FORM 1

MEDICINE

ALL CANDIDATES MUST COMPLETE BOTH SIDES OF THIS APPLICATION EXCEPT THOSE FILING FOR LIMITED PERMIT ONLY.

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

APPLICATION FOR LICENSE AND FIRST REGISTRATION

DEPARTMENT USE ONLY

W515598 $500
7-12-94

N.Y.S. License Number 196198 7/30/94 DE

$35.00 ... Refund ...

1 SOCIAL SECURITY NUMBER: 105-62-9483

2 FIRST 3 LETTERS OF LAST NAME: SOH

3 BIRTH DATE: 02 23 65 (mo. day yr.)

4 PRINT FULL NAME EXACTLY AS YOU WISH IT TO APPEAR ON YOUR LICENSE, IF DETERMINED ELIGIBLE

Last: SOHAM
First: MAHENDRANAUTH
Middle:

5 ADDRESS

Care of:
Street: 263 WESTMINSTER RD
City: BROOKLYN
State: NY Zip Code: 11218

The above address is: ☐ Permanent address of record ☐ Temporary mailing address

6 TELEPHONE

At home: 212 - 5860242 (area code, number)
At work: 718 - 2756020 (area code, number)

7 Citizenship: ☒ United States ☐ Alien lawfully admitted for permanent residence in the United States. Alien Registration Number ______ (Attach a copy of alien registration card) Citizen of ______

8 Name as it appears on diploma or other credentials: Mahendranauth Soham

9 Have you previously applied for a New York medical license or a limited permit? ☐ Yes ☒ No

10 Have you ever been convicted of a crime (felony or misdemeanor) in any state or country? ☒ No

11 Have you ever been charged with a crime (felony or misdemeanor) in any state or country, the disposition of which was other than by acquittal or dismissal? ☒ No

12 Have you ever surrendered your license or been found guilty of professional misconduct, unprofessional conduct, incompetence or negligence in any state or country? ☒

13 Are charges pending against you for professional misconduct, unprofessional conduct, incompetence or negligence in any state or country? ☒

14 Has any hospital or licensed facility restricted or terminated your professional training, employment, or privileges or have you ever voluntarily or involuntarily resigned or withdrawn from such association to avoid imposition of such measures? ☒

If the answer to questions 10-14 is "Yes," submit a letter giving complete explanation, include copies of any court records, and if you possess, a copy of the "Certificate of Relief from Disabilities" or your "Certification of Good Conduct."

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

☒ National Board Examination (See Licensure Requirements - Section IV)

☐ National Board Examination/Osteopath (See Licensure Requirements - Section IV)

☐ Admission to the licensing examination in New York State (See Licensure Requirements - Section IV)
Give date of FLEX examination requested: (Month and Year) ______

Requested exam center: ☐ New York City Area (includes Long Island) ☐ Albany Area ☐ Buffalo Area

February 1992

COMPLETE OTHER SIDE

☐ Acceptance of Federation Licensing Examination (FLEX) taken outside New York State.
Give dates and locations of all FLEX examinations taken. ______________________________

My FLEX Identification number (FIN) is: ______________________________

☐ Endorsement of license from another State or Country.
Name State or Country: ______________________________
Other: ______________________________

☐ 5th Pathway (Section 6528 of the Education Law)

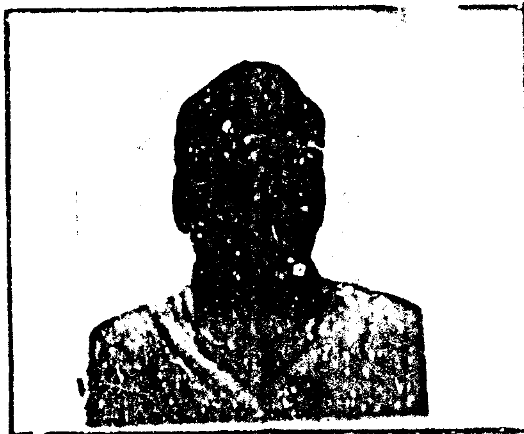
16 I am a graduate of the following medical program

Name of Medical School Attended and Location	Number of Years Attended	Clerk Completed	Dates Of Attendance: From	Dates Of Attendance: To	Diploma or Degree Obtained (If school is located Outside the United States, attach a copy)
ALBANY MEDICAL COLLEGE	2	YES	1988	1990	M.D.
SOPHIE DAVIS SCHOOL OF BIOMEDICAL EDUCATION [illegible]	5	YES	1982	1987	BS

17 Are you licensed as a physician in any states or countries? ☐ Yes ☒ No NOTE: Licensure in another jurisdiction is not a requirement for licensure in New York State.) If Yes, list each jurisdiction and appropriate information in the columns below. In addition, a Form 3A must be submitted for each license listed.

