Fields of Opportunities

STATE OF IOWA

CHESTER J. CULVER
GOVERNOR
PATTY JUDGE
LT. GOVERNOR

IOWA BOARD OF MEDICINE
ANN E. MOWERY, Ph.D.
EXECUTIVE DIRECTOR

August 21, 2008

Nicola Louise Moore, M.D.
[redacted]

Dear Dr. Moore:

Congratulations! This is a letter of confirmation informing you that you have been issued license number **37992** with an effective date of **August 21, 2008**, authorizing you to practice medicine and surgery in the state of Iowa. This license will expire **December 1, 2009**. Enclosed you will find your certificate of license.

A renewal notice will be mailed to you 60 days prior to the expiration date. Please be aware that the renewal fee must be paid immediately. *Please keep this letter for proof of your expiration date as you will not receive a wallet sized card until you renew your license.*

Every practitioner who administers, prescribes, or dispenses any controlled substance must be registered under both state and federal controlled substance acts. For more information contact the Iowa Board of Pharmacy at (515) 281-5944.

Please contact this office should you need further verification, or have had any change of address. Notifying the Board promptly of an address change will ensure that information sent from this office will promptly reach you.

Sincerely,

Sylvia H. Crook
Licensing Specialist
Iowa Board of Medicine

cc: file

400 SW 8th STREET, SUITE C, DES MOINES, IA 50309-4686
PHONE:515-281-5171 FAX:515-242-5908 www.medicalboard.iowa.gov

Crook, Sylvia [IBM]

From: Crook, Sylvia [IBM]
Sent: Thursday, August 21, 2008 2:33 PM
To: [redacted]
Subject: Iowa Medical License
Importance: High

Dear Dr. Moore,

I am pleased to inform you that your permanent Iowa medical license has been issued. Please make note of the following information:

Iowa License # 37992
Original Issue Date: 8/21/08
Expiration Date: 12/01/09

Your expiration date is based on your birth month and birth year. You will always renew your license by the first day of your birth month, always in an even or odd numbered year depending on the year you were born. Fees and continuing education requirements will be prorated down accordingly for your first renewal to reflect a shorter than normal initial licensure period.

An official confirmation letter and wall certificate will be sent to you within the next two weeks. Please contact me with any questions, either by phone or e-mail. I am generally available Monday - Thursday, between the hours of 7:00 a.m. and 5:30 p.m.

Sylvia H. Crook
Licensing Specialist
Iowa Board of Medicine
400 S.W. 8th Street, Suite C
Des Moines, IA 50309-4686
(515) 281-5172 - phone
(515) 242-5908 - fax
e-mail address: sylvia.crook@iowa.gov

Application for Iowa Physician License
IOWA BOARD OF MEDICINE
400 S.W. 8th Street, Suite C, Des Moines, IA 50309-4686, (515)-281-6641

Section 1—Type of License
Indicate the type of license you are applying for below. If you have questions about the type of license you should apply for, call (515) 281-6641.

- [x] **Permanent License—$505 Application Fee**
This license allows an M.D. or D.O. to practice medicine and surgery or osteopathic medicine and surgery in Iowa.

- [ ] **Resident License—$205 Application Fee**
This license is for physicians who are entering a post-graduate training program in Iowa. A resident license restricts a physician's practice to the board-approved program listed in Section 15 of the application and is valid only for practice within that program under the supervision of a licensed physician.

- [ ] **Special License—$355 Application Fee**
This license is for physicians who do not meet qualifications for permanent licensure, but are held in high esteem for their unique contributions to medicine and are being appointed as a member of the academic staff at a college of medicine or osteopathic medicine. A special license restricts a physician's practice to the college of medicine or osteopathic medicine.

- [ ] **Temporary License—$255 Application Fee**
This license is for physicians who are participating in one of the following board approved activities. Temporary licensure is not meant to be used as a way for a physician to practice before permanent licensure is granted. It is not intended for locum tenens physicians. Indicate which board approved activity you will be participating in.

  - [ ] Covering for an Iowa licensed physician who unexpectedly is not available to provide medical care to his/her patients.
  - [ ] Demonstrating or proctoring that involves providing hands-on patient care to patients in Iowa.
  - [ ] Conducting a procedure on a patient in Iowa when the consultant's expertise in the procedure is greater than that of the Iowa-licensed physician who requested the procedure.
  - [ ] Providing medical care to patients in Iowa if the physician is enrolled in an out-of-state resident training program and does not hold a resident or permanent license in the home state of the resident training program.
  - [ ] Serving as a camp physician.
  - [ ] Participating as a learner in a program of further medical education that allows hands-on patient care when the physician does not currently hold a license in good standing in any United States jurisdiction.
  - [ ] Another activity approved by the Board.

- [ ] **Reinstatement of Inactive Iowa License—$555 Application Fee**
This process applies only to physicians who hold a permanent Iowa license that has been inactive for more than 12 months.

Applicant Name: Moore Nicola Louise

Section 2— Identifying Information

Complete every item. Enter your full legal name. Do not enter an initial for your middle name, unless an initial is your legal middle name. Licenses are issued in the physician's legal name. List other names you have used, such as a nickname or name that is used on the diploma, if different from your legal or maiden name. Describe any identifying marks, such as scars, birthmarks, or tattoos. An e-mail will be sent to the applicant's e-mail address and the other e-mail address listed after a review of the application is completed. The other e-mail address can be for the person assisting you with the application process.

Full Legal Name:

Last	First	Middle	Suffix
Moore	Nicola	Louise	

Other Name(s) Used: ☑ Check if Not Applicable

Maiden Name:

Current Home Address:
Street, City, State, Zip
(County– for Iowa addresses only) [redacted]

Home Phone: [redacted]

Current Work Address:
Street, City, State, Zip,
(County– for Iowa addresses only)
Boston Healthcare for the Homeless Program
729 Massachusetts Avenue
Boston, MA 02118

Work Phone: (857) 654-1000

Applicant E-mail: [redacted]

Other E-mail: [redacted]

Mailing/ Website Address: This address will be the address used for all correspondence from this office and will be displayed on our website with your license information.

☐ Work ☑ Home

Social Security Number: [redacted]

Privacy Act Notice: Disclosure of your Social Security Number on this license application is required by 42 U.S.C. Section 666(a)(13) and Iowa Code Section 252J.8(1). The number will be used in connection with the collection of child support obligations and as an internal means to accurately identify licensees, and may be shared with taxing authorities as allowed by law including Iowa Code Section 421.18.

Height: [redacted] **Weight:** [redacted] **Hair Color:** [redacted] **Eye Color:** [redacted]

Identifying Marks: ☑ Check if not applicable

U.S. Citizen? ☑ Yes ☐ No

If No, Visa Type or Alien Registration Number:

Section 3—Birth Information
Complete every item. Provide your date of birth in month/day/year format.

Date of Birth: December 30, 1955	**City of Birth:** London
State of Birth: England	**Country of Birth:** United Kingdom
Father's Full Name: [redacted]	
Mother's Full Name: [redacted]	

Section 4—Medical Education
List all medical schools you have attended, even those you did not graduate from. Provide an explanation below if 1) it took longer than five years or fewer than four years to complete your medical education, 2) had a break in your medical education, or 3) the end date of your education is different than the date of your degree.

033-020

Institution	City, State, Country	From (Mo/Yr)	To (Mo/Yr)
Albert Einstein College of Medicine	Bronx, N.Y., U.S.A.	08/95	06/99 5-99
		(all 6-27 email ph.)	

Degree Received: MD **Date of Degree (Mo/Yr):** 06/99

A copy of my diploma is submitted herewith. I further state that I am the identical person to whom this diploma was granted, that the same was procured in the regular course of study without fraud or misrepresentation and that the copy presented is a true copy.

Explanation:

If you are an international medical graduate, are you currently certified by the Educational Commission for Foreign Medical Graduates (ECFMG) or did you complete a Fifth Pathway Program?

ECFMG: ☐ Yes ☐ No **Fifth Pathway Program:** ☐ Yes ☐ No

Section 5—Post-Graduate Medical Training

List all post-graduate training programs you have attended in the United States or Canada, even those you did not complete. List internships, residencies, and fellowships separately. Applicants applying for a special or temporary license must also list post-graduate training programs attended outside the United States or Canada.

