 PENNSYLVANIA Department of State
For questions about this website, please Click Here to send an E-Mail , or to contact your Board directly, Click Here .
Click the X at the upper right corner to close this window and return to the list of licensees.
Person Information
Name: ERIC KFIR YAHAV
Address Information
Address(city state zipcode): Philadelphia PA 19149
License Information
Type: Medical Physician and Surgeon Secondary Type: Number: MD445512 Profession: Medicine Status: Active Issue Date: 4/9/2012 Expires: 12/31/2014 Last Renewed: 12/7/2012
Discipline Action History
No disciplinary actions were found for this license.
The information above is considered primary source for verification of license credentials.

MD445512 (01/2012)

Regular Mailing Address STATE BOARD OF MEDICINE P.O. BOX 2649 HARRISBURG, PA 17106-2649 717-783-1400/717-787-2881 Email: st.medicine@pa.gov	Courier Delivery Address STATE BOARD OF MEDICINE 2601 NORTH THIRD STREET HARRISBURG, PA 17110
---	---

**APPLICATION FOR A LICENSE TO PRACTICE MEDICINE
WITHOUT RESTRICTION FOR GRADUATES OF UNACCREDITED
MEDICAL SCHOOLS (SCHOOLS OUTSIDE THE U.S. AND CANADA)**

Submit the \$85 fee, check or money order, made payable to the "Commonwealth of Pennsylvania." **FEES ARE NOT REFUNDABLE.** Note: A processing fee of \$20 will be charged for any check or money order returned unpaid by your bank, regardless of the reason for non-payment. Your cancelled check is your receipt of payment.

TO BE COMPLETED BY APPLICANT
(Please print or type)

NAME:	Last YAHAV	First ERIC	Middle KFIR
--------------	-------------------	-------------------	--------------------

ADDRESS:	Street	[REDACTED]	
-----------------	--------	------------	--

City:	[REDACTED]	State:	[REDACTED]	ZIP:	[REDACTED]
--------------	------------	---------------	------------	-------------	------------

DATE OF BIRTH:	Month Day Year [REDACTED]	SOCIAL SECURITY NUMBER:	[REDACTED]
-----------------------	---------------------------	--------------------------------	------------

EMAIL ADDRESS:	[REDACTED]
-----------------------	------------

PHONE NUMBER:	[REDACTED]
----------------------	------------

If your medical/licensure records are listed under another name or names, please list below:

APPLYING USING FCVS (FEDERATION CREDENTIAL VERIFICATION SERVICE):	<input type="checkbox"/> YES	<input checked="" type="checkbox"/> NO
--	------------------------------	--

HAVE YOU PREVIOUSLY HELD A PA MEDICAL TRAINING LICENSE?:	<input type="checkbox"/> YES LICENSE NO. _____	<input checked="" type="checkbox"/> NO
---	---	--

APPLICATION FOR UNRESTRICTED LICENSE - INTERNATIONAL

NAME OF APPLICANT:	Last YAHAV	First ERIC	Middle LEIR
--------------------	---------------	---------------	----------------

NAME & ADDRESS OF MEDICAL SCHOOL

1. NAME OF MEDICAL SCHOOL:	ROSS UNIVERSITY School of MEDICINE
----------------------------	------------------------------------

ADDRESS OF SCHOOL:	P.O. BOX 266, ROSEAU, COMMONWEALTH OF DOMINICA, WI
--------------------	--

DATE OF ATTENDANCE:	FROM	Month	Day	Year	TO	Month	Day	Year
		09	01	2002		05	31	2006

2. NAME OF MEDICAL SCHOOL:	
----------------------------	--

ADDRESS OF SCHOOL:	
--------------------	--

DATE OF ATTENDANCE:	FROM	Month	Day	Year	TO	Month	Day	Year	DATE OF GRADUATION	Month	Day	Year
---------------------	------	-------	-----	------	----	-------	-----	------	--------------------	-------	-----	------

EXAMINATION INFORMATION

CHECK LICENSING EXAMINATION(S) PASSED:	<input type="checkbox"/> FLEX	STATE WHERE TAKEN	DATE TAKEN COMPONENT 1:	_____
			COMPONENT 2:	_____

<input type="checkbox"/> NATIONAL BOARD	PART I:	PART II:	PART III:
---	---------	----------	-----------

<input checked="" type="checkbox"/> USMLE	STEP 1: 10/04	STEP 2: 1/06	STEP 3: 10/08
---	---------------	--------------	---------------

<input type="checkbox"/> LMCC - CANADIAN	
--	--

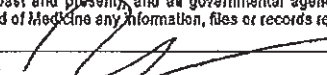
<input type="checkbox"/> STATE BOARD	INDICATE STATE WHERE TAKEN: _____
--------------------------------------	-----------------------------------

ACGME POST GRADUATE TRAINING

PGY1 HOSPITAL:	MT. SINAI School of MEDICINE, JAMAICA, NY	FROM: (mm/dd/yyyy)	TO: (mm/dd/yyyy)
		07/1/2006	6/31/2007

PGY2 HOSPITAL:	COOPER UNIVERSITY HOSPITAL CAMDEN, NJ	FROM: (mm/dd/yyyy)	TO: (mm/dd/yyyy)
		7/1/07	6/31/08