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

I give permission to the New York State Education Department to release my examination results to my professional school on a confidential basis for the purposes of program review and institutional research. ☒ Yes ☐ No Please Initial: [initials]



AFFIDAVIT

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

Under penalties of perjury, I declare and affirm that the statements made in the application, including accompanying statements and transcripts, are true, complete and correct. I understand that any false or misleading information in, or in connection with my application may be cause for denial or loss of licensure

[signature] ______ Signature of Candidate

7/29/94 ______ Date

7/29/94 ______ Date of Photograph

RETURN TO: Division of Professional Licensing Services, Fee Section, Cultural Education Center, Albany, New York, 12230.

FORM 2
MEDICINE

ALL CANDIDATES MUST COMPLETE THIS FORM.

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

CANDIDATE EDUCATION AND TRAINING RECORD

1. [redacted] Social Security Number
2. S O H — First 3 letters of Last Name
3. BIRTH DATE [redacted] mo day yr

4. PRINT FULL NAME EXACTLY AS YOU WISH IT TO APPEAR ON YOUR LICENSE, IF DETERMINED ELIGIBLE. (IMPORTANT: A request that contains only initials and the surname cannot be honored.)

Last: SOHAN
First: MAHENDRANAUTH
Middle:

5. ADDRESS Misc. Bldg & Apt. etc.:
Street: 263 WESTMINSTER RD
City: BROOKLYN
State: NEW YORK
ZIP Code: [redacted]

6. Basis of licensure sought (Form 1, #15) ☐ National Board; ☐ N.Y.S. Exam.; ☐ FLex Outside NYS; ☐ Endorsement

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

SCHOOLS ATTENDED-Location Write names of schools in original language and translate.	NUMBER OF YEARS ATTENDED	ATTENDANCE Entrance Class	Entrance Date	Leaving Class Completed	Leaving Date	Diploma or degree obtained Quote titles in original language and translate.
Elementary or Primary School Redeemer Lutheran School Guyana South America	4	Standard 1	~~1969~~ 1973	Standard 4	1977	(Proof of completion need not be submitted)
Secondary or High School Erasmus Hall High School	3	10th grade	9/79	yes	6/82	(Proof of completion need not be submitted)
Guyana Progressive College (Guyana, South America)	2	8th grade	9/77	10th grade	6/79	
Postsecondary PreProfessional (Exclusive of Medical School) Sophie Davis School of Biomedical Education (7yrs combined BS/MD program)	5	~~9/82~~ 1st year	9/82	yes	6/87	Candidates using Form 2A need not verify preprofessional training. Candidates using Form 2N must arrange that verification of preprofessional training be submitted directly from the school.
Medical Education (Professional) (List *all* Medical Schools Attended) ALBANY MEDICAL COLLEGE	2	3rd year	8/88	yes	6/90	(See Form 2A or 2N for verification requirements)

December 1989

• COMPLETE OTHER SIDE •

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

Inclusive Clerkship Dates	Clinical Area	Name of Health Care Facility and Address	Medical School In Which Taken/Address

9. * Provide a chronological list of all activities since graduation from professional school to the present. Include vacation periods and periods of employment.

FROM		TO		Type of Professional Activity, Including Name and Address of Employer Beginning with Date of Graduation from Professional School
Month	Year	Month	Year	
6	90	6	94	Residency Training in OB/GYN at St Lukes/Roosevelt Hospital Center, Manhattan NY!

10. Professional Certificates/Other Examinations

MSKP	Date:	Score:	Certificate No.:	
Proficiency Examination	Name:	Date Medicine Passed	Date English Passed	Certificate No.
Specialty Boards (if more space is needed attach on separate sheet).				
Fifth Pathway	Name and Location of Medical School	Name and Location of Hospital	Inclusive Dates of Attendance	

* If more space is needed, please attach additional sheets of paper.

