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

Application for Licensure

1		MA, = 0 2003
	and First Registration	60 \$735 ER
Ľ	Applicants Must Complete All Six Pages Of This Application <u>In Ink</u>	NYS License Number
1	Social Security Number (Leave this blank if you do not have a U.S. Social Security Number)	Date Issued 7-1-03
2	Birth Date Month 2 Day Year 63	Initials
3	Print Name Exactly As You Wish It To Appear On Your License Last M: dd/e+oN	5 Telephone/E-Mail Address Daytime Phone
	First /ameR Middle Yve++e	Area Code Phone Number
4	Mailing Address (You must notify the Department promptly of any address or name changes.)	
	Apt/Bldg. Suffe M348	E-Mail Address (Please print clearly) tamer modeled Mindsyng Com
Pi	City]
6		
7	Name as it appears on degree or other credentials (if different from above): Same as Citizenship: Violed States Alien lawfully admitted for a permanent residence in the United	a bove
 	Citizenship:	_ •
8	I wish to become licensed on the basis of:	
	Acceptable examination scores (see page 3 of this form) Endorsement of another (See "Applicants Licent No") I am using FCVS to collect my credentials:	er license sed in Another State* section of instructions.)
9	Have you previously applied for a New York State License or a limited permit to practice medicine?	YES ENO
10	Have you ever been found guilty after trial, or pleaded guilty, no contest, or noto contendere to a crime (fe misdemeanor) in any court?	
11	Are criminal charges pending against you in any court?	YES YO
12	Has any licensing or disciplinary authority refused to issue you a license or ever revoked, annulled, cance surrender of, suspended, placed on probation, refused to renew a professional license or certificate held previously, or ever fined, censured, reprimanded or otherwise disciplined you?	elled, accepted by you now or YES YES NO
13	Are charges pending against you in any jurisdiction for any sort of professional misconduct?	YES O
14	Has any hospital or licensed facility restricted or terminated your professional training, employment, or pri or have you ever voluntarily or involuntarily resigned or withdrawn from such association to avoid impositi of such measures?	vileges on E YES L NO
	NOTE: Known are and RV - N I	· · · · · · · · · · · · · · · · · · ·

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."

Medicine Form 1, Page 1 of 6, September 2002

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. School Name / High School or Secondary School
Robert W. Groves Postsecondary Preprofessional School(s) (Exclusive of Medical School) S C School Name If you completed clinical derkships in a country other than where your medical school is located, give the dates and location of these derkships. Attach additional sheets if necessary. City C. Ş Medical Education (Professional, list all medical achools attended) School Name Ş School Name School Name Garden City. Decatur Atlanta Morehouse Inclusive Clerkship Dates Scott A NAME OF SCHOOLS ATTENDED AND LOCATIONS School College OF GA State/Country State/Country State/Country State/Country State/Country Clinical Area Medicine Form 1, Page 2 of 6, September 2002 B. NUMBER OF YEARS ATTENDED 1 Name of Health Care Fadilty And Address Mo y mo y 186/ 60 Entrance Date mo / 3 C. ATTENDANCE 4 184 PM 188 / SE Leaving Date ᇙ 3 D. TITLE OF DIPLOMA OR DEGREE OBTAINED (INDICATE YEAR High School Diploma 1981 Backelors OBTAINED) Chemistry Medical School with which Clerkship Affiliated and Address 1981 E. IF NO DIPLOMA
OR DEGREE,
INDICATE NUMBER
OF CREDITS EARNED

6 Are you	licensed or	have you ever been I	icensed as a physicia , you must also subm	n in any oth	er state o	r country? ee pages <u>14</u> - <u>15</u> .	Yes 🗹	No 🗆
If yes,	ist each juns	diction, π appropriate	, you must also subm		Ba	sis of Licensure		Any Limitations
State or Country		Date License issued	Number	Examir (Date pa		Endorsement	Other	on License
Ala bama	i.	08/2002	00024856	05/5	2002			NONE
Alabama Georgia	-	09/2002	05/987	05/9	002			NONE
Have y	you complete u currently ho	ction only if you are ad all portions of the e		ram not re	gistered t	oy New York State	or LCME or A Yes Yes	OA accredited. No No
18 Are yo	ou applying fo , list name ar	or licensure on the band location of medica	sis of a Fifth Pathway I school or hospital an	program?	sive dates	of attendance.	Yes G	No No
			cal School or Hospital				usive Dates of A	uttendance
19 List in	english, all	specialty qualification	ns you have earned. ((i.e., Board	Specialty	Certification or Dip	lomate Certifica	ite)
	. /	Name of Qualif	ications		N	ame and location of	of organization i	ssuing credential
-	N/N	4						
20 _	(plying for USMLE Ste OR cessfully completed to	ep 3 he examination combi	ination indic	cated belo	N :		
			EXAMIN	NATION CO	MBINATI	ons		
	USML	E Steps 1, 2, and 3			USMLE S	Step 1, NBME Part	II, and USMLE	Step 3
	FLEX	Parts I, II, and III				Steps 1 and 2 and		
	_	Components I and II				Step 1, NBME Part art I, USMLE Step		
		Parts I, II, and III Parts I and II and US	SMLE Steo 3			Steps 1 and 2 and		
			2 and NBME Part III			arts I and II and FL		
		Part I, and USMLE				mponent I and US	MLE Step 3	
	☐ USML	E Step 1, and NBME	Parts II and III			Parts I, II, and III		
	Date e	examination sequenc	e was completed	_05/	Other: / 200 ;			
			Medicine Fo	rm 1. Page	3 of 6, S	eptember 2002		

