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 JUDY CHARMANE WASHINGTON.

Witness my hand and the seal of the New York State Education Department this 3 June, 2011.

Connie F. Mitchell, Clerk II
Professional Licensing Services

DATED
06/03/2011

DO Exp Ref $60 mafield Rig 2/PGT/5075/ AccCA Cert 5-10-05

Medicine Form 1

RECEIVED
PROFESSIONAL LICENSING UNIT II
2005 APR 28 AM 8:07

The University of the State of New York
THE STATE EDUCATION DEPARTMENT
Office of the Professions
Division of Professional Licensing Services
89 Washington Avenue
Albany, NY 12234-1000
www.op.nysed.gov

Department Use Only

QS 79842
60 ER 795
$60 ERC Reg. 5/17/05

☐ | 60 | $735 | ER

Application for Licensure and First Registration

Applicants Must Complete All Six Pages Of This Application *In Ink*

DB OK 6/16/05

NYS License Number 236582

Date Issued 6-17-05

Initials

1 Social Security Number *(Leave this blank if you do not have a U.S. Social Security Number)* [redacted]

2 Birth Date Month [redacted] Day [redacted] Year [redacted]

3 Print Name Exactly As You Wish It To Appear On Your License

Last: WASHINGTON
First: JUDY
Middle: CHARMAME

4 Mailing Address (You must notify the Department promptly of any address or name changes.)

Apt./Bldg. [redacted]
Street [redacted]
City: SUMMIT
State: NJ Zip Code [redacted]
Province/Country If not U.S.

5 Telephone/E-Mail Address

Daytime Phone [redacted]
Area Code Phone Number

E-Mail Address (Please print clearly) [redacted]

6 Name as it appears on degree or other credentials (if different from above): Judy C. Washington, MD

7 Citizenship: ☑ United States ☐ Alien lawfully admitted for a permanent residence in the United States ☐ Other Immigration
Citizen of: ______
Attach a photocopy of the front and back of your Alien Registration Card

8 I wish to become licensed on the basis of:
☑ Acceptable examination scores *(see page 3 of this form)* ☐ Endorsement of another license *(See "Applicants Licensed in Another State" section of instructions.)*
I am using FCVS to collect my credentials: ☐ YES ☐ NO

9 Have you previously applied for a New York State License or a limited permit to practice medicine? ☐ YES ☑ NO

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

11 Are criminal charges pending against you in any court? YES NO

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

13 Are charges pending against you in any jurisdiction for any sort of professional misconduct? YES NO

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? YES NO

NOTE: If you answer "Yes" to any questions numbered 10-14, 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."

15 In the spaces below, give an accurate record of your educational preparation. **Be sure to complete items A-E for each school.** Please print. List diploma or degree titles in original language and translate. If no diploma or degree, indicate number of credits earned. Attach additional sheets if necessary.

A. NAME OF SCHOOLS ATTENDED AND LOCATIONS	B. NUMBER OF YEARS ATTENDED	C. ATTENDANCE		D. TITLE OF DIPLOMA OR DEGREE OBTAINED (INDICATE YEAR OBTAINED)	E. IF NO DIPLOMA OR DEGREE, INDICATE NUMBER OF CREDITS EARNED
		Entrance Date	Leaving Date		
High School or Secondary School School Name: Woodlawn High School City: Birmingham State/Country: Alabama (USA	4	8/71 mo/yr	5/75 mo/yr		
Postsecondary Preprofessional School(s) (Exclusive of Medical School) School Name: University of Montevallo City: Montevallo State/Country: Alabama	4	8/75 mo/yr	5/79 mo/yr	BSdegree 1979	
School Name: City: State/Country:		__/__ mo/yr	__/__ mo/yr		
Medical Education (Professional, list all medical schools attended) School Name: Meharry Medical College City: Nashville State/Country: Tennessee (USA)	4	8/79 mo/yr	5/83 mo/yr	MD-degree 1983	
School Name: City: State/Country:		__/__ mo/yr	__/__ mo/yr		

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

16 Are you licensed or have you ever been licensed as a physician in any other state or country? Yes [x] No [ ]

If yes, list each jurisdiction. If appropriate, you must also submit a Form 3A or 3B. See pages 14 - 15.

