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

NO FEE RECEIVED
MAY - 6 2003

☐ 60 | $735 | ER

Application for Licensure and First Registration

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

NYS License Number 229074

Date Issued 7-1-03

Initials Rea

1 **Social Security Number** *(Leave this blank if you do not have a U.S. Social Security Number)* 260 21 2391

2 **Birth Date** Month 02 Day 28 Year 63

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

Last Middleton
First Tamer
Middle Yvette

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

Apt./Bldg. Suite M348
Street [redacted] Station Main PO Box 11011
City Rochester
State NY Zip Code 14620 2782
Province/Country If not U.S.

5 **Telephone/E-Mail Address**

Daytime Phone [redacted]
Area Code Phone Number

E-Mail Address (Please print clearly)
tamermiddleton@mindspring.com

6 Name as it appears on degree or other credentials (if different from above): Same as 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?	☐ YES	☑ NO
11	Are criminal charges pending against you in any court?	☐ YES	☑ 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?	☐ YES	☑ NO
13	Are charges pending against you in any jurisdiction for any sort of professional misconduct?	☐ YES	☑ 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?	☐ YES	☑ 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."

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 Robert W. Groves High School School Name Garden City, GA City / State/Country	4	08 / 1977 mo / yr	06 / 1981 mo / yr	High School Diploma 1981	
Postsecondary Preprofessional School(s) (Exclusive of Medical School) Agnes Scott College School Name Decatur GA City / State/Country School Name City / State/Country	4	09 / 1981 mo / yr __ / __ mo / yr	05 / 1985 mo / yr __ / __ mo / yr	Bachelor's Chemistry 1981	
Medical Education (Professional, list all medical schools attended) Morehouse School of Medicine School Name Atlanta GA City / State/Country School Name City / State/Country	4	07 / 1996 mo / yr __ / __ mo / yr	05 / 2000 mo / yr __ / __ mo / yr	MD	

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
N/A			

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	
Alabama	09/2002	00024856	05/2002			NONE
Georgia	09/2002	051987	05/2002			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
N/A	

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 05/2002

21 Provide a chronological list of all activities since graduation from professional 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 Professional School. Include Name and Address of Employers.
07/2000	06/2001	Internship, Family Practice — Columbus Regional Medical Center 1900 10th Ave. Ste 100, Columbus, GA 31904
07/2001	Present	Residency, Family Practice — Columbus Regional Medical Center 1900 10th Ave Ste 100, Columbus, GA 31904

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)
		___/___/___
N/A		___/___/___
		___/___/___
		___/___/___

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.

(in process)

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

27 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: TJM

28 **PHOTOGRAPH REQUIREMENT:**

Date of photo: 2/27/03

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: Tamer J. Middleton

NOTARY

State of Georgia County of Muscogee

On the 28 day of March in the year 2003 before me, the undersigned, personally appeared Tamer Middleton, 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 Mary Alice Dowdell

Notary ID number _____

Expiration date MY COMMISSION EXPIRES AUGUST 26, 2004
Month Day Year

Mail this form and appropriate fee to: New York State Education Department, Office of the Professions, Fee Section, Division of Professional Licensing Services, 89 Washington Avenue, Albany, NY 12234-1000. DO NOT SEND CASH. Make check or money order payable to the New York State Education Department.

The University of the State of New York
THE STATE EDUCATION DEPARTMENT

946125

CERTIFICATION OF COMPLETION

(Coursework/Training in Identification and Reporting of Child Abuse and Maltreatment)

PART A — TRAINEE INFORMATION

1. Trainee must complete all items in Part A. Return to provider for completion of Part B, "Certification by Approved Provider".
2. The provider will return the Certification form, with Part B completed, to the trainee. It is the trainee's responsibility to submit the original copy of this Certification form to the New York State Education Department at the appropriate time. It should be submitted along with other relevant forms when the trainee applies initially for, or renews, a license, registration certificate, or permit.
3. Address for submitting form is as follows:
   - Professional License or Permit: New York State Education Department, **Division of Professional Licensing Services**, [give name of profession], Cultural Education Center, Albany, New York 12230.
   - Reregistering Licensees: Your certificate should be included with your reregistration application in the envelope provided with those materials.
   - Teacher Certification: New York State Education Department, **Office of Teaching**, Cultural Education Center, Albany, New York 12230.

