



STATE OF CONNECTICUT

DEPARTMENT OF PUBLIC HEALTH

March 25, 2009

Janelle Luk M.D.
7 Ocean View Dr., Apt. 605
Boston, MA 02125

Dear Licensee:

I am pleased to inform you that you have met all requirements for licensure as a **Physician/Surgeon** in Connecticut. Your license number is **047487** and is effective as of the date of this letter. Your formal license will be mailed to you in the near future. Your name will appear on your license as shown above unless you notify us otherwise.

It is your responsibility to notify the Department of Public Health, Office of Practitioner Licensing and Certification, in writing, of any changes of name, residence address or business address, either within or outside Connecticut. Such notification to the Department of Public Health is required by law; failure to provide same may jeopardize the status of your license.

Please note that your license must be renewed annually during your month of birth. Renewal will be required in the first birth month which immediately follows the issuance of licensure. Failure to renew your license within ninety (90) days of the due date will result in your license becoming void. In that event, re-licensure would require a new application to the department and a review of all credentials to determine whether you satisfy current licensing requirements.

Should you have any questions or concerns regarding the renewal of your license, please contact the renewal staff at (860) 509-7603.

Respectfully,

A handwritten signature in black ink that reads "Stephen B. Carragher".

Stephen B. Carragher
Health Program Supervisor
Practitioner Licensing and Investigations Section

SBC:AB



Phone: (860) 509-7603
Telephone Device for the Deaf--(860) 509-7191
410 Capitol Avenue - MS # 12MQA
P.O. Box 340308 Hartford, CT 06134
An Equal Opportunity Employer

Website for licensure verification <http://www.ct-clic.com>



STATE OF CONNECTICUT
DEPARTMENT OF PUBLIC HEALTH

4.75

PHYSICIAN APPLICATION

Initial licensure (\$450) Reinstatement (\$450) CT License No.: _____ Date Granted: _____

PLEASE INDICATE (X) THE EXAMINATION (S) YOU COMPLETED:

<input type="checkbox"/>	National Board of Medical Examiners (NBME)	<input type="checkbox"/>	Federation Licensing Examination (FLEX)
<input type="checkbox"/>	State Board Licensing Exam _____ (State) Year Taken: _____	<input type="checkbox"/>	Licentiate of the Medical Council of Canada (LMCC)
<input checked="" type="checkbox"/>	United States Medical Licensing Examination (USMLE)	<input type="checkbox"/>	Combination of Segments (please specify)
<input type="checkbox"/>	National Board of Osteopathic Examiners (NBOME)		

Do you plan to use the Federation Credentials Verification Service (FCVS) to verify your credentials? Yes Packet ID# _____ No

Last Name: LUK First Name: JANELLE MI: _____ Maiden Name: _____

Date of Birth: 9/19/1979 Social Security No.: [REDACTED] Gender: FEMALE

Name and Mailing Address: This will be how your name and address will appear on your official license, your address of record for all mailings from this office and releasable pursuant to Freedom of Information requests.

Name on License: JANELLE LUK
Address: 7 OCEAN VIEW DR, APT 605

City, State, Zip: BOSTON, MA, 02125

Daytime Phone Number: (203) 606-2689 E-mail: JANELLE.LUK@GMAIL.COM

RACE/ETHNIC DATA: (This section is voluntary. Information gathered will be used solely for the purpose of examining the demographics of Connecticut licensees. This data will not be used for discriminatory purposes and will not be considered in the evaluation of your application.)

- AMERICAN INDIAN OR ALASKAN NATIVE: Persons having origins in any of the original peoples of North America, and who maintain cultural identification through tribal affiliation or community recognition.
- ASIAN OR PACIFIC ISLANDER: Persons having origins in any of the original peoples of the Far East, Southeast Asia the Indian Subcontinent of the Pacific Islands. This area includes, for example, China, Japan, Korea, the Philippine Islands, and Samoa.
- BLACK: Persons having origins in any of the black racial groups of Africa.
- HISPANIC: Persons of Mexican, Puerto Rican, Central or South American or other Spanish culture or origin, regardless of race.
- WHITE (not of Hispanic Origin): Persons having origins in any of the original peoples of Europe, North Africa, or the Middle East.