PGY3 HOSPITAL:	COOPER UNIVERSITY HOSPITAL CAMDEN, NJ	FROM: (mm/dd/yyyy)	TO: (mm/dd/yyyy)
		7/1/08	6/31/09

LEGAL QUESTIONS		
You must answer the following questions.		
If you answer "YES" to #2 through #9, provide complete details on a separate sheet as well as certified copies of relevant documents. <u>Sign and date below.</u>		
		Yes No
1.	Do you hold or have you ever held an unrestricted license, certification, or registration (active or inactive, current or expired) to practice medicine and/or surgery in any jurisdiction? <u>If yes, list the jurisdiction(s) here: NEW JERSEY</u>	X
2.	Have you withdrawn an application for a license, certificate or registration, had an application for a license denied or refused, or for any disciplinary reason agreed not to reapply for a license, certificate or registration in any profession in any state or jurisdiction?	X
3.	Have you had disciplinary action taken against your license, certificate or registration issued to you in any profession in any other state or jurisdiction?	X
4.	Have you been convicted, found guilty or pleaded not contendere, or received probation without verdict or accelerated rehabilitative disposition (ARD) as to any felony or misdemeanor, including any drug law violations, or do you have any criminal charges pending and unresolved in any state or jurisdiction? You are not required to disclose any ARD or other criminal matter that has been expunged by order of a court.	X
5.	Since May 19, 2002, have you been arrested for criminal homicide, aggravated assault, sexual offenses or drug offenses in any state, territory or country?	X
6.	Have you had practice privileges denied, revoked or restricted in a hospital or other health care facility, or have you been charged by a hospital, university, or research facility with violating research protocols, falsifying research, or engaging in other research misconduct?	X
7.	Have you had your DEA registration denied, revoked or restricted or have you had your provider privileges terminated by any medical assistance agency for cause?	X
8.	Are you, or have you ever been, addicted to the intemperate use of alcohol or to the habitual use of narcotics or other habit-forming drugs? Note: You may answer "NO" if you are currently a participant in or have successfully completed the requirements of the Pennsylvania Department of State Professional Health Monitoring Program.	X
9.	Since May 19, 2002, have any malpractice complaints been filed against you? If yes, the Board requires that you submit a copy of the <u>entire Civil Complaint</u> which must include the <u>docket number, filing date, and the date you were served.</u>	X
SIGNED STATEMENT		
<p>Note that disclosing your social security number on this application is <u>mandatory</u> in order for the State Board of Medicine to comply with the requirements of the federal Social Security Act pertaining to child support enforcement, as implemented in the Commonwealth of Pennsylvania at 23 Pa. C.S. 4304.1(a). In order to enforce domestic child support orders, the Commonwealth's licensing boards must provide to the Department of Public Welfare information prescribed by DPW about the licensee, including the social security number. Additionally, disclosing the number is <u>mandatory</u> in order for this board to comply with the reporting requirements of the federal National Practitioner Data Bank and the Healthcare Integrity and Protection Data Bank. Reports to the NPDB/HIPDB must include the licensee's social security number.</p> <p>I verify that the statements in this application are true and correct to the best of my knowledge, information and belief. I understand that false statements are made subject to the penalties of 18 Pa. C.S. Section 4904 relating to unsworn falsification to authorities and may result in the suspension or revocation of my license or certificate. I hereby authorize all hospitals, institutions or organizations, my references, personal physicians, employers (past and present), and all governmental agencies and instrumentalities (local, state, federal or foreign) to release to the Pennsylvania State Board of Medicine any information, files or records requested by the Board.</p>		
Signature of Applicant		Date <u>2/12/12</u>

RECEIVED DIRECT

MD AH
(1/2012)

PENNSYLVANIA STATE BOARD OF MEDICINE

VERIFICATION OF ACGME APPROVED GRADUATE MEDICAL TRAINING
(Graduates of Unaccredited Medical Schools)

SECTION 1 - TO BE COMPLETED BY APPLICANT

NAME: Last **YAHAV** First **ERIC** Middle **KFIR**

- If training began before July 1, 1987, one year of approved training at a first (PGY 1) or second (PGY 2) year level must be verified. If the training began on or after July 1, 1987, three (3) years of approved training are required, one at first (PGY 1) year level, one at second (PGY 2) year level and one at third (PGY3) year level.
- Training at a first (PGY 1) year must be ACGME approved entry level (training which requires no previous training). Training at a second (PGY 2) year and third (PGY3) year must be ACGME approved and can be any specialty.
- If training was completed at more than one hospital, duplicate this form and submit to each hospital.

SECTION 2 - TO BE COMPLETED BY PROGRAM DIRECTOR WHERE THE GRADUATE TRAINING OCCURRED

If training was in Pennsylvania, information must coincide with data on graduate license. For applicants still in the third year of training, this form may be completed and signed by the program director fifteen (15) days prior to the completion of the approved training. Forms postmarked or signed prior to the fifteen days will not be accepted.

HOSPITAL WHERE TRAINING WAS COMPLETED: **Queens Hospital**

NAME OF SPONSORING INSTITUTION: **MT. Sinai School of Medicine**

LOCATED IN: CITY **Queens** STATE **New York**

YEAR	FROM (DATE)	TO (DATE)	SPECIALTY	PGY LEVEL
1 ST YEAR	7/1/2006	6/30/2007	OB/GYN	1
2 ND YEAR				
3 RD YEAR				

ACGME OK

"I certify that the above named applicant successfully completed/will successfully complete this graduate medical training and that there was/is no disciplinary action outstanding against this applicant. If this applicant does not complete this training, the Board will be notified." If there has been disciplinary action regarding this applicant, please provide a separate statement outlining the details.

