THE STATE EDUCATION DEPARTMENT / THE UNIVERSITY OF THE STATE OF NEW YORK / ALBANY, NY 12230

OFFICE OF THE PROFESSIONS
DIVISION OF PROFESSIONAL LICENSING SERVICES
Public Information Unit
Tel. (518) 474-3817 EXT: 330
Fax (518) 473-0578
E-mail: DPLSDSU@MAIL.NYSED.GOV

[redacted]

RE: BRIAN EDWARD PARK
MD#: 189223

To Whom It May Concern:

I am writing in response to your FOIL request dated June 13, 2012 regarding the above captioned licensed professional.

Enclosed you will find certified copies of the documents you requested. The street portion of the address, zip code, photograph, social security number and date of birth of the licensee have been redacted pursuant to Public Officers Law §87.2(b) except for the signature of the licensee, that has been partially redacted. The moral character questions on the re-registration applications and on the application for licensure have been redacted pursuant to Public Officers Law §87.2(b) as well.

We were not able to locate the re-registration application for the period of 12/01/00 through 11/30/01. The Freedom of Information Law does not require an agency to prepare any record not possessed by the agency (Public Officers Law Section 89[3].

We withheld the exams scores pursuant to Public Officers Law §87.2(b).

The New York State Education Department does not maintain information regarding medical malpractice issues. Malpractice issues are maintained by the County Courts where the licensee practices. We do not maintain hospital admitting privileges either.

Complaints against physicians are investigated by the Office of Professional Medical Conduct, New York State Department of Health (NYSDOH). Disciplinary information related to physicians is available through the NYSDOH's website: www.health.state.ny.us/nysdoc/opmc/main.htm.

Enclosed you will find a bill for $7.00 to cover the cost of the copies.

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STATE OF NEW YORK)
SS:
COUNTY OF ALBANY)

In accordance with the **Civil Practice Law and Rules Article 45**, I, Connie F. Mitchell, Clerk II in the Division of Professional Licensing Services of the New York State Education Department, have caused this certificate to be prepared. I certify that I have legal custody of the official original records of the Division of Professional Licensing Services and I attest that the attached are true and correct copies of the original documents in our files relating to BRIAN EDWARD PARK.

Witness my hand and the seal of the New York State Education Department this 9 July, 2012.

Connie F. Mitchell

Connie F. Mitchell, Clerk II
Professional Licensing Services

DATED
07/09/2012

FORM 1
MEDICINE

ALL CANDIDATES MUST COMPLETE THIS FORM

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

APPLICATION FOR LICENSE AND FIRST REGISTRATION

COMPLETE BOTH SIDES OF THIS APPLICATION

Department Use Only

M50455 5/16 60

500 LX

160 375 ER

$106 prorate

N.Y.S. License Number 189883 6/18/98 TK

QUALS. . . . . .

APPROVED . . . . . .

1. [redacted] Social Security Number
2. PAR 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: PARK
First: BRIAN
Middle: EDWARD

5. ADDRESS (check only one) ☑ permanent address of record ☐ temporary mailing address*

Care of:
Misc. (Bldg. & Apt., etc.):
Street: [redacted]
City: LONG ISLAND CITY
State: NEW YORK ZIP Code: [redacted]

6. TELEPHONE
At home [redacted] area code number
At work [redacted] area code number

7. CITIZENSHIP ☑ United States ☐ Alien Lawfully admitted for permanent residence in the United States.
Alien Registration Number _____
Citizen of _____

8. Name as it appears on diploma or other credentials. Brian Edward Park. M.D.
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? [redacted]
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? [redacted]
12. Have you ever surrendered your license or been found guilty of professional misconduct, unprofessional conduct, incompetence or negligence in any state or country? [redacted]
13. Are charges pending against you for professional misconduct, unprofessional conduct, incompetence or negligence in any state or country? [redacted]
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? [redacted]
    - If the answer to questions 10–14 is "Yes," submit a letter giving a complete explanation as applicable, also include copies of your court records and a copy of the "Certificate of Relief from Disabilities" or your "Certificate of Good Conduct."
15. I wish to be licensed in New York State on the basis of:
    - ☒ National Board Examination (See Licensure Requirements – Sec. IV)
    - ☐ National Board Examination/Osteopath (See Licensure Requirements – Sec. IV)
    - ☐ Admission to the licensing examination in New York State (See Licensure Requirements – Sec. IV)
      Give Date of Flex examination requested (Month and Year) _____
      Requested exam center: ☐ New York City Area, (Incs. Long Island) ☐ Albany Area ☐ Buffalo Area

December 1989

• 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	Class Completed	ATTENDANCE		Diploma or Degree Obtained (if school is located Outside the United States, attach a copy)
			Entrance Date	Leaving Date	
School Ohio STATE UNIVERSITY College of Medicine Columbus, Ohio	4		9-85	6-89	M.D.

