healing art, or denied permission to take an examination in any state, territory, country, or U.S. federal jurisdiction, or is any such action pending?

Yes No

IF YOU ANSWERED YES, PROVIDE DETAILS ON A SEPARATE ATTACHMENT.

20. Have you ever voluntarily surrendered a license to practice medicine or any other healing arts in this or any other state, or voluntarily surrendered your narcotic (controlled substance) permit (state or federal) to any licensing board or any other agency, or is any such action pending?

Yes No

IF YOU ANSWERED YES, PROVIDE DETAILS ON A SEPARATE ATTACHMENT.

21. Have you ever had staff privileges in a hospital denied, suspended, limited, revoked, or not renewed for medical disciplinary cause, or resigned from a medical staff in lieu of disciplinary or administrative action, or is any such action pending?

YOU MUST DISCLOSE ANY INFORMAL OR CONFIDENTIAL DISCIPLINARY ACTION.

Yes No

22. Do you have any condition which in any way impairs or limits your ability to practice medicine with reasonable skill and safety, including but not limited to, any of the following?

Yes No

IF YES, PLEASE CHECK THE APPROPRIATE BOX(ES) BELOW:

- ☐ A condition which required admission to an inpatient psychiatric treatment facility.
- ☐ Alcohol or chemical substance dependency or addiction.
- ☐ Emotional, mental or behavioral disorder.
- ☐ Other (explain): ______________________

FOR ANY OF THE BOXES CHECKED ABOVE, PLEASE SUBMIT COMPLETE OFFICIAL INPATIENT AND OUTPATIENT TREATMENT RECORDS, EVIDENCE OF ONGOING REHABILITATION TREATMENT, AND A PERSONAL WRITTEN EXPLANATION.

FOR ALL OF THE BELOW, YOU ARE REQUIRED TO LIST ANY CONVICTION THAT HAS BEEN SET ASIDE AND DISMISSED OR EXPUNGED, OR WHERE A STAY OF EXECUTION HAS BEEN ISSUED.

23A. Have you ever been convicted of, or pled nolo contendere to, ANY violation (include every misdemeanor or felony) of any local, state, or federal law of any state, territory, country, or U.S. federal jurisdiction?

23B. Is any criminal action related to the above pending?

23 (A) Yes No

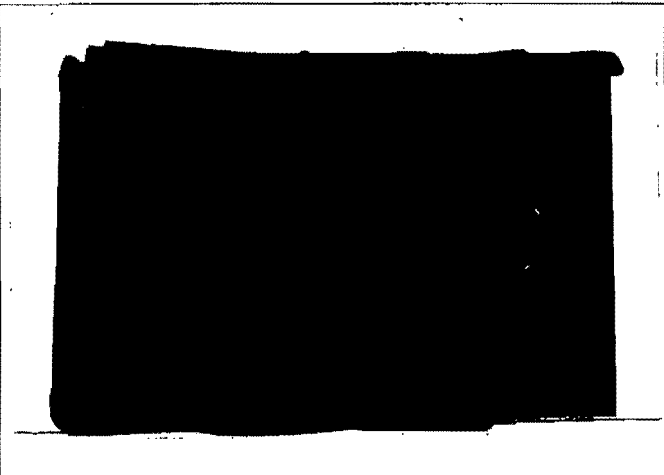
23 (B) Yes No

IF YOU ANSWERED YES TO 23A OR 23B, PROVIDE DETAILS ON A SEPARATE ATTACHMENT.

NAME OF APPLICANT: NICOLA LOUISE MOORE

DATE OF BIRTH:

L1C



Notice: All items in this application are mandatory; none are voluntary. Failure to provide any of the requested information will delay the processing of your application. The information provided will be used to determine your qualifications for licensure per Section 2080 of the California Business and Professions Code, which authorizes the collection of this information. The information on your application may be transferred to other medical licensing authorities, the Federation of State Medical Boards, or other governmental or law enforcement agencies. You have the right to review your application subject to the provisions of the Information Practices Act. The Chief of the Licensing Program is the custodian of records.