If the hospital has no seal or stamp to affix to this document, I will have the form notarized to verify that it was completed by this hospital.

Signature of Program Director: _____ Date: **3/22/2012**

(Seal) Notary Signature _____
Notary Commission Expiration Date: _____

RETURN COMPLETED FORM DIRECTLY TO THE BOARD IN OFFICIAL HOSPITAL ENVELOPE

RECEIVED DIRECT

MD AH
(1/2012)

PENNSYLVANIA STATE BOARD OF MEDICINE

VERIFICATION OF ACGME APPROVED GRADUATE MEDICAL TRAINING
STANDARD OF QUALITY IN RESIDENT MEDICAL EDUCATION

SECTION 1 - TO BE COMPLETED BY APPLICANT

NAME:	Last YAHAV	First ERIC	Middle KFIR
--------------	-------------------	-------------------	--------------------

1. If training began before July 1, 1987, one year of approved training at a first (PGY 1) or second (PGY 2) year level must be verified. If the training began on or after July 1, 1987, three (3) years of approved training are required, one at first (PGY 1) year level, one at second (PGY 2) year level and one at third (PGY3) year level.
2. Training at a first (PGY 1) year must be ACGME approved entry level (training which requires no previous training). Training at a second (PGY 2) year and third (PGY3) year must be ACGME approved and can be any specialty.
3. If training was completed at more than one hospital, duplicate this form and submit to each hospital.

SECTION 2 - TO BE COMPLETED BY PROGRAM DIRECTOR WHERE THE GRADUATE TRAINING OCCURRED

If training was in Pennsylvania, information must coincide with data on graduate license. For applicants still in the third year of training, this form may be completed and signed by the program director fifteen (15) days prior to the completion of the approved training. Forms postmarked or signed prior to the fifteen days will not be accepted.

HOSPITAL WHERE TRAINING WAS COMPLETED:	<i>Cover University Hospital</i>
NAME OF SPONSORING INSTITUTION:	<i>UMDNJ - Robert Wood Johnson Medical School - Camden</i>
LOCATED IN:	CITY <i>Camden</i> STATE <i>NJ</i>

	FROM (MM/DD/YYYY)	TO (MM/DD/YYYY)	SPECIALTY	PGY LEVEL
1 ST YEAR	<i>7/1/2007</i>	<i>6/30/2008</i>	<i>Obstetrics & Gynecology</i>	<i>2</i>
2 ND YEAR	<i>7/1/2008</i>	<i>6/30/2009</i>	<i>Obstetrics & Gynecology</i>	<i>3</i>
3 RD YEAR	<i>7/1/2009</i>	<i>6/30/2010</i>	<i>Obstetrics & Gynecology</i>	<i>4</i>

ACGME

"I certify that the above named applicant successfully completed will successfully complete this graduate medical training and that there was/is no disciplinary action outstanding against the applicant. If this applicant does not complete this training, the Board will be notified." If there has been disciplinary action regarding this applicant, please provide a separate statement outlining the details.

If the hospital has no seal or stamp to affix to this document, I will have the form notarized to verify that it was completed by this hospital.

Signature of Program Director <i>Robin Perry MD</i>	Date <i>3/19/2012</i>
---	-----------------------

(Seal)	Notary Signature _____ Notary Commission Expiration Date: _____
--------	--

RETURN COMPLETED FORM DIRECTLY TO THE BOARD IN OFFICIAL HOSPITAL ENVELOPE

MAR 29 2012

By _____

11/17 (01/2012) AH
 RECEIVED DIRECT

PENNSYLVANIA STATE BOARD OF MEDICINE						
VERIFICATION OF MEDICAL EDUCATION (For Graduates of Unaccredited Medical Schools)						
SECTION 1 - TO BE COMPLETED BY APPLICANT						
NAME:	Last	YAHAV		First	ERIC	
				Middle	KFIR	
NAME OF MEDICAL SCHOOL:	ROSS UNIVERSITY SCHOOL OF MEDICINE					
LOCATION:	630 HIGHWAY 1, POETH BRUNSWICK, NJ 08902					
Submit the verification of medical education form to your medical school(s) and request the school(s) return the completed form along with a certified copy of your diploma and transcripts directly to the Board in an official school envelope.						
SECTION 2 - TO BE COMPLETED BY DEAN OR REGISTRAR OF MEDICAL SCHOOL						
NAME OF MEDICAL SCHOOL:	ROSS UNIVERSITY SOM					
NAME OF MEDICAL STUDENT:	Last	Yahav		First	Eric	
				Middle		
DATE STUDENT BEGAN TO ATTEND THIS MEDICAL SCHOOL:	Month	9	Day	9	Year 2002	
TOTAL NUMBER OF ACADEMIC YEARS COMPLETED IN THIS MEDICAL SCHOOL:	4					
TOTAL NUMBER OF WEEKS OF ACADEMIC INSTRUCTION COMPLETED:	154					
TOTAL NUMBER OF WEEKS OF CLINICAL INSTRUCTION COMPLETED:	90					
DATE OF GRADUATION:	Month	5	Day	31	Year 2006	
I CERTIFY THAT ALL OF THE INFORMATION LISTED ABOVE IS CORRECT						
SIGNATURE OF DEAN/REGISTRAR:			Upon completion, school must return this completed form and certified copies of the diploma and official transcript directly to the Pennsylvania State Board of Medicine in an official school envelope. DO NOT RETURN THIS FORM TO THE APPLICANT			
DATE:	Month	2				Day
(Seal of School)						
Regular Mailing Address STATE BOARD OF MEDICINE P.O. BOX 2849 HARRISBURG, PA 17108-2849 717-793-1400/717-767-2381			Courier Delivery Address STATE BOARD OF MEDICINE 2801 NORTH THIRD STREET HARRISBURG, PA 17110			