1 Print name exactly as it currently appears on New York State Education Department records:

Last: MIDDLETON
First: TAMER
Middle: YVETTE

2 Print your address:

Care of:
Misc. (Bldg. & Apt., etc.):
Street: 3001 Presidential Dr
City: Columbus
State: GA Zip Code: 31904-

3 Date of Birth: 02/26/63 (Mo. Day Yr.)

4 Social Security number: [redacted]

5 Complete information below if you hold or are applying for, professional license(s) or a permit:

Name of Profession(s): Physician applying for NY license
N.Y.S License Number:
N.Y.S License Number:
Permit #:

6 Complete information below if you hold, or are applying for a teaching certificate:

Certificate Title(s):

N.Y.S. Certificate Number (other than Social Security Number, if any):

Trainee's Signature: ~~Tamer Y Middleton, MD~~ Date: 5/21/03

PART B — CERTIFICATION BY APPROVED PROVIDER

1. Provider must complete Part B.
2. The EDUCATION DEPARTMENT-ORIGINAL COPY and TRAINEE COPY should be returned to the trainee within ten calendar days of the completion of the coursework or training.
3. The provider of the coursework or training must retain the PROVIDER COPY. This copy must be retained in the provider's files for not less than five years from the date the course was completed.

Pursuant to Chapter 544 of the Laws of 1988, I certify that the person indicated in Part A has completed the required coursework or training regarding the identification and reporting of child abuse and maltreatment.

Joseph T. Gleason
Name of Authorized Certifying Officer (Print or Type)

Signature of Authorized Certifying Officer

NYSPCC
Approved Provider Name

80026
Identification Number

5/15/03
Date(s) of Coursework or Training

PR 2 (H) - 5/91

STATE EDUCATION DEPARTMENT COPY

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

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 [redacted]
Month Day Year

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

Last: Middleton
First: TAMER
Middle: Yvette

4 MAILING ADDRESS:

Apt./Bldg.: Suite #349 Box #101
Street: 1600 South Avenue
City: Rochester
State: NY Zip Code: 14620 2782
Province/Country If not U.S.:

5 TELEPHONE/E-MAIL

HOME: 706-321-9352
Area Code Number

WORK: 706-507-1000
Area Code Number

tamermiddleton@mindspring.com
E-Mail Address

6 Print name under which your degree or diploma was awarded *(if different from above)* Tamer Y. Middleton

7 Preprofessional School Attended: Agnes Scott College

8 Professional School Attended: Morehouse School of Medicine
Address: 720 Westview Drive Atlanta, GA 30310-1495

9 Name of Degree/Diploma: Bachelor's of Arts - Chemistry Date awarded: 6/02/85

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: Tamer Y. Middleton Date: 5/28/03

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: 8 / 6 / 96 Completion Date: 5 / 15 / 00

4 Degree/diploma conferred: M.D. Date of conferral: 5 / 15 / 00

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: 73911

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: _____ *Date:* ____ / ____ / ____

Type or print name: Angela L. Walker Franklin,Ph.D.

Title: Associate Dean for Student Affairs

(SEAL)

Medical school: Morehouse School of Medicine

Address: 720 Westview Dr. SW
Atlanta,GA 30310

Telephone: (404) 752-1658 *Fax* (404) 752-8686

E-mail address: _____

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.

Qw 6/28/03 – Pkt for Rec

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

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

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: [redacted]
Month Day Year

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

Last: Middleton
First: TAMER
Middle: Yvette

4 MAILING ADDRESS:
Apt./Bldg.: Suite N348 Box 1101
Street: 1001 South Avenue
City: Rochester
State: NY Zip Code: [redacted] 20 2282
Province/Country If not U.S.:

5 Print name under which postgraduate training was completed: Tamer Y. Middleton

6 Hospital in which postgraduate training was completed: ~~Grady Memor~~ The Medical Center / Columbus Regional
Address: 710 Center Street Columbus, GA 31902

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: Tamer Y Middleton Date: 5 / 29 / 03

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 TAMER Middleton
(Physician's name)

a graduate of Morehouse 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

The Medical Center, Columbus, Georgia
(Name and location of Hospital)

Level of Training (example: PGY-1)	Clinical Area	Inclusive dates (mm/dd/yy)	Successfully completed
PGY-1	Family Practice	6/21/00 to 6/30/01	☒ YES ☐ NO ☐ In progress; satisfactory to date
PGY-2	Family Practice	7/1/01 to 6/30/02	☒ YES ☐ NO ☐ In progress; satisfactory to date
PGY-3	Family Practice	7/1/02 to 6/27/03	☐ YES ☐ NO ☒ In progress; satisfactory to date
		___/___/___ to ___/___/___	☐ 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 and completed this form and hereby attest that the statements made herein are strictly true in every respect and are supported by hospital records.

