Medicine Form 1

The University of the State of New York
THE STATE EDUCATION DEPARTMENT
Office of the Professions
Division of Professional Licensing Services
89 Washington Avenue
Albany, NY 12234-1000
www.op.nysed.gov

MIM

Application for Licensure and First Registration

2/2 Photocopy of

Applicants Must Complete All Six Pages Of This Application ***In Ink***

DBOK 1-9-12 MIM

Department Use Only

RECEIVED
PROFESSIONAL LICENSING
2011 NOV 28 P 1:00

11/29

☐ 60 | $735 | ER

NYS License Number 263943

Date Issued 1/10/12

Initials

1 **Social Security Number**
(Leave this blank if you do not have a U.S. Social Security Number) [redacted]

2 **Birth Date** Month 09 Day 19 Year 79

3 **Print Name Exactly As You Wish It To Appear On Your License**

Last LUK
First JANELLE
Middle

4 **Mailing Address** (You must notify the Department promptly of any address or name changes.)

Apt./Bldg.
Street 578 MAIN STREET
City WEST HAVEN
State CT Zip Code 06516
Province/Country If not U.S.

5 **Telephone/E-Mail Address**

Daytime Phone 2036062689
Area Code Phone Number

E-Mail Address (Please print clearly)
JANELLE.LUK@GMAIL.COM

6 Name as it appears on degree or other credentials (if different from above): _____

7 Citizenship: ☒ United States ☐ Alien lawfully admitted for a permanent residence in the United States ☐ Other Immigration
Citizen of: _____
Attach a photocopy of the front and back of your Alien Registration Card

8 I wish to become licensed on the basis of:
☒ Acceptable examination scores *(see page 3 of this form)* ☐ Endorsement of another license
(See "Applicants Licensed in Another State" section of instructions.)
I am using FCVS to collect my credentials: ☐ YES ☒ NO

9	Have you previously applied for a New York State License or a limited permit to practice medicine?	☐ YES ☑ NO
10	Have you ever been found guilty after trial, or pleaded guilty, no contest, or nolo contendere to a crime (felony or misdemeanor) in any court?	☑ NO
11	Are criminal charges pending against you in any court?	☑ NO
12	Has any licensing or disciplinary authority refused to issue you a license or ever revoked, annulled, cancelled, accepted surrender of, suspended, placed on probation, refused to renew a professional license or certificate held by you now or previously, or ever fined, censured, reprimanded or otherwise disciplined you?	☑ NO
13	Are charges pending against you in any jurisdiction for any sort of professional misconduct?	☑ NO
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?	☑ NO

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

fee

FORM 2
MEDICINE

The University of the State of New York
THE STATE EDUCATION DEPARTMENT
Office of the Professions
Division of Professional Licensing Services
89 Washington Avenue
Albany, NY 12234-1000

Mg 12/6/11

RECEIVED
PROFESSIONAL LICENSING
2011 DEC 2 P 1:00

CERTIFICATION OF PROFESSIONAL AND PREPROFESSIONAL EDUCATION

APPLICANT INSTRUCTIONS

This form is for use by individuals whose application (Form 1 with fee or Form 5 with fee) is postmarked prior to December 1, 2002 and are not using FCVS. After December 1, 2002, you may only use this form if you completed a New York State Licensure Qualifying or LCME or AOA accredited program.

1. Complete Section I. Enter your name as it appears on your New York State Licensure Application (Form 1) or Limited Permit Application (Form 5B). Be sure to sign and date item 10.
2. Send this form to the professional school you attended to complete Section II. Be sure to include any fee required. If you graduated from a medical school that was not registered by New York State or accredited by LCME/AOA, notify the school that a transcript must accompany this form. **International Medical Graduates may not use this form if Form 1 and fee are submitted after November 30, 2002.**
3. If you attended a medical school that has been closed, send this form to the official repository of the records for that school (e.g., SEESCYT).
4. This form must be signed by the Registrar, Dean, Rector, or Principal of the medical school and sent back directly to the Office of the Professions by that school official in an official school envelope to the address at the end of this form. Forms sent back by the applicant or other parties will not be accepted.

SECTION I: APPLICANT INFORMATION

1 SOCIAL SECURITY NUMBER [redacted]
(Leave this blank if you have no U.S. Social Security Number)

2 BIRTH DATE 09 / 19 / 79
Month Day Year

3 PRINT FULL NAME EXACTLY AS IT APPEARS ON YOUR LICENSURE APPLICATION (FORM 1) OR LIMITED PERMIT APPLICATION (FORM 5B)

Last LUK
First JANELLE
Middle

4 MAILING ADDRESS:

Apt./Bldg.
Street 578 MAIN STREET
City WEST HAVEN
State CT Zip Code 06516
Province/Country If not U.S.

5 TELEPHONE/E-MAIL

HOME 203-606-2689
Area Code Number

WORK 203-785-4706
Area Code Number

JANELLE.LUK@GMAIL.COM
E-Mail Address

6 Print name under which your degree or diploma was awarded *(if different from above)*: JANELLE LUK

7 Preprofessional School Attended: CORNELL UNIVERSITY

8 Professional School Attended: YALE UNIVERSITY SCHOOL OF MEDICINE
Address: 367 CEDAR STREET, NEW HAVEN, CT 06510

9 Name of Degree/Diploma: DOCTOR OF MEDICINE Date awarded: JUNE, 2005

10 I request and give my permission to the school listed in item 8 above to complete Section II of this form and mail it to the New York State Education Department at the address at the end of this form, and to release any other information requested by the State Education Department in connection with my application for licensure.

Applicant's signature: [redacted] Date: 11 / 14 / 11

CERTIFICATION BY PROFESSIONAL SCHOOL OFFICIAL IS TO BE MADE ON NEXT PAGE

FORM 2PGT
MEDICINE

The University of the State of New York
THE STATE EDUCATION DEPARTMENT
Office of the Professions
Division of Professional Licensing Services
89 Washington Avenue
Albany, NY 12234-1000

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2011 NOV 28 P 1:00

Certification of completion of approved postgraduate training will be accepted only if it is signed and dated no more than one month prior to the completion date of the training period in which credit is sought.

11/29/11

CERTIFICATION OF APPROVED POSTGRADUATE TRAINING

(To be used only by applicants not using FCVS who need to verify approved postgraduate training programs in the US and Canada)

APPLICANT INSTRUCTIONS

1. Complete Section I. Enter your name as it appears on your Licensure Application (Form 1). Be sure to sign and date item 7.
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. If you have completed more than one residency, you may photocopy this form.
3. This form must be sent directly to the Department 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 Chair. If the Department cannot determine that this verification came directly from the hospital, the postgraduate hospital training will not be credited.

SECTION I: APPLICANT INFORMATION

1 SOCIAL SECURITY NUMBER: [redacted]
(Leave this blank if you do not have a U.S. Social Security Number)

2 BIRTH DATE: 09 / 19 / 79
Month Day Year

11/29/11

3 PRINT FULL NAME EXACTLY AS IT APPEARS ON YOUR APPLICATION (FORM 1):

Last: LUK
First: JANELLE
Middle:

4 MAILING ADDRESS:

Apt./Bldg.:
Street: 578 MAIN STREET
City: WEST HAVEN
State: CT Zip Code: 06516
Province/Country If not U.S.:

5 Print name under which postgraduate training was completed: BRIGHAM AND WOMEN'S HOSPITAL/MASSACHUSETTS GENERAL HOSPITAL INTEGRATED RESIDENCY PROGRAM IN OBSTETRICS AND GYNECOLOGY

6 Hospital in which postgraduate training was completed: BRIGHAM AND WOMEN'S HOSPITAL

Address: 75 FRANCIS STREET, BOSTON MA 02115

7 I request and give my permission to the hospital listed in item 6 above to complete Section II of this form and mail it to the New York State Education Department at the address at the end of this form, and to release any other information requested by the State Education Department in connection with my application for licensure.

Applicant's signature: [redacted] Date: 11 / 21 / 11

15 In the spaces below, give an accurate record of your educational preparation. **Be sure to complete items A-E for each school.** Please print. List diploma or degree titles in original language and translate. If no diploma or degree, indicate number of credits earned. Attach additional sheets if necessary.

A. NAME OF SCHOOLS ATTENDED AND LOCATIONS	B. NUMBER OF YEARS ATTENDED	C. ATTENDANCE		D. TITLE OF DIPLOMA OR DEGREE OBTAINED (INDICATE YEAR OBTAINED)	E. IF NO DIPLOMA OR DEGREE, INDICATE NUMBER OF CREDITS EARNED
		Entrance Date	Leaving Date		
High School or Secondary School WEST ORANGE HIGH SCHOOL (School Name) WEST ORANGE (City) NEW JERSEY (State/Country)	2	8 (mo) 1995 (yr)	6 (mo) 1997 (yr)	HIGH SCHOOL DIPLOMA	
Postsecondary Preprofessional School(s) (Exclusive of Medical School) RUTGERS UNIVERSITY (School Name) NEW BRUNSWICK (City) NEW JERSEY (State/Country)	2	8 (mo) 1997 (yr)	7 (mo) 1999 (yr)		126 credits
CORNELL UNIVERSITY (School Name) ITHACA (City) NEW YORK (State/Country)	2	8 (mo) 1999 (yr)	6 (mo) 2001 (yr)	BACHELOR OF SCIENCE	
Medical Education (Professional, list all medical schools attended) YALE UNIVERSITY SCHOOL OF MEDICINE (School Name) NEW HAVEN (City) CONNECTICUT (State/Country)	4	8 (mo) 2001 (yr)	6 (mo) 2005 (yr)	DOCTOR OF MEDICINE	
(School Name) (City) (State/Country)		___/___ (mo/yr)	___/___ (mo/yr)		

If you completed clinical clerkships in a country other than where your medical school is located, give the dates and location of these clerkships. Attach additional sheets if necessary.

Inclusive Clerkship Dates	Clinical Area	Name of Health Care Facility And Address	Medical School with which Clerkship Affiliated and Address

16 Are you licensed or have you ever been licensed as a physician in any other state or country? Yes ☑ No ☐

If **yes**, list each jurisdiction. If appropriate, you must also submit a Form 3A or 3B. See pages 14 - 15.

State or Country	Date License Issued	Number	Basis of Licensure			Any Limitations on License
			Examination (Date passed)	Endorsement	Other	
MA	6/30/2005	225606 COSTON LP				
CT	7/1/2009	047487	USMLE 7/20/2007			NONE

17 **Complete this section only if you are a graduate of a program not registered by New York State or LCME or AOA accredited.** N/A

Have you completed all portions of the examination requirements for ECFMG certification? ☐ Yes ☐ No

Do you currently hold a valid ECFMG certificate? ☐ Yes ☐ No

Please complete and forward the ECFMG form.

18 Are you applying for licensure on the basis of a Fifth Pathway program? ☐ Yes ☒ No

If Yes, list name and location of medical school or hospital and the inclusive dates of attendance.

Name and Location of Medical School or Hospital	Inclusive Dates of Attendance

19 List in English, all specialty qualifications you have earned. (i.e., Board Specialty Certification or Diplomate Certificate)

Name of Qualifications	Name and location of organization issuing credential

20

☐ I will be applying for USMLE Step 3

OR

☒ I have successfully completed the examination combination indicated below:

EXAMINATION COMBINATIONS

- ☒ USMLE Steps 1, 2, and 3
- ☐ FLEX Parts I, II, and III
- ☐ FLEX Components I and II
- ☐ NBME Parts I, II, and III
- ☐ NBME Parts I and II and USMLE Step 3
- ☐ NBME Part I, USMLE Step 2 and NBME Part III
- ☐ NBME Part I, and USMLE Steps 2 and 3
- ☐ USMLE Step 1, and NBME Parts II and III
- ☐ USMLE Step 1, NBME Part II, and USMLE Step 3
- ☐ USMLE Steps 1 and 2 and NBME Part III
- ☐ USMLE Step 1, NBME Part II, and FLEX Component II
- ☐ NBME Part I, USMLE Step 2, and FLEX Component II
- ☐ USMLE Steps 1 and 2 and FLEX Component II
- ☐ NBME Parts I and II and FLEX Component II
- ☐ FLEX Component I and USMLE Step 3
- ☐ NBOME Parts I, II, and III
- ☐ Other: _____

Date examination sequence was completed STEP1 7/7/2003; STEP 2 12/9/04; CLINICAL SKILLS 10/21/04; STEP3: 7/20/2007

21 Provide a chronological list of all activities since graduation from medical school to the present. Include vacation periods and periods of employment. Attach additional sheets if necessary.

DATE (mm/dd/yy) From	DATE (mm/dd/yy) To	Type of Activity, Beginning with Date of Graduation from Medical School. Include Name and Address of Employers.
06/10/05	07/01/05	Summer vacation (APPROXIMATELY 1 MONTH)
07/01/05	06/24/09	INTERGRATED RESIDENCY PROGRAM IN OBSTETRICS & GYNECOLOGY AT BRIGHAM & WOMEN'S HOSPITAL, PARTNERS HEALTH CARE, 75 FRANCIS STREET BOSTON, MA 02115
06/24/09	07/01/09	1 WEEK VACATION
07/01/09	06/15/12	REPRODUCTIVE, ENDOCRINOLOGY & INFERTILITY FELLOWSHIP PROGRAM, YALE UNIVERSITY SCHOOL OF MEDICINE, 333 CEDAR STREET, NEW HAVEN, CT 06510

22 If you hold a New York State license in another profession, indicate the profession, your license number and date of licensure below. N/A

Profession	License Number	Date of Initial Licensure (mm/dd/yy)
		/ /
		/ /
		/ /
		/ /

23 **CHILD ABUSE IDENTIFICATION AND REPORTING: (check only one of the following.)**

- ☐ I graduated from a **medical school** in New York State after September 1, 1990.
- ☐ I completed the child abuse coursework and have enclosed a certificate of completion from an approved provider.
- ☐ I am filing for an exemption to the requirement and have enclosed the exemption form.
- ☒ I am going to take the Child Abuse Identification course and submit the required form.

24

GENDER AND ETHNICITY: (This item is optional.)

Information on gender and ethnicity is sought solely to allow the Education Department to collect and analyze data concerning diversity in the licensed professions. The ethnic and gender data you provide will be used only for statistical, research, and program evaluation purposes. It will not be released to the public. This information has absolutely no bearing on your qualification for licensure.

GENDER: ☐ Male ☒ Female

ETHNICITY: ☐ White (not Hispanic) ☐ Black (not Hispanic) ☒ Asian ☐ Hispanic ☐ Native American

25

STUDENT LOAN DISCLOSURE:

The State Education Department is required* to ask these questions about any student loans made or guaranteed by the New York State Higher Education Services Corporation, and to forward any "yes" responses to the New York State Higher Education Services Corporation. **Your license application is not complete without this information.**

(a) Do you have any outstanding loans made or guaranteed by the New York State Higher Education Services Corporation? ☐ Yes ☒ No

(b) If you have such a loan(s), is any part in default? ☐ Yes ☒ No

*New York State Education Law, section 6501-a

26

CHILD SUPPORT OBLIGATION:

Everyone applying for a professional license, permit, or registration, or any renewal thereof, must file a written statement that, as of the date of the filing, she or he is, or is not, under an obligation to pay child support*. **Individuals who are four months or more in arrears in child support or who have failed to comply with a summons, subpoena or warrant relating to a paternity or child support proceeding may be subject to suspension of their business, professional, drivers and/or recreational licenses and permits.** The intentional submission of false written statements for the purpose of frustrating or defeating the lawful enforcement of sup-port obligations is punishable under section 175.35 of the Penal Law.

You must complete this section before we can issue the credential for which you have applied. Individuals who are not in compliance with their obligation to pay child support can be issued a credential for no more than six months in order to comply with their child support obligations.

Check only A or B below. If you check B, you must check one of the five statements listed below it.

A ☒ **I am not** under an obligation to pay child support;

OR

B ☐ I **am** under an obligation to pay child support *and* (please check only one of the following)

- ☐ I am current and **am not** four months or more in arrears in the payment of child support; or,
- ☐ I am making payments by income execution or by court agreed payment plan or by a plan agreed to by the parties; or,
- ☐ The child support obligation is the subject of a pending court proceeding; or,
- ☐ I am receiving public assistance or supplemental security income; or,
- ☐ None of the above four statements apply.

*New York State General Obligations Law, section 3-503

27 EDUCATION PROGRAM REVIEW

I give permission to the New York State Education Department to release my examination results to my professional school for the confidential purposes of program review and institution research and planning. I may rescind this authority at any time by notifying the Division of Professional Licensing Services in writing.

☐ Yes

☒ No

Please initial: _____

28 AFFIDAVIT WITH ACKNOWLEDGMENT (Notarization required.)

APPLICANT

I declare and affirm that the statements made in this application, including accompanying documents, 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 and may result in criminal prosecution.

Signature of the applicant: _____

Date: 11 (Month) / 14 (Day) / 2011 (Year)

NOTARY

State of Ct. County of New Haven

On the 14 day of November in the year 2011 before me, the undersigned, personally appeared Janelle Lut., personally known to me or proved to me on the basis of satisfactory evidence to be the individual whose name is subscribed to this application and acknowledged to me that he/she executed the application and swore that the statements made by him/her in the application and all supporting materials are true, complete, and correct.

Notary Public signature _____ Robert Sacco

Notary ID number 71819

Expiration date: 1 (Month) / 31 (Day) / 2016 (Year)

ROBERT A. SACCO
NOTARY PUBLIC
MY COMMISSION EXPIRES 1/31/16
ACCOUNT #71819

Mail this form and appropriate fee to: New York State Education Department, Office of the Professions, PO Box 22063, Albany, NY 12201. DO NOT SEND CASH. Make check or money order payable to the New York State Education Department.

089-8-5754

Wild Iris
MEDICAL EDUCATION, INC.

OFFICIAL CERTIFICATE OF COMPLETION

Janelle Luk

CT MEDICINE License 047487

Passed the Post-Test and Earned this Certificate for

New York State: Child Abuse and Neglect

3 Contact Hours

WRITTEN BY
Nancy Evans, BS

Ann Johnson, R.N.
Chief Executive Officer
Wild Iris Medical Education, Inc.

DATE

December 21, 2011

This course is approved by the New York State Education Department (provider ID #80607) and meets the requirement for mandated reporters of child abuse in the state of New York.

Wild Iris Medical Education is approved as a provider by the New York State Department of Education Professional Education Program. New York State Education Department, 89 Washington Ave. 2nd Floor, Office of Professions, Division of Professional Licensing Services, Albany, NY, 12234

Certificate ID: WIME OCjR8rol6I2w8ll5pu34

WILD IRIS MEDICAL EDUCATION, INC. - PO BOX 257 - COMPTCHE, CA 95427 (707-937-0518)
http://www.wildirismedical.com | contact@wildirismedicaleducation.com
WildIrisMedical.com is a division of Wild Iris Medical Education, Inc.

Luk

SECTION II : CERTIFICATION OF PROFESSIONAL EDUCATION

INSTRUCTION TO SCHOOL: Please complete this section, sign certifying statement, attach the information required in Item 5 and send directly to the Office of the Professions at the address shown below. **This form will not be accepted if returned by the applicant or any other party.**

1 ***For Applicants from N.Y.S. Registered or LCME/AOA Accredited Medical Schools:***

Applicant met LCME/AOA requirements for admission to medical/osteopathic school? ☑ **YES** ☐ **NO**

If No, number of preprofessional postsecondary credit hours completed by applicant prior to admission to medical school _____ semester hours or _____ quarter hours

2 Did the applicant receive advanced standing based on prior academic work? ☐ **YES** ☑ **NO**

If Yes, indicate when the prior work was completed below and submit **an official transcript of studies at your institution**, and copies of documentation in your file to support the granting of transfer credit.

Name of Institution: _____ Dates of attendance: _____ to _____

3 Applicant's Entrance date: 08 / 28 / 2001 Completion Date: 05 / 20 / 2005

4 Degree/diploma conferred: Doctor of Medicine Date of conferral: 05 / 23 / 2005

5 ***For All Other Applicants:***

Years of education required for admission into your medical school: _____

Preprofessional credential/degree submitted by applicant for admission into your medical school: _____

Was Social Service required? ☐ **YES** ☐ **NO** If Yes, give inclusive dates and name of institution in which requirement was met.

Institution: _____ Dates: _____ to _____

Was a pre-graduation internship required? ☐ **YES** ☐ **NO** If Yes, give inclusive dates and name of institution in which requirement was met.

Institution: _____ Dates: _____ to _____

Submit with this form:

A. An official transcript (course record, index, or marksheets) showing courses taken at your institution and accepted from other institutions for transfer of credit or convalidation.
The transcript must bear the original signature of the registrar, dean, principal or rector and original seal of the school.

B. A copy of documentation from your files to support the granting of transfer credit or convalidated course and clerkships.

C. List of clinical clerkship completed outside jurisdiction where medical school is located, including (for each): area or specialty, starting and ending dates of clerkship, and name and address of hospital where clerkship was performed.

FOR ATTENDEES OF CIFAS, CETEC, AND UTESA, this list must include all clerkships completed, both inside and outside the jurisdiction where the medical school is/was located.

I certify that to the best of my knowledge and belief the foregoing is a true statement of the record of the individual named on this form.

Signature: [redacted] *Date:* 11 / 28 / 2011

Type or print name: Terri Tolson

Title: Registrar

Medical school: Yale University School of Medicine

Address: 367 Cedar Street
New Haven, CT 06510

Telephone: 203.785.2644 *Fax* 203.737.5495

E-mail address: terri.tolson@yale.edu

(SEAL)

CERTIFICATION IS NOT ACCEPTABLE UNLESS DATED AFTER GRADUATION.

Return this form Directly to: → New York State Education Department, Office of the Professions, Division of Professional Licensing Services, Medicine Licensing Unit, 89 Washington Avenue, Albany, NY 12234-1000.

SECTION II : CERTIFICATION OF POSTGRADUATE TRAINING

INSTRUCTION TO HOSPITAL: Please complete this section, sign certifying statement, and return the form ***directly*** to the Division of Professional Licensing Services at the address shown below. **This form will not be accepted if returned by the applicant.**

This is to certify that JANELLE LUK
(Physician's name)

a graduate of YALE UNIVERSITY SCHOOL OF MEDICINE
(Medical school)

was enrolled in a postgraduate training program(s) approved by the Accreditation Council on Graduate Medical Education, the American Osteopathic Association, or Royal College of Physicians and Surgeons of Canada at BRIGHAM & WOMEN'S HOSPITAL, 75 FRANCIS ST., BOSTON, MA 02115
(Name and location of Hospital) *(ACGME number)*

Level of Training (example: PGY-1)	Clinical Area	Inclusive dates (mm/dd/yy)	Successfully completed
PGY-1	OBGYN	6/20/05 to 6/30/06	☒ YES ☐ NO ☐ In progress; satisfactory to date
PGY-2	OBGYN	7/01/06 to 6/30/07	☒ YES ☐ NO ☐ In progress; satisfactory to date
PGY-3	OBGYN	7/01/07 to 6/30/08	☒ YES ☐ NO ☐ In progress; satisfactory to date
PGY-4	OBGYN	8/30/08 to 6/30/09	☒ YES ☐ NO ☐ In progress; satisfactory to date
		___/___/___ to ___/___/___	☐ YES ☐ NO ☐ In progress; satisfactory to date

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

☐ Explanation is attached

I am the director of medical education or department chair of the clinical area. I was the program director for the physician named above during the postgraduate training indicated and have carefully read all statements on this form and hereby attest that the statements made herein are strictly true in every respect and are supported by [redacted]

Signature of Director/Chair: [redacted] Date: 11/23/2011

Type or print name of Director/Chair: ROBERT L. BARBIERI, M.D.

Title or official position: CHAIR OB/GYN

Institution: BRIGHAM & WOMEN'S HOSPITAL

Address: 75 FRANCIS ST., BOSTON, MA 02115

(SEAL)

Telephone: 617.732-4265 Fax: 617.277-1440

E-mail Address:

Return this form directly to: → New York State Education Department, Office of the Professions, Division of Professional Licensing Services, Medicine Licensing Unit, 89 Washington Avenue, Albany, NY 12234-1000