Name of Facility: University of Rochester Address: (Street, City, County, State, Zip) 777 South Clinton Avenue Rochester, N.Y. 14620	From (Mo/Yr) 06/99	To (Mo/Yr) 09/02
Type of Training: ○ Intern ◉ Resident ○ Chief Resident ○ Fellow ○ Research		
Program Specialty: Family Medicine		

Name of Facility: University of Rochester Address: (Street, City, County, State, Zip) 777 South Clinton Avenue Rochester, N.Y. 14620	From (Mo/Yr) 09/02	To (Mo/Yr) 06/03
Type of Training: ○ Intern ○ Resident ○ Chief Resident ◉ Fellow ○ Research		
Program Specialty: Family Planning		

Name of Facility: Address: (Street, City, County, State, Zip)	From (Mo/Yr)	To (Mo/Yr)
Type of Training: ○ Intern ○ Resident ○ Chief Resident ○ Fellow ○ Research		
Program Specialty:		

Name of Facility: Address: (Street, City, County, State, Zip)	From (Mo/Yr)	To (Mo/Yr)
Type of Training: ○ Intern ○ Resident ○ Chief Resident ○ Fellow ○ Research		
Program Specialty:		

Applicant Name:

Section 6—Chronology of Activities
Provide a chronological listing of all medical and non-medical activities from the date you entered medical school to the present date, with no gaps in time. Do not substitute a resume or a curriculum vitae for this section. Include exact nature, location, and time frame of each activity. For any non-working time, you must state on the form exactly what your activities were such as "vacation" or "seeking employment." Applicants may copy this page or attach additional sheets of paper, labeled with your name and signed by you, if more space is needed.

Activity	Location (City/State)	From (Mo/Yr)	To (Mo/Yr)
Medical School	Bronx, N.Y.	08/95	06/99
Residency	Rochester, N.Y.	06/99	09/02
medical leave during residency	Rochester, N.Y.	09/01	10/01
medical leave during residency	Rochester, N.Y.	02/02	03/02
Fellowship	Rochester, N.Y.	09/02	06/03
per diem work at residency site	Rochester, N.Y.	07/03	10/03
Work (volunteer) in Zimbabwe	Bulawayo, Zimbabwe	11/03	07/04
vacation	[redacted]	08/04	09/04
Work in Sudan	Ler, South Sudan	10/04	02/05
Study (tropical medicine)	Liverpool, England, U.K.	02/05	05/05
vacation	[redacted]	06/05	07/05
Work in Massachusetts	Provincetown, MA	08/05	12/05
Work in Zambia	Katete, Zambia	01/06	05/06
Work in Massachusetts	Provincetown, MA	06/06	09/06
vacation	[redacted]	10/06	10/06
Work in Zimbabwe	Bulawayo, Zimbabwe	11/06	01/08
caring for ill elderly mother	[redacted]	02/08	~~05/08~~ present
Work in Boston	Boston, MA	05/08	~~09/08~~ present

Applicant Name: Moore Nicola Louise

Section 7—Hospital Privileges

List hospitals where you were granted privileges within the last five years. Do not list hospital privileges that were granted to you as part of your post-graduate training program. Do not guess on the dates of your privileges; verify the dates with the facility prior to completing the application. You will be required to correct any incorrect dates.

☐ Not Applicable, check here if you have not held any hospital privileges that were not part of your training program.

Hospital Name	Address	From (Mo/Yr)	To (Mo/Yr)
Strong Memorial Hospital	601 Elmwood Ave, Rochester, NY	12/02 10-02	12/04 9-03 ✓
Highland Hospital	1000 South Ave, Rochester, NY	09/02 10-02	12/04 9-03 ✓
Beth Israel Deaconess MedCtr	330 Brookline Ave, Boston, MA	08/05	03/08 10-06 ✓
	(see attached 6-27 email jh		
	(see attached 7-17 email jh)		

Applicant Name: Moore Nicola Louise

Section 8— Medical/Osteopathic License Information

List all state and Canadian provinces where you currently hold or have held any type of medical/osteopathic license. Do not guess on the license number or original issue date of your license, verify the information with the licensing agency prior to completing the application. You will be requested to correct any incorrect information. Applicants applying for a special or temporary license must also list licenses held outside the United States or Canada.

☐ Not Applicable, check here if you have never held any medical/osteopathic licenses.

State/Country	License Number	Original Issue Date (Mo/Yr)	License Type (i.e. Training, Permanent)
Massachusetts, U.S.A.	223184	09/05 2-05	Permanent
New York, U.S.A.	219226	09/00	Permanent
California, U.S.A.	89646	12/04	Permanent
		(per 6-27 email. jb)	

1-17-08 email per date jb

Section 9— Other Professional License Information

List all state and Canadian provinces where you currently hold or have ever held any professional license, such as a chiropractic, nursing, or physician assistant license. Applicants applying for a special or temporary license must also list licenses held outside the United States or Canada.

☒ Not Applicable, check here if you have not held any other professional licenses.

State/Country	License Number	Original Issue Date (Mo/Yr)	License Type & Profession (i.e.Training/Nurse)

Section 10—Examination Information

Indicate the license examination you have taken. If you took a combination of examinations, indicate all that are applicable to your examination history. Applicants who took longer than seven years to pass the USMLE or COMLEX are required to be specialty board certified by a member board of the American Board of Medical Specialties or the American Osteopathic Association. Applicants who do not meet this rule will need to request a waiver of this licensure rule. Contact the Director of Licensure & Administration at (515) 281-6492 to discuss requesting a waiver of this rule.

☑	**USMLE**	**Did you pass Steps 1-3 within seven years?**	☑ **Yes**	☐ **No**
☐	**COMLEX**	**Did you pass Levels 1-3 within seven years**	☐ **Yes**	☐ **No**

☐ **NBME**

☐ **NBOME**

☐ **FLEX**

☐ **LMCC**

☐ **State Board Examination** **State:**

☐ **SPEX Examination within the last ten years**

☐ **Not Applicable**

Section 11—Practice Information

List your proposed Iowa practice or proposed post-graduate training location. If it is unknown, please explain. Indicate if you are specialty board certified by an American Board of Medical Specialties (ABMS) or American Osteopathic Association (AOA) specialty board. If you are applying for a temporary or special license, list the specialties for which you are certified and indicate in which country.

Proposed Iowa Practice or Proposed Post-Graduate Training Program Address:
(Institution/Group, Street, City, State, Zip Code)

Council Bluffs Center
Planned Parenthood of Nebraska and Council Bluffs, Inc.
1604 Second Avenue
Council Bluffs, IA 51501

Are you ABMS specialty board certified?	◉ Yes	○ No
Are you AOA specialty board certified?	○ Yes	○ No
Are you specialty certified in another country?	○ Yes	○ No

Specialty:	**Date Certified:**	**Country:**
1. Family Practice	1. 08/2004	1. U.S.A.
2.	2.	2.
3.	3.	3.

Applicant Name: Moore Nicola Louise

Section 12— Question Definitions
It is important to review the definitions below before answering the questions in this section.

"Ability to practice medicine with reasonable skill and safely" means all of the following: The cognitive capacity to make appropriate clinical diagnoses, to exercise reasoned medical judgments and to learn and keep abreast of medical developments; The ability to communicate medical judgments and information to patients and other health care providers; and The capability to perform medical tasks such as physical examinations and surgical procedures, with or without the use of aids or devices.

"Medical condition" means any physiological, mental or psychological condition, impairment or disorder, including drug addiction and alcoholism.

"Chemical substances" means alcohol, legal and illegal drugs or medications, including those taken pursuant to a valid prescription for legitimate medical purposes and in accordance with the prescriber's direction, as well as those used illegally.

"Currently" The medical condition has had an ongoing or adverse impact on the ability to function and practice.

"Improper use of drugs or other chemical substances" means all of the following: The use of any controlled drug, legend drug or other chemical substance for any purpose other than as directed by a licensed health care practitioner; and the use of any substance, including, but not limited to, petroleum products, adhesive products, nitrous oxide and other chemical substances for mood enhancement.

"Illegal use of drugs or other chemical substances" means the manufacture, possession, distribution or use of any chemical substances prohibited by law (e.g. heroin).

Iowa Physician Health Program (IPHP)

The IPHP is a confidential, voluntary program offered to physicians who may be dealing with impairment issues, such as, but not limited to alcohol or drug abuse, dependency or addiction, neuropsychiatric disorder, or physical disability. The IPHP develops an individualized program for each physician, with the goal of allowing the physician to continue to practice with reasonable skill and safety. Oftentimes, the Licensure Committee of the Board will refer physicians with impairment issues to the IPHP for review and bases licensure decisions on its recommendations.

