55

THE UNIVERSITY OF THE STATE OF NEW YORK
THE STATE EDUCATION DEPARTMENT
DIVISION OF PROFESSIONAL LICENSING SERVICES
99 WASHINGTON AVENUE
ALBANY, NEW YORK 12210

MEDICINE

FORM 1 — APPLICATION FOR PROFESSIONAL LICENSE

(For Graduates of American or Canadian Medical Schools Only)

DEPT. USE ONLY

FINANCE
AUG 75 00091

QUALS. 8/13/75 BGM
APPROVED .....
LIC. NO. 124783
DATE AUG 14 1975

[First] [Middle] [Last]

Print name Gary Joseph Guarnaccia

Permanent mailing address [redacted]

City Fort Lee State N.J. ZIP code [redacted]

Telephone number where you can be reached at all times:

Area code [redacted] Number [redacted]

Birth date [redacted] Citizen of [redacted]

(If you were not born in the United States, your own *original certificate* of citizenship *or* of declaration of intention *or* of derivative citizenship *must* be submitted. Document will be returned by certified mail.)

High school Fort Lee High Location Fort Lee N.J.

College Columbia Univ Location Manhattan N.Y.

Professional school N.J. Col. of Medicine Location Newark N.J.

Date graduated June 1974 Degree received MD

If employed, give name and address of employer

Bellevue Hospital Corp N.Y. N.Y.

If you have ever taken a New York State licensing examination, name profession No

Has any state rejected your application?* [redacted]

Have you ever been convicted of any crime?* [redacted]

Have you ever been found guilty of unprofessional conduct?* [redacted]

* If yes, explain in an accompanying letter.

APPLICATION FOR LICENSURE BY: (Please check the appropriate item.)

(✓) Acceptance of Certification of National Board of Medical Examiners.

( ) Acceptance of Certification of National Board of Examiners for Osteopathic Physicians and Surgeons.

( ) Acceptance of Federation Licensing Examination (FLEX) taken outside of New York State.

( ) Endorsement of out-of-state medical license.

( ) Admission to New York State Licensing Examination (FLEX).

If applying for admission to New York State examination please indicate:

Time of examination requested: June.....; December.....

Place of examination requested ( ) New York; ( ) Albany; ( ) Syracuse; ( ) Buffalo

NOTE: ALL APPLICANTS SHOULD READ CAREFULLY THE ATTACHED CIRCULAR OF INSTRUCTION BEFORE CONTINUING TO COMPLETE APPLICATION.

DO NOT WRITE IN THIS SECTION

FEE NO.	EX. DATE	EX. PLACE	IDENT. NO.	SUBJECTS	CARD SENT	TO	BY

New address .....

27115

NOT TO BE FILLED IN BY APPLICANT

CERTIFICATION BY SECRETARY OF STATE BOARD OF MEDICAL EXAMINERS

(NOT TO BE COMPLETED IF APPLICANT TOOK FEDERATION LICENSING EXAMINATION)

Name of applicant in full — *Last Name* / *First Name* / *Middle Name*

Place of examination..... Dates of examination .....

License number ..... Date issued .....

Name in which applicant's license is issued.....

SUBJECTS OF WRITTEN EXAMINATION	RATING	SUBJECTS OF WRITTEN EXAMINATION	RATING

Number of examinations retaken after failures..... Final average.....

CERTIFICATE

I hereby certify that to the best of my knowledge and belief the foregoing is a true statement of the record of the applicant named on the first page of this form and further certify that this board has never taken any disciplinary action against the applicant and that insofar as this board has knowledge there have been no charges preferred against him/her nor has any information been presented to the board relating to any question of unprofessional or immoral conduct and I recommend endorsement of his/her license by the State of New York.

Signature .....

(SEAL) *Secretary of the*.....

Date .....

INSTRUCTION TO THE MEDICAL BOARD: Please complete above certification and return this form to the applicant.

SPACES FOR NEW YORK STATE EDUCATION DEPARTMENT USE ONLY

ITEM	COMMENT, IF ANY	APPROVED	DISAPPROVED	BY	DATE
Professional school		✓			
Grades				Bgm	8/13/75
Recommendations:					
Board or Exec. Secretary to State Board for Medicine		✓			
D.P.L.S.				[illegible]	8/13/75

POSTGRADUATE HOSPITAL TRAINING AND PRACTICE (LIST CHRONOLOGICALLY)

DESCRIPTION	NAME OF INSTITUTION	DATES		LOCATION
		From	To	
Resident	Bellevue Hosp.	July 74	current	N.Y. N.Y

MEMBERSHIPS IN MEDICAL SOCIETIES (GIVE DATES)

IMPORTANT: Any false or misleading information in, or in connection with, any application, may be cause for debarment on the ground of lack of good moral character.

Under penalties of perjury, I declare and affirm that the statements made in the foregoing application, including accompanying statements and transcripts are true, complete and correct.

[signature] M.D.

Signature of Applicant

6/29/75

Date

Date of Photograph 7/17/75

HAVE YOU PRINTED YOUR NAME AT THE TOP OF PAGE ONE?

PERSONAL SIGNATURES OF THREE LICENSED PHYSICIANS RECOMMENDING APPLICANT

This certifies that I have been PERSONALLY acquainted with the applicant since the year indicated opposite my name, that I BELIEVE OF MY OWN KNOWLEDGE THAT HE/SHE IS OF GOOD MORAL CHARACTER AND I KNOW OF NOTHING WHICH WOULD MILITATE AGAINST HIS/HER LICENSURE IN NEW YORK STATE, that the use of my signature signifies my willingness to submit a letter of recommendation if requested and that ANY RESERVATIONS I might have about the applicant I agree to send by registered mail in a confidential letter to the department.

Personal Signature	*Post Office Address (including street and number)*	*State in Which Licensed*	*Have Known Applicant Since*
Joseph F. Kuss MD	330 E 33rd St	N.Y.	1974
Louis Rendo MD	56-45 Main St	NY	1974
Rita L. Santero MD	86-43 Sanders St	N.J.	1973

CERTIFICATION BY MEDICAL SCHOOL

(Items (1) and (2) must be completed)

It is hereby certified that the applicant named herein:

(1) Satisfactorily completed, prior to matriculation in professional school, all of the required preprofessional education.

Columbia University, New York

(Preprofessional school(s))

(2) Was graduated from this medical school after the completion of not less than four satisfactory courses of not less than 8 months each with the degree of Doctor of Medicine **on** June 3, 1974

Name Mary F. Mansey *(Original signature)*

Mary F. Mansey

Official position Assistant Registrar

Medical school College of Medicine & Dentistry of NJ (COLLEGE SEAL)

Date July 10, 1975

Certification is not acceptable unless dated after graduation.

Please return this form to the applicant for further processing.

SE 124783-1 REGISTRATION APPLICATION FOR PERIOD 01/01/86 - 12/31/88 $ 22

MEDICINE

SINCE YOU LAST REGISTERED HAVE YOU BEEN CONVICTED OF ANY CRIME (FELONY OR MISDEMEANOR)? [ ] YES [V] NO

SINCE YOU LAST REGISTERED HAS ANY STATE OTHER THAN NEW YORK REVOKED OR SUSPENDED A PROFESSIONAL LICENSE HELD BY YOU? [ ] YES [V] NO

WILL YOU BE PRACTICING IN NEW YORK STATE DURING THE PERIOD INDICATED? [V] YES [ ] NO

IF NO. [ ] INACTIVE [ ] RETIRED

LAST PRACTICED IN NYS ___ / ___ MO YR

BIRTHDATE 10 [illegible] MO DAY YR

GUARNACCIA GARY J
37 JONESON AVENUE
ENGLEWOOD CLIFFS NJ

RE26633 [redacted]

FOR DEPOSIT ONLY NYSED

OFFICE USE ONLY

LIC NO 124783
SUB-CHK GUAS
FEE 220
PD 40 APP 1
YR 86 TYPE 21
PER

SIGN BELOW AND DATE

[signature] (DATE)
SIGNATURE

CHECK BOX IF NAME OR ADDRESS CHANGED → [ ]

124783GUA3000022002206018A00000

6. If the data items asterisked (*) are not provided or are incorrect, please check box and complete Data Change Form below. ☐

REGISTRATION APPLICATION

PERIOD 01/01/89 - 12/31/91

$ 220
PAY THIS AMOUNT

PROFESSION MEDICINE

1. Since you last registered has any state other than New York instituted charges against you for professional misconduct, unprofessional conduct, incompetence or negligence or revoked, suspended, or accepted surrender of a professional license held by you? ☐ Yes ☑ No

2. Since you last registered have you been convicted of any crime (felony or misdemeanor) in any state or country; is any criminal charge now pending against you in any state or country; or have you been charged with any crime the disposition of which was other than by acquittal or dismissal? ☐ Yes ☑ No

3. Will you be practicing in New York State during the period indicated?
☑ Yes ☐ No

IF ANSWER NO, ☐ OUT OF STATE ☐ RETIRED

4. Last practiced in NYS ____ MO. ____ YR.

RK83156

OFFICE USE ONLY
08/08/88
LIC. NO. 124783
BIR CHK 0882
*DOB [redacted]
*SSN
FEE 220
PC 60 OFF 1
YR 89 TYPE 8A
PDL

GUARNACCIA GARY J
37 JOHNSON AVENUE
ENGLEWOOD CLIFFS NJ [redacted]

5. SIGN BELOW AND DATE

X ______________________ ______________
(SIGNATURE) (DATE)

6. If the data items asterisked (*) are not provided or are incorrect, please check box and complete Data Change Form below. ☒

REGISTRATION APPLICATION

PROFESSION: MEDICINE

PERIOD: 01/01/81 - 12/31/82

$ 330.00
PAY THIS AMOUNT

SEE INSTRUCTIONS ON REVERSE SIDE

1. (a) Since you last registered has disciplinary action been taken by you...
   (b) Since you last registered have you been convicted of a crime...
   (c) FOR HEALTH PROFESSIONALS ONLY: Since you last registered has any hospital...

2. (a) Will you be practicing in NYS during the period indicated? ☑ YES ☐ NO
   (b) IF NO. ☐ INACTIVE ☐ RETIRED

3. Last practiced in NYS: 01/90 (Mo. Yr.)

4. Date of birth: [redacted]

5. Social Security#: [redacted]
   If Social Security has not been issued, check one box below:
   ☐ Applied for on ____
   ☐ Will not be issued

GUARNACCIA GARY J
17 JOHNSON AVENUE
ENGLEWOOD CLIFFS NJ [redacted]

PRIVACY NOTIFICATION: The authority to request personal information from you, including identifying numbers such as Federal Social Security and Federal Employer Identification Numbers, and the authority to maintain such information in files is found in Section ... of the Tax Law. Disclosure of this information by you is mandatory, and will be used for ... purposes.

OFFICE USE ONLY

08/27/90
LIC. NO 124783
MD OR GDA3
DOB [redacted]
SSN [redacted]
FEE 330
PR 60 OFF 1
YR 91 TYPE RR
PCN

REGISTRATION APPLICATION

PROFESSION: MEDICINE

PERIOD: 01/01/95 - 12/31/96

$ 330 : 713 00 0698 6
PAY THIS AMOUNT

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

R2058441

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
518 474-1817

READ INSTRUCTIONS ON REVERSE SIDE BEFORE COMPLETING THIS FORM

OFFICE USE ONLY	
DATE:	08/01/94
LIC NO:	124783
NM:	GUA3
DOB:	01/21/48
SSN:	140384732
FEE:	330
PR: 60	OFF: 1
YR: 95	TYPE: RR
PY:	
CA:	Y

GUARMACCIA GARY J
SUITE 200
112-03 QUEENS BLVD
FOREST HILLS NY 11375-0000

7

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

1 (a) **Since you last registered** has any state other than New York instituted charges against you for professional misconduct, unprofessional conduct, incompetence or negligence or revoked, suspended, or accepted surrender of a professional license held by you? ☐ Yes ☒ No

(b) **Since you last registered**, have you been convicted of any crime (felony or misdemeanor) in any state or country or have you been charged with any crime the disposition of which was other than acquittal or dismissal? ☐ Yes ☒ No

(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? ☐ Yes ☒ No

FOLD

2 Do you wish to register in New York State for the period indicated? ☒ Yes ☐ No

3 Are you currently practicing in New York State? ☒ 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 11 2486203
Applicable only if you are an employer required to report employment taxes to the IRS.

FOLD

7 New York State law requires 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.

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

CA: Y

8 You must comply with the statutory requirement for completion of approved course work in infection control and barrier precautions to prevent the transmission of HIV and HBV in healthcare settings. Questions may be referred to the Infection Control/Occupational Health Unit of the NYS Department of Health at (518) 473-0814.

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

Signature 9/20/94
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

124783GUA300600000601 97

REGISTRATION REMITTANCE DOCUMENT

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

QA34456 B25[illegible]

08/27/98
LIC: 124783
NME: GUA3
YR: 97
OFF: 1
DOB: [redacted]
SSN: [redacted]
EIN:

GUARNACCIA GARY J
SUITE 200
112-03 QUEENS BLVD
FOREST HILLS NY 11375-0000

PROFESSION: 60 MEDICINE
PERIOD: 01/01/97 - 12/31/98

$ 800
AMOUNT DUE

Complete and sign reverse side of this application

1. Do you wish to register for the period indicated?

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?

b. Has any other state or country [illegible] your professional conduct [illegible] incompetence or negligence, or revoked, suspended, or accepted surrender of, a professional license from you?

c. Has any hospital or licensed facility restricted, 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, incompetence, or negligence?

3. a. Are you under an obligation to pay child support?

b. If you are under such an obligation, do you meet one of the four requirements listed in the Child Support law section below?

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 reason for disciplinary action, including the loss of my license, and that willful failure to register while engaging to practice my profession is [illegible] professional misconduct.

(Signature)

Date

12478360A3006000060199

REGISTRATION REMITTANCE DOCUMENT

[redacted]

[redacted] 08/01/00
LIC 124783
[redacted]
[redacted]
[redacted]
[redacted]
[redacted]

GUARNACCIA GARY J
SUITE 200
112-03 QUEENS BLVD
FOREST HILLS NY 11375-0000

PROFESSION 00 MEDICINE
PERIOD 01/01/00 - 12/31/00

Complete and sign reverse side of this application

Name/address change
Complete only if change has occurred

Name

Street

City

State/Zip

$ 600
AMOUNT DUE

124783GUA300600006010 1

REGISTRATION REMITTANCE DOCUMENT

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

08/02/00
LIC: 124783
NME: GUA3
VR: 01
OFF: 1
DOB: [redacted]
SSN:
EIN:

GUARNACCIA GARY J
SUITE 200
112-03 QUEENS BLVD
FOREST HILLS NY 11375-0000

PROFESSION: 60 - MEDICINE
PERIOD: 01/01/01 - 12/31/02

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

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?

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?

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?

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

322713508 [illegible]
119 110820900

DO NOT WRITE IN THIS BOX
FOR OFFICIAL USE ONLY

Under penalties of perjury, I certify that the statements in this application and any accompanying documentation are true, complete, and correct. I understand that any misrepresentation made in connection with my application may be cause for disciplinary action, including the loss of my license, and that willful failure to inform [illegible] to practice my profession constitutes professional misconduct.

Signature [illegible] Business phone ( ) [illegible]

2. Have you [illegible] 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? ___Yes ✓No

b. Has any other state or country instituted charges against you for professional misconduct, unprofessional conduct, incompetence or negligence, or revoked, suspended, or accepted surrender of a professional license held by you? ___Yes ✓No

124783GUA3006000060103

REGISTRATION RENEWAL DOCUMENT

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

08/01/02
LIC: 124783
NME: GUA3
YR: 03
OFF: 1
DOB: [redacted]
SSN:
EIN:

GUARNACCIA GARY J
SUITE 200
112-03 QUEENS BLVD
FOREST HILLS NY 11375-0000

PROFESSION: 60 MEDICINE
PERIOD: 01/01/03 - 12/31/04

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? Yes / No
   b. Has any licensing or disciplinary authority revoked, annulled, cancelled, accepted surrender of, suspended, placed on probation, or refused to issue or renew a professional license or certificate held by you now or previously, or fined, censured, reprimanded or otherwise disciplined you? Yes / No
   c. Are criminal charges pending against you in any court? Yes / No
   d. Are charges pending against you in any jurisdiction for any sort of professional misconduct? Yes / No
   e. Has any hospital or licensed facility restricted or terminated your professional training, employment, or privileges, or have you voluntarily or involuntarily resigned or withdrawn from such association to avoid the imposition of such action due to professional misconduct, unprofessional conduct, incompetency, or negligence? 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

3226156 0000066000
235 88302002

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 phone ([redacted] Date 8/20/02

REGISTRATION RENEWAL DOCUMENT

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

08/01/02

LIC: 124783
NME: GUA3
YR: 03
OFF: 1
DOB: [redacted]
SSN:
EIN:

GUARNACCIA GARY J
SUITE 200
112-03 QUEENS BLVD
FOREST HILLS NY 11375-0000

PROFESSION: 60 MEDICINE
PERIOD: 01/01/03 - 12/31/04

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 E - 1001

1. Do you wish to register for the period indicated? — Yes

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 a qualified alien as defined below? — Yes — No

3226156 [illegible]
235 88302002

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 phone ([redacted] Date 8/20/02

CS 6 - 06/99

REGISTRATION RENEWAL DOCUMENT

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

08/03/04
LIC: 124783
NME: GUA3
YR: 05
OFF: 1
EIN:

GUARNACCIA GARY J
SUITE 200
112-03 QUEENS BLVD
FOREST HILLS NY 11375-0000

PROFESSION: 60 MEDICINE
PERIOD: 01/01/05 - 12/31/06

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

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

[redacted]

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] 11/16/14

REGISTRATION RENEWAL DOCUMENT

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

08/01/06
LIC: 124783
NME: GUA3
YR: 07
OFF: 1
EIN:

GUARNACCIA GARY J
SUITE 200
112-03 QUEENS BLVD
FOREST HILLS NY 11375-0000

PROFESSION: 60 MEDICINE
PERIOD: 01/01/07 - 12/31/08

Complete and sign reverse side of this application

Cat 21P-032204

Name/address change
Complete only if change has occurred

Name

Street

City

State/Zip

$ 600
AMOUNT DUE

1. Do you wish to register for the period indicated? ..... ☑ Yes ☐ No

2. Since your last registration application,
   a. Have you been found guilty after trial, or pleaded guilty, no contest, or nolo contendere to a crime (felony or misdemeanor) in any court? ..... ☐ Yes ☑ No
   b. Has any licensing or disciplinary authority revoked, annulled, cancelled, accepted surrender of, suspended, placed on probation, or refused to issue or renew a professional license or certificate held by you now or previously, or fined, censured, reprimanded or otherwise disciplined you? ..... ☐ Yes ☑ No
   c. Are criminal charges pending against you in any court? ..... ☐ Yes ☑ No
   d. Are charges pending against you in any jurisdiction for any sort of professional misconduct? ..... ☐ Yes ☑ No
   e. Has any hospital or licensed facility restricted or terminated your professional training, employment, or privileges, or have you voluntarily or involuntarily resigned or withdrawn from such association to avoid the imposition of such action due to professional misconduct, unprofessional conduct, incompetency, or negligence? ..... ☐ 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 an alien admitted for permanent residence in the U.S.? ..... ☑ Yes ☐ No

DO NOT WRITE IN THIS BOX
FOR OFFICIAL USE ONLY

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

Signature _____ Daytime phone (718) 268-8382 Date 9/30/06

CP21R 110705

REGISTRATION RENEWAL DOCUMENT

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

08/01/08
LIC: 124783
NME: GUA3
YR: 09
OFF: 1
EIN:

GUARNACCIA GARY J
SUITE 200
112-03 QUEENS BLVD
FOREST HILLS NY 11375-0000

PIN: QX36778

PROFESSION: 60 MEDICINE
PERIOD: 01/01/09 - 12/31/10

Cat 21-080406

Address change
Complete only if change has occurred

Street

City

State/Zip

$ 600
AMOUNT DUE

Complete and sign reverse side of this application

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? ..... ☐ Yes ☑ No
   b. Has any licensing or disciplinary authority revoked, annulled, cancelled, accepted surrender of, suspended, placed on probation, or refused to issue or renew a professional license or certificate held by you now or previously, or fined, censured, reprimanded or otherwise disciplined you? ..... ☐ Yes ☑ No
   c. Are criminal charges pending against you in any court? ..... ☐ Yes ☑ No
   d. Are charges pending against you in any jurisdiction for any sort of professional misconduct? ..... ☐ Yes ☑ No
   e. Has any hospital or licensed facility restricted or terminated your professional training, employment, or privileges, or have you voluntarily or involuntarily resigned or withdrawn from such association to avoid the imposition of such action due to professional misconduct, unprofessional conduct, incompetency, or negligence? ..... ☐ 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? ..... N/A ☐ Yes ☐ No

4. Are you a U.S. citizen or an alien admitted for permanent residence in the U.S.? ..... ☑ Yes ☐ No

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875 12012008

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 _____ Daytime phone (718) 460-8383 Date 11/12/2008

CW21B.110705

OFFICE OF THE PROFESSIONS
NEW YORK STATE EDUCATION DEPARTMENT

Registration Renewal - Transaction Summary

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

License Number : 124783
Profession : MEDICINE
Renewal Period : 01/01/2011 through 12/31/2012

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

GUARNACCIA GARY J
SUITE 200
112-03 QUEENS BLVD
FOREST HILLS NY 11375 - 0000

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

Offices Selected for Renewal:

	Address	Fee
1)	SUITE 200, 112-03 QUEENS BLVD, FOREST HILLS, NY, 11375,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?	No
2) Has any licensing or disciplinary authority revoked, annulled, cancelled, accepted surrender of, suspended, placed on probation, or refused to issue or renew a professional license or certificate held by you now or previously, or fined, censured, reprimanded or otherwise disciplined you?	No
3) Are criminal charges pending against you in any court?	No
4) Are charges pending against you in any jurisdiction for any sort of professional misconduct?	No
5) Has any hospital or licensed facility restricted or terminated your professional training, employment, or privileges, or have you voluntarily or involuntarily resigned or withdrawn from such association to avoid the imposition of such action due to professional misconduct, unprofessional conduct, incompetency, or negligence?	No
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 : VUJN5FC5F5D2
Payment Date : 10/25/2010
Amount Paid : $ 600