This form may be completed online, printed and mailed to the address listed below.

Nebraska Department of Health and Human Services
Division of Public Health
Licensure Unit
P O Box 94986
301 Centennial Mall South
Lincoln, NE 68509-4986
(402) 471-2118

Licensure Fees:

Please see cover letter for correct fee.
Please write check to:
DHHS, Licensure Unit

REV. 4/05

LICENSURE UNIT

MAY 23 2008

RECEIVED

APPLICATION FOR LICENSE TO PRACTICE

(check appropriate category)

✓	MEDICINE AND SURGERY		OSTEOPATHIC MEDICINE AND SURGERY

APPLYING FOR LICENSURE BY EXAMINATION:

(check appropriate item)

✓	UNITED STATES MEDICAL LICENSING EXAMINATION (USMLE)
	NATIONAL BOARDS OF MEDICAL EXAMINERS (N.B.M.E.)
	NATIONAL BOARDS OF OSTEOPATHIC MEDICAL EXAMINERS (N.B.O.M.E.)
	FLEX ENDORSEMENT (took and passed FLEX exam in state of _____)
	LICENTIATE OF THE MEDICAL COUNCIL OF CANADA (L.M.C.C.)
	COMBINATION OF USMLE AND FLEX
	COMBINATION OF USMLE AND NATIONAL BOARD

APPLYING FOR LICENSURE BY RECIPROCITY:

	RECIPROCITY BY STATE EXAMINATION (Passed State exam in the State of _____)

Reciprocity candidates must meet all the requirements for licensure by examination, except instead of a national examination, these candidates may have taken a State Board Examination.

Legal Name	Last: Moore	First: Nicola	Middle: Louise	Maiden:
Date of Birth (MO/DAY/YR)	12/30/55	Place of Birth (City/State/Country)	London, England, U.K.	
Social Security Number:	[redacted]			
Telephone: (optional)	617-868-9887	FAX: (optional)		
E-Mail Address (optional)	drnicolamoore@yahoo.com			
Address (Dr. office or residence)	Street/PO/Route: 1 Richdale Avenue, Apt. 15			
	City: Cambridge	State: MA	Zip: 02140	
Indicate the date that you sent your fingerprint cards to the Nebraska State Patrol	5/19/08			

Have you ever sought or been granted medical licensure under another name? ***(answer yes or no)***	No
If yes, indicate other name(s) used:	
Have you ever held a license in any health profession in the State of Nebraska? (physical therapy, nursing, **temporary education permit**, etc.) ***(answer yes or no)***	No
If yes, please explain:	
Have you ever held a license in any jurisdiction in a health profession other than medicine and surgery? ***(answer yes or no)***	No
If yes, please explain:	

PRELIMINARY AND PRE-MEDICAL EDUCATION

Give name and location of institutions attended, beginning with high school, listing diplomas or certificates and date received for preliminary and pre-medical education.

Institution:	Westlake School
City/State/Country:	Los Angeles, CA, U.S.A.
Diploma/Certificate:	High School Diploma
Date: (MO/YR)	06/1972
Institution:	Yale University
City/State/Country:	New Haven, CT, U.S.A.
Diploma/Certificate:	B.A.
Date: (MO/YR)	12/1976
Institution:	Columbia University
City/State/Country:	New York, New York, U.S.A.
Diploma/Certificate:	no diploma/degree (pre-medical studies)
Date: (MO/YR)	completed 7/1995

MEDICAL EDUCATION I have spent 4 years in the study of medicine in the institution(s) listed below:			
Name of Institution	Albert Einstein College of Medicine		
City/State/Country	Bronx, NY, U.S.A.		
Attended From	(M/D/Y) 8/1/1995	To	(M/D/Y) 6/3/99
Degree Conferred (MD, DO, MBBS, etc)	MD		
Name of Institution			
City/State/Country			
Attended From	(M/D/Y)	To	(M/D/Y)
Degree Conferred (MD, DO, MBBS, etc)			
You must request that official documentation showing successful completion of an accredited school or college of medicine be sent directly to the Department from the institution. This must indicate the degree you received and the date it was conferred. Documents not written in English must be accompanied by an official English translation.			
FOREIGN MEDICAL GRADUATES			
Foreign medical graduates MUST have ECFMG send an official verification of their **permanent ECFMG Certificate that is valid indefinitely** directly to our office (the ECFMG phone number is 215-386-5900 and the website is www.ECFMG.org). **My ECFMG number is:** _____			