	e a chronological list o yment. Attach addit	tional sneets if necess	aly.				n periods and	penous or
	(mm/dd/yy)				uation from Professi			
01/2000	06/2001	Internship	, Family	Practice	Columbus 1900 10th	Regional Are. Ste	Medical 100, Colum	Center nbus, GA 3194
07/2001	ob/2001 Present	Residency	Family	. Aractice	1900 10th	Regional Ave Ste	Medical 100, Col	Center- lunbus, CA3196
			· · · · · · · · · · · · · · · · · · ·					
22 If yo	u hold a New York Stat	te license in another p	orofession, inc	dicate the professi	on, your license nu	nber and date o	f licensure bel	ow.
	Profes	ssion		Licens	se Number	Date of Ini	tial Licensure (mm/dd/yy)
-	N	/A				<u> </u>		
-		,					_//_	
23 CHILL	ABUSE IDENTIFICA	TION AND REPORTI	NG: (check	only one of the fo	ollowing.)			
	I graduated from a							
		hild abuse coursework				n an approved p	orovider. {\f	Res)
		exemption to the requ					(uh	
			Indiana Cam	m 1. Page 4 of 6,	Sentember 2002			

GENDER AND ETHNICITY: (This item is on	otional.)			
information on gender and ethnicity is southelicensed professions. The ethnic and purposes. It will not be released to the publications.	ght solely to allow the Edu	cation Departme will be used o solutely no bea	ent to collect and a nly for statistical, i ring on your qualific	nalyze data concerning diversity in research, and program evaluation cation for licensure.
	Famolo			
The Aite (and Hispanis)	Stack (not Hispanic)	Asian	Hispanic	Native American
ETHNICITY: C. Market (not Hispanic)				
STUDENT LOAN DISCLOSURE: The State Education Department is required	* to sek these questions abo	eut arny student k	oans made or guara	nteed by the New York State Higher
Education Services Corporation, and to forward	and any "yes" responses to ut	e New York Stat	e Higher Education	Services Corporation. Your license
application is not complete without this Inf (a) Do you have any outstanding loans made		/ York	Yes	1 No
State Higher Education Services Corpo	ration?			□ No.
(b) If you have such a loan(s), is any part in	n default?		L Yes	INO
*New York State Education Law, section 650)1-a			
Everyone applying for or renewing a profe is, or is not, under an obligation to pay of suspension of their business, profess frustrating or defeating the lawful enforcer You must complete this section before we	nild support", Individuals Williams and/or driver's licens nent of support obligations is	es. The intention punishable unde for which you ha	nal submission of far r section 175.35 of the	ise written statements for the purpose (e Penal Law. als who are not in compliance with the
You must complete this section before vobligation to pay child support can be issued. Check only A or B below. If you check	ed a credential for no more I	nan six months in	order to comply with	their child support obligations.
_				
A lam not under an obligation to p	nay child support;			
OR				
B I am under an obligation to pay	child support and (please ch	eck only one of	the following)	
am current and am not four				mod to by the parties or
☐ I am making payments by inc☐ The child support obligation				ged to by the parties, or,
The child support obligation I am receiving public assista			<u>.,</u>	
None of the above four state		,		
*New York State General Obligations La	rw, section 3-503			
	Medicine Form 1, Pa	ige 5 of 6. Septi	ember 2002	

