

PRINT PROFESSION
 Medicine

FORM 1F — APPLICATION FOR PROFESSIONAL LICENSE BASED
 ON FOREIGN STUDY

IMPORTANT — Please allow ample time for processing application. Follow instructions on inside of this form.

DEPT. USE ONLY

Print name [First] Mohammad [Middle] [Maiden] [Last] Afsharinehr

Permanent mailing address [REDACTED]

City Brooklyn State New York ZIP code [REDACTED]

Telephone number where you can be reached at all times:
 Area code [REDACTED] Number [REDACTED]

Birth date [REDACTED] Citizen of [REDACTED]

Are you a U.S. citizen? Yes No

If not, are you submitting a Declaration of Intention to become a citizen with this application?
 Yes No

If employed, give name and address of employer Unity Hospital
1545 St. John's Place, Brooklyn, New York 11213

55
 # 249
 3/28/75

STATE ACTION
 QUALS. 6/3/75
 INT. 7/17/75
 EXP. 11/10/75
 LIC. NO. 125622
 DATE OCT 08 1975

If you have ever taken a New York State licensing examination, name profession and date.

Has any state rejected your application? Yes* No

Have you ever been convicted of any crime in the U.S. or elsewhere? No

Have you ever been found guilty of unprofessional conduct in the U.S. or elsewhere?
 *If yes, explain in an accompanying letter.

APPLICATION FOR LICENSURE BY: (Please check the appropriate item.)

Acceptance of Federation Licensing Examination (FLEX) taken outside of New York State. (Medical Applicants Only.)

Endorsement of license from another state or country. If yes, name state or country and professional title or designation.
New Jersey - Medicine - M.D.
Mercer County

Admission to New York State Licensing Examination.
 If applying for admission to New York State examination please indicate:
 Time of examination requested: (Month and year).....
 Place of examination requested: (Name city).....

DO NOT WRITE IN THIS SECTION

| FEE NO. | EX. DATE | EX. PLACE | IDENT. NO. | SUBJECTS | CARD SENT | TO | BY |
|---------|----------|-----------|------------|---|-----------|----|----|
| | | | | Accept flex Exam, Grades taken in New Jersey on June 1976 | | | |

New address

Per DI 9/2/75

STATEMENT OF FOREIGN EDUCATION AND CREDENTIALS

Name: Mohammed Afsharimehr Profession: Medicine Date of birth: 12/24/44

General Instructions: Before consideration can be given to foreign credentials, the following must be submitted:

- a. Original credentials from foreign schools. These must include:
 1. Proof of graduation from secondary school
 2. University student books, official transcripts, rank sheets and examination certificates, or other official documents showing exact dates of attendance, and subjects pursued year by year in higher and professional study.
 3. Diploma or degree certificate.

b. Translations of credentials. Documents written in a language other than English must be submitted with full, complete and literal translations including both printed and written matter, and without embellishments or elaborations by the translator. Translations must be made by a person properly qualified in the language to be translated, such as: (1) A member of the language department of a college or university registered by the New York State Education Department who is actually teaching the language to be translated, or (2) An officer or employee of an official translation bureau or agency satisfactory to the Department, or (3) An American consul in the country where the education was taken, or (4) A consul general or diplomatic representative duly accredited in the United States and not representing a country behind the "Iron Curtain," or (5) A representative of a foreign government agency, such as a minister of foreign affairs in a country not behind the "Iron Curtain." Translations must contain an affidavit of verification at the end, sworn to by the person making the translation, that he has read the translation after it has been completed; that it is a true and correct translation of the original; that the entire document has been translated and nothing omitted. Failure to comply with this requirement will result in translations being returned to the applicant. The Department will not accept translations by the applicant, unless they have been checked and verified by a qualified translator. If copies are submitted with translations, the original translations will be returned with the original credentials by certified mail at the time other originals are returned.

c. License, if license is required for admission to examination.