Applicant Declaration/Signature and NOTARY

STATE OF New York

COUNTY OF Monroe

The applicant, NICOLA LOUISE MOORE (PLEASE PRINT FULL NAME), [redacted] (DATE OF BIRTH), being first duly sworn upon his/her oath deposes and says: that I am the person herein named subscribing to this application; that I have read the complete application, know the full content thereof, and declare under penalty of perjury, that all of the information contained herein and evidence or other credentials submitted herewith are true and correct; that I am the lawful holder of the degree of Doctor of Medicine as prescribed by this application, that the same was procured in the regular course of instruction and examination, and that it, together with all the credentials submitted, were procured without fraud or misrepresentation or any mistake of which I am aware and that I am the lawful holder thereof. Further, I hereby authorize all hospitals, institutions or organizations, my references, personal physicians, employers (past, present, and future), business and professional associates (past, present, and future), and all government agencies (local, state, federal, or foreign) to release to the Medical Board of California or its successors any information, files or records, including medical records, educational records, and records of psychiatric treatment and treatment for drug and/or alcohol abuse or dependency, requested by that Board in connection with this application; or any further or future investigation by that Board necessary to determine my medical competence, professional conduct, or physical or mental ability to safely engage in the practice of medicine. I further authorize the Medical Board of California or its successors to release to the organizations, individuals, or groups listed above any information which is material to this application or any subsequent licensure. **I UNDERSTAND THAT FALSIFICATION OR MISREPRESENTATION OF ANY ITEM OR RESPONSE ON THIS APPLICATION OR ANY ATTACHMENT HERETO IS A SUFFICIENT BASIS FOR DENYING OR REVOKING A LICENSE.**

SIGNATURE OF APPLICANT: Nicola Louise Moore
(PLEASE SIGN FULL NAME, NOT INITIALS)

Signed and sworn to before me this 13 day of March 2003
MONTH YEAR

Amy Burchell
SIGNATURE OF NOTARY PUBLIC

1000 South Ave, Roch, NY 14620
ADDRESS

My commission expires July 24, 2005

NOTARY SEAL: AMY B... NOTARY PUBLIC, S... QUALIFIED ... County MY COMMISSION EXP. ... 2005 01BU4984838

L1D

3/2?/03

STATE OF CALIFORNIA — STATE AND CONSUMER SERVICES AGENCY GRAY DAVIS, Governor

MEDICAL BOARD OF CALIFORNIA
1426 Howe Avenue, Suite 54, Sacramento, CA 95825-3236
(916) 263-2499/FAX (916) 263-2487
Internet: www.medbd.ca.gov

03 APR -4 AM 8:33

CERTIFICATE OF MEDICAL EDUCATION

MEDICAL SCHOOL: PLEASE COMPLETE THIS FORM IN THE ENGLISH LANGUAGE.

This certifies that NICOLA LOUISE MOORE [redacted]
FULL NAME OF APPLICANT U.S. SOCIAL SECURITY NO. DATE OF BIRTH-MM/DD/YYYY

enrolled in Albert Einstein College of Medicine 1300 Morris Park Ave. Bronx, NY 10461
NAME OF MEDICAL SCHOOL LOCATION

on the 16th day of August, 1995 and was granted the following credits on enrollment:
MONTH YEAR

Advanced Credits: *Credits previously obtained at an approved medical, dental, or osteopathic school.**

MEDICAL SCHOOL TOTAL CREDITS DATES

The undersigned further certifies that the records of this institution show that the applicant attended in this institution 4 (NUMBER OF YEARS) years of resident instruction of 176 (NUMBER OF WEEKS) weeks each, completing at least 4,000 hours, of which at least 80 percent actual attendance is required, in the subjects set forth hereunder (Business and Professions Code Section 2089), and that the applicant:

☒ was granted the degree Bachelor/Doctor of Medicine by OR ☐ withdrew from

the above mentioned medical school on the 3rd day of June, 1999.
MONTH YEAR

Anatomy	Embryology	Physical Medicine
Otolaryngology	Histology	Therapeutics
Obstetrics and Gynecology	Human Sexuality as defined in Section 2090	Neuroanatomy
Radiology, including Radiation Safety	Medicine	Child Abuse Detection and Treatment
Tropical Medicine	Surgery, including Orthopedic Surgery	Geriatric Medicine
Physiology	Urology	Pediatrics
Biochemistry	Psychiatry	Pharmacology
Pathology, Bacteriology and Immunology	Neurology	Anesthesia
Ophthalmology	Alcoholism and Chemical Dependency	Spousal or Partner Abuse Detection & Treatment**
Dermatology	Preventive medicine, including Nutrition	Family Medicine***
		Pain Management and End-of-Life Care****