To self-report to the IPHP or obtain additional information, contact the Coordinator of IPHP at 515-281-6491.

Section 12—Questions

Respond "yes" or "no" to each item. The Board expects full disclosure of events, whether you consider them to be minor or major in nature. It is better to disclose information than to not disclose it.

For every "yes" response, you must provide a separate statement of explanation that is signed and dated. This statement must include full details, including dates, locations, actions, organizations or parties involved. You must also provide the requested supporting documentation. The Board may request additional supporting information, if needed.

A criminal background check packet will be sent to your home address after your application has been submitted. Your answer to question #6 of the application and the question on the background check waiver should contain the same information. Discrepancies between the application and the criminal background check waiver could result in disciplinary action. Some states have court records available online, which you may want to review if you are unsure how to answer this question. Iowa's court record website is www.iowacourts.state.ia.us.

Applicants must answer all questions. Current IPHP participants, may answer "No" to questions 1 through 5.

Yes	No	
○	◉	1. Do you currently have a medical condition which in any way impairs or limits your ability to practice medicine with reasonable skill and safety? **If yes**, provide a description of your condition and submit the "Verification of Medical Condition" form which is to be completed by your treating physician(s).
○	◉	2. Are you receiving ongoing treatment or participating in a monitoring program that reduces or eliminates the limitations or impairments caused by either your medical condition or use of alcohol, drugs, or other chemical substances? **If yes**, provide details of your treatment or program, copies of treatment evaluations, statement from the program indicating your progress and practice recommendations.
○	◉	3. Does your field of practice, or the setting or the manner in which you have chosen to practice medicine, reduce or eliminate the limitations or impairments caused by your medical condition or use of alcohol, drugs or other chemical substances? **If yes**, provide a description of your practice and how it has changed since the diagnosis of your medical condition.
○	◉	4. Are you currently engaged in the illegal or improper use of drugs or other chemical substance? **If yes**, provide an explanation.
○	◉	5. Does your current use of alcohol, drugs or other chemical substances in any way impair or limit your ability to practice medicine with reasonable skill and safety? **If yes**, explain your current usage and how this impairs your ability to practice.

Yes	No	
○	⊙	6. Have you ever been convicted of, or entered a plea of guilty, nolo contendere, or no contest to a crime other than a minor traffic offense, in any jurisdiction? You must include all misdemeanors and felonies, even if adjudication was withheld by the court so that you would not have a record of conviction. (For example, you must report if your conviction was expunged, you received a deferred judgment, or you received an executive pardon.) Driving under the influence or driving while impaired is not a minor traffic offense. **If yes**, provide details of the charge and the final outcome. Provide copies of any court/legal documents related to each incident.
○	⊙	7. During medical school, were you ever terminated, requested to withdraw, or placed on probation? **If yes**, provide an explanation.
○	⊙	8. Have you ever received a certificate of non-compliance from the College Student Aid Commission regarding non-payment of a student loan? **If yes**, provide an explanation.
○	⊙	9. Have you ever been terminated, asked to withdraw, or asked to repeat a portion of an internship, residency, or fellowship? **If yes**, provide an explanation.
○	⊙	10. Have you ever received a warning or reprimand, been asked to participate in remediation or been placed on probation during an internship, residency or fellowship program? **If yes**, provide an explanation.
⊙	○	11. Have you ever taken a leave of absence for any reason (maternity, family, personal, financial) during your medical school education, internship, residency, or fellowship? **If yes**, provide an explanation.
○	⊙	12. Have you ever been denied a license to practice medicine or a license to practice another profession? **If yes**, provide an explanation and a copy of the notice of denial.
○	⊙	13. Have you ever surrendered any professional license for any reason? **If yes**, provide an explanation and a copy of all official documents relating to the surrender.
○	○	13a. If yes, was a license disciplinary action pending against you or were you under investigation by a professional licensing agency at the time you surrendered the license? **If yes**, provide an explanation and a copy of all related official documents.
○	⊙	14. Have you ever been denied a Drug Enforcement Administration (DEA) or state controlled substance registration certificate? **If yes**, provide an explanation and a copy of the notice of denial.

Yes	No	
○	⊙	15. Have you ever surrendered your state or controlled substances registration or had it restricted in any way? **If yes,** provide an explanation and a copy of all official documents relating to this.
○	⊙	16. Aside from ordinary initial requirements of proctorship, have you had your clinical privileges or medical staff status at any hospital or health care entity, nursing facility, clinic, or other professional health care organization ever been limited, suspended, revoked, not renewed, voluntarily relinquished, denied, or subject to other disciplinary or probationary conditions? **If yes,** provide an explanation and a copy of all related official documents.
○	⊙	17. Have you ever been terminated, sanctioned, penalized, had to repay monies to or been denied provider participation in any Medicaid, Medicare or other publicly funded healthcare program? **If yes,** provide an explanation and a copy of all related official documents.
○	⊙	18. Have you ever been denied membership or renewal or been subject to any disciplinary action, sanction or warning in any medical or osteopathic organization or professional society? **If yes,** provide an explanation and a copy of all related official documents.
○	⊙	19. Have you ever been investigated or subject to an inquiry/review by any professional licensing agency, including investigations or reviews which resulted in no formal action? (Answer "Yes" if you have ever been contacted by an investigator or Board agent to review a complaint or report filed against you.) **If yes,** provide an explanation of the inquiry, including dates, state, charges, final outcome and a copy of all related official documents
○	⊙	20. Has any jurisdiction of the U.S. or other nation ever limited, restricted, warned, censured, placed on probation, suspended, revoked or filed charges against any license you held? **If yes,** provide an explanation and a copy of all related official documents.
○	⊙	21. Are you in violation of any child support order or written agreement to pay child support? **If yes,** provide an explanation.
○	⊙	22. Have any professional liability suits ever been filed against you? **If yes,** complete the attached Professional Liability Suit Information form along with a copy of the requested legal documents listed on that form.
○	⊙	23. Have any judgments or settlements been paid on your behalf as a result of a professional liability case? **If yes,** complete the attached Professional Liability Suit Information form along with a copy of the requested legal documents listed on that form.

Section 13— Affidavit of Applicant

Enter the state and county in which the affidavit is being notarized. Sign the affidavit in the presence of a notary. The notary must supply the jurisdiction at the beginning of the affidavit, sign, enter the date of the notarization, and the expiration date of his/her commission. Attach a recent photo of yourself that has been taken within the last 90 days.

State of: MASSACHUSETTS **County of:** Middlesex

I, NICOLA LOUISE MOORE

hereby swear or affirm, under penalty of perjury, that I am the person described and identified; that the attached photo is a true likeness of myself; that I am the person named in the diploma which accompanies this application; that I am the lawful holder of said diploma; that said diploma was procured in the regular course of instruction and examination without fraud or misrepresentation.

I certify that I have carefully read the questions on this application and have answered them completely and truthfully. I declare under penalty of perjury that my answers, and all other statements or information submitted by me in this application process, are true and correct. If it is determined at any time that I have provided misleading or false information on or in support of this application, I understand that my application may be denied or that I may be subject to disciplinary action and criminal prosecution if I am already licensed.

I understand that I am required to update answers or information submitted with this application if the response or the information changes during the time period the application is pending. I also understand that this application is a public record in accordance with Iowa Code chapter 22 and that application information is public information, subject to the exceptions contained in Iowa law. Finally, in submitting this application, I consent to any reasonable inquiry that may be necessary to verify the information I have provided on or in conjunction with this application.

I also declare, under penalty of perjury, that if I did not personally complete the foregoing application that I have fully read and confirmed each question and accompanying answer and take full responsibility for all answers contained in this application.

Nicola Louise Moore

Signature of Applicant

Susan Daley Susan Daley

Signature of Notary Public

May 13, 2008

Sworn/Affirmed to before me on

proved to me by my license

10-01-2010

My commission expires:

SUSAN D. DALEY
Notary Public
Commonwealth of Massachusetts
My Commission Expires Oct 1, 2010

Notary Seal or Stamp

[redacted]

Office Use Only	
License Number:	37992
Issue Date:	8/21/08
Expiration Date:	12/01/09
Initials:	SM

Applicant Name: Moore Nicola Louise

SUSAN D. DALEY
Notary Public
Commonwealth of Massachusetts
My Commission Expires Oct 1, 2010

Section 12 – Questions:

Question #11. Have you ever taken a leave of absence for any reason (maternity, family, personal, financial) during your medical school education, internship, residency, or fellowship? **If yes,** provide an explanation.