* Return this Form *Together* with Form 1, Form 1D, and fee to:

Fee Section, Division of Professional Licensing Services,
Cultural Education Center, Albany, New York 12230

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

544173

CERTIFICATION OF COMPLETION

(Coursework/Training in Identification and Reporting of Child Abuse and Maltreatment)

PART A — TRAINEE INFORMATION

1. Trainee must complete all items in Part A. Return to provider for completion of Part B, "Certification by Approved Provider".
2. The provider will return the Certification form, with Part B completed, to the trainee. It is the trainee's responsibility to submit the original copy of this Certification form to the New York State Education Department at the appropriate time. It should be submitted along with other relevant forms when the trainee applies initially for, or renews, a license, registration certificate, or permit.
3. Address for submitting form is as follows:
   - Professional License or Permit: New York State Education Department, Division of Professional Licensing Services, [give name of profession], Cultural Education Center, Albany, New York 12230.
   - Reregistering Licensees: Your certificate should be included with your reregistration application in the envelope provided with those materials.
   - Teacher Certification: New York State Education Department, Office of Teaching, Cultural Education Center, Albany, New York 12230.

1 Print name exactly as it currently appears on New York State Education Department records:

Last: SOHAN
First: MAHENDRANAUTH
Middle:

2 Print your address:

Care of:
Misc. (Bldg. & Apt., etc.):
Street: 263 WESTMINSTER ROAD
City: BROOKLYN
State: NY Zip Code: [redacted]

3 Date of Birth: [redacted] (Mo. Day Yr.)

4 Social Security number: [redacted]

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

Name of Profession(s): M.D.

N.Y.S License Number:

N.Y.S License Number:

Permit #:

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

Certificate Title(s):

N.Y.S. Certificate Number (other than Social Security Number, if any):

Trainee's Signature: [signature] Date: 7/7/93

PART B — CERTIFICATION BY APPROVED PROVIDER

1. Provider must complete Part B.
2. The EDUCATION DEPARTMENT-ORIGINAL COPY and TRAINEE COPY should be returned to the trainee within ten calendar days of the completion of the coursework or training.
3. The provider of the coursework or training must retain the PROVIDER COPY. This copy must be retained in the provider's files for not less than five years from the date the course was completed.

Pursuant to Chapter 544 of the Laws of 1988, I certify that the person indicated in Part A has completed the required coursework or training regarding the identification and reporting of child abuse and maltreatment.

JUNE NARUS NOVAK
Name of Authorized Certifying Officer (Print or Type)

[signature]
Signature of Authorized Certifying Officer

ST. LUKES-ROOSEVELT H.C.
Approved Provider Name

40051
Identification Number

7/7/93
Date(s) of Coursework or Training

PR 2 (10-91)

STATE EDUCATION DEPARTMENT COPY

MAN closing
letters of study
7-28-94
TB

FORM 2A
MEDICINE

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

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

CERTIFICATION OF PROFESSIONAL EDUCATION: REGISTERED OR ACCREDITED PROGRAMS

CANDIDATE INSTRUCTIONS

1. Complete Section I. Enter your name as it appears on your Application (Form 1).
2. Send this form to the professional school you attended. See "Licensure Requirements" for additional instruction. Be sure to include any fee required.
3. Certification is not acceptable unless dated after graduation.

SECTION I: CANDIDATE INFORMATION

1. [redacted] Social Security Number
2. S O H First 3 letters of Last Name
3. BIRTH DATE [redacted] mo. day yr.

4. PRINT FULL NAME EXACTLY AS YOU WISH IT TO APPEAR ON YOUR LICENSE, IF DETERMINED ELIGIBLE. (IMPORTANT: A request that contains only initials and the surname cannot be honored.)