Signature of Director/Chair: John R Bucholtz DO Date: 6/12/03

Type or print name of Director/Chair: John R. Bucholtz, D.O.

Title or official position: Program Director
Family Practice Residency Program
Transitional Year Program

Institution: The Medical Center (SEAL)

Address: 1960 10th Ave Suite 100
Columbus GA 31902

Telephone: 706.571.1430 Fax: 706.571.1604

E-mail Address: john.bucholtz@cvhs.net

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

US·MLE
United States
Medical
Licensing
Examination™

United States Medical Licensing Examination™ (USMLE™)
Certified Transcript of Scores

[redacted]

Reg 2PGT
6/25-03

This Transcript was prepared by the Federation of State Medical Boards

Date of Certification: 06/19/2003

MAILED DIRECTLY
FROM RESPECTIVE
INSTITUTION

New York State Board for Medicine
ATTN: Medical Processing Unit
Div of Professional Licensing Services
New York State Education Dept
89 Washington Ave
Albany, NY 12234-1000

Examinee: Middleton, Tamer
USMLE ID#: [redacted]
DOB: [redacted]
Alt Name(s): Middleton, Tamer Yvette

Results for all Steps taken by this examinee (and for which results have been reported to date) are shown below. For Steps that span more than one day, the test date reflects the day on which the examination began. Scores are reported on two scales. The recommended minimum passing score ("Passing") on each scale is shown in parentheses.

STEP1	Test Date	Pass/ Fail	Three-Digit Score	(Passing)	Two-Digit Score	(Passing)	Comments
	6/9/1998	PASS	187	(179)	[redacted]	(76)	

STEP2	Test Date	Pass/ Fail	Three-Digit Score	(Passing)	Two-Digit Score	(Passing)	Comments
	2/25/2000	[redacted]	[redacted]	[redacted]	[redacted]	[redacted]	

STEP3 State Board	Test Date	Pass/ Fail	Three-Digit Score	(Passing)	Two-Digit Score	(Passing)	Comments
GEORGIA	5/14/2002	PASS	190	(182)	78	(75)	

A search of the Board Action Data Bank of the Federation of State Medical Boards (FSMB) reveals no reported information on the above-named examinee.

Authenticity of USMLE Transcripts

An original, certified transcript of United States Medical Licensing Examination scores is printed using black ink on blue safety paper and is produced only by the Educational Commission for Foreign Medical Graduates, Federation of State Medical Boards, or National Board of Medical Examiners. The TamperSafe® Hologram in the lower left corner certifies the authenticity of this document. Alteration or forgery of a USMLE transcript may result in appropriate legal action and/or a determination of irregular behavior, as described below.

To Test for Authenticity: Touch, rub or breathe on TouchSafe® Fingerprint and the word **VALID** will appear. When liquid bleach is applied to the face of the document, the paper will turn brown. Also, when photocopied, a security statement containing the words **UNOFFICIAL COPY, NOT AN ORIGINAL DOCUMENT**, will appear prominently across the face of the entire document.

INTERPRETATION OF SCORES

USMLE transcripts include a complete score history and notations of any examinations for which the examinee sat and no scores were reported, such as "Incomplete" or "Indeterminate." Scores are reported on two different scales. For each Step, the mean and standard deviation of scores on the three-digit scale for the original anchor group of first-time examinees from medical schools in the United States was 200 and 20, respectively. Most scores fall between 140 and 280. An equivalent value score on a two-digit scale is also provided. A score of 75 on the two-digit scale is the recommended minimum passing score. The recommended minimum passing score on each scale is shown on the front of the transcript next to the examinee's score for each examination administration. The level of proficiency required to meet the recommended minimum passing level for each USMLE Step is reviewed periodically and is subject to change.

Factors which influence an examinee's score include the examinee's general understanding of the subject matter being tested and the specific set of test items used for an administration. The Standard Error of Measurement (SEM) provides an index of the variation in scores that would be expected to occur if an examinee were tested repeatedly using different sets of items covering similar content. The SEM for a USMLE score is usually in the range of 4 to 8 score points on the three-digit scale and 1 to 2 score points on the two-digit scale.