Explanation re: Question #11

I was a resident in Family Medicine at the University of Rochester from 6/99 to 9/02. During my residency, I twice had surgery: a resection for colon cancer in August, 2001 and for bowel obstruction from adhesions associated with the initial resection in March 2002. These surgeries were associated with sick leave of approximately 12 weeks in total. Hence, my completion of residency was delayed from the normal June date to September of 2002.

Mirtha Louise Moore 5/15/08

Iowa Board of Medicine
400 SW 8th Street, Suite C, Des Moines, IA 50309-4686
(515) 281-6641 www.medicalboard.iowa.gov

Verification of Medical Condition

Applicant: You are required to provide a statement explaining any medical condition you have experienced that has had an ongoing or adverse impact on your ability to function and practice. Physicians who had a condition that interrupted their education or training should also complete this form.

The physician who diagnosed and provides, or provided, treatment for the condition should complete the form.

Treating Physician: Complete and mail the form directly to the Iowa Board of Medicine. This form is also on our website as a pdf document which can be completed using the computer and printing the document. The applicant's signature on page three of this form authorizes the release of information, favorable or otherwise, directly to the Board.

Applicant's Name (Print Legibly): NICOLA LOUISE MOORE

Applicant's Date of Birth (Month/Day/Year): 12/30/55

Nature of Medical Condition (include specific diagnosis):

Surgery for colonic polyp.

Summary of Treatment:

1) Colon resection 8/6/2001
2) Lysis of adhesions 3/14/2002

Treatment Period: From 8/2/2001 **To** 6/20/2002

Recommended Treatment: periodic colonoscopy.

Is/Was the applicant in compliance with his/her treatment? **Yes** ☒ **No** ☐
If no, please explain.

Is the applicant taking any prescribed medications for this condition? Yes ☐ No ☒
If yes, please list the medication(s).

Provide a summary of other prescription medications this applicant is taking.

none

Has this medical condition in any way affected the applicant's ability to practice medicine with reasonable skill and safety? Yes ☐ No ☒
If yes, please explain.

Do any limitations need to be in place with regard to the applicant's practice of medicine?
Yes ☐ No ☒
If yes, please explain.

If treatment were to cease for any reason, could the applicant's condition in any way affect his/her ability to practice medicine with reasonable skill and safety? Yes ☐ No ☒
If yes, please explain.

Is ongoing monitoring warranted? Yes ☐ No ☒
If yes, please explain.

Treating Physician Information:

Name (print legibly): L. O. SCHOENIGER MD

Signature: [signature] **Date:**

Address: 601 ELMWOOD AVE ROCHESTER NY 14642

Phone: 585 273-4713 **Fax:** 273-

Authorization for Release of Information-Verification of Medical Condition

The applicant must sign this form and submit it with the Verification of Medical Condition form. The treating physician may retain this release of information for his/her own records.

I, NICOLA LOUISE MOORE (print name), do hereby authorize a disclosure of records concerning myself to the Iowa Board of Medicine (IBM). This release includes records of a public, private or confidential nature.

I acknowledge that the information released to the IBM may include material that is protected by federal and/or state laws applicable to substance abuse and mental health information. If applicable, I specifically authorize the release of confidential information to and from the IBM relating to substance abuse or dependence and/or mental health.

I further agree that the IBM may receive confidential information and records, including, but not limited to the following records:

- Medical Records
- Education Records
- Personnel or employment records, including records of any remedial, probationary, disciplinary, or any other adverse information contained in those records.
- Post-graduate training (internship, residency, & fellowship) records, including records of any remedial, probationary, disciplinary, or any other adverse information contained in those records.
- Any information the IBM deems reasonably necessary for the purposes set forth in this release.

Release of Liability. I do hereby irrevocably and unconditionally release, covenant not to sue, and forever discharge any person or entity, including but not limited to any medical school, residency or fellowship training program, hospital, health care provider, health care facility, licensing board, impaired practitioner program, agency, or organization, which releases information to the IBM pursuant to this release from any liability, claim, or cause of action arising out of the release of such information. I further irrevocably and unconditionally release, covenant not to sue, and forever discharge the IBM, the State of Iowa, and its employees and agents from any liability, claim, or cause of action arising out of the collection or release of information pursuant to this release.

A photocopy of this release form will be valid as an original thereof, even though the photocopy does not contain an original writing of my signature.

This authorization is valid until completion of the licensure process. I understand I have the right to revoke this authorization in writing, except to the extent that the IBM has already taken action in reliance upon this consent.

I have read and fully understand the contents of this "Authorization to Release Information."

Nicola Louise Moore — Signature of Physician

5/14/08 — Date

PROHIBITION ON REDISCLOSURE

This form does not authorize redisclosure of medical information beyond the limits of this consent. Where information has been disclosed from records protected by federal law for alcohol/drug abuse records or by state law for mental health records, federal requirements (42 C.F.R. Part 2) and state requirements (Iowa Code Ch. 228) prohibit further disclosure without the specific written consent of the patient except as otherwise permitted by such law and/or regulations. A general authorization for the release of medical or other information is not sufficient for these purposes. Civil and/or criminal penalties may attach for unauthorized disclosure of alcohol/drug abuse or mental health information.

Iowa Board of Medicine
400 SW 8th Street, Suite C, Des Moines, IA 50309-4686
(515) 281-6641 www.medicalboard.iowa.gov

Post-Graduate Training Verification

Applicant: Submit this form to each training program where you were enrolled in an internship, residency, or fellowship to complete this form. Complete the top portion and page two of the form only and submit the form to the training program(s).

Program: Complete and mail the completed form directly from the training program to the Iowa Board of Medicine. Any processing fees are the applicant's responsibility. Programs where the applicant is a current resident must mail this form separate from the application.

Applicant's Name (Print Legibly): NICOLA LOUISE MOORE

Applicant's Date of Birth (Month/Day/Year): 12/30/55

It is hereby certified that NICOLA LOUISE MOORE (Name of Applicant)

received post-graduate training at University of Rochester/Department of Family Medicine Highland Hospital (Name of Program/Facility)

located at 1381 South Avenue, Rochester, NY 14620 USA (Address, City, State, Zip, Country)

From 09/02 (Month/Year) To 06/03 (Month/Year) Program Specialty: Reproductive Health

Type of Training Program (select one):

Internship ____ Resident ____ Chief Resident ____ Fellowship X Research ____

Did the applicant complete all required years of the post-graduate training program?

Yes X No ____ (explain) Anticipated date of completion ____

Was the program accredited by the ACGME, AOA, RCPSC, or CFPC when the applicant attended?

Yes ____ No X

Was any disciplinary action ever taken against the applicant? Yes ____ No X
If yes, provide details of the disciplinary action and a copy of any documentation related to the event.

Is there any derogatory* information on file? Yes ____ No X
If yes, provide details of the derogatory information and a copy of any documentation related to the event.
*Derogatory information can include probation, investigation, remediation, and/or other disciplinary actions.

Institutional Seal

If the institution does not have an official seal, the form must be notarized.

Completed by the Program Director, Program Coordinator, or Graduate Medical Education Representative:

Print Name: SUSAN M. GARDNER, PROGRAM COORDINATOR

Signature: Susan M. Gardner

Date (month/day/year): 06/09/08 Phone: 585-506-9484 x128

Fax: 585-473-2245 E-mail: susan_gardner@urmc.rochester.edu

Note: Attaching letter from Eric Schaff, MD showing support during his time as director

UNIVERSITY OF
ROCHESTER
MEDICAL CENTER

DEPARTMENT OF FAMILY MEDICINE
AT HIGHLAND HOSPITAL

August 13, 2004

Medical Board of California
Licensing Program
1426 Howe Avenue, Suite 54
Sacramento, CA 95825-3236

RE: Nicola Moore, MD [redacted]) (ATS# 149806)

To Whom It May Concern:

This is a strong letter of support for Nicola Moore, MD, for a California license to practice medicine. Dr. Moore was a Family Planning Clinical and Research Fellow at the Reproductive Health Program at the University of Rochester, Department of Family Medicine from 9/02 to 6/03. She began her fellowship upon completion of her residency in Family Medicine in 9/02. Her non-traditional start date for the fellowship was due to medical problems during her residency which were associated with three months of medical leave, and hence, a three-month delay in completing residency.