RECEIVED DIRECT

This Diploma makes known that
Ross University

On the Nomination of the Faculty of the School of

Medicine has admitted

Eric R. Sir **Hahav**

to the degree of

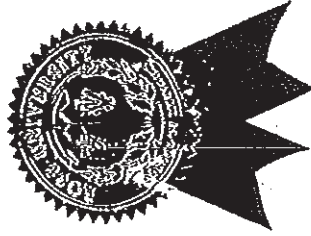
Doctor of Medicine

and has herewith conferred all the Honors, Rights and Privileges to that degree appertaining.

Given this 31st day of 2700 in the year two thousand

57

In Witness Whereof the Seal of the University and the Signatures of the Chairman of the Board and President thereof are herunto affixed.



Dennis Keller

Chairman of the Board of Directors

Thomas C. Kelly

President of the University



EDUCATIONAL COMMISSION FOR
FOREIGN MEDICAL GRADUATES

3624 Market St
Philadelphia, PA 19104-2685 USA
215-388-5900 | 215-388-3185 FAX
www.ecfm.org

2008

PENNSYLVANIA STATE BOARD OF MEDICINE
TAMMY RADEL
ADMIN OFFICER
P.O. BOX 2649
HARRISBURG, PA, 17105-2649

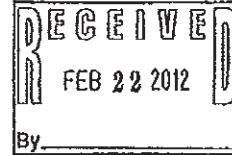
State Board Code:
039
Please include this
number on all requests

ECFMG® CERTIFICATION STATUS REPORT

USMLE™/ECFMG Identification Number: 0-883-754-0
Applicant's Name: Eric Kir Yahav
Applicant's Date of Birth: 06/23/1975
ECFMG Certified: Yes
Certificate Issue Date: 06/16/2008
English Test Valid Through: Valid Indefinitely
Clinical Skills Assessment Valid Through: Valid Indefinitely

Passing Performance on Medical Science Examinations:			
Examination	Date	Two Digit Score	Three Digit Score
USMLE Step 1	08 Oct 2004	*	*
USMLE Step 2 CK	17 Jan 2006	*	*

Most Recent Passing Performance on Clinical Skills Examination:	
Examination	Date
USMLE Step 2 CS	23 Nov 2005



Name of Medical School and Country: Ross University School of Medicine, Roseau, DOMINICA

Degree Year: 2006

† Medical Education Credentials Status: Complete

This information is reported directly from ECFMG computer records and is current as of 02/17/12.

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How to Verify the Authenticity of this Report:

This report was issued to the named recipient on the date shown below. To verify the authenticity of this report, visit <https://cvsonline2.ecfm.org/verify/verify.aspx> and enter the unique verification code at the bottom of the report. The information contained in this report is current as of the issue date. Any changes to the physician's status after the issue date will not be reflected, and you are encouraged to request an updated report.

The purpose of this Status Report is to indicate whether this individual is certified by ECFMG. It reflects only examinations that were used to fulfill requirements for ECFMG Certification. The most recent passing performance on the clinical skills examination is reflected, regardless of whether this individual was required to take a clinical skills examination for ECFMG Certification. This Status Report is not a complete score history of all examinations for this individual. This Status Report does not include examinations that were taken but not passed. Furthermore, if this individual passed examinations that were not used to fulfill the requirements for ECFMG Certification, these examinations are not included.

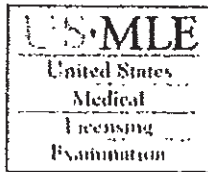
* To obtain a complete history of and scores for USMLE Step examination(s) that may have been taken by this individual, contact the appropriate registration entity to request a USMLE transcript.

† Since July 1986, ECFMG has verified medical school credentials directly with the medical schools, or through a reasonable alternative that has been approved by the ECFMG Medical Education Credentials Committee.

Important Note:

Requesting organizations must normally secure and retain the physician's signed authorization to obtain certification information. Organizations may not resell the information or make it available to any party beyond the initial request as authorized by the physician. The information may only be used to confirm ECFMG certification for the purpose for which the physician provided authorization.

Report Verification Code: DPZ283JRO8



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

This document was prepared by the
Federation of State Medical Boards of the United States, Inc.
Federation Place, 400 Fuller Water Road, Suite 300, Dallas, TX 76039-3856 -- Telephone (817) 868-4041

M/D AH

Date: 02/23/2012

Recipient

Pennsylvania State Board of Medicine
ATTN: Tammy Dougherty
2601 N Third Street
Harrisburg, PA 17110

RECEIVED DIRECT

Examinee: Yahav, Erio
All Name(s): Yahav, Erio Kfir

Examinee ID#: 0-663-754-0
Date of Birth: [REDACTED]

Results for 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. Where numeric scores are reported, there are two scales used and the recommended minimum passing score ("MP") on each scale is shown in parentheses.