ANNOTATIONS APPEARING UNDER "COMMENTS"

Circumstances in connection with an administration shown on this transcript may result in one or more annotations listed next to the score. A description of each "Comment" is provided below:

Indeterminate - Results that cannot be certified as representing a valid measure of the examinee's knowledge or competence as sampled by the examination. Decisions to classify results as indeterminate may be made on the basis of factors that include, but are not limited to, unexplained inconsistency of performance within the examination or between administrations of the same Step. **No score is reported.** Information regarding the nature of the indeterminate score and the determination of the Committee on Score Validity is available. If such information is not enclosed with this transcript, it may be obtained by contacting the organization from which you received the transcript or the USMLE Secretariat, 3750 Market Street, Philadelphia, PA 19104, telephone (215) 590-9700.

Incomplete - The examinee sat for some, but not all, of the scheduled examination. **No score is reported.**

Irregular Behavior - The Committee on Irregular Behavior determined that the examinee engaged in irregular behavior. Examples of irregular behavior are described in the current edition of the *USMLE Bulletin of Information.* Information regarding the nature of the irregular behavior and the determination of the Committee is available. If such information is not enclosed with this transcript, it may be obtained by contacting the organization from which you received the transcript or the USMLE Secretariat, 3750 Market Street, Philadelphia, PA 19104, telephone (215) 590-9700.

Score Not Available - The score is not available. Further review and/or analysis may be pending, or it may have been determined that the score cannot be reported.

Test Accommodations - Following review and approval of a request from the examinee, test accommodations were provided in the administration of the examination.

ANNOTATIONS APPEARING AS "NOTE"

Circumstances not in connection with an administration shown on this transcript may result in one or more annotations and an explanation or instructions to contact the appropriate individual or organization. The "Note" will appear at the end of the document.

BOARD ACTION DATA BANK INFORMATION APPEARING AS "NOTE"

The Board Action Data Bank of the Federation of State Medical Boards (FSMB) contains actions reported to the FSMB by U.S. licensing and disciplinary boards, Canadian licensing authorities, the U.S. Armed Forces, the U.S. Department of Health and Human Services, and other credentialing entities. To be included in the Bank, an action must be a matter of public record or be legally releasable to state medical boards or other entities with recognized authority to review physician credentials. Certain actions reported to and released by the Board Action Data Bank are not disciplinary or otherwise prejudicial in nature. Such actions are reported to ensure that records are complete and to assist in preventing misrepresentation or the use of lost or stolen credentials by unauthorized persons. Once reported to the FSMB, an action becomes part of the permanent record of the individual physician, and the existence of such an action may be indicated on the USMLE transcript by a "Note".

6/17

THE UNIVERSITY OF THE STATE OF NEW YORK
THE STATE EDUCATION DEPARTMENT
DIVISION OF PROFESSIONAL LICENSING SERVICES
89 WASHINGTON AVENUE
ALBANY, NEW YORK 12234-1000

RECEIVED
PROFESSIONAL LICENSING
UNIT 2

WHEN RESPONDING, PLEASE INCLUDE NAME, ADDRESS, PROFESSION, SSN, AND A DAY PHONE#.
DATE: 05/14/03
PROFESSION: 60
ID NUMBER : 260212391

MIDDLETON TAMER YVETTE
SUITE N 348
BOX 101
1000 SOUTH AVE
ROCHESTER NY [redacted]

2-26-63

Dear Applicant:

As of this date, your application is incomplete. Please furnish the information indicated below:

Our records indicate that your application is incomplete because we have not received your Licensure fee of $ 735
No further action can be taken on your application until we have received this fee.

SINCERELY,

Mona Sutherland
(518)474-3817 ext. 260
Fax:(518)402-2323
E-Mail:OPUNIT2@MAIL.NYSED.GOV

60
MIDDLETON
735 ER

229074MID4004810060105

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

02/01/05
LIC: 229074
NME: MID4
YR: 05
OFF: 1
EIN:

MIDDLETON TAMER YVETTE
SUITE N 348
BOX 101
1000 SOUTH AVE
ROCHESTER NY 14620-2782

PROFESSION: 60 MEDICINE
PERIOD: 07/01/05 - 01/31/07

Cat 21P:032204

Complete and sign reverse side of this application

Name/address change
Complete only if change has occurred

Name

Street

City

State/Zip

$ 481
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 continuing to practice my profession constitutes professional misconduct.