7 I give permission to the Nev	w York State Education Department to release my examination results to my professional school
for the confidential purpose	es of program review and institution research and planning. I may rescind this authority at any
time by notifying the Divisio	n of Professional Licensing Services in writing.
time by nourying are because	
	Yes No Please initial: //g/M
PHOTOGRAPH REQUIRE	MENT:
	Date of photo:
APPLICANT I declare and affirm that the	OWLEDGMENT (Notarization required.) The statements made in this application, including accompanying documents, are true, complete that any false or misleading information in, or in connection with, my application may be cause are and may result in criminal prosecution.
Signature of the applicant:	19 aproleton
Oignature of the approximation	
NOTARY ()	NA (4 (10° a da
State of Yewgia	y of MUSIUSE
On the all a day	y of metal in the year with the haring free times expressed and the haring free times and personally
appeared 10ml D	n, doll for , personally known to me or proved to me on the basis of satisfactory evidence
to be the individual whos	se name is subscribed to this application and acknowledged to me that he/she executed the
	at the statements made by him/her in the application and all supporting materials are true,
complete, and correct.	Dag (10 10 10 10 10 10 10 10 10 10 10 10 10 1
Notary Public signature	Mary alice Sowdell
110001 y 1 dono orginataro	
	\mathcal{O}
Notary ID number	
Expiration date MY COMM	Dey Year
Professional Licensing Service	e fee to: New York State Education Department, Office of the Professions, Fee Section, Division of ces, 89 Washington Avenue, Albany, NY 12234-1000. DO NOT SEND CASH. Make check or money
order payable to the New Yon	K State Education Department. Medicine Form 1, Page 6 of 6, September 2002
	Machine Line of Laboratory and Laboratory

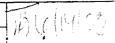
CERTIFICATION OF COMPLETION

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

PART A	ART A TRAINEE INFORMATION							
2. The provi original c submitted permit.	to a grant of the contract of							
. Drofoce	ional License or Permit. New York State Education Department	Division of Professional Licensing Services, Igive						
• Reregi	f profession], Cultural Education Center, Albany, New York 12230 stering Licensees: Your certificate should be included with your relaterials.	registration application in the envelope provided with						
• <u>Teache</u> York 1	r Certification: New York State Education Department, Office o							
1 Print nate Education	ne exactly as it currently appears on New York State a Department records:	5 Complete information below if you hold or are applying for, professional license(s) or a permit:						
Last	MIDDLETON	Name of Profession(s): Physician applying for NY license						
First	MAMER	N.Y.S License Number:						
Middle	NNEHHE IIIIIIIIIIIIIIIIIIIIIIIIIIIIIIIII							
2 Print vo		N.Y.S License Number:						
 	ur address:							
Care of Misc. (Bldg		Permit #:						
Apt., etc.)		6 Complete information below if you hold, or						
Street	Seel Precedent AME	are applying for a teaching certificate:						
City	COLUMBUS	Certificate Title(s):						
State	GA Code 311964-							
3 Date of	Mo. Day Yr.	N.Y.S. Certificate Number (other than Social Security Number, if any):						
4 Social S	Security number							
Trainee's	Signature: France y Michelleton, MD	Date: 5/21/03						
PART B	CERTIFICATION BY APPROVED	PROVIDER						
Provider The ED calendar The profor not I	must complete Part B. UCATION DEPARTMENT-ORIGINAL COPY and TRAINEE days of the completion of the coursework or training. Vider of the coursework or training must retain the PROVIDER COess than five years from the date the course was completed.	COPY should be returned to the traince within ten PY. This copy must be retained in the provider's files						
Pursuant t	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.							
)	1. T Classes	NYSPCC						
Name of A	athorized Coulfying Officer (Print or Type)	pproved Provider Name 80026						
I Varue of Al		entification Number,						
Signature	Authorized Certifying Officer	115/03 Ale(s) of Coursework or Training						
- Co	υ	netal or compensive or righting						

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.

- 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.

SECTION I: APPLICANT INFORMATION
SECTION : APPLICANT INFORMATION
1 SOCIAL SECURITY NUMBER Month Day Year
(Leave this blank if you have no U.S. Social Security Number)
PRINT FULL NAME EXACTLY AS IT APPEARS ON YOUR LICENSURE APPLICATION (FORM 1) OR LIMITED PERMIT APPLICATION (FORM 5B)
Last Middleton 5 TELEPHONE/E-MAIL
First THMER HOME
Middle y
MAILING ADDRESS: WORK
Apt/Bldg. Spyters Book and Dob Shi Hood
Street * 5 0 0 7 5 0 4 4 4 6 4 8 n we n we n we Area Code Number
City Rochester tamer middleton @mindpring.
State NY Zip Code 14620 2786 E-Mail Address
Province/Country If not U.S.
Print name under which your degree or diploma was awarded (if different from above) To mer Y. Middleton
7 Preprofessional School Attended: Agnes Scott College
8 Professional School Attended: More house School of Medicine
Address: 150 Westview Drive Atlanta, GA 30310-1495
9 Name of Degree/Diploma: Backelor's of Arts-Chemistry Date awarded: 5/02/85
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:

	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
· <u></u>	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? 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:
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:
	Was a pre-graduation internship required?
	Institution:
	Submit with this form:
	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.
	eturn this form irectly 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.
Sep	stember 2002 FORM 2, PAGE 2 OF 2

' FORM 2, PAGE 2 OF 2

FORM 2PGT MEDICINE 1.6

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

Ovision of Professional Licensing Services

By 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.

.003 JUN 1

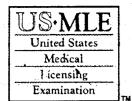
CERTIFICATION OF APPROVED POSTGRADUATE TRAINING

(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.
 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: 2 BIRTH DATE:
(Leave this blank if you do not have a U.S. Social Security Number) Month Day Year
PRINT FULL NAME EXACTLY AS IT APPEARS ON YOUR APPLICATION (FORM 1): Last M; ddle Ho N First TAMER Middle Yve + + e Mailing Apt/Bldg. Suite N345 Box Toil City Cochester State NY Zip Code Province/Country If not U.S.
Print name under which postgraduate training was completed:
Hospital in which postgraduate training was completed: Grady Memor The Medical Center / Columbus Regional Address: 710 Center Street Columbus, GA 31902
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: Jane 4 Medictheton Date: 5 129 103
September 2002 FORM 2PGT, PAGE 1 OF 2

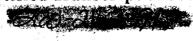
٦	This is to certify that	Middleton)		
ā	his is to certify that AMER (Physician's nan graduate of More house (Medical school)	School of M	ledicine		
v A	vas enrolled in a postgraduate training progr American Osteopathic Association, or Royal	College of Physicians and	Surgeons of Canada at	e Medical Education, the	
-	The Madical Center, (Name and location of Hospital)	columbus, Gen	514		
	Level of Training (example: PGY-1)	Clinical Area	Inclusive dates (mm/dd/yy)	Successfully completed	Ì
	PCY-1	Family Prucker	4 / 21 / 00 to	YES NO In progress; satisfactory to date	
	PC4-2	Fam hy Practice	7 / 1 / 01 to	YES NO In progress; satisfactory to date	POR
	P64-3	Practice	7 / 1 / 02 to	YES NO In progress; satisfactory to date	
			/ to	YES NO In progress; satisfactory to date	
			// to	☐ YES ☐ NO ☐ In progress; satisfactory to date	
l an pos eve Sign	Explanation is attached the director of medical education or departn tograduate training indicated and have carefull ry respect and are supported by hospital reconstruction of Director/Chair: or print name of Director/Chair:	nent chair of the clinical are y read and completed this	ea. I was the program directo form and hereby attest that the	r for the physician named above d	uring the
itle	or official position:	Cutu Pr.	hn R. Bucholtz, D.O. ogram Director	(SEAL)	
.ddre	ution: The Medical Person of Automotion of A	Soute 100 Fa	mily Practice Resident ansitional Year Program	cy Program	
	hone: 706.571.1430 il Address: John. buch				

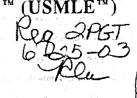
SECTION II: CERTIFICATION OF POSTGRADUATE TRAINING



United States Medical Licensing Examination™ Certified Transcript of Scores

PROFESSIONAL LIGENSING





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#:

Alt Name(s):

3:038-845**:**2

DOB:

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	Pass/	Three-Digit		Two-Digit				
	Date	Fail	Score	(Passing)	Score	(Passing)	Comments	× **	
	6/9/1998	PASS	187,	(179)	7.764	3 (6,7)	The second of th	3 T (8)	
STEP2	Test	Pass/	Thre	e-Digit	Twe	o-Digit	and the second s		
	Date	Fail	Score	(Passing)	Score	(Passing)	Comments		
	2/25/2000	Poss	* 1 9	AT (BAR)	the transmission				
STEP3	Test	Pass/	Thre	e-Digit	Tw	o-Digit	in the community of the second		
State Board	Date	Fail	Score	(Passing)	Score	(Passing)	Comments		
GEORGIA	5/14/2002	PASS	190	, ** (182) *÷	⁶ ~∴ 78~	*(75) * 😲	A CONTRACTOR OF THE CONTRACTOR		

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 563687

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 <u>not</u> 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".