* Each school where professional medical instruction was received MUST complete one of these forms. If more than one school was attended, photocopies of this blank form may be made and used.
** ONLY applicable to medical students who enrolled in medical school on or after September 1, 1994.
*** ONLY applicable to medical students who graduate from medical school on or after May 1, 1998
**** Only applicable to medical students who enrolled in medical school on or after June 1, 2000.

MEDICAL SCHOOL SEAL MUST BE IMPRINTED BELOW.

ATTENTION MEDICAL SCHOOL: The person who signs this form MAY NOT be related to the applicant by blood, marriage or adoption.

Only the President, Dean, or Registrar may sign this form. If that signature authority is being delegated to another person, evidence of that delegation must be attached to this form (may be a photocopy). Such delegation must be on official letterhead and must be dated within the last 12 months.

Signed and the school seal affixed this 27th day of March, 2003.
MONTH YEAR

BY Lillian Lombardi
~~XXXXXXXXXXXX~~ REGISTRAR

L2

STATE OF CALIFORNIA — STATE AND CONSUMER SERVICES AGENCY GRAY DAVIS, Governor

MEDICAL BOARD OF CALIFORNIA

1426 Howe Avenue, Suite 54, Sacramento, CA 95825-3236
(916) 263-2499/FAX (916) 263-2487 Internet: www.medbd.ca.gov

CERTIFICATE OF COMPLETION OF ACGME/RCPSC POSTGRADUATE TRAINING

To be completed by the facility for every medical school graduate completing postgraduate training in the United States or Canada.

ATTENTION PROGRAM DIRECTORS AND DIRECTORS OF MEDICAL EDUCATION: THE PERSON WHO SIGNS THIS FORM MAY NOT BE RELATED TO THE APPLICANT BY BLOOD, MARRIAGE, OR ADOPTION. Only the Program Director and the Director of Medical Education may sign this form. If that signature authority is being delegated to another person, evidence of that delegation must be attached to this form (may be a photocopy). Such delegation must be on official letterhead and must be dated within the last 12 months.

PART 1: To be completed by the APPLICANT.

LAST NAME of Applicant: MOORE
First Name: NICOLA
Middle Initial: L

U.S. Social Security Number:
Date of Birth: MM/DD/YYYY
Telephone Number: Home Work:

Current Address:

City State Zip Code

PART 2: To be completed by the PROGRAM DIRECTOR.

ATTENTION PROGRAM DIRECTOR! ***Do not sign and date this form before the last day of any postgraduate training year which will be used by the applicant to qualify for licensure.*** **Completion of this form will certify that the individual named in PART 1 above completed a period of accredited postgraduate training at this facility. If a period of training WAS NOT completed in a satisfactory manner, please provide a separate detailed narrative explanation. The following information is provided to certify "satisfactory" completion. PLEASE SEE THE REVERSE FOR A DEFINITION OF "SATISFACTORY."**

Name of Facility: Univ. Rochester / Highland Hosp.
Address of Facility: 885 South Avenue

Name of Program Director: Stephen H. Sykes, MD
Telephone Number: (585) 442-7470

Signature of Program Director: [signature]
Date Signed: 3/13/03

List Categorical Specialty Area of Training Completed by Trainee: Family Practice
Date Training Commenced: 6/21/99
Date Training Completed: 9/22/02

If the training was rotating or transitional, list the specific rotations and the number of weeks spent in each (SEE THE REVERSE FOR INFORMATION ON SATISFYING THE GENERAL MEDICINE TRAINING REQUIREMENT):

PART 3: To be completed by the DIRECTOR OF MEDICAL EDUCATION and affixed with the official facility seal.