Dr. Moore was an exemplary fellow with excellent knowledge and experience. She currently holds an appointment as an instructor in the Department of Family Medicine at the University of Rochester.

I strongly support her license in California. If I can be of further assistance, please let me know.

Sincerely,

Eric Schaff, MD
Professor of Family Medicine, of Pediatrics, and of Obstetrics and Gynecology
University of Rochester School of Medicine

Reproductive Health Program
Highland Hospital
1000 South Avenue, Box 101
Rochester, New York 14620
(585) 271-1206 Fax: (585) 271-9055

06-17-08A10:24 RCVD 5/27

Iowa Board of Medicine
400 SW 8th Street, Suite C, Des Moines, IA 50309-4686
(515) 281-6641 www.medicalboard.iowa.gov

Certification of Medical Education

Applicant: The board requires each medical school where you received all or part of your medical education to complete this form and attach an official transcript of your education. Complete the top portion and page two of the form only and submit the form to the medical school(s).

School: Complete this form, attach an official transcript of the applicant's education, and mail the completed form directly from the medical school to the **Iowa Board of Medicine.** A translation of any transcript not in English is also required. Any processing fees are the applicant's responsibility.

Applicant's Name (Print Legibly): NICOLA LOUISE MOORE

Applicant's Date of Birth (Month/Day/Year): 12/30/1955

It is hereby certified that Nicola L. Moore
(Name of Applicant)

received their medical education at Albert Einstein College of Medicine of Yeshiva University
(Name of School)

located at 1300 Morris Park Avenue, Bronx, NY 10461
(Address, City, State, Zip, Country)

From 08/16/1995 (Month/Year) To 05/24/1999 (Month/Year) Date Diploma Received 06/03/1999 (Month/Year)

Granted a diploma with the degree of DOCTOR of Medicine

Was the school accredited by the Liaison Committee of Medical Education or the American Osteopathic Association at the time the applicant graduated?

Yes XXX No _____ Not Applicable _____

Is the above school name different from when the applicant attended? Yes _____ No XXX

List previous school name: _____

Any disciplinary action or derogatory information on file? Yes _____ No XXX
If yes, provide a copy of documentation related to the action or information.

Institutional Seal

If the institution does not have an official seal, the form must be notarized.

Completed by the [redacted] Registrar:

Print Name: Sarifa Switzer

Signature: Sarifa Switzer

Date (month/day/year): 06/11/08 Phone: (718) 430-2102

Fax: (718) 430-8840 E-mail: sswitzer@aecom.yu.edu

06-17-08A10:24 RC

Authorization for Release of Information—Certification of Medical Education

The applicant must sign this form and submit it with the Certification of Medical Education. The medical school may retain this release of information for their own records.

I, NICOLA LOUISE MOORE (print name), do hereby authorize a disclosure of records concerning myself to the Iowa Board of Medicine (IBM). This release includes records of a public, private or confidential nature.

I acknowledge that the information released to the IBM may include material that is protected by federal and/or state laws applicable to substance abuse and mental health information. If applicable, I specifically authorize the release of confidential information to and from the IBM relating to substance abuse or dependence and/or mental health.

I further agree that the IBM may receive confidential information and records, including, but not limited to the following records:

- Medical Records
- Education Records
- Personnel or employment records, including records of any remedial, probationary, disciplinary, or any other adverse information contained in those records.
- Post-graduate training (internship, residency, & fellowship) records, including records of any remedial, probationary, disciplinary, or any other adverse information contained in those records.
- Any information the IBM deems reasonably necessary for the purposes set forth in this release.

Release of Liability. I do hereby irrevocably and unconditionally release, covenant not to sue, and forever discharge any person or entity, including but not limited to any medical school, residency or fellowship training program, hospital, health care provider, health care facility, licensing board, impaired practitioner program, agency, or organization, which releases information to the IBM pursuant to this release from any liability, claim, or cause of action arising out of the release of such information. I further irrevocably and unconditionally release, covenant not to sue, and forever discharge the IBM, the State of Iowa, and its employees and agents from any liability, claim, or cause of action arising out of the collection or release of information pursuant to this release.

A photocopy of this release form will be valid as an original thereof, even though the photocopy does not contain an original writing of my signature.

This authorization is valid until completion of the licensure process. I understand I have the right to revoke this authorization in writing, except to the extent that the IBM has already taken action in reliance upon this consent.

I have read and fully understand the contents of this "Authorization to Release Information."

Nicola Louise Moore — Signature of Physician

5/15/08 — Date

PROHIBITION ON REDISCLOSURE

This form does not authorize redisclosure of medical information beyond the limits of this consent. Where information has been disclosed from records protected by federal law for alcohol/drug abuse records or by state law for mental health records, federal requirements (42 C.F.R. Part 2) and state requirements (Iowa Code Ch. 228) prohibit further disclosure without the specific written consent of the patient except as otherwise permitted by such law and/or regulations. A general authorization for the release of medical or other information is not sufficient for these purposes. Civil and/or criminal penalties may attach for unauthorized disclosure of alcohol/drug abuse or mental health information.

YESHIVA UNIVERSITY

IN RECOGNITION OF THE SATISFACTORY FULFILLMENT
OF THE REQUIRED COURSE OF STUDY AT THE

ALBERT EINSTEIN COLLEGE OF MEDICINE

AND UPON THE RECOMMENDATION OF THE FACULTY,
THE TRUSTEES OF YESHIVA UNIVERSITY BY VIRTUE OF THE
AUTHORITY VESTED IN THEM HAVE CONFERRED UPON

NICOLA LOUISE MOORE

THE DEGREE OF

DOCTOR OF MEDICINE

WITH ALL THE RIGHTS, PRIVILEGES, AND HONORS THEREUNTO PERTAINING
IN TESTIMONY WHEREOF THIS DIPLOMA IS GRANTED IN THE CITY OF
NEW YORK ON THE THIRD DAY OF JUNE, 1999.

CHAIRMAN, BOARD OF TRUSTEES

CHAIRMAN, BOARD OF OVERSEERS

PRESIDENT

VICE PRESIDENT FOR MEDICAL AFFAIRS AND DEAN

5-27

Iowa Board of Medicine
400 SW 8th Street, Suite C, Des Moines, IA 50309-4686
(515) 281-6641 www.medicalboard.iowa.gov

06-23-08 02:15 RCVD

Post-Graduate Training Verification

Applicant: Submit this form to each training program where you were enrolled in an internship, residency, or fellowship to complete this form. Complete the top portion and page two of the form only and submit the form to the training program(s).

Program: Complete and mail the completed form directly from the training program to the Iowa Board of Medicine. Any processing fees are the applicant's responsibility. Programs where the applicant is a current resident must mail this form separate from the application.

Applicant's Name (Print Legibly): NICOLA LOUISE MOORE

Applicant's Date of Birth (Month/Day/Year): 12/30/55

It is hereby certified that Nicola Louise Moore
(Name of Applicant)

received post-graduate training at Univ. Rochester/Highland Hosp
(Name of Program/Facility)

located at 777 S. Clinton Avenue
(Address, City, State, Zip, Country)

From 6/1/99 (Month/Year) To 9/22/02 (Month/Year) Program Specialty: Family Practice

Type of Training Program (select one):
Internship ____ Resident ✓ Chief Resident ____ Fellowship ____ Research ____

Did the applicant complete all required years of the post-graduate training program?
Yes ✓ No ____ (explain) ____ Anticipated date of completion ____

Was the program accredited by the ACGME, AOA, RCPSC, or CFPC when the applicant attended?
Yes ✓ No ____

Was any disciplinary action ever taken against the applicant? Yes ____ No ✓
If yes, provide details of the disciplinary action and a copy of any documentation related to the event.

Is there any derogatory* information on file? Yes ____ No ✓
If yes, provide details of the derogatory information and a copy of any documentation related to the event.
*Derogatory information can include probation, investigation, remediation, and/or other disciplinary actions.

Institutional Seal

If the institution does not have an official seal, the form must be notarized.

Completed by the Program Director, Program Coordinator, or Graduate Medical Education Representative:

Print Name: Laurie Donohue MD

Signature: [signature]

Date (month/day/year): 6/10/08 Phone: 585-279-4830

Fax: 585-442-8319 E-mail: laurie_donohue@urmc.rochester.edu

Iowa Board of Medicine
400 SW 8th Street, Suite C, Des Moines, IA 50309-4686
(515) 281-6641 www.medicalboard.iowa.gov

Hospital Privilege Verification

Applicant: Submit this form to each hospital where you held privileges within the last five years. Complete the top portion and page two of the form only and submit the form to the hospital.

