RECEIVED
JAN 2 1 2011
Board of Registration in Medicine

REDACTED COPY

Application #: 246480
Date of Issue: ___/___/___

Board of Registration in Medicine
200 Harvard Mill Square, Suite 330 - Wakefield, MA 01880
Telephone: (781) 876-8210 Fax: (781) 876-8383 www.massmedboard.org

FULL LICENSE APPLICATION

Application Fee: Please enclose a check or money order in the amount of $600.00 made payable to the Commonwealth of Massachusetts. The application fee is non-refundable.

Check One: [X] U.S./Canadian Graduate [ ] International Graduate

Legal Name (do not use nicknames or initials, unless they are part of your legal name)

Lesko Jennifer Marie

Last Name (type or print clearly) First Middle Suffix (Jr., etc.)

[X] M.D. [ ] D.O. [ ] Ph.D [ ] Other degree__________ [ ] Male [X] Female

Other Name(s) Used - List any other name(s) you have used which may appear on your identifying documents, such as medical education and examination records. If not applicable, check here [ ]

Entire Last Name (type or print clearly) First Middle Suffix (Jr., etc.)

Date of Birth: ___ ___ ___ Social Security Number:
Month Day Year

Place of Birth: Edison NJ
City State/Province/Territory Country if not USA

*Mailing Address: __________ Telephone: __________
Number and Street

City State/Province/Territory Zip (or postal) Code

Home Address: __________ Telephone: __________
Number and Street

City State/Province/Territory Zip (or postal) Code

Business Address: 250 E Superior St 5th Floor Telephone: 312.472.4673
Number and Street

Chicago IL 60611
City State/Province/Territory Zip (or postal) Code

E-mail Address: __________ Fax number: 312.472.4687

Are you applying for licensure through FCVS? (See instructions page 12) [ ] Yes [X] No

*** The Board will use your Mailing Address for all correspondence**

PRINT NAME: Lesko, Jennifer Marie

Pre-medical School

Facility: University of Pennsylvania Degree: BA From 08 97 To 5/21/01
Street: 3451 Walnut St City: Philadelphia State: PA

Facility: ______ Degree: ______ __/__/__ __/__/__
Street: ______ City: ______ State: ______

Medical School

Facility: Weill Medical College of Cornell University Degree: MD From 08/25/03 To 5/25/07
Street: 1300 York Ave City: New York State: NY

Facility: ______ Degree: ______ __/__/__ __/__/__
Street: ______ City: ______ State: ______

Date of medical school graduation: 5 / 30 / 07
Month Day Year

Note: U.S. graduates must include a written explanation for the duration of medical education longer than four (4) years, and for any breaks in medical education. International graduates must provide a written explanation for the duration of medical education longer than six (6) years and any breaks in medical education.

Postgraduate Education:

List all postgraduate training in chronological order from medical school to the present. Include the name and address of the facility, your position, e.g. PGY 1, 2, fellow, etc. and dates of affiliation. You must account for all periods of training or postgraduate work from the time you graduated from medical school.

Facility: McGaw Medical Center of Northwestern University Position: Intern From 6/18/07 To 6/29/08
Street: 420 E Superior St. 12th floor City: Chicago State: IL

Facility: ______ Position: PGY-2 6/30/08 6/29/09
Street: ______ City: ______ State: ______

Facility: ______ Position: PGY-3 6/30/09 6/29/10
Street: ______ City: ______ State: ______

Facility: ______ Position: PGY-4 6/30/10 present
Street: ______ City: ______ State: ______

Facility: ______ Position: ______ __/__/__ __/__/__
Street: ______ City: ______ State: ______

Examination History

Please contact the appropriate examination entity and have certified transcript of your scores sent directly to this Board. If you are using FCVS, your examination scores will be sent to the Board with your credentials packet.

List each licensure examination, U.S. or international, you have taken (USMLE, NBME, NBOME, LMCC, Etc.).If additional space is necessary, please enclose a separate sheet with your application and include all the information below. If you answer "yes" to question #5 on the Full Supplement, you must also complete the required information.

Examination	Most Recent Date taken (Month/Year)	Passed (P) or Failed (F)		Number of attempts
USMLE Step I	May 2005	☒ P	☐ F	1
USMLE Step II	January 2007	☒ P	☐ F	1
USMLE Step III	August 2008	☒ P	☐ F	1
NBME Part I		☐ P	☐ F	
NBME Part II		☐ P	☐ F	
NBME Part III		☐ P	☐ F	
FLEX Component 1		☐ P	☐ F	
FLEX Component 2		☐ P	☐ F	
FLEX Pre-1985		☐ P	☐ F	
NBOME Part 1		☐ P	☐ F	
NBOME Part II		☐ P	☐ F	
NBOME Part III		☐ P	☐ F	
COMLEX Level 1		☐ P	☐ F	
COMLEX Level 2		☐ P	☐ F	
COMLEX Level 3		☐ P	☐ F	
COMVEX		☐ P	☐ F	
LMCC – Single		☐ P	☐ F	
LMCC – Part I		☐ P	☐ F	
LMCC – Part II		☐ P	☐ F	
State Board Exam	(State of examination)	☐ P	☐ F	

PRINT NAME: Lesko, Jennifer Marie

Hospital Affiliations and Employment

List hospital appointments, in chronological order, where you had active staff privileges. Include the name and address of the facility, your position and dates of affiliation. Also include periods of unemployment or employment outside of medicine. Attach a separate sheet of paper if necessary.

