Initial Medical Licensure
PERSONAL INFORMATION
09/2003 INT

STATE OF MARYLAND
BOARD OF PHYSICIANS

P.O. Box 37217 • Baltimore, MD 21297
Telephone: 410-764-4777 Fax: 410-358-2252 Toll Free: 800-492-6836

APPLICATION FOR INITIAL MEDICAL LICENSURE

74036

FOR BANK USE ONLY
Date
Check Number 1130
Amt Paid 817.00
Name Code
AppID 17

Please print legibly or type the required information. Do not leave any item unanswered. If an item does not apply to you, write "N/A" (Not Applicable) for that item. An incomplete application form will delay the processing of your application.

1. **Your Complete Current Legal Name:** As listed on your U.S. birth/marriage certificate, U.S. passport, or most recent document issued by the INS.

Last name and generational indicator (Jr., Sr., II, III, etc.):
MADDEN

First name and middle name:
TESSA ELAINE

(If applicable, please check a box and complete below) ☐ Complete Maiden Name OR ☐ Complete Former Name

Stop! **If any credential you submit bears a name other than your current legal name as listed above, or if you have been licensed in another state under any name other than your current legal name, sign and date an attachment which includes each different name, an explanation of why the name differs from your current legal name, and a copy of the legal document to support the name change.**

2. **Public Address:** Your public address of record. This address, usually your office, is available to the public and will be posted on the internet.

Street Address: **If you change your address prior to being licensed, immediately notify the Board in writing.**
622 WEST 168TH ST

DEPT OF OBGYN PH 16-29

City: NEW YORK
State: NY
Zip Code: 10032-

3. **Non-Public Address:** This address, usually your home, is for Board use only. However, if no public address is listed, this address will be made public.

Street Address: **(Do NOT use a P. O. Box) If you change your address prior to being licensed, immediately notify the Board in writing.**
[redacted]

City [redacted] State [redacted] Zip Code [redacted]

4. **Telephone (s):** Home [redacted] Office: [redacted]

Cell/Pager: [redacted] E-mail address: [redacted]

5. **Date of Birth:** Month [redacted] Day [redacted] Year [redacted]

6. **Gender:** [redacted]le [redacted] Female

7. **Race:** Multiracial applicants may select all applicable categories [redacted] American Indian or Alaska Native [redacted] Asian [redacted] Black or African American [redacted] Native Hawaiian or other Pacific Islander [redacted] White

Ethnicity: [redacted] Hispanic or Latino [redacted] Not Hispanic or Latino

8. **Social Security Number:** [redacted] **Federal Employer Identification Number:** - -

For Board Use Only

License Number: D62919 BPQA School Code: 028002
Date Issued: 03/24/05 Federation School Code: 026060
Licensed By: [signature] Licensing Exam: USMLE

Initial Medical Licensure
CHRONOLOGY
09/2003 INT

Print Your Name: TESSA E MADDEN Date: 2/7/05

9. **Chronology of Activities: DO NOT ATTACH RESUME OR CURRICULUM VITAE**

Beginning with the date you completed medical school and continuing through the present, list chronologically all o your activities. Account for all periods of time including each post-graduate training program you attended, regardl of whether or not you completed the program; each job you held, regardless of whether or not it was medically relat or you were compensated; and any period of unemployment.

Date Medical School was Completed:	month	year
	05	01

Activities after completing medical school: Please type or print.

From (month / year)		To (month / year)	Activity / Address
07 / 01	TO	06 / 05	Activity: RESIDENT IN OB/GYN NEW YORK PRESBYTERIAN/C Address: DEPT OF OB/GYN 622 W. 168TH ST, PH-16-29, NEW YORK, NY
month / year	TO	month / year	Activity: Address:
month / year	TO	month / year	Activity: Address:
month / year	TO	month / year	Activity: Address:
month / year	TO	month / year	Activity: Address:
month / year	TO	month / year	Activity: Address:
month / year	TO	month / year	Activity: Address:
month / year	TO	month / year	Activity: Address:

CONTINUED ON PAGE 3: **If you will need more space than page 3 allows, please photocopy page 3 for your use or attach a separate sheet. Please sign and date each sheet you attach.**

Initial Medical Licensure CHRONOLOGY 09/2003 INT

Print Your Name: TESSA E MADDEN Date: 2/7/05

Chronology (Cont'd) Please photocopy this page if more space is needed. Sign and date all additional enclose them between pages 2 and 3 of the application.