Hospital: Complete and mail the form directly from the hospital to the Iowa Board of Medicine. Any processing fees are the applicant's responsibility.

Applicant's Name (Print Legibly): NICOLA LOUISE MOORE
Applicant's Date of Birth (Month/Day/Year): 12/30/55

It is hereby certified that NICOLA LOUISE MOORE
(Name of Applicant)

had hospital privileges at Strong Memorial Hospital (Pediatrics)
(Name of Hospital)

located at 601 Elmwood Ave, Rochester, NY 14642
(Address, City, State, Zip, Country)

From 10/02 (Month/Year) To 9/03 (Month/Year)

Was any disciplinary action ever taken against the applicant?
Yes_____ No X
If yes, provide details of the disciplinary action and a copy of any documentation related to the event.

Is there any derogatory* information on file?
Yes_____ No X
If yes, provide details of the derogatory information and a copy of any documentation related to the event.
*Derogatory information can include probation, investigation, remediation, and/or other disciplinary actions.

Institutional Seal

If the institution does not have an official seal, the form must be notarized.

Completed by the Medical Staff Office:
Print Name: Jamaia Green
Signature: Jamaia G
Date (month/day/year): 7/16/08 Phone: 784-8822
Fax: 784-8867 E-mail: _____

UNIVERSITY of ROCHESTER MEDICAL CENTER

FAX COVER SHEET

Medical Staff Office

Internal Address: 601 Elmwood Ave, Box 612, Rochester, NY 14642
Actual Address: 135 Corporate Woods, Suite 130, Rochester, NY 14623
Phone: (585) 784-8822
Fax: (585) 784-9367

To: Iowa Board
Judy Hojati

From: Tammy Green
Medical Staff Office

Fax: (515)281-8641

Pages: 2

Phone:

Date: 7/16/08

Re: Hospital Affiliation or Claim History

Message:

5-12

Iowa Board of Medicine
400 SW 8th Street, Suite C, Des Moines, IA 50309-4686
(515) 281-6641 www.medicalboard.iowa.gov

Hospital Privilege Verification

Applicant: Submit this form to each hospital where you held privileges within the last five years. Complete the top portion and page two of the form only and submit the form to the hospital.

Hospital: Complete and mail the form directly from the hospital to the Iowa Board of Medicine. Any processing fees are the applicant's responsibility.

Applicant's Name (Print Legibly): NICOLA LOUISE MOORE

Applicant's Date of Birth (Month/Day/Year): 12/30/55

It is hereby certified that Dr. Nicola Moore
(Name of Applicant)

had hospital privileges at Highland Hospital
(Name of Hospital)

located at 1000 South Ave. Roch. NY 14620
(Address, City, State, Zip, Country)

From 10/02 (Month/Year) To 9/03 (Month/Year)

Was any disciplinary action ever taken against the applicant?
Yes_____ No X
If yes, provide details of the disciplinary action and a copy of any documentation related to the event.

Is there any derogatory* information on file?
Yes_____ No X
If yes, provide details of the derogatory information and a copy of any documentation related to the event.
*Derogatory information can include probation, investigation, remediation, and/or other disciplinary actions.

Institutional Seal

If the institution does not have an official seal, the form must be notarized.

Completed by the Medical Staff Office:

Print Name: Tamara Green

Signature: Tamara G

Date (month/day/year): 5/28/08 Phone: (585) 784-8822

Fax: 784-8367 E-mail: _____

Iowa Board of Medicine
400 SW 8th Street, Suite C, Des Moines, IA 50309-4686
(515) 281-6641 www.medicalboard.iowa.gov

Hospital Privilege Verification

Applicant: Submit this form to each hospital where you held privileges within the last five years. Complete the top portion and page two of the form only and submit the form to the hospital.

Hospital: Complete and mail the form directly from the hospital to the Iowa Board of Medicine. Any processing fees are the applicant's responsibility.

Applicant's Name (Print Legibly): NICOLA LOUISE MOORE

Applicant's Date of Birth (Month/Day/Year): 12/30/55

It is hereby certified that Dr. Nicola Moore
(Name of Applicant)

had hospital privileges at Strong Memorial Hospital
(Name of Hospital)

located at 601 Elmwood Ave. Roch. NY 14642
(Address, City, State, Zip, Country)

From 10/02 (Month/Year) To 9/03 (Month/Year)

Was any disciplinary action ever taken against the applicant?
Yes_____ No X
If yes, provide details of the disciplinary action and a copy of any documentation related to the event.

Is there any derogatory* information on file?
Yes_____ No X
If yes, provide details of the derogatory information and a copy of any documentation related to the event.
*Derogatory information can include probation, investigation, remediation, and/or other disciplinary actions.

Institutional Seal

If the institution does not have an official seal, the form must be notarized.

Completed by the Medical Staff Office:

Print Name: Tamara Green

Signature: Tamara Green

Date (month/day/year): 5/28/08 Phone: (585) 784-8822

Fax: (585) 784-8367 E-mail: Tamara_Green@urmc.rochester.edu

Iowa Board of Medicine
400 SW 8th Street, Suite C, Des Moines, IA 50309-4686
(515) 281-6641 www.medicalboard.iowa.gov

Hospital Privilege Verification

Applicant: Submit this form to each hospital where you held privileges within the last five years. Complete the top portion and page two of the form only and submit the form to the hospital.

Hospital: Complete and mail the form directly from the hospital to the Iowa Board of Medicine. Any processing fees are the applicant's responsibility.

Applicant's Name (Print Legibly): NICOLA LOUISE MOORE

Applicant's Date of Birth (Month/Day/Year): 12/30/55

It is hereby certified that Nicola L. Moore MD
(Name of Applicant)

had hospital privileges at Beth Israel Deaconess Medical Center
(Name of Hospital)

located at 330 Brookline Avenue Boston MA 02215 USA
(Address, City, State, Zip, Country)

From 08/2005 To 10/2006
(Month/Year) (Month/Year)

Was any disciplinary action ever taken against the applicant?
Yes_____ No ✓
If yes, provide details of the disciplinary action and a copy of any documentation related to the event.

Is there any derogatory* information on file?
Yes_____ No ✓
If yes, provide details of the derogatory information and a copy of any documentation related to the event.
*Derogatory information can include probation, investigation, remediation, and/or other disciplinary actions.

Institutional Seal

If the institution does not have an official seal, the form must be notarized.

Completed by the Medical Staff Office:

Print Name: Ruth Pistorino

Signature: R Pistorino

Date (month/day/year): _____ Phone: 617-632-0384

Fax: 617-632-0370 E-mail: RPistori@BIDMC.HARVARD.EDU

Ruth Pistorino personally appeared before me, and proved his/her identification through satisfactory evidence, which were BIDMC ID to be the person whose name is signed on the preceding or attached document in my presence on this 2 day of Jun, 2008

MeenBee Wood
Notary Public

Commonwealth of Massachusetts
My Commission Expires December 1, 2011

Beth Israel Deaconess
Medical Center

June 02, 2008

To Whom it May Concern:

Due to the increasing volume in requests for verification of affiliation, please accept this letter in response to your query.

Beth Israel Deaconess Medical Staff providers are credentialed in accordance with Regulation 243, CMR 3.05 of the Massachusetts Board of Registration in Medicine.

The information provided below satisfies the Massachusetts Board of Registration in Medicine regulations for reasonable inquiries, Joint Commission on Accreditation of Healthcare Organization standards, Beth Israel Deaconess Medical Staff Bylaws, and is accurate to the best of our knowledge.

Practitioner Name:	Nicola L. Moore, MD
Department:	Medicine
Division:	Internal Medicine
Staff Category:	Was Courtesy in good standing
Admitting Privileges:	Yes
Dates of Affiliation:	8/17/2005 To 10/15/2006
Temporary Privilege Dates	8/5/2005 To 12/1/2005
Clinical Performance:	There have been no alterations in privileges resulting, directly or indirectly, from concerns about the professional performance, clinical skills, physical or mental health status, or any concerns related to chemical dependency impairment of this clinician.
Liability Claims:	Please contact the member's malpractice insurance carrier(s) for information regarding liability claims.