POST-GRADUATE MEDICAL EDUCATION Indicate whether service was Internship, Residency or Fellowship.	
Name of Institution	University of Rochester
Name of Internship/ Residency/Fellowship	Family Medicine / Residency
City/State/Country	Rochester, N.Y., U.S.A.
Attended From:	(M/D/Y) 6/99
Attended To:	(M/D/Y) 9/02
Name of Institution	University of Rochester
Name of Internship/ Residency/Fellowship	Family Planning / Fellowship
City/State/Country	Rochester, N.Y., U.S.A.
Attended From:	(M/D/Y) 9/02
Attended To:	(M/D/Y) 6/03
Name of Institution	
Name of Internship/ Residency/Fellowship	
City/State/Country	
Attended From:	(M/D/Y)
Attended To:	(M/D/Y)
You must request that official documentation showing successful completion of postgraduate medical education be sent directly to the Department from the program. A Certificate of Post-Graduate Medical Education form must be completed by the Program Director. The form is attached to this application packet. United States graduates must show successful completion of at least one year of postgraduate medical education in the U.S. or Canada. Foreign graduates must show at least three years of postgraduate medical education in the U.S. or Canada or approved graduate medical education. Documents not written in English must be accompanied by an official English translation.	

LICENSURE IN OTHER STATES

Have you ever been granted medical licensure by any State or Territory? ***(answer yes or no)***	Yes

If yes, list all current and non-current licenses below:

You must request a Verification of Licensure or Letter of Good Standing from each State Medical and Osteopathic Board from each location where you hold or have held a license to practice medicine and surgery, a temporary education permit and/or a locum tenens. This document must be sent directly to our office.

State or Territory	License Number	Effective Date	Expiration Date
Masssachusetts	223184	2/16/05	12/30/08
New York	219226	9/14/00	11/30/09
California	89646	12/17/04	12/31/08

MAINTENANCE OF COMPETENCY

Nebraska statute requires that you present proof that, **within the three years immediately preceding this application for licensure**, you meet *one of the following criteria*. Check the criteria which applies to you:

☐	I have been in the active practice of the profession of medicine and surgery in some other state, a territory, the District of Columbia, or Canada for a period of one **year within the three years immediately preceding this application**. *List this information in the section of this application marked "Professional Activities".*
☐	I have had at least one year of approved graduate medical **education within the three years immediately preceding this application.** *List this information in the section of this application marked "Post-Graduate Medical Education".*
☑	I have completed at least 75 hours of Category I Continuing Education as approved by the ACCME or AOA in medicine and surgery **within the three years immediately preceding this application.** *Submit proof of attendance at continuing education, as well as information about the content for Board approval.*
☐	I have completed a refresher course in medicine and surgery **within the three years immediately preceding this application.** *Submit proof of attendance at a refresher course, as well as information about the content for Board approval. This information can be a course brochure, a course syllabus or other official documentation.*
	I have completed the Special Purpose Examination (SPEX) administered by the Federation of State Medical Boards (FSMB) on the following date _____. *Have your SPEX score sent directly to this office from the FSMB.*

PROFESSIONAL ACTIVITIES – List in chronological order **all activities since graduation, including absences from work, except for incidental sick leave and usual vacation.** Also list all periods of non-professional activity or employment for more than three months. Please account for all time if engaged in private practice and explain all gaps in activity. Use additional page(s) if necessary.*

From: Month/Year	8/1995	To: Month/Year	9/2002
Name of Facility:	University of Rochester		
City/State/Country:	Rochester, N.Y., U.S.A.		
Activity:	Residency in Family Medicine		

From: Month/Year	9/2002	To: Month/Year	6/2003
Name of Facility:	University of Rochester		
City/State/Country:	Rochester, N.Y., U.S.A.		
Activity:	Fellowship in Family Planning		