month year TO month year **Activity:**

Address:

month year TO month year **Activity:**

Address:

month year TO month year **Activity:**

Address:

month year TO month year **Activity:**

Address:

month year TO month year **Activity:**

Address:

month year TO month year **Activity:**

Address:

month year TO month year **Activity:**

Address:

month year TO month year **Activity:**

Address:

month year TO month year **Activity:**

Address:

month year TO month year **Activity:**

Address:

Print Your Name: TESSA E MADDEN Date: 2/7/05

10. **MEDICAL EDUCATION: List all medical schools you have attended** From: MM/YY To MM/YY

WASHINGTON UNIV. SCHOOL OF MEDICINE 08/97 - 05/01

Medical School From Which You Received Your Medical Degree: WASHINGTON UNIV SCHOOL OF MEDICINE

Name of University Affiliation (if applicable): *

Street Address: 660 SOUTH EUCLID AVENUE

City: ST. LOUIS **State/Province:** MO **Country of citizenship during medical education:** USA

Language(s) of Instruction: ENGLISH

Type of Degree: [X] M.D. [ ] D.O. [ ] M.D./Ph.D [ ] M.B.B.S. [ ] M.B.B.Ch [ ] Other:_____ (specify)

Date Degree The date you officially received your degree after all prerequisite obligations, required training, government service, etc. **Was Conferred:** was satisfied.

Month 05 Day 18 Year 01

GRADUATES OF FOREIGN MEDICAL SCHOOLS (Schools not in the U.S. or its territories, Puerto Rico, or Canada)
Attach the following documents to this application:

1) A copy of your valid ECFMG certificate or Fifth Pathway Certificate;

2) A copy of your medical school diploma and a certified translation;

3) If you listed an affiliation above (see * in 10 above), attach a copy of the Certificate of Medical Education and Examinations Taken, Good Conduct Certificate or Intern Certificate. The certificate must include your name, name of the medical school, name of the university, and a certified translation .

If your name is not written the same way on all documents you must submit documentation to explain how and why your name differs and submit one of the following documents to support the name change; Passport, INS card, birth certificate, court document, marriage license, court decree.

11. **How have you satisfied Maryland's *written and oral* English language competency requirements?**
(See *English Language Competency Requirements for Medical Licensure in Maryland* in the introductory material included with your application.)

a. [X] I graduated from a medical school **or**, after at least three years of attendance, a high school (includes GED), undergraduate college, or university **where English was the *only* language of instruction throughout** (you must provide documentation); **or**

b. I passed either [ ] the TOEFL **or** [ ] the ECFMG English test after December 31, 1973 **AND** I passed the [ ] TSE **or** [ ] OPI.
If you have taken the Test of English as a Foreign Language (TOEFL) and either the Test of Spoken English (TSE) or the Oral Proficiency Interview (OPI), please request that Education Testing Service and/or Language Testing International send verification of your scores directly to the Board.

Are you claiming speech impairment? [X] NO [ ] YES If "YES," please write or call the Board for additional information.

Stop! Following this page you will find Form MBP IML2, *Verification of Education and English Language Instruction.* Complete Part 1 of form IML2, send it to the institution which granted your medical degree, or to the institution where you satisfied Maryland's English language competency requirements, if it was other than your medical school. Please instruct the institution to mail the completed IML2 directly to the Board in an envelope that clearly bears the institution's name and

12. POSTGRADUATE TRAINING (DO NOT ATTACH RESUME OR CURRICULUM VITAE.) List in chronological order **ALL** postgraduate training undertaken in th United States, its territories or possessions, Puerto Rico, or Canada regardless of whether you did or did not complete the program, and regardless of whether y were or were not compensated. (Copies of training certificates are helpful, but not required.)

NOTE: On a case by case basis, the Board may consider **full time teaching in an LCME accredited medical school in the United States** as an alternative to the accredited postgraduate clinical medical education required in the Code of Maryland Regulations 10.32.01.03D. Applicants who intend to request considerat of teaching experience as an alternative to accredited postgraduate clinical medical education should contact the Board's licensure division for further informatio

Effective October 1, 2000, graduates of all medical schools NOT in the U.S., its territories or possessions, Puerto Rico, or Canada are required to sub evidence acceptable to the Board of successful completion of 2 years of training in a postgraduate clinical medical education program accredited by accrediting organization recognized by the Board (ACGME, AOA, or equivalent). If you have not met this requirement, DO NOT submit this applicatio

A Fifth Pathway Program graduate must have been a U.S. citizen during the time of medical education and must have successfully completed two years of ACG accredited postgraduate clinical medical education ***after*** successfully completing a Board approved Fifth Pathway program. If you have not met these two critera, DO NOT SUBMIT THIS APPLICATION.

