DATA SHEET

APPLICATION FOR LICENSURE WITHOUT EXAMINATION

Reciprocity ..... Endorsement NBME, 7-1-82

NAME Jaffe (Last) Joshua (First) Samuel (Middle)

1. Premedical Education .....
2. Medical Education Harvard Med. School, 1981
3. State License by Written Examination ..... (State / Year / Grade)
4. National Board Certificate 242705 (Number) 1982 (Year) (Grade)
5. Photograph Furnished - Yes
6. Fee Paid - Check #..... Amount 150.00 T.N.# 84-119 Date 5/14/84
7. References .....
8. Citizenship USA
9. Probable Location .....Specialty .....
10. Alphabetical Index Checked Yes Correspondence File Reviewed Yes

Application Complete .....

Issuance of Certificates

authorized by ..... Date .....
Lawrence K. Pickett, M.D., Chairman

Certificate Number ~~25669~~ 25610 Issued 5-18-84

Medical Board (2-75) 2500

FOR OFFICE USE: Appl. rec'd: 5/14/84 ck#465958 Check: 150.00 TS #: 84-119

RECEIVED
MAY 11 1984
CONN. DEPT. OF HEALTH SERVICES

STATE OF CONNECTICUT DEPARTMENT OF HEALTH SERVICES
DIVISION OF MEDICAL QUALITY ASSURANCE

PHYSICIAN'S APPLICATION FOR LICENSE WITHOUT EXAMINATION

I hereby apply to the Connecticut Medical Examining Board for certification without examination for licensure to practice medicine in the State of Connecticut by: (Check appropriate box)

(A) ___ Endorsement of my certificate issued by the National Board of Medical Examiners.
CERTIFICATE #: 242705 DATE: 7/1/82

B. ___ Endorsement of my certificate issued by the Federation of State Medicals Boards of the United States. STATE: _____ DATE: _____

C. ___ Endorsement of my license issued after written examination by the licensing authority named below. STATE: _____ DATE: _____

D. ___ Endorsement of my license issued after written examination by the Medical Council of Canada. DATE: _____

* * * * * * * * * * * * * * * * * * *

In support of this application I submit the following information:

1. FULL NAME: JOSHUA (First) SAMUEL (Middle) JAFFE (Last)

PRESENT ADDRESS: 29 COURT ST #3 (Street) NEW HAVEN (Town) CT (State) 06511 (Zip)

TELEPHONE NO. (Where you can be reached 8:30 - 4:30, Monday - Friday): 203-785-3111

PLACE OF BIRTH: NEW YORK, NY (Town, State or Country) DATE OF BIRTH: 12/9/55 (Month/Day/Year)

Social Security #: _____

2. MEDICAL EDUCATION:

LIST NAMES AND LOCATIONS OF ALL MEDICAL SCHOOLS ATTENDED	DATE ENTER (Mo. Yr.)	DATE DEPART. (Mo. Yr.)
HARVARD MEDICAL SCHOOL, BOSTON MA	9/77	6/81

Doctor of Medicine Degree Awarded by: HARVARD (Name of School) Date Awarded: 6/81 (Mo./Yr.)

NOTE: IF FOREIGN MEDICAL SCHOOL, APPLICANTS MUST HAVE E.C.F.M.G. CERTIFICATION

--OVER--

3. MEDICAL LICENSURE: List all states you have ever been licensed to practice medicine in:

STATE	LIC. NUMBER	DATE LICENSED ISSUED	LICENSED BY: Exam	Endorsement

4. Have you ever been declined a license after a written examination? No

If Yes, list states and why: _____

5. Have you ever been brought before a Medical Examining Board, Medical Society or a criminal court on charges of unprofessional conduct or criminal behavior, or had a license to practice medicine suspended or revoked? No

IF YES, PLEASE EXPLAIN: _____

6. MEDICAL PRACTICE: List all medical practice you have engaged in since graduation from medical school (include Internship and Residency):

HOSPITALS ASSOCIATED WITH	LOCATION (ADDRESS)	DATE ENTERED (Mo. Yr.)	DATE DEPART (Mo. Yr.)
Yale New Haven Hospital	789 Howard Ave New Haven CT	6 81	→ present

7. SPECIALTY: (If applicable, please enclose copy of Specialty Board Certificate)

NAME OF AMERICAN BOARD

I am a Diplomate of the American Board of: _____

8. Answer ONLY if applying for endorsement of Medical Council of Canada license.
Have you attached a "Certificate of Standing" with scores from the Medical Council of Canada? _____

--CONTINUED--

9. CERTIFICATES OF MORAL CHARACTER - Have at least two (2) physicians complete "Recommendation Forms" and forward them directly to this office. Indicate below who will be completing these forms.