MEDICAL EDUCATION:

List name and location of medical school(s) attended _____ Dates of Attendance _____
YALE UNIVERSITY SCHOOL OF MEDICINE JUNE 2001 → JUNE 2005

MD/DO DEGREE AWARDED BY: YALE UNIVERSITY SCHOOL OF MEDICINE DATE AWARDED: MAY 23rd, 2005
(Name of school)

01

LICENSURE: List all states in which you have ever been licensed to practice medicine:

State	License/Permit Number	Date Issued
MA	(limited) # 225606	JUNE, 20 0 th 2005

SPECIALTY:

If certified by a specialty board approved by the American Board of Medical Specialties (ABMS), indicate name of Board:

American Board of: _____ Date Certified: _____

MEDICAL PRACTICE: Attach a CV or list all medical practice you have engaged in since graduation from medical school (identify internship and residency):

Hospitals Associated With	Location	Dates
BRIGHTON AND WOMEN'S HOSPITAL AND MASSACHUSETTS GENERAL HOSPITAL INTEGRATED RESIDENCY PROGRAM	BOSTON	JUNE 2005 - JUNE 2009

STATEMENT OF PROFESSIONAL HISTORY: Please answer the following questions referring to the instructions, if applicable.

- Have you ever been censured, disciplined, dismissed or expelled from, had admissions monitored or restricted, had privileges limited, suspended or terminated, been put on probation, or been requested to resign or withdraw from any of the following:
 -Any hospital, nursing home, clinic, or similar institution;
 -Any health maintenance organization, professional partnership, corporation, or similar health practice organization, either private or public;
 -Any professional school, clinical clerkship, internship, externship, preceptorship or postgraduate training program; -Any third party reimbursement program, whether governmental or private?

If your answer is "yes", give full details, names, addresses, etc. on separate notarized statement.

Yes No
- Have you ever had your membership in or certification by any professional society or association suspended or revoked for reasons related to professional practice?
If your answer is "yes", give names of professional society or association, date and reasons your membership or certification was suspended or revoked on a separate notarized statement.

Yes No
- Has any professional licensing or disciplinary body in any state, the District of Columbia, a United States possession or territory, or a foreign jurisdiction, limited, restricted, suspended or revoked any professional license, certificate, or registration granted to you, or imposed a fine or reprimand, or taken any other disciplinary action against you?
If your answer is "yes", give full details, names, addresses, etc. on a separate notarized statement.

Yes No
- Have you ever, in anticipation or during the pendency of an investigation or other disciplinary proceeding, voluntarily surrendered any professional license, certificate or registration issued to you by any state, the District of Columbia, a United States possession or territory, or a foreign jurisdiction?
If your answer is "yes" give full details, names, addresses, etc. on a separate notarized statement.

Yes No

5. Have you ever been subject to, or do you currently have pending, any complaint, investigation, charge, or disciplinary action by any professional licensing or disciplinary body in any state, the District of Columbia, a United States possession or territory, or a foreign jurisdiction or any disciplinary board/committee of any branch of the armed services? You need not report any complaints dismissed as without merit.

Yes No

If your answer is "yes" give full details, names, addresses, etc. on a separate notarized statement.

6. Have you ever entered into, or do you currently have pending, a consent agreement of any kind, whether oral or written, with any professional licensing or disciplinary body in any state, the District of Columbia, a United States possession or territory, any branch of the armed services or a foreign jurisdiction?

Yes No

If your answer is "yes" give full details on a separate notarized statement and submit notarized copy of agreement.

7. Have you ever been found guilty or convicted as a result of an act which constitutes a felony under the laws of this state, federal law or the laws of another jurisdiction and which, if committed within this state, would have a felony under the laws of this state?