If after 10/1/92 you passed any medical licensing exam (or part, step, or component thereof) that you failed three times, either before or after 10/1/92, then you must successfully complete another year of ACGME/AOA accredited clinical postgraduate training in addition to the year(s) usually required by Maryland. **All** of additional year must have begun after the date of the last fail. Teaching will not be accepted as an alternative to a year required following three or more fails. If have not met this requirement, DO NOT submit this application. If you failed any part, step, or component of a medical exam four times, DO NOT SUBMIT THIS APPLICATION; you are not eligible for medical licensure in Maryland.

NOTE: Postgraduate training program cycles usually run from July 1 to June 30. If the dates of your postgraduate training are not within the usual cycle, fall short of the complete cycle, or extend beyond the usual cycle, please attach a complete explanation of why your training was "off-cycle."

PG Year #s	Place of Training:	Specialty:	month / year TO month / ye	Accredited by:
1-4	NEW YORK PRESBYTERIAN HOSP / COLUMBIA Address: 622 WEST 168th ST, PH 16-29 NEW YORK, NY 10032	OB/GYN	07 01 TO 06 0	ACGME ☒ AOA ☐ RCPSC
PG Year #s	Place of Training:	Specialty:	month / year TO month / ye	Accredited by:
	Address:			ACGME ☐ AOA ☐ RCPSC
PG Year #s	Place of Training:	Specialty:	month / year TO month / ye	Accredited by:
	Address:			ACGME ☐ AOA ☐ RCPSC
PG Year #s	Place of Training:	Specialty:	month / year TO month / ye	Accredited by:
	Address:			ACGME ☐ AOA ☐ RCPSC
PG Year #s	Place of Training:	Specialty:	month / year TO month / ye	Accredited by:
	Address:			ACGME ☐ AOA ☐ RCPSC

(ATTACH A SEPARATE SIGNED AND DATED PAGE IF ADDITIONAL SPACE IS NEEDED)

STOP! Following page 6 you will find Form MBP IML3, *Verification of Postgraduate Medical Education.* Fo of the programs you have listed above, complete Part I of the IML3 and send a *copy (front and back) IML3 to the Program Director. Contact all programs before you send the IML3 as many program charge a fee for verification of training, Which is the responsibility of the applicant.

* , to copy both sides of Form IML3 before mailing it to the Program Director.

Print Your Name: TESSA E MADDEN Date: 2/7/05

13. Hospital Privileges After Postgraduate Training: Please list all hospitals where you have had privileges or have provided services **after the completion of your postgraduate training** for the five year period preceding the filing of this application. Copy this page if more space is needed and enclose each signed and dated addition between pages 6 and 7.

	month	year	TO	month	year
Hospital:			TO		
Complete Address:	**Department**				
Hospital:			TO		
Complete Address:	**Department**				
Hospital:			TO		
Complete Address:	**Department**				
Hospital:			TO		
Complete Address:	**Department**				
Hospital:			TO		
Complete Address:	**Department**				
Hospital:			TO		
Complete Address:	**Department**				
Hospital:			TO		
Complete Address:	**Department**				
Hospital:			TO		
Complete Address:	**Department**				
Hospital:			TO		
Complete Address:	**Department**				
Hospital:			TO		
Complete Address:	**Department**				

STOP! **Remember, following this page you will find MBP Form IML3, *Verification of Postgraduate Medical Education.* For each of the postgraduate medical education programs you listed above, complete Part I of the IML3 and send the IML3 to each Program Director. Please remember to copy both sides of Form IML3 if you make additional copies. Contact all programs before you send the IML 3 as some programs now charge a fee for verification of training which is the responsibility of the applicant.**

14. **Medical Licensing Examinations** (USMLE, NBME, NBOME, FLEX, FLEX-Weighted Average, Medical Council of Canada, and licensing exams given by individual states prior to January 1, 1985) **DO NOT SUBMIT THIS APPLICATION until you have received written verification of having passed all parts, steps, or components of your medical licensing examinations or if you have more than 3 fails on any step, part or component of an examination.**

Identify below ALL the medical licensing examinations that you have ever taken. Ask the administering authority of each exam to send the complete medical licensing examination history and scores directly to this Board. In each examination category below, you will find information to help you contact the administering authority.