From: Month/Year	7/2003	To: Month/Year	10/2003
Name of Facility:	University of Rochester		
City/State/Country:	Rochester, N.Y., U.S.A.		
Activity:	family practice work (per-diem)		

From: Month/Year	11/2003	To: Month/Year	7/2004
Name of Facility:	Mpilo Central Hospital		
City/State/Country:	Bulawayo, Zimbabwe		
Activity:	family practice work (volunteer)		

From: Month/Year	10/2004	To: Month/Year	2/2005
Name of Facility:	Ler Hospital - Medicins Sans Frontieres (Holland)		
City/State/Country:	Ler, South Sudan		
Activity:	family practice work		

* See next page for continuation.

CONTROLLED SUBSTANCES REGISTRATION

A separate Nebraska Controlled Substances Registration is not required upon providing proof of a Federal Controlled Substances Registration (DEA number) to this office. Check one of the following:

✓	I have enclosed a photocopy of my current Federal Controlled Substances Registration. My Federal Controlled Substances Registration Number is BM7981536, and it expires on 1/31/2011.
	I am currently applying for a Federal Controlled Substances Registration, and will send a photocopy of such when I receive the registration.
	I do not have nor am I applying for a Federal Controlled Substances Registration and I will not be prescribing, administering or dispensing controlled substances in Nebraska. I understand that at such time that I do intend to prescribe, administer or dispense controlled substances in Nebraska, I will first need to have a Federal Controlled Substances Registration issued to me. At that time I am also to supply a photocopy of the registration to the State of Nebraska.

From: Month/Year	2/2005	To: Month/Year	5/2005
Name of Facility:	Liverpool School of Tropical Medicine		
City/State/Country:	Liverpool, England, U.K.		
Activity:	Study of Tropical Medicine		

From: Month/Year	8/2005	To: Month/Year	12/2005
Name of Facility:	Outer Cape Health Services		
City/State/Country:	Provincetown, Massachusetts, U.S.A.		
Activity:	family practice work		

From: Month/Year	1/2006	To: Month/Year	5/2006
Name of Facility:	St. Francis Hospital		
City/State/Country:	Katete, Zambia		
Activity:	family practice work		

From: Month/Year	6/2006	To: Month/Year	9/2006
Name of Facility:	Outer Cape Health Services		
City/State/Country:	Provincetown, Massachusetts, U.S.A.		
Activity:	family practice work		

From: Month/Year	11/2006	To: Month/Year	1/2008
Name of Facility:	St. Luke's Mission Hospital		
City/State/Country:	Bulawayo, Zimbabwe		
Activity:	family practice work		

From: Month/Year	5/2008	To: Month/Year	Present
Name of Facility:	Boston Healthcare for the Homeless Program		
City/State/Country:	Boston, Massachusetts, U.S.A.		
Activity:	family practice work		

Trish Louise Moore 5/16/08

REGULATORY INFORMATION

If you answer YES to any of the following questions, explain the circumstances and outcomes on the back of this application. **You must sign and date any additional pages that you attach to the application. Please read the information at the end of this section regarding the malpractice and misdemeanor/felony conviction information that is required.**

1	Has any State or Territory of the U.S. ever taken any of the following actions against your license?	***(answer yes or no)***
	Denied	No
	Revoked	No
	Suspended	No
	Limited	No
	If yes, explain circumstances and outcomes.	
2	Has any licensing or disciplinary authority ever taken any of the following actions against your license?	***(answer yes or no)***
	Limited	No
	Restricted	No
	Suspended	No
	Revoked	No
3	Has any licensing or disciplinary authority placed your license on probation? ***(answer yes or no)***	No
4	Have you ever voluntarily surrendered a license issued to you by a licensing or disciplinary authority? ***(answer yes or no)***	No
5	Have you ever voluntarily limited in any way a license issued to you by a licensing or disciplinary authority? ***(answer yes or no)***	No