Name of the Director of Medical Education:
Name of Facility:

Address of Facility:

City State Zip Code Telephone Number: ( )

PART 4: Signature of DIRECTOR OF MEDICAL EDUCATION certifying satisfactory completion of training.

Attention: Director of Medical Education! *Do not sign and date this form before the last day of any postgraduate training year which will be used by the applicant to qualify for licensure. This form may be signed by the current Director of Medical Education; it does not need to be signed by the person who was the Director of Medical Education at the time of the training listed above.*

Notice to Applicant: If this form is used to verify postgraduate training beyond that which is required for licensure, this form can be signed by the Director of Medical Education and the Program Director before the final day of training. However, if you are licensed after the date upon which training was completed AND if the form was signed before the final day of the training year, a new form must be completed and submitted to the Medical Board of California.

HOSPITAL OR NOTARY SEAL

CHRISTINE BAIR
Notary Public, State of New York
No. 01BA6078413
Qualified in Monroe County
Commission Expires July 29, 20 06
[signature] Christine Bair

OFFICIAL HOSPITAL SEAL OR NOTARY SEAL, DATE AND SIGNATURE MUST BE AFFIXED IN THE BOX TO THE LEFT TO CERTIFY TRAINING.

I hereby declare under penalty of perjury under the laws of the State of California that the above statements are true and correct and that the training program is approved by the ACGME or the RCPSC to offer the type and level of training completed by the applicant and that the applicant was trained in an approved ACGME or RCPSC program position.

Signature of Director of Medical Education:
Date Signed:

L3A

STATE OF CALIFORNIA -- STATE AND CONSUMER SERVICES AGENCY ARNOLD SCHWARZENEGGER, Governor

MEDICAL BOARD OF CALIFORNIA
LICENSING PROGRAM
1426 Howe Avenue, Suite 54
Sacramento, CA 95825-3236
(916) 263-2382 FAX (916) 263-2487
www.medbd.ca.gov

CERTIFICATE OF COMPLETION OF ACGME/RCPSC POSTGRADUATE TRAINING

To be completed by the facility for every medical school graduate completing postgraduate training in the United States or Canada.

ATTENTION PROGRAM DIRECTORS AND DIRECTORS OF MEDICAL EDUCATION: THE PERSON WHO SIGNS THIS FORM MAY NOT BE RELATED TO THE APPLICANT BY BLOOD, MARRIAGE, OR ADOPTION. Only the Program Director and the Director of Medical Education may sign this form. If that signature authority is being delegated to another person, evidence of that delegation must be attached to this form (may be a photocopy). Such delegation must be on official letterhead and must be dated within the last 12 months.

PART 1: To be completed by the APPLICANT.

LAST NAME of Applicant	First Name	Middle Initial
MOORE	NICOLA	L

U.S. Social Security Number:	Date of Birth: MM/DD/YYYY	Telephone Number: Home: Work:
[redacted]	[redacted]	[redacted]

Current Address: [redacted]

City	State	Zip Code
[redacted]	[redacted]	[redacted]

PART 2: To be completed by the PROGRAM DIRECTOR.

ATTENTION PROGRAM DIRECTOR! *Do not sign and date this form before the last day of any postgraduate training year which will be used by the applicant to qualify for licensure.* Completion of this form will certify that the individual named in PART 1 above completed a period of accredited postgraduate training at this facility. If a period of training WAS NOT completed in a satisfactory manner, please provide a separate detailed narrative explanation. The following information is provided to certify "satisfactory" completion. PLEASE SEE THE REVERSE FOR A DEFINITION OF "SATISFACTORY."

Name of Facility:	Address of Facility:
UNIVERSITY OF ROCHESTER DEPT FAM MEDICINE	1000 SOUTH AVE, BOX 101, ROCH. NY 14620

Name of Program Director:	Telephone Number:
ERIC SCHAFF, MD	(585) 233 2124

Signature of Program Director:	Date Signed:
[signature]	8/13/04

List Categorical Specialty Area of Training Completed by Trainee:	Date Training Commenced:	Date Training Completed:
FAMILY PLANNING Fellowship	9/02	6/03

If the training was rotating or transitional, list the specific rotations and the number of weeks spent in each (SEE THE REVERSE FOR INFORMATION ON SATISFYING THE GENERAL MEDICINE TRAINING REQUIREMENT):

PART 3: To be completed by the DIRECTOR OF MEDICAL EDUCATION and affixed with the official facility seal.