Facility / Street	Position / City	State	From	To
Facility: Prentice Women's Hospital of Northwestern Memorial Hospital; Street: 250 E Superior St. 5th floor	Position: resident; City: Chicago	IL	6/18/07	6/30/11 (present)
Facility: NorthShore University HealthSystem formerly Evanston Hospital; Street: 2650 Ridge Ave	Position: resident; City: Evanston	IL	6/18/07	6/29/09
Facility: Stroger/Cook County Hospital; Street: 1900 W Polk St.	Position: resident; City: Chicago	IL	6/30/09	present
Facility: ; Street:	Position: ; City:		_/_/_	_/_/_

1. List other states (abbreviations) where you are currently or have ever had a full license: ______ ___

2. a) Are you certified by the American Board of Medical Specialties? ☐ Yes ☒ No
   b) Are you certified by the American Board of Osteopathic Medicine? ☐ Yes ☒ No

3. List Board Certification(s): will complete ABOG Certification date: __/__/__
   written board exam 6/27/2011 Certification date: __/__/__

4. List your practice special(ies) Obstetrics & Gynecology

5. Have you attached an up-to-date copy of your curriculum vitae? ☒ Yes ☐ No

6. Reason for requesting a Massachusetts medical license: I am beginning a Family Planning Fellowship in the Department of Obstetrics & Gynecology

7. Name of Facility: Brigham & Women's Hospital of Harvard University
   Address: 75 Francis Street City: Boston

8. Anticipated starting date in Massachusetts: 7 / 1 / 2011

Under the penalties of perjury, I declare that I have examined this full application and all its accompanying instructions, forms and statements, and to the best of my knowledge and belief, the information contained herein is true, correct and complete. As an applicant for a full license to practice medicine, I understand that a criminal record check may be conducted for conviction and pending criminal case information from the Criminal History Systems Board only and that it will not necessarily disqualify me from licensure.

[signature]
Signature of Applicant

12 / 19 / 2010
Month Day Year

(Continued on page5)

NATIONAL PROVIDER IDENTIFIER (NPI)

The primary purpose of the NPI is to uniquely identify health care providers as "health care providers" in HIPAA standard transactions. The NPI will replace all other identifiers assigned to health care providers, such as those assigned by health plans, government programs and health care purchasers for purposes of conducting these business transactions. Under the final HIPAA NPI Rule, all individual and organization covered providers **were required to obtain an NPI by May 23, 2007.**

You must supply the Board of Registration in Medicine with your valid NPI. If you do not have an NPI number, you can apply for an NPI directly by using the NPPES web site at www.NPPES.cms.hhs.gov.

My current NPI is: 1659565653

Penalties for Falsifying Information on the National Provider Identifier Application

18 U.S.C. 1001 authorizes criminal penalties against an individual who in any matter within the jurisdiction of any department or agency of the United States knowingly and willfully falsifies, conceals or covers up by any trick, scheme or device a material fact, or makes any false, fictitious or fraudulent statements or representations, or makes any false writing or document knowing the same to contain any false, fictitious or fraudulent statement or entry. Individual offenders are subject to fines of up to $250,000 and imprisonment for up to five years. Offenders that are organizations are subject to fines of up to $500,000. 18 U.S.C. 3571(d) also authorizes fines of up to twice the gross gain derived by the offender if it is greater than the amount specifically authorized by the sentencing statute.

Please sign and date to confirm that all of the information on this form is true and accurate.

Signature________________ Date: 12/19/2010

Full License Application

RECEIVED
JAN 18 2011
Board of Registration in Medicine

Board of Registration in Medicine
200 Harvard Mill Square, Suite 330 - Wakefield, MA 01880
Telephone: (781) 876-8210 Fax: (781) 876-8383 www.massmedboard.org

MEDICAL EDUCATION VERIFICATION

APPLICANT INSTRUCTIONS: Please complete the waiver for release of information and forward this form to your university/medical school(s) or university of graduation for verification.

I authorize the medical school/university listed below to provide any and all information pertaining to my medical education at your institution.

Applicant's Signature: [signature] Date of Birth: ______

Print or Type Name: Lesko (Last name) Jennifer (First Name) M (Middle Initial) Social Security No: ______

Other Name(s): ______ (Please type or print name(s))

Name of Medical School: Weill Medical College of Cornell University

Address: 1300 York Ave Suite C-118 City: New York State or Province: NY

INSTRUCTIONS TO THE DEAN OR DESIGNATED OFFICIAL OF MEDICAL SCHOOL

Please complete this form and forward it, together with a copy of the official transcript (which indicates courses taken, dates and hours of attendance, and scores, grades, or evaluations) and mail it to the Board of Registration in Medicine.

APPLICANT'S EDUCATIONAL HISTORY

If name of institution was different from the above named institution when applicant attended, please enter name below:

______

Premedical Education: Does your school have a premedical school education requirement? ☐ Yes ☐ No

If "yes," indicate where the applicant completed premedical school.

Applicant's Undergraduate School: ______

Undergraduate School Address: ______

(Continued on page 2)

Page:3/3 From:3124720909 JAN-03-2011 13:45

Enrollment and Participation: Our records indicate that

(type or print the applicant's name): LESKO (Last name) JENNIFER (First name) M (Middle initial)

attended our medical school on the following dates (indicate the month, day and year in the section below):

ATTENDANCE DATES:	FROM	TO	FROM	TO
	08/25/2003	06/18/2004	07/03/2006	05/25/2007
	08/30/2004	04/07/2005	__/__/__	__/__/__
	05/31/2005	06/23/2006	__/__/__	__/__/__

The applicant attended 165 total weeks or ____ total months (must be included) of not less than 32 weeks in each academic year of continuing on-campus education.

check one ☑ was awarded a degree in DOCTOR of MEDICINE on (month/day/year) 05/30/2007

☐ was NOT awarded degree. Please explain reason(s). ________

Unusual Circumstances: The following questions apply to unusual circumstances that occurred during any part of the applicant's medical education. All questions must be answered. **If you answer "YES" to any of the questions below, please enclose an explanation.**

	YES	NO
1. Did the applicant take any leaves of absence or breaks from his/her medical education?		
2. Was the applicant ever placed on probation?		
3. Was the applicant ever disciplined or under investigation?		
4. Were any negative reports ever filed by instructors regarding the applicant?		

COMMENTS: ________

AFFIX INSTITUTIONAL SEAL HERE

(if the institution does not have a seal, this form must be notarized). INTERNATIONAL MEDICAL SCHOOLS MUST ATTACH A COPY OF THE MEDICAL SCHOOL DIPLOMA AND A TRANSCRIPT OR PROVIDE AN EXPLANATION.