6	Have you ever been requested to appear before any licensing agency? ***(answer yes or no)***	No
7	Have you ever been notified of any charges or complaints filed against you by any licensing or disciplinary authority or criminal prosecution authority? ***(answer yes or no)***	No
8	Are you aware of any pending disciplinary actions against your license in any jurisdiction? ***(answer yes or no)***	No
9	Are you aware of any on-going investigations of a disciplinary complaint against your license in any jurisdiction? ***(answer yes or no)***	No
10	Have you ever been addicted to, dependent upon or chronically impaired by alcohol, narcotics, barbiturates, or other drugs which may cause physical and/or psychological dependence: ***(answer yes or no)***	No
11	During the past ten years, have you voluntarily entered or been involuntarily admitted to an institution or health care facility for treatment of a mental or emotional disorder/condition? ***(answer yes or no)***	No
12	During the last ten years, have you been diagnosed with or treated for bipolar disorder, schizophrenia, or any psychotic disorder? ***(answer yes or no)***	No

13	Have you ever been convicted of a felony*? ***(answer yes or no)***	No
	Failure to disclose any such convictions regardless of when the conviction occurred could result in disciplinary action, including but not limited to a minimum of $500 civil fine.	
14	Have you ever been convicted of a misdemeanor*? ***(answer yes or no)***	No
	Failure to disclose any such convictions regardless of when the conviction occurred could result in disciplinary action, including but not limited to a minimum of $500 civil fine.	
15	Have you ever been denied a Federal Drug Enforcement Administration (DEA) Registration or State controlled substances registration? ***(answer yes or no)***	No
16	Have you ever been called before any licensing agency or lawful authority concerned with DEA controlled substances? ***(answer yes or no)***	No
17	Have you ever surrendered your State or Federal controlled substances registration? ***(answer yes or no)***	No
18	Have you ever had your State or Federal controlled substances registration restricted in any way? ***(answer yes or no)***	No
19	Have you ever been notified of any malpractice claim against you **? ***(answer yes or no)***	No

All applicants must complete the following:		
Effective July 1, 2004, the Department is authorized to assess an administrative penalty in the amount of $10 per day, not to exceed a total of $1,000 when evidence exists that a person has practiced medicine and surgery prior to being issued a license or permit.		
20	Have you practiced medicine and surgery in Nebraska prior to issuance of a Nebraska Permit or License? ***(answer yes or no)***	No
	If yes, how many days have you practiced medicine and surgery in Nebraska prior to issuance of a Nebraska Permit or License?	Total Number of ***DAYS***
Students of medicine and surgery enrolled in an accredited college of medicine who gratuitously practice medicine and surgery under the supervision of a licensed physician are exempt from needing a Permit or License in the State of Nebraska, pursuant to Neb. Rev. Stat. 71-1, 103 (4). Once an individual has graduated from medical school, however, a Permit or License is required in the State of Nebraska in order to practice medicine and surgery. The question above, therefore, refers to the time since you have graduated from medical school until such time as you have received a Permit or License to practice medicine and surgery in the State of Nebraska.		

** **Required Misdemeanor/Felony Conviction Information** If you have had any misdemeanor or felony convictions you must submit:	
1	Official Court Record, which includes charges and disposition;
2	Copies of Arrest records;
3	A letter from the applicant explaining the nature of the conviction;
4	All addiction/mental health evaluations and proof of treatment, if the conviction involved a drug and/or alcohol related offense and if treatment was obtained and/or required; and
5	A letter from the probation officer addressing probationary conditions and current status, if the petitioner is currently on probation.

* **Required Malpractice Information** Regarding your malpractice, claim(s), **please include the following information. Sign and date your explanation**.	
A	State the **total number of claims ever filed against you;** *and*
B	Submit a **detailed explanation** (see below) of each claim ever filed against you. Do *not* send copies of forms completed for insurance companies or other entities.
C	For any malpractice claims that are **currently pending**, submit copies of the court documents that outline the statement of charges (often called the "Complaint") and a letter from the attorney stating the current status of the claim.
Include the following information regarding each claim:	
1	Name, sex and age of patient;
2	Date of occurrence;
3	Initial event (procedure/diagnosis);
4	Subsequent event that precipitated the claim – include the time sequence in relation to the initial event;
5	Damages – a description of damages or alleged damages resulting from the initial and subsequent events;
6	Date of filing of malpractice claim in court (if applicable);
7	Outcome of claim – include the court disposition, whether or not the case was settled, and **the amount of any monetary settlement or judgement made on your behalf. If no money was paid on your behalf, you must indicate this**.
8	Date of final outcome of claim.