Name of the Director of Medical Education:	Name of Facility:
Thomas L. Campbell, Professor + Chair	Dept. of Family Medicine University of Rochester

Address of Facility: 885 South Avenue

City	State	Zip Code	Telephone Number:
Rochester	NY	14620	(585) 442-7470

PART 4: Signature of DIRECTOR OF MEDICAL EDUCATION certifying satisfactory completion of training.

Attention: Director of Medical Education! *Do not sign and date this form before the last day of any postgraduate training year which will be used by the applicant to qualify for licensure. This form may be signed by the current Director of Medical Education; it does not need to be signed by the person who was the Director of Medical Education at the time of the training listed above.*

Notice to Applicant: If this form is used to verify postgraduate training beyond that which is required for licensure, this form can be signed by the Director of Medical Education and the Program Director before the final day of training. However, if you are licensed after the date upon which training was completed AND if the form was signed before the final day of the training year, a new form must be completed and submitted to the Medical Board of California.

HOSPITAL OR NOTARY SEAL

OFFICIAL HOSPITAL SEAL OR NOTARY SEAL, DATE AND SIGNATURE MUST BE AFFIXED IN THE BOX TO THE LEFT TO CERTIFY TRAINING.

I hereby declare under penalty of perjury under the laws of the State of California that the above statements are true and correct and that the training program is approved by the ACGME or the RCPSC to offer the type and level of training completed by the applicant and that the applicant was trained in an approved ACGME or RCPSC program position.

Signature of Director of Medical Education:	Date Signed:
[signature]	8/23/14

L3A

LICENSING PROGRAM
1426 Howe Avenue, Suite 54
Sacramento, CA 95825-3236
(916) 263-2382 FAX (916) 263-2487
www.medbd.ca.gov

Please **READ** all instructions prior to completing this application. ALL questions on this application must be answered, and all supporting documents must be submitted as per instructions. **Please type or print neatly. When space provided is insufficient, attach additional sheets of paper. All attachments are considered part of the application. FALSIFICATION OR MISREPRESENTATION OF ANY ITEM OR RESPONSE ON THIS APPLICATION OR ANY ATTACHMENT HERETO IS A SUFFICIENT BASIS FOR DENYING OR REVOKING A LICENSE.**

1. NAME: Last: MOORE | First: NICOLA | Middle: LOUISE

2. Other names you have used (include maiden name):

3. U.S. Social Security Number*

4A. (PUBLIC ADDRESS; will be released by the Board to the public): Number and Street/P.O. Box/Rural Route/Apartment Number, if any.

City | State | Zip Code | Country: USA

4B. (CONFIDENTIAL ADDRESS): Number and Street/Rural Route/Apartment Number, if any. [Applicants must provide a confidential street address if a P. O. Box is used as the Public Address in #4A above.]

City | State | Zip Code | Country: USA

5. Telephone Number:
Home:
Work:

6. California Driver's License Number (optional):
NUMBER | EXPIRATION

7. Date of Birth (Month/Day/Year) and **Place of Birth:**

8. Sex: ☐ Male ☒ Female

MBC USE ONLY — Personal Data

9. Have you ever been licensed to practice medicine in any state, territory, province, country, or U.S. federal jurisdiction? ☒ Yes ☐ No

IF YES, LIST THE JURISDICTION, LICENSE NUMBER, DATE ISSUED AND DATES OF PRACTICE IN THAT JURISDICTION. PLEASE INCLUDE PERMANENT, TEMPORARY, TRAINING, PROVISIONAL, LIMITED LICENSE, OR PERMIT. AN ORIGINAL OFFICIAL LETTER OF GOOD STANDING (LGS), OR COMPARABLE LICENSE HISTORY CERTIFICATION, IS REQUIRED FOR EACH PERMANENT, TEMPORARY, TRAINING, PROVISIONAL, LIMITED LICENSE, OR PERMIT OBTAINED IN ANY U.S. STATE, U.S. OR CANADIAN TERRITORY, CANADIAN PROVINCE, OR U.S. FEDERAL JURISDICTION. EACH LGS, OR COMPARABLE CERTIFICATION, SHOULD BE MAILED BY THE ISSUING AUTHORITY DIRECTLY TO THE MEDICAL BOARD OF CALIFORNIA.