Signature [signature] Daytime phone (585) 455-8169 Date 3-2-05

Cal21B.092904

229074MID400600060107

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

09/01/06
LIC: 229074
NME: MID4
YR: 07
OFF: 1
EIN:

MIDDLETON TAMER YVETTE
SUITE N 348
BOX 101
1000 SOUTH AVE
ROCHESTER NY [redacted]

PROFESSION: 60 MEDICINE
PERIOD: 02/01/07 - 01/31/09

Cat 21P:032204

Complete and sign reverse side of this application

Name/address change
Complete only if change has occurred

Name
PO Box 78142
Street
Atlanta
GA 30357
City
State/Zip

$ 600
AMOUNT DUE

1. Do you wish to register for the period indicated?	Yes	X 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 continuing to practice my profession constitutes professional misconduct.

Signature [signature] Daytime phone ( ) [redacted] Date 2/7/07

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

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 [redacted]
Month Day Year

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

Last: Middleton
First: Tamer
Middle: Yvette

4 MAILING ADDRESS

Apt./Bldg: Suite N349 Box 1011
Street: 1600 South Avenue
City: Rochester
State: NY
ZIP Code: 14626 2782
Province/Country if not U.S.:

5 TELEPHONE/E-MAIL

HOME: 706-321-9332
Area Code Number

WORK: 706-571-1000
Area Code Number

tamermiddleton@mindspring.com
E-Mail Address

6 Print name under which your degree or diploma was awarded *(if different from above)*: Tamer Y. Middleton

7 Preprofessional School Attended: Agnes Scott College

8 Professional School Attended: Morehouse School of Medicine
Address: 720 Westview Drive Atlanta GA 30310-1495

9 Name of Degree/Diploma: Bachelor's of Arts - Chemistry Date awarded: 6/02/85

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: Tamer Y. Middleton Date: 5 / 25 / 03

27 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: TJM

28 **PHOTOGRAPH REQUIREMENT:**

Date of photo: 5/2003

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: Tamara J. Mcclellan

NOTARY

State of Georgia County of Dougherty

On the 28 day of March in the year 2003 before me, the undersigned, personally appeared Tamara Mcclellan, 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 Mary Alice Darnell

Notary ID number _____

Expiration date MY COMMISSION EXPIRES AUGUST 26 2004
Month Day Year

Mail this form and appropriate fee to: New York State Education Department, Office of the Professions, Fee Section, Division of Professional Licensing Services, 89 Washington Avenue, Albany, NY 12234-1000. DO NOT SEND CASH. Make check or money order payable to the New York State Education Department.

The University of the State of New York
THE STATE EDUCATION DEPARTMENT

946125

CERTIFICATION OF COMPLETION

(Coursework/Training in Identification and Reporting of Child Abuse and Maltreatment)

PART A — TRAINEE INFORMATION

1. Trainee must complete all items in Part A. Return to provider for completion of Part B, "Certification by Approved Provider".
2. The provider will return the Certification form, with Part B completed, to the trainee. It is the trainee's responsibility to submit the original copy of this Certification form to the New York State Education Department at the appropriate time. It should be submitted along with other relevant forms when the trainee applies initially for, or renews, a license, registration certificate, or permit.
3. Address for submitting form is as follows:
   - Professional License or Permit: New York State Education Department, **Division of Professional Licensing Services**, [give name of profession], Cultural Education Center, Albany, New York 12230.
   - Reregistering Licensees: Your certificate should be included with your reregistration application in the envelope provided with those materials.
   - Teacher Certification: New York State Education Department, **Office of Teaching**, Cultural Education Center, Albany, New York 12230.

1 Print name exactly as it currently appears on New York State Education Department records:

Last: MIDDLETON
First: TAMER
Middle: YVETTE

2 Print your address.

Care of:
Mail (Bldg & Apt, etc.):
Street: 3001 Pierpoint AVE
City: Columbus
State: GA Zip Code: 31904-

3 Date of Birth: 02 26 63 (Mo. Day Yr.)

4 Social Security number: [redacted]

5 Complete information below if you hold or are applying for, professional license(s) or a permit:

Name of Profession(s): Physician applying for NY license
N.Y.S License Number:
N.Y.S License Number:
Permit #:

6 Complete information below if you hold, or are applying for a teaching certificate:

Certificate Title(s):

N.Y.S. Certificate Number (other than Social Security Number, if any):

Trainee's Signature: Tamer Y Middleton, MD Date: 5/21/03

PART B — CERTIFICATION BY APPROVED PROVIDER

1. Provider must complete Part B.
2. The EDUCATION DEPARTMENT-ORIGINAL COPY and TRAINEE COPY should be returned to the trainee within ten calendar days of the completion of the coursework or training.
3. The provider of the coursework or training must retain the PROVIDER COPY. This copy must be retained in the provider's files for not less than five years from the date the course was completed.