AFFIDAVIT

I, Nicola Louise Moore, depose and say that I am the person referred to in the foregoing application and supporting documents and that I am of good moral character. I have carefully read the questions in the foregoing application and have answered them completely, without reservations of any kind, and I declare under penalty of perjury that my answers and all statements made by me herein and all supporting documents are true and correct to the best of my knowledge. I further solemnly swear upon my honor that if granted a license to practice Medicine and Surgery within the State of Nebraska, that I shall abide by the laws of Nebraska.

Signature of Applicant Nicola Louise Moore Date 5/13/08
(M/D/Y)

State of MASSACHUSETTS)
County of Middlesex)

In Cambridge (city) in said county on this 13 day of May, 2008,
Nicola Moore personally appeared before me, and being duly sworn, deposes and says that he/she has carefully and truthfully completed this application. Proved to me By NY License

(SEAL)

Susan Daley
Notary Public

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

My Commission Expires 10-01-2010
Month/Day/Year

ALBERT EINSTEIN COLLEGE OF MEDICINE
YESHIVA UNIVERSITY
Jack and Pearl Resnick Campus
Office of the Registrar

Transcript for: **MOORE, NICOLA L.**
Matriculated: 1995

Class of: 1999
Printed: 05/22/2008

Year 1

Biochemistry	P	Cell Biology	P	*Epidemiology	P
*Genetics . .	P	*Gross Anatomy/Embryology	P	Histology. .	P
*Immunology .	P	*Intro to Patient	P	Neuroscience	P
*Physiology .	P	*Psychopathology.	P		

Year 2

Cardiovascular System[1,3]	P	Clinical Examination .	P	Endocrine System[1,2,3] . .	
GI/Liver System[1,2,3] . .	P	Hematology[1,2,3]	H	Intro Disease Mechanisms[3]	
Micro/Infect. Disease[1,3]	H	Nervous System[1]	P	Parasitology[3]	P
Pharmacology	P	Renal System[1,3]	P	Reproductive Systems[1,2,3]	P
Respiratory System[1,3] . .	P	Rheumatologic Disease[1]	H		

Year 3

Family Medicine Clerkship	H	Medicine Clerkship .	HP	**Neurology Clerkship.	P
Obstetrics/GYN Clerkship	HP	Pediatrics Clerkship	HP	Psychiatry Clerkship	HP
Surgery Clerkship. . . .	P				

Year 4

Ambulatory Care/Ind.Hea.	H	Cardiology Preceptorship	P	Clinical Ophthalmology	P
Diagnostic Radiology LIJ	HP				
Extramural elective. . .		Maternal & Child Health. . .	H		
*Geriatrics Clerkship . .	P	Medicine Subinternship	HP		

MD Degree granted June 03, 1999

Not valid without seal.

Certified by:

Grading: (Year 1 & Year 2)
H=Honors *P=Pass Only
F=Fail E=Exempt I=Incomplete
(Year 3 & Year 4)
H=Honors HP=High Pass P=Pass
LP=Low Pass F=Fail I=Incomplete
D=Deferred E=Exempt N=Ungraded
** Clerkships 2 weeks or less, Pass/Fail only

Sarifa Switzer

Mrs. Sarifa Switzer
Registrar

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

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

Date : 05/27/2008

Recipient:

Nebraska Board of Medicine and Surgery
ATTN: Vicki Bumgarner
PO Box 94986
Lincoln, NE 685094986

Examinee: Moore, Nicola Louise
Alt Name(s):

Examinee ID#: 5-030-515-0
Date of Birth: 12/30/1955

Results for Steps taken by this examinee (and for which results have been reported to date) are shown below. For Steps that span more than one day, the test date reflects the day on which the examination began. Where numeric scores are reported, there are two scales used and the recommended minimum passing score ("MP") on each scale is shown in parentheses.