Last: SOHAM
First: MAHENDRANAUTH
Middle:

5. ADDRESS
Misc. (Bldg. & Apt. etc.):
Street: 263 WESTMINSTER ROAD
City: BROOKLYN
State: NEW YORK
ZIP Code: [redacted]

6. Basis of licensure sought (Form 1, #15) ☒ National Board ☐ N.Y.S. Exam.; ☐ FLex Outside NYS; ☐ Endorsement ☐ Limited Permit

7. Print name under which degree or diploma was awarded:
MAHENDRANAUTH SOHAN
(Name)

8. High School Attended: ERASMUS HALL HIGH SCHOOL
(Name)

9. Professional school attended: ALBANY MEDICAL COLLEGE
(Name)

Address ALBANY, NEW YORK Date degree was awarded 5/90

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

December 1989

SECTION II. CERTIFICATION OF EDUCATION

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

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

Preprofessional Education:

(1) Satisfactorily completed, prior to matriculation in professional school the following preprofessional education:

City College of New York
Print Name of Institution

to 1988 — Dates of Attendence

BS 2/88 — Degree Granted

Professional Education

(1) Was admitted to ALBANY MEDICAL COLLEGE
Print Name of Medical School

on August 15, 1988 (Month Day Year) and satisfactorily completed the program on

May 18, 1990 (Month Day Year) and was awarded the degree of

DOCTOR OF MEDICINE — Degree

May 24, 1990 — Date

If the applicant was credited with advanced standing based on prior academic work, give institution name and dates of attendance.

Name of Institution: City College of New York as part of the Sophie Davis Program

Dates of Attendence 08/83 to 2/1/88

Attach the following to this form:

(1) Official transcript of studies at your institution.
(2) Copies of documentation in your file to support the granting of transfer credit.

Name [signature]
(original signature)

Richard H. Edmonds, Ph.D.
(Type or print above name)

(COLLEGE SEAL)

Title Executive Associate Dean

Medical School Albany Medical College

Location Albany, New York

Telephone Number 518-262-5523

Date 7/21/94

Certification is not acceptable unless dated after graduation.

RETURN TO: Division of Professional Licensing Services, Medical Unit, Cultural Education Center, Albany, New York 12230

FORM 2PGT
MEDICINE

ALL CANDIDATES MUST COMPLETE THIS FORM.

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

CERTIFICATION OF APPROVED POSTGRADUATE TRAINING

1-26-94 HK

Any certification signed and submitted earlier then one month prior to the completion of the training period will be returned to the hospital by the division without processing.

CANDIDATE INSTRUCTION

1. Complete Section I. Enter your name as it appears on your Application. (Form 1)
2. Please send this form to the director of medical education of the hospital(s) in which you completed postgraduate training. One form must be submitted to verify each residency.
3. If you have completed more than 3 residencies, you may have the director of medical education complete a photocopy of the form.
4. This form must be sent directly to this office by the hospital in which you did your residency. If the hospital in which you did your residency does not have a director of medical education, the form may be completed by the department chief. If the Department cannot determine that this verification came directly from the Hospital, the post graduate hospital training will not be credited.

SECTION I: CANDIDATE INFORMATION

1. [redacted] Social Security Number
2. SOH First 3 letters of Last Name
3. BIRTH DATE [redacted] mo. day yr.

4. PRINT FULL NAME EXACTLY AS YOU WISH IT TO APPEAR ON YOUR LICENSE, IF DETERMINED ELIGIBLE. (IMPORTANT: A request that contains only initials and the surname cannot be honored.)

Last: SOHAN
First: MAHENDRANAUTH
Middle:

SECTION II: CERTIFICATION OF POSTGRADUATE TRAINING

This is to certify that MAHENDRANAUTH SOHAN (Physician's Name)

a graduate of ALBANY MEDICAL COLLEGE (Medical School)

was enrolled in a residency training program approved by the Accreditation Council on Graduate Medical Education or the American Osteopathic Association at ST LUKES / ROOSEVELT HOSPITAL (Name of Hospital)

Amsterdam Ave at 114th St. NYC NY 10025 (Location of Hospital)

from 6 (Date) 19 90 thru ~~present~~ June (Date) 19 94 in the clinical area of

OBSTETRICS / GYNECOLOGY (Clinical Area) and that the

above named physician successfully completed this training on ~~presently in training~~ 6/23/94 (Date)

December 1989

• COMPLETE OTHER SIDE •

If this physician did not successfully complete the postgraduate training program, please attach a letter of explanation with this form.