THE UNIVERSITY OF THE STATE OF NEW YORK
THE STATE EDUCATION DEPARTMENT
DIVISION OF PROFESSIONAL LICENSING SERVICES
89 WASHINGTON AVENUE

89 WASHINGTON AVENUE
ALBANY, NEW YORK 12234-1000, ROFESSIONAL CICEMSING

MIDDLETON TAMER YVETTE SUITE N 348 BOX 101 1000 SOUTH AVE

ROCHESTER

NY 14

WHEN RESPONDING, PLEASE IN-CLUDE NAME, ADDRESS, PROFES-SION, SSN, AND A DAY PHONE#.

DATE: 05/14/03

PROFESSION: 60

ID NUMBER : 260212391 -

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

MIDDLETON 735 EK

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,φ.,	ROCHESTER NY #4620-2782		EIN:
Эрте	BOX 101 ÉRILE M. 348°°		VR:
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		90/10/20	

Complete and sign reverse side of this application

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THE STATE EDUCATION DEPARTMENT
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Do you wish to register for the period indicated?		Voc No
2. Since your last registration application,	Market Control of the	الانتسان الانتسان
a. Have you been found quilty after trial, or pleaded quilty, no contest, or note content	odere to a crime (felony or mindomonad in any asysta	ملاحل المحكا
b. Has any licensing or disciplinary authority revoked, annulled, cancelled, accepted	surrender of succeeded placed on probation, or referred	165]
to issue or renew a professional license or certificate held by you now or previously,	or fined, censured, reprimanded or otherwise disciplined you?	Yes Lino
d. Are charges pending against you in any jurisdiction for any sort of professional mis	Charles the Control of the Control o	Yes KNo
e. Has any hospital or licensed facility restricted or terminated your professional train	samula:	YesNo
or involuntarily resigned or withdrawn from such association to avoid the imposition of	ing, employment, or privileges, or have you voluntarily	* 1
unprofessional conduct, incompetency, or negligence?	or such action due to professional misconotici,	Yes No
One Assessment and the second the second terms of the second terms		
b. If you are under such an obligation, do you meet one of the four requirements liste	od in the Child Compared and a section below?	Yes KNo
A Are you all S offices or as align admitted for some asset assistance in at a second	The state of the s	YesNo
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NATURAL PROPERTY OF THE PROPER	DO NOT WRITE IN THIS BOX	
•	FOR OFFICIAL USE ONLY	
	•	
I certify that the statements made in this application and any accompanying documental	ation are true, complete and correct. Lunderstand that any microny	nontetion or one
imac or mareading anormation made in connection with my application may result in a	Criminal prosecution and may be cause for disciplinary action, incl.	escriculori ur dely
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y the state of the	on constitutes professional miscorragia,	
(1. 10 M) 11/4 (M)		
Signature David	me phone (585) 455-8169 Date 3-2-60	5
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05/01/04 - 01/31/09 PERIOD:

PROFESSION: 60 MEDICINE

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REGISTRATION RENEWAL DOCUMENT
THE STATE EDUCATION DEPARTMENT
Professional Licensing Service
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Complete and sign reverse side of this application

Name/address change Complete only it change has occurred

to issue or renew a professional lice. Are criminal charges pending ag d. Are charges pending against you e. Has any hospital or licensed factor involuntarily resigned or withdraw unprofessional conduct, incompete 3. a. Are you under an obligation to pa b. If you are under such an obligation	tion, trial, or pleaded guilty, no contest, or authority revoked, annulled, cancelle ense or certificate held by you now or ainst you in any court? If in any jurisdiction for any sort of pro- lity restricted or terminated your profe on from such association to avoid the ncy, or negligence? ay child support? on, do you meet one of the four requi	r noto contendere to a crime (felony or misdemeanor) in any court? Yes In noto contendere to a crime (felony or misdemeanor) in any court? Yes Yes Yes Treviously, or fined, censured, reprimanded or otherwise disciplined you? Yes Yes Interesting, employment, or privileges, or have you voluntarily employment.	No
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raise or misreading information made th	Connection with my application may	g documentation are true, complete and correct. I understand that any misrepresentative result in criminal prosecution and may be cause for disciplinary action, including my profession constitutes professional misconduct. Date 2/2/07	tion or any the loss of

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.