USMLE STEP 1

			Three-Digit Score		Two-Digit Score		
	Test Date	Pass/Fail	Total	MP	Total	MP	Comments
	06/10/1997	Pass	214	176	86	75	

USMLE STEP 2

Clinical Knowledge (CK)

			Three-Digit Score		Two-Digit Score		
	Test Date	Pass/Fail	Total	MP	Total	MP	Comments
	08/25/1998	Pass	201	170	82	75	

USMLE STEP 3

			Three-Digit Score		Two-Digit Score		
	Test Date	Pass/Fail	Total	MP	Total	MP	Comments
EW YORK	07/19/2000	Pass	194	177	80	75	

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

Interpretation of results

USMLE transcripts include a complete results history and notations of any examinations for which the examinee sat and no results were reported, e.g., "Incomplete." On those Step examinations for which numeric scores are reported, two different scales are used. The first is a three-digit score scale on which most scores fall between 140 and 280. The recommended minimum passing score is shown on the front of the transcript next to the examinee's score for each administration. The second is a two-digit scale on which a score of 75 is the recommended minimum passing score. The level of proficiency required to meet the recommended minimum passing level for each USMLE Step is reviewed periodically and is subject to change.

For examinations with reported scores, the Standard Error of Measurement (SEM) provides an index of the variation that would be expected to occur if an examinee were tested repeatedly using different sets of items covering similar content. The SEM is usually in the range of 4 to 8 points on the three-digit scale and 1 to 2 points on the two-digit scale.

STEP 2 CLINICAL SKILLS (CS)

The Clinical Skills (CS) component of Step 2 was introduced in 2004 and the USMLE transcript has been modified to reflect this change. The Step 2 examination that existed prior to the introduction of Step 2 CS continues to be administered as the Clinical Knowledge (CK) component of Step 2. The label "Step 2 CK" is used for this examination whether taken before or after the introduction of the Step 2 CS component.

Step 2 CS results are reported as pass or fail. Had the two-digit reporting scale been used, examinees would have had to achieve a score of 75 or higher in order to pass.

Some individuals may be required to take and pass Step 2 CS prior to registering for Step 3. Transcript users can find information on eligibility requirements for all USMLE examinations in the *USMLE Bulletin of Information* and from periodic Step 2 CS updates, available at the USMLE website (www.usmle.org).

ANNOTATIONS APPEARING UNDER "COMMENTS"

Circumstances in connection with an administration shown on this transcript may result in one or more annotations listed next to the score. A description of each "Comment" is provided below:

Indeterminate - Results that cannot be certified as representing a valid measure of the examinee's knowledge or competence as sampled by the examination. Decisions to classify results as indeterminate may be made on the basis of factors that include, but are not limited to, unexplained inconsistency of performance within the examination or between administrations of the same Step. **No score is reported.** Information regarding the nature of the indeterminate score and the determination of the Committee on Score Validity is available. If such information is not enclosed within this transcript, it may be obtained by contacting the organization from which you received the transcript or the USMLE Secretariat, 3750 Market Street, Philadelphia, PA 19104, telephone (215) 590-9700.

Incomplete - The examinee sat for some, but not all, of the scheduled examination. **No score is reported.**

Irregular Behavior - The Committee on Irregular Behavior determined that the examinee engaged in irregular behavior. Examples of irregular behavior are described in the current edition of the *USMLE Bulletin of Information*. Information regarding the nature of the irregular behavior and the determination of the Committee is available. If such information is not enclosed with this transcript, it may be obtained by contacting the organization from which you received the transcript or the USMLE Secretariat, 3750 Market Street, Philadelphia, PA 19104, telephone (215) 590-9700.

Score Not Available - The score is not available. Further review and/or analysis may be pending, or it may have been determined that the score cannot be reported.

Test Accommodations - Following review and approval of a request from the examinee, test accommodations were provided in the administration of the examination.

ANNOTATIONS APPEARING AS "NOTE"

Circumstances not in connection with an administration shown on this transcript may result in one or more annotations and an explanation or instructions to contact the appropriate individual or organization. The "Note" will appear at the end of the document.