Jurisdiction	License Number	Date of Issuance	Dates of Practice in that Jurisdiction
New York	219-226	09/14/00	7/99 - 9/03

MBC USE ONLY — License Data; LGS

10. Do you hold any other professional license in any state, territory, province, country, or U.S. federal jurisdiction? ☐ Yes ☒ No

IF YES: PROFESSION: ______, LICENSE NO.: ______, JURISDICTION: ______.

HAS THIS LICENSE EVER BEEN REVOKED, OR SUBJECT TO DISCIPLINE? IF YES, PLEASE PROVIDE ALL OFFICIAL DOCUMENTATION REGARDING THE MATTER IN ADDITION TO A WRITTEN EXPLANATION. YOU ARE ALSO REQUIRED TO REPORT ANY MATTER THAT IS PENDING OR IN WHICH CHARGES HAVE BEEN DROPPED OR EXPUNGED.

☐ Yes ☒ No

MBC USE ONLY — Other Professional Licenses

11A. Are you currently, or have you ever been, a participant in a postgraduate training program in a facility in the U.S. or Canada? (You must include every residency, internship, and fellowship, whether or not completed.) ☒ Yes ☐ No

IF YES, LIST NAMES AND ADDRESSES OF ALL FACILITIES. SUBMIT AN ORIGINAL CERTIFICATE OF COMPLETION OF ACGME/RCPSC POSTGRADUATE TRAINING (FORM L3A) FROM EACH FACILITY. (DO NOT COMPLETE FORM L3AS TO DOCUMENT TRAINING RECEIVED IN RESEARCH FELLOWSHIP PROGRAMS.) ALL TRAINING MUST BE LISTED, REGARDLESS OF WHETHER IT WAS SATISFACTORILY COMPLETED OR WILL BE USED TO MEET LICENSING REQUIREMENTS.

Facility Name	Address	Categorial Specialty Area	Dates of Attendance
Highland Hospital	1000 South Avenue Roch NY 14620	Family Medicine	6/99-9/02
Repro Heath, Fam Med	1000 South Ave Roch NY	Reproductive Health	9/02-6/03

MBC USE ONLY — Postgraduate Training

QUESTIONS 11B through 18B:
If you answer YES to any of the following questions, please provide ALL official documentation regarding the matter in addition to your written personal explanations. An applicant must provide official hearing/court documents and original letters of explanation from medical schools or training program directors. *If these documents are not provided with the application, they will be requested before review of the application can proceed.* APPLICANTS ARE REQUIRED TO REPORT ANY MATTER THAT IS PENDING OR IN WHICH CHARGES HAVE BEEN DROPPED OR EXPUNGED.

11B. Have you ever withdrawn from, or been suspended, dismissed or expelled from a medical school or postgraduate training program OR have you ever taken a leave of absence from such a school or program? Yes No

IF YOU ANSWERED YES, BOTH APPLICANT AND SCHOOL/PROGRAM MUST PROVIDE DETAILS ON A SEPARATE ATTACHMENT.

12. Has a claim or action for damages ever been filed against you in the course of the practice of medicine or any other healing art which resulted in a malpractice settlement, judgement, or arbitration award of over $30,000.00? Yes No

IF YOU ANSWERED YES, PROVIDE DETAILS ON A SEPARATE ATTACHMENT.

* MANDATORY DISCLOSURE OF U.S. SOCIAL SECURITY NUMBERS
Disclosure of your U.S. social security number is mandatory. Section 30 of the Business and Professions Code and Public Law 94-455 (42 USCA 405(c)(2)(C)) authorize collection of your social security number. Your social security number will be used exclusively for tax enforcement purposes, for purposes of compliance with any judgment or order for family support in accordance with Section 17520 of the Family Code, or for verification of licensure or examination status by a licensing or examination entity which utilizes a national examination and where licensure is reciprocal with the requesting state. If you fail to disclose your social security number your application for initial licensure will not be processed AND you will be reported to the Franchise Tax Board, which may assess a $100 penalty against you.