I am the director of medical education or departmental chief of the clinical area. I was the program director for the physician named above during the postgraduate training indicated and have carefully read and completed this form and hereby attest that the statements made herein are strictly true in every respect and are supported by hospital records.

Signature of Director/Chief Solan Chao Date 7/22/94

Print Name of Director/Chief SOLAN CHAO, MD

Print Title DIRECTOR, DEP'T OB/GYN Telephone Number: 212-523-

- **RETURN TO:** Division of Professional Licensing Services, Medical Unit, Cultural Education Center, Albany, New York 12230

REGISTRATION APPLICATION

PROFESSION: MEDICINE

710 00 000 6
DEPOSIT ONLY NYSED

PERIOD: 07/01/96 - 01/31/98 $ 261
PAY THIS AMOUNT

OFFICE USE ONLY
DATE: 02/05/96
LIC NO: 196678
NM: SOH8
DOB: [redacted]
SSN: [redacted]
FEE: 261
PR: 60 OFF: 1
YR: 96 TYPE: RR
PY:
CA: Y

- Make check or money order payable to "New York State Education Department." C59514 5-03
- To make sure that your registration is processed timely, please mail your application promptly. Receipt is requested at least 60 days before the start of the new period shown above.
- This application may ONLY be used by the person whose name appears below.
- Please read instructions on reverse side before completing this form.

The University of the State of New York
THE STATE EDUCATION DEPARTMENT
Office of the Professions
Professional Licensing Services
Cultural Education Center
Albany, NY 12230
(518) 474-3817

SOHAN MAHENDRANAUTH
~~APT 10M~~ apt 29C
~~260 W 60TH STREET~~ 75 West End Avenue 7
NEW YORK NY 10023-0000

- The above address is: [X] Home [ ] Practice

1 (a) **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? [redacted] [X] No

(b) **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 acquittal or dismissal? [redacted] [X] No

(c) **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? [redacted] [X] No

2 Do you wish to register in New York State for the period indicated? [X] Yes [ ] No
(Registration is required to practice your profession or use your professional title within New York State.)

3 Are you currently practicing in New York State? [X] Yes [ ] No
If no, provide month and year last practiced. ____ / ____ (Mo / Yr)

4-5 Enter Date of Birth and Social Security Number ONLY if it is missing or incorrect in the OFFICE USE ONLY BOX above.

4 Date of Birth [redacted] (Mo Day Yr)

5 Social Security Number [redacted]
If Social Security number has not been provided, check appropriate box below:
[ ] *number applied for or pending* [ ] *explanation attached*

6 Federal Employer Identification Number [ ][ ] - [ ][ ][ ][ ][ ][ ][ ] *(applicable only if you are an employer required to report employment taxes to the I.R.S.)*

7 Your profession must comply with a one-time requirement for two hours of coursework or training in the recognition and reporting of child abuse and maltreatment. Your registration will not be processed until this requirement has been satisfied. Your current status with regard to this requirement is noted to the right. **See reverse side for details.**

X or N - Requirement has not been satisfied. You must submit either a Certificate of Completion or Exemption.
Y - Requirement has been satisfied. You do not have to submit any additional information.
E - Exemption has been granted. You do not have to submit any additional information.

CA: Y

8 You must comply with the statutory requirement for completion of approved course work in infection control and barrier precautions to prevent the transmission of HIV and HBV in healthcare settings. Questions may be referred to the Infection Control/Occupational Health Unit of the NYS Department of Health at (518) 473-8815.

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.

[signature] Sohan MD 5/22/96
(Signature) (Date)

DECEASED NOTIFICATION

If you are aware that the licensee is deceased, please complete and sign the following statement in order to permit us to change our license records and to prevent future correspondence from being mailed.

THE LICENSEE WHOSE NAME APPEARS ABOVE IS DECEASED. Approximate date of death was ____ / ____ / ____

____________ (Signature) ____________ (Relationship to deceased) ____ / ____ / ____ (Date)

This is your application to register your [illegible] for the period indicated in the upper left corner of the application. Registration is required if you practice your profession or use your [illegible]. To be sure that your registration is processed timely, please mail your application promptly. Receipt is requested [illegible] of the new period.