Have you ever failed any medical licensing examination (or part, step, or component thereof)? NO [X] YES [ ] Since October 1, 1992, have you passed any medical licensing examination (or part, step, or component thereof) which at any time you had failed three times? NO [X] YES [ ]

If you answered "Yes" to a. **and** b., you must have successfully completed another year of ACGME-accredited clinical postgraduate training, in addition to the year(s) of training usually required for licensure in Maryland. No part of the additional year may have been taken before the date of the last fail. If you have not met this requirement, you are not eligible for licensure in Maryland at this time. DO NOT submit this application until you have fulfilled this requirement. **DO NOT SUBMIT AN APPLICATION IF YOU HAVE FAILED ANY PART, STEP, COMPONENT OR APPROVED EXAMINATION COMBINATION MORE THAN 3 TIMES You are not eligible for medical licensure in Maryland. For a complete explanation see enclosed notice regarding the regulation change effective July 22, 2002.**

a. **State Board Examination** List state(s):_____
STATE BOARD DOES NOT INCLUDE STEP 3 OF USMLE, ORAL EXAMS, OR INTERVIEWS. State Board Examinations were licensing exams given by individual states. State Board Examinations taken after December 31, 1984 are not accepted for licensure in Maryland.

Following page 8, you will find supplemental form MBP IML7, *State Board Licensure and Examination Certification*. Send a copy of this form to the state(s) which administered your licensing exam and ask the state(s) to send your exam results directly to the Maryland Board of Physicians. Also send a copy to each state that has ever issued you a license. **NOTE: Many states charge a fee for exam transcripts. Contact each state board**

Federation of State Medical Boards (See reverse if you took a combination of these exams or combined either with the NBME exams)

b. [ ] FLEX-Weighted Average: **All FLEX-Weighted exams prior to 1985 must have been taken in one sitting (3 consecutive days). Flex weighted average exams taken in more than one sitting must have current ABMS or AOA Board Certification unless you are currently certified by a member board of the American Board of Medical Specialties.**

c. [ ] FLEX Components 1 and 2: **Examinations must be passed within 5 years of each other.**

d. [X] USMLE Steps 1, 2, and 3: **Passing scores on all parts must have been completed within a 10-year period beginning with the month and year when the applicant first passed either step 1 or step 2.**

If you took any of the above examinations you must ask the Federation of State Medical Boards (FSMB) to send your transcripts to the Board by accessing their website at www.fsmb.org. *Click transcript requests.*

e. [ ] **National Board of Medical Examiners** (See reverse if you combined this examination with FLEX or USMLE exams)

If you have received NBME certification, ask NBME to send to the Board both the Endorsement of Certification ***and*** the Record of Scores. All requests must be made through the NBME website at **http://www.nbme.org/programs/nbmecert.htm**
If you took NBME exams but were not certified, or you took NBME as part of hybrid exams, ask NBME to send only your Record of Scores.

f. [ ] **National Board of Osteopathic Medical Examiners Certifications issued before January 1, 1971 are not accepted for licensure in Maryland.**

If you have received NBOME certification, ask NBOME to send to this Board the verification of certification and the complete history of your medical examinations. Contact NBOME at 773-714-0622 for instructions and fee information.

g. [ ] **Medical Council of Canada**
Licentiate of the Medical Council of Canada
Please request that verification of your Licenciate Certification and a complete LMCC examination history be sent directly to this Board.
Call MCC at 613-521-6012 for instructions and fee information.

CONTINUED ON PAGE 8

HYBRID EXAMINATIONS

The following combinations are the only hybrid examinations accepted by the Maryland Board.

Passing scores on all parts of hybrid examinations must have been completed within a 10-year period, beginning with the month and year the examinee first passes a part or component or step of the combined examination. ALL HYBRID EXAMINATIONS MUST HAVE BEEN COMPLETED BEFORE JANUARY 1, 2000.

h. ☐	USMLE 1	+	NBME II	+	NBME III	n. ☐	FLEX 1	+	USMLE 3
i. ☐	USMLE 1	+	USMLE 2	+	NBME III	o. ☐	FLEX 2	+	USMLE 1 + NBME II
j. ☐	USMLE 1	+	NBME II	+	USMLE 3	p. ☐	FLEX 2	+	USMLE 1 + USMLE 2
k. ☐	NBME I	+	USMLE 2	+	USMLE 3	q. ☐	FLEX 2	+	NBME I + USMLE 2
l. ☐	NBME I	+	USMLE 2	+	NBME III	r. ☐	FLEX 2	+	NBME I + NBME II
m. ☐	NBME I	+	NBME Ii	+	USMLE 3				