17. I am a licensed physician in the following states or countries:

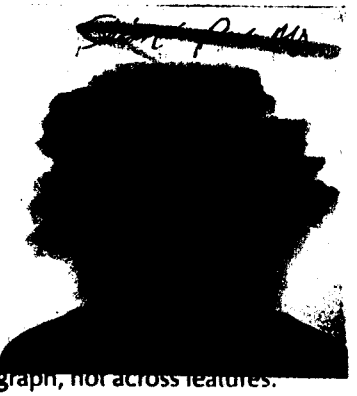
State or Country	Date License Issued	Number	Basis of Licensure			Any Limitations on License
			Examination (Date Passed)	Endorsement	Other	

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.

Brian [redacted] MD) 4.12.92
Signature of candidate Date



W
tograph, not across features.

Date of Photograph 4-11-92

• **RETURN TO: Fee Section, Division of Professional Licensing Service**
Cultural Education Center, Albany, New York 12230

FORM 2
MEDICINE

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

CANDIDATE EDUCATION AND TRAINING RECORD

ALL CANDIDATES MUST COMPLETE THIS FORM.

1. [redacted] — [redacted] — [redacted] Social Security Number
2. P A R 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: P A R K
First: B R I A N
Middle: E D W A R D

5. ADDRESS
Misc. (Bldg. & Apt., etc.)
Street: [redacted]
City: L O N G I S L A N D C I T Y
State: N E W Y O R K
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	ATTENDANCE Entrance Date	ATTENDANCE Leaving Class Completed	ATTENDANCE Leaving Date	Diploma or degree obtained Quote titles in original language and translate.
Elementary or Primary School						
Kettering Oakview Elementary School	6 months	Kindergarten	9-68		2-69	(Proof of completion need not be submitted
Kettering Beavertown Elementary School	2 yrs	Kindergarten	2-69	2nd grade	3-71	
Ohio George L. Ernst Elementary	4 yrs	2nd grade	3-71	6th grade	5-75	
Secondary or High School						
Kettering Van Buren Jr High School	3 yrs	7th grade	9-75	9th grade	6-78	(Proof of completion need not be submitted High School Diploma
Ohio Fairmont West High School	3 yrs	10th grade	9-78	12th grade	6-81	
Postsecondary PreProfessional (Exclusive of Medical School)						
OBERLIN College, Oberlin Ohio	4 yrs	Freshman	9-81	Senior	6-85	Candidates using Form 2A need not verify preprofessional training.
Wright State University. Fairborn Ohio	3 months	Sophomore	6-83	Sophomore	8-83	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)						
Ohio State University College of Medicine	4	1st year	9-85	4th year	6-89	(See Form 2A or 2N for verification requirements)

• 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	
7	89	current		OB/GYN RESIDENCY Lenox Hill Hospital 100 E. 77th ST. New York. NY 10021

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

365390

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: PARK
First: BRIAN
Middle: EDWARD

2 Print your address:

Care of:
Misc. (Bldg. & Apt., etc.):
Street: [redacted]
City: LONG ISLAND CITY
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): PHYSICIAN
N.Y.S License Number:
Applying
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: Brian E Park MD Date: 3-14-92

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.

Adrienne Taylor, RN, AVP/Nursing
Name of Authorized Certifying Officer (Print or Type)

Adrienne Taylor RN AVP
Signature of Authorized Certifying Officer

Lenox Hill Hospital
Approved Provider Name

40212
Identification Number

3-14-92
Date(s) of Coursework or Training

PR 2 (10) - 5/91

STATE EDUCATION DEPARTMENT COPY

NK Medical
Md 4/7/92

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. PAR — 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: PARK
First: BRIAN
Middle: EDWARD

5. ADDRESS
Misc. (Bldg. & Apt., etc.): [redacted]
Street: [redacted]
City: ASTORIA
State: NY
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:
BRIAN EDWARD PARK M.D.
(Name)

8. High School Attended: Kettering FAIRMONT WEST
(Name)

9. Professional school attended: The Ohio State University College of Medicine
(Name)
Address 370 West 9th Ave, Columbus, Ohio 43210 Date degree was awarded June 9th, 1989

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

December 1989

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:

Oberlin College
Print Name of Institution

1981- 1984
Dates of Attendence

A.B./Chemistry
Degree Granted

Professional Education

(1) Was admitted to The Ohio State University College of Medicine
Print Name of Medical School

on 9 (Month) 9 (Day) 1985 (Year) and satisfactorily completed the program on

May (Month) 30 (Day) 1989 (Year) and was awarded the degree of

Doctor of Medicine
Degree

June 9, 1989
Date

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

Name of Institution: _____

Dates of Attendence _____

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 _____
(original signature)

Melanie S. Kennedy, M.D.
(Type or print above name

722030

(COLLEGE SEAL)

Title Associate Dean for Student Affairs

Medical School The Ohio State University

Location Columbus, Ohio

Telephone Number 614- 292-5674

Date March 23, 1992

Certification is not acceptable unless dated after graduation.

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

Rec'd 6/10/92

pull for H

FORM 2 POST 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

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.

MAILED DIRECTLY FROM RESPECTIVE INSTITUTION

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 forms 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. P A R First 3 letters of Last Name
3. BIRTH DATE [redacted] mo. day yr.