Original credentials will be returned by certified mail after consideration. Affidavits, letters and translations will be retained.
 Special Instructions: In the spaces below, give an accurate record of your educational preparation.

| [Quote names of schools in original language and translate.] | LOCATION | NUMBER OF YEARS ATTENDED | ATTENDANCE | | Diploma or degree obtained [Quote titles in original language and translate.] |
|--|--------------|--------------------------|-----------------|--------------|--|
| | | | Class Completed | Leaving Date | |
| Elementary or Primary School Golzar گلزار | Tehran, Iran | 6 | 9/51 | Yes | 7/57 (Proof of completion of elementary school need not be submitted.) |
| Secondary or High School Safarshah High School سافرشاه | Tehran, Iran | 6 | 9/57 | Yes | 7/63 |

| | | | | | | | | | |
|--|----------------|---|------|-----|------|--|--|--|--|
| Secondary or High School | | | | | | | | | |
| Safergehen High School <i>2/2</i> | Tehran, Iran | 6 | 9/57 | Yes | 7/65 | | | | |
| Higher and Professional Study | | | | | | | | | |
| Tehran University Medical College | Tehran, Iran | 7 | 9/63 | Yes | 7/70 | | | | |
| Post-graduate Study in the U.S. | | | | | | | | | |
| Mercer Medical Center - Rotating Internship | Trenton, N.J. | 1 | 7/73 | Yes | | | | | |
| Unity Hospital - Resident In On-Gyn | Brooklyn, N.Y. | 1 | 7/74 | | | | | | |

Special Professional Qualifications (List any certificates or attainments with specific dates, for example: ECFMG, Diplomate, Specialty Board certificate. Submit all original certificates.)

ECFMG-2/70 - 131 770 0
N.J. State Medical License - 10/74 - 29346

| | | | | | | | |
|---|----------------|---|------|-----|------|--|--|
| Secondary or High School | | | | | | | |
| Safarjeh High School سفرجه | Tehran, Iran | 6 | 9/57 | Yes | 7/63 | Certificate of Completion of Secondary Education گواهینامه اتمام تحصیلات ثانویه | |
| Higher and Professional Study | | | | | | | |
| Tehran University Medical College | Tehran, Iran | 7 | 9/63 | Yes | 7/70 | Doctor of Medicine دکترای پزشکی Refer to Item 5645 E of translation. Photostatic copy of original and translation submitted. | |
| Post-graduate Study in the U.S. | | | | | | | |
| Mercer Medical Center - Rotating Internship | Trenton, N.J. | 1 | 7/73 | Yes | 6/74 | Refer to photostatic copy of Mercer Medical Center "Certificate" already in your possession. | |
| Unity Hospital - Resident In On-Gyn | Brooklyn, N.Y. | 1 | 7/74 | | | | |

Special Professional Qualifications (List any certificates or attainments with specific dates, for example: ECFMG, Diplomate, Specialty Board certificate. Submit all original certificates.)

ECFMG-2/70 - 131 770 0
N.J. State Medical License - 10/74 - 29346

LICENSE NO. **125622-1** REGISTRATION APPLICATION FOR PERIOD **01/01/86 - 12/31/88**
MEDICINE

5
PAY THRU

1. SINCE YOU LAST REGISTERED, HAVE YOU BEEN CONVICTED OF ANY CRIME (FELONY OR MISDEMEANOR)? YES NO
2. SINCE YOU LAST REGISTERED HAS ANY STATE OTHER THAN NEW YORK REVOKED OR SUSPENDED A PROFESSIONAL LICENSE HELD BY YOU? YES NO
3. WILL YOU BE PRACTICING IN NEW YORK STATE DURING THE PERIOD INDICATED? YES NO
4. LAST PRACTICED IN NYS IF NO. INACTIVE RETIRED
5. BIRTHDATE MO DAY YR
6. SIGN BELOW AND DATE: AWWA [Signature] 11/28/85
7. CHECK BOX IF NAME OR ADDRESS CHANGED DATE

AFSHARINEHR NONAMNAD
PO BOX 387
7 PINEWOOD ROAD
OLSBESTBURY NY

11568-0000

125622A F820000220022060186R R0

OFFICE USE
LIC NO. **08/21**
NM CHK **1256**
FEE **202**
PR **60**
YR **86**
PEN

LICENSE NO. 125622 REGISTRATION APPLICATION FOR 01/01/86-12/31/88
MEDICINE

READ INSTRUCTIONS ON REVERSE SIDE BEFORE COMPLETING

1. SINCE YOU LAST REGISTERED (OR HAVE YOU BEEN CONVICTED OF ANY CRIME (FELONY OR MILD MISDEMEANOR)?) YES NO
2. SINCE YOU LAST REGISTERED, HAS ANY STATE OTHER THAN NEW YORK REVOKED OR SUSPENDED A PROFESSIONAL LICENSE HELD BY YOU? YES NO
3. WILL YOU BE PRACTICING IN NEW YORK STATE DURING THE PERIOD INDICATED? YES NO
4. LAST PRACTICED IN NYS YES NO
Mo. 12/85
5. BIRTHDATE YES NO
Mo. 12/85
6. SIGN N. White Date 12/16/85