USMLE STEP 1

Test Date	Pass/Fail	Three-Digit Score		Two-Digit Score		Comments
		Total	MP	Total	MP	
10/08/2004	Pass	182	182	75	75	
06/21/2001	Fail	180	182	74	75	

USMLE STEP 2

Clinical Knowledge (CK)

Test Date	Pass/Fail	Three-Digit Score		Two-Digit Score		Comments
		Total	MP	Total	MP	
01/17/2006	Pass	189	182	77	75	
10/11/2005	Fail	174	182	71	75	
07/05/2005	Fail	178	182	73	75	

Clinical Skills (CS)*

Test Date	Pass/Fail	Three-Digit Score		Two-Digit Score		Comments
		Total	MP	Total	MP	
11/23/2005	Pass					

USMLE STEP 3

	Test Date	Pass/Fail	Three-Digit Score		Two-Digit Score		Comments
			Total	MP	Total	MP	
NEW JERSEY	10/06/2008	Pass	198	187	81	75	
NEW JERSEY	05/28/2008	Fail	156	187	58	75	

NOTE: A search of the Board Action Data Bank of the Federation of State Medical Boards (FSMB) reveals no reported information on this examinee.

RECEIVED
FEB 24 2012
By

This document was printed from a secure website and accurately reflects score information maintained by the FSMB.



CHRIS CHRISTIE
Governor

KIM GUADAGNO
Lt. Governor

New Jersey Office of the Attorney General

Division of Consumer Affairs
State Board of Medical Examiners
P.O. Box 183, Trenton, NJ 08626-0183



JEFFREY S. CHIESA
Attorney General

THOMAS R. CALCAGNI
Director

For overnight deliveries:
140 East Front St.
PO Box 183, 3rd Floor
Trenton, NJ 08608
(609) 826-7100
(609) 826-7101 FAX

March 6, 2012

Pennsylvania State Board of Medicine
P.O. Box 2649
Harrisburg, PA 17105-2649

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To Whom It May Concern:

The New Jersey State Board of Medical Examiners has been requested by Eric Kfir Yahav to forward a letter of good standing regarding the Medical Doctor's license to practice in the State of New Jersey.

A review of the Board's files indicates that Eric Kfir Yahav was issued a New Jersey license 25MA08534300 on or about 02/04/2009 and is currently Active with an expiration date of 06/30/2013. A review of the Board's files further indicates that no public disciplinary action has been taken against this Medical Doctor.

Very truly yours,

BOARD OF MEDICAL EXAMINERS

William V. Roeder
Executive Director

WVR/dd/mac

MAR 12 2012

the DataBank

P.O. Box 10832
Chantilly, VA 20153-0832

http://www.npdb-hipdb.hrsa.gov

550000073238852
Process Date: 02/23/2012
Page: 1 of 1

SELF-QUERY RESPONSE

This self-query was processed under the provisions of:

Title IV (NPDB)

Section 1921 (NPDB)

Section 1128E (HIPDB)

SEARCH RESULTS			
Medical Malpractice Payment Report(s):	No Reports	Health Plan Action(s):	No Reports
State Licensure Action(s):	No Reports	Professional Society Action(s):	No Reports
Exclusion or Debarment Action(s):	No Reports	DEA/Federal Licensure Action(s):	No Reports
Government Administrative Action(s):	No Reports	Judgment or Conviction Report(s):	No Reports
Clinical Privileges Action(s):	No Reports	Peer Review Organization Action(s):	No Reports

SUBJECT IDENTIFICATION INFORMATION

Subject Name: YAHAV, ERIC KEFIR
Gender: MALE
Date of Birth: [REDACTED]
Other Name(s) Used:
Organization Name:
Organization Type:
Home or Work Address: [REDACTED]
City, State, ZIP: [REDACTED]
Telephone:
Social Security Numbers (SSN):
Individual Taxpayer Identification Numbers (TIN):
Professional School(s) & Year of Graduation: ROSS UNIVERSITY SCHOOL OF MEDICINE (2006)
Occupation/Field of Licensure (Code): PHYSICIAN (MD)
State License Number, State of Licensure: 25MA08534300, NJ
Specialty: OBSTETRICS & GYNECOLOGY
Drug Enforcement Administration (DEA) Numbers: FV1290179
National Provider Identifiers (NPI): 1013156686
Federal Employer Identification Numbers (FEIN):
Unique Physician Identification Numbers (UPIN):

PAYMENT INFORMATION

Credit Card Number:	XXXXXXXXXXXX2017	Expiration Date:	12/2014
Additional Paper Copies Requested:	0		
NPDB Charge:	\$8.00*	NPDB Bill Reference Number:	H27736322
HIPDB Charge:	\$8.00*	HIPDB Bill Reference Number:	H27736322
* Each charge will appear separately on your credit card statement.		Transaction Date:	02/23/2012

Copies of these reports are enclosed for restricted/limited use as prescribed by Title IV of Public Law 99-660, as amended, and Section 1921 of the Social Security Act, as amended by Section 5(b) of the Medicare and Medicaid Patient and Program Protection Act of 1987, and as amended by the Omnibus Budget Reconciliation Act of 1990 and by Section 1128E of the Social Security Act. Information from the NPDB and HIPDB is confidential and must be used solely for the purpose for which it was disclosed. ANY PERSON WHO VIOLATES THE CONFIDENTIALITY PROVISIONS AS SPECIFIED IN TITLE IV IS SUBJECT TO A CIVIL MONEY PENALTY OF UP TO \$11,000 FOR EACH VIOLATION. Subjects of reports who obtain information about themselves from the NPDB and/or HIPDB are permitted to share that information with anyone they choose.