If you do not expect to practice or [illegible] York State during the period indicated, you may voluntarily place your license on inactive status by checking "NO" to [illegible] without a fee by the beginning of the new period. Please note: If you become inactive, a registration certificate [illegible] will not be sent to you until you reactivate your registration. Should you later decide to register for practice within New York, [illegible] late registration fees for the period your license was inactive.

If you do not return this application, [illegible] status, your license will be automatically declared not registered. Should you later attempt to register for practice within the [illegible] or late registration fees for each month your license was not registered.

[illegible] COMPLETING THE APPLICATION

Please indicate [illegible] on the reverse side is a home address or a practice address.

1. Answer each question. A response [illegible] not prevent or delay your reregistration.

   (a) If you answer "YES", submit [illegible] and give a brief explanation of each action.

   (b) If you answer "YES", submit [illegible] for each conviction. Do not check "YES" for minor traffic violations, charges that were dismissed, [illegible]

   For purposes of item 1[illegible] of Regents identifies this profession a health profession.
   (c) If you answer "YES", submit [illegible] of the separation.

2. Check "YES", if you plan to [illegible] the period indicated. Registration is required if you practice your profession or use your professional title within New York [illegible] in this State and wish to claim inactive status, check "NO" and return the application without a fee. (see above box for [illegible])

3. If you are not currently [illegible] last practiced in New York State.

4. Please provide your date of birth. [illegible] in this profession are based on the licensee's month of birth.

5. Enter your Social Security Number[illegible] Social Security Number, you must provide an explanation as indicated.

6. If you are an employer and hold [illegible] Employer Identification Number *, you must enter your employer identification number in the boxes provided.

7. Licensees who complete [illegible] program registered by the State Education Department as fulfilling the educational requirements for licensure [illegible] of the coursework and do not have to submit a Certificate of Completion nor file for an exemption. The coursework or training [illegible] specifically approved for that purpose by the New York State Education Department. Only approved providers can [illegible] Completion form required for reregistration. You should return the copy marked STATE EDUCATION DEPARTMENT COPY [illegible] If you need to locate an approved provider, you should call Professional Licensing Services for assistance.

   Section 59.12 of [illegible] provides for exemption from the course requirement in cases where the nature of an individual's [illegible] If you believe you may qualify for such an exemption, call Professional Licensing Services to request an exemption [illegible]

8. Please read the important [illegible] regarding HIV and HBV requirement in this profession.

9. Read the affirmation, [illegible] the fee must be paid with a check or money order made payable to the NEW YORK STATE EDUCATION [illegible] only. DO NOT SEND CASH. Section 6502 (7) of the Education Law requires a $25.00 penalty fee be charged [illegible] anyone who submits a bad check for registration or licensure. Such replacement fees must be paid by certified check, [illegible] replacement fees are not submitted within 60 days of the notice of a bad check, section 59.8 (g) of the Regulations of the C[illegible] registration may be voided.

- DECEASED NOTIFICATION [illegible] licensee named on the application is deceased, please complete the appropriate information on the front and return the [illegible] enclosed envelope.

- NAME AND ADDRESS [illegible] card ONLY if you are reporting a change of name and/or address.

- When returning [illegible] of the materials together.

*(Collection of this information is required by Section 5 of the New York State Tax Law. It will be used for tax administration purposes only.)

[illegible]

REGISTRATION APPLICATION PERIOD: 02/01/98 - 01/31/00

PROFESSION: MEDICINE

$ 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

3. (a) Are you under an obligation to pay child support? If no, proceed to question #4 below. ☐ YES ☒ NO
(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 ordered payment or repayment 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

OFFICE USE ONLY

DATE: 02/19/98

LIC. NO.: 196678

NM CHK: SOH8

DOB: [redacted]

SSN: [redacted]

FEE: 600 / 600

PR: 60 OFF: 1

YR: 98 TYPE: RR

PEN: Y

CA:

5. - Will you be practicing in NYS during the period indicated ? ✓ Yes ___ No
If NO, are you ___ Inactive ___ Retired

- Enter the date you last practiced in New York State. 0 2 / 9 8 (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 association to avoid imposition of such action due to professional misconduct, unprofessional conduct, incompetence or negligence ? ___ Yes ✓ No
If Yes, please provide documentation

SOHAN MAHENDRANAUTH
SUITE 1H
40 W 77TH STREET
NEW YORK NY 10024-0000

6. DATE OF BIRTH: [redacted] Mo Day Yr

7. SOCIAL SECURITY NUMBER: [redacted] ☐ if applied for or pending ☐ Explanation attached

8. FEDERAL EMPLOYER IDENTIFICATION NUMBER: ☐☐-☐☐☐☐☐☐☐ (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, any application may be cause for disciplinary action, including the loss of my license, and that willful failure to register or its continuing to practice my profession constitutes professional misconduct.