RP

Ruthie Pistorino
Professional Staff Affairs Office

330 Brookline Ave., PA 620
Boston, MA 02215

Phone # 617-632-0384
Fax # 617-632-0370

6-2-08

Iowa Board of Medicine
400 SW 8th Street, Suite C, Des Moines, IA 50309-4686
(515) 281-6641 www.medicalboard.iowa.gov

Hospital Privilege Verification

Applicant: Submit this form to each hospital where you held privileges within the last five years. Complete the top portion and page two of the form only and submit the form to the hospital.

Hospital: Complete and mail the form directly from the hospital to the Iowa Board of Medicine. Any processing fees are the applicant's responsibility.

Applicant's Name (Print Legibly): NICOLA LOUISE MOORE

Applicant's Date of Birth (Month/Day/Year): 12/30/55

It is hereby certified that Nicola L. Moore MD
(Name of Applicant)

had hospital privileges at Beth Israel Deaconess Medical Center
(Name of Hospital)

located at 330 Brookline Avenue Boston MA 02215 USA
(Address, City, State, Zip, Country)

From 08/2005 (Month/Year) To 10/2006 (Month/Year)

Was any disciplinary action ever taken against the applicant?
Yes_____ No ✓

If yes, provide details of the disciplinary action and a copy of any documentation related to the event.

Is there any derogatory* information on file?
Yes_____ No ✓

If yes, provide details of the derogatory information and a copy of any documentation related to the event.
*Derogatory information can include probation, investigation, remediation, and/or other disciplinary actions.

Institutional Seal

If the institution does not have an official seal, the form must be notarized.

Completed by the Medical Staff Office:

Print Name: Ruth Pistorino

Signature: R Pistorino

Date (month/day/year): _____ Phone: 617-632-0384

Fax: 617-632-0370 E-mail: RPISTORI@BIDMC.HARVARD.EDU

Ruth Pistorino personally appeared before me, and proved his/her identification through satisfactory evidence, which were BIDMC ID to be the person whose name is signed on the preceding or attached document in my presence on this 2 day of Jan, 2008

MeanGee Wood
Notary Public
Commonwealth of Massachusetts
My Commission Expires December 1, 2011

Commonwealth of Massachusetts
Board of Registration in Medicine

5/27

560 Harrison Avenue, G-4
Boston, Massachusetts 02118
(617) 654-9800

DEVAL L. PATRICK
GOVERNOR

TIMOTHY P. MURRAY
LIEUTENANT GOVERNOR

Enforcement Division Fax: (617) 451-9568
Legal Division Fax: (617) 357-8453
Licensing Division Fax: (617) 426-9358

MARTIN CRANE, MD
BOARD CHAIR

NANCY ACHIN AUDESSE
EXECUTIVE DIRECTOR

5/20/2008

To Whom It May Concern:

This certifies that Nicola L Moore M.D., a 1999 graduate of Albert Einstein College of Medicine Yeshiva Univ, has been duly registered by this board as provided by the laws of the Commonwealth.

Certificate Number 223184 was issued to Dr. Moore on 02/16/2005. This license is Current. The expiration date is 12/30/2008.

Listed below is certain complaint and disciplinary information on this physician. Please note that the Board can neither confirm nor deny the existence of open complaints.

Closed Complaint Information
Our files contain 0 closed complaint(s) on this physician.

Final Board Disciplinary Action
Our files contain 0 Board Discipline(s) to this physician.

This information is derived from Board files from January 1, 1987 to the present. It does not include all the information contained in a license application.

As a service to the public and to designated agencies, the Massachusetts Board of Registration in Medicine offers an online profile of all physicians with full licenses who are licensed in the Commonwealth. This profile is updated daily and may include public information that is not otherwise contained in this certification letter. You may access this information at the Board's website: www.massmedboard.org.

Finally, the Board tallies closed complaints separately from disciplinary actions. If the same underlying incident gives rise to both a complaint and a disciplinary action, the Board counts this as two separate actions. In the same way, multiple disciplinary actions are tallied separately, even if they arise from a single set of circumstances.

SEAL

Staff Member, Board of Registration in Medicine
Carrie Doyle

Iowa Board of Medicine
400 SW 8th Street, Suite C, Des Moines, IA 50309-4686
(515) 281-6641 www.medicalboard.iowa.gov

Professional Licensure Verification

Applicant: Submit this form to each jurisdiction where you were issued a license. Complete the top portion and page two of the form only and submit the form to the appropriate licensing agency.

State or Provincial Licensure Board: Complete and mail the form directly to the Iowa Board of Medicine. Any processing fees are the applicant's responsibility.

Applicant's Name (Print Legibly): NICOLA LOUISE MOORE

Applicant's Date of Birth (Month/Day/Year): 12/30/55

It is hereby certified that _____
(Name of Licensee)

Date of Birth: _____ Profession: _____ Issued License Number: _____

By _____ On _____
(State or Province) (Month/Year)

License Type: Permanent _____ Training/Educational _____ Temporary _____ Other _____

Has the licensee ever been investigated or had a complaint filed against him/her?
Yes _____ No _____ Unable to Disclose _____
If Yes, provide a copy of the documentation related to the investigation or complaint.

Has disciplinary action ever been initiated, invoked, or is disciplinary action pending?
Yes _____ No _____ Unable to Disclose _____
If Yes, provide a copy of the documentation related to the disciplinary action.

Has the licensee ever voluntarily relinquished their medical license?
Yes _____ No _____ Unable to Disclose _____
If Yes, provide a copy of the documentation related to this event.

Institutional Seal

If the institution does not have an official seal, the form must be notarized.

Completed by State or Provincial Licensure Board:

Print Name: _____

Signature: _____

Date (month/day/year): _____ Phone: _____

Fax: _____ E-mail: _____

Authorization for Release of Information-Verification of Licensure

The applicant must sign this form and submit it with the Verification of Licensure form. The licensing agency may retain this release of information for their own records.

I, NICOLA LOUISE MOORE (print name), do hereby authorize a disclosure of records concerning myself to the Iowa Board of Medicine (IBM). This release includes records of a public, private or confidential nature.

I acknowledge that the information released to the IBM may include material that is protected by federal and/or state laws applicable to substance abuse and mental health information. If applicable, I specifically authorize the release of confidential information to and from the IBM relating to substance abuse or dependence and/or mental health.

I further agree that the IBM may receive confidential information and records, including, but not limited to the following records:

- Medical Records
- Education Records
- Personnel or employment records, including records of any remedial, probationary, disciplinary, or any other adverse information contained in those records.
- Post-graduate training (internship, residency, & fellowship) records, including records of any remedial, probationary, disciplinary, or any other adverse information contained in those records.
- Any information the IBM deems reasonably necessary for the purposes set forth in this release.

Release of Liability. I do hereby irrevocably and unconditionally release, covenant not to sue, and forever discharge any person or entity, including but not limited to any medical school, residency or fellowship training program, hospital, health care provider, health care facility, licensing board, impaired practitioner program, agency, or organization, which releases information to the IBM pursuant to this release from any liability, claim, or cause of action arising out of the release of such information. I further irrevocably and unconditionally release, covenant not to sue, and forever discharge the IBM, the State of Iowa, and its employees and agents from any liability, claim, or cause of action arising out of the collection or release of information pursuant to this release.

A photocopy of this release form will be valid as an original thereof, even though the photocopy does not contain an original writing of my signature.

This authorization is valid until completion of the licensure process. I understand I have the right to revoke this authorization in writing, except to the extent that the IBM has already taken action in reliance upon this consent.

I have read and fully understand the contents of this "Authorization to Release Information."

Nicola Louise Moore — Signature of Physician

5/16/08 — Date

PROHIBITION ON REDISCLOSURE

This form does not authorize redisclosure of medical information beyond the limits of this consent. Where information has been disclosed from records protected by federal law for alcohol/drug abuse records or by state law for mental health records, federal requirements (42 C.F.R. Part 2) and state requirements (Iowa Code Ch. 228) prohibit further disclosure without the specific written consent of the patient except as otherwise permitted by such law and/or regulations. A general authorization for the release of medical or other information is not sufficient for these purposes. Civil and/or criminal penalties may attach for unauthorized disclosure of alcohol/drug abuse or mental health information.