Signature: [signature]

Print Name: CLARE ROONEY

Title: REGISTRAR

Date: JAN 11 2011 Telephone: (212) 746-1050

This form will not be accepted unless it is stamped with the institutional seal or notarized.

Seal Verified
DATE: 1/31/11
INITIALS: AR

RECEIVED

DEC 2 4 2010

Board of Registration in Medicine

Application #: 246480
Date of Issue: ___/___/___

Board of Registration in Medicine
200 Harvard Mill Square, Suite 330 - Wakefield, MA 01880
Telephone: (781) 876-8210 Fax: (781) 876-8383 www.massmedboard.org

FULL LICENSE APPLICATION

Application Fee: Please enclose a check or money order in the amount of $600.00 made payable to the Commonwealth of Massachusetts. The application fee is non-refundable.

Check One: [X] U.S./Canadian Graduate [ ] International Graduate

Legal Name (do not use nicknames or initials, unless they are part of your legal name)

Lesko Jennifer Marie

Last Name (type or print clearly) First Middle Suffix (Jr., etc.)

[X] M.D. [ ] D.O. [ ] Ph.D [ ] Other degree________ [ ] Male [X] Female

Other Name(s) Used - List any other name(s) you have used which may appear on your identifying documents, such as medical education and examination records. If not applicable, check here [ ]

Entire Last Name (type or print clearly) First Middle Suffix (Jr., etc.)

Date of Birth: ___ ___ ___ Social Security Number: ___
Month Day Year

Place of Birth: Edison NJ
City State/Province/Territory Country if not USA

*Mailing Address: ___ Telephone: ___
Number and Street

___ IL ___
City State/Province/Territory Zip (or postal) Code

Home Address: ___ Telephone: ___
Number and Street

City State/Province/Territory Zip (or postal) Code

Business Address: 250 E Superior Street, 5th Floor Telephone: 312.472.4673
Number and Street

Chicago IL 60611
City State/Province/Territory Zip (or postal) Code

E-mail Address ___ Fax number: 312.472.4687

Are you applying for licensure through FCVS? (See instructions page 12) [ ] Yes [X] No

*** The Board will use your Mailing Address for all correspondence**

CK.# 1005
12/28/10
WS

Application #: 246480
Date of Issue: ___/___/___

Board of Registration in Medicine
200 Harvard Mill Square, Suite 330 - Wakefield, MA 01880
Telephone: (781) 876-8210 Fax: (781) 876-8383 www.massmedboard.org

FULL LICENSE APPLICATION

Application Fee: Please enclose a check or money order in the amount of $600.00 made payable to the Commonwealth of Massachusetts. The application fee is non-refundable.

Check One: [X] U.S./Canadian Graduate [ ] International Graduate

Legal Name (do not use nicknames or initials, unless they are part of your legal name)

Lesko	Jennifer	Marie	
Last Name (type or print clearly)	First	Middle	Suffix (Jr., etc.)

[X] M.D. [ ] D.O. [ ] Ph.D [ ] Other degree__________ [ ] Male [X] Female

Other Name(s) Used - List any other name(s) you have used which may appear on your identifying documents, such as medical education and examination records. If not applicable, check here [ ]

Entire Last Name (type or print clearly)	First	Middle	Suffix (Jr., etc.)

Date of Birth: ___ Month Day Year Social Security Number: ___

Place of Birth: Edison (City) NJ (State/Province/Territory) Country if not USA

*Mailing Address: ___ Number and Street ___ Telephone: ___

___ City ___ State/Province/Territory ___ Zip (or postal) Code

Home Address: ___ Number and Street ___ Telephone: ___

___ City ___ State/Province/Territory ___ Zip (or postal) Code

Business Address: 250 E Superior St 5th Floor (Number and Street) Telephone: 312.472.4673

Chicago (City) IL (State/Province/Territory) 60611 (Zip (or postal) Code)

E-mail Address ___ Fax number: 312.472.4687

Are you applying for licensure through FCVS? (See instructions page 12) [ ] Yes [X] No

*** The Board will use your Mailing Address for all correspondence**

PRINT NAME: Lesko, Jennifer Marie

Pre-medical School

Facility: University of Pennsylvania Degree: BA From 8/01/97 To 5/30/01
Street: 3451 Walnut Street City: Philadelphia State: PA

Facility: ______ Degree: ______ __/__/__ __/__/__
Street: ______ City: ______ State: ______

Medical School

Facility: Weill Medical College of Cornell University Degree: MD From 08/01/03 To 05/20/07
Street: 1300 York Ave City: New York State: NY

Facility: ______ Degree: ______ __/__/__ __/__/__
Street: ______ City: ______ State: ______

Date of medical school graduation: 05 / 30 / 2007
Month Day Year

Note: U.S. graduates must include a written explanation for the duration of medical education longer than four (4) years, and for any breaks in medical education. International graduates must provide a written explanation for the duration of medical education longer than six (6) years and any breaks in medical education.

Postgraduate Education:

List all postgraduate training in chronological order from medical school to the present. Include the name and address of the facility, your position, e.g. PGY 1, 2, fellow, etc. and dates of affiliation. You must account for all periods of training or postgraduate work from the time you graduated from medical school.

Facility: McGaw Medical Center of Northwestern University Position: Intern From 6/30/07 To 6/30/08
Street: 420 E Superior St. 12th floor City: Chicago State: IL

Facility: ↓ Position: PGY-2 7/1/08 6/30/09
Street: ______ City: ______ State: ______

Facility: ↓ Position: PGY-3 7/1/09 6/30/10
Street: ______ City: ______ State: ______

Facility: ↓ Position: PGY-4 7/1/10 6/30/11
Street: ______ City: ______ State: ______

Facility: ______ Position: ______ __/__/__ __/__/__
Street: ______ City: ______ State: ______

Examination History

Please contact the appropriate examination entity and have certified transcript of your scores sent directly to this Board. If you are using FCVS, your examination scores will be sent to the Board with your credentials packet.

List each licensure examination, U.S. or international, you have taken (USMLE, NBME, NBOME, LMCC, Etc.). If additional space is necessary, please enclose a separate sheet with your application and include all the information below. If you answer "yes" to question #5 on the Full Supplement, you must also complete the required information.

Examination	Most Recent Date taken (Month/Year)	Passed (P)	Failed (F)	Number of attempts
USMLE Step I	May 2005	☒ P	☐ F	1
USMLE Step II	January 2007	☒ P	☐ F	1
USMLE Step III	August 2008	☒ P	☐ F	1
NBME Part I		☐ P	☐ F	
NBME Part II		☐ P	☐ F	
NBME Part III		☐ P	☐ F	
FLEX Component 1		☐ P	☐ F	
FLEX Component 2		☐ P	☐ F	
FLEX Pre-1985		☐ P	☐ F	
NBOME Part 1		☐ P	☐ F	
NBOME Part II		☐ P	☐ F	
NBOME Part III		☐ P	☐ F	
COMLEX Level 1		☐ P	☐ F	
COMLEX Level 2		☐ P	☐ F	
COMLEX Level 3		☐ P	☐ F	
COMVEX		☐ P	☐ F	
LMCC - Single		☐ P	☐ F	
LMCC – Part I		☐ P	☐ F	
LMCC – Part II		☐ P	☐ F	
State Board Exam	(State of examination)	☐ P	☐ F	

Board of Registration in Medicine
200 Harvard Mill Square, Suite 330 - Wakefield, MA 01880
Telephone: (781) 876-8210 Fax: (781) 876-8383 www.massmedboard.org

POSTGRADUATE TRAINING VERIFICATION

APPLICANT'S AUTHORIZATION: I authorize the release of information from my postgraduate training program listed below, as requested by the Massachusetts Board of Registration in Medicine.

Applicant's Signature: [signature] Date: 12/10/10

Print or Type Name: Jennifer Lesko

Name of Institution: McGaw Medical Center of Northwestern University

INSTRUCTIONS TO THE PROGRAM DIRECTOR

Please complete this form and forward it to the applicant in a **sealed envelope, signed across the seal**. If the department was a "rotating" or "transitional" program, please submit documentation of the rotations, dates and hours of training.

Name of Institution: McGaw Medical Center of Northwestern

If name of Institution was different when applicant attended, please enter name:

Enrollment and Participation: Our records indicate that Jennifer Lesko (Print applicant's name) participated in the following program:

(List each year separately with from and to dates)

Program Type (internship, residency, fellowship)	PGY (1,2,3,4)	Department or type of specialty training	Dates Attended (MONTH/DAY/YEAR) FROM	TO	Completed (YES/NO)	Accredited By (ACGME, RSC, AOA or not accredited
Residency	1-4	OB/Gyn	6/18/07	12/9/10	NO	ACGME
	PGY1	OB/Gyn	6/18/07	6/29/08	Yes	ACGME
	PGY2	OB/Gyn	6/30/08	6/29/09	Yes	ACGME
	PGY3	OB/Gyn	6/30/09	6/29/10	Yes	ACGME
	PGY4	OB/Gyn	6/30/10	1/4/10	NO	ACGME

(Continued on page 2)

01/04/2011 11:18 3129267780 BOARD OF MEDICINE
JAN. 4. 2011 11:20AM

Board of Registration in Medicine
200 Harvard Mill Square, Suite 330 - Wakefield, MA 01880
Telephone: (781) 876-8210 Fax: (781) 876-8383 www.massmedboard.org

MALPRACTICE HISTORY

Applicant's Instructions: Complete this waiver for release of information and forward a copy to each of your current and past liability carrier(s) over the past ten (10) years. If you have been in a training program within the past ten (10) years, a copy of this form must be forwarded to your training program risk management office. You must account for any gaps in your claims history. If you have additional liability carriers, you may photocopy this form. **Please return the completed Malpractice History form(s) with your original signature to the Board of Registration in Medicine.**

Waiver for Release of Information
I authorize my professional liability carrier(s) listed below to release to the Commonwealth of Massachusetts, Board of Registration in Medicine, my malpractice history and any and all claims or actions for damages, including the following:

1. the name(s) of the claimant(s)
2. nature and date of claim(s)
3. amounts paid, if any, and
4. other disposition or information in its possession, custody or control on my current policy number, and/or any other policy I have had with this or any other carrier
5. dates of policy coverage must be included.

Liability Carrier's Instructions: If the applicant has any open or closed cases that have gone to trial, whether or not monies were paid, a copy of the complaint or summons, disposition or judgment and amount of monies paid on behalf of the applicant must be forwarded directly to the Board. IF THE APPLICANT DOES NOT HAVE ANY CLAIMS HISTORY, PLEASE CONFIRM THAT THERE ARE "NO CLAIMS" ON YOUR LETTERHEAD WITH THE DATES OF COVERAGE AND FORWARD TO THE BOARD. TRAINING PROGRAMS ARE ALSO REQUIRED TO PROVIDE THE MALPRACTICE HISTORY AND DATES OF COVERAGE.

Liability Carrier: Northwestern Memorial Insurance Company From: 06 / 07 To: 7 / 11
City: Chicago State: IL Policy Number: —

Liability Carrier: ______ From: ___/___ To: ___/___
City: ______ State: ______ Policy Number: ______

Liability Carrier: ______ From: ___/___ To: ___/___
City: ______ State: ______ Policy Number: ______

Applicant's signature: [signature] 12 / 4 / 2010
Date

Print Name: Jennifer Yesko

Address: ______ City: ______

State: ______ Zip code: ______

Additional forms available at the Board's website at www.massmedboard.org

21 03/01/11

Board of Registration in Medicine
200 Harvard Mill Square, Suite 330 - Wakefield, MA 01880
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POSTGRADUATE TRAINING VERIFICATION

APPLICANT'S AUTHORIZATION: I authorize the release of information from my postgraduate training program listed below, as requested by the Massachusetts Board of Registration in Medicine.

Applicant's Signature: [signature] Date: 12/6/10

Print or Type Name: Jennifer Lesko

Name of Institution: McGaw Medical Center of Northwestern University

INSTRUCTIONS TO THE PROGRAM DIRECTOR

Please complete this form and forward it to the applicant in a **sealed envelope, signed across the seal**. If the department was a "rotating" or "transitional" program, please submit documentation of the rotations, dates and hours of training.

Name of Institution: McGAW Medical Center of Northwestern

If name of Institution was different when applicant attended, please enter name:

Enrollment and Participation: Our records indicate that Jennifer Lesko (Print applicant's name) participated in the following program:

(List each year separately with from and to dates)

Program Type (Internship, residency, fellowship)	PGY (1,2,3,4)	Department or type of specialty training	Dates Attended (MONTH/DAY/YEAR) FROM	TO	Completed (YES/NO)	Accredited By (ACGME, RSC, AOA or not accredited
Residency	1-4	OB/Gyn	6/18/07	12/9/10	NO	ACGME

(Continued on page 2)

APPLICANT'S NAME: Jennifer Lesko

POSTGRADUATE VERIFICATION FORM PAGE - 2

Unusual Circumstances: The following questions apply to unusual circumstances that occurred during any part of the applicant's medical education. Please circle the appropriate response. **If you answer yes to any of these questions, please enclose an explanation.**

QUESTIONS	YES	NO
1. Did the applicant take any leaves of absence or breaks from his/her post-graduate training?		
2. Was the applicant ever placed on probation?		
3. Was the applicant ever disciplined or under investigation?		
4. Were any negative reports ever filed by instructors regarding the applicant?		
5. Were any limitations or special requirements imposed on the applicant because of questions of academic incompetence or disciplinary problems?		

6. During the applicant's participation, our postgraduate medical training ☐ was accredited by: ☑ ACGME ☐ Other:________

COMMENTS:________

Certification: I hereby certify that the above information is correct, to the best of my knowledge.

AFFIX INSTITUTIONAL SEAL HERE

(If the institution does not have a seal, this form must be notarized by a notary public).

Program Director's Signature: [signature]

Print Name: Magdy Milad

Academic Title:________

Telephone: (312) 472.4673 Today's Date: 12/9/10

PLEASE RETURN THIS COMPLETED FORM TO THE APPLICANT IN A SEALED ENVELOPED WITH YOUR SIGNATURE ACROSS THE SEAL OF THE ENVELOPE.

Seal Verified

DATE: 12/30/10

INITIALS: AB

Board of Registration in Medicine
200 Harvard Mill Square, Suite 330 - Wakefield, MA 01880
Telephone: (781) 876-8210 Fax: (781) 876-8383 www.massmedboard.org

POSTGRADUATE TRAINING VERIFICATION

APPLICANT'S AUTHORIZATION: I authorize the release of information from my postgraduate training program listed below, as requested by the Massachusetts Board of Registration in Medicine.

Applicant's Signature: [signature] Date: 12/10/10

Print or Type Name: Jennifer Lesko

Name of Institution: McGaw Medical Center of Northwestern University

INSTRUCTIONS TO THE PROGRAM DIRECTOR

Please complete this form and forward it to the applicant in a sealed envelope, signed across the seal. If the department was a "rotating" or "transitional" program, please submit documentation of the rotations, dates and hours of training.

Name of Institution: McGaw Medical Center of Northwestern

If name of institution was different when applicant attended, please enter name:

Enrollment and Participation: Our records indicate that Jennifer Lesko (Print applicant's name) participated in the following program:

(List each year separately with from and to dates)

Program Type (internship, residency, fellowship)	PGY (1,2,3,4)	Department or type of specialty training	Dates Attended (MONTH/DAY/YEAR) FROM	TO	Completed (YES/NO)	Accredited By (ACGME, RSC, AOA or not accredited
Residency	1-4	OB/Gyn	6/18/07	12/9/10	NO	ACGME
	PGY1	OB/Gyn	6/18/07	6/29/08	Yes	ACGME
	PGY2	OB/Gyn	6/30/08	6/29/09	Yes	ACGME
	PGY3	OB/Gyn	6/30/09	6/29/10	Yes	ACGME
	PGY4	OB/Gyn	6/30/10	to date	NO	ACGME

(Continued on page 2)

APPLICANT'S NAME: Jennifer Lesko

POSTGRADUATE VERIFICATION FORM PAGE - 2

Unusual Circumstances: The following questions apply to unusual circumstances that occurred during any part of the applicant's medical education. Please circle the appropriate response. **If you answer yes to any of these questions, please enclose an explanation.**

QUESTIONS	YES	NO
1. Did the applicant take any leaves of absence or breaks from his/her post-graduate training?		
2. Was the applicant ever placed on probation?		
3. Was the applicant ever disciplined or under investigation?		
4. Were any negative reports ever filed by instructors regarding the applicant?		
5. Were any limitations or special requirements imposed on the applicant because of questions of academic incompetence or disciplinary problems?		

6. During the applicant's participation, our postgraduate medical training ☐ was accredited by: ☑ ACGME ☐ Other: ____________

COMMENTS: ____________

Certification: I hereby certify that the above information is correct, to the best of my knowledge.

AFFIX INSTITUTIONAL SEAL HERE

(If the institution does not have a seal, this form must be notarized by a notary public).

Program Director's Signature: [signature]

Print Name: Magdy Milad

Academic Title: Assistant Professor / Program Director

Telephone: 312.472.4673 Today's Date: 1.04.11

PLEASE RETURN THIS COMPLETED FORM TO THE APPLICANT IN A SEALED ENVELOPED WITH YOUR SIGNATURE ACROSS THE SEAL OF THE ENVELOPE.

Seal Verified

DATE: 12/30/10

INITIALS: AB

SUPPLEMENT FORM

PRINT NAME: Jennifer Lesko DATE: 12/4/2010

IMPORTANT NOTE: If you answer "yes" to any of these questions, you must provide the additional information on pages 4-10.