OK for NY M.D./Yr ACCREDITED Hosp. Trng. 6/16/92 / JD Dated / Init.

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: PARK
First: BRIAN
Middle: EDWARD

SECTION II: CERTIFICATION OF POSTGRADUATE TRAINING

This is to certify that BRIAN EDWARD PARK
Physician's Name

a graduate of THE OHIO STATE UNIVERSITY COLLEGE OF MEDICINE
Medical School

was enrolled in a residency training program approved by the Accreditation Council on Graduate Medical Education or the American Osteopathic Association at LENOX HILL HOSPITAL
Name of Hospital

100 EAST 77 STREET NEW YORK, NEW YORK 10021
(Location of Hospital)

from JULY 1 (Date) 19 89 thru PRESENT 6/3/92 (Date) 19 in the clinical area of

OBSTETRICS AND GYNECOLOGY
Clinical Area

and that the above named physician successfully completed this training on ~~JUNE 30, 1992~~ IT IS ANTICIPATED THAT DR. PARK WILL COMPLETE HIS THIRD YEAR OF TRAINING ON JUNE 30, 1992
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 Robert E. McMasters Date JUNE 3, 1992

Print Name of Director/Chief ROBERT E. MCMASTERS, M.D.

Print Title COORDINATOR OF MEDICAL EDUCATION Telephone Number: 212-439-2005

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

'92 JUN -9 P3:13

REGISTRATION APPLICATION

PROFESSION: MEDICINE

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

$ 330
PAY THIS AMOUNT

OFFICE USE ONLY

DATE: 08/11/92
LIC. NO.: 189223
NM: PAR3
DOB: [redacted]
SSN: [redacted]
FEE: 330
PR: 330 OFF: 1
YR: 93 TYPE: RR
PEN:
CHILD ABUSE (Y)

Make check or money order payable to [illegible]

This application may [illegible] the person whose name appears on this form. Other licensees [illegible] Professional Licensing Services [illegible] request an application form.

BEFORE COMPLETING THIS FORM READ ENCLOSED INSTRUCTIONS

RW2929

PARK BRIAN EDWARD
[redacted]
ASTORIA NY [redacted]

1. (a) Since you last registered, has an, state other than New York instituted charges against you for professional misconduct, unprofessional conduct, incompetence or ☐ Yes ☒ No

[redacted] revoked, suspended, or accepted surrender of a professional license held by you?

(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 by acquittal or dismissal? [redacted]

(c) **FOR HEALTH PROFESSIONALS ONLY:** Since you last registered, has any hospital or licensed facility restricted or terminated your professional training, employment, or privileges or have you ever voluntarily or involuntarily resigned or withdrawn from such association to avoid imposition of such action due to professional misconduct, unprofessional conduct, incompetence or negligence? [redacted] ☒ Yes ☐ No

2 (a) Will you be practicing in NYS during the period indicated?

(b) IF NO, ARE YOU ☐ INACTIVE ☐ RETIRED ☐ PRACTICING OUTSIDE NYS

3 Last practiced in NYS: 12 92 (Mo. / Yr)

4 DATE OF BIRTH: [redacted] (Mo. Day Yr)

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

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

7 Federal Employer Identification #
(If you have Federal Employer Identification Number you must provide.)

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

SIGNATURE [redacted] M.D. DATE: 12 / 7 / 92

Fold Line

REGISTRATION APPLICATION

PROFESSION: MEDICINE

PERIOD: 01/01/95 - 11/30/96 **$ 316.** PAY THIS AMOUNT 316

Make check or money order payable to "New York State Education Department."

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

RZ39973

READ INSTRUCTIONS ON REVERSE SIDE BEFORE COMPLETING THIS FORM

OFFICE USE ONLY

DATE: 08/01/94
LIC NO: 189223
NM: PAR3
DOB: [redacted]
SSN: [redacted]
FEE: 316
PR: 60 OFF: 1
YR: 95 TYPE: RR
PY:
CA: Y

PARK BRIAN EDWARD
[redacted]
ASTORIA **NY** [redacted] 7

This application may ONLY be used by the person whose name appears above.

1. (a) **Since you last registered**, has an, 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]

   (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]

   (c) **Since you last registered**, 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 imposition of such action due to professional misconduct, unprofessional conduct, incompetence or negligence? [redacted]

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

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

6. Federal Employer Identification Number
   (Use this if you are an employer required to report employment taxes to the IRS.)

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 the requirement is noted to the right. SEE REVERSE SIDE

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

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

[redacted] (Signature) 10/27/94 (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 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)

FOLD

FOLD

This is your application [illegible] professional license for the period indicated in the upper left corner of the application. [illegible] is required if you practice your profession or use your professional title within New York State.

If you do not expect to [illegible] professional title within New York State during the period indicated, you may voluntarily [illegible] on inactive status by checking "NO" to Item 2 and returning the completed application [illegible] by the beginning of the new period. Please note: If you become inactive, a registration [illegible] will not be issued and future notices will not be sent to you until you reactivate your [illegible]. If you later decide to register for practice within New York, you will not be assessed [illegible] registration fees for the period your license was inactive.