Yes No

If your answer is "yes" give full details on a separate notarized statement and furnish a Certified Court Copy (with court seal affixed) of the original complaint, the answer, the judgment, the settlement, and/or the disposition of the case.

8. Have you ever been denied or surrendered a state or federal controlled substance registration, had it revoked or restricted in any way, or been warned, reprimanded or fined by the responsible agency?

Yes No

If your answer is "yes", give full details, dates, etc., on a separate notarized statement.

On this 6 day of January / 2009 (month/year) JANELLE LUK (applicant's name) personally appeared before me, who being duly sworn says that she/he is the person referred to in the foregoing application and that the photograph attached hereto is a true picture of self and that the statements made herein are true in every respect.

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

Janelle Luk
SIGNATURE OF APPLICANT

Notary Public Signature Kirkon (month/year) January 2009

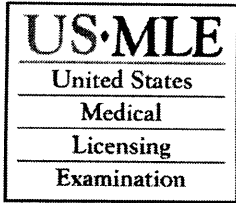
My Commission Expires 12/31/2010

Please return this application, the fee for \$450.00 (certified bank check or money order) and a separate certified bank check or money order for \$4.75 made payable to, "Treasurer, State of Connecticut" to:

Department of Public Health
Physician Licensure-Remittance Unit
410 Capitol Ave., MS# 12MOA
P.O. Box 340308
Hartford, CT 06134-0308



IMPORTANT: Please do not send this form and fee unless you have read and understood the licensing policies and requirements. No fees are refundable should you not be eligible for licensure.



United States Medical Licensing Examination™ (USMLE™) Certified Transcript of Scores

This document was prepared by the
Federation of State Medical Boards of the United States, Inc.
Federation Place, PO Box 619850, Dallas, TX 75261-9850 -- Telephone (817) 868-4041

Date : 02/19/2009

Recipient:

Connecticut Medical Examining Board
ATTN: Maritsa Morales, Licensing
410 Capitol Ave
MS 13PHO
PO Box 340308
Hartford, CT 06134-0308

Examinee: Luk, Janelle
Alt Name(s):

Examinee ID#: 5-117-093-4
Date of Birth: 09/19/1979

Results for Steps taken by this examinee (and for which results have been reported to date) are shown below. For Steps that span more than one day, the test date reflects the day on which the examination began. Where numeric scores are reported, there are two scales used and the recommended minimum passing score ("MP") on each scale is shown in parentheses.

USMLE STEP 1

Test Date	Pass/Fail	Three-Digit Score		Two-Digit Score		Comments
		Total	MP	Total	MP	
07/07/2003	Pass	213	182	87	75	

USMLE STEP 2

Clinical Knowledge (CK)

Test Date	Pass/Fail	Three-Digit Score		Two-Digit Score		Comments
		Total	MP	Total	MP	
12/09/2004	Pass	195	182	80	75	

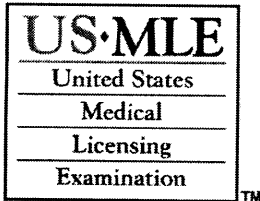
Clinical Skills (CS)*

Test Date	Pass/Fail	Three-Digit Score		Two-Digit Score		Comments
		Total	MP	Total	MP	
10/21/2004	Pass					

USMLE STEP 3

	Test Date	Pass/Fail	Three-Digit Score		Two-Digit Score		Comments
			Total	MP	Total	MP	
MASSACHUSETTS	07/20/2007	Pass	196	184	80	75	

NOTE: A search of the Board Action Data Bank of the Federation of State Medical Boards (FSMB) reveals no reported information on this examinee.



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Test Date	Pass/Fail	Three-Digit Score		Two-Digit Score		Comments
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Clinical Skills (CS)*

Test Date	Pass/Fail	Three-Digit Score		Two-Digit Score		Comments
		Total	MP	Total	MP	
10/21/2004	Pass					

USMLE STEP 3

	Test Date	Pass/Fail	Three-Digit Score		Two-Digit Score		Comments
			Total	MP	Total	MP	
MASSACHUSETTS	07/20/2007	Pass	196	184	80	75	

NOTE: A search of the Board Action Data Bank of the Federation of State Medical Boards (FSMB) reveals no reported information on this examinee.