5-27

State of California Department of Consumer Affairs

MEDICAL BOARD OF CALIFORNIA
LICENSING PROGRAM
2005 EVERGREEN ST SUITE 1200
SACRAMENTO CA 95815-3831
TELEPHONE: (800) 633-2322
FAX: (916) 263-2944

www.mbc.ca.gov

05-02-05P1:32 RCVD

May 28, 2008

IOWA STATE BOARD OF MEDICAL EXAMINERS
400 SW 8TH ST STE C
DES MOINES IA 50309-4686

To Whom It May Concern:

This is to certify that on the date of this letter the records of the Medical Board of California (Board) indicate the following information:

Physician:	NICOLA LOUISE MOORE
License No.:	A 89646
Issued:	December 17, 2004
Exam Type:	A written examination
Expiration Date:	December 31, 2008
Status:	Renewed/current
Board Discipline:	NO

Further public records pertaining to the above licensee may be available from the Board's Web site at www.mbc.ca.gov.

Kimberly Kirchmeyer
Deputy Director

SEAL

COMMONWEALTH OF MASSACHUSETTS

Board of Registration in Medicine

Active License

Nicola L Moore M.D.

[redacted]

Lic. # 223184

Expires: 12/30/2008

State of California Department of Consumer Affairs

The Medical Board of California
1426 Howe Avenue, Suite 54
Sacramento, California 95825-3236

PHYSICIAN AND SURGEON

CERTIFICATE NO. **A89648** EXPIRATION **12/31/2008**

NICOLA LOUISE MOORE

[redacted]

ORIGINAL ISSUANCE DATE
12/17/2004

RECEIPT NO.
00000554

05-27-05PM 2:21 RCVD

The Medical Board of California

certifies that

Nicola Louise Moore

a graduate of

Albert Einstein College of Medicine of Yeshiva University

possesses the qualifications, education and training prescribed by law and is hereby granted a license as a

Physician and Surgeon

entitled to practice the profession of medicine in the State of California.

Given under our hands and the seal of the Medical Board of California this 17th day of December, 2004.

Mitchell S. Karlan M.D.
President, Division of Licensing

Secretary, Division of Licensing

No. A 89646

The University of the State of New York
Education Department
Office of the Professions

REGISTRATION CERTIFICATE

Do not accept a copy of this certificate

License Number: 219420-1 Certificate Number: 6116455

MOORE NICOLA LOUISE
[redacted]

is registered to practice in New York State through 12/30/2009 as a(n)
PHYSICIAN

LICENSEE/REGISTRANT

EXECUTIVE SECRETARY

ACTING COMMISSIONER OF EDUCATION

ASSOCIATE COMMISSIONER
OFFICE OF THE PROFESSIONS

This document is valid only if it has not expired, name and address are correct, it has not been tampered with and is an original - not a copy. To verify that this registration certificate is valid or for more information please visit www.op.nysed.gov.

THE UNIVERSITY OF THE STATE OF NEW YORK

EDUCATION DEPARTMENT

BE IT KNOWN THAT

NICOLA LOUISE MOORE

HAVING GIVEN SATISFACTORY EVIDENCE OF THE COMPLETION OF PROFESSIONAL AND OTHER REQUIREMENTS PRESCRIBED BY LAW IS QUALIFIED TO PRACTICE

MEDICINE AND SURGERY

IN THE STATE OF NEW YORK

IN WITNESS WHEREOF THE EDUCATION DEPARTMENT GRANTS THIS LICENSE UNDER ITS SEAL AT ALBANY, NEW YORK THIS FOURTEENTH DAY OF SEPTEMBER, 2000.

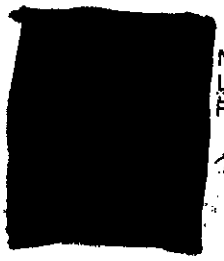
LICENSE NUMBER
219226

PRESIDENT OF THE UNIVERSITY
AND COMMISSIONER OF EDUCATION

EXECUTIVE SECRETARY
STATE BOARD FOR
MEDICINE

4024883

New York State Identification
Physician



NICOLA LOUISE MOORE
License #: 219226
Registered Until: Nov 30, 2009

Nicola Moore

Verify current licensee status
at www.op.nysed.gov

American Board of Family Practice

Nicola Louise Moore, M.D.

having met all its requirements

is hereby certified to be a

Diplomate

of this Board for the period

2004-2011

Executive Director and Secretary

President

Section 14— Authorization for Release of Information
All applicants must sign and date this section.

I, NICOLA LOUISE MOORE (print name), do hereby authorize a disclosure of records concerning myself to the Iowa Board of Medicine (IBM). This release includes records of a public, private or confidential nature.

I acknowledge that the information released to the IBM may include material that is protected by federal and/or state laws applicable to substance abuse and mental health information. If applicable, I specifically authorize the release of confidential information to and from the IBM relating to substance abuse or dependence and/or mental health.

I further agree that the IBM may receive confidential information and records, including, but not limited to the following records:

- Medical Records
- Education Records
- Personnel or employment records, including records of any remedial, probationary, disciplinary, or any other adverse information contained in those records.
- Post-graduate training (internship, residency, & fellowship) records, including records of any remedial, probationary, disciplinary, or any other adverse information contained in those records.
- Any information the IBM deems reasonably necessary for the purposes set forth in this release.

Release of Liability. I do hereby irrevocably and unconditionally release, covenant not to sue, and forever discharge any person or entity, including but not limited to any medical school, residency or fellowship training program, hospital, health care provider, health care facility, licensing board, impaired practitioner program, agency, or organization, which releases information to the IBM pursuant to this release from any liability, claim, or cause of action arising out of the release of such information. I further irrevocably and unconditionally release, covenant not to sue, and forever discharge the IBM, the State of Iowa, and its employees and agents from any liability, claim, or cause of action arising out of the collection or release of information pursuant to this release.

A photocopy of this release form will be valid as an original thereof, even though the photocopy does not contain an original writing of my signature.

This authorization is valid until completion of the licensure process. I understand I have the right to revoke this authorization in writing, except to the extent that the IBM has already taken action in reliance upon this consent.

I have read and fully understand the contents of this "Authorization to Release Information."

Nicola Louise Moore — Signature of Physician

5/15/08 — Date

PROHIBITION ON REDISCLOSURE

This form does not authorize redisclosure of medical information beyond the limits of this consent. Where information has been disclosed from records protected by federal law for alcohol/drug abuse records or by state law for mental health records, federal requirements (42 C.F.R. Part 2) and state requirements (Iowa Code Ch. 228) prohibit further disclosure without the specific written consent of the patient except as otherwise permitted by such law and/or regulations. A general authorization for the release of medical or other information is not sufficient for these purposes. Civil and/or criminal penalties may attach for unauthorized disclosure of alcohol/drug abuse or mental health information.

5-21

06-06-08A11:11 RCVD

Iowa Board of Medicine
Waiver
For Completing Criminal History Background Checks

I hereby give permission for the Iowa Board of Medicine to conduct both an Iowa criminal history record check with the Division of Criminal Investigation (DCI) and a national check through the Federal Bureau of Investigation (FBI). Any information maintained by the DCI and the FBI may be released as allowed by law.

PLEASE PRINT

Name: MOORE (Last) NICOLA (First) LOUISE (Middle)

Other Names Used (Include maiden name):

Street Address: [redacted]

City: [redacted] **State:** [redacted] **Zip:** [redacted] **Daytime Phone:** [redacted]

E-mail Address: [redacted]

Social Security Number: [redacted] **Gender:** F

Date of Birth (Month/Date/Year): 12/30/1955

Answer the following question. For a "Yes" answer, please attach an explanation. Do not write the explanation on this waiver form.

YES	NO	
☐	☒	Have you ever been convicted of, or entered a plea of guilty, nolo contendere, or no contest to a crime other than a minor traffic offense, in any jurisdiction? You must include all misdemeanors and felonies, even if adjudication was withheld by the court so that you would not have a record of conviction. (For example, you must report if your conviction was expunged, you received a deferred judgment, or you received an executive pardon.) Driving under the influence or driving while impaired is not a minor traffic offense.

I understand that if a license is granted by this Board, it will be based, in part, on the truth of the information on the waiver and on the application for licensure, which, if false, may subject me to criminal prosecution and revocation of the license. I declare under penalty of perjury that my answers and all statements made on the waiver and on the licensure application are true and correct. Should I furnish any false information on this waiver or on the application for licensure, I hereby agree that such act shall constitute cause for denial, suspension or revocation of my license to practice medicine in Iowa.

Nicola Louise Moore — Signature of Applicant

June 4, 2008 — Date

DCI & Sex Offender Search Completed on 6-6-08

For Office Use Only—Do Not Write in Boxes

FBI Search Completed on 7-1-08