If you do not return this [illegible] register or to claim inactive status, your license will be automatically declared [illegible]. If you later attempt to register for practice within the State, you may be assessed [illegible] registration fee for each month your license was not registered.

[illegible] FOR COMPLETING THE APPLICATION

1. Answer all questions. [illegible] your reregistration.
   (a) If you answer "YES" [illegible] explanation of each action.
   (b) If you answer "YES", submit a certified copy of the court records for each conviction. Do not check "YES" for minor traffic violations, charges that were dismissed or acquittals.

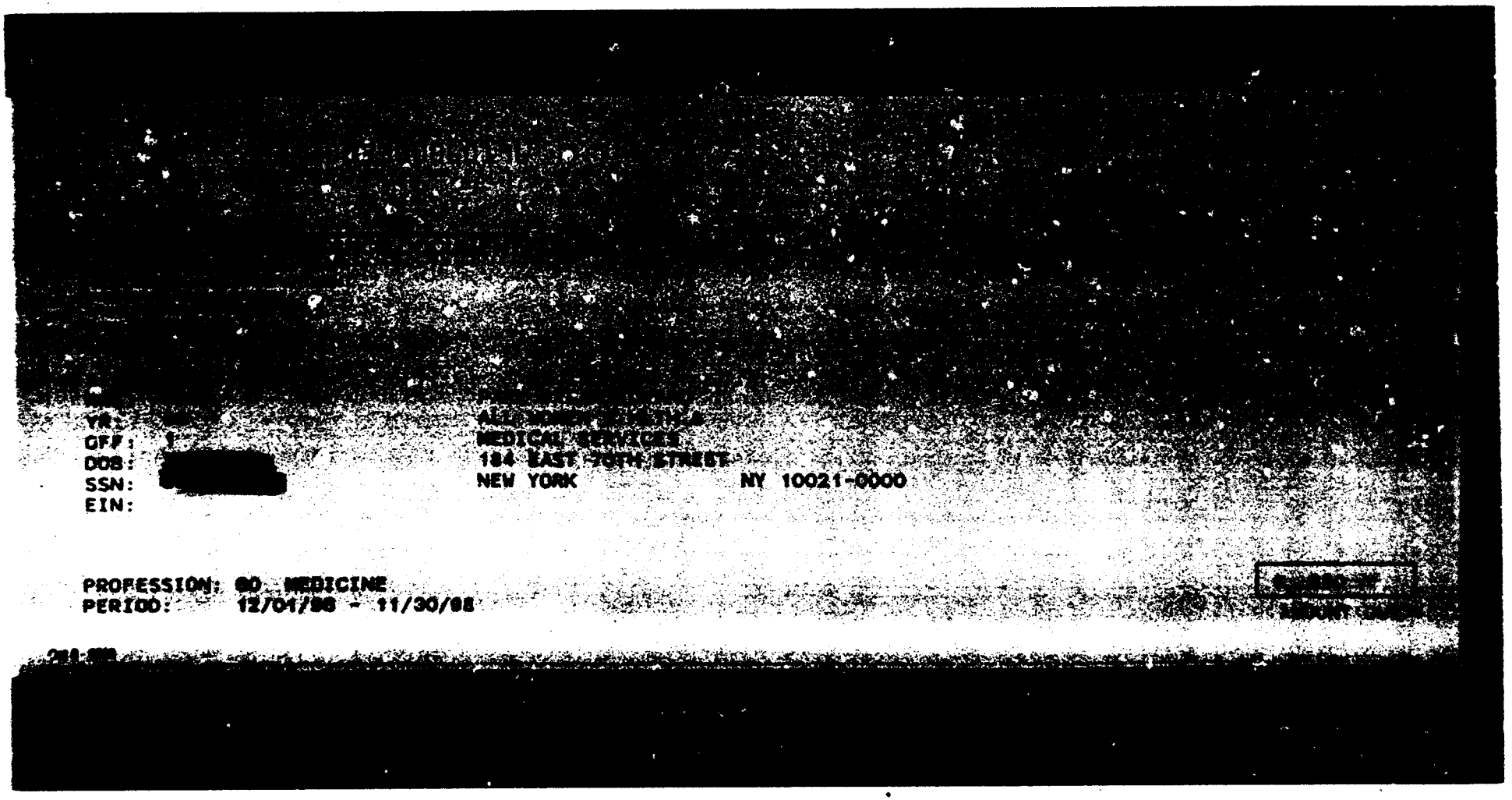
   For purposes of Item 1(c), [illegible] of the Rules of the Board of Regents identifies this profession a health profession.
   (c) If you answer "YES", [illegible] describing the details of the [illegible].
2. Check "YES", if you plan to [illegible] State during the period. Registration is required if you practice your profession or [illegible] title within New York State. If you do not plan to practice in the State and [illegible] status, check "NO" and return the application without a fee. (see above box for more [illegible])
3. If you are not currently [illegible] month and year you last practiced in New York State.
4. Please provide your date of [illegible]
5. Enter your Social Security [illegible]. If you do not have a Social Security Number, you must provide an explanation as [illegible]
6. If you are an employer and [illegible] Employer Identification Number, you must enter your employer identification number in the [illegible]

   (The authority to collect this [illegible] contained in Section 5 of the New York State Tax Law; it will be used for tax administration [illegible])
7. Licensees who complete, on [illegible] an academic program registered by the State Education Department as [illegible] requirements for licensure are credited with completion of the coursework [illegible] exemption. The coursework [illegible] State Education Department [illegible] required for reregistration. You should return the copy marked STATE EDUCATION DEPARTMENT COPY with your reregistration application. If you need to locate a provider, you should call Professional Licensing Services for assistance.

