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 JOAN M. FLEISCHMAN.

Witness my hand and the seal of the New York State Education Department this 27 May, 2011.

Connie F. Mitchell

Connie F. Mitchell, Clerk II
Professional Licensing Services

DATED
05/27/2011

REGISTRATION APPLICATION PERIOD: 02/01/04 - 01/31/06

PROFESSION: MEDICINE

$ 600.00 PAY THIS AMOUNT

READ INSTRUCTIONS ON THE BACK BEFORE COMPLETING FORM

ALL PROFESSIONS ARE **REQUIRED** TO ANSWER THE QUESTIONS BELOW:

1. **Since you last registered,** has any state other than New York instituted charges against you for professional misconduct, unprofessional conduct, incompetence or negligence or revoked, suspended, or accepted surrender of a professional license held by you? [redacted]

2. **Since you last registered,** have you been convicted of any crime (felony or misdemeanor) in any state or country or have you been charged with any crime the disposition of which was other than by acquittal or dismissal? [redacted]

3. (a) Are you under an obligation to pay child support? ☐ YES ☒ NO
   If no, proceed to question #4 below.
   (b) If yes, do you meet one of the four requirements listed below? ☐ YES ☐ NO
   1) I am current or not four or more months in arrears in the payment of child support;
   2) I am making payments by income execution or by a court agreed payment or repayment plan or by a plan agreed to by the parties;
   3) My child support obligation is the subject of a pending court proceeding;
   4) I am receiving public assistance or supplemental security income.

4. I am a U.S. Citizen or I am an alien lawfully admitted for permanent residence in the U.S. or I am a non immigrant alien lawfully admitted to the U.S. as defined on the back of this form. ☒ YES ☐ NO

OFFICE USE ONLY

DATE:	01/16/04
LIC. NO.:	192823
NM CHK:	FLE3
DOB:	[redacted]
SSN:	
FEE:	600
PR:	60 OFF: 1
YR:	04 TYPE: RR
PEN:	
CA:	Y

5.
- Will you be practicing in NYS during the period indicated ? X Yes ___ No
  If NO, are you ___ Inactive ___ Retired.
- Enter the date you last practiced in New York State: 0 1 / 0 4 (month/year)
  If you are currently in practice, enter the present date.
- Since you last registered, 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 action due to professional misconduct, unprofessional conduct, incompetence or negligence ? ___ Yes X No
  If Yes, please provide documentation.

FLEISCHMAN JOAN M
WOMEN/FAMILY HEALTH
SUITE 404
188 MONTAGUE ST
BROOKLYN NY 11201-0000

6. **DATE OF BIRTH:** [redacted] Mo. Day Yr.

7. **SOCIAL SECURITY NUMBER:** [redacted] ☐ # applied for or pending ☐ Explanation attached

8. **FEDERAL EMPLOYER IDENTIFICATION NUMBER:** [redacted] (applicable only if you are an employer required to report employment taxes to the I.R.S.)

9. Under penalties of perjury, I declare and affirm that the statements above are an accurate representation and that such statements, including any accompanying documentation and explanations, are true, complete, and correct. I understand that any false or misleading information or statement in, or in connection with, my application may be cause for disciplinary action, including the loss of my license, and that willful failure to register while continuing to practice my profession constitutes professional misconduct.

Signature: [redacted] *Date:* 1/15/04

192823FLE3006000060106

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

09/01/05
LIC: 192823
NME: FLE3
YR: 06
OFF: 1
EIN:

FLEISCHMAN JOAN M
WOMEN/FAMILY HEALTH
SUITE 404
188 MONTAGUE ST
BROOKLYN NY 11201-0000

PROFESSION: 60 MEDICINE
PERIOD: 02/01/06 - 01/31/08

Name/address change
Complete only if change has occurred

Name

Street

City

State/Zip

$ 600
AMOUNT DUE

Complete and sign reverse side of this application

Cat 21F:032204

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 an alien admitted for permanent residence in the U.S.? ____ 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 wilful failure to register while continuing to practice my profession constitutes professional misconduct.

Signature _____ Daytime phone ( ) _____ Date _____

192823FLE3006000060108

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

12/17/07
LIC: 192823
NME: FLE3
YR: 08
OFF: 1
EIN:

FLEISCHMAN JOAN M
WOMEN/FAMILY HEALTH
SUITE 404
188 MONTAGUE ST
BROOKLYN NY 11201-0000

PIN: QU47251

PROFESSION: 60 MEDICINE
PERIOD: 02/01/08 - 01/31/10

****
*** 2ND REQUEST ***
****

Address change
Complete only if change has occurred

Street

City

State/Zip

$ 800
AMOUNT DUE

Cat 21:080406

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?	[redacted]	o
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?		o
c. Are criminal charges pending against you in any court?		o
d. Are charges pending against you in any jurisdiction for any sort of professional misconduct?		o
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?		o
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.?	☑ Yes	☐ No

133 12312007

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 [redacted] Daytime phone [redacted] Date 12/28/07

Cal21B 110705

☐ Acceptance of Federation Licensing Examination (FLEX) taken outside New York State.
Give dates and locations of all FLEX examinations taken. _____

My FLEX identification number (FIN) is: _____

☐ Endorsement of license from another State or Country.
Name State or Country: _____
Other: _____

☐ 5th Pathway (Section 6528 of the Education Law.)

16. I am a graduate of the following medical program:

Name of Medical School Attended and Location	Number of Years Attended	Class Completed	Dates Of Attendance		Diploma or Degree Obtained (If school is located Outside the United States, attach a copy)
			From	To	
HARVARD MEDICAL SCHOOL BOSTON, MA	4	1992	9/86	6/92	MD / MPA Joint Degree

17. Are you licensed as a physician in any states or countries? ☐ Yes ☒ No. (NOTE: Licensure in another jurisdiction is not a requirement for licensure in New York State.) If Yes, list each jurisdiction and appropriate information in the columns below. In addition, a Form 3A must be submitted for each license listed.