- 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
- 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

form. International Medical Graduates may not use this form if Form 1 and fee	e are submitted after November 30, 2002.
3 If you attended a medical school that has been closed, send this form to the official	
4 This form must be signed by the Registriar, Doon, Reuter, or Principal of the niedical by that school official in an official school envelope to the address at the end of this not be accepted.	al school and sent back directly to the Office of the Professions is form. Forms sent back by the applicant or other parties will
SECTION I: APPLICANT INFORMATION	
1 SOCIAL SECURITY NUMBER	2 BIRTH DATE
(Ceave this blank if you have no U.S. Social Security Number)	Month Day Year
PRINT FULL NAME EXACTLY AS IT APPEARS ON YOUR LICENSURE AP OR LIMITED PERMIT APPLICATION (FORM 5B)	PPLICATION (FORM 1)
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First THMER	номє
Middle V v e + + e	706 H3 21 H9 3 3 2
4 MAILING ADDRESS	WORK
Apt/8103 Su: +e N348 Blo 2010	706451141000
Street 1000 South Avenue	Area Cope Number
co Ruchester	tomermicolleton@mindepring-com
State NY	E Mail Address
Province Country	
Print name under which your degree or diploma was awarded (it different from above)	Tamer Y. Middleten
7 Preprofessional School Attended Agnes Scott College	
B Professional School Attended Mare Nouse Salutof Ma	edicine
Acdress 150 Westview Drive A	Hanty GH 30310-1495
Name of DegreerDiplomar Bockeler's of Arts - Chemistry	Date awarded. 6/02/85
i recuest and give my permission to the school listed in item 8 above to complete Sectional department at the address at the end of this form, and to release any other information with my application for licensure	ion II of this form and mail it to the New York State Education requested by the State Education Department in connection
Approant's signature lame & Meddleton	Date: 5 , 2 Y , 63
September 2002 CERTIFICATION BY PROSESSES	

7	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
1	time by notifying the Division of Professional Licensing Services in writing.
	Yes W No Please initial: 19/19
3 F	PHOTOGRAPH REQUIREMENT:
	Date of photo:
9	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:
	NOTARY / j
	State of Granty of Tribiblioges
	State of County
	Notary Public signature Dillu Clare Wordell
	Notary ID number
	Expiration date WY COMMISSION EXPIRES ANGUST 26, 2003
Pro	il this form and appropriate fee to: New York State Education Department, Office of the Professions, Fee Section, Division of fessional Licensing Services, 89 Washington Avenue, Albany, NY 12234-1000. DO NOT SEND CASH. Make check or money er payable to the New York State Education Department.
om	er bayable to the new Tork State Education Department

CERTIFICATION OF COMPLETION

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

1. Trainee must complete all items in Part A. Return to provider for completion of Part B, "Certification by Approved Providence of Provider will return the Certification form, with Part B completed, to the trainee. It is the trainee's responsibility to storiginal copy of this Certification form to the New York State Education Department at the appropriate time. It is submitted along with other relevant forms when the trainee applies initially for, or renews, a license, registration cert permit. 3. Address for submitting form is as follows: • Professional License or Permit: New York State Education Department, Division of Professional Licensing Servi	should be			
name of profession], Cultural Education Center, Albany, New York 12230. • Reregistering Licensees: Your certificate should be included with your reregistration application in the envelope provitiose materials. • Teacher Certification: New York State Education Department, Office of Teaching, Cultural Education Center, Alb York 12230.	ces, (give			
Print name exactly as it currently appears on New York State Education Department records: Let MIDDLETON	se(s) or a			
Carc of Mose (Bldg & Apt, dec) Since 1 3001 Pierpoint Ave are applying for a teaching certificate City Code 311904- 5 Date of Birth: Date of Birth: N.Y.S. Certificate Number (other to Security Number, if any):	e:			
Traince's Signature: 4 famor y Middleton, MD Date: 5/21/03				
PART B CERTIFICATION BY APPROVED PROVIDER				
 Provider must complete Part B. 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. 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 coursework or training regarding the identification and reporting of child abuse and maltreatment.	required			
) TCI NYSPCC				
Napre of Authorized Confrying Officer (Print or Type) Approved Provider Name 80026				
1 Value of Authorized Carditalis officer (Little of Table)				
Identification Number, 5/15/03				

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

RUBLIBURG CAMER YVETUS

SUITE N 348 BOX 101 1000 SOUTH AVE WHEN RESPONDING, PLEASE IN-CLUDE NAME, ADDRESS, PROFES-SION, SSN, AND A DAY PHONE#. DATE: 05/14/03

PROFESSION: 60

ID NUMBER : 260212391

14620-2782 ROCHESTER

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. It 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 examince 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.

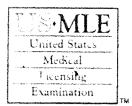
Test Accommodations - Following review and approval of a request from the examinee, test accommodations were provided in the administration of the examination.

ANNOTATIONS APPEARING AS "NOTE"

Circumstances <u>not</u> 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.

