THE STATE EDUCATION DEPARTMENT / THE UNIVERSITY OF THE STATE OF NEW YORK / ALBANY, NY 12230

OFFICE OF THE PROFESSIONS
DIVISION OF PROFESSIONAL LICENSING SERVICES
Public Information Unit
Tel. (518) 474-3817 EXT: 330
Fax (518) 473-0578
E-mail: DPLSDSU@MAIL.NYSED.GOV

STATE OF NEW YORK)
SS:
COUNTY OF ALBANY)

In accordance with the **Civil Practice Law and Rules Article 45**, I, Connie F. Mitchell, Clerk II in the Division of Professional Licensing Services of the New York State Education Department, have caused this certificate to be prepared. I certify that I have legal custody of the official original records of the Division of Professional Licensing Services and I attest that the attached are true and correct copies of the original documents in our files relating to NICOLA LOUISE MOORE.

Witness my hand and the seal of the New York State Education Department this 14 July, 2011.

Connie F. Mitchell, Clerk II
Professional Licensing Services

DATED
07/14/2011

4/13/06 F

FORM 1

MEDICINE

The University of the State of New York
THE STATE EDUCATION DEPARTMENT
Office of the Professions
Division of Professional Licensing Services
Cultural Education Center
Albany, NY 12230

DEPARTMENT USE ONLY

710 00 069 6
FOR DEPOSIT ONLY NYSED

203137

APPLICATION FOR LICENSE AND FIRST REGISTRATION

735 | FR

1 SOCIAL SECURITY NUMBER: [redacted]
(Leave this blank if you have no U.S. Social Security Number)

2 BIRTH DATE: [redacted] mo. day yr.

DB 9-13-00 Cleared

3 PRINT FULL NAME AS YOU WISH IT TO APPEAR ON YOUR LICENSE:

Last: MOORE
First: NICOLA
Middle: LOUISE

NYS License Number 9/14/00
219226

4 MAILING ADDRESS CHECK ONE: [X] HOME ADDRESS [ ] WORK ADDRESS

Care of:
Street: [redacted]
City: ROCHESTER
State: NY Zip Code: [redacted]
Province/Country If not U.S.:

5 TELEPHONE
HOME: [redacted] Area Code Number
WORK: [redacted] Area Code Number

The above address is: [X] permanent address of record [ ] temporary mailing address

IMPORTANT: The applicant is responsible for notifying the Department of any name or address changes.

6 Name as it appears on diploma or other credentials (if different from above): ____

7 Citizenship: [X] United States [ ] Alien lawfully admitted for permanent residence in the United States. (Attach a copy of the front and back of the alien registration card) [ ] Other Immigration ____

8 Mother's Maiden Name *(family name before her marriage)*: FALK

9 I wish to become licensed on the basis of: [X] acceptable examination scores *(see page 3 of this form)* [ ] endorsement of another license *(See Pg. 11.)*

I am using FCVS to collect my credentials: [ ] YES [X] NO

10 Have you previously applied for a New York State license or a limited permit to practice medicine ? [ ] YES [X] NO

11 Have you ever been convicted of a crime (felony or misdemeanor) in any state or country ? [redacted]

12 Have you ever been charged with a crime (felony or misdemeanor) in any state or country, the disposition of which was other than by acquittal or dismissal ? [redacted]

13 Have you ever surrendered your license or been found guilty of professional misconduct, unprofessional conduct, incompetence or negligence in any state or country ? [redacted]

14 Are charges pending against you for professional misconduct, unprofessional conduct, incompetence or negligence in any state or country ? [redacted]

15 Has any hospital or licensed facility restricted or terminated your professional training, employment, or privileges or have you ever voluntarily or involuntarily resigned or withdrawn from such association to avoid imposition of such measures ? [redacted]

NOTE: If any answer to any question 11-15 is "Yes," submit a letter giving complete explanation. Include copies of any court records, and if you possess one, a copy of the "Certificate of Relief from Disabilities" or your "Certificate of Good Conduct."

16 In the space below, give a complete record of your education preparation. Attach additional sheets if necessary.

SCHOOLS ATTENDED AND LOCATION (including country) List schools in original language and translate.	Number of Years Attended	Diploma or Degree Obtained *List diploma or degree titles in original language and translate. Indicate year obtained*	If no diploma or degree, number of credits earned
High School or Secondary Westlake School	3	High School Diploma	
Postsecondary Preprofessional (Exclusive of Medical School) Yale College (Yale University)	4	BA	
Medical Education (Professional) (List all medical schools attended) Albert Einstein College of Medicine	4	MD	

17 If you completed clinical clerkships in a country other than where your medical school is located, give the dates and location of these clerkships. Attach additional sheets if necessary.