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

I give permission to the New York State Education Department to release my examination results to my professional school on a confidential basis for the purposes of program review and institutional research. ☒ Yes ☐ No Please Initial: JS

AFFIDAVIT

I hereby certify that I have read the statutory provisions, Rules of the Board of Regents and Regulations of the Commissioner of Education distributed to me by the State Education Department.

Under penalties of perjury, I declare and affirm that the statements made in the application, including accompanying statements and transcripts, 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.

6/9/93
Signature of Candidate — Date

Date of Photograph

RETURN TO [illegible]

192823FLE3006000060110

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

09/29/09
LIC: 192823
NME: FLE3
YR: 10
OFF: 1
EIN:

FLEISCHMAN JOAN M
WOMEN/FAMILY HEALTH
SUITE 404
188 MONTAGUE ST
BROOKLYN NY 11201-0000

PIN: AB44235

PROFESSION: 60 MEDICINE
PERIOD: 02/01/10 - 01/31/12

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 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? . . . . .

[redacted] No

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 [X] No

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

[redacted]

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 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 [redacted] Daytime phone ( ) 10/16 Date 09

"FORM 1 MEDICINE ALL CANDIDATES MUST COMPLETE BOTH SIDES OF THIS APPLICATION <u>EXCEPT</u> THOSE FILING FOR LIMITED PERMIT ONLY.	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, New York 12230 **APPLICATION FOR LICENSE AND FIRST REGISTRATION**	DEPARTMENT USE ONLY 710 00 069 6 FOR DEPOSIT ONLY NYSED CASH NO: 8 P01069 JUN 21 93

1 [redacted] SOCIAL SECURITY NUMBER

2 F L E — FIRST 3 LETTERS OF LAST NAME

3 BIRTH DATE [redacted] mo. day yr.

60 | ☑ 590 | ☐ | LX
☐ 465 | ☐ | ER
☐

4 PRINT FULL NAME EXACTLY AS YOU WISH IT TO APPEAR ON YOUR LICENSE, IF DETERMINED ELIGIBLE. (IMPORTANT: A request that contains only initials and the surname cannot be honored).

Last: FLEISCHMAN
First: JOAN
Middle: M

N.Y.S. License Number: 192823 7/1/93

5 ADDRESS

Care of: JOAN FLEISCHMAN
Misc. (Bldg. & Apt., etc.): [redacted]
Street: [redacted]
City: BRONX
State: NY Zip Code: [redacted]

The above address is: ☐ Permanent address of record ☑ Temporary mailing address

QUALS............................
APPROVED........................

6 TELEPHONE
At home [redacted] area code number
At work [redacted] area code number

7 Citizenship: ☒ United States ☐ Alien lawfully admitted for permanent residence in the United States. Citizen of ____________ Alien Registration Number ____________ (Attach a copy of alien registration card)

8 Name as it appears on diploma or other credentials. Joan Marie Fleischman.

		Circle Below	
9	Have you previously applied for a New York medical license or a limited permit?	Yes	(No)
10	Have you ever been convicted of a crime (felony or misdemeanor) in any state or country?	[redacted]	
11	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]	
12	Have you ever surrendered your license or been found guilty of professional misconduct, unprofessional conduct, incompetence or negligence in any state or country?	[redacted]	
13	Are charges pending against you for professional misconduct, unprofessional conduct, incompetence or negligence in any state or country?	[redacted]	
14	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]	

JUN 2 1 93

If the answer to questions 10-14 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 "Certification of Good Conduct."

15 I wish to be licensed in New York State on the basis of:

☒ National Board Examination (See Licensure Requirements - Section IV)

☐ National Board Examination/Osteopath (See Licensure Requirements - Section IV)

☐ Admission to the licensing examination in New York State (See Licensure Requirements - Section IV) Give date of FLEX examination requested: (Month and Year): ____________.

Requested exam center:
☐ New York City Area (Includes Long Island)
☐ Albany Area
☐ Buffalo Area

February 1992

COMPLETE OTHER SIDE

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, New York 12230

ALL CANDIDATES MUST COMPLETE THIS FORM

CANDIDATE EDUCATION AND TRAINING RECORD

1 [redacted] SOCIAL SECURITY NUMBER

2 FLE FIRST 3 LETTERS OF LAST NAME

3 BIRTH DATE [redacted] mo. day yr.

4 PRINT FULL NAME EXACTLY AS YOU WISH IT TO APPEAR ON YOUR LICENSE, IF DETERMINED ELIGIBLE. (IMPORTANT: A request that contains only initials and the surname cannot be honored.)

Last FLEISCHMAN
First JOAN
Middle M

5 ADDRESS

Care of JOAN FLEISCHMAN
Misc. (Bldg. & Apt., etc.) [redacted]
Street [redacted]
City BRONX
State NY Zip Code [redacted]

6 Basis of Licensure sought (Form 1, #15):

- [x] National Board
- [ ] Endorsement
- [ ] N.Y.S. Examination
- [ ] Limited Permit
- [ ] FLEX Outside N.Y.S.

7 IN THE SPACES BELOW, GIVE AN ACCURATE RECORD OF YOUR EDUCATIONAL PREPARATION. If necessary - attach a separate sheet.

SCHOOLS ATTENDED-Location Write names of schools in original language and translate.	NUMBER OF YEARS ATTENDED	ATTENDANCE				Diploma or degree obtained (Quote titles in original language and translate.)
		Entrance		Leaving		
		Class	Date	Class	Date	
Elementary or Primary School ONAWAY / WOODBURY	8	M	6/69		6/77	(Proof of completion need not be submitted.)
High School or Secondary School WOODBURY JR HIGH SCHOOL SHORTRIDGE HIGH SCHOOL	3 4		9/77		6/81	(Proof of completion need not be submitted.)
Post Secondary Pre-Professional (Exclusive of Medical School) UNIV OF CHICAGO	4		9/81		6/85	Candidates using Form 2A need not verify preprofessional training. Candidates using Form 2N must arrange that verification of preprofessional training be submitted directly from the school.
Medical Education (Professional) **(List all Medical Schools Attended)** HARVARD MEDICAL SCHOOL	6		9/86		6/92	(See Form 2A or 2N for verification requirements.)

