FORM 1
MEDICINE

ALL CANDIDATES MUST COMPLETE THIS FORM

THE UNIVERSITY OF THE STATE OF NEW YORK
THE STATE EDUCATION DEPARTMENT
DIVISION OF PROFESSIONAL LICENSING SERVICES

APPLICATION FOR LICENSE AND FIRST REGISTRATION

COMPLETE BOTH SIDES OF THIS APPLICATION

Department Use Only

710 00 063 6
FOR DEPOSIT ONLY NYSED
CASH NO.: #

E48957 SP-4 60

370 LX
295 ER
60 PR

1. [redacted] Social Security Number
2. GOR 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 GORDON
First MARCUS
Middle TULIO

5. ADDRESS (check only one) ☒ permanent address of record ☐ temporary mailing address*

* If temporary address has been provided, please also note special instructions about temporary mailing addresses contained in "Licensure Requirements."

Care of
Misc. (Bldg. & Apt., etc.) [redacted]
Street [redacted]
City Flushing
State New York ZIP [redacted] Country

N.Y.S. License Number KC
163240 10/20/86

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

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

7. CITIZENSHIP ☒ United States ☐ Alien Lawfully admitted for permanent residence in the United States.
Citizen of _____

8. Name as it appears on diploma or other credentials. Marcus Tulio Gordon

9. Have you previously applied for a New York State 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?	☐ Yes	☒ No
11. Have you ever been charged with a crime (felony or misdemeanor) in any state or country, the disposition of which was other than in acquittal or dismissal?	☐ Yes	☒ No
12. Have you ever surrendered your license or been found guilty of professional misconduct, unprofessional conduct, incompetence or negligence in any state or country?	☐ Yes	☒ No
13. Are charges pending against you for professional misconduct, unprofessional conduct, incompetence or negligence in any state or country?	☐ 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your professional training, employment, or privileges or have you ever voluntarily or involuntarily resigned or withdrawn from such association to avoid imposition of such manner?	☐ Yes	☒ No

If the answer to questions 10–14 is "Yes," submit a letter giving a complete explanation as applicable, also include copies of your court records and a copy of the "Certificate of Relief from Disabilities" or your "Certificate of Good Conduct."

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

☒ National Board Certificate (See page 4).
☐ National Board Certificate/Osteopath (See page 5).
☐ Admission to the licensing examination in New York State (See page 5).
Give date of Flex examination requested (Month and Year) _____
Requested exam center: ☐ New York City Area ☐ Albany Area ☐ Buffalo Area
☐ 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.)

• COMPLETE OTHER SIDE •

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

Name of Medical School Attended and Location	Number of Years Attended	Class Completed	ATTENDANCE		Diploma or Degree Obtained (if school is located Outside the United States, attach a copy)
			Entrance Date	Leaving Date	
School Albert Einstein College of Medicine 1300 Morris Park Ave Bronx, New York 10461	4	/55 4th yr medical school	9/81	6/85	M.D.

17. I am a licensed physician in the following states or countries:

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

AFFIDAVIT

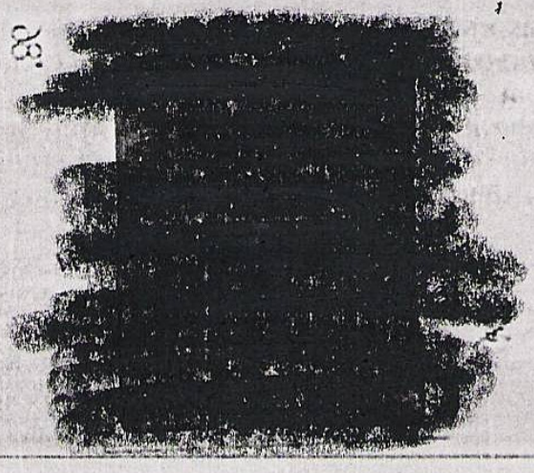
I hereby certify that I have read the statutory provisions, Rules of the Board of Regents and Regulations of the Commissioner of Education distributed to me by the State Education Department.

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.

[redacted]
Signature of candidate

8/28/86
Date

• DO NOT STAPLE •



Date of Photograph August 28, 1986

FORM 2
MEDICINE

THE UNIVERSITY OF THE STATE OF NEW YORK
THE STATE EDUCATION DEPARTMENT
DIVISION OF PROFESSIONAL LICENSING SERVICES

ALL CANDIDATES MUST COMPLETE THIS FORM.

CANDIDATE EDUCATION AND TRAINING RECORD

1. [redacted] Social Security Number

2. GOR 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: GORDON

First: MARCUS

Middle: TULIO

5. Basis of licensure sought (see item 15 on Form 1): ☐ by examination ☒ by endorsement

6. In the spaces below, give an accurate record of your educational preparation.

SCHOOLS ATTENDED-Location Quote names of schools in original language and translate	NUMBER OF YEARS ATTENDED	ATTENDANCE Entrance Class	 Date	 Leaving Class Completed	 Date	Diploma or degree obtained Quote titles in original language and translate.
Elementary or Primary School Our Lady of Grace New York, New York	9	Kindergarten	9/64	8th grade	6/73	(Proof of completion of elementary school need not be submitted.
Secondary or High School Cardinal Hayes New York, NY DeWitt Clinton New York, NY	2 1	9th grade 12th grade	9/73 9/76	11th grade 12th grade	6/76 6/77	(Proof of completion of secondary or high school need not be submitted)
Post Secondary Study (Exclusive of Medical School) Cheyney State College Cheyney, Pa City College of New York New York, New York	½ 3 ½	1st year undergraduate 2nd year undergraduate	9/77 1/78	1st year (Freshman) 2Eb → 4th year (senior) undergraduate	1/78 6/81	(Proof of completion of pre-professional training *must be* submitted directly by the school)
Medical Education (List all Medical Schools Attended) Albert Einstein College of Medicine New York N.Y.	4	1st year medical school	9/81	4th year medical school	6/85	(See Form 2A or 2N for submission requirements)

• COMPLETE OTHER SIDE •

7. * If Clinical Clerkships were completed in a country other than where your medical school is located, give the dates and location of those clerkships.

Exact Clerkship Dates	Clinical Area	Health Care Facility Where Taken/Location	Medical School In Which Taken/Location

8. List all training activities chronologically since graduation from professional school to the present. Vacation periods, and periods of unemployment *must* be included. (Proof must be submitted for all medical experience claimed in the Unites States or Canada.)

FROM		TO		Type of Professional Training, Including Name and Address of Employer, Beginning with Date of Graduation from Professional School
Month	Year	Month	Year	
7	85	7	86	Internship - Montefiore Hospital / Medical Center - Surg

9. Professional Certificates/Other Examinations

MSKP	Date:		Certificate No.:	
Proficiency Examination	Name:	Date Medicine Passed	Date English Passed	Certificate No.

Specialty Boards (if more space is needed attach on separate sheet).

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

FORM 2A
MEDICINE

THE UNIVERSITY OF THE STATE OF NEW YORK
THE STATE EDUCATION DEPARTMENT
DIVISION OF PROFESSIONAL LICENSING SERVICES

9/17/86
SD

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

CERTIFICATION OF PROFESSIONAL EDUCATION: REGISTERED OR ACCREDITED PROGRAMS

CANDIDATE INSTRUCTION

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. This form should be used only if your professional scool offers an accredited medical curriculum.

SECTION I: CANDIDATE INFORMATION

1. [redacted] Social Security Number

2. G O R 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	GORDON
First	MARCUS
Middle	TULIC

5. Basis of Licensure sought (see item 15 on Form 1): ☐ by examination ☒ by endorsement

6. Print name under which degree or diploma was awarded:
Marcus M. Gordon
(Name)

7. High School Attended: [illegible] (Name)

8. Professional school attended: Albert Einstein College of Medicine
(Name)
Address 1300 Morris Park Ave Bronx N.Y. 10461 Date degree was awarded June, 1985

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

SECTION II: CERTIFICATION OF EDUCATION

INSTRUCTION TO SCHOOL: Please complete this section of this licensure application form and sign the certifying statement. This form must be returned directly to the Division of Professional Licensing Services. This form will not be accepted if returned by the applicant.

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

It is hereby certified that the candidate named herein: Marcus T. Gordon, M.D.

(1) Satisfactorily completed, prior to matriculation in professional school, all of the required preprofessional education.

List Professional School(s)/Location CUNY City College, New York, New York

(2) Enrolled in this professional school on August 24, 1981

(3) Was graduated from this professional school after the completion of a medical program with the degree of M.D. on June 4, 1985

(4) The medical program completed was 44 months of study.

Name Dr. Albert S. Kuperma[redacted]
(Original signature)

Official position Associate Dean for Educational Affairs

Medical School Albert Einstein College of Medicine

(COLLEGE SEAL)

Date August 28, 1986

Certification is not acceptable unless dated after graduation.

FORM 2PGT
MEDICINE

THE UNIVERSITY OF THE STATE OF NEW YORK
THE STATE EDUCATION DEPARTMENT
DIVISION OF PROFESSIONAL LICENSING SERVICES

#111981

ALL CANDIDATES MUST COMPLETE THIS FORM.

CERTIFICATION OF APPROVED POST GRADUATE TRAINING

CANDIDATE INSTRUCTION

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 post graduate 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.

SECTION I: CANDIDATE INFORMATION

1. [redacted] Social Security Number
2. GOR 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 GORDON
First MARCUS
Middle TULIC

SECTION II: CERTIFICATION OF POST GRADUATE TRAINING

This is to certify that Marcus Tulio Gordon,
Physician's Name

a graduate of Albert Einstein College of Medicine
Medical School

participated in a post graduate training program offered by Montefiore Hospital
and Medical Center
Name of Hospital

from July 1 19 82 thru July 1 19 83 in the clinical area of
Date Date

Surgery and that the
Clinical Area

above named physician successfully completed this training on July 1, 1986.
Date

This hospital does have an approved residency program in this clinical area. If this physician did not successfully complete the post graduate training program, please attach a letter of explanation with this form.

I was the program director for the physician named above during the post graduate training indicated and have carefully read and completed this form and hereby attest that the statements made herein are strictly true in every respect.

PRINT NAME of hospital director or director of medical ed[redacted]

Signature of hospital director or director of medical [redacted]

Date 5/28/86

- RETURN TO: Division of Professional Licensing Services, Office of Comparative Education, Cultural Education Center, Room 3007, Albany, New York 12230