MBC USE ONLY
NY046
School Code

L8A

governmental entity.

13A. Have you ever been charged with, or been found to have committed, unprofessional conduct, professional incompetence, gross negligence, or repeated negligent acts or malpractice by any medical licensing board, other agency, or hospital?

13B. Has any disciplinary action ever been filed or taken, including but not limited to, informal or confidential discipline, consent orders, or letters of warning, regarding any healing arts license which you now hold or have ever held?

13C. Is any such action as described above pending?

IF YOU ANSWERED YES TO 13A, 13B OR 13C, PROVIDE DETAILS ON A SEPARATE ATTACHMENT.

13 (A) Yes No
13 (B) Yes No
13 (C) Yes No

14. Have you ever been denied a license, permission to practice medicine or any other healing art, or denied permission to take an examination in any state, territory, country, or U.S. federal jurisdiction, or is any such action pending?

IF YOU ANSWERED YES, PROVIDE DETAILS ON A SEPARATE ATTACHMENT.

Yes No

15. Have you ever voluntarily surrendered a license to practice medicine or any other healing arts in this or any other state, or voluntarily surrendered your narcotic (controlled substance) permit (state or federal) to any licensing board or any other agency, or is any such action pending?

IF YOU ANSWERED YES, PROVIDE DETAILS ON A SEPARATE ATTACHMENT.

Yes No

16. Have you ever had staff privileges in a hospital denied, suspended, limited, revoked, or not renewed for medical disciplinary cause, or resigned from a medical staff in lieu of disciplinary or administrative action, or is any such action pending?

YOU MUST DISCLOSE ANY INFORMAL OR CONFIDENTIAL DISCIPLINARY ACTION.

Yes No

17. Do you have any condition which in any way impairs or limits your ability to practice medicine with reasonable skill and safety, including but not limited to, any of the following?

Yes No

IF YES, PLEASE CHECK THE APPROPRIATE BOX(ES) BELOW:

- ☐ A condition which required admission to an inpatient psychiatric treatment facility.
- ☐ Alcohol or chemical substance dependency or addiction.
- ☐ Emotional, mental or behavioral disorder.
- ☐ Other (explain): ____________

FOR ANY OF THE BOXES CHECKED ABOVE, PLEASE SUBMIT COMPLETE OFFICIAL INPATIENT AND OUTPATIENT TREATMENT RECORDS, EVIDENCE OF ONGOING REHABILITATION TREATMENT, AND A PERSONAL WRITTEN EXPLANATION.

FOR ALL OF THE BELOW, YOU ARE REQUIRED TO LIST ANY CONVICTION THAT HAS BEEN SET ASIDE AND DISMISSED OR EXPUNGED, OR WHERE A STAY OF EXECUTION HAS BEEN ISSUED.

18A. Have you ever been convicted of, or pled nolo contendere to, ANY violation (include every misdemeanor or felony) of any local, state, or federal law of any state, territory, country, or U.S. federal jurisdiction?

18B. Is any criminal action related to the above pending?

IF YOU ANSWERED YES TO 18A OR 18B, PROVIDE DETAILS ON A SEPARATE ATTACHMENT.