Signature: [signature] M.D. Date: 2/20/98

1966782SOH8006000060100

REGISTRATION REMITTANCE DOCUMENT

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

09/01/99
LIC: 196878
NME: SOH8
YR: 00
OFF: 1
DOB: [illegible]
SSN: [illegible]
EIN:

SOHAN MAHENDRANAUTH
SUITE 1H
40 W 77TH STREET
NEW YORK NY 10024-0000

Name/address change
Complete only if change has occurred

Name

Street

City

State/Zip

$ 600

AMOUNT DUE

PROFESSION: 60 MEDICINE
PERIOD: 02/01/00 - 01/31/02

Complete and sign reverse side of this application

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? X 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? X 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? X No

3. a. Are you under an obligation to pay child support? __ Yes X 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? X Yes __ No

32298008 307
047 03662080

DO NOT WRITE IN THIS BOX
FOR OFFICIAL USE ONLY

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) ____________ Business phone ____________ Date 2/10/00

2. Since you last filed a registration application:

REGISTRATION REMITTANCE DOCUMENT

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

03/08/00

LIC: 196678
NME: SOH8
YR: 00
OFF: 1
DOB: [redacted]
SSN: [redacted]
EIN:

SOHAN MAHENDRANAUTH
SUITE 1H
40 W 77TH STREET
NEW YORK NY10024-0000

E72542 920

UP HOLD

PROFESSION 60 MEDICINE
PERIOD: 02/01/00 - 01/31/02

$ 10 | 10
AMOUNT DUE

Complete and sign reverse side of this application

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? ✓ 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? ✓ 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? ✓ 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. "I am a U.S. citizen or I am a qualified alien as defined below." ✓ Yes ___ No

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) [illegible] Business phone (212) 769-4171 Date 3/17/2000

REGISTRATION APPLICATION PERIOD: 02/01/02 - 01/31/04

PROFESSION: MEDICINE

$ 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

3. (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 repayment 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

OFFICE USE ONLY

DATE: 02/15/02
LIC. NO.: 196678
NM CHK: SOH8
DOB: [redacted]
SSN: [redacted]
FEE: 600
PR: 60 OFF: 1
YR: 02 TYPE: RR
PEN
CA: Y

5. Will you be practicing in NYS [illegible] ✓ Yes ___ No
   If NO, are you ___ Inactive ___ Retired

   Enter the date you last practiced in New York State: 0 2 0 2 mth/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 association to avoid imposition of such action due to professional misconduct, unprofessional conduct incompetence or negligence ? ___ Yes X No
   If Yes, please provide documentation

SOHAN MAHENDRANATH
[redacted]
OZONE PARK NY [redacted]

6. DATE OF BIRTH: [redacted]
   Mo. Day Yr

7. SOCIAL SECURITY NUMBER: [redacted]
   ☐ # applied for or pending ☐ Explanation attached

8. FEDERAL EMPLOYER IDENTIFICATION NUMBER: 13-4123341
   applicable only if you are an employer required to report employment taxes to the IRS

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: [signature] Date: 2/23/02

196678SOH8006000060104

REGISTRATION RENEWAL DOCUMENT

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

12/15/03
LIC 196678
NME SOH8
YR 04
OFF 1
DOB [redacted]
SSN
EIN

SOHAN MAHENDRANAUTH
106-12 LIBERTY AVE
OZONE PARK NY 11417-0000

****
*** 2ND REQUEST ***
****

PROFESSION 60 MEDICINE
PERIOD 02/01/04 - 01/31/06

Complete and sign reverse side of this application

Name/address change
Complete only if change has occurred

Name

Street

City

State Zip

$ 600
AMOUNT DUE

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? ✓ 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? ✓ No

c. Are criminal charges pending against you in any court? ✓ No

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

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 [signature] Business phone ([redacted] Date 1/24/04