QUESTIONS **YES** **NO**

1. Since your enrollment in college, have you been subject to any disciplinary action (see definition) at an academic institution?

2-A. Have you ever been terminated or granted a leave of absence by a medical school or any postgraduate training program or have you ever withdrawn from a medical school or any postgraduate training program or had to repeat a year of postgraduate training?

2-B. Have you ever, for any reason, been placed on probation by a medical school or any postgraduate training program?

3. Have you ever applied for licensure or to sit for an examination or taken an examination under a different name? If so, previous name:______________________________

4. Since your enrollment in college, have you been denied the privilege of taking or finishing an examination or been accused of cheating and/or improper conduct during an examination?

5. Have you ever failed any of the following examinations: FLEX, any State Board examination, any part of the National Boards, any Step of the USMLE, NBOME, or have you failed to gain certification from the National Board of Medical Examiners, any other certification body or any foreign licensing or certification body?

6-A. Have you ever, for any reason, been denied a medical license, whether full, limited, temporary, or have you withdrawn an application for medical licensure?

6-B. Have you ever voluntarily surrendered a license to practice medicine or any healing art?

7. Have you ever, for any reason, lost American Board of Medical Specialty or been denied required recertification by one or more specialty boards?

8-A. Are any formal disciplinary charges pending against you, or do you have knowledge of any pending investigation into your professional competence or conduct by any governmental authority, health care facility, group practice or professional medical society or association (international, national, state or local)? (See definition).

8-B. Has any disciplinary action ever been taken against you for violation of laws, rules, by-laws, or standards of practice by any governmental authority, healthcare facility, group or professional medical society or association (national, state or local)?

Applicant's Signature:______________________________ Date: 12/4/2010

		YES	NO
9-A.	Have you ever voluntarily relinquished any medical staff membership?		
9-B.	Has your medical staff membership, medical privileges or medical staff status at any hospital been limited, suspended, revoked, not renewed or subject to probationary conditions or has processing toward any of those ends been instituted or recommended by a medical staff committee or governing board?		
9-C.	Have you ever been denied medical staff membership, or advancement in medical staff status, or has such denial been recommended by a standing medical staff committee or governing body?		
9-D.	Have you ever, for any reason, withdrawn an application for hospital privileges or appointment?		
10.	Have you ever been charged with any criminal offense, other than a minor traffic offense?		
11.	Has your privilege to possess, dispense or prescribe controlled substances ever been suspended revoked, denied, restricted or surrendered, or have you ever been called before or warned by any state or other jurisdiction including a federal agency regarding such privileges?		
12.	Has any professional liability insurance provider ever restricted, limited, terminated, imposed a surcharge or co-payment, or placed any condition related to professional competency or conduct on your coverage or have you ever voluntarily restricted, limited or terminated your insurance coverage in response to any inquiry by a professional liability insurance provider?		
13.	Have you ever been the subject of any suspension or probation proceedings instituted Blue Cross or Blue Shield, Medicare, Medicaid, or any other medical Reimbursement plan; or have you ever been restricted from receiving payments from any Blue Cross or Blue Shield, Medicare, Medicaid (any state), or third party programs?		
14.	Have you ever had an application for membership as a participating provider rejected by any HMO/PPO/IPA or other prepaid health care plan or your contract as a participating provider terminated by any HMO/PPO/IPA or other prepaid plan?		
15-A.	In the past ten (10) years, has any medical malpractice claim been made against you, whether or not a lawsuit was filed in relation to the claim?		
15-B.	In the past ten (10) years, has any lawsuit, other than a medical malpractice suit, which is related to your competency to practice medicine, or your professional conduct in the practice of medicine, been filed against you or has such a suit been settled, adjudicated or otherwise resolved?		

Applicant's Signature: ______________________ **Date:** 12/4/2010

JENNIFER LESKO

EDUCATION

Northwestern University Prentice Women's Hospital — Chicago, IL
Resident Physician — June 2007-present

Honors: Chief of Education — 2010-2011
Elected by Northwestern University residents and faculty to develop the Summer Series program, to coordinate the 2-year academic lecture series, to develop skill-based simulations, to serve as a representative of the residents in education matters, to serve as a mentor to students.
CREOG Score Award — 2009, 2010
Achieved >90th percentile on CREOGs.
Outstanding Teacher Award — 2010
Selected by 3rd year medical students for teaching excellence.

Cornell University Weill Cornell Medical College — New York, NY
Doctor of Medicine — May 2007

University of Pennsylvania College of Arts and Sciences — Philadelphia, PA
Bachelor of Arts, *summa cum laude* — May 2001
Major: Biological Basis of Behavior   Minors: English, Chemistry

Honors:
Phi Beta Kappa — 2001
Psi Chi Psychology Honor Society — 2000
Golden Key National Honor Society — 2000
Exceptional Summer Student Award, National Institute of Neurological Disorders and Strokes, NIH — 2000

RESEARCH & WORK EXPERIENCE

Northwestern Department of Obstetrics & Gynecology
Maternal Fetal Medicine Division — Chicago, IL
Co-Investigator, Sponsor: Alan Peaceman, MD — Aug. 2009-present
Studying effects of bariatric surgery on pregnancy outcomes.

First Peking University Hospital
Departments of Perinatology and Family Planning — Beijing, China
Co-Investigator, Sponsors: Huixia Yang, MD & Melissa Simon, MD, MPH — April 2010-present
Studying sexual attitudes during the antenatal and immediate postpartum period in Chinese women living in Beijing.

Northwestern Department of Obstetrics & Gynecology — Chicago, IL
Family Planning Division — Oct. 2009-present
Co-Investigator, Sponsor: Cate Stika, MD
Studying patterns of contraceptive counseling in reproductive-age patients who are prescribed Category D and Category X drugs.

University of Copenhagen Herlev Hospital — Copenhagen, Denmark
Department of Gynecologic Oncology — Apr. 2007-May 2007
Internship, Sponsor: Benny Andreassen, MD
Studied the screening, diagnosis, and treatment of cervical cancer within a socialist system.