February 1992

EDUCATIONAL PREPARATION BY APPLICANT IS TO BE MADE ON REVERSE SIDE

9 If clinical clerkships were completed in a country other than where your medical school is located, give the dates and location of these clerkships.

Inclusive Clerkship Dates	Clinical Area	Name of Health Care Facility and Address	Medical School in Which Taken/Address

10 Provide a chronological list of all activities since graduation from professional school to the present. Include vacation periods and periods of unemployment.

Date From	Date To	Type of Professional Activity, Including Name and Address of Employer, Beginning with Date of Graduation from Professional School
7/92	6/93	Medicine Internship Montefiore Hospital

11 Professional Certificates/Other Examinations.

MSKP	Date:	Score:	Certificate Number:	
Proficiency Examination	Name:	Date Medicine Passed:	Date English Passed:	Certificate Number:
Proficiency Examination				

Fifth Pathway	Name and Location of Medical School	Name and Location of Hospital	Inclusive Dates of Attendance

If more space is needed, please attach additional sheets of paper.

Return with this Form 3 together with [illegible] Division of Professional Licensing Services, Medicine, [illegible] New York [illegible]

The University of the State of New York
THE STATE EDUCATION DEPARTMENT

M-1 [redacted]3

CERTIFICATION OF COMPLETION

(Coursework/Training in Identification and Reporting of Child Abuse and Maltreatment)

PART A — TRAINEE INFORMATION

1. Trainee must complete all items in Part A. Return to provider for completion of Part B, "Certification by Approved Provider".
2. The provider will return the Certification form, with Part B completed, to the trainee. It is the trainee's responsibility to submit the original copy of this Certification form to the New York State Education Department at the appropriate time. It should be submitted along with other relevant forms when the trainee applies initially for, or renews, a license, registration certificate, or permit.
3. Address for submitting form is as follows:
   - Professional License or Permit: New York State Education Department, Division of Professional Licensing Services, [give name of profession], Cultural Education Center, Albany, New York 12230.
   - Reregistering Licensees: Your certificate should be included with your reregistration application in the envelope provided with those materials.
   - Teacher Certification: New York State Education Department, Office of Teaching, Cultural Education Center, Albany, New York 12230.

1 Print name exactly as it currently appears on New York State Education Department records:

Last: [redacted]
First: [redacted]
Middle: [redacted]

2 Print your address:

Care of: [redacted]
Misc. (bldg. & Apt., etc.): [redacted]
Street: [redacted]
City: [redacted]
State: [redacted] Zip Code: [redacted]

93 JUN 30 A8:08

3 Date of Birth: [redacted] Mo. Day Yr

4 Social Security numb[redacted]

5 Complete information below if you hold, or are applying for, professional license(s) or a permit:

Name of Profession(s): MD

N.Y.S License Number: [redacted]

N.Y.S License Number:

Permit #:

6 Complete information below if you hold, or are applying for a teaching certificate:

Certificate Title(s):

N.Y.S. Certificate Number (other than Social Security Number, if any):

Trainee's Signature: [redacted] Date: June 16, 1993

PART B — CERTIFICATION BY APPROVED PROVIDER

1. Provider must complete Part B.
2. The EDUCATION DEPARTMENT-ORIGINAL COPY and TRAINEE COPY should be returned to the trainee within ten calendar days of the completion of the coursework or training.
3. The provider of the coursework or training must retain the PROVIDER COPY. This copy must be retained in the provider's files for not less than five years from the date the course was completed.

Pursuant to Chapter 544 of the Laws of 1988, I certify that the person indicated in Part A has completed the required coursework or training regarding the identification and reporting of child abuse and maltreatment.

LEAH HARRISON RN-CNP
Name of Authorized Certifying Officer (Print or Type)

[redacted] RN CNP
Signature of Authorized Certifying Officer

MONTEFIORE MEDICAL CTR
Approved Provider Name

40136
Identification Number

June 16, 1993
Date(s) of Coursework or Training

PR 2 (10) - 591

STATE EDUCATION DEPARTMENT COPY

FORM 2A

MEDICINE

Graduates of N.Y.S. Registered or LCME Accredited Programs must complete this Form.

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, New York 12230

☐ Tentative
☐ Final

All fields
M.D.
6/11/93

CERTIFICATION OF PROFESSIONAL EDUCATION: REGISTERED OR ACCREDITED PROGRAMS

CANDIDATE INSTRUCTIONS

1. Complete Section I. Enter your name as it appears on your application Form 1.
2. Send this form to the professional school you attended. See "Licensure Requirements" for additional instruction. Be sure to include any fee required.
3. Certification is not acceptable unless dated after graduation.

SECTION I: CANDIDATE INFORMATION

1 [redacted] SOCIAL SECURITY NUMBER

2 FLE FIRST 3 LETTERS OF LAST NAME

3 BIRTH DATE [redacted] mo. day yr.

4 PRINT FULL NAME EXACTLY AS YOU WISH IT TO APPEAR ON YOUR LICENSE, IF DETERMINED ELIGIBLE. (IMPORTANT: A request that contains only initials and the surname cannot be honored.)

Last FLEISCHMANN
First JOAN
Middle M

5 ADDRESS

Care of JOAN FLEISCHMANN
Misc. (Bldg. & Apt., etc.) [redacted]
Street
City BRONX
State NY Zip Code [redacted]

MAY 17 1993

6 Basis of Licensure sought (Form 1, #15): ☑ National Board ☐ Endorsement ☐ N.Y.S. Examination ☐ Limited Permit ☐ FLEX Outside N.Y.S.

7 Print name under which degree or diploma was awarded: JOAN MARIE FLEISCHMAN

8 High School Attended: SHORTRIDGE HIGH SCHOOL, INDIANAPOLIS

9 Professional School Attended: HARVARD MEDICAL SCHOOL

Address: 25 SHATTUCK ST BOSTON 02115 Date degree was awarded: 6/92

CERTIFICATION BY PROFESSIONAL SCHOOL OFFICIAL IS TO BE MADE ON REVERSE SIDE

SECTION II: CERTIFICATION OF EDUCATION

INSTRUCTION TO SCHOOL: Please complete this section, sign the [illegible] and return the form directly to the Division of Professional Licensing Services. This form will not be accepted if submitted by the applicant.