18 (A) Yes No
18 (B) Yes No

License Data

STATE OF New York

COUNTY OF New York

The applicant, NICOLA LOUISE MOORE (PLEASE PRINT FULL NAME), ________ (DATE OF BIRTH), being first duly sworn upon his/her oath deposes and says: that I am the person herein named subscribing to this application; that I have read the complete application, know the full content thereof, and declare under penalty of perjury, that all of the information contained herein and evidence or other credentials submitted herewith are true and correct; that I am the lawful holder of the degree of Doctor of Medicine as prescribed by this application, that the same was procured in the regular course of instruction and examination, and that it, together with all the credentials submitted, were procured without fraud or misrepresentation or any mistake of which I am aware and that I am the lawful holder thereof. *Further, I hereby authorize all hospitals, institutions or organizations, my references, personal physicians, employers (past, present, and future), business and professional associates (past, present, and future), and all government agencies (local, state, federal, or foreign) to release to the Medical Board of California or its successors any information, files or records, including medical records, educational records, and records of psychiatric treatment and treatment for drug and/or alcohol abuse or dependency, requested by that Board in connection with this application; or any further or future investigation by that Board necessary to determine my medical competence, professional conduct, or physical or mental ability to safely engage in the practice of medicine. I further authorize the Medical Board of California or its successors to release to the organizations, individuals, or groups listed above any information which is material to this application or any subsequent licensure.* **I UNDERSTAND THAT FALSIFICATION OR MISREPRESENTATION OF ANY ITEM OR RESPONSE ON THIS APPLICATION OR ANY ATTACHMENT HERETO IS A SUFFICIENT BASIS FOR DENYING OR REVOKING A LICENSE.**

SIGNATURE OF APPLICANT: Nicola Louise Moore
(PLEASE SIGN FULL NAME, NOT INITIALS)

Signed and sworn to before me this 28th day of July (MONTH) 2004 (YEAR)

George Grossman
Notary Public State of NY
30-1587800
Certificate Filed In NY Cnty
2/28/08 Commission Expires

NOTARY SEAL

SIGNATURE OF NOTARY PUBLIC [signature]

ADDRESS

My commission expires 2/28/08

L8B

07A-43 (Revised 11/03)

Person Id : 1230286 **Name :** Moore,Nicola

Question	Answer
I Have Completed Cme And Can Document An Average Of 25 Hours Of Approved Cme Each Calendar Year Resulting In A Minimum Of 100 Hours Over The Last 4 Years.	YES
I Have Completed 12 Hours Of Pain Management And End-Of-Life Care (Must Be Completed By December 31, 2006).	YES
I Am Exempt From The Completion Of 12 Hours Of Pain Management And End-Of-Life Care Continuing Education Requirement Because I Am A Radiologist Or Pathologist.	NO
Only For General Internists And Family Physicians Who Have 25% Of Their Patient Population Aged 65 Years Or Older: I Have Completed At Least 20% Of The Required Cme In Geriatric Medicine Or The Care Of Older Patients. Click No If Not Applicable.	YES
Enter Name/Address Of Facility Where You Or Your Immediate Family Hold Financial Interest. Type "None", If None Held.	NONE
I Certify Under Penalty Of Perjury Under The Laws Of The State Of California That The Information Contained In This Application Is True And Correct.	YES
I Have Read My Profile On The Medical Board Web Site At Www.Medbd.Ca.Gov And Acknowledge The Information Contained Therein As Current And Accurate.	YES

Total Questions Asked For Person : 1230286 7

STATE DEPARTMENT OF CONSUMER AFFAIRS
INTERNET CASHIERING SYSTEM
MEDICAL BOARD OF CALIFORNIA
SUPPLEMENTAL INFORMATION REPORT

From Date: 09/20/2008 **To Date:** 09/20/2008

ATRISUPPINF

01-JUL-11 13:53:09

Person Id : 1230286 **Name :** Moore,Nicola

Question	Answer
I Have Completed Cme And Can Document An Average Of 25 Hours Of Approved Cme Each Calendar Year Resulting In A Minimum Of 100 Hours Over The Last 4 Years.	YES
I Have Read My Profile On The Medical Board Web Site At Www.Medbd.Ca.Gov And Acknowledge The Information Contained Therein As Current And Accurate.	YES
I Certify Under Penalty Of Perjury Under The Laws Of The State Of California That The Information Contained In This Application Is True And Correct.	YES
Enter Name/Address Of Facility Where You Or Your Immediate Family Hold Financial Interest. Type "None", If None Held.	NONE
Only For General Internists And Family Physicians Who Have 25% Of Their Patient Population Aged 65 Years Or Older: I Have Completed At Least 20% Of The Required Cme In Geriatric Medicine Or The Care Of Older Patients. Click No If Not Applicable.	YES
I Am Exempt From The Completion Of 12 Hours Of Pain Management And End-Of-Life Care Continuing Education Requirement Because I Am A Radiologist Or Pathologist.	NO
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Total Questions Asked For Person : 1230286 7