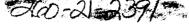
BOARD ACTION DATA BANK INFORMATION APPEARING AS "NOTE"

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

da - 21-239



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	Pass/	Thre	e-Digit	Two	-Digit	
	Date	Fail	Score	(Passing)	Score	(Passing)	Comments
	6/9/1998	PASS	187	(179)	77%	(75)	
STEP2	Test	Pass/	Thre	e-Digit	Two	o-Digit	
	Date	Fail	Score	(Passing)	Score	(Passing)	Comments
	2/25/2000	PASS	. 191	(170)	79	* (75)	
STEP3	Test	Pass/	Thre	e-Digit	Two	-Digit	
State Board	Date	Fail	Score	(Passing)	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 5636374

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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. a graduate of More house School of Medicine 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 shadrent Center, Columbus, Georgia (Name and location of Hospital) Successfully completed Clinical Area Level of Training (example: PGY-1) Inclusive dates (mmVdd.yy) YES NO Family PCY-1 In progress; satis-Principal factory to date YES ON C PG4-2 ☐ In progress; satisfactory to date Faul YES NO 3 / 4 / 02 to P64-3 ☑ In progress; satis-Prictie factory to date YES NO ☐ In progress; satisfactory to date ☐ 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 if am the director of medical education or department chart of the clinical area. It was the program director for the physician harned 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: Type or print name of Director/Chair. Title or official position: --- John R. Bucholtz, D.O. institution: The Medical Confin Program Director (SEAL) Address 1900 10th No. South 100 Transitional Year Program Colombia 6A 31401 Telephone 766.57/1430 Fax 764.571.1264 E-mai Address john brilling @ cols out

New York State Education Department, Office of the Professions, Division of Professional Licensing

Services: Medicine Licensing Unit, 89 Washington Avenue, Albany, NY 12234-1000

10: -

Return this form directly

SECTION II: CERTIFICATION OF PROFESSIONAL EDUCATION	
INSTRUCTION TO SCHOOL: Please complete this section, sign certifying statement, attach the info the Office of the Professions at the address shown below. This form will not be accepted if return	ormation required in item 5 and send directly to led by the applicant or any other party.
Tot Applicants from N. F.S. Registered or LCME/AOA Accredited Medical Schools:	
Applicant met LCME/AOA requirements for admission to medical/osteopathic school?	· · · · · ·
if No-number of preprofessional postsecondary credit hours completed by applicant prior to admiss medical school semester hours or quarter hours	sion to
Did the applicant receive advanced standing based on prior academic work? If Yes, indicate when the prior work was completed below and submit an official transcript of studi documentation in your file to support the granting of transfer credit. Name of Institution: Dates of attendance:	ies at your Institution, and copies of
Applicant's Entrance date: 8 / 6 96 Completion Date: 5 /	15 / 00
Degree diploma conferred: M.D. Date of c	onferral: 5 / 15 / 00
5 For All Other Applicants:	The second secon
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? TYES NO If Yes, give inclusive dates and name	of institution in which requirement was met.
Institution: Dates.	
Was a pre-graduation internship required?	and name of institution in which requirement
Institution: Dates.	to
Submit with this form:	
An official transcript (course record, index, or marksheets) showing courses taken at yo and accepted from other institutions for transfer of credit or convalidation. The transcript must bear the original signature of the registrar, dean, principal or	
B. A copy of documentation from your files to support the granting of transfer credit or con-	
C List of clinical circreship completed outside jurisdiction where mix tion! school is located starting and ending dates of cierkship, and name and address of hospital where clerkship.	
FOR ATTENDEES OF CIFAS, CETEC, AND UTESA, this list must include all clerkships completed, both 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 paged on this to
Signature:	
Type or pront name: Angela L. Walker Franklin, Ph.D.	
The 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	
	RTIFICATION IS NOT ACCEPTABLE UNLESS DATED AFTER GRADUATION,
Return this form Directly to: New York State Education Department, Office of the Professions, Division of Licensing Unit, 85 Washington Avenue, Albany, NY 12234-1000.	f Professional Licensing Services, Medicine

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NY 14620-2782 ROCHEZIER

Complete and sign reverse side of this application

SEBICD: 03/01/02 - 01/31/03 SBOLESZION: 00 MEDICINE

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REGISTRATION RENEWAL DOCUMENT
THE STATE EDUCATION DEPARTMENT
TO descorat Decensing Services
SE Washington Avenue
Reserving Tassa 1000

Name/saddress change has occurred Complete only if change has occurred

Street

Name

AMOUNT DUE

481 \$ State/Zip VIIO

Do you wish to register for the period indicated?	Yes	No
2. Since your last registration application,	The second secon	
 a. Have you been found guilty after trial, or pleaded guilty, no contest, or noto contende 	re to a crime (fellony or misdemeanor) in any court? Yes	. <u>/ No</u>
 b. Has any licensing or disciplinary authority revoked, annulled, cancelled, accepted sur 	render of suspended placed on probation, or refused	
to issue or renew a professional license or certificate held by you now or previously, or f	ned censured renomanded or otherwise describined you?	No
C. Are criminal charges manding aggreed you in only court?	·····Yes	No
d. Are charges pending against you in any jurisdiction for any sort of professional misco	ndust?	No No No
 e. Has any hospital or licensed facility restricted or terminated your professional training 	employment or provileges or have you voluntarily	No
or involuntarily resigned or withdrawn from such association to avoid the imposition of s	uch action due to professional micropolitics	
unprofessional conduct, incompetency, or negligence?	Yes	₩ _N
3 a. Are you under an obligation to pay child support?	Yes	$\sqrt{N_0}$
b. If you are under such an obligation, do you meet one of the four requirements listed in	n the Child Support Law section below?	No
4. Are you a U.S. citizen or an alien admitted for permanent residence in the U.S.?	·	No
ON THE PLANTER	¥ ∠Yes	140
AND POPERSON	DO NOT WRITE IN THIS BOX	
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 d. Are charges pending against you in any jurisdiction for any sort of professione. Has any hospital or licensed facility restricted or terminated your profession or involuntarily resigned or withdrawn from such association to avoid the importunprofessional conduct, incompetency, or negligence? 3. a. Are you under an obligation to pay child support? b. If you are under such an obligation, do you meet one of the four requirement. 4. Are you a U.S. citizen or an alien admitted for permanent residence in the U.S. 	cepted surrender of, suspended, placed on probation, or refused ously, or fined, censured, reprimanded or otherwise disciplined you? Yes all misconduct? I yes all training, employment, or privileges, or have you voluntarily sition of such action due to professional misconduct. Yes Yes atts listed in the Child Support Law section below? Yes	No
R48 8515588) 25452483 PANNA	DO NOT WRITE IN THIS BOX FOR OFFICIAL USE ONLY	<u></u>
I certify that the statements made in this application and any accompanying docatalse or misleading information made in connection with my application may resimplicense; and that the willful failure to register while continuing to practice my profile. Signature	ult in criminal prosecution and may be cause for disciplinary action, including	
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FORM 2PGT

MEDICINE

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The University of the State of New York
THE STATE EDUCATION DEPARTMENT
Confice of the Professions
Ovision 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

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. If 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: (Leave this blank if you do not have a U.S. Social Security Number) 2 BIRTH DATE: Month Day Year	
3 PRINT FULL NAME EXACTLY AS IT APPEARS ON YOUR APPLICATION (FORM 1):	
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4 MAILING Aptisting S u i + e N 3 u 8 B o x 1 o 1	
5 Print name under which postgraduate training was completed. Tomor Y. Middle tow	
Address The Center Street Columbus, Col 31902	-
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 behavior with my application for licensure.	
Applicant's signature: Tame of the distribution Date: 5 129 103	
September 2002 FORM 2PGT, PAGE 1 OF ;	

The University of the State of New York Medicine Form 1 THE STATE EDUCATION DEPARTMENT Office of the Professions Division of Professional Licensing Services 89 Washington Avenue Albany, NY 12234-1000 www.op.nysed.gov **Application for Licensure** and First Registration Applicants Must Complete All Six Pages Of This Application In Ink NYS License Number Social Security Number Initials Telephone/E-Mall Address Daytime Phone E-Mail Address (Please print clearly) State Province/Country If not U.S. Name as it appears on degree or other credentials (if different from above): Citzenship: Other Immigration Citizen of Attach a photocopy of the front and back of your Alien Registration Card 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.) Have you previously applied for a New York State License or a limited permit to practice medicine? YES **₽**No Have you ever been found guilty after trial, or pleaded guilty, no contest, or noto contendere to a crime (felony or ☐ YES L'NO misdemeanor) in any court? Are criminal charges pending against you in any court? M NO YES YES Has any Ecensing or disciplimary authority refused to issue you a license or ever revoked, annulled, cancelled, accepted YES 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? Are charges pending against you in any jurisdiction for any sort of professional misconduct? YES 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?

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 possessione, a copy of the "Certificate of Relief from Disabilities" or your "Certificate of Good Conduct."

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

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