CERTIFICATION BY N.Y.S. REGISTERED OR LCME ACCREDITED MEDICAL SCHOOL

1 Preprofessional Education:

1. The applicant has successfully completed 60 semester hours of preprofessional education: ☒ Yes ☐ No

   If No, please explain the basis on which applicant was admitted to medical school: _____

2. Did the program include the required New York State Child Abuse Reporting Information: ☐ Yes ☐ No

2 Professional Education:

Was admitted to Harvard Medical School (Name of Medical School)

on September 2, 1986 (Month/Day/Year) and satisfactorily completed the program on June 4, 1992* (Month/Day/Year) and was awarded the degree of M.D. (Degree) on June 4, 1992 (Month/Day/Year).

*1988-1990: Joint MD/MPP program

3 If the applicant was credited with advanced standing based on prior academic work, give institution name and dates of attendance.

Name of Institution: _____

Dates of Attendance: _____

Attach the following to this form:

1. Official transcript of studies at your institution.
2. Copies of documentation in your file to support the granting of transfer credit.

Signature: [redacted]

Print or Type Name: Carol A. Duffey

Title: Registrar

Medical School: Harvard Medical School

Address: 25 Shattuck Street
Boston, Massachusetts 02115

Telephone Number: 617-432-1515

Date: May 17, 1993

(COLLEGE SEAL)

Certification is not acceptable unless dated after graduation. Tentative certification will be accepted for examination applicants with final certification to be submitted upon graduation. Provided applicant is awarded the degree the day before the first day of the examination.

RETURN TO: [illegible]

FORM 2PGT	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, New York 12230	Any certification signed and submitted earlier then one month prior to the completion of the training period will be returned to the hospital by the division without processing.
• MEDICINE		
• ALL CANDIDATES MUST COMPLETE THIS FORM		

CERTIFICATION OF APPROVED POSTGRADUATE TRAINING

CANDIDATE INSTRUCTIONS

1. Complete Section I. Enter your name as it appears on your 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.
3. If you have completed more than 3 residencies, you may have the director of medical education complete a photocopy of the form.
4. This form must be sent directly to this office 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 chief. If the Department cannot determine that this verification came directly from the hospital, the post graduate hospital training will not be credited.

SECTION I: CANDIDATE INFORMATION

1	2	3
[redacted] SOCIAL SECURITY NUMBER	FLE FIRST 3 LETTERS OF LAST NAME	BIRTH DATE [redacted] mo. day yr.

4 PRINT FULL NAME EXACTLY AS YOU WISH IT TO APPEAR ON YOUR LICENSE, IF DETERMINED ELIGIBLE. (IMPORTANT: A request that contains only initials and the surname cannot be honored.)

Last: FLEISCHMAN
First: JOAN
Middle: M

5 ADDRESS

Care of: JOAN FLEISCHMAN
Misc. (Bldg. & Apt., etc.): [redacted]
Street: [redacted]
City: BRONX
State: NY
Zip Code: [redacted]

6 Print name under which postgraduate training was completed: JOAN FLEISCHMAN

7 Hospital in which postgraduate training was completed: MONTEFIORE HOSPITAL

Address: 111 E 210 St. Bronx, N.Y. 10467

CERTIFICATION BY AN OFFICIAL IS TO BE MADE ON REVERSE SIDE

SECTION II: CERTIFICATION OF POSTGRADUATE TRAINING

This is to certify that JOAN MARIE FROSCHMAN
(Physician's Name)

a graduate of HARVARD
(Medical School)

was enrolled in a residency training program approved by the Accreditation Council on Graduate Medical Education or the American Osteopathic Association

at Montefiore Med. Ctr. 111 E 210 St. Bronx, N.Y 10467
(Name and Location of Hospital)

from July 1 1992 thru June 30 1993 in the clinical area of Family Practice
(Clinical Area)

and that the above named physician successfully completed this training on June 30, 1993.

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

I am the director of medical education or departmental chief 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/Chief: [redacted] MD

Print or Type Name of Director/Chief: VICTORIA GORSKI

Title or Official Position: Director of Residency Training

Institution: Dept. Family Med. - Montefiore Med Ctr. (SEAL)

Address: 3544 Jerome Ave.
Bronx, N.Y. 10467

Telephone Number: (718) 920-5521

Date: 5/18/93

RETURN TO: Division of Professional Licensing Services, [illegible] Education Center, Albany, New York [illegible]

FORM 1SL

STUDENT LOAN DISCLOSURE

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, New York 12230

ALL CANDIDATES ARE REQUIRED TO COMPLETE THIS FORM

Chapter 78 of the laws of 1991 has added a new section 6501-a to the Education Law. That provision requires that the State Education Department ask the questions below regarding any student loans made or guaranteed by the New York State Higher Education Services Corporation. The effective date of this legislation was September 1, 1991. **Your license application is not complete until this information has been received.**

Please complete the information below. Please return it to Fee Unit, Division of Professional Licensing Services, Cultural Education Center, Albany, New York 12230 with your application, Form 1 and fee.

INSTRUCTIONS FOR COMPLETING AND SUBMITTING THIS FORM

1. Complete items 1-5 by printing all information clearly in the boxes provided.
2. Complete items 6 & 7 by placing an (X) in the appropriate box.
3. Complete item 8 by dating and signing.
4. Return this form with Form 1 and fee.