Inclusive Clerkship Dates	Clinical Area	Name of Health Care Facility And Address	Medical School with which Clerkship Affiliated and Address

18 Provide a chronological list of all activities since graduation from professional school to the present. Include vacation periods and periods of employment. Attach additional sheets if necessary.

DATE (mm/dd/yy) From	To	Type of Activity, Beginning with Date of Graduation from Professional School. Include Name and Address of Employers.
06/03/99	present	Resident, Dept of Family Medicine
(06/03/99)		885 South Avenue, Rochester, NY 14620

COMPLETE NEXT PAGE

19 Complete item 19 only if you are a graduate of a program not registered by New York State or LCME or AOA accredited.

Have you completed all portions of the examination requirements for ECFMG certification ? ☐ Yes ☐ No

Do you currently hold a valid ECFMG certificate ? ☐ Yes ☐ No

Please complete and forward the ECFMG form enclosed with this application packet.

20 Are you applying for licensure on the basis of a Fifth Pathway program? ☐ Yes ☒ No

If Yes, list name and location of medical school or hospital and the inclusive dates of attendance.

Name and Location of Medical School or Hospital	Inclusive Dates of Attendance

21 List in English, all specialty qualifications you have earned. (i.e., Board Specialty Certification or Diplomate Certificate)

Name of Qualifications	Name and location of organization issuing credential

22 ☒ I will be applying for USMLE Step 3

OR

☐ I have successfully completed the examination combination indicated below:

EXAMINATION COMBINATIONS

- ☐ USMLE Steps 1, 2, and 3
- ☐ FLEX Parts I, II, and III
- ☐ FLEX Components I and II
- ☐ NBME Parts I, II, and III
- ☐ NBME Parts I and II and USMLE Step 3
- ☐ NBME Part I, USMLE Step 2 and NBME Part III
- ☐ NBME Part I, and USMLE Steps 2 and 3
- ☐ USMLE Step 1, and NBME Parts II and III
- ☐ USMLE Step 1, NBME Part II, and USMLE Step 3
- ☐ USMLE Steps 1 and 2 and NBME Part III
- ☐ USMLE Step 1, NBME Part II, and FLEX Component II
- ☐ NBME Part I, USMLE Step 2, and FLEX Component II
- ☐ USMLE Steps 1 and 2 and FLEX Component II
- ☐ NBME Parts I and II and FLEX Component II
- ☐ FLEX Component I and USMLE Step 3
- ☐ NBOME Parts I, II, and III
- ☐ Other: ______________________

Date examination sequence was completed ______________________

23 Are you licensed or have you ever been licensed as a physician in any other state or country? ☐ Yes ☒ No

If yes, list each jurisdiction. In addition, you must have a Form 3A or 3B, as appropriate, submitted. See pages 14 - 15.

State or Country	Date License Issued	Number	Basis of Licensure			Any Limitations on License
			Examination (Date passed)	Endorsement	Other	

24 If you hold a New York State license in another profession, indicate the profession, your license number and date of licensure below.

Profession	License Number	Date of Initial Licensure (mandatory)
		___/___/___
		___/___/___
		___/___/___
		___/___/___

25 **CHILD SUPPORT OBLIGATION:**

New York State General Obligations Law, section 3-503, requires every applicant for a professional license, permit, or registration, or any renewal thereof, to file a written statement that, as of the date of the filing, he or she is, or is not, under an obligation to pay child support. Individuals who are four months or more in arrears in child support may be subject to suspension of their business, professional and/or driver's licenses. The intentional submission of false written statements for the purpose of frustrating or defeating the lawful enforcement of support obligations is punishable pursuant to section 175.35 of the Penal Law.

You must complete this section before we can issue the credential for which you have applied. Individuals who are under an obligation to pay child support but are not in compliance with the General Obligations Law can be issued a credential for no more than six months to discharge child support obligations consistent with that law.

Check only A or B below. If you check B, you must check one of the five statements listed below it.

A ☒ I am not under an obligation to pay child support:

OR

B ☐ I am under an obligation to pay child support *and* (please check only one of the following)

- ☐ I am current and am not four months or more in arrears in the payment of child support; or,
- ☐ I am making payments by income execution or by court agreed payment plan or by a plan agreed to by the parties; or,
- ☐ The child support obligation is the subject of a pending court proceeding; or,
- ☐ I am receiving public assistance or supplemental security income; or,
- ☐ None of the above four statements apply.

26 **STUDENT LOAN DISCLOSURE:**

(a) Do you have any outstanding loans made or guaranteed by the New York State Higher Education Services Corporation ? ☐ Yes ☐ No

(b) If you have such a loan(s), is any part in default ? ☐ Yes ☐ No

NOTE: Education Law (Section 6501-a) requires the State Education Department to ask the questions above and forward any "yes" responses to question (b) to the New York State Higher Education Services Corporation. Your license application is not complete without this information.