State or Country	Date License Issued	Number	Basis of Licensure			Any Limitations on License
			Examination (Date passed)	Endorsement	Other	
New Jersey	3/17/1989	MA52836	NBME (7/2/84	NBME		No
Maryland	7/17/84	D31108	NBME 7/2/84	NBME		NO
Tennessee	5/20/1996	27890	"	"		No

17 **Complete this section 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 [x] No

Do you currently hold a valid ECFMG certificate? [ ] Yes [x] No

Please complete and forward the ECFMG form.

18 Are you applying for licensure on the basis of a Fifth Pathway program? [ ] Yes [x] 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

19 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

20

[ ] I will be applying for USMLE Step 3

OR

[x] 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
- [x] 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 7/2/84

21 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.
5/29/83	June 30,83	Vacation
July 1, 83	June 30, 84	Internship - Greater Baltimore Medical Center 6565 North Charles St. Ste 203, Baltimore MD 21204
July 84	June 1, 85	employed Central Maryland Medical Group (No longer in Business)
July 85	June 30, 86	General Surgery - Morristown Memorial Hospital 100 Madison Ave, PO Box 1956, Morristown NJ 07962
June 1, 85	June 30, 85	Vacation / Marriage / Moving to NJ.
June 30, 86	June 30 87	- Maternity leave / Vacation
July 1, 87	June 30, 1990	Family Medicine Residency - Mountainside Family Practice 793 Bloomfield Ave, Verona, NJ 07044
July 1, 1990	5/25/96	Employed - Faddan & Washington PA - Hurlock & Cambridge MD private practice dissolved.
5/29/96	5/25/2002	Asst. Professor in Family Medicine - East TN State -
		James Quillen School of Medicine - Memorial ETSU
		Family Practice Residency - 2525 de Sales Ave, Chattanooga
		TN - 37204
5/25/2002	6/1/2002	Vacation / Relocation to NJ
6/3/2002	present	Asst Prof of Family Medicine - UMDNJ New Jersey Medical School 185 South Orange Ave MSB-B648 Newark, NJ, 07103

22 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 (mm/dd/yy)
		/ /
		/ /
		/ /
		/ /

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

☐ I graduated from a medical school in New York State 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.

☐ I am going to take the Child Abuse Identification course and submit the required form.

24

GENDER AND ETHNICITY: (This item is optional.)

Information on gender and ethnicity is sought solely to allow the Education Department to collect and analyze data concerning diversity 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.

GENDER: ☐ Male ☑ Female

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

25

STUDENT LOAN DISCLOSURE:

The State Education Department is required* to ask these questions about any student loans made or guaranteed by the New York State Higher Education Services Corporation, and to forward any "yes" responses to the New York State Higher Education Services Corporation. **Your license application is not complete without this information.**

(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

*New York State Education Law, section 6501-a

26

CHILD SUPPORT OBLIGATION:

Everyone applying for or renewing a professional license, permit, or registration must 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 under 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 not in compliance with their obligation to pay child support can be issued a credential for no more than six months in order to comply with their child support obligations.

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.

*New York State General Obligations Law, section 3-503

27	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 the Division of Professional Licensing Services in writing. ☒ Yes ☐ No Please initial: ______

28 PHOTOGRAPH REQUIREMENT:

Date of photo: 10/04

29 AFFIDAVIT WITH ACKNOWLEDGMENT (Notarization required.)

APPLICANT

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 and may result in criminal prosecution.

Signature of the applicant: ______ MD

NOTARY

State of New Jersey County of UNION

On the 15TH day of April in the year 2005 before me, the undersigned, personally appeared Judy C. Washington MD personally known to me or proved to me on the basis of satisfactory evidence to be the individual whose name is subscribed to this application and acknowledged to me that he/she executed the application and swore that the statements made by him/her in the application and all supporting materials are true, complete, and correct.