1 [redacted] SOCIAL SECURITY NUMBER

2 MD PROFESSION

3 BIRTH DATE [redacted] mo. day yr.

4 PRINT FULL NAME EXACTLY AS IT APPEARS ON YOUR APPLICATION.

Last FLEISCHMAN

First JOAN

Middle M

5 ADDRESS

Care of JOAN FLEISCHMAN

Misc. (Bldg. & Apt., etc.) [redacted]

Street [redacted]

City BRONX

State NY Zip Code [redacted]

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

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

8 Under penalty of perjury, I declare and affirm that the above information is true, complete, and correct.

5/6/93
DATE

[redacted]
SIGNATURE

February 1992

REGISTRATION APPLICATION

PROFESSION MEDICINE

PERIOD 01/01/95 - 01/31/96 **$ 179** PAY THIS AMOUNT

Make check or money order payable to New York State Education Department

RZ49013

The University of the State of New York
THE STATE EDUCATION DEPARTMENT
Office of Professional Credentialing
Professional Licensing Services
Cultural Education Center
Albany, NY 12230
(518) 474-3817

OFFICE USE ONLY

DATE: 08/01/94
LIC NO: 192823
NM: FLE3
DOB: [redacted]
SSN: [redacted]
FEE: 179
PR: 60 OFF: 1
YR: 95 TYPE: RR
PY:
CA: Y

READ INSTRUCTIONS ON REVERSE SIDE BEFORE COMPLETING THIS FORM

FLEISCHMAN JOAN M
[redacted]
BRONX NY [redacted]

7

This application may ONLY be used by the person whose name appears above

1 (a) **Since you last registered**, has any state other than New York instituted charges against you for professional misconduct, unprofessional conduct, incompetence or negligence or revoked, suspended, or accepted surrender of a professional license held by you? [redacted]

(b) **Since you last registered**, have you been convicted of any crime (felony or misdemeanor) in any state or country or have you been charged with any crime the disposition of which was other than acquittal or dismissal? [redacted]

(c) **Since you last registered**, 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 imposition of such action due to professional misconduct, unprofessional conduct, incompetence or negligence? [redacted]

2. Do you wish to register in New York State for the period indicated? ☑ Yes ☐ No
(Registration is required to practice your profession and use your professional title within New York State)

3. Are you currently practicing in New York State? ☑ Yes ☐ No
If no, provide month and year last practiced ___ / ___
Mo Yr

4. Date of Birth [redacted]
Mo Day Yr

5. Social Security # [redacted]
If Social Security # has not been provided check appropriate box below
☐ number applied for or pending ☐ explanation attached

6. Federal Employer Identification Number
(applicable only if you are an employer required to report employment taxes to the IRS)

7. Your profession must comply with a one-time requirement for two hours of coursework or training in the recognition and reporting of child abuse and maltreatment. Your registration will not be processed until this requirement has been satisfied. Your current status with regard to the requirement is noted to the right. SEE REVERSE SIDE
X or N - Requirement has not been satisfied. You must submit either a Certificate of Completion or Exemption.
Y - Requirement has been satisfied. You do not have to submit any additional information.
E - Exemption has been granted. You do not have to submit any additional information.
CA: Y

8. You must comply with the statutory requirement for completion of approved course work in infection control and barrier precautions to prevent the transmission of HIV and HBV in healthcare settings. Questions may be referred to the Infection Control/Occupational Health Unit of the NYS Department of Health at (518) 473-8815.

9. Under penalties of perjury, I declare and affirm that the statements above are an accurate representation and that such statements, including any accompanying documentation and explanations, are true, complete and correct. I understand that any false or misleading information or statement, in, or in connection with, my application may be cause for disciplinary action, including the loss of my license.

[redacted] 11 / 25 / 94
(Signature) (Date)

DECEASED NOTIFICATION

If you are aware that the licensee is deceased, please complete and sign the following statement in order to permit us to change our records and to prevent future correspondence from being mailed.

The licensee whose name appears above is deceased. Approximate date of death was ___ / ___ / ___.

___ ___ ___ / ___ / ___
(Signature) (Relationship to deceased) (Date)

FOLD FOLD

PLS CAT. 7 5/94

This is your application to register your professional license for the period indicated in the upper left corner of the application. Registration is required if you practice your profession or use your professional title within New York State.

If you do not expect to practice or use your professional title within New York State during the period indicated, you may voluntarily place your license on inactive status by checking "NO" to item 2 and returning the completed application without fee by the beginning of the new period. Please note: If you become inactive, a registration certificate will not be issued and future notices will not be sent to you until you reactivate your registration. Should you later decide to register for practice within New York, you will not be assessed delayed or late registration fees for the period your license was inactive.

If you do not return this application, either to register or to claim inactive status, your license will be automatically declared not registered. Should you later attempt to register for practice within the State, you may be assessed delayed or late registration fees for each month your license was not registered

INSTRUCTIONS FOR COMPLETING THE APPLICATION

1. Answer all questions. A response of "YES" to any question will not prevent or delay your reregistration.

   (a) If you answer "YES", submit a list of charges involved for each state and give a brief explanation of each action

   (b) If you answer "YES", submit a certified copy of the court records for each conviction. Do not check "YES" for minor traffic violations, charges that were dismissed or acquittals.

   For purposes of Item 1(c), section 29.2 of the Rules of the Board of Regents identifies this profession a health profession.

   (c) If you answer "YES", submit a statement describing the details of the separation.

2. Check "YES", if you plan to practice in New York State during the period. Registration is required if you practice your profession or use your professional title within New York State. If you do not plan to practice in the State and wish to claim inactive status, check "NO" and return the application without a fee (see above box for more information.)

3. If you are not currently practicing, enter the month and year you last practiced in New York State.

4. Please provide your date of birth.

5. Enter your Social Security Number in Item 5. If you do not have a Social Security Number, you must provide an explanation as indicated.

6. If you are an employer and hold a Federal Employer Identification Number, you must enter your employer identification number in the boxes provided.

   (The authority to collect this information is contained in Section 5 of the New York State Tax Law; it will be used for tax administration purposes.)

7. Licensees who complete, on or after September 1, 1990 an academic program registered by the State Education Department as fulfilling the educational requirements for licensure are credited with completion of the coursework and do not have to submit a Certificate of Completion nor file for an exemption. The coursework or training must be specifically approved for that purpose by the New York State Education Department; only approved providers can furnish the Certificate of Completion form required for reregistration. You should return the copy marked **STATE EDUCATION DEPARTMENT COPY** with your reregistration application. If you need to locate a provider, you should call Professional Licensing Services for assistance.