Pursuant to Chapter 544 of the Laws of 1988, I certify that the person indicated in Part A has completed the required coursework or training regarding the identification and reporting of child abuse and maltreatment.

Joseph T. Gleason
Name of Authorized Certifying Officer (Print or Type)

Joseph T. Gleason
Signature of Authorized Certifying Officer

NYSPCC
Approved Provider Name

80026
Identification Number

5/15/03
Date(s) of Coursework or Training

PR 2 (Ill) - 5/91

PROVIDER COPY

THE UNIVERSITY OF THE STATE OF NEW YORK
THE STATE EDUCATION DEPARTMENT
DIVISION OF PROFESSIONAL LICENSING SERVICES
89 WASHINGTON AVENUE
ALBANY, NEW YORK 12234-1000

WHEN RESPONDING, PLEASE INCLUDE NAME, ADDRESS, PROFESSION, SSN, AND A DAY PHONE#.
DATE: 05/14/03
PROFESSION: [illegible]
ID NUMBER : 260212391

[illegible] TAMER YVETTE
SUITE N 348
BOX 101
1000 SOUTH AVE
ROCHESTER NY 14620-2782

Dear Applicant:

As of this date, your application is incomplete. Please furnish the information indicated below:

Our records indicate that your application is incomplete because we have not received your Licensure fee of $ 735 No further action can be taken on your application until we have received this fee.

SINCERELY,

Mona Sutherland
(518)474-3817 ext. 250
Fax:(518)402-2323
E-Mail:OPUNIT2@MAIL.NYSED.GOV

Authenticity of USMLE Transcripts

An original, certified transcript of United States Medical Licensing Examination scores is printed using black ink on blue safety paper and is produced only by the Educational Commission for Foreign Medical Graduates, Federation of State Medical Boards, or National Board of Medical Examiners. The TamperSafe® Hologram in the lower left corner certifies the authenticity of this document. Alteration or forgery of a USMLE transcript may result in appropriate legal action and/or a determination of irregular behavior, as described below.

To Test for Authenticity: Touch, rub or breathe on TouchSafe® Fingerprint and the word **VALID** will appear. When liquid bleach is applied to the face of the document, the paper will turn brown. Also, when photocopied, a security statement containing the words **UNOFFICIAL COPY, NOT AN ORIGINAL DOCUMENT**, will appear prominently across the face of the entire document.

INTERPRETATION OF SCORES

USMLE transcripts include a complete score history and notations of any examinations for which the examinee sat and no scores were reported, such as "Incomplete" or "Indeterminate." Scores are reported on two different scales. For each Step, the mean and standard deviation of scores on the three-digit scale for the original anchor group of first time examinees from medical schools in the United States was 200 and 20, respectively. Most scores fall between 140 and 280. An equivalent value score on a two-digit scale is also provided. A score of 75 on the two-digit scale is the recommended minimum passing score. The recommended minimum passing score on each scale is shown on the front of the transcript next to the examinee's score for each examination administration. The level of proficiency required to meet the recommended minimum passing level for each USMLE Step is reviewed periodically and is subject to change.

Factors which influence an examinee's score include the examinee's general understanding of the subject matter being tested and the specific set of test items used for an administration. The Standard Error of Measurement (SEM) provides an index of the variation in scores that would be expected to occur if an examinee were tested repeatedly using different sets of items covering similar content. The SEM for a USMLE score is usually in the range of 4 to 8 score points on the three-digit scale and 1 to 2 score points on the two-digit scale.

ANNOTATIONS APPEARING UNDER "COMMENTS"

Circumstances in connection with an administration shown on this transcript may result in one or more annotations listed next to the score. A description of each "Comment" is provided below:

Indeterminate - Results that cannot be certified as representing a valid measure of the examinee's knowledge or competence as sampled by the examination. Decisions to classify results as indeterminate may be made on the basis of factors that include, but are not limited to, unexplained inconsistency of performance within the examination or between administrations of the same Step. **No score is reported.** Information regarding the nature of the indeterminate score and the determination of the Committee on Score Validity is available. If such information is not enclosed with this transcript, it may be obtained by contacting the organization from which you received the transcript or the USMLE Secretariat, 3750 Market Street, Philadelphia, PA 19104, telephone (215) 590-9700.