CONFIDENTIAL DOCUMENT - FOR AUTHORIZED USE ONLY

Eric Kfir Yahav, MD

NJ: 25MA08534300
NPI: 1013156686
DEA: Active

Current Employment

CAMcare Health Corporation- Camden, NJ
(In association with Cooper University Hospital)
Healthcare Provider, Dept of Ob/Gyn
July 2010- current

Residency

Cooper University Hospital- Camden, NJ
PGY 2-4: Obstetrics and Gynecology
July 2007- June 2010

Internship

Mt Sinai School of Medicine - Jamaica, NY
PGY-1: Obstetrics and Gynecology
July 2006 - June 2007

Medical Education

Ross University School of Medicine - Dominica, WI 9/2002 - 5/2006
Medical Doctor degree awarded 5/2006

Graduate Education

New York University, New York, NY
Masters in Psychology 9/1997-12/1998
Masters degree awarded 12/1998

Undergraduate Education

Columbia University, New York, NY
Pre-med 1/1999-5/2001

Pennsylvania State University, State College, PA
Major: Psychology
Minor: Health Science 9/1993-5/1997
Bachelor of Science degree awarded 5/1997

Volunteer

Central Park Medical Unit
Emergency Medical Technician 5/1998-4/2002
My position as a Volunteer EMT included all the duties of basic life support in a volunteer ambulance organization that patrols Central Park, NY and its surrounding neighborhoods.

Research Experience

St. Luke's/Roosevelt Obesity Research Center 4/1998-5/2002

Research Coordinator for NIH granted research studies on obesity and eating disorders. I worked with many pioneers in obesity research and eating disorders from around the world. My research was published and presented at symposiums around the country.

Publications/Presentations/Poster Sessions

1. *Psychosomatic Medicine, Cortisol, hunger and desire to binge eat in obese binge eaters following a stress test.* Gluck ME, Gellebter A, Hung J & Yahav E., Publication Date: 11 / 2004 , Volume: 66(6), Pages: 876-881
2. *British Journal of Nutrition, Peripheral and central signals in control of eating in normal, obese, and binge-eating humans.* Hellstrom PM, Gellebter A, Naslund E, Schmidt PT, Yahav E, Hashim SA, Yeomans MR., Publication Date: 2004 , Volume: 92, Pages: S47-57
3. *Physiol Behavior, Gastric capacity, test meal intake, and appetitive hormones in binge eating disorder.* Gellebter A, Yahav E, Gluck ME, Hashim SA., Publication Date: 2004 , Volume: 81, Pages: 735-40
4. *Psychosomatic Medicine, Cortisol, Hunger, and Desire to binge eat following a cold stress test in obese women with binge eating disorder.* Gluck ME, Gellebter A Hung J, Yahav E., Publication Date: 2004 , Volume: 66, Pages: 876-881
5. *Obesity Surgery, Obese patients undergoing Roux-Y gastric bypass surgery have inadequate protein intake related to protein intolerance for up to one year after surgery.* Moize V, Gellebter A, Gluck ME, Yahav E, Colarusso T, Drake V et al., Publication Date: 2003 , Volume: 13, Pages: 23-28

Other Awards/Accomplishments

1. Chief Resident - Cooper University Hospital Ob/Gyn 2009-2010
2. President of Jewish Students Association - Ross University
3. President of Pre-Med Association - Columbia University.

Licensure/certifications (all active and in good standing)

NJ Medical license: 25MA08534300, active since 2009

NPI: 1013156686, active since 2009

DEA: Active since 2009

BLS: Certified

ACLS: Certified

No past or current legal actions pending.

Examinations

USMLE Step 1	10/2004 PASS
USMLE Step 2 CS	11/2005 PASS
USMLE Step 2 CK	1/2006 PASS
USMLE Step 3	10/2008 PASS
ABOG Written Exam	6/2011 PASS

The Federation of State Medical Boards
of the United States, Inc
PO Box 619850
Dallas, Texas 75261-9850
Telephone: (817)868-4000
FAX (817)868-4099

BOARD ACTION CLEARANCE REPORT

April 09, 2012

Attn: Tammy Dougherty
Pennsylvania State Board of Medicine
Tammy Dougherty
PO Box 2649
Harrisburg, PA 17105

Re: Board Action Query Dated: April 09, 2012
Your Reference Number: ahollinger
FSMB Batch Number: BQ2057067

The following is a report of the search results from the Board Action Data Bank as of April 09, 2012 for practitioners submitted as part of the above-referenced batch for which NO board actions were identified.