Notary Public signat______

Notary ID number 2394469

Expiration date 11 / 27 / 2007
(Month / Day / Year)

RENEE Y. DE LA TORRE
Notary Public, State of New Jersey
Commission Expires Nov. 27, 2007

Mail this form and appropriate fee to: New York State Education Department, Office of the Professions, Fee Section, Division of Professional Licensing Services, 89 Washington Avenue, Albany, NY 12234-1000. DO NOT SEND CASH. Make check or money order payable to the New York State Education Department.

6-14-05

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

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 for 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, permit, or teaching certificate.
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), 89 Washington Avenue, Albany, NY 12234.
   - 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, 89 Washington Avenue, Albany, NY 12234.

1 SOCIAL SECURITY NUMBER: [redacted]
(Leave this blank if you do not have a U.S. Social Security Number)

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

3 PRINT YOUR FULL NAME EXACTLY AS IT CURRENTLY APPEARS ON NEW YORK STATE EDUCATION DEPARTMENT RECORDS

Last: WASHINGTON
First: JUDY
Middle: CHARMAINE

4 MAILING ADDRESS (You must notify the Department promptly of any address or name changes.)

Line 1: [redacted]
Line 2: [redacted]
Line 3:
City: SUMMIT
State: NJ
Zip Code: [redacted]

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

Name of Profession(s): Physician

New York State License Number:

New York State License Number:

Permit Number:

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

Certificate Title(s):

New York State Certificate Number (other then Social Security Number, if any):

Trainee's Signature: [signature], MD Date: 06 / 14 / 05 (mo. day yr.)

Part B: Certification by Approved Provider

1. Provider must complete Part B.
2. Two copies 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 a 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 198, 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.

[redacted]
Signature of Authorized Certifying Officer

Karen Mauceri
Name of Authorized Certifying Officer

Medical Society of the State of New York
Approved Provider Name

10608
Identification Number

Date(s) of Coursework or Training

JUN-14-2005 TUE 02:51 PM FAX NO. P. 02/02

File NB CA

S.Ff
f²05

FORM 2
MEDICINE

The University of the State of New York
THE STATE EDUCATION DEPARTMENT
Office of the Professions
Division of Professional Licensing Services
89 Washington Avenue
Albany, NY 12234-1000

RECEIVED PROFESSIONAL LICENSING UNIT D
2005 MAY -5 A 8:07

CERTIFICATION OF PROFESSIONAL AND PREPROFESSIONAL EDUCATION

APPLICANT INSTRUCTIONS

1. Complete Section I. Enter your name as it appears on your New York State Licensure Application (Form 1) or Limited Permit Application (Form 5B). Be sure to sign and date item 10.
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. **International Medical Graduates may not use this form if Form 1 and fee are submitted after November 30, 2002.**
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., SEESCYT).
4. This form must be signed by the Registrar, Dean, Rector, or Principal of the medical school and sent back directly to the Office of the Professions by that school official in an official school envelope to the address at the end of this form. Forms sent back by the applicant or other parties 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

71034 3

3 PRINT FULL NAME EXACTLY AS IT APPEARS ON YOUR LICENSURE APPLICATION (FORM 1) OR LIMITED PERMIT APPLICATION (FORM 5B)

Last: WASHINGTON
First: JUDY
Middle: CHARMANE

4 MAILING ADDRESS:

Apt./Bldg. [redacted]
Street [redacted]
City: SUMMIT
State: NJ
Zip Code [redacted]
Province/Country If not U.S.: UNITED STATES

5 TELEPHONE/E-MAIL

HOME [redacted]
Area Code Number
WORK [redacted]
Area C[redacted]
E-Mail [redacted]

6 Print name under which your degree or diploma was awarded *(if different from above)*: Judy Washington-Foote

7 Preprofessional School Attended:

8 Professional School Attended: Meharry Medical College
Address: 1005 Dr. DB Todd Blvd, Nashville, TN, 37208-3599

9 Name of Degree/Diploma: Medical (MD) Date awarded: 5/29/83

10 I request and give my permission to the school listed in item 8 above to complete Section II of this form and mail it to the New York State Education Department at the address at the end of this form, and to release any other information requested by the State Education Department in connection with my application for licensure.