AFSHARIMENR MONTAID
FO BOX 387
OLSWESTBURY NY

916234203

| | | |
|-----------------|----------|-----|
| OFFICE USE ONLY | 12/06/85 | U |
| LIC NO. | 125622 | |
| NM CHK | AF52 | |
| FEE | 181 | 220 |
| PR | 60 | |
| VR | 86 | |
| PEN | | |
| OFF TYPE | 1 | R |

\$ 18.00
PAY THIS AMOUNT

125622AF520018.00022060186RR0000

REGISTRATION APPLICATION
PROFESSION MEDICINE

PERIOD 01/01/93 - 12/31/94

\$ 330
PAY THIS AMOUNT

BEFORE COMPLETING THIS FORM READ ENCLOSED INSTRUCTIONS

AFSHARI MICHAEL
216 04 UNION TPK
BAYSIDE

NY 11364-0000

RH41658

100 069 6
UNRECORDED

OFFICE USE ONLY

DATE: 10/26/92
LIC. NO.: 125622
NM: AFSS2
DOB: 12/24/44
SSN: 156568648
FEE: 330
PR: 60 OFF: 1
YR: 93 TYPE: RR
PEN:
CHILD ABUSE N

PROFESSION: MEDICINE

PAY THIS AMOUNT

1. (a) Since you last registered have any state other than New York, instituted charges against you for professional misconduct, negligence or malpractice or revoked, suspended, or accepted surrender of a professional license held by you? Yes No
 (b) Have you last registered had a new board certified of any crime (felony or misdemeanor) or any state or country or have you been charged with any crime the disposition of which was other than by acquittal or dismissal? Yes No

(c) FOR HEALTH PROFESSIONALS ONLY: Since you last registered, has any hospital or health care facility restricted or restricted your professional use, employment or privileges or has it ever voluntarily or involuntarily or through any association or with whom from such association or such action due to professional misconduct, unprofessional conduct, incompetence or negligence? Yes No

2. (a) Will you be practicing in NYS during the period indicated? Yes No
 (b) IF NO, REACTIVE RETIRED

3. Last practice in NYS: 10/90

4. Date of Birth: [REDACTED]

5. Social Security # [REDACTED]
 * If Social Security # has not been provided, check appropriate box: Not applied for or pending Other (specify)

6. Federal Employer Identification # [REDACTED] (If you have a Federal Employer identification #, you must provide)

7. If your name or address has changed, or is stated incorrectly, complete the appropriate form or the Data Change form. Check this box to indicate change.

8. 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 statements in, or in connection with, my application may be cause for disciplinary action, including the loss of my license.

AFSHARI MICHAEL
 7 PINEWOOD ROAD
 CHESTER SURRY
 NY
 OCT 17 1990

(Signature) *Michael Afshari MD*

(Date) 10/19/90

| | |
|-----------------|--|
| OFFICE USE ONLY | |
| RS25662 I | |
| 10/04/90 | |
| LIC. NO. 125622 | |
| NMCHK AFS2 | |
| DOB [REDACTED] | |
| SSN [REDACTED] | |
| FEE 60 OFF 1 | |
| PR 91 TYPE RR | |
| YR | |
| PEN | |

PRIVACY NOTIFICATION: The authority to request personal information from you, including identifying numbers such as Federal Social Security and Federal Employer Identification Numbers, and the authority to maintain such information is found in Section 5 of the Tax Law. Disclosure of this information by you is mandatory, and will be used for tax administration purposes.

misemeanor in any state or country or have you been charged with any crime the disposition of which was other than by acquittal or dismissal?

Yes No

FOR HEALTH PROFESSIONALS ONLY: 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 No

2 (a) Will you be practicing in NYS during the period indicated?
Last to No, and you INACTIVE RETIRED PRACTICING OUTSIDE NYS

3 LAST PRACTICED IN NYS # [redacted] 4 DATE OF BIRTH: [redacted]
Mo. [redacted] Day [redacted] Yr [redacted]

5 Attached documentation regarding child abuse coursework: Certificate of Completion Certificate of Exemption

6 Social Security # [redacted] If Social Security # has not been provided check appropriate box below
 applied for or pending Other (explain)

7 Federal Employer Identification # [redacted] If you have Federal Employer Identification Number, you must provide!

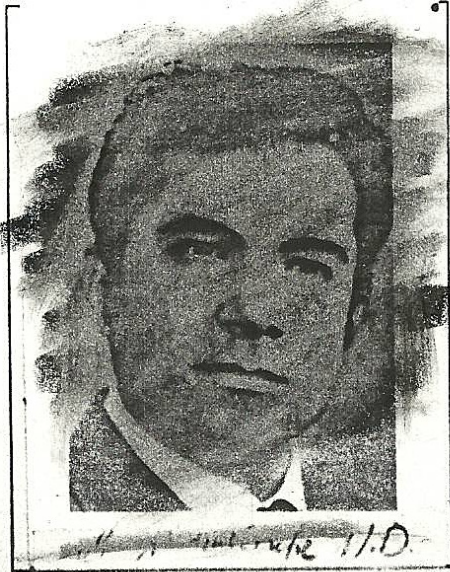
8 Under penalties of perjury, I declare and affirm that the statements above are an accurate representation and that such statements, including any accompanying documentation and explanations, are true, complete and correct. I understand that any false or misleading information or statement on or in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

SIGNATURE

DATE: 01 / 07 / 92

[Handwritten Signature]

AFFIDAVIT



Under penalties of perjury, I declare and affirm that the statements made in the foregoing application, including accompanying statements and transcripts are true, complete and correct.

M. Aghazimehr M.D. 2.26.74
 Signature of applicant Date

Date of photograph 1974

PERSONAL SIGNATURES OF PERSONS RECOMMENDING APPLICANT

- NOTE: (1) Signatures are required by five citizens unrelated to applicant, of whom at least three must be licensed in the profession for which applicant wishes to be licensed. Preferably those should be persons with whom the applicant has been professionally associated.
- (2) Applicants for professional engineering and/or land surveying should obtain signatures from five citizens, three of whom are licensed in New York State.
- (3) If it is impossible to obtain signatures from professional persons in the United States who are licensed in the applicant's profession, he should attempt to obtain signatures from professional persons licensed in another profession.
- (4) If it is impossible to obtain signatures from professional persons in the United States, the applicant may submit letters of recommendation from five persons in his own country.

THIS CERTIFIES THAT I HAVE BEEN PERSONALLY ACQUAINTED WITH THE APPLICANT SINCE THE YEAR INDICATED OPPOSITE MY NAME; THAT I BELIEVE HIM TO BE OF GOOD MORAL CHARACTER AND WORTHY OF LICENSURE IN NEW YORK STATE; AND THAT ANY RESERVATIONS I MAY HAVE ABOUT THE APPLICANT I AGREE TO SEND BY CERTIFIED MAIL IN A CONFIDENTIAL LETTER TO THE DIVISION OF PROFESSIONAL LICENSING SERVICES.

| Please print name | Personal signature | Profession | P. O. address (Including street, city and ZIP code) | Known since |
|----------------------|-----------------------------|--------------|---|-----------------------------|
| ROBERT T. HEELAN | <i>Robert T. Heelan</i> | PHYSICIAN | 275 DEGRAFF ST. BALLYVA, N.Y. | 1973 ¹ JULY, '74 |
| BERNARD S. GOFFEN | <i>Bernard S. Goffen</i> | MD PHYSICIAN | 26 W. WOODS ROAD, GREAT NECK, N.Y. | July, 1974 |
| Robert I. Rubenstein | <i>Robert I. Rubenstein</i> | Physician | 701 Crown St Bklyn NY | July 74 |
| CHARLES ROZAKES | <i>Charles Rozakes</i> | MD | 175 Cathedral Ave, Hempstead N.Y. | July 1974 |
| BENNY DIBIASE | <i>Benny D. DiBisce</i> | MD | 1249 East 86th St. Brooklyn NY | July 1974 |

Important: Please mail Form 1F to Division of Professional Licensing Services, State Education Department, 99 Washington Avenue, Albany, New York 12210.

REGISTRATION REMITTANCE DOCUMENT

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

710 00 069 6
FOR DEPOSIT ONLY NYSED
CASH NO-F

C80290 N 12 98

10/23/96

LIC: 125622
NME: AFS2
YR: 96
OFF: 1
DOB: [REDACTED]
SSN: [REDACTED]
EIN: [REDACTED]

AFSHARI MICHAEL
216-04 UNION TPK
BAYSIDE

NY [REDACTED]

PROFESSION: 80 MEDICINE
PERIOD: 12/01/96 - 11/30/98

\$ 270
AMOUNT DUE

Complete and sign reverse side of this application

PL 56 0995

1. Do you wish to register for the period indicated?

2. Since you last filed a registration application:

a. Have you been convicted or charged with any crime (felony or misdemeanor) in any state or country, the disposition of which was other than acquittal or dismissal?

b. Has any other state or country 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?

c. Has any hospital or licensed facility revoked 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?

b. If you are under such an obligation, do you meet one of the four requirements listed in the Child Support Law section below?

Under penalties of perjury, I certify that the statements in this application and any accompanying documentation are true, complete, and correct. I understand that any misrepresentation made 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.

Yes No
 Yes No
 Yes No
 Yes No
 Yes No
 Yes No

(Signature) _____

(Date) 11, 07, 96

J25B22AFSS2003300060196

REGISTRATION REMITTANCE DOCUMENT

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

07/01/98

LIC: 125822

NME: AFS2

YR: 98

OFF: 1

DOB: [REDACTED]

SSN: [REDACTED]

ETN: [REDACTED]

Q446521 8238

AFSHARI MICHAEL
218-04 UNION TPKE
BAYSIDE

NY [REDACTED]

PROFESSION: 80 MEDICINE
PERIOD: 12/01/90 - 11/30/98

CM-8-0808

\$ 330
AMOUNT DUE

1. Do you wish to register for the period indicated?

Yes No

2. Since you last filed a registration application:

NEED
A. Have you been convicted or charged with any crime, felony or misdemeanor in any state or country, the disposition of which was other than acquittal or dismissal?

Yes No

b. Has any other state or country 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?

Yes No

c. 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?

Under penalties of perjury, I certify that the statements in this application and any accompanying documentation are true, complete, and correct. I understand that any misrepresentation made 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)

M. Nelson

Date: 10/16/96

REGISTRATION APPLICATION
PROFESSION: MEDICINE

PERIOD: 12/01/98 - 11/30/00

710 00 069 6

\$ 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? YES NO
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? YES NO
2. (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 support 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

E 38551 810 8

OFFICE USE ONLY

DATE: 12/04/98

LIC. NO.: 125622

NM CHK: AFS2

DOB: [REDACTED]

SSN: [REDACTED]

FZE: 600

PR: 60

YR: 98

PEN:

CA: Y

600.00
OFF: 1
TYPE: RR

3. - Will you be practicing in NYS during the period indicated?
If NO, are you Inactive Retired. Yes No
- Enter the date you last practiced in New York State: 12/01/98 (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 associations to avoid imposition of such action due to professional misconduct, unprofessional conduct, incompetence or negligence? Yes No
If Yes, please provide documentation.

AFSHARI MICHAEL

216-04 UNION TPK

BAYSIDE

NY [REDACTED]

6. DATE OF BIRTH:

Mo. Day Yr. [REDACTED]

7. SOCIAL SECURITY NUMBER:

applied for or pending Explanation attached

8. FEDERAL EMPLOYER IDENTIFICATION NUMBER:

00-2476624

(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: 12/04/98

PROFESSION: 80 MEDICINE
PERIOD: 12/01/00 - 11/30/02

Complete and sign reverse side of this application

AMOUNT DUE
\$ 600

125622AFS2006000060100

REGISTRATOR REMITTANCE DOCUMENT

The University of the State of New York
The STATE EDUCATION DEPARTMENT
Professional Licensing Services
College Education Center
Albany, NY 12242

LIC: 07/03/00
123822
NRE: AFS2
YR: 00
D.F.: 1
DCB: 1
SSN: [REDACTED]
EIN: [REDACTED]

AFSHARI MICHAEL
215-04 NICHOLSON
BAYSIDE

NY [REDACTED]

PROFESSION: 80 MEDICINE
PERIOD: 12/01/00 - 11/30/02

Name/address change
Complete only if change has occurred

Name _____
Street _____
City _____
State/Zip _____
\$ 600

1. Do you wish to register for the period indicated?

Yes No

2. Since you last filed a registration application:

a. Have you been convicted or charged with any crime (felony or misdemeanor) in any state or country, the disposition of which was other than acquittal or dismissal?

Yes No

b. Has any other state or country 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?

Yes No

c. 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

Yes No

DO NOT WRITE IN THIS BOX FOR OFFICIAL USE ONLY

2334538 000 0000000000
091 00162000

Under penalties of perjury, I certify that the statements in this application and any accompanying documentation are true, complete, and correct. I understand that any misrepresentation made in connection with my application may be cause for disciplinary action, including the loss of my license, and may constitute a crime or constitute professional misconduct.