Practitioners Cleared with No Actions as of April 09, 2012

Item	Name	DOB	School	Yr/Grad	Request ID
1	YAHAV, ERIC K FIR	[REDACTED]		2006	25134742

LICENSE HISTORY
State Board
NEW JERSEY

PLEASE NOTE: The licensure history information contained in these reports is not considered licensure verification but rather an indicator of known states of historical licensure for these individuals. Use of this information should be limited to cross-reference purposes.



COMMONWEALTH OF PENNSYLVANIA
STATE BOARD OF MEDICINE
P. O. BOX 2848
HARRISBURG, PENNSYLVANIA 17105
st.medicine@ps.gov
www.dos.state.pa.us/med
March 5, 2012

Telephone: 717-783-1400/787-2381
Fax: 717-787-7769

ERIC KEIR YAHAV

EVALUATOR: AARON

RE: DISCREPANCY NOTICE -- Unrestricted (IMG)

Dear Doctor:

The Board has received your application for an unrestricted medical license. The items listed below are needed to complete your application. A license cannot be issued until all items are received, approved and the application is complete. You may not practice in the Commonwealth of Pennsylvania as a Physician and Surgeon until a license has been issued by the Board.

- > Verification of ACGME Approved Graduate Medical Training must be received DIRECTLY from the Hospital(s) in official, sealed hospital envelope.
- > Letter(s) of good standing must be received DIRECTLY from the State Board in an official State Board Envelope from the following states:
 - o NEW JERSEY

APPLICATIONS NOT COMPLETED WITHIN SIX MONTHS
WILL REQUIRE UPDATES OF CERTAIN DOCUMENTS.

You may check the status of your application online at www.mylicense.state.pa.us. Click on the link [duplicate licenses/address changes/application status](#). First time users will be required to register and create a user ID and password. Your registration code to register is: GyejKaJ8

The Federation of State Medical Boards
of the United States, Inc
PO Box 619850
Dallas, Texas 75261-9850
Telephone: (817)868-4000
FAX (817)868-4099

BOARD ACTION CLEARANCE REPORT

February 22, 2012

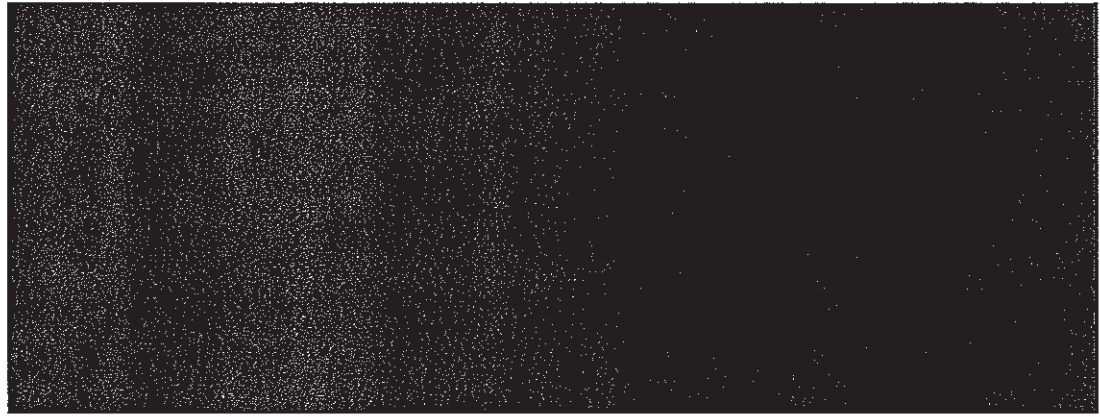
Attn: Tammy Dougherty
Pennsylvania State Board of Medicine
Tammy Dougherty
PO Box 2649
Harrisburg, PA 17105

initial

Re: Board Action Query Dated: February 22, 2012
Your Reference Number: PGI
FSMB Batch Number: BQ2033145

The following is a report of the search results from the Board Action Data Bank as of February 22, 2012 for practitioners submitted as part of the above-referenced batch for which NO board actions were identified.

Practitioners Cleared with No Actions as of February 22, 2012

Item	Name	DOB	School	Yr/Grad	Request ID
					

4 YAHAV, ERIC [REDACTED] 2006 24904169

LICENSE HISTORY
State Board
NEW JERSEY

PLEASE NOTE: The licensure history information contained in these reports is not considered licensure verification but rather an indicator of known states of historical licensure for these individuals. Use of this information should be limited to cross-reference purposes.

Person Info Name: ERIC KFIR YAHAV Address Info Street Address [REDACTED] Email: [REDACTED] Phone [REDACTED] Fax [REDACTED] City [REDACTED] State [REDACTED] Zipcode [REDACTED] Country [REDACTED] County [REDACTED]	
Survey Response Summary Question Response Summary	
Are you submitting a name change with this renewal?	N
Do you hold a license/certificate (active, inactive or expired) to practice in any other state or jurisdiction?	Y
Since your initial application or last renewal, whichever is later, have you had disciplinary action taken against your license, certificate or registration issued to you in any profession in any other state or jurisdiction?	N
Since your initial application or last renewal, whichever is later, have you been convicted, found guilty or pleaded nolo contendere, or received probation without verdict, or accelerated rehabilitative disposition (ARD) as to any felony or misdemeanor, including any drug law violations, or do you have any criminal charges pending and unresolved in any state or jurisdiction? You are not required to disclose any ARD or other criminal matter that has been expunged by order of a court.	N
Since your initial application or last renewal, whichever is later, have you withdrawn an application for a license, certificate or registration, had an application denied or refused, or for disciplinary reasons agreed not to reapply for a license, certificate or registration in any profession in any other state or jurisdiction?	N
Since your initial application or last renewal, whichever is later, have you been arrested for criminal homicide, aggravated assault, sexual offenses or drug offenses in any state, territory or country?	N
Since your last renewal, have you been the subject of a civil malpractice law suit? If yes, please submit a copy of the entire Civil Complaint which must include the filing date and the date you were served. If you previously reported the complaint, email or fax the docket number to the Board. (email at st-medicine@state.pa.us or fax at 717-787-7769)	N
Since your initial application or last renewal, whichever	