   Section 59.12 of the Regulations of the Commissioner of Education provides for exemption from the course requirement in cases where [illegible] individual's practice precludes any contact with children. If you believe you may qualify [illegible] call Professional Licensing Services to request an exemption application.
8. Please read the important [illegible] side regarding a HIV/HBV [illegible] in your profession.
9. Read the affirmation, sign [illegible] must be paid with a check or money order [illegible] only. DO NOT SEND CASH. Section [illegible] will be charged, in addition to the original [illegible] a bad check for registration or licensure. Such replacement fees must [illegible] bank check, or money order. If replacement fees are not submitted within [illegible] Section [illegible] the Regulations of the Commissioner of Education [illegible]

DECEASED NOTIFICATION: If you [illegible] named on the [illegible], please complete the appropriate [illegible]

NAME AND ADDRESS [illegible] you are reporting [illegible] address. When returning [illegible]
Please print your [illegible]


YR:
OFF:
DOB:
SSN:
EIN:
MEDICAL SERVICES
184 EAST 70TH STREET
NEW YORK NY 10021-0000
PROFESSION: 80 MEDICINE
PERIOD: 12/01/98 - 11/30/99

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? [redacted]

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? [redacted]

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? [redacted]

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

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) [signature] MD 10 9 96

REGISTRATION REMITTANCE DOCUMENT

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

11/07/96
LIC: 189223
NME: PAR3
YR: 96
OFF: 1
DOB: [redacted]
SSN: [redacted]
EIN:

PARK BRIAN EDWARD
ALL WOMEN'S HLTH &
MEDICAL SERVICES
184 EAST 70TH STREET
NEW YORK NY10021-0000

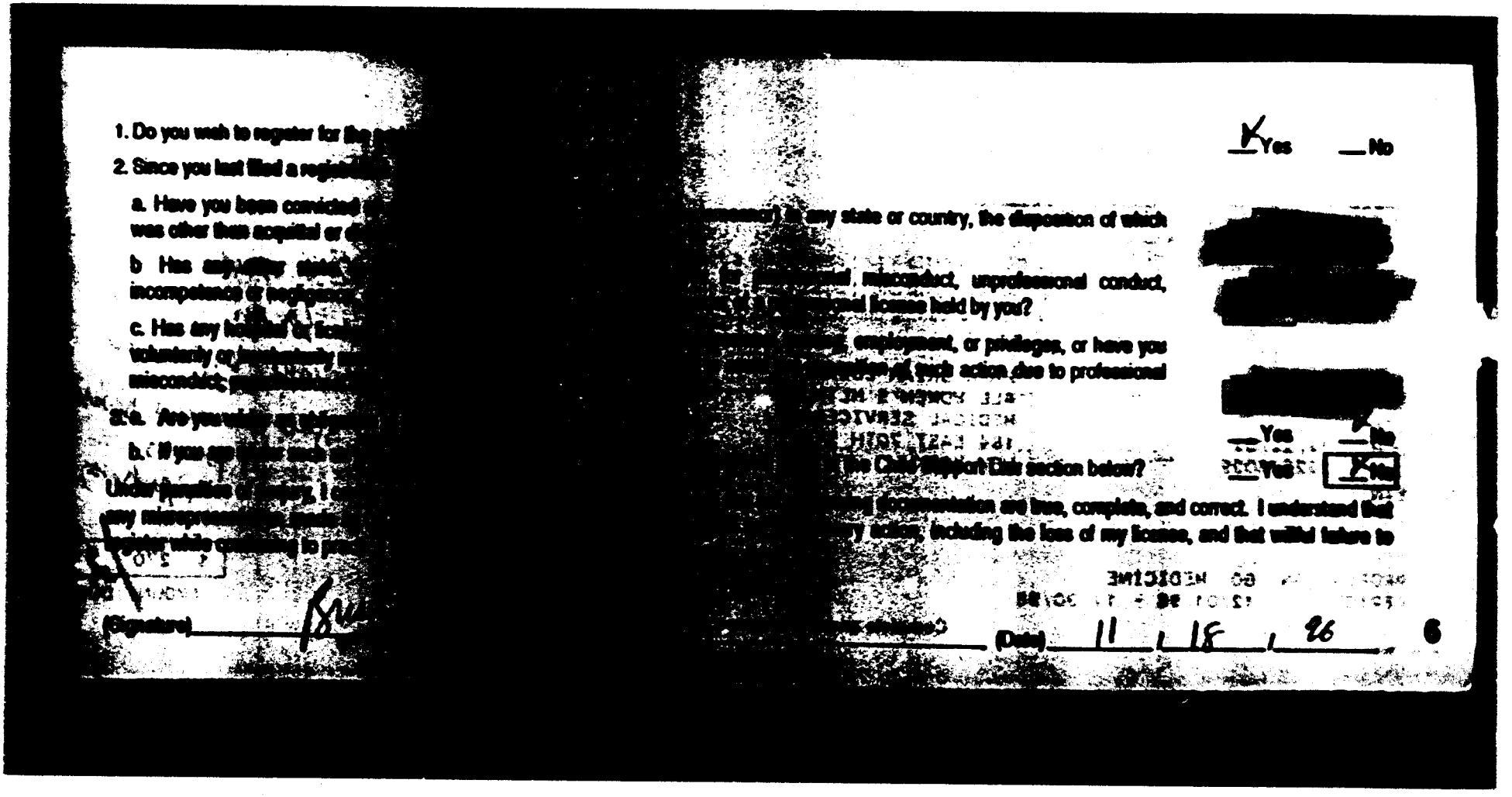
110 00 U69 6
FOR DEPOSIT ONLY NYSED

C817 pd. Applicant needs check for an additional $270 to the NY State Education Department finalize application

PROFESSION: 60 MEDICINE
PERIOD: 12/01/96 - 11/30/98

$ 270 / 270
AMOUNT DUE

Complete and sign reverse side of this application



1. Do you wish to register for the
2. Since you last filed a regist
a. Have you been convicted
was other than acquittal or
b Has any other state
incompetence or negligen
c. Has any hospital or
voluntarily or involuntarily
misconduct
2a. Are you
b. If you ar
Under penalty
any misrepresentation
(Signature)

Yes No

any state or country, the disposition of which

misconduct, unprofessional conduct,
license held by you?