Weill Cornell Medical College Department of Public Health — New York, NY
Research Assistant, Sponsor: Madelon Finkel, PhD. — Apr. 2006-May 2007
Developed low technology cervical cancer screening methods for villages around Vellore, India.

Memorial Sloan Kettering Cancer Center

Outcomes Research Department New York, NY
Research Assistant, Sponsor: Deborah Schrag, MD. June 2004-Aug. 2004

Interviewed elderly, colorectal cancer patients about treatment decision-making. Researched the British Deprivation Payment System. Drafted a study of the Medicare Modernization Act's effects on cancer care.

The Urban Institute
Health Policy Center Washington, DC
Research Assistant, Sponsor: A. Bowen Garrett, PhD. Aug. 2001-May 2003

Analyzed the health care coverage and health access by Medicaid-eligible adults and the uninsured.

University of Pennsylvania
School of Medicine Department of Pharmacology Philadelphia, PA
Research Assistant, Sponsor: Randall Pittman, PhD. Jan. 1999-May 2001

Researched the roles of the nuclear matrix and the nuclear import system in the pathology of Spinocerebellar Ataxia Type-3. Completed an Independent Study and a Senior Honors Thesis.

National Institutes of Health
National Institute of Neurological Disorders and Strokes Bethesda, MD
Summer Intern, Sponsor: Marjorie Garvey, MD. June 2000-Aug. 2000

Tested patients with Transcranial Magnetic Stimulation to elicit a correlation between motor stimulation and Attention Deficit Hyperactivity Disorder. Presented a poster on the abnormalities of neuron firing in ADHD individuals.

EXTRACURRICULAR ACTIVITIES

Summer Series Coordinator 2010

Coordinated a 9 week course in humanities and medicine with the theme of "Patient and Personal Narrative: Enhancing Our Practice Through Perspective."

Summer Series Assistant Coordinator 2009

Assisted with several sessions including gynecology and sexuality, the art of observation, and the history of gynecologic surgery.

Weill Cornell Community Clinic, *Statistics Chair & Session Coordinator* Feb 2003-March 2007
American Medical Student Association, *Regional Trustee of Region II, Regional Trustee-at-Large, Associate Trustee of Region II, Financial & Keynotes Coordinator for Northeast Regional Conference, Chapter President* April 2004-May 2007
Cornell Obstetrics & Gynecology Society, *Vice President* April 2006-May 2007
Universal Health Care Task Force, *Member* August 2004-2005
Basis of Disease Course, *Student Representative* June 2004-2005
Student Health Policy Forum, *President* Apr. 2004-May 2007
Medical Spanish Class at Cornell, *Elected First Year Organizer* Aug. 2003-July 2004
Cornell KICS, *Volunteer* Sept. 2003-Apr. 2005

PROFESSIONAL MEMBERSHIPS

American Congress of Obstetricians and Gynecologists 2006-present
American Reproductive Health Professionals 2009-present

PUBLICATIONS

Katz M, Lesko J, Kirchoff-Torres KF, Zach V, Levine SR. Cerebrovascular Disease and Pregnancy. *Fetal and Maternal Medicine Review* 2010; 21:2 1-49.

Davidoff A, Sommers AS, Lesko J, Yemane A. Medicaid and State-Funded Coverage for Adults: Estimates of Eligibility and Enrollment. *The Kaiser Commission on Medicaid and the Uninsured.* April 2004.

PRESENTATIONS

US Residency Training and Evidence-Based Practice. Department of Obstetrics and Gynecology, First Peking University Hospital, Beijing China. April 2010.

Transgender Health Care: Issues for the Ob/Gyn. Department of Obstetrics and Gynecology, Northwestern University, Chicago, IL. May 2008.

Cervical Cancer in the Danish Health Care Delivery System. The David Rogers Health Policy Colloquium. Cornell University, New York, NY. May 2007.

PERSONAL

Conversational in basic Spanish. Rudimentary knowledge of Slovak.

Enjoy reading 20th century literature and non-fiction, cooking, swimming, running, triathlons, visiting art museums, writing short stories, traveling, listening to live music, and viewing independent films.

Commonwealth of Massachusetts
Board of Registration in Medicine
Physician Renewal Application

Physician Name: Jennifer M Lesko, M.D. **License No.:** 246480

Current Status: Active **License Expiration Date:** 8/4/2011

1) **Activity Status:** Active

2) **Address & Contact Information**

Mailing Address:

One Brigham Circle
Department of Women's Health 3rd Floor
Boston
Massachusetts - 02116
United States of America

Home Address:

Business Address:

3) **Email Address:**

4) **Fax Number:** (312) 472-4687

5) **Specialties**
Obstetrics and Gynecology

6) **Current American Board of Medical Specialties (ABMS) or American Osteopathic Association (AOA) Information**

ABMS/AOA	Board Name	Certification	Subspecialty
		None Reported	

7) **Drug License Numbers**

Massachusetts	Federal (DEA)	Federal (DEA) XS

8) **Other states where you are now licensed to practice**
None Reported

9) **States where you were previously licensed**
None Reported

10) **Work Sites**
List of all work sites in Massachusetts, including health care facilities (where you are credentialed), private office, clinics, nursing homes, etc

WorkSite	Location
Brigham & Women's Hospital	Obstetrics & Gynecology

Commonwealth of Massachusetts
Board of Registration in Medicine
Physician Renewal Application

Physician Name: Jennifer M Lesko, M.D. **License No.:** 246480

11) Care of patients in Massachusetts
Average weekly hours involved in: **a) inpatient care** 15 hrs/wk
b) outpatient care 25 hrs/wk

12) Medical Liability Insurance Information

Insurance Carrier	Policy Start Date	Policy End Date	Policy Type
CRICO	07/01/2011	12/31/2011	Claims made with tail coverage

13) Do you perform any surgery in your Massachusetts office?