Incomplete - The examinee sat for some, but not all, of the scheduled examination. **No score is reported.**

Irregular Behavior - The Committee on Irregular Behavior determined that the examinee engaged in irregular behavior. Examples of irregular behavior are described in the current edition of the *USMLE Bulletin of Information*. Information regarding the nature of the irregular behavior and the determination of the Committee is available. If such information is not enclosed with this transcript, it may be obtained by contacting the organization from which you received the transcript or the USMLE Secretariat, 3750 Market Street, Philadelphia, PA 19104, telephone (215) 590-9700.

Score Not Available - The score is not available. Further review and/or analysis may be pending, or it may have been determined that the score cannot be reported.

Test Accommodations - Following review and approval of a request from the examinee, test accommodations were provided in the administration of the examination.

ANNOTATIONS APPEARING AS "NOTE"

Circumstances not in connection with an administration shown on this transcript may result in one or more annotations and an explanation or instructions to contact the appropriate individual or organization. The "Note" will appear at the end of the document.

BOARD ACTION DATA BANK INFORMATION APPEARING AS "NOTE"

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USMLE
United States
Medical
Licensing
Examination™

United States Medical Licensing Examination™ (USMLE™)
Certified Transcript of Scores

Reg 2PGT 6/25-03

[redacted]

This Transcript was prepared by the Federation of State Medical Boards

Date of Certification: 06/19/2003

MAILED DIRECTLY FROM RESPECTIVE INSTITUTION

New York State Board for Medicine
ATTN: Medical Processing Unit
Div of Professional Licensing Services
New York State Education Dept
89 Washington Ave
Albany, NY 12234-1000

Examinee: Middleton, Tamer
USMLE ID#: 5-038-845-3
DOB: 02/26/1963
Alt Name(s): Middleton, Tamer Yvette

Results for all Steps taken by this examinee (and for which results have been reported to date) are shown below. For Steps that span more than one day, the test date reflects the day on which the examination began. Scores are reported on two scales. The recommended minimum passing score ("Passing") on each scale is shown in parentheses.

STEP1	Test Date	Pass/ Fail	Three-Digit Score	(Passing)	Two-Digit Score	(Passing)	Comments
	6/9/1998	PASS	187	(179)	77	(75)	

STEP2	Test Date	Pass/ Fail	Three-Digit Score	(Passing)	Two-Digit Score	(Passing)	Comments
	2/25/2000	PASS	191	(170)	79	(75)	

STEP3 State Board	Test Date	Pass/ Fail	Three-Digit Score	(Passing)	Two-Digit Score	(Passing)	Comments
GEORGIA	5/14/2002	PASS	190	(182)	78	(75)	

A search of the Board Action Data Bank of the Federation of State Medical Boards (FSMB) reveals no reported information on the above-named examinee.

Patent 5633374

SEE REVERSE SIDE FOR EXPLANATION OF INFORMATION REPORTED ABOVE.

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 TAMER Middleton
(Physician's name)

a graduate of Morehouse 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

The Medical Center Columbus, Georgia
(Name and location of Hospital)

Level of Training (example: PGY-1)	Clinical Area	Inclusive dates (mm/dd/yy)	Successfully completed
PGY-1	Family Practice	6/21/00 to 6/30/01	☒ YES ☐ NO ☐ In progress; satisfactory to date
PGY-2	Family Practice	7/1/01 to 6/30/02	☒ YES ☐ NO ☐ In progress; satisfactory to date
PGY-3	Family Practice	7/1/02 to 6/27/03	☐ YES ☐ NO ☒ In progress; satisfactory to date
		/ / to / /	☐ 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 and completed this form and hereby attest that the statements made herein are strictly true in every respect and are supported by hospital records.

Signature of Director/Chair: John R Bucholtz DO Date 6/12/03

Type or print name of Director/Chair: John R. Bucholtz, D.O

Title or official position: Program Director
Family Practice Residency Program
Transitional Year Program

Institution: The Medical Center (SEAL)

Address 1961 10th Ave Suite 100
Columbus GA 31902

Telephone 706-571-1430 Fax 706-571-1004

E-mail Address john.bucholtz@crhs.net

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 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: 8 / 6 / 96 Completion Date: 5 / 15 / 00

4 Degree/diploma conferred: M.D. Date of conferral: 5 / 15 / 00

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: _____ *Date* ____ / ____ / ____

Type or print name: Angela L. Walker Franklin, Ph.D.

