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

Department Use Only

☐ 60 | $735 | ER

Application for Licensure and First Registration

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

NYS License Number 250943

Date Issued 10/31/03

Initials

1 Social Security Number
(Leave this blank if you do not have a U.S. Social Security Number) 264061680

2 Birth Date Month 10 Day 14 Year 53

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

Last KELLER

First KIMBERLY

Middle ANN

5 Telephone/E-Mail Address

Daytime Phone 717 851 2722
Area Code Phone Number

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

Apt./Bldg.

Street 481 WEST MARKET ST

City YORK

State PA Zip Code 17401

Province/Country if not U.S.

E-Mail Address (Please print clearly)
KHELLER@WELLSPAN.ORG

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? [redacted] ☒ NO

11 Are criminal charges pending against you in any court? [redacted] ☒ 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? [redacted] ☒ NO

13 Are charges pending against you in any jurisdiction for any sort of professional misconduct? [redacted] ☒ 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? [redacted] ☒ NO

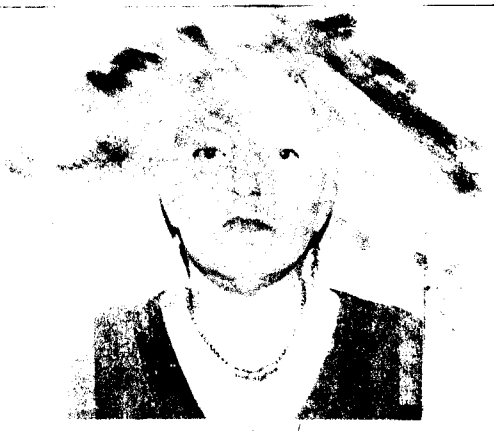
NOTE: If you answer "Yes" to any questions numbered 10-14, submit a letter giving complete explanation. Include copies of any court records, and if you possess one, a copy of the "Certificate of Relief from Disabilities" or your "Certificate of Good Conduct."

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: [redacted]

28 **PHOTOGRAPH REQUIREMENT:**



Date of photo: 6/7/03

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]

NOTARY

State of _____ County of _____

On the _____ day of _____ in the year _____ before me, the undersigned, personally appeared _____, 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 _____

Notary ID number _____

Expiration date _____ / _____ / _____
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.

OP OFFICE OF THE PROFESSIONS

Registration Renewal - Transaction Summary

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

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 12601 - 0000

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

Offices Selected for Renewal:

	Address	Fee
1)	45 READE PLACE, POUGHKEEPSIE, NY, 12601,US	$ 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

OFFICE OF THE PROFESSIONS

Registration Renewal - Transaction Summary

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

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)	45 READE PLACE, 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?	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	3779478750
Payment Date	08/04/2011
Amount Paid	$ 600

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

Department Use Only

☐ 60 | $735 | ER

Application for Licensure and First Registration

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

NYS License Number 250943

Date Issued 10/31/08

Initials

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

2 **Birth Date** Month [redacted] Day [redacted] Year [redacted]

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

Last HELLER

First KIMBERLY

Middle ANN

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

Apt./Bldg.

Street [redacted]

City YORK

State PA Zip Code [redacted]

Province/Country If not U.S.

5 **Telephone/E-Mail Address**

Daytime Phone [redacted]
Area Code Phone Number

E-Mail Address (Please print clearly) [redacted]

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? [redacted] NO

11 Are criminal charges pending against you in any court? [redacted] 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? [redacted] NO

13 Are charges pending against you in any jurisdiction for any sort of professional misconduct? [redacted] 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? [redacted] 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."

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	043142E	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

- ☐ 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 _____

OFFICE OF THE PROFESSIONS
89 Washington Avenue
Albany, NY 12234
518-474-3817

Registration Renewal - Transaction Summary

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 12601-0000

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

Offices Selected for Renewal:

	Address	Fee
1)	45 READE PLACE POUGHKEEPSIE, NY 12601-00	$ 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

OFFICE OF THE PROFESSIONS
89 Washington Avenue
Albany, NY 12234
518-474-3817

Registration Renewal - Transaction Summary

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)	45 READE PLACE 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?	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	:3779478750
Payment Date	:08/04/2011
Amount Paid	:$ 600

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 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) From	DATE (mm/dd/yy) To	Type of Activity, Beginning with Date of Graduation from Medical School. Include Name and Address of Employers.
7/85	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 SCHOOL OF MED PITTSBURGH PA
9/96	PRESENT	ATTENDING PHYSICIAN WELLSPAN HEALTH MATERNAL FETAL MEDICINE YORK PA.

22 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)
		/ /
		/ /
		/ /
		/ /

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.

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 FOREST HIGH SCHOOL School Name OCALA FL USA City State/Country	3	7 / 68 mo / yr	6 / 71 mo / yr	HIGH SCHOOL DIPLOMA	
Postsecondary Preprofessional School(s) (Exclusive of Medical School) MASSACHUSETTS GENERAL HOSPITAL SCHOOL OF NURSING School Name BOSTON MA USA City State/Country	3	7 / 74 mo / yr	6 / 77 mo / yr	DIPLOMA	
EMMANUEL COLLEGE School Name BOSTON MA USA City State/Country	3	9 / 78 mo / yr	7 / 81 mo / yr	BACHELOR OF SCIENCE	
Medical Education (Professional, list all medical schools attended) UNIVERSITY OF MASSACHUSETTS SCHOOL OF MEDICINE School Name WORCESTER MA USA City State/Country	4	7 / 81 mo / yr	6 / 85 mo / 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