14) Claims Made
a) New: Have you received notification of a claim, whether or not a lawsuit was filed on that claim, or has any medical malpractice claim been made against you during this time period?
b) Pending: Are there any unresolved malpractice claims against you today, i.e., any claims that have not been resolved, settled or adjudicated during this time period?

15) Claims Closed
Has any medical malpractice claim against you (whether or not a lawsuit was filed on that claim) been resolved, settled, or adjudicated during this time period?

16) Other Civil Lawsuits
Question 16 refers to claims or actions related to your competency to practice medicine or your professional conduct in the practice of medicine.
a) New: Have there been any claims, other than medical malpractice claims, filed against you during this time period?
b) Resolved: Have you resolved, settled or adjudicated any lawsuits, other than medical malpractice claims, during this period?

17) Criminal Charges
a) Have you been charged with any criminal offense during this period?
b) Have any criminal offenses/charges against you been resolved during this time period?
c) Are there any criminal charges pending against you today?
d) Are any Application of Issuance of Process pending against you?

18) Other Issues
a) Have you withdrawn an application to any governmental authority, health care facility, group practice employer or professional association?
b) Have you ever taken a leave of absence from any health care facility, group practice or employer?
c) Have you been the subject of an investigation by any governmental authority, including the Massachusetts Board of Registration in Medicine or any other state medical board, health care facility, group practice, employer or professional association?
d) Have you been the subject of a disciplinary action taken by any governmental authority, health care facility, group practice, employer or professional association?

19) Have your privileges to possess, dispense or prescribe controlled substances been suspended, revoked, denied, restricted by or surrendered to any state or federal agency?

20) Have you withdrawn an application for a medical license, allowed a license application to become obsolete or have you been denied a medical license for any reason?

21) Has any medical liability insurance carrier restricted, limited, terminated, imposed a surcharge or co-payment, or placed any condition related to professional competency or conduct on your coverage, or have you voluntarily restricted, limited or terminated your insurance coverage in response to an inquiry by a medical liability insurance carrier?

Commonwealth of Massachusetts
Board of Registration in Medicine
Physician Renewal Application

Physician Name: Jennifer M Lesko, M.D. **License No.:** 246480

22) **Have you completed all CME requirements (100 hours of CME of which 10 hours must be in risk management. Requirement: 40 hours credit in Category 1 and 60 hours in Category 2) for this renewal period? (If you are in an approved Residency/ Fellowship program, or if your are renewing your license for the first time, please answer Yes)**

23) **Do you have a medical condition that interferes in any way or limits your ability to practice medicine?**

24) **Have you used any chemical substance(s) which in any way interferes with your ability to practice medicine?**

Commonwealth of Massachusetts
Board of Registration in Medicine
Physician Renewal Application

Physician Name: Jennifer M Lesko, M.D. **License No.:** 246480

Compliance with Legal Responsibilities

Online profile:

[X] I have reviewed my Physician Profile and confirm that the information is accurate.

1) I understand and agree to comply with my obligations to report abuse or neglect of children pursuant to M.G.L. c. 119 sec. 51A and I understand the punishment for failure to comply.

2) I understand and agree to comply with my obligations to report abuse or neglect of disabled persons pursuant to M.G.L. c. 19C sec. 10 and I understand the punishment for failure to comply.

3) I understand and agree to comply with my obligations to report abuse, neglect or Financial exploitation of elderly persons pursuant to M.G.L. c. 19A sec. 15 and I understand the punishment for failure to comply.

4) I understand and agree to comply with my obligations to report the treatment of wounds, burns and other injuries pursuant to M.G.L. c. 112 sec. 12A and I understand the punishment for failure to comply.

5) I understand and agree to comply with my obligations to report the treatment of victims of rape or sexual assault pursuant to M.G.L. c. 112 sec. 12A 1/2 and I understand the punishment for failure to comply.

6) I understand and agree to comply with my obligations to report a physician to the Board of Medicine pursuant to M.G.L. c. 112 sec. 5F, when i have a reasonable basis to believe that a person violated any provisions of M.G.L. c. 112 sec. 5 or any Board regulation.

7) I understand and agree to comply with my obligations related to charging and collecting fees from Medicare beneficiaries in accordance with the Medicare fee schedule, pursuant to M.G.L. c. 112 sec. 2.

8) I understand and have complied with my obligations to file Massachusetts tax returns and to pay Massachusetts taxes and I understand that, pursuant to M.G.L. c. 62C sec. 49A, my license shall not be issued or renewed unless I make this certification under penalties of perjury.

9) I understand and agree to comply with my obligations related to the reporting of the wages of employees and contractors pursuant to M.G.L. c. 62E Sec. 2.

10) I understand and agree to comply with my obligations related to the withholding and remitting of child support payments pursuant to M.G.L. c. 119A.

11) I understand and agree to comply with my obligations to file an Incident Report with the Board when certain adverse events occur in my private office, pursuant to M.G.L c. 112 sec. 5 and 243 CMR 3.00 et seq. and I understand that the Patient Care Assessment (PCA) programs at the health care facilities where I practice report certain Major Incidents to the Board.

12) I understand and agree to comply with my obligations to disclose ownership interest in any partnership, corporation, firm or other legal entity to which I have referred a patient for physical therapy services, pursuant to M.G.L c. 112 sec. 12AA.

13) I am aware of my obligations and responsibilities under the Health Insurance Portability and Accountability Act of 1996 (HIPAA), including the requirement that I obtain and provide to the Board a National Provider Identifier (NPI) number.

14) I understand and am in compliance with HIPAA and all other federal and state obligations placed upon me as a physician.

15) I understand that as an applicant for a license renewal to practice medicine a criminal record check may be conducted for conviction and pending criminal case information only from the Criminal History Systems Board and that it will not necessarily disqualify me.

[X] **I have reviewed the above statements and certify that I understand my requirement to comply with the responsibilities and obligations of each and agree to do so.**

[X] **Under penalties of perjury, I declare that I have examined this renewal application and all of its accompanying instructions, forms and statements, and to the best of my knowledge and belief, I certify that the information contained herein is true, accurate, and complete.**