BOARD ACTION DATA BANK INFORMATION APPEARING AS "NOTE"

The Board Action Data Bank of the Federation of State Medical Boards (FSMB) contains actions reported to the FSMB by U.S. licensing and disciplinary boards, Canadian licensing authorities, the U.S. Armed Forces, the U.S. Department of Health and Human Services, and other credentialing entities. To be included in the Data Bank, an action must be a matter of public record or be legally releasable to state medical boards or other entities with recognized authority to review physician credentials. Certain actions reported to and released by the Board Action Data Bank are not disciplinary or otherwise prejudicial in nature. Such actions are reported to ensure that records are complete and to assist in preventing misrepresentation or the use of lost or stolen credentials by unauthorized persons. Once reported to the FSMB, an action becomes part of the permanent record to the individual physician, and the existence of such an action may be indicated on the USMLE transcript by a "Note".

State of Nebraska
Department of Health and Human Services
Licensure Unit
P O Box 94986
301 Centennial Mall South
Lincoln, NE 68509-4986
(402) 471-2118

CERTIFICATE OF POST-GRADUATE MEDICAL EDUCATION

Applicants must have the **current Program Director** of the institution where they completed their post-graduate medical education complete the following form and **affix the Official School Seal**. An **original** signature from the Program Director is required. Please mail the form directly to the address printed above.

Print Name NICOLA LOUISE MOORE **SS#** [redacted]

NOTE: The information below must be completed ONLY by an official of the program/facility.
NOT TO BE COMPLETED BY APPLICANT

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

Has successfully completed Reproductive Health Fellowship
(Name of Residency/Internship/Fellowship)

located at : University of Rochester/Highland Hospital (Name of Hospital/Teaching Institution) **in** Rochester, NY, USA (City, State, Country)

From 09/23/02 (Month/Day/Year) **To** 06/30/03 (Month/Day/Year)

At the time this applicant was enrolled in this Program, this Program was:

_____ **ACGME* or AOA* accredited**

_____ **RCPSC* or CFPC* accredited**

X **was not accredited by any of the above listed entities**

*ACGME - Accreditation Council for Graduate Medical Education
*AOA – American Osteopathic Association
*RCPSC – Royal College of Physicians and Surgeons of Canada
*CFPC – College of Family Physicians of Canada

Any Disciplinary Action? Yes _____ No X If yes, provide details of the disciplinary action.

Any Derogatory Information on File? Yes _____ No X If yes, provide details of the derogatory information.

* Signature Susan M. Gardner
Signature of CURRENT PROGRAM DIRECTOR
(Signature stamp **NOT** acceptable)

Print Name SUSAN M. GARDNER

Title Program Coordinator

Date (month/day/year) 06/09/08

Phone # 585-506-9484 x128

Fax # 585-473-2245

E-mail susan_gardner@urmc.rochester.edu

INSTITUTIONAL SEAL

(If your institution does not have an official seal, this form must be notarized)

* Signature of current Program Coordinator. The Director is out of the office for 2 weeks.
Note: Attaching letter from Eric Schaffer, MD showing support during his time as director

LICENSURE UNIT

JUN 20 2008

RECEIVED

State of Nebraska
Department of Health and Human Services
Licensure Unit
P O Box 94986
301 Centennial Mall South
Lincoln, NE 68509-4986
(402) 471-2118

CERTIFICATE OF POST-GRADUATE MEDICAL EDUCATION

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Print Name NICOLA LOUISE MOORE **SS#** [redacted]

NOTE: The information below must be completed ONLY by an official of the program/facility.
NOT TO BE COMPLETED BY APPLICANT

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

Has successfully completed Family Practice Residency
(Name of Residency/Internship/Fellowship)

located at : Univ. Rochester/Highland **in** Rochester, NY USA
(Name of Hospital/Teaching Institution) (City, State, Country)

From 6/21/99 **To** 9/22/02
(Month/Day/Year) (Month/Day/Year)

At the time this applicant was enrolled in this Program, this Program was:

✓ **ACGME* or AOA* accredited**

_____ **RCPSC* or CFPC* accredited**

_____ **was not accredited by any of the above listed entities**

*ACGME - Accreditation Council for Graduate Medical Education
*AOA – American Osteopathic Association
*RCPSC – Royal College of Physicians and Surgeons of Canada
*CFPC – College of Family Physicians of Canada

Any Disciplinary Action? Yes _____ No ✓ If yes, provide details of the disciplinary action.