Integrated Residency Program in Obstetrics and Gynecology

February 2, 2009

Department of Public Health
 Office of Practitioner Licensing and Certification
 Physician/Surgeon Licensure Unit
 410 Capital Ave., MS# 12APP
 PO BOX 340308
 Hartford, CT 06134-0308

To Whom It May Concern:

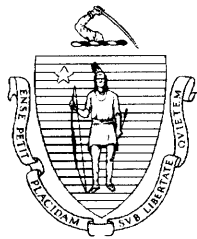
Janelle Luk, M.D., is currently a resident in good standing in the Department of Obstetrics and Gynecology at Brigham and Women's Hospital - Massachusetts General Hospital Integrated Residency Program. She began her training on June 20, 2005 and is expected to successfully complete her training on June 19, 2009. If you need further information, please do not hesitate to contact my office at 617-732-7801.

Sincerely,

Kelly L. Paulina

Kelly L. Paulina → *DL*
 Residency Coordinator
 Department of Obstetrics and Gynecology
2/23/09

PG4-4
NO - derogatory info



Commonwealth of Massachusetts Board of Registration in Medicine

200 Harvard Mill Square, Suite 330
Wakefield, Massachusetts 01880
(781) 876-8200

DEVAL L. PATRICK
GOVERNOR

TIMOTHY P. MURRAY
LIEUTENANT GOVERNOR

Enforcement Division Fax: (781) 876-8381
Legal Division Fax: (781) 876-8380
Licensing Division Fax: (781) 876-8383

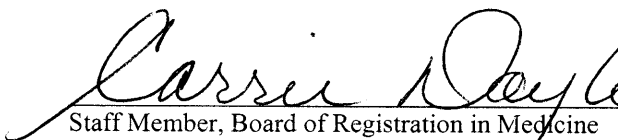
Verification of Limited License

March 11, 2009

To Whom It May Concern:

This is to certify that Dr. Janelle Luk has been granted a limited license number 225606 to serve as a Resident in Obstetrics and Gynecology and authority to practice medicine only at the Brigham & Women's Hospital. Service at the hospital began on June 20, 2005 and will expire on June 30, 2009.

Our files contain no derogatory information on this physician.


Staff Member, Board of Registration in Medicine
Carrie Doyle

Seal

Please be advised that the above information is based entirely on examination of our open and closed complaint files, as well as post-1986 disciplinary actions. It is not based on a review of the application for licensure, renewal of licensure or any reports that the Board is required to receive by statute (from courts, insurers, hospitals, etc...).

[e/share/verifications/Limited-No]





STATE OF CONNECTICUT

DEPARTMENT OF PUBLIC HEALTH

January 16, 2009

Janelle Luk M.D.
7 Ocean View Dr., Apt. 605
Boston, MA 02125

Dear Applicant,

Your Endorsement application for Physician/Surgeon licensure is incomplete. This office has not received the following items as checked :

- Photograph
- Notarized Application
- Social Security Number
- ✓ State License Verification Form *No license (will submit later indicating no license) (in residency)*
- ✓ Official Transcripts of Medical Education
- ✓ Verification of Residency Training
- ✓ Transcript of Examination Scores
- \$4.75 Fee to Query NPDB
- Application fee \$450 made payable to "Treasurer, State of Connecticut";

Please arrange for the items indicated to be sent directly from the primary source to:

Department of Public Health
Office of Practitioner Licensing and Certification
Physician/Surgeon Licensure Unit
410 Capitol Ave., MS# 12APP
P.O. Box 340308
Hartford, CT 06134-0308

Should you have questions or wish to monitor the status of your application, please contact this office at (860) 509-7603.

AB



Phone:
Telephone Device for the Deaf (860) 509-7191
410 Capitol Avenue - MS # 12APP
P.O. Box 340308 Hartford, CT 06134
An Equal Opportunity Employer