Applicant's signature: [redacted] Date: 4 / 13 / 05

SECTION II : CERTIFICATION OF PROFESSIONAL EDUCATION

INSTRUCTION TO SCHOOL: Please complete this section, sign certifying statement, attach the information required in Item 5 and 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 ***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

2 Did the applicant receive advanced standing based on prior academic work? ☐ YES ☒ NO
If Yes, indicate when the prior work was completed below and submit **an official transcript of studies at your Institution**, and copies of documentation in your file to support the granting of transfer credit.

Name of Institution: ____________________ Dates of attendance: __________ to __________

3 Applicant's Entrance date: 08 / 20 / 79 Completion Date: 05 / 27 / 83

4 Degree/diploma conferred: Doctor of Medicine Date of conferral: 05 / 29 / 83

5 ***For All Other Applicants:***

Years of education required for admission into your medical school: at least 3 years

Preprofessional credential/degree submitted by applicant for admission into your medical school: B.S.

Was Social Service required? ☐ YES ☒ NO If Yes, give inclusive dates and name of institution in which requirement was met.

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 or convalidation.
The transcript must bear the original signature of the registrar, dean, principal or rector and original seal of the school.

B. A copy of documentation from your files to support the granting of transfer credit or convalidated course and clerkships.

C. List of clinical clerkship completed outside jurisdiction where medical school is located, including (for each): area or specialty, 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: [redacted] *Date:* 05 / 03 / 05

Type or print: Cynthia A. Murr[redacted]

Title: Registrar

Medical school: Meharry Medical College

Address: 1005 D.B. Todd Blvd.
Nashville, TN 37208

Telephone: 615-327-6223 *Fax* 615-327-6228

E-mail address: cmurry@mmc.edu

(SEAL)

CERTIFICATION IS NOT ACCEPTABLE UNLESS DATED AFTER GRADUATION.

Return this form Directly to: →	New York State Education Department, Office of the Professions, Division of Professional Licensing Services, Medicine Licensing Unit, 89 Washington Avenue, Albany, NY 12234-1000.

7 ule NDCA

FORM 2PGT
MEDICINE

RECEIVED PROFESSIONAL LICENSING UNIT II
2005 MAY -6 AM 8:07

The University of the State of New York
THE STATE EDUCATION DEPARTMENT
Office of the Professions
Division of Professional Licensing Services
89 Washington Avenue
Albany, NY 12234-1000

Certification of completion of approved postgraduate training will be accepted only if it is signed no more than one month prior to the completion date of the training period in which credit is sought.

CERTIFICATION OF APPROVED POSTGRADUATE TRAINING

(To be used only by applicants not using FCVS who need to verify approved postgraduate training programs in the US and Canada)

APPLICANT INSTRUCTIONS

1. Complete Section I. Enter your name as it appears on your Licensure Application (Form 1). Be sure to sign and date item 7.
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 do not have a U.S. Social Security Number)

2 BIRTH DATE: [redacted]
Month Day Year

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

14
5.04 H7
5.17.07

Last: WASHINGTON
First: JUDY
Middle: CHARMAINE

4 MAILING ADDRESS:
Apt./Bldg: [redacted]
Street: [redacted]
City: SUMMIT
State: NJ
Zip Code: [redacted]
Province/Country If not U.S.: UNITED STATES

5 Print name under which postgraduate training was completed: Judy C. Washington

6 Hospital in which postgraduate training was completed: Greater Baltimore Medical Center
Address: 6565 North Charles St. Suite 203 Baltimore, MD 21204

7 I request and give my permission to the hospital listed in item 6 above to complete Section II of this form and mail it to the New York State Education Department at the address at the end of this form, and to release any other information requested by the State Education Department in connection with my application for licensure.

Applicant's signature: [redacted] Date: 4/13/05

SECTION II : CERTIFICATION OF POSTGRADUATE TRAINING

INSTRUCTION TO HOSPITAL: Please complete this section, sign certifying statement, and return the form *directly* to the Division of Professional Licensing Services at the address shown below. **This form will not be accepted if returned by the applicant.**

This is to certify that JUDY C. WASHINGTON
(Physician's name)

a graduate of ______________________
(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
GREATER BALTIMORE MEDICAL CENTER
(Name and location of Hospital)

Level of Training (example: PGY-1)	Clinical Area	Inclusive dates (mm/dd/yy)	Successfully completed
PGY-1	INTERNAL MEDICINE	7/1/83 to 6/30/84	☒ YES ☐ NO ☐ In progress; satisfactory to date
		__/__/__ to __/__/__	☐ YES ☐ NO ☐ In progress; satisfactory to date
		__/__/__ to __/__/__	☐ YES ☐ NO ☐ In progress; satisfactory to date
		__/__/__ to __/__/__	☐ YES ☐ NO ☐ In progress; satisfactory to date
		__/__/__ to __/__/__	☐ YES ☐ NO ☐ In progress; satisfactory to date

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: [redacted] Date: 4/28/05

Type or print name of Director/Chair: Suzanne M. Caccamese

Title or official position: Associate Program Director

Institution: Greater Baltimore Medical Center

(SEAL)

Address: 6565 N. Charles St. Ste 203
Baltimore, MD 21204

Telephone: 4438493740 Fax: 4438498138

E-mail Address: scaccamese@gbmc.org

Return this form directly to:

New York State Education Department, Office of the Professions, Division of Professional Licensing Services, Medicine Licensing Unit, 89 Washington Avenue, Albany, NY 12234-1000

236582WAS2004100060107

REGISTRATION RENEWAL DOCUMENT

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

01/02/07
LIC: 236582
NME: WAS2
YR: 07
OFF: 1
EIN:

WASHINGTON JUDY CHARMANE

SUMMIT NJ

Address change
Complete only if change has occurred

Street

City

State/Zip

PROFESSION: 60 MEDICINE
PERIOD: 08/01/07 - 09/30/08

$ 410
AMOUNT DUE

Complete and sign reverse side of this application

Cat 21[illegible]

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 willful failure to register while continuing to practice my profession constitutes professional misconduct.

Signature ____________________ Daytime phone (   ) ____________ Date ____________

Registration Renewal - Transaction Summary

License Number : 236582
Profession : MEDICINE
Renewal Period : 10/01/2008 through 09/30/2010

We recommend that you print and keep this transaction summary. Thank you for using OP Registration Online.

WASHINGTON JUDY CHARMANE
[redacted]
SUMMIT NJ [redacted]

Renewal Status : **Paid On-line - Renewal Complete**

Offices Selected for Renewal:

	Address	Fee
1)	[redacted] MIT, NJ, [redacted]	$ 600

Response to Questions :

	Question	Response
1)	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]
2)	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?	[redacted]
3)	Are criminal charges pending against you in any court?	[redacted]
4)	Are charges pending against you in any jurisdiction for any sort of professional misconduct?	[redacted]
5)	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]
6)	Are you under an obligation to pay child support?	No
7)	Are you a U.S. citizen?	Yes

License Renewal Payment Details:

Receipt No : VTHN2DDAD97D
Payment Date : 08/28/2008
Amount Paid : $ 600

Return to Main Page

Registration Renewal - Transaction Summary

Main Page | Logout

License Number : 236582
Profession : MEDICINE
Renewal Period : 10/01/2010 through 09/30/2012

We recommend that you print and keep this transaction summary. Thank you for using OP Registration Online.

WASHINGTON JUDY CHARMANE

SUMMIT NJ

Renewal Status : **Paid On-line - Renewal Complete**

Offices Selected for Renewal:

	Address	Fee
1)	SUMMIT, NJ, US	$ 600

Response to Questions :

	Question	Response
1)	Have you been found guilty after trial, or pleaded guilty, no contest, or nolo contendere to a crime (felony or misdemeanor) in any court?	
2)	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?	
3)	Are criminal charges pending against you in any court?	
4)	Are charges pending against you in any jurisdiction for any sort of professional misconduct?	
5)	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?	
6)	Are you under an obligation to pay child support?	No
7)	Are you a U.S. citizen?	Yes

License Renewal Payment Details:

Receipt No : VRFN5E8394E5
Payment Date : 09/06/2010
Amount Paid : $ 600

Return to Main Page