27 **GENDER AND ETHNICITY: (This item is optional. See note below.)**

NOTE: Information on gender and ethnicity is sought solely to allow the Education Department to collect and analyze data concerning representation in the licensed professions. The ethnic and gender data you provide will be used only for statistical, research, and program evaluation purposes. It will not be released to the public. This information has absolutely no bearing on your qualification for licensure.

ETHNICITY: ☒ White (not Hispanic) ☐ Black (not Hispanic) ☐ Asian ☐ Hispanic ☐ Native American

GENDER: ☐ Male ☒ Female

28 **CHILD ABUSE IDENTIFICATION AND REPORTING: (check only one of the following:)**

☒ I graduated from a New York State medicine program after September 1, 1990.

☐ I completed the child abuse coursework and have enclosed a certificate of completion from an approved provider.

☐ I am filing for an exemption to the requirement and have enclosed the exemption form.

29 **PHOTOGRAPH REQUIREMENT:** →

Date of photo: 6/4/99

I give permission to the New York State Education Department to release my examination results to my professional school for the confidential purposes of program review and institution research and planning. I may rescind this authority at any time by notifying, in writing, the Division of Professional Licensing Services.

☒ Yes ☐ No Please initial: NLM

Under penalties of perjury, I declare and affirm that the statements made in this application, including accompanying documents, are true, complete and correct. I understand that any false or misleading information in, or in connection with, my application may be cause for denial or loss of licensure.

Signature of applicant: [signature] Date: 3/27/00

Mail this form and appropriate fee to: New York State Education Department, Office of the Professions, Fee Section, Division of Professional Licensing Services, Cultural Education Center, Albany, NY 12230. DO NOT SEND CASH. Make checks or money orders payable to the New York State Education Department.

PNW 4/20/00 7

FORM 2
MEDICINE

The University of the State of New York
THE STATE EDUCATION DEPARTMENT
Office of the Professions
Division of Professional Licensing Services
Cultural Education Center
Albany, NY 12230

CERTIFICATION OF PROFESSIONAL AND PREPROFESSIONAL EDUCATION

APPLICANT INSTRUCTIONS

1. Complete Section 1. Enter your name as it appears on your New York State Licensure Application (Form 1).
2. Send this form to the professional school you attended to complete Section II. Be sure to include any fee required. If you graduated from a medical school that was not registered by New York State or accredited by LCME/AOA, notify the school that a transcript must accompany this form.
3. If you attended a medical school that has been closed, send this form to the official repository of the records for that school (e.g. CONEB).
4. This form must be signed by the Registrar, Dean, Rector, or Principal of the medical school and sent directly to the Office of the Professions by that school official in an official school envelope. Forms sent back by the applicant will not be accepted.

SECTION I: APPLICANT INFORMATION

1 SOCIAL SECURITY NUMBER [redacted]
(Leave this blank if you have no U.S. Social Security Number)

2 BIRTH DATE [redacted] *Month Day Year*

3 PRINT FULL NAME EXACTLY AS IT APPEARS ON YOUR LICENSURE APPLICATION (FORM 1)

Last: MOORE
First: NICOLA
Middle: LOUISE
Maiden or Previous name:

4 MAILING ADDRESS:
Apt./Bldg. [redacted]
Street
City: ROCHESTER
State: NY Zip Code [redacted]
Province/Country If not U.S.

(check only one) [X] permanent address of record [ ] temporary mailing address until: __/__/__ *mo. day yr.*

5 TELEPHONE: WORK [redacted] *Area Code Number* HOME [redacted] *Area Code Number*

6 Print name under which your degree or diploma was awarded *(if different from above)*: ________

7 Preprofessional School Attended: Yale University

8 Professional School Attended: Albert Einstein College of Medicine
Address: 1300 Morris Park Avenue, Bronx NY 10461

9 Name of Degree/Diploma: MD Date awarded: 6/3/99

SECTION II : CERTIFICATION OF PROFESSIONAL EDUCATION

INSTRUCTION TO SCHOOL: Please complete this section, sign certifying statement, [illegible] send directly to the Office of the Professions at the address shown below. This form will not be accepted if returned by the applicant or any other party.

1 Applicant's Entrance date: 06 / 16 / 1995   Completion/Withdrawal Date: 5 / 24 / 1999

2 Degree/diploma conferred: Doctor of Medicine   Date of [illegible]: [illegible] / [illegible] / [illegible]

3 Did the applicant receive advanced standing based on prior academic work? ☐ YES ☐ NO
If Yes, indicate when the prior work was completed below.
Name of Institution: ______________________ Dates of attendance: __________ to __________
Submit with this form: (1) An official transcript of studies at your institution, and
(2) Copies of documentation in your file to support the granting of transfer credit.

4 *For Applicants from N.Y.S. Registered or LCME/AOA Accredited Medical Schools:*
Applicant met LCME/AOA requirements for admission to medical/osteopathic school? ☒ YES ☐ NO

If No, number of preprofessional postsecondary credit hours completed by applicant prior to admission to medical school __________ semester hours or __________ quarter hours.

5 *For All Other Applicants:*

Years of education required for admission into your medical school: __________

Preprofessional credential/degree submitted by applicant for admission into your medical school: __________

Was Social Service required? ☐ YES ☐ NO   If Yes, give inclusive [illegible]

Institution: ______________________ Dates: __________ to __________

Was a pre-graduation internship required? ☐ YES ☐ NO   If Yes, give inclusive dates and name of institution in which requirement was met.

Institution: ______________________ Dates: __________ to __________

Submit with this form:

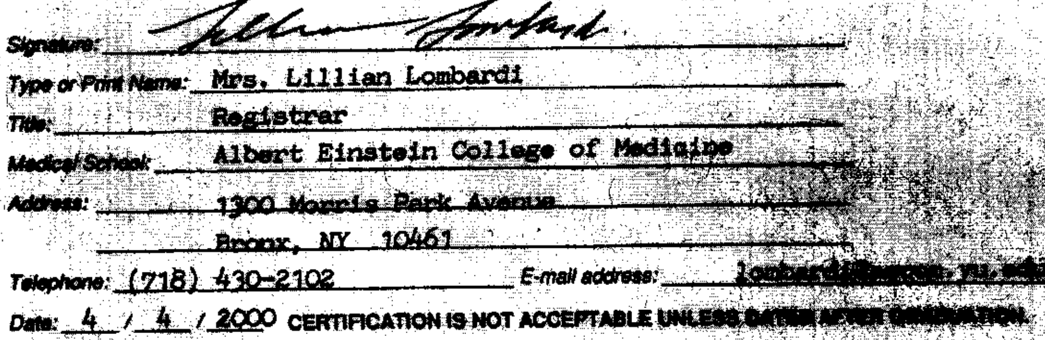
A. An official transcript (course record, index, or marksheets) showing courses taken at your institution and accepted from other institutions for transfer of credit of convalidation.
The transcript must bear the original signature of the dean, principal, rector, or registrar and original seal of the school.

B. A copy of documentation from your files to support the granting of transfer credit [illegible]

C. List of clinical clerkship completed outside jurisdiction where medical school is located [illegible] starting and ending dates of clerkship, and name and address of hospital where clerkship was performed.

FOR ATTENDEES OF CIFAS, CETEC, AND UTESA, this list must include all clerkships completed, both inside and outside the jurisdiction where the medical school is/was located.

I certify that to the best of my knowledge and belief the foregoing is a true statement of the record of the individual named on this form.



Signature: [signature]

Type or Print Name: Mrs. Lillian Lombardi

Title: Registrar

Medical School: Albert Einstein College of Medicine   (SEAL)

Address: 1300 Morris Park Avenue
Bronx, NY 10461

Telephone: (718) 430-2102   E-mail address: [illegible]

Date: 4 / 4 / 2000 CERTIFICATION IS NOT ACCEPTABLE UNLESS DATED AFTER GRADUATION.

Return this Form and material requested above to: New York State Education Department, Office of the Professions, Division of Professional Licensing Services, Medicine Licensing Unit, Cultural Education Center, Albany, NY 12230.

7-10-01

FORM 2PGT
MEDICINE

The University of the State of New York
THE STATE EDUCATION DEPARTMENT
Office of the Professions
Division of Professional Licensing Services
Cultural Education Center
Albany, NY 12230

[illegible]

CERTIFICATION OF APPROVED POSTGRADUATE TRAINING

(To be used only for U.S. and Canadian approved postgraduate training programs)

Filends 3

APPLICANT INSTRUCTIONS

1. Complete Section 1. Enter your name as it appears on your Licensure Application (Form 1).
2. Please send this form to the director of medical education of the hospital(s) in which you completed postgraduate training. One form must be submitted to verify each residency. If you have completed more than one residency, you may photocopy this form.
3. This form must be sent directly to the Department by the hospital in which you did your residency. If the hospital in which you did your residency does not have a director of medical education, the forms may be completed by the department chair. If the Department cannot determine that this verification came directly from the hospital, the postgraduate hospital training will not be credited.

SECTION I: APPLICANT INFORMATION

1 SOCIAL SECURITY NUMBER: [redacted]

(Leave this blank if you have no U.S. Social Security Number)

2 BIRTH DATE: [redacted]

3 PRINT FULL NAME EXACTLY AS IT APPEARS ON YOUR APPLICATION (FORM 1):

OK / yeHT

Last: MOORE

First: NICOLA

Middle: LOUISE

RECEIVED
PROFESSIONAL LICENSING
UNIT II
2001 JUL -3 PM 12:4

4 MAILING ADDRESS:

Apt./Bldg.:

Street: [redacted]

City: ROCHESTER

State: NY Zip Code: [redacted]

Province/Country If not U.S.:

5 Print name under which postgraduate training was completed: NICOLA LOUISE MOORE

6 Hospital in which postgraduate training was completed: Highland Hospital / Dept. of Family Medicine

Address: 885 South Avenue, Rochester, NY 14620

SECTION II: CERTIFICATION OF POSTGRADUATE TRAINING

INSTRUCTION TO HOSPITAL: Please complete this section, sign certifying [illegible] Licensing Services at the address shown below. This form will not be accepted [illegible]

This is to certify that Nicola Moore, MD
(Physician's Name)

a graduate of Albert Einstein
(Medical school)

was enrolled in a postgraduate training program(s) approved by the Accreditation Council on Graduate Medical Education, the American Osteopathic Association, or Royal College of Physicians and Surgeons of Canada at Univ. Rochester/ Highland Hosp Family Medicine
(Name and location of Hospital)

Level of Training (example PGY-1)	Clinical Area	[illegible]	[illegible]
PGY1	Family Practice	06 / [illegible] / [illegible] to 06 / [illegible] / [illegible]	☐ yes ☐ no ☐ in progress; [illegible]
		__/__/__ to __/__/__	☐ yes ☐ no ☐ in progress; anticipated by date
		__/__/__ to __/__/__	☐ yes ☐ no ☐ in progress; anticipated by date
		__/__/__ to __/__/__	☐ yes ☐ no ☐ in progress; [illegible]
		__/__/__ to __/__/__	☐ yes ☐ no ☐ in progress; [illegible]

If this physician did not successfully complete the postgraduate training program, please attach a letter of explanation with this form.

☐ Explanation is attached

I am the director of medical education or department chair of the clinical area. I was the program director for the physician named above during the postgraduate training indicated and have carefully read and completed this form and hereby attest that the statements made herein are strictly true in every respect and are supported by hospital records.

Signature of Director/Chair: [signature]

Type or Print Name of Director/Chair: Jeffrey J. Harp, DO

Title or Official position: Residency Director

Institution: Univ. Rochester/ Highland Hosp (SEAL)

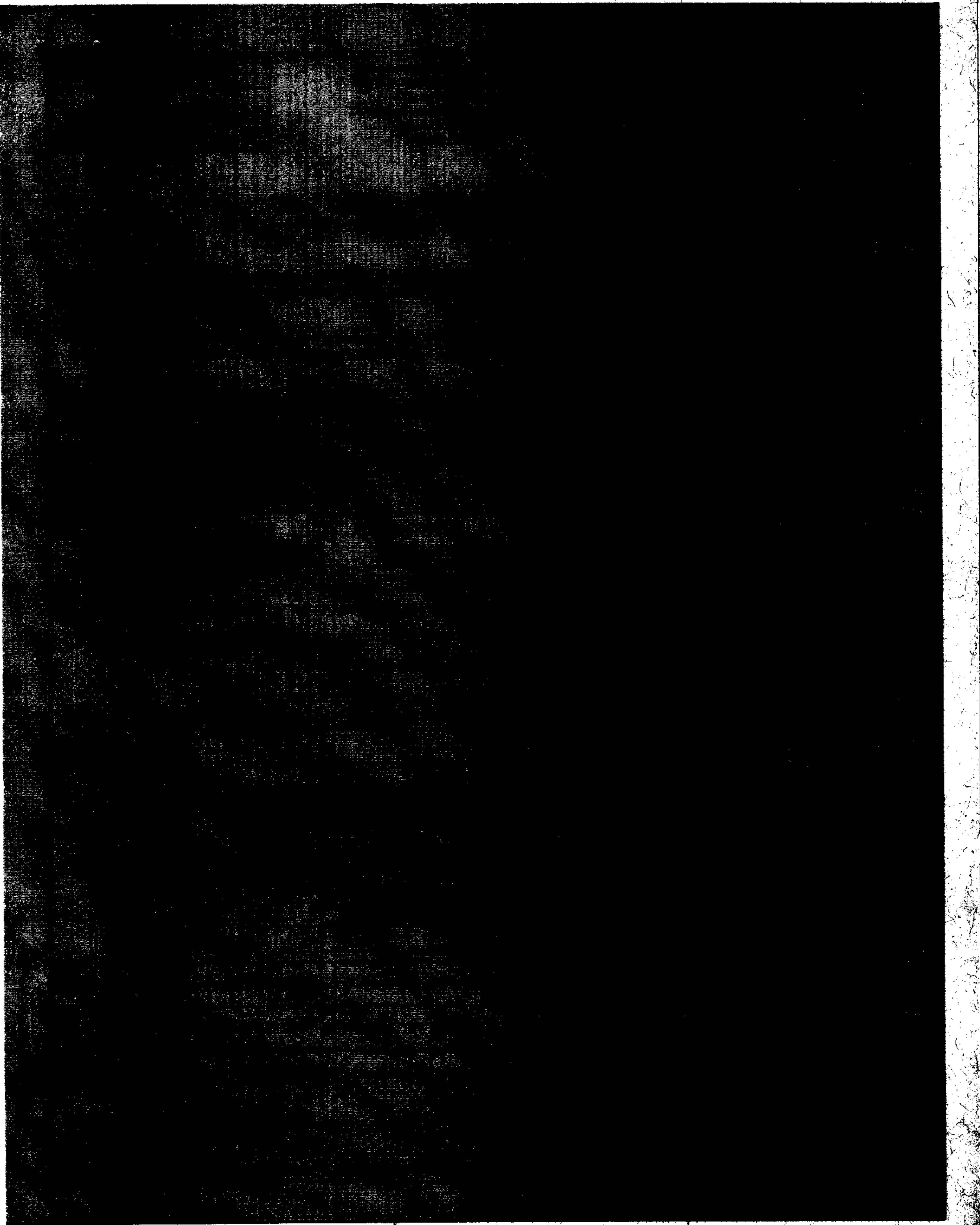
Address: 885 South Ave

Rochester NY 14620

Telephone: 716-442-7470 Date: 6 / 22 / 0[illegible]

E-mail Address:

Return this Form to: New York State Education Department, Office of the Professions, Division of Professional Licensing Services, Medicine Licensing Unit, [illegible]



THE UNIVERSITY OF THE STATE OF NEW YORK
THE STATE EDUCATION DEPARTMENT
DIVISION OF PROFESSIONAL LICENSING SERVICES
CULTURAL EDUCATION CENTER
ALBANY, NEW YORK 12230

WHEN RESPONDING, PLEASE INCLUDE NAME, ADDRESS, PROFESSION, SSN, AND A DAY PHONE#.
DATE: 09/14/00
PROFESSION: 60
SOC SEC NO:

MOORE NICOLA LOUISE

ROCHESTER NY

To: Higher Education Services Corp.

The applicant named above has indicated that they have an outstanding loan(s) made or guaranteed by the New York State Higher Education Services Corp.

219226M006000100060202

REGISTRATION RENEWAL DOCUMENT

THE STATE EDUCATION DEPARTMENT
Professional Licensing Services
89 Washington Avenue
Albany, NY 12234-1000

01/22/03
LIC: 219226
NME: M006
YR: 02
OFF: 2
DOB:
SSN:
EIN:

MOORE NICOLA LOUISE
ROCHESTER NY

PROFESSION: 60 MEDICINE
PERIOD: 09/01/02 - 11/30/03

Name/address change
Complete only if change has occurred

Name

Street

Rochester

NY
State/Zip

$ 10
AMOUNT DUE

Complete and sign reverse side of this application

1. Do you wish to register for the period indicated? X Yes ___ No

2. Since your last registration application,

a. Have you been found guilty after trial, or pleaded guilty, no contest, or nolo contendere to a crime (felony or misdemeanor) in any court?

b. Has any licensing or disciplinary authority revoked, annulled, cancelled, accepted surrender of, suspended, placed on probation, or refused to issue or renew a professional license or certificate held by you now or previously, or fined, censured, reprimanded or otherwise disciplined you?

c. Are criminal charges pending against you in any court?

d. Are charges pending against you in any jurisdiction for any sort of professional misconduct?

e. Has any hospital or licensed facility restricted or terminated your professional training, employment, or privileges, or have you voluntarily or involuntarily resigned or withdrawn from such association to avoid the imposition of such action due to professional misconduct, unprofessional conduct, incompetency, or negligence?

3. a. Are you under an obligation to pay child support? ___ Yes X No

b. If you are under such an obligation, do you meet one of the four requirements listed in the Child Support Law section below? ___ Yes ___ No

4. Are you a U.S. citizen or a qualified alien as defined below? X Yes ___ No

DO NOT WRITE IN THIS BOX
FOR OFFICIAL USE ONLY

I certify that the statements made in this application and any accompanying documentation are true, complete and correct. I understand that any misrepresentation or any false or misleading information made in connection with my application may result in criminal prosecution and may be cause for disciplinary action, including the loss of my license; and that the willful failure to register while continuing to practice my profession constitutes professional misconduct.

Signature ________ Business phone (________ Date 2/3/03

Cat 6 - 050801

219226M006006000060103

REGISTRATION RENEWAL DOCUMENT

THE STATE EDUCATION DEPARTMENT
Professional Licensing Services
89 Washington Avenue
Albany, NY 12234-1000

07/01/03
LIC: 219226
NME: MOOG
YR: 03
OFF: 1
DOB:
SSN:
EIN:

MOORE NICOLA LOUISE

ROCHESTER NY

Name/address change
Complete only if change has occurred

Name

Street

City

State/Zip

$ 600
AMOUNT DUE

PROFESSION: 60 MEDICINE
PERIOD: 12/01/03 - 11/30/05

Complete and sign reverse side of this application

1. Do you wish to register for the period indicated? .... ___ Yes ___ No

2. Since your last registration application,

a. Have you been found guilty after trial, or pleaded guilty, no contest, or nolo contendere to a crime (felony or misdemeanor) in any court? ...... ___ Yes ___ No

b. Has any licensing or disciplinary authority revoked, annulled, cancelled, accepted surrender of, suspended, placed on probation, or refused to issue or renew a professional license or certificate held by you now or previously, or fined, censured, reprimanded or otherwise disciplined you? . ___ Yes ___ No

c. Are criminal charges pending against you in any court? .... ___ Yes ___ No

d. Are charges pending against you in any jurisdiction for any sort of professional misconduct? .... ___ Yes ___ No

e. Has any hospital or licensed facility restricted or terminated your professional training, employment, or privileges, or have you voluntarily or involuntarily resigned or withdrawn from such association to avoid the imposition of such action due to professional misconduct, unprofessional conduct, incompetency, or negligence? .... ___ Yes ___ No

3. a. Are you under an obligation to pay child support? .... ___ Yes ___ No

b. If you are under such an obligation, do you meet one of the four requirements listed in the Child Support Law section below? .... ___ Yes ___ No

4. Are you a U.S. citizen or a qualified alien as defined below? .... ___ Yes ___ No

DO NOT WRITE IN THIS BOX
FOR OFFICIAL USE ONLY

I certify that the statements made in this application and any accompanying documentation are true, complete and correct. I understand that any misrepresentation or any false or misleading information made in connection with my application may result in criminal prosecution and may be cause for disciplinary action, including the loss of my license; and that the willful failure to register while continuing to practice my profession constitutes professional misconduct.

Signature ______________________ Business phone (   ) ______________ Date ______________

Cat 6A - 0508

219226M00600600060105

REGISTRATION RENEWAL DOCUMENT

THE STATE EDUCATION DEPARTMENT
Professional Licensing Services
89 Washington Avenue
Albany, NY 12234-1000

07/01/06
LIC: 219226
NME: [illegible]
YR: 06
OFF: 1
EIN:

MOORE NICOLA LOUISE
[illegible]
CAMBRIDGE MA [illegible]

PROFESSION: 60 MEDICINE
PERIOD: 12/01/06 - 11/30/07

Complete and sign reverse side of this application

Name/address change
Complete only if change has occurred

Name ______
Street ______
______
City ______
State/Zip ______

$ 600
AMOUNT DUE

[illegible]

1. Do you wish to register for the period indicated? .... X Yes ___ No

2. Since your last registration application,

a. Have you been found guilty after trial, or pleaded guilty, no contest, or nolo contendere to a crime (felony or misdemeanor) in any court? ....

b. Has any licensing or disciplinary authority revoked, annulled, cancelled, accepted surrender of, suspended, placed on probation, or refused to issue or renew a professional license or certificate held by you now or previously, or fined, censured, reprimanded or otherwise disciplined you

c. Are criminal charges pending against you in any court? ....

d. Are charges pending against you in any jurisdiction for any sort of professional misconduct? ....

e. Has any hospital or licensed facility restricted or terminated your professional training, employment, or privileges, or have you voluntarily or involuntarily resigned or withdrawn from such association to avoid the imposition of such action due to professional misconduct, unprofessional conduct, incompetency, or negligence? ....

3. a. Are you under an obligation to pay child support? .... ___ Yes ___ No

b. If you are under such an obligation, do you meet one of the four requirements listed in the Child Support Law section below? .... ___ Yes ___ No

4. Are you a U.S. citizen or an alien admitted for permanent residence in the U.S.? .... X Yes ___ No

32450483 60000 048 09212005	DO NOT WRITE IN THIS BOX FOR OFFICIAL USE ONLY

I certify that the statements made in this application and any accompanying documentation are true, complete and correct. I understand that any misrepresentation or any false or misleading information made in connection with my application may result in criminal prosecution and may be cause for disciplinary action, including the loss of my license; and that the willful failure to register while continuing to practice my profession constitutes [illegible]

Signature [signature] Daytime phone [redacted] Date 9/12/05

219226M006006000060107

REGISTRATION RENEWAL DOCUMENT
THE STATE EDUCATION DEPARTMENT
Professional Licensing Services
89 Washington Avenue
Albany, NY 12234-1000

07/02/07
LIC: 219226
NME: [illegible]
YR: 07
OFF: 1
EIN:

[illegible] NICOLA LOUISE
CAMBRIDGE MA

5483660

PROFESSION: 60 MEDICINE
PERIOD: 12/01/07 - 11/30/09

[illegible]

Complete and sign reverse side of this application

Address change
Complete only if change has occurred

Street

City

State/Zip

$ 600
AMOUNT DUE

1. Do you wish to register for the period indicated? .... [X] Yes ___ No

2. Since your last registration application,

a. Have you been found guilty after trial, or pleaded guilty, no contest, or nolo contendere to a crime (felony or misdemeanor) in any court? ....

b. Has any licensing or disciplinary authority revoked, annulled, cancelled, accepted surrender of, suspended, placed on probation, or refused to issue or renew a professional license or certificate held by you now or previously, or fined, censured, reprimanded or otherwise disciplined you? ....

c. Are criminal charges pending against you in any court? ....

d. Are charges pending against you in any jurisdiction for any sort of professional misconduct? ....

e. Has any hospital or licensed facility restricted or terminated your professional training, employment, or privileges, or have you voluntarily or involuntarily resigned or withdrawn from such association to avoid the imposition of such action due to professional misconduct, unprofessional conduct, incompetency, or negligence? ....

3. a. Are you under an obligation to pay child support? .... ___ Yes X No

b. If you are under such an obligation, do you meet one of the four requirements listed in the Child Support Law section below? .... ___ Yes [___ No]

4. Are you a U.S. citizen or an alien admitted for permanent residence in the U.S.? .... X Yes [___ No]

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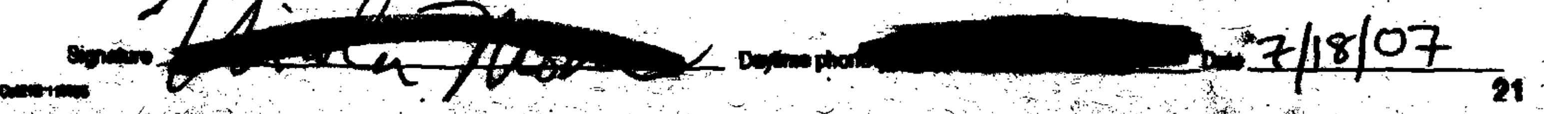
DO NOT WRITE IN THIS BOX
FOR OFFICIAL USE ONLY

I certify that the statements made in this application and any accompanying documentation are true, complete and correct. I understand that any misrepresentation or any false or misleading information made in connection with my application may result in criminal prosecution and may be cause for disciplinary action, including the loss of my license; and that the willful failure to register while continuing to practice my profession constitutes professional misconduct.

Signature ______________ Daytime phone ______________ Date 7/18/07



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REGISTRATION RENEWAL DOCUMENT
THE STATE EDUCATION DEPARTMENT
Professional Licensing Services
89 Washington Avenue
Albany, NY 12234-1000

07/01/08
LIC: 218228
NME: MOOS
YR: 08
OFF: 1
EIN:

MOORE NICOLA LOUISE
CAMBRIDGE MA

PIN: QZ83815

PROFESSION: 60 MEDICINE
PERIOD: 12/01/08 - 11/30/11

Address change
Complete only if change has occurred

Street

City

State/Zip

$ 600
AMOUNT DUE

Complete and sign reverse side of this application

1. Do you wish to register for the period indicated? .... X Yes __ No

2. Since your last registration application,

a. Have you been found guilty after trial, or pleaded guilty, no contest, or nolo contendere to a crime (felony or misdemeanor) in any court? ....

b. Has any licensing or disciplinary authority revoked, annulled, cancelled, accepted surrender of, suspended, placed on probation, or refused to issue or renew a professional license or certificate held by you now or previously, or fined, censured, reprimanded or otherwise disciplined y

c. Are criminal charges pending against you in any court? ....

d. Are charges pending against you in any jurisdiction for any sort of professional misconduct? ....

e. Has any hospital or licensed facility restricted or terminated your professional training, employment, or privileges, or have you voluntarily or involuntarily resigned or withdrawn from such association to avoid the imposition of such action due to professional misconduct, unprofessional conduct, incompetency, or negligence? ....

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b. If you are under such an obligation, do you meet one of the four requirements listed in the Child Support Law section below? .... __ Yes __ No

4. Are you a U.S. citizen or an alien admitted for permanent residence in the U.S.? .... X Yes __ No

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DO NOT WRITE IN THIS BOX
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I certify that the statements made in this application and any accompanying documentation are true, complete and correct and, further, I attest that I have updated my physician profile within the six months prior to the expiration date of my registration period as a condition of registration renewal in compliance with section 2995-a(4) of the Public Health Law. I understand that any misrepresentation or any false or misleading information made in connection with my application may result in criminal prosecution and may be cause for disciplinary action, including the loss of my license; and that the willful failure to register while continuing to practice my profession constitutes professional misconduct.

Signature ______ Daytime ph[redacted] Date 7/13/09