   Section 59.12 of the Regulations of the Commissioner of Education provides for exemption from the course requirement in cases where the nature of an individual's practice precludes any contact with children. If you believe you may qualify for such an exemption, call Professional Licensing Services to request an exemption application.

8. Please read the important information on the reverse side regarding a HIV/HBV requirement in your profession

9. Read the affirmation, sign and date the application. If you are registering, the fee must be paid with a check or money order made payable to the **NEW YORK STATE EDUCATION DEPARTMENT** in U.S. funds only. **DO NOT SEND CASH.** Section 6502 (7) of the Education Law requires a $25.00 penalty fee be charged, in addition to the original fee owed, to anyone who submits a bad check for registration or licensure. Such replacement fees must be paid by certified check, bank check, or money order. If replacement fees are not submitted within 60 days of the notice of a bad check, section 59.8 (g) of the Regulations of the Commissioner of Education stipulates that the registration may be voided.

- **DECEASED NOTIFICATION:** If you are aware that the licensee named on the application is deceased, please complete the appropriate information on the front and return using the enclosed envelope.
- **NAME AND ADDRESS CHANGE:** Use the enclosed card **ONLY** if you are reporting a change of name and/or address.
- **When returning the application, please do not staple, tape or clip any of the materials together. Please print your profession and profession code on the front of the return envelope. The professions and codes are listed on page 4.**

REGISTRATION APPLICATION

PROFESSION: MEDICINE

PERIOD: 02/01/96 - 01/31/98

710 00 069 6
$ 330 DEPOSIT ONLY NYSED
PAY THIS AMOUNT

OFFICE USE ONLY
DATE: 09/04/95
LIC NO: 192823
NM: FLEI
DOB: [redacted]
SSN: [redacted]
FEE: 330
PR: 60 OFF: 1
YR: 96 TYPE: RR
PY:
CA: Y

- Make check or money order payable to "New York State Education Department."
- To make sure that your registration is processed timely, please mail your application promptly. Receipt is requested at least 60 days before the start of the new period shown above.
- This application may ONLY be used by the person whose name appears below.
- Please read instructions on reverse side before completing this form.

C 9808 JA-9 95

The University of the State of New York
THE STATE EDUCATION DEPARTMENT
Office of the Professions
Professional Licensing Services
Cultural Education Center
Albany, NY 12230
(518) 474-3817

FLEISCHMAN JOAN M
[redacted]
BRONX NY 1[redacted]

7

- The above address is: ☐ Home ☐ Practice

FOLD

1 (a) Since you last registered, has any state other than New York instituted charges against you for professional misconduct, unprofessional conduct, incompetence or negligence, or revoked, suspended, or accepted surrender of a professional license held by you? [redacted]

(b) Since you last registered, have you been convicted of any crime (felony or misdemeanor) in any state or country, or have you been charged with any crime the disposition of which was other than acquittal or dismissal? [redacted]

(c) Since you last registered, 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 action due to professional misconduct, unprofessional conduct, incompetence or negligence? [redacted]

2 Do you wish to register in New York State for the period indicated? ☒ Yes ☐ No
(Registration is required to practice your profession or use your professional title within New York State.)

3 Are you currently practicing in New York State? ☒ Yes ☐ No
If no, provide month and year last practiced. ____ / ____ Mo. Yr.

4-5 Enter Date of Birth and Social Security Number ONLY if it is missing or incorrect in the OFFICE USE ONLY BOX above.

4 Date of Birth: ☐☐ ☐☐ ☐☐ Mo. Day Yr.

5 Social Security Number: ☐☐☐ - ☐☐ - ☐☐☐☐
If Social Security number has not been provided, check appropriate box below:
☐ *number applied for or pending* ☐ *explanation attached*

6 Federal Employer Identification Number: ☐☐ - ☐☐☐☐☐☐☐
(applicable only if you are an employer required to report employment taxes to the I.R.S.)

FOLD

7 Your profession must comply with a one-time requirement for two hours of coursework or training in the recognition and reporting of child abuse and maltreatment. Your registration will not be processed until this requirement has been satisfied. Your current status with regard to this requirement is noted to the right. *See reverse side for details.*

X or N - Requirement has not been satisfied. You must submit either a Certificate of Completion or Exemption. CA: Y
Y - Requirement has been satisfied. You do not have to submit any additional information.
E - Exemption has been granted. You do not have to submit any additional information.

8 You must comply with the statutory requirement for completion of approved course work in infection control and barrier precautions to prevent the transmission of HIV and HBV in healthcare settings. Questions may be referred to the Infection Control/Occupational Health Unit of the NYS Department of Health at (518) 473-8815.

9 Under penalties of perjury, I declare and affirm that the statements above are an accurate representation and that such statements, including any accompanying documentation and explanations, are true, complete, and correct. I understand that any false or misleading information or statement in, or in connection with, my application may be cause for disciplinary action, including the loss of my license.