[Signature]

Business Phone: _____

1. Do you wish to register for the period indicated?

Yes No

2. Since you last filed a registration application:

a. Have you been convicted or charged with any crime (felony or misdemeanor) in any state or country, the disposition of which was other than acquittal or dismissal?

Yes No

b. Has any other state or country 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?

Yes No

125622AFS2006000060102

245175
2-12-03
CASH NO: P

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

Name/address change
Complete only if change has occurred

07/01/02
IC: 125622
WE: AFS2
R: 02
FF: 1
JB:
SN:
IN:

AFSHARI MICHAEL
216-04 UNION TPK
BAYSIDE NY

Name
Street
City
State/Zip

PROFESSION: 60 MEDICINE
PERIOD: 12/01/02 - 11/30/04

\$ 600

AMOUNT DUE

Complete and sign reverse side of this application

x01

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

6000015
039 08112008

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 M. Afsari Daytime phone [REDACTED] Date 8/6/08

Cal 21-00006

125622AFS2006000060108

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

Address change
Complete only if change has occurred

07/01/08
LIC: 125622
NME: AFS2
YR: 08
OFF: 1
EIN:
AFSHARI MICHAEL
216-04 UNION TPK
BAYSIDE NY 11364-0000

Street

City

State/Zip

PIN: PG29529
PROFESSION: 60 MEDICINE
PERIOD: 12/01/08 - 11/30/10

\$ 600
AMOUNT DUE

Complete and sign reverse side of this application

Do you wish to register for the period indicated?

Yes No

Since your last registration application,

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?

Yes No

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?

Yes No

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

Yes No

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

Yes No

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?

Yes No

6. Are you under an obligation to pay child support?

Yes No

7. 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

8. Are you a U.S. citizen or a qualified alien as defined below?

Yes No

DO NOT WRITE IN THIS BOX FOR OFFICIAL USE ONLY

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

52901

Signature

M. [Signature]

Business phone

[Redacted]

Date

9/3/02

6

1. Do you wish to register for the period indicated?..... for one year effective 2/1/07.....

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

32451357
831 07242886

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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

[Signature]

Daytime phone

[Redacted]

Date

07/19/06

21

125622AFS2006000060104

REGISTRATION RENEWAL DOCUMENT

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

Name/address change
Complete only if change has occurred

07/01/04
LIC: 125622
NME: AFS2
YR: 04
OFF: 1
DOB: [REDACTED]
SSN: [REDACTED]
EIN:

AFSHARI MICHAEL
216-04 UNION TRK
BAYSIDE NY [REDACTED]

Name

Street

City

State/Zip

PROFESSION: 60 MEDICINE
PERIOD: 12/01/04 - 11/30/06

\$ 600
AMOUNT DUE

Complete and sign reverse side of this application

Cat 6 - 1001

125622AFS2006000060106

REGISTRATION RENEWAL DOCUMENT

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

Name/address change
Complete only if change has occurred

07/03/06
LIC: 125622
NME: AFS2
YR: 06
OFF: 1
EIN:

AFSHARI MICHAEL
216-04 UNION TRK
BAYSIDE NY [REDACTED]

Name

Street

City

State/Zip

PROFESSION: 60 MEDICINE
PERIOD: 12/01/06 - 11/30/08

300 \$ 600
AMOUNT DUE

Complete and sign reverse side of this application

Cat 21P: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 a qualified alien as defined below? Yes No

22447413
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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 M. [Signature] Business phone [Redacted] Date 7/24/04



Registration Renewal - Transaction Summary

89 Washington Avenue
Albany, NY 12234
518-474-3817

[Main Page](#) | [Logout](#)

License Number : 125622
Profession : MEDICINE
Renewal Period : 12/01/2010 through 11/30/2012

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

AFSHARI MICHAEL
216-04 UNION TPK
BAYSIDE NY 11364-0000

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

Offices Selected for Renewal:

| Address | Fee |
|--|--------|
| 1) 216-04 UNION TPK, BAYSIDE, NY, 11364 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? | No |
| 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? | No |
| 3) Are criminal charges pending against you in any court? | No |
| 4) Are charges pending against you in any jurisdiction for any sort of professional misconduct? | No |
| 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? | No |
| 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 : VXJN6B5B8147
Payment Date : 12/01/2010
Amount Paid : \$ 600