is later, have you had your DEA registration denied, revoked or restricted?	N																	
Since your initial application or last renewal, whichever is later, have you had practice privileges denied, revoked or restricted in a hospital or health care facility?	N																	
Since your initial application or last renewal, whichever is later, have your provider privileges been denied, revoked or restricted by any medical assistance agency for cause?	N																	
Do you maintain current medical professional liability insurance in the Commonwealth of Pennsylvania?	N																	
Have you met your current CE requirements?	Y																	
Education Information																		
<table border="1"> <tr> <td colspan="5"><u>EdIt</u></td> </tr> <tr> <td>Profession:</td> <td>Medicine</td> <td>School:</td> <td>ROSS UNIV</td> <td>Credit Hours:</td> <td>Education Type:</td> </tr> <tr> <td>From:</td> <td></td> <td>To:</td> <td>5/31/2006</td> <td></td> <td></td> </tr> </table>		<u>EdIt</u>					Profession:	Medicine	School:	ROSS UNIV	Credit Hours:	Education Type:	From:		To:	5/31/2006		
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Profession:	Medicine	School:	ROSS UNIV	Credit Hours:	Education Type:													
From:		To:	5/31/2006															
Employment Information																		
No employment records																		
remarks Remarks:																		
Continuing Education Information																		
No CE Course records																		

Person Info
 Name: ERIC KFIR YAHAV
 Address Info
 Street Address: [REDACTED] Email: [REDACTED]
 Phone [REDACTED]
 Fax [REDACTED]
 City [REDACTED]
 State [REDACTED]
 Zipcode [REDACTED]
 Country [REDACTED]
 County [REDACTED]

Survey Response Summary
 Question Response Summary

Are you submitting a name change with this renewal?	N
Do you hold a license/certificate (active, inactive or expired) to practice in any other state or jurisdiction?	Y
Since your initial application or last renewal, whichever is later, have you had disciplinary action taken against your license, certificate or registration issued to you in any profession in any other state or jurisdiction?	N
Since your initial application or last renewal, whichever is later, have you been convicted, found guilty or pleaded nolo contendere, or received probation without verdict, or accelerated rehabilitative disposition(ARD) as to any felony or misdemeanor, including any drug law violations, or do you have any criminal charges pending and unresolved in any state or jurisdiction? You are not required to disclose any ARD or other criminal matter that has been expunged by order of a court.	N
Since your initial application or last renewal, whichever is later, have you withdrawn an application for a license, certificate or registration, had an application denied or refused, or for disciplinary reasons agreed not to reapply for a license, certificate or registration in any profession in any other state or jurisdiction?	N
Since your initial application or last renewal, whichever is later, have you been arrested for criminal homicide, aggravated assault, sexual offenses or drug offenses in any state, territory or country?	N
Since your last renewal, have you been the subject of a civil malpractice law suit? If yes, please submit a copy of the entire Civil Complaint which must include the filing date and the date you were served. If you previously reported the complaint, email or fax the docket number to the Board. (email at st-medicine@state.pa.us or fax at 717-787-7769)	N
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Since your initial application or last renewal, whichever is later, have your provider privileges been denied, revoked or restricted by any medical assistance agency for cause?	N															
Do you maintain current medical professional liability insurance in the Commonwealth of Pennsylvania?	N															
Have you met your current CE requirements?	Y															
Education Information																
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From:	To:	5/31/2006														
Employment Information																
No employment records																
remarks																
Remarks:																
Continuing Education Information																
No CE Course records																

myLicense Renewal Question Responses

License Number: MD445512

Name : ERIC KFIR YAHAV

Online Submission Date : 12/7/2012 12:16:01AM

<u>Renewal Question</u>	<u>Response</u>
Are you submitting a name change with this renewal?	N
Are you licensed in another licensing jurisdiction in this profession (any status)?	Y
Since your last renewal, has a licensing jurisdiction taken any disciplinary action against you?	N
Since your last renewal, have you been convicted of a crime?	N
Since your last renewal, have you withdrawn an application for licensure in another licensing jurisdiction?	N
Have you met your current CE requirements?	Y
Since your last renewal, have your provider privileges been terminated by any medical assistance agency for cause?	N
Since your last renewal, have you had practice privileges denied, revoked or restricted in a hospital or health care facility?	N
Since your last renewal, have you had your DEA registration denied, revoked or restricted?	N
Since your last renewal, have you been arrested for criminal homicide, aggravated assault, sexual offenses or drug offenses in any state, territory or country?	N
Do you maintain current medical professional liability insurance in the Commonwealth?	N
Medical Renewal - Since your last renewal, have you been the subject of a civil malpractice law suit?	N