employment, or privileges, or have you
action due to professional

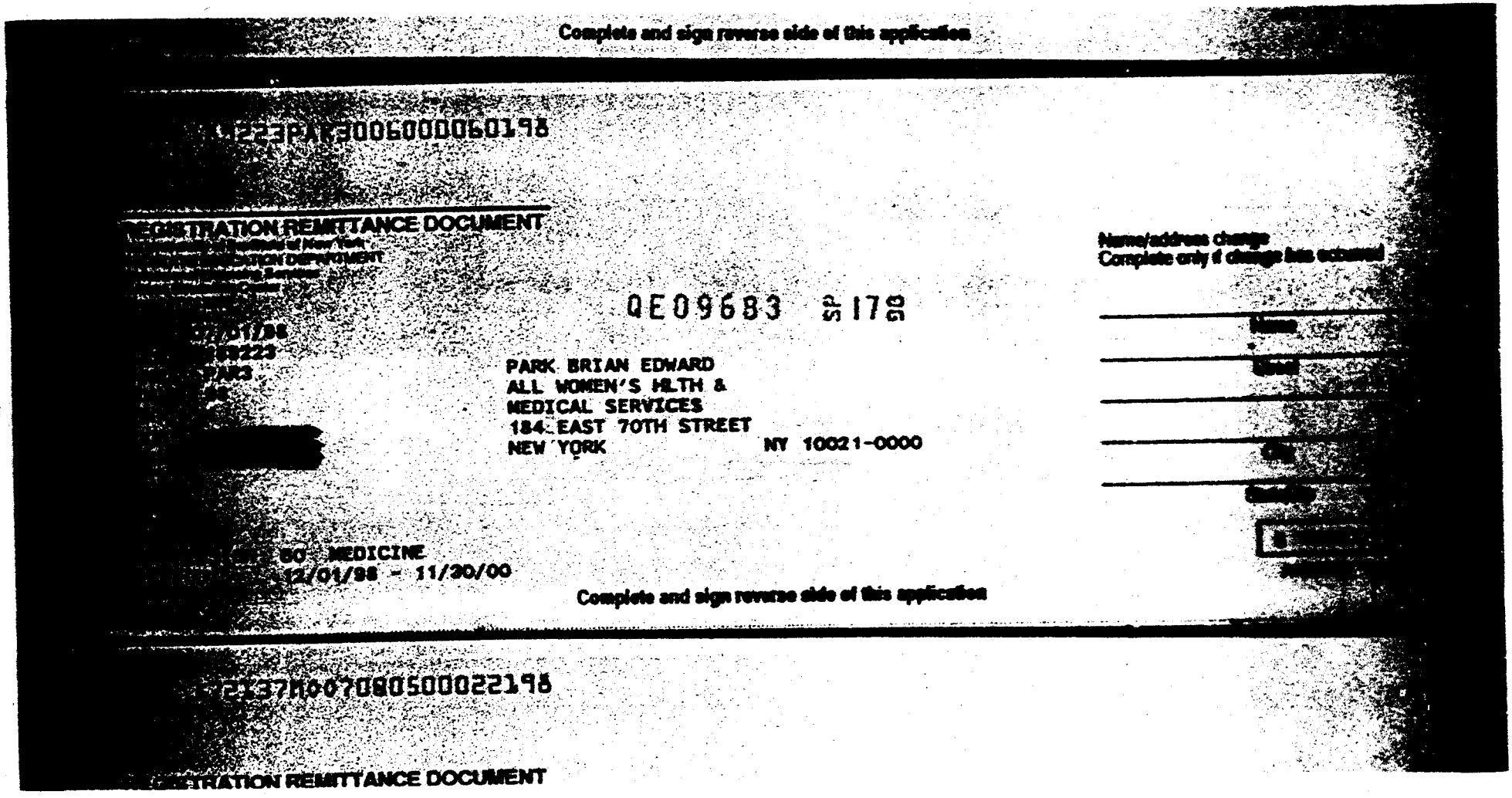
Yes No

the Child Support Data section below?

Yes No

documentation are true, complete, and correct. I understand that
any action, including the loss of my license, and that willful failure to

(Date) 11 / 18 / 96



Complete and sign reverse side of this application

1223PAR300600060198

REGISTRATION REMITTANCE DOCUMENT

QE09683 SP 17 00

PARK BRIAN EDWARD
ALL WOMEN'S HLTH &
MEDICAL SERVICES
184 EAST 70TH STREET
NEW YORK NY 10021-0000

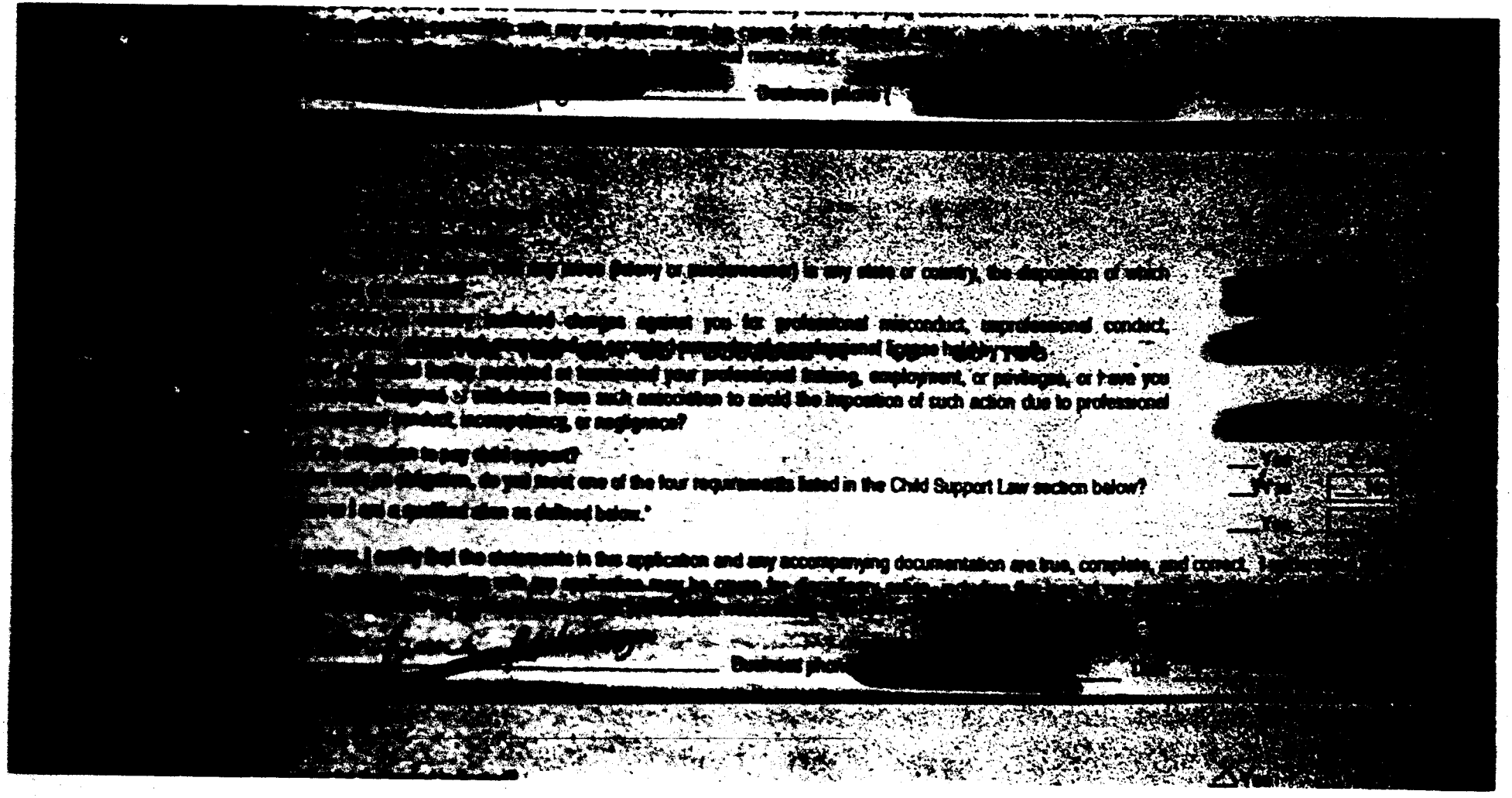
00 MEDICINE
12/01/98 - 11/30/00

Name/address change
Complete only if change has occurred

Complete and sign reverse side of this application

1237N0070080500022198

REGISTRATION REMITTANCE DOCUMENT



189223PAR3006000060102

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

07/01/02
LIC: 189223
NME: PAR3
YR: 02
OFF: 1
DOB: [redacted]
SSN: [redacted]
EIN:

PARK BRIAN EDWARD
ALL WOMEN'S HLTH &
MEDICAL SERVICES
184 EAST 70TH STREET
NEW YORK NY 10021-0000

Name/address change
Complete only if change has occurred

Name

Street

City

State/Zip

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

$ 600
AMOUNT DUE

Complete and sign reverse side of this application

Cat 6 - 1001

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

   [redacted] ___ Yes ✓ No

3. a. Are you under an obligation to pay child support? ___ Yes ✓ No
   b. If you are under such an obligation, do you meet one of the four requirements listed in the Child Support Law section below? ___ Yes ___ No

4. Are you a U.S. citizen or a qualified alien as defined below? ✓ Yes ___ No

32441461 [redacted]
329 09252002

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 [redacted] Business pho[redacted] Date 9-17-02

189223PAR3006000060104

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

07/01/04
LIC: 189223
NME: PAR3
YR: 04
OFF: 1
DOB:
SSN: [redacted]
EIN:

PARK BRIAN EDWARD
ALL WOMEN'S HLTH &
MEDICAL SERVICES
184 EAST 70TH STREET
NEW YORK NY 10021-0000

PROFESSION: 80 MEDICINE
PERIOD: 12/01/04 - 11/30/06

Name/address change
Complete only if change has occurred

Name

Street

City

State/Zip

$ 600
AMOUNT DUE

Complete and sign reverse side of this application

Cat 6 - 1001

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

[redacted] ✓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

[redacted]

DO NOT WRITE IN THIS BOX
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Signature [redacted] Business phone ([redacted] Date 9-13-09

189223PAR3006000060106

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

07/03/06
LIC: 189223
NME: PAR3
YR: 06
OFF: 1
EIN:

PARK BRIAN EDWARD
ALL WOMEN'S HLTH &
MEDICAL SERVICES
184 EAST 70TH STREET
NEW YORK NY 10021-0000

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

Complete and sign reverse side of this application

Cat.21P:032204

Name/address change
Complete only if change has occurred

Brian E. Park, M.D., P.C.
Name
[redacted]
Street
New York
NY [redacted]
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? .....
   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? .....
   c. Are criminal charges pending against you in any court? .....
   d. Are charges pending against you in any jurisdiction for any sort of professional misconduct? .....
   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? .....

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

[redacted]
154 09192006

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

Signature [redacted] Daytime phone ([redacted] Date 9-14-06

PRINT NAME

189223PAR3006000060108

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

07/01/08
LIC: 189223
NME: PAR3
YR: 08
OFF: 1
EIN:

PARK BRIAN EDWARD
[redacted]
NEW YORK NY [redacted]

PIN: QW82638

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

Complete and sign reverse side of this application

Cat 21:000408

Address change
Complete only if change has occurred

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

[redacted]

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

3264524
001 09152003

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 [redacted] Daytime phone [redacted] Date 9-9-08

CA21B 1107/05

OFFICE OF THE PROFESSIONS
NEW YORK STATE EDUCATION DEPARTMENT
89 Washington Avenue
Albany, NY 12234
518-474-3817

Registration Renewal - Transaction Summary

License Number : 189223
Profession : MEDICINE
Renewal Period : 12/01/2010 through 11/30/2012

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

PARK BRIAN EDWARD
[redacted]
NEW YORK NY[redacted]

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

Offices Selected for Renewal:

	Address	Fee
1)	[redacted] NEW YORK, NY[redacted] US	$ 600

Response to Questions :

Question	Response
1) Have you been found guilty after trial, or pleaded guilty, no contest, or nolo contendere to a crime (felony or misdemeanor) in any court?	[redacted]
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?	[redacted]
3) Are criminal charges pending against you in any court?	[redacted]
4) Are charges pending against you in any jurisdiction for any sort of professional misconduct?	[redacted]
5) Has any hospital or licensed facility restricted or terminated your professional training, employment, or privileges, or have you voluntarily or involuntarily resigned or withdrawn from such association to avoid the imposition of such action due to professional misconduct, unprofessional conduct, incompetency, or negligence?	[redacted]
6) Are you under an obligation to pay child support?	No
7) Are you a U.S. citizen?	Yes

License Renewal Payment Details:

Receipt No : VLFN6B593F7C
Payment Date : 10/19/2010
Amount Paid : $ 600

Return to Main Page

Version 4.3

OP Homepage | List of Professions | Contact Us | Online Verifications