NAME: Norman Rawski MD No. Yrs. Acquainted 2

ADDRESS: 100 York St New Haven CT

NAME: CP Noel McCarthy, MD No. Yrs. Acquainted 3

ADDRESS: 460 State St North Haven CT

Affix a recent passport type photograph (2½" x 3½") here.

(Affix notary seal here. A portion of notary seal must overlap photograph.)

All of the above statements contained herein are true and correct to the best of my knowledge and belief.

Joshua S. Jaffe Date 5/18/84

Signature of Applicant

State of CONNECTICUT)
County of NEW HAVEN) ss.

On this 9th day of May 1984, Joshua S. Jaffe (applicant's name) personally appeared before me, who being duly sworn says that she/he is the person referred to in the foregoing application and that the photograph attached hereto is a true picture of himself and that the statements made herein are true in every respect.

Joshua S. Jaffe

Signature of Applicant

Sworn to before me this 9th day of May 19 84.

Elise C. Collins

Signature of Notary Public

My Commission expires March 31, 1985.

3/83

BOX 1

SOC. SEC. NO. xxx-xx-8780 FED. EMPLOYER ID. NO.
IF SOC. SEC. NO. IS MISSING OR DIFFERENT THAN ABOVE PLEASE ENTER BELOW

			-			-		

IF FED. EMPLOYER ID. NO. IS MISSING OR DIFFERENT THAN ABOVE PLEASE ENTER BELOW

			-			-		

IF YOU HAVE NEITHER A S.S.N. NOR A F.E.I.N., INDICATE REASON

____ APP. FOR NO. PENDING

____ NOT U.S. CITIZEN ____ OTHER _____

TYPE 01

BOX 3 YOU MUST RENEW YOUR LICENSE/CERTIFICATE BY THE DUE DATE INDICATED.

RENEWAL FEE: $565.00 DUE DATE 12/31/10

LICENSE/CERTIFICATE NUMBER 025610

Profession PHYSICIAN/SURGEON

BOX 2 Make Any Changes or Corrections in Box 4

0001694 FP **PRSRT T6 0 1463 06069
JOSHUA S. JAFFE, MD
PO BOX 1040
50 AMENIA RD
SHARON CT 06069

BOX 4 Print or Type Changes in Space Provided At The Right.

LAST NAME (101)
FIRST NAME (102) MI (103)
ADD 1 (111)
ADD 2 (112)
ADD 3 (113)
CITY (114) ST (115)
ZIP (116) COUNTRY

Check appropriate address box: ☐ Office ☐ Residence

STATE OF CONNECTICUT
DEPARTMENT OF PUBLIC HEALTH
DIVISION OF HEALTH SYSTEMS REGULATION
POST OFFICE BOX 1080 HARTFORD, CT 06143-1080

4402561001565001231201000049186351

INSTRUCTIONS ANSWER EACH QUESTION, READ THE STATEMENTS THAT FOLLOW AS THEY RELATE TO YOUR LICENSE, AND SIGN BELOW.

1. WITHIN THE LAST YEAR HAVE YOU BEEN CONVICTED OF A FELONY OR HAVE YOU HAD ANY DISCIPLINARY ACTION TAKEN AGAINST YOU OR ANY SUCH ACTIONS PENDING BY ANOTHER STATE'S LICENSURE/CERTIFICATION AUTHORITY? NO ✓ YES ____
2. ARE YOU PRESENTLY WORKING IN YOUR LICENSED/CERTIFIED PROFESSION? NO ____ YES ✓ HOURS OF PRACTICE PER WEEK 50
3. WHAT IS THE ADDRESS OF YOUR PRIMARY PLACE OF EMPLOYMENT? STREET 50 AMENIA ROAD
   CITY SHARON STATE CT ZIP 06069 TYPE OF AGENCY MEDICAL PRACTICE PHONE # 860 364 0538
4. WHAT IS THE ADDRESS OF YOUR RESIDENCE? STREET 26 JEWETT HILL CITY SHARON STATE CT ZIP 06069
   PHONE # 860 364 0788
5. HIGHEST DEGREE HELD MD 6. IF YOU HAVE BEEN CERTIFIED BY ANY AMERICAN SPECIALTY BOARD IN THE PAST YEAR, PLEASE SPECIFY BOARD AND DATE _____