Any Derogatory Information on File? Yes _____ No ✓ If yes, provide details of the derogatory information.

Signature _____
Signature of CURRENT PROGRAM DIRECTOR
(Signature stamp **NOT** acceptable)

Print Name Laurie Donohue MD

Title Associate Program Director

Date (month/day/year) 6/10/08

Phone # 585-279-4830

Fax # 585-442-8319

E-mail laurie_donohue@urmc.rochester.edu

INSTITUTIONAL SEAL

(If your institution does not have an official seal, this form must be notarized)

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

May 28, 2008

LICENSURE UNIT
JUN 02 2008
RECEIVED

NEBRASKA BOARD OF MEDICINE AND SURGERY
HEALTH AND HUMAN SERVICES
REGULATION AND LICENSURE CREDENTIALING DIVISION
PO BOX 94986
LINCOLN NE 68509-4986

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

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

Carrie Doyle

Staff Member, Board of Registration in Medicine
Carrie Doyle

THE UNIVERSITY OF THE STATE OF NEW YORK
THE STATE EDUCATION DEPARTMENT
DIVISION OF PROFESSIONAL LICENSING SERVICES
CERTIFICATION & VERIFICATION UNIT
89 WASHINGTON AVENUE
ALBANY, NEW YORK 12234

LICENSURE UNIT

MAY 27 2008

RECEIVED

NE

THIS IS TO CERTIFY THAT ACCORDING TO THE RECORDS OF THE DIVISION OF PROFESSIONAL LICENSING SERVICES, NEW YORK STATE EDUCATION DEPARTMENT, ALBANY, NEW YORK, MOORE NICOLA LOUISE
WAS ISSUED LICENSE/CERTIFICATE NUMBER 219226 FOR THE PRACTICE OF MEDICINE ON 09/14/00.

OUR RECORDS ALSO INDICATE THE FOLLOWING INFORMATION:
DATE OF BIRTH: 12/30/55
SCHOOL ATTENDED: ALBERT EINSTEIN MED COL
DATE OF GRADUATION: 06/03/99
DEGREE EARNED: MD

PROGRAM WAS ACCEPTABLE IN ACCORDANCE WITH THE NYS REGULATIONS OF THE COMMISSIONER OF EDUCATION. REQUIREMENTS MET AT THE TIME OF LICENSURE.

BASIS OF LICENSURE:

DATE	EXAM	SCORE
07/00	USMLE STEP3	80
08/98	USMLE STEP2	82
06/97	USMLE STEP1	86

EXMS TAKEN=03

A LICENSE IS VALID DURING THE LIFE OF THE HOLDER UNLESS REVOKED, ANNULLED OR SUSPENDED BY THE BOARD OF REGENTS. A LICENSEE MUST REGISTER PERIODICALLY WITH THIS DEPARTMENT TO PRACTICE IN THIS STATE

CURRENTLY REGISTERED: YES REG PERIOD ENDS: 11/30/09
ADDRESS: APT 15 1 RICHDALE AVE
CAMBRIDGE MA 02140-0000
DEROGATORY INFORMATION: NO CHARGES HAVE BEEN PREFERRED AGAINST THIS LICENSEE.
COMMENTS:

I MARTIN CARMODY, PRINCIPAL CLERK, DIVISION OF PROFESSIONAL LICENSING SERVICES OF THE NEW YORK STATE EDUCATION DEPARTMENT, DO HEREBY STATE THAT AS PRINCIPAL CLERK OF SAID DIVISION, I HAVE LEGAL CUSTODY OF THE OFFICIAL RECORDS OF THE DIVISION OF PROFESSIONAL LICENSING SERVICES AND TO THE BEST OF MY KNOWLEDGE, THE AFORESAID INFORMATION IS TRUE AND CORRECT.

Martin Carmody 05/22/08
PRINCIPAL CLERK