196678SOH800600000060106

REGISTRATION RENEWAL DOCUMENT

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

12/15/05

LIC: 196678
NME: SOH8
YR: 06
OFF: 1
EIN:

SOHAN M[illegible]
106-12 LIBERTY AVE
OZONE PARK NY 11417-0000

Name/address change
Complete only if change has occurred

Name

Street

City

State/Zip

$ 600
AMOUNT DUE

****
*** 2ND REQUEST ***
****

PROFESSION: 60 MEDICINE
PERIOD: 02/01/06 - 01/31/08

Complete and sign reverse side of this application

[illegible]

1. Do you wish to register for the period indicated? ✓ Yes __ No

2. Since your last registration application,

a. Have you been found guilty after trial, or pleaded guilty, no contest, or nolo contendere to a crime (felony or misdemeanor) in any court? ✓ 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? ✓ No

c. Are criminal charges pending against you in any court? ✓ No

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

057 01172006

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 [signature] Daytime phone (718) 322-1188 Date 1-11-06

OP

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

[illegible]

196678
MEDICINE
02/01/2008 through [illegible] 31 201[illegible]

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

S[illegible]IAN [illegible]NDRANAUTH
106-12 LIBERTY AVE
OZONE PARK NY 11417 - 0000

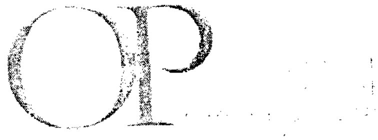
Paid On-line - Renewal Complete

[illegible]

106-12 LIBERTY AVE OZONE PARK NY [illegible]

[illegible]

1. Have you been found guilty [illegible] nolo contendere to a crime, felony or misdemeanor [illegible] — No
2. Has any licensing or disciplinary [illegible] surrender of [illegible] license or certificate suspended, placed on probation [illegible] held by you now or previously [illegible] — No
3. Are criminal charges pending against you [illegible] — Nc
4. Are charges pending against you [illegible] professional misconduct? — No
5. Has any hospital or licensed facility restricted or terminated your professional training, employment or privileges [illegible] voluntarily or involuntarily resigned or withdrawn from such association to avoid the imposition [illegible] professional misconduct, unprofessional conduct, incompetency or negligence? — No
6. Are you under an obligation [illegible] — Yes
7. Do you meet one of the following requirements [illegible] — Yes
   a. I am not four or more months in arrears [illegible]
   b. I am making payments [illegible] repayment plan or by plan agreed to by the parties [illegible]
   c. the child support obligation is the subject of a pending [illegible]
   d. I am receiving public assistance [illegible]
8. Are you a U.S. citizen or [illegible] the U.S.? — Yes



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

196673
MEDICINE
02/01/2010 through 01/31/2012

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

106-12 LIBERTY AVE
OZONE PARK NY 11417 - 0000

Paid On-line - Renewal Complete

106-12 LIBERTY AVE, OZONE PARK NY

1. Have you been found guilty after trial, or pleaded guilty, no contest, or nolo contendere to a crime (felony or misdemeanor) ...? 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 measures due to professional misconduct, unprofessional conduct, incompetency, or negligence? No

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

7. Do you meet one of the following requirements: Yes
a. I am not four or more months in arrears in the payment of child support, or
b. I am making payments by income execution or court-ordered payment or repayment plan or by plan agreed to by the parties, or
c. the child support obligation is the subject of a pending court proceeding, or
d. I am receiving public assistance or supplemental security income.

8. Are you a U.S. citizen? Yes

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

196618
MEDICINE
02/01/2012 through 01/31/2014

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

106-12 LIBERTY AVE
OZONE PARK NY 11417 - 0000

Paid On-line - Renewal Complete

1 106-12 LIBERTY AVE, OZONE PARK NY

		Response
1	Have you been found guilty ... of a crime, felony or misdemeanor in any ...?	No
2	Has any licensing or disciplinary authority revoked, annulled, ... 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 ... training, employment or privileges ... association to avoid the imposition of ... professional conduct ...	No
6	Are you under an obligation ...	[illegible]
7	Are you a U.S. citizen?	Yes

License Renewal Payment Details: