



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	
PENNSYLVANIA	5/1989	043742E	1986			NONE
MASSACHUSETTS	1986	59126	1986			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.  
 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
BOARD CERTIFICATION OB/GYN	AMERICAN BOARD OF OB/GYN
BOARD CERTIFICATION, MATERNAL FETAL MEDICINE	AMERICAN BOARD OF OB/GYN

20  I will be applying for USMLE Step 3  
 OR  
 I have successfully completed the examination combination indicated below:

**EXAMINATION COMBINATIONS**

<input type="checkbox"/> USMLE Steps 1, 2, and 3	<input type="checkbox"/> USMLE Step 1, NBME Part II, and USMLE Step 3
<input type="checkbox"/> FLEX Parts I, II, and III	<input type="checkbox"/> USMLE Steps 1 and 2 and NBME Part III
<input type="checkbox"/> FLEX Components I and II	<input type="checkbox"/> USMLE Step 1, NBME Part II, and FLEX Component II
<input checked="" type="checkbox"/> NBME Parts I, II, and III	<input type="checkbox"/> NBME Part I, USMLE Step 2, and FLEX Component II
<input type="checkbox"/> NBME Parts I and II and USMLE Step 3	<input type="checkbox"/> USMLE Steps 1 and 2 and FLEX Component II
<input type="checkbox"/> NBME Part I, USMLE Step 2 and NBME Part III	<input type="checkbox"/> NBME Parts I and II and FLEX Component II
<input type="checkbox"/> NBME Part I, and USMLE Steps 2 and 3	<input type="checkbox"/> FLEX Component I and USMLE Step 3
<input type="checkbox"/> USMLE Step 1, and NBME Parts II and III	<input type="checkbox"/> NBOME Parts I, II, and III
	<input type="checkbox"/> Other: _____

Date examination sequence was completed \_\_\_\_\_

27 EDUCATION 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: CEA

28 PHOTOGRAPH REQUIREMENT:



Date of photo: 8/7/08

29 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: [Redacted Signature]

NOTARY

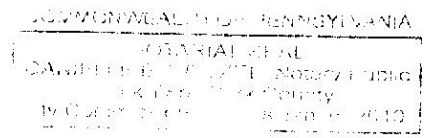
State of NY County of Albany

On the 7 day of August in the year 2008 before me, the undersigned, personally appeared [Redacted Name], 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 [Redacted Signature]

Notary ID number \_\_\_\_\_

Expiration date 12 / 31 / 2010  
Month Day Year



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.



OFFICE  
OF THE  
PROFESSIONS

## Registration Renewal - Transaction Summary

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

[Main Page](#) | [Logout](#)

License Number : 250943  
Profession : MEDICINE  
Renewal Period : 10/01/2010 through 09/30/2011

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

HELLER KIMBERLY ANN  
~~45 READE PLACE~~  
POUGHKEEPSIE NY 12604-0000

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

**Offices Selected for Renewal:**

	Address	Fee
1)	<del>45 READE PLACE</del> POUGHKEEPSIE, NY <del>12604-0000</del>	\$ 315

**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 : VTHN5C99D736  
Payment Date : 07/07/2010  
Amount Paid : \$ 315



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

## Registration Renewal - Transaction Summary

[Main Page](#) | [Logout](#)

License Number : 250943  
 Profession : MEDICINE  
 Renewal Period : 10/01/2011 through 09/30/2013

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

HELLER KIMBERLY ANN  
~~45 READE PLACE~~  
 POUGHKEEPSIE NY 12601-0000

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

**Offices Selected for Renewal:**

	Address	Fee
1)	<del>45 READE PLACE</del> POUGHKEEPSIE, NY, 12601, 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?	<del>No</del>
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?	<del>No</del>
3) Are criminal charges pending against you in any court?	<del>No</del>
4) Are charges pending against you in any jurisdiction for any sort of professional misconduct?	<del>No</del>
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?	<del>No</del>
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 : 3779478750  
 Payment Date : 08/04/2011  
 Amount Paid : \$ 600

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**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

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**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

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**CHILD SUPPORT OBLIGATION:**

Everyone applying for or renewing a professional license, permit, or registration must file a written statement that, as of the date of the filing, he or she is, or is not, under an obligation to pay child support\*. **Individuals who are four months or more in arrears in child support may be subject to suspension of their business, professional and/or driver's licenses.** The intentional submission of false written statements for the purpose of frustrating or defeating the lawful enforcement of support 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

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)		Type of Activity, Beginning with Date of Graduation from Medical School. Include Name and Address of Employers.			
From	To				
4/85	6/89	RESIDENCY OB/GYN		BOSTON CITY HOSPITAL BOSTON, MA	
7/89	6/91	FELLOWSHIP		MATERNAL FETAL MEDICINE MAGEE WOMENS HOSP PITTSBURGH PA	
7/91	8/91	VACATION			
8/91	9/96	ATTENDING PHYSICIAN ASST PROFESSOR		MAGEE WOMENS HOSPITAL UNIV. OF PITTSBURGH PITTSBURGH PA	
9/96	PRESENT	ATTENDING PHYSICIAN WELSPAN HEALTH		MATERNAL FETAL MEDICINE YORK PA.	

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

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

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**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.

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 School Name <u>FOREST HIGH SCHOOL</u> City <u>Ocala</u> State/Country <u>FL USA</u>	3	<u>7</u> / <u>68</u> mo/yr	<u>6</u> / <u>71</u> mo/yr	HIGH SCHOOL DIPLOMA	
Postsecondary Preprofessional School(s) (Exclusive of Medical School) School Name <u>MASSACHUSETTS GENERAL HOSPITAL SCHOOL OF NURSING</u> City <u>BOSTON</u> State/Country <u>MA USA</u>	3	<u>7</u> / <u>74</u> mo/yr	<u>6</u> / <u>77</u> mo/yr	DIPLOMA	
School Name <u>EMMANUEL COLLEGE</u> City <u>BOSTON</u> State/Country <u>MA USA</u>	3	<u>9</u> / <u>79</u> mo/yr	<u>7</u> / <u>81</u> mo/yr	BACHELOR OF SCIENCE	
Medical Education (Professional, list all medical schools attended) School Name <u>UNIVERSITY OF MASSACHUSETTS SCHOOL OF MEDICINE</u> City <u>WORCESTER</u> State/Country <u>MA USA</u>	4	<u>7</u> / <u>81</u> mo/yr	<u>6</u> / <u>85</u> mo/yr	DOCTOR OF MEDICINE	
City _____ State/Country _____		<u>   </u> / <u>   </u> mo/yr	<u>   </u> / <u>   </u> 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