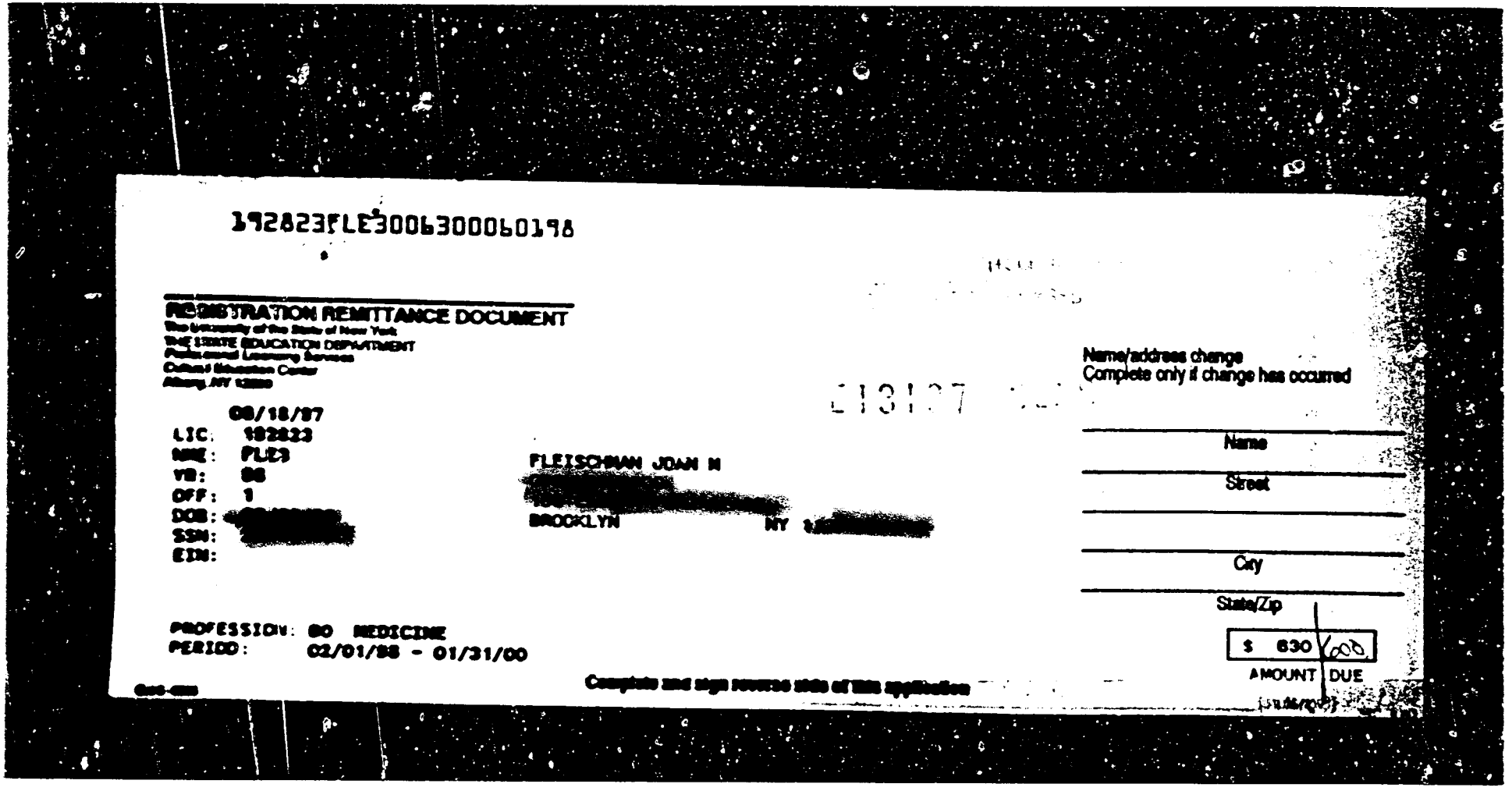
[redacted] 12/20/95
(Signature) *(Date)*

DECEASED NOTIFICATION

If you are aware that the licensee is deceased, please complete and sign the following statement in order to permit us to change our license records and to prevent future correspondence from being mailed.

THE LICENSEE WHOSE NAME APPEARS ABOVE IS DECEASED. Approximate date of death was ____ / ____ / ____ .

_____ _____ ____ / ____ / ____
(Signature) *(Relationship to deceased)* *(Date)*



192823FLE3006300060198

REGISTRATION REMITTANCE DOCUMENT

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

08/18/97
LIC: 192823
NME: FLEI
YR: 98
OFF: 1
DOB: [redacted]
SSN: [redacted]
EIN:

FLEISCHMAN JOAN M
[redacted]
BROOKLYN NY [redacted]

