South Carolina
Department of Labor, Licensing and Regulation
Board of Medical Examiners

License Verification

STATE BOARD OF MEDICINE
PO BOX 2649
HARRISBURG PA 17105

Name: [illegible] Profession: [illegible] Office Phone: [illegible]

Birth Date: [illegible] Specialty: [illegible]

License No: [illegible] Date Issued: [illegible] Expiration: [illegible]

Basis: [illegible] School: [illegible] Graduated: [illegible]

Primary Source Verification of Graduation Certified

Hospital Affiliation(s): [illegible] GENERAL HOSPITAL

Status: ACTIVE

[illegible]

[illegible]

License History
Temporary License Number:
Temporary License Issue Date:
Limited License Number:
Limited License Issue Date:

Kathryn Spires

[illegible]

Kathryn Spires, Administrative Specialist

Annette H. [illegible]

Approved [illegible]

Annette H. [illegible]
Assistant Administrator [illegible]

The Federation of State Medical Boards
of the United States, Inc.
PO Box 619850
Dallas, Texas 75261-9850
Telephone 817-868-4000
FAX 817-868-4099

BOARD ACTION CLEARANCE REPORT

September 08, 2008

Attn: Deputy Board Admin Officer
Pennsylvania State Bd of Med
PO Box 2649
2601 North Third Street
Harrisburg, PA [illegible]

Re: Board Action Query Dated: September 08, 2008
Your Reference Number: [illegible]
FSMB Batch Number: [illegible]

The following is a report of the search results from the Board Action Data Bank as of September 08, 2008 for practitioners on the above referenced batch in which NO board actions were identified.

Practitioners Cleared with No Actions as of September 08, 2008

Item	Name	DOB	School	Yr Grad	RequestID
1	[illegible]	[redacted]		[illegible]	[illegible]

LICENSE HISTORY
State Board
MICHIGAN
SOUTH CAROLINA
WASHINGTON

PLEASE NOTE: The licensure history information contained in these reports is not considered licensure verification but rather an indicator of known states of historical licensure for these individuals. Use of this information should be limited to cross-reference purposes.

CURRICULUM VITAE

HUBERT O. BOKA, M.D

Contact Information

Telephone:

Email:

Education

08/1997-06/2002 University of Illinois at Chicago School of Medicine (MD)

Postgraduate Training

06/2002 - 06/2006 OB/GYN Residency, State University of New York

Buffalo NY

08/2006-12/2006 Volunteer with Doctors Without Borders, 0 [illegible] in [illegible]

Africa

Togo, Benin, Cameroon, Niger

11/2006-Present Attending Physician

Chesterfield General Hospital

711 Chesterfield Highway

Cheraw, S.C 29520

Professional Experience

1992-1995 University of Chicago Assistant Research, Department of General Surgery

2005-2006 Administrative Chief Resident, State University of New York at Buffalo

Honors and Awards

2003-2004 Brows Best first year Resident Award

2004-2005 Wayne Johnson Excellence in Maternal Fetal Medicine Award

2005 Chairman's Resident Award Group Resident Recipient

Outstanding Mentor, University of Illinois at Chicago 1998 - 2000

Honors grades: Internal Medicine and Ob/Gyn Sub internship 2002

Teaching:

2002-2006 - Assistant Clinical Faculty Member, State University of New York at Buffalo

May 2003 - July 2002 Tutored premedical student and [illegible] first year medical students

Licensure

USMLE STEP 1, STEP 2 and STEP 3

American Board of Obstetrics and Gynecology: Board Eligible

Societies

ACOG Member since 2002

National Medical Association - Member since 2005

State Board of Medicine
717-783-1400
717-787-2381

RECEIVED DIRECT

VERIFICATION OF MEDICAL EDUCATION

For Graduates of Accredited Medical Schools

SECTION 1: To be completed by applicant:

Name: [illegible] [illegible] [illegible]
Last First Middle

Name of medical school: [illegible]

Location: [illegible]

SUBMIT THE VERIFICATION OF MEDICAL EDUCATION FORM TO YOUR MEDICAL SCHOOL AND REQUEST YOUR SCHOOL TO RETURN THE COMPLETED FORM DIRECTLY TO THE BOARD IN AN OFFICIAL SCHOOL ENVELOPE.

SECTION 2: To be completed by Dean or Registrar of medical school:

Name of medical student: [illegible]

Date student began to attend this medical school: [illegible]

Date of graduation: [illegible]

[Seal of School] I certify that all of the above information is correct.
Signature of
Dean or Registrar: [signature]

Date: [illegible]

Upon completion, school must return this completed form directly to the Pennsylvania State Board of Medicine in official school envelope. DO NOT RETURN TO APPLICANT.

Regular Mailing Address
State Board of Medicine
P.O. Box 2649
Harrisburg, PA 17105-2649

Courier Delivery Address
State Board of Medicine
2601 North Third Street
Harrisburg, PA 17110

SOUTH CAROLINA
WASHINGTON

1	KIM SAMUEL	[illegible]	1992	[illegible]

LICENSE HISTORY
State Board
CALIFORNIA
NEW YORK

2	[illegible] JAMES	[illegible]	2001	[illegible]

LICENSE HISTORY
State Board
No License Information Available

4	SCHMITT ERICA	[illegible]	2001	[illegible]

LICENSE HISTORY
State Board
No License Information Available

5	[illegible] DAVID	[illegible]	2006	[illegible]

LICENSE HISTORY
State Board
No License Information Available

6	SHOWALTER JOHN	[illegible]	2007	[illegible]

LICENSE HISTORY
State Board
No License Information Available

7	[illegible] NICOLE	[illegible]	2001	[illegible]

LICENSE HISTORY
State Board
[illegible]

PLEASE NOTE: The licensure history information contained in these reports is not considered licensure verification but rather an indication of known states of historical licensure for these individuals. Use of this information should be limited to cross reference purposes.

The Federation of State Medical Boards
of the United States, Inc
P.O. Box [illegible]
Dallas, Texas [illegible]
Telephone (817) [illegible]
FAX (817) [illegible]

BOARD ACTION CLEARANCE REPORT

August 05, 2008

Attn: [illegible], Action Officer
Pennsylvania State Bd. of Med.
P.O. Box 2649
2601 North Third Street
Harrisburg, PA [illegible]

Re: Board Action Query Dated: August 05, 2008
Your Reference Number: [illegible]
FSMB Batch Number: [illegible]

The following is a report of the search results from the Board Action Data Bank as of August 05, 2008 for the above referenced batch for which NO board actions were identified.

Practitioners Cleared with No Actions as of August 05, 2008

Item	Name	DOB	School	Yr Grad	Request ID
7	ANANDAPPA, ROSHANI	[illegible]		[illegible]	[illegible]
8	ATTALLAH, HAMDI	[illegible]		[illegible]	[illegible]
9	BOSK, ROSEMARIE	[illegible]		[illegible]	[illegible]
[illegible]	CLARK, MATTHEW	[illegible]		[illegible]	[illegible]
[illegible]	TOKA, HUBERT	[illegible]		[illegible]	[illegible]

LICENSE HISTORY (ANANDAPPA, ROSHANI)
State Board
No License Information Available

LICENSE HISTORY (ATTALLAH, HAMDI)
State Board
CALIFORNIA
MICHIGAN

LICENSE HISTORY (BOSK, ROSEMARIE)
State Board
NEW JERSEY

LICENSE HISTORY (CLARK, MATTHEW)
State Board
No License Information Available

LICENSE HISTORY (TOKA, HUBERT)
State Board
MICHIGAN

Regular Mailing Address
STATE BOARD OF MEDICINE
P.O. BOX 2649
HARRISBURG, PA 17105-2649
717-783-1400/717-787-2381
Email: st-medicine@state.pa.us

Courier Delivery Address
STATE BOARD OF MEDICINE
2601 NORTH THIRD STREET
HARRISBURG, PA 17110

APPLICATION FOR A LICENSE TO PRACTICE MEDICINE WITHOUT RESTRICTION
For Graduates of ACCREDITED Medical Schools (SCHOOLS IN THE U.S. AND CANADA)

Application Fee: $35.00 not refundable. Make check payable to the "Commonwealth of Pennsylvania."
Note: A processing fee of $20.00 will be charged for any check or money order returned unpaid by your bank, regardless of the reason for non-payment.

Please Print or Type

NAME [illegible] [illegible] [illegible] [illegible]
Last First Middle

Permanent Address: [redacted]
Street
[redacted]
City State Zip Code

(All correspondence and the license will be mailed to this address unless the Board is notified of a change.)

Email address: [redacted]

Date of Birth: [redacted] Social Security Number: [redacted]
MM-DD-YYYY

If your medical licensure records are listed under another name or names list below:

Are you applying using credentials verification from FCVS? YES (NO)

Have you previously held a Pennsylvania graduate training license?

YES, My license number is (NO)

LIST MEDICAL SCHOOL(S) ATTENDED **DATES OF ATTENDANCE**

[illegible] From [illegible] to 06/2002
MM/YYYY MM/YYYY

From to
MM/YYYY MM/YYYY

Date of Graduation 13/06/2002
MM/DD/YYYY

Check licensing examination(s) passed

( ) FLEX - indicate state where taken Date taken: Component I Component II
( ) NATIONAL BOARD - PART I PART II PART III
(X) USMLE STEP 1 [illegible] STEP 2 [illegible] STEP 3 [illegible]
( ) LMCC - Canadian
( ) STATE BOARD - indicate state where taken

PENNSYLVANIA
Department of State

For questions about this website, please Click Here to send an E-Mail , or to contact your Board directly, Click Here.

Click the X at the upper right corner to close this window and return to the list of licensees.

Person Information

Name: HUBERT GAMWO FOKA

Address Information

Address(city state zipcode): NORTH VERSAILLES PA 15137

License Information

Type:	Medical Physician and Surgeon	Secondary Type:		Number:	MD435506
Profession:	Medicine	Status:	Active		
Issue Date:	9/8/2008	Expires:	12/31/2012	Last Renewed:	12/18/2010

Discipline Action History

No disciplinary actions were found for this license.

The Information above is considered primary source for verification of license credentials.

myLicense Renewal Question Responses

License Number: MD435506

Name : HUBERT GAMWO FOKA

Online Submission Date : 12/17/2008 8:04:50AM

Renewal Question	Response
Are you submitting a name change with this renewal?	N
Are you licensed in another licensing jurisdiction in this profession (any status)?	Y
Since your last renewal, has a licensing jurisdiction taken any disciplinary action against you?	N
Since your last renewal, have you been convicted of a crime?	N
Since your last renewal, have you withdrawn an application for licensure in another licensing juristiction?	N
Have you met your current CE requirements?	Y
Since your last renewal, have your provider privileges been terminated by any medical assistance agency for cause?	N
Since your last renewal, have you had practice privileges denied, revoked or restricted in a hospital or health care facility?	N
Since your last renewal, have you had your DEA registration denied, revoked or restricted?	N
Since your last renewal, have you been arrested for criminal homicide, aggravated assault, sexual offenses or drug offenses in any state, territory or country?	N
Do you maintain current medical professional liability insurance in the Commonwealth?	N
Medical Renewal - Since your last renewal, have you been the subject of a civil malpractice law suit?	N

Online Submission Date : 12/18/2010 12:15:57AM

Renewal Question	Response
Are you submitting a name change with this renewal?	N
Are you licensed in another licensing jurisdiction in this profession (any status)?	N
Since your last renewal, has a licensing jurisdiction taken any disciplinary action against you?	N
Since your last renewal, have you been convicted of a crime?	N
Since your last renewal, have you withdrawn an application for licensure in another licensing juristiction?	N
Have you met your current CE requirements?	Y
Since your last renewal, have your provider privileges been terminated by any medical assistance agency for cause?	N
Since your last renewal, have you had practice privileges denied, revoked or restricted in a hospital or health care facility?	N
Since your last renewal, have you had your DEA registration denied, revoked or restricted?	N
Since your last renewal, have you been arrested for criminal homicide, aggravated assault, sexual offenses or drug offenses in any state, territory or country?	N
Do you maintain current medical professional liability insurance in the Commonwealth?	Y
Medical Renewal - Since your last renewal, have you been the subject of a civil malpractice law suit?	Y

Person Info
Name:HUBERT GAMWO FOKA
Address Info

Street Address [redacted] **Email:** [redacted]
Phone
Fax
City
State
Zipcode
Country
County

Survey Response Summary
Question Response Summary

Question	Response
Are you submitting a name change with this renewal?	N
Do you hold a license/certificate (active, inactive or expired) to practice in any other state or jurisdiction?	N
Since your initial application or last renewal, whichever is later, have you had disciplinary action taken against your license, certificate or registration issued to you in any profession in any other state or jurisdiction?	N
Since your initial application or last renewal, whichever is later, have you been convicted, found guilty or pleaded nolo contendere, or received probation without verdict, or accelerated rehabilitative disposition(ARD) as to any felony or misdemeanor, including any drug law violations, or do you have any criminal charges pending and unresolved in any state or jurisdiction? You are not required to disclose any ARD or other criminal matter that has been expunged by order of a court.	N
Since your initial application or last renewal, whichever is later, have you withdrawn an application for a license, certificate or registration, had an application denied or refused, or for disciplinary reasons agreed not to reapply for a license, certificate or registration in any profession in any other state or jurisdiction?	N
Since your initial application or last renewal, whichever is later, have you been arrested for criminal homicide, aggravated assault, sexual offenses or drug offenses in any state, territory or country?	N
Since your last renewal, have you been the subject of a civil malpractice law suit? If yes, please submit a copy of the entire Civil Complaint which must include the filing date and the date you were served. If you previously reported the complaint, email or fax the docket number to the Board. (email at st-medicine@state.pa.us or fax at 717-787-7769)	Y

Since your initial application or last renewal, whichever is later, have you had your DEA registration denied, revoked or restricted?	N
Since your initial application or last renewal, whichever is later, have you had practice privileges denied, revoked or restricted in a hospital or health care facility?	N
Since your initial application or last renewal, whichever is later, have your provider privileges been denied, revoked or restricted by any medical assistance agency for cause?	N
Do you maintain current medical professional liability insurance in the Commonwealth of Pennsylvania?	Y
Have you met your current CE requirements?	Y

Education Information

No education records

Employment Information

No employment records

remarks
Remarks:
Continuing Education Information

No CE Course records

Regular Mailing Address
STATE BOARD OF MEDICINE
P.O. BOX 2649
HARRISBURG, PA 17105-2649
717-783-1400/717-787-2381
Email: [illegible]@state.pa.us

Courier Delivery Address
STATE BOARD OF MEDICINE
2601 NORTH THIRD STREET
HARRISBURG, PA 17110

APPLICATION FOR A LICENSE TO PRACTICE MEDICINE WITHOUT RESTRICTION
For Graduates of ACCREDITED Medical Schools (SCHOOLS IN THE U.S. AND CANADA)

Application Fee: $35.00 (not refundable) - Make check payable to the "Commonwealth of Pennsylvania"
Note: A processing fee of $20.00 will be charged for any check or money order returned unpaid by [illegible] bank, regardless of the reason for non-payment.

Please Print or Type

NAME FOKA HUBERT GAMBO
Last First Middle

Permanent Address: [redacted]
Street

All correspondence and the license will be mailed to this address unless the Board is notified of a change.

[redacted]
City State Zip Code

Email address: [redacted]

Date of Birth: [redacted] Social Security Number: [redacted]
MM DD YYYY

If your medical licensure records are listed under another name or names, list below:

Are you applying using credentials verification from FCVS? ___ YES X NO

Have you previously held a Pennsylvania graduate training license?

___ YES My license number is: X NO

LIST MEDICAL SCHOOL(S) ATTENDED **DATES OF ATTENDANCE**

U.I.C. Chicago From 08/1998 to 06/2002
MM/YYYY MM/YYYY

From ___ to ___
MM/YYYY MM/YYYY

Date of Graduation: 03/05/2002
MM/DD/YYYY

Check licensing examination(s) passed:

( ) FLEX - indicate state where taken: ___ Date taken: Component 1 ___ Component 2 ___
( ) NATIONAL BOARD - PART I ___ PART II ___ PART III ___
(X) USMLE STEP 1 ___ STEP 2 ___ STEP 3 ___
( ) LMCC - Canadian
( ) STATE BOARD - indicate state where taken:

ACGME Post Graduate Training:

PGY1 Hospital *Children's Hospital Buffalo* From [illegible] to [illegible]

PGY2 Hospital *Children's Hospital Buffalo* From [illegible] to [illegible]

Answer the following questions. If "YES" is answered to #2 through #9, provide complete details on a separate sheet as well as certified copies of relevant documents. Sign and date below.

Question	Yes	No
1) Do you hold or have you ever held an unrestricted license, certificate, or registration (active or inactive, current or expired) to practice medicine and/or surgery in another jurisdiction? **If yes, list the jurisdiction(s) here:** *[illegible]*	✓	
2) Have you ever withdrawn an application for a license, certification, or registration, had an application denied or refused, or agreed not to reapply in another state, territory or country?		✓
3) Has any disciplinary action been taken against your license, certification, or registration in another state, territory or country?		✓
4) Have you been convicted, found guilty, or pleaded guilty or nolo contendere, or received probation without verdict as to any felony or misdemeanor, including any drug law violation, in any state or federal court?		✓
5) Since May 19, 2002, have you been arrested for criminal homicide, aggravated assault, sexual offenses or drug offenses in any state, territory or country?		✓
6) Have you had practice privileges denied, revoked or restricted at a hospital or other health care facility, or have you been charged by a hospital, university, or research facility with violating research protocols, falsifying research, or engaging in other research misconduct?		✓
7) Have you had your DEA registration denied, revoked or restricted or have you had your provider privileges terminated by any medical assistance agency for cause?		✓
8) Are you, or have you ever been, addicted to the intemperate use of alcohol or to the habitual use of narcotics or other habit forming drugs? (**Note: You may answer "NO" if you are currently a participant in or have successfully completed the requirements of the Board's Professional Health Monitoring Program.**)		✓
9) Since May 19, 2002, have any malpractice complaints been filed against you? If yes, the board requires that you submit a copy of the **entire Civil Complaint** which must include the **docket number, filing date**, and the **date you were served**.		✓

[illegible]

[illegible]

Signature of Applicant *[signature]* Date *[illegible]*

49 (01) (REV. 04/06)
State Board of Medicine
P. O. BOX 2649
HARRISBURG, PA 17105-2649

Certification of Moral Character

To be completed by two physicians who hold an unrestricted license in good standing in the United States or Canada and have known you for at least six months. ORIGINAL SIGNATURES ARE REQUIRED.

Name of Applicant: [illegible handwriting]

I hereby certify that I know the applicant to be of good moral character and to the best of my knowledge, he/she is not addicted to the intemperate use of alcohol or to the habitual use of a narcotic or other habit forming drug. I recommend the applicant for a license to practice medicine in the Commonwealth of Pennsylvania.

I have been personally acquainted with the applicant for 9 year(s) 2 month(s).

SIGNATURE Reginald Ebirim Date JUNE-08-08

Print or type name as signed above REGINALD EBERIM

State in which licensed ILLINOIS License Number 036113328

Name of Applicant ____________________

I hereby certify that I know the applicant to be of good moral character and to the best of my knowledge, he/she is not addicted to the intemperate use of alcohol or to the habitual use of a narcotic or other habit forming drug. I recommend the applicant for a license to practice medicine in the Commonwealth of Pennsylvania.

I have been personally acquainted with the applicant for ____ year(s) ____ month(s).

SIGNATURE ____________________ Date ____________

Print or type name as signed above ____________________

State in which licensed ____________ License Number ____________

Return Completed Form to Applicant

[illegible] (REV. [illegible])
State Board of Medicine
P. O. BOX 2649
HARRISBURG, PA 17105-2649

Certification of Moral Character

To be completed by two physicians who hold an unrestricted license in good standing in the United States or Canada and have known you for at least six months. ORIGINAL SIGNATURES ARE REQUIRED.

Name of Applicant: [illegible]

I hereby certify that I know the applicant to be of good moral character and to the best of my knowledge, he/she is not addicted to the intemperate use of alcohol or to the habitual use of a narcotic or other habit forming drug. I recommend the applicant for a license to practice medicine in the Commonwealth of Pennsylvania.

I have been personally acquainted with the applicant for [illegible] year(s) [illegible] month(s)

SIGNATURE: [illegible] Date: 1 6 08

Print or type name as signed above: CONDOM FRANCIS

State in which licensed: S C License Number: 9C6

Name of Applicant:

I hereby certify that I know the applicant to be of good moral character and to the best of my knowledge, he/she is not addicted to the intemperate use of alcohol or to the habitual use of a narcotic or other habit forming drug. I recommend the applicant for a license to practice medicine in the Commonwealth of Pennsylvania.

I have been personally acquainted with the applicant for ______ year(s) ______ month(s)

SIGNATURE: ______ Date: ______

Print or type name as signed above: ______

State in which licensed: ______ License Number: ______

Return Completed Form to Applicant

RECEIVED DIRECT

Regular Mailing Address
STATE BOARD OF MEDICINE
P.O. BOX 2049
HARRISBURG, PA 17105-2649
717-783-1400/717-787-2381
Email: st-medicine@state.pa.us

Courier Delivery Address
STATE BOARD OF MEDICINE
2601 NORTH THIRD STREET
HARRISBURG, PA 17110

VERIFICATION OF ACGME APPROVED GRADUATE MEDICAL TRAINING

Accredited Medical School Graduates

NAME: TOKA (Last) HUBERT (First) GAMWO (Middle)

1. If training began before July 1, 1987, one year of approved training at a first (PGY-1) or second (PGY-2) year level must be verified. If the training began on or after July 1, 1987, two (2) years of approved training are required, one at first (PGY-1) year level and one at second (PGY-2) year level.
2. Training at a first (PGY-1) year must be ACGME approved entry level training which requires no previous training. Training at a second (PGY-2) year must be ACGME approved and can be any specialty.
3. If training was completed at more than one hospital, duplicate this form and submit to each hospital.

<u>This Section to be completed by the program director at the hospital where the graduate training occurred</u>

If training was in Pennsylvania, information must coincide with data on graduate license. For applicants still in the second year of training, this form may be completed and signed by the program director fifteen (15) days prior to the completion of the approved training. Forms postmarked or signed prior to the fifteen days will not be accepted.

NAME OF HOSPITAL WHERE TRAINING WAS COMPLETED: Women & Children's Hospital of Buffalo

NAME OF SPONSORING INSTITUTION: University at Buffalo

LOCATED IN: Buffalo (City) NY (State)

ACGME

1st Year from *06 17 02 to 06 25 06 Specialty: Ob/Gyn Level (PGY): 1-4

2nd Year from ______ To ______ Specialty ______ Level (PGY) ______

*Completed PGY1 through PGY4 years in the program

I certify that the above named applicant successfully completed/will successfully complete this graduate medical training and that there was/is no disciplinary action outstanding against this applicant. If this applicant does not complete this training, the Board will be notified.

The hospital has no seal or stamp to affix to this document. Therefore, I will have this form notarized to verify that this form was completed by this hospital.

[signature]
Program Director's Signature

6-12-08
Date

(Seal of Hospital)

SHARON A. GREEN
NOTARY PUBLIC, STATE OF NEW YORK
REGISTRATION No. 01GR6081824
QUALIFIED IN ERIE COUNTY
My Commission Expires October 7, 20[illegible]

(Notary Seal)

Notary's Signature [signature]

Notary's Commission expires on [illegible]

RETURN COMPLETED FORM DIRECTLY TO THE BOARD IN OFFICIAL HOSPITAL ENVELOPE

RECEIVED DIRECT

University at Buffalo

February 13, 2008

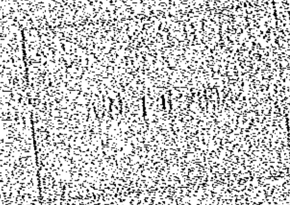
RE: John Yeh, MD signatory

To Whom It May Concern:

This is to formally authorize Armando Arroyo, MD and Bruce Rodgers, MD to sign all documents regarding the residency program of the Department of Gynecology-Obstetrics, University at Buffalo, the State University of New York, in my absence. Dr. Arroyo and Dr. Rodgers are permitted to sign all documents requiring the Program Director's signature. This shall be in effect from today, February 13, 2008, until August 31, 2008.

Sincerely,

John Yeh, MD
Professor and Chairman
Program Director



[illegible] (REV [illegible])
State Board of Medicine
717-783-1400
717-787-2381

RECEIVED DIRECT

VERIFICATION OF MEDICAL EDUCATION
For Graduates of Accredited Medical Schools

SECTION 1: To be completed by applicant.

Name: BOKA (Last) HUBERT (First) GAMW[illegible] (Middle)

Name of medical school: UNIVERSITY OF ILLINOIS AT CHICAGO

Location: CHICAGO ILLINOIS

SUBMIT THE VERIFICATION OF MEDICAL EDUCATION FORM TO YOUR MEDICAL SCHOOL AND REQUEST YOUR SCHOOL TO RETURN THE COMPLETED FORM DIRECTLY TO THE BOARD IN AN OFFICIAL SCHOOL ENVELOPE.

SECTION 2: To be completed by Dean or Registrar of medical school.

Name of medical student: [illegible]

Date student began to attend this medical school: [illegible]
MM/DD/YYYY

Date of graduation: [illegible]
MM/DD/YYYY

I certify that all of the above information is correct.

[Seal of School]

Signature of Dean or Registrar

[illegible]

Date: [illegible]

Upon completion, school must return this completed form directly to the Pennsylvania State Board of Medicine in an official school envelope.

DO NOT RETURN TO APPLICANT

Regular Mailing Address
State Board of Medicine
P.O. Box 2649
Harrisburg, PA 17105-2649

Courier Delivery Address
State Board of Medicine
2601 North Third Street
Harrisburg, PA 17110

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.
[illegible] Dallas, TX [illegible] Telephone [illegible]

Date: [illegible]

Recipient:

[illegible]

Examinee: [illegible]
Date of Birth: [illegible]

Results for Steps taken by this examinee [illegible] are shown below. [illegible]

USMLE STEP 1

Test Date	Pass/Fail	Three Digit Score Total	Three Digit Score MP	Two Digit Score Total	Two Digit Score MP	Comments
[illegible]	Pass	[illegible]	[illegible]	[illegible]	[illegible]	

USMLE STEP 2

Clinical Knowledge (CK)

Test Date	Pass/Fail	Three Digit Score Total	Three Digit Score MP	Two Digit Score Total	Two Digit Score MP	Comments
[illegible]	Pass	[illegible]	[illegible]	[illegible]	[illegible]	

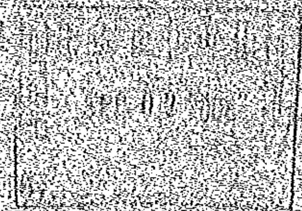
USMLE STEP 3

	Test Date	Pass/Fail	Three Digit Score Total	Three Digit Score MP	Two Digit Score Total	Two Digit Score MP	Comments
[illegible]	[illegible]	Pass	[illegible]	[illegible]	[illegible]	[illegible]	
[illegible]	[illegible]	Fail	[illegible]	[illegible]	[illegible]	[illegible]	

NOTE: [illegible]

CURRICULUM VITAE

HUBERT G. FOKA, M.D.



Contact Information

Telephone
Email

Education
06/1997-05/2002 University of Illinois at Chicago, School of Medicine (M.D.)

Postgraduate Training
06/2002- 06/2006 OB/GYN Resident, State University of New York
Buffalo N.Y.

03/2006-10/2006 Volunteer, MD, Doctors Without Borders (France) in Sub-
Saharan region in Africa.
Togo, Benin, Cameroon Niger

11/2006-Present Attending Physician

Chesterfield General Hospital
711 Chesterfield Highway
Cheraw S.C. 29520

Professional Experience

1997-1998 University of Chicago, Assistant Research, Department of General
Surgery

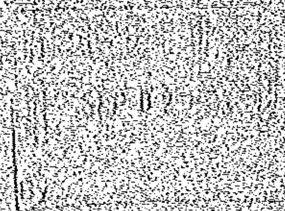
2005-2006 Administrative Chief Resident, State University of New York at
Buffalo

Honors and Awards
2003-2004 Berlex best First year Teaching Resident Award
2004-2005 Wayne Johnson Excellence in Maternal Fetal Medicine Award
2005 Chairman's Resident Award Group Resident Recipient
Outstanding Mentor, University of Illinois at Chicago 1998-2002
Honors grades, Internal Medicine and Ob/Gyn Sub Internship 2002

Teaching
2002-2006 - Assistant Clinical Faculty Member, State University of New York at Buffalo
May 2000 - July 2002 - Tutored premedical student and newly enrolled first year medical students

Licensure
USLME STEP 1, STEP 2 and STEP 3
American Board of Obstetrics and Gynecology: Board Eligible

Societies
ACOG Member since 2002
National Medical Association - Member since [illegible]



National Practitioner Data Bank
Healthcare Integrity and Protection Data Bank
P.O. Box 10832
Chantilly, VA 20153-0832

http://www.npdb-hipdb.hrsa.gov

DCN: 5500000052490105
Process Date: [illegible]
Page: [illegible] of [illegible]

To: [illegible]

SEP 0 2

By

From: **The Healthcare Integrity and Protection Data Bank**

Re: **Response to Your Self-Query**

The enclosed information is released by the Healthcare Integrity and Protection Data Bank (HIPDB) for restricted use under the provisions of Section 1128E of the Social Security Act.

Section 1128E was established by Section 221(a) of Public Law 104-191, the Health Insurance Portability and Accountability Act of 1996, as amended. The statute established the HIPDB to combat fraud and abuse in health insurance and health care delivery and to improve the quality of patient care. The HIPDB serves as a source of final adverse action information on health care practitioners, providers, and suppliers. The HIPDB collects and releases information related to adverse licensure actions, health care-related convictions and judgments, exclusions from Federal and State health care programs, and other adjudicated actions or decisions. Responsibility for operating the HIPDB resides with the Secretary of the U.S. Department of Health and Human Services (HHS), Office of Inspector General, and HRSA, Division of Practitioner Data Banks. Regulations governing the HIPDB are codified at 45 CFR Part 61.

Reports from the HIPDB contain limited summary information and should be used in conjunction with information from other sources in granting clinical privileges or making employment, affiliation, contracting, or licensure decisions. The HIPDB response may contain more than one report on a particular incident, if two or more actions were taken as a result of a single incident (e.g., an adverse licensure action and an exclusion from the Medicare and Medicaid programs). The HIPDB is a flagging system and a report may be included for a variety of reasons that do not necessarily reflect adversely on the professional competence or conduct of the subject named in the report.

All information received from the HIPDB is considered confidential and must be used solely for the purpose for which it was disclosed. Subjects of reports who obtain information about themselves from the HIPDB are permitted to share that information with anyone they choose.

If you require additional assistance, visit the NPDB-HIPDB web site (http://www.npdb-hipdb.hrsa.gov) or contact the NPDB-HIPDB Customer Service Center at 1-800-767-6732 (TDD: 1-703-802-9395). Information Specialists are available to speak with you weekdays from 8:30 a.m. to 6:00 p.m. (5:30 p.m. on Fridays) Eastern Time. The NPDB-HIPDB Customer Service Center is closed on all Federal holidays.

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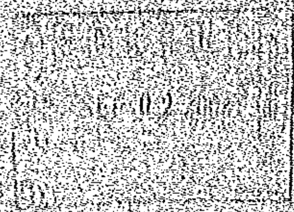
DCN: 5500000052498305
Process Date: [illegible]
Page: [illegible] of [illegible]

NPDB RESPONSE TO SELF-QUERY

A. SUBJECT ON WHOM DISCLOSURE IS REQUESTED

Subject Name: [illegible]
Gender: [illegible]
Date of Birth:
Other Name(s) Used:
Organization Name:
Organization Type: [illegible]
Other, as Specified:
Home or Work Address:
City, State, ZIP:
Country:
Social Security Numbers (SSN):
Individual Taxpayer Identification Numbers (ITIN):
Federal Employer Identification Numbers (FEIN):
National Provider Identifiers (NPI):
Drug Enforcement Administration (DEA) Numbers: [illegible]
Unique Physician Identification Numbers (UPIN):
Professional School(s) & Year(s) of Graduation: [illegible]
Occupation/Field of Licensure (Code): [illegible]
State License Numbers, State of Licensure: [illegible]
Other, as Specified:
Specialty: [illegible]



B. PAYMENT INFORMATION

Payment Type: [illegible]
Account Number: [illegible]
Expiration Date: [illegible]
Transaction Date: [illegible]
Transaction Number: [illegible]
Total Charge: $8.00

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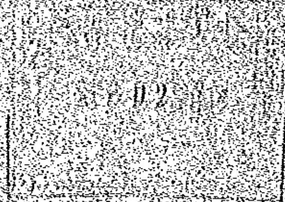
C. SEARCH RESULT

Based on the subject identification information provided by you in Section A above, a search of the NPDB has located the following 0 report(s).

Recipients should verify that the subject identified in Section A is, in fact, the subject of interest.

Copies of these reports are enclosed for restricted limited use as prescribed by Title IV of Public Law 99-660, as amended. Recipients should verify that the subject identified in Section A of the report(s) is, in fact, the subject of interest. Information from the NPDB is confidential and must be used solely for the purpose for which it was disclosed. ANY PERSON WHO VIOLATES THE CONFIDENTIALITY PROVISIONS AS SPECIFIED IN TITLE IV IS SUBJECT TO A CIVIL MONEY PENALTY OF UP TO $11,000 FOR EACH VIOLATION. Subjects of reports who obtain information about themselves from the NPDB are permitted to share that information with anyone they choose.



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Page: of

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HIPDB RESPONSE TO SELF-QUERY

A. SUBJECT ON WHOM DISCLOSURE IS REQUESTED

Subject Name:
Gender:
Date of Birth:
Other Name(s) Used:
Organization Name:
Organization Type:
Other, as Specified:
Home or Work Address:
City, State, ZIP:
Country:
Social Security Numbers (SSN):
Individual Taxpayer Identification Numbers (ITIN):
Federal Employer Identification Numbers (FEIN):
National Provider Identifiers (NPI):
Drug Enforcement Administration (DEA) Numbers:
Unique Physician Identification Numbers (UPIN):
Professional School(s) & Year(s) of Graduation:
Occupation/Field of Licensure (Code):
State License Numbers, State of Licensure:
Other, as Specified:
Specialty:

B. PAYMENT INFORMATION

Payment Type:
Account Number:
Expiration Date:
Transaction Date:
Transaction Number:
Total Charge: $8.00

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Chantilly, VA 20153-0832

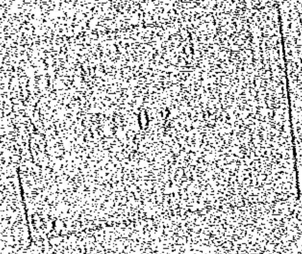
http://www.npdb-hipdb.hrsa.gov

C. SEARCH RESULT

Based on the subject identification information provided by you in Section A above, a search of the HIPDB has located the following 0 report(s).

Recipients should verify that the subject identified in Section A is, in fact, the subject of interest.

Copies of these reports are enclosed for restricted limited use as prescribed by Section 1128E of the Social Security Act. Recipients should verify that the subject identified in Section A of the report(s) is, in fact, the subject of interest. Information from the HIPDB is confidential and must be used solely for the purpose for which it was disclosed. Subjects of reports who obtain information about themselves from the HIPDB are permitted to share that information with anyone they choose.



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MD BL

RECEIVED DIRECT

STATE OF WASHINGTON
[illegible]

MEDICAL QUALITY ASSURANCE COMMISSION

August 19, 2008

[illegible]

Pennsylvania State Board
POB 2649
Harrisburg PA 17105-2649

Subject: Credential Verification

To Whom it May Concern:

This will verify the status of the Physician And Surgeon License for HUBERT FOKA

Sections may be blank because the information is not in our database or is not applicable for this credential type.

Year of Birth: 08/01/1964
Credential Number: MD.MD.00047009
Credential Type: Physician And Surgeon License
Current Credential Status: ACTIVE IN RENEWAL
First Credential Date: 08/17/2006
Expiration Date: 08/01/2007
Last Renewal Date:
Examination:
Exam Level:
Score:

ACCORDING TO OUR RECORDS, THIS LICENSE HAS NOT BEEN DISCIPLINED. LICENSE IS ALSO IN GOOD STANDING.

Please call me at (360) 236-4785 if you have questions or visit our Online Provider Credential Search at www.doh.wa.gov

Betty Elliott
Betty Elliott, Customer Service Specialist

RECEIVED DIRECT

STATE OF MICHIGAN
DEPARTMENT OF COMMUNITY HEALTH
LANSING

JENNIFER M. GRANHOLM — GOVERNOR

JANET OLSZEWSKI — DIRECTOR

VERIFICATION OF LICENSURE
MICHIGAN BOARD OF MEDICINE
VERIFICATION OF LICENSURE AS OF 08/01/2008

STATE BOARD OF MEDICINE
PO BOX 2649
HARRISBURG PA 17105-2649

NAME: Hubert G Poka   BIRTHDATE: [redacted]

ADDRESS: [redacted]

TYPE: Medical Doctor   ORIGINAL DATE: 07/26/2006

LICENSE NUMBER: [illegible]   STATUS: [illegible]   EXPIRATION DATE: 01/31/2007

OBTAINED BY: Examination

DISCIPLINARY ACTION: NONE

OPEN FORMAL COMPLAINTS: NONE

DANIEL J. BURNS