Title: Associate Dean for Student Affairs

Medical school: Morehouse School of Medicine (SEAL)

Address 720 Westview Dr. SW
Atlanta, GA 30310

Telephone (404) 752-1658 *Fax* (404) 752-8686

E-mail address _____

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, 85 Washington Avenue, Albany, NY 12234-1000.

229074MID400481006010S

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

02/01/05
LIC: 229074
NME: MID4
YR: 05
OFF: 1
FIN:

MIDDLETON TAMER YVETTE
SUITE N 348
BOX 101
1000 SOUTH AVE
ROCHESTER NY 14620-2782

Name/address change
Complete only if change has occurred

Name

Street

City

State/Zip

PROFESSION: 60 MEDICINE
PERIOD: 07/01/05 - 01/31/07

Complete and sign reverse side of this application

$ 481
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

45105

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 Stanley J. Middleton MD Daytime phone (585) 455-8169 Date 3-2-05

229074MID4006000060107

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

09/01/06
LIC: 229074
NME: MID4
YR: 07
OFF: 1
EIN:

MIDDLETON TAMER YVETTE
SUITE N 348
BOX 101
1000 SOUTH AVE
ROCHESTER NY [redacted]

PROFESSION: 60 MEDICINE
PERIOD: 02/01/07 - 01/31/09

Complete and sign reverse side of this application

Name/address change
Complete only if change has occurred

Name
Po Box 78172
Street
Atlanta
City
GA 30357
State/Zip

$ 600
AMOUNT DUE

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

[redacted]

DO NOT WRITE IN THIS BOX
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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 James J. Mistretta Daytime phone ([redacted]) [redacted] Date 2/2/07

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

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

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: [redacted] *Month Day Year*

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

Last: Middleton
First: Tamer
Middle: Yvette

4 MAILING ADDRESS:

Apt/Bldg.: Suite M348 Box 101
Street: 1000 South Avenue
City: Rochester
State: NY Zip Code: 14620 2782
Province/Country If not U.S.:

5 Print name under which postgraduate training was completed: Tamer Y. Middleton

6 Hospital in which postgraduate training was completed: ~~Brady Memorial~~ The Medical Center / Columbus Regional
Address: 710 Center Street Columbus, GA 31902

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: Tamer Y. Middleton Date: 5/29/03

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 239074

Date Issued 7-1-03

Initials [illegible]

1 Social Security Number *(Leave this blank if you do not have a U.S. Social Security Number)* 260212391

2 Birth Date Month 02 Day 26 Year 63

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

Last Middleton

First Tamer

Middle Yvette

5 Telephone/E-Mail Address

Daytime Phone 5853416292
Area Code Phone Number

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

Apt./Bldg. Suite M348

Street 1000 South Ave - Box 1011

City Rochester

State NY Zip Code 14620 2782

Province/Country If not U.S.

E-Mail Address (Please print clearly)
tamermiddleton@mindspring.com

6 Name as it appears on degree or other credentials (if different from above): Same as 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?	☐ YES	☑ NO
11	Are criminal charges pending against you in any court?	☐ YES	☑ 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?	☐ YES	☑ NO
13	Are charges pending against you in any jurisdiction for any sort of professional misconduct?	☐ YES	☑ 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?	☐ YES	☑ 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."

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: Robert W. Groves High School City: Garden City, State/Country: GA	4	08 1977 mo yr	06 1981 mo yr	High School Diploma 1981	
Postsecondary Preprofessional School(s) (Exclusive of Medical School) School Name: Agnes Scott College City: Decatur, State/Country: GA	4	09 1981 mo yr	05 1985 mo yr	Bachelor's Chemistry 1981	
School Name City, State/Country		mo / yr	mo / yr		
Medical Education (Professional, list all medical schools attended) School Name: Morehouse School of Medicine City: Atlanta, State/Country: GA	4	09 1996 mo yr	05 2000 mo yr	MD	
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
N/A			

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	
Alabama	09/2002	00024856	05/2002			NONE
Georgia	09/2002	051997	05/2002			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
N/A	

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 05/2002

21 Provide a chronological list of all activities since graduation from professional 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 Professional School. Include Name and Address of Employers
07/2000	06/2001	Internship, Family Practice — Columbus Regional Medical Center 1900 10th Ave. Ste 100, Columbus, GA 31904
07/2001	Present	Residency, Family Practice — Columbus Regional Medical Center 1900 10th Ave Ste 100, Columbus, GA 31904

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)
N/A		/ /
		/ /
		/ /
		/ /

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. (in process)

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