Name/address change
Complete only if change has occurred

Name

Street

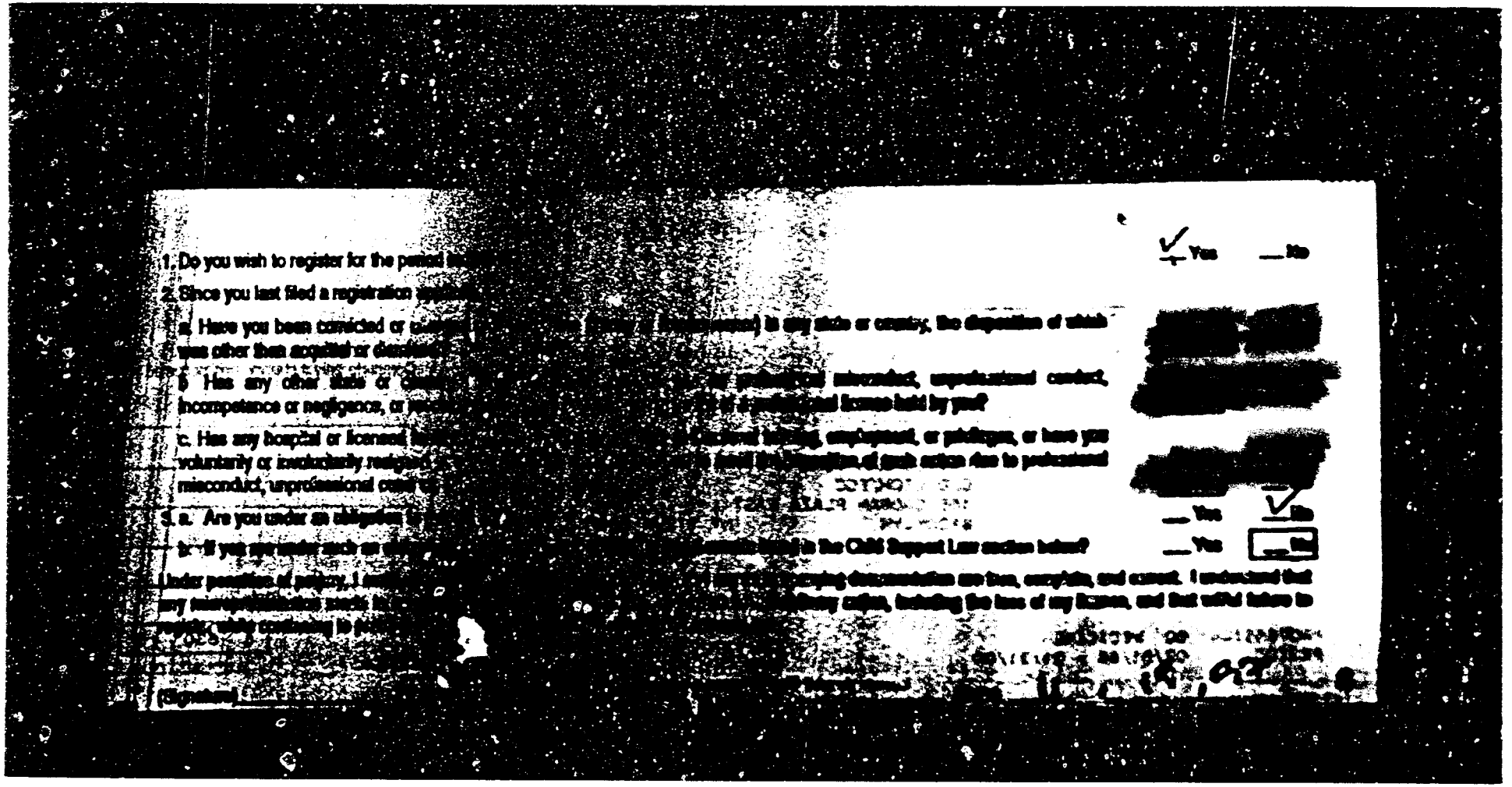
City

State/Zip

PROFESSION: 80 MEDICINE
PERIOD: 02/01/98 - 01/31/00

$ 630.00
AMOUNT DUE

Complete and sign reverse side of this application



REGISTRATION APPLICATION PERIOD: 02/01/00 - 01/31/02

PROFESSION: MEDICINE

$ 600 00

PAY THIS AMOUNT

READ INSTRUCTIONS ON THE BACK BEFORE COMPLETING FORM

E30809 E-1

ALL PROFESSIONS ARE REQUIRED TO ANSWER THE QUESTIONS BELOW.

1. Since you last registered, has any state other than New York instituted charges against you for professional misconduct, unprofessional conduct, incompetence or negligence or revoked, suspended, or accepted surrender of a professional license held by you? [redacted]

2. Since you last registered, have you been convicted of any crime (felony or misdemeanor), in any state or country or have you been charged with any crime the disposition of which was other than by acquittal or dismissal? [redacted]

3. (a) Are you under an obligation to pay child support? ☐ YES ☒ NO
If no, proceed to question #4 below
(b) If yes, do you meet one of the four requirements listed below? ☐ YES ☒ NO

1) I am current or not four or more months in arrears in the payment of child support;
2) I am making payments by income execution or by a court ordered payment or repayment plan or by a plan agreed to by the parties;
3) My child support obligation is the subject of a pending court proceeding;
4) I am receiving public assistance or supplemental security income

4. I am a U.S. Citizen or I am an alien lawfully admitted for permanent residence in the U.S. or I am a non-immigrant alien lawfully admitted to the U.S. as defined on the back of this form ☒ YES ☐ NO

OFFICE USE ONLY

DATE: 01/24/00
LIC. NO.: 192823
NM CHK: FLE3
DOB: [redacted]
SSN: [redacted]
FEE: 600 600.
PR: 60 OFF: 1
YP: 00 TYPE: RR
PEN:
CA: Y

5. Will you be practicing in NYS during the period indicated? X Yes ___ No
If NO, are you ___ Inactive ___ Retired

Enter the date you last practiced in New York State: 01/00 (month/year)
If you are currently in practice, enter the present date.

6. Since you last registered, 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 action due to professional misconduct, unprofessional conduct, incompetence or negligence? ___ Yes X No
If Yes, please provide documentation.

FLEISCHMAN JOAN M
[redacted]
BROOKLYN NY [redacted]

7. DATE OF BIRTH: [redacted] Mo Day Yr

8. SOCIAL SECURITY NUMBER: [redacted]
☐ # applied for or pending ☐ Explanation attached

9. FEDERAL EMPLOYER IDENTIFICATION NUMBER: ☐☐-☐☐☐☐☐☐☐ (applicable only if you are an employer required to report employment taxes to the I.R.S.)

10. Under penalties of perjury I declare and affirm that the statements above are an accurate representation and that such statements, including any accompanying documentation and explanations, are true, complete and correct. I understand that any false or misleading information or statement in, or in connection with, my application may be cause for disciplinary action including the loss of my license and that willful failure to register while continuing to practice my profession constitutes professional misconduct.

Signature [redacted] Date 1/24/00

192823FLE3000100060202

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

07/24/03
LIC: 192823
NME: FLE3
~~YR:~~ 02
OFF: 2
DOB:
SSN: [redacted]
EIN:

FLEISCHMAN JOAN M
[redacted]
BROOKLYN NY [redacted]

Name/address change
Complete only if change has occurred

Name
Women and Family Health, 188 Montague St, Suite 404
Street
Brooklyn NY
City
State/Zip

PROFESSION: 60 MEDICINE
PERIOD: 02/01/02 - 01/31/04

$ 10
AMOUNT DUE

Complete and sign reverse side of this application

Cat 6 - 1001

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 7/31/03

CS 16A - 0503

192823FLE3006000060102

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

01/14/02
LIC: 192823
NME: FLE3
YR: 02
OFF: 1
DOB: [redacted]
SSN:
EIN:

FLEISCHMAN JOAN M
[redacted]
BROOKLYN NY [redacted]

****
*** 2ND REQUEST ***
****

PROFESSION: 60 MEDICINE
PERIOD: 02/01/02 - 01/31/04

Complete and sign reverse side of this application

1001

Name/address change
Complete only if change has occurred

Name

Street

City

State/Zip

$ 600.00
AMOUNT DUE

u wish to register for the period indicated? — ✓ Yes — No

your last registration application,

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

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

criminal charges pending against you in any court?

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

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

you under an obligation to pay child support? — Yes — ✓ No

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

ou a U.S. citizen or a qualified alien as defined below? — ✓ Yes — No

DO NOT WRITE IN THIS BOX
FOR OFFICIAL USE ONLY

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

Signature [redacted] Business phone ([redacted] Date 1/20/02