- If your hybrid exams included any part of the NBME examination, contact NBME at **http://www.nbme.org/programs/nbmecert.htm.** or call 215-590-9592 for instructions and request that your Endorsement of Certification *and* your Record of Scores be sent directly to the Board of Physician Quality Assurance.
- If your hybrid exams included only FLEX and USMLE examinations, request your transcript from the Federation of State Medical Boards at *www.fsmb.org.*

15. Licensing History:

a. ☐ I have never been licensed in the U.S., its territories, or Puerto Rico and have never been licensed or registered in Canada.

b. ☐ I have an application for license pending in the following states:_____, _____, _____, _____, _____

c. Please list below all licenses ever issued to you by a U. S. state/territory or Puerto Rico. Also list all Canadian licenses and registrations.

d. Has any disciplinary action ever been taken against your license? ☒ No ☐ Yes If yes, please enclose an explanation.

STATE (Or Puerto Rico or Canadian Province)	LICENSE NUMBER or Registration Number	CURRENT STATUS					
		Active	Inactive	Expired/Lapsed	Surrendered in good standing	Surrendered / Suspended	Revoked
NEW YORK	234443	X					

(If more space is needed, please attach an additional signed and dated sheet)

RECEIVED
MARYLAND BOARD OF PHYSIC

Stop! Following this page you will find form MBP IML7. Complete Part 1 of form IML7 and send a copy to each medical board in the U.S., its possessions and territories, Puerto Rico, and Canada that ever issued you a license/registration or administered to you a state/provincial licensing examination. Please check with each board first to determine if a fee is charged for the verification. The addresses and telephone numbers of all U.S. state medical boards can be found on the Federation of State Medical Board internet site at **www.fsmb.org.**

16. Check **YES** or **NO.**

YES	NO	
X		Did you successfully complete a medical licensing exam (USMLE, NBME, etc.) within the 15-year period prior to filing this application?
X		During the past 10 years, have you maintained uninterrupted licensure since you were first issued a license in the United States, its territories, Puerto Rico, or Canada ?
	X	Do you have lifetime certification from, or within the past 10 years have you been certified or recertified by, a specialty board recognized by the American Board of Medical Specialties, the American Osteopathic Association, or the Royal College of Physicians and Surgeons of Canada?

If "YES," in which specialty were you certified? _____ Date certified _____

⇒ **If you have answered "NO" to all three of the above questions, you MUST take the Special Purpose Examination. After you submit this application, contact the Federation of State Medical Boards at 817-571-2949 and arrange to take the SPEX in Maryland, and have scores sent to the Maryland Board directly.**

17. **Character and Fitness Questions** (Check either **YES** or **NO**)

	YES	NO	
a.	[redacted]	[redacted]	Has a state licensing or disciplinary board (including Maryland), or a comparable body in the armed services, denied your application for licensure, reinstatement, or renewal?
b.			Has a state licensing or disciplinary board (including Maryland), or a comparable body in the armed services, taken action against your license? Such actions include, but are not limited to, limitations of practice, required education admonishment, reprimand, suspension, or revocation. [Refer to the document *Grounds for Board Action in Maryland* included in your application packet.]
c.			Has any licensing or disciplinary board in any jurisdiction (including Maryland), or a comparable body in the armed services, filed any complaints or charges against you or investigated you for any reason?
d.			Have you ever withdrawn your application for a medical license or other health professional license?
e.			Has a hospital, related health care institution, HMO, or alternative health care system investigated you or brought charges against you?
			Has a hospital, related health care facility, HMO, or alternative health care system denied your application for, or failed to renew your privileges; or limited, restricted, suspended, or revoked your privileges in any way?
g.			Have you commited a criminal act to which you plead guilty or nolo contendere, or for which you were convicted or received probation before judgement?
h.			Have you committed an offense involving alcohol or controlled dangerous substances to which you plead guilty or nolo contendere, or for which you were convicted or received probation before judgement? Such offenses include, but are not limited to, driving while under the influence of alcohol and/or controlled dangerous substances.
i.			Excluding minor traffic violations, are you currently under arrest or released on bond, or are there any current or pending charges against you in any court of law?
j.			Do you illegally use drugs?
k.			Do you have any physical or mental condition that currently impairs your ability to practice medicine or that would cause reasonable questions to be raised about your physical, mental, or professional competency?
l.			Have you ever been named as a defendant in a medical malpractice action?
m.			Are you in default of a service obligation that you incurred by receiving State or federal funds for your medical education?
n.			Have you failed to make arrangements to satisfy State or Federal loans that financed your medical