↓ DO NOT WRITE IN THIS AREA ↓

020009 0066 013101 025610 0056500 101810 S

7. IF YOU ARE AN **OPTOMETRIST,** ARE YOU QUALIFIED TO HOLD YOURSELF OUT AS AUTHORIZED TO PRACTICE ADVANCED OPTOMETRIC CARE? ____ YES ____ NO
8. IF YOU ARE AN **EMT, EMT-I,** OR **MRT,** OR HOLD A LICENSE/CERTIFICATE IN A **LEAD** OR **ASBESTOS** DISCIPLINE, PROVIDE REFRESHER COURSE COMPLETION DATE _____ AND COURSE APPROVAL NUMBER _____.
9. IF YOU ARE A **CHIROPRACTOR, DENTAL HYGIENIST, OCCUPATIONAL THERAPIST OR ASSISTANT, OPTICIAN, OPTOMETRIST, OR SOCIAL WORKER,** YOU MUST COMPLY WITH MANDATORY CONTINUING EDUCATION REQUIREMENTS FOR LICENSE RENEWAL; **PHYSICIAN ASSISTANTS AND ADVANCED PRACTICE RNs** MUST MAINTAIN CERTIFICATION FROM THE NATIONAL CERTIFYING BODY THAT QUALIFIED THEM FOR INITIAL LICENSURE, IN ORDER TO RENEW SUCH LICENSES.
10. IF YOU ARE LICENSED AS AN **APRN, DENTAL HYGIENIST, CHIROPRACTIC, NATUROPATHIC, PODIATRIC, OSTEOPATHIC OR HOMEOPATHIC PHYSICIAN, OPTOMETRIST OR PHYSICIAN/SURGEON** WHO PROVIDES DIRECT PATIENT CARE SERVICES, YOU MUST MAINTAIN PROFESSIONAL LIABILITY INSURANCE OR OTHER INDEMNITY AGAINST LIABILITY FOR PROFESSIONAL MALPRACTICE, IN ACCORDANCE WITH CT GENERAL STATUTES.

I HAVE REVIEWED THE INFORMATION PROVIDED AND REQUESTED ON THIS CARD. I VERIFY THAT IT IS ACCURATE AND THAT I SATISFY THE REQUIREMENTS LISTED ABOVE AS THEY APPLY TO MY LICENSE/CERTIFICATE.

SIGNATURE _____ DATE 10/15/10

BOX 1

SOC. SEC. NO. xxx-xx-8780 FED. EMPLOYER ID. NO.
IF SOC. SEC. NO. IS MISSING OR DIFFERENT THAN ABOVE PLEASE ENTER BELOW
0 [illegible] 0 - [illegible] - [illegible]

IF FED. EMPLOYER ID. NO. IS MISSING OR DIFFERENT THAN ABOVE PLEASE ENTER BELOW
| | | - | | | - | | | | |

IF YOU HAVE NEITHER A S.S.N. NOR A F.E.I.N., INDICATE REASON
___ APP. FOR NO. PENDING
___ NOT U.S. CITIZEN ___ OTHER ___

TYPE 01

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RENEWAL FEE: $565.00 DUE DATE 12/31/11

LICENSE/CERTIFICATE NUMBER 025610

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SHARON CT 06069

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FIRST NAME (102) MI (103)
ADD 1 (111)
ADD 2 (112)
ADD 3 (113)
CITY (114) ST (115)
ZIP (116) COUNTRY

Check appropriate address box: ☐ Office ☐ Residence

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DEPARTMENT OF PUBLIC HEALTH
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POST OFFICE BOX 1080 HARTFORD, CT 06143-1080

4402561001565001231201100057846644

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2. ARE YOU PRESENTLY WORKING IN YOUR LICENSED/CERTIFIED PROFESSION? NO ___ YES ✓ HOURS OF PRACTICE PER WEEK 50
3. WHAT IS THE ADDRESS OF YOUR PRIMARY PLACE OF EMPLOYMENT? STREET 50 AMENIA Road
CITY SHARON STATE CT ZIP 06069 TYPE OF AGENCY Medical Practice PHONE # 860 364 0536
4. WHAT IS THE ADDRESS OF YOUR RESIDENCE? STREET 26 Jewett Hill Rd CITY Sharon STATE CT ZIP 06069
PHONE # 860 364 0788
5. HIGHEST DEGREE HELD MD 6. IF YOU HAVE BEEN CERTIFIED BY ANY AMERICAN SPECIALTY BOARD IN THE PAST YEAR, PLEASE SPECIFY BOARD AND DATE ___

↓ DO NOT WRITE IN THIS AREA ↓

020001 0040 0079 01 025610 0056500 102611 S

7. IF YOU ARE AN OPTOMETRIST, ARE YOU QUALIFIED TO HOLD YOURSELF OUT AS AUTHORIZED TO PRACTICE ADVANCED OPTOMETRIC CARE? ___ YES ___ NO
8. IF YOU ARE AN EMT, EMT-I, OR MRT, OR HOLD A LICENSE/CERTIFICATE IN A LEAD OR ASBESTOS DISCIPLINE, PROVIDE REFRESHER COURSE COMPLETION DATE ___ AND COURSE APPROVAL NUMBER ___.
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[signature]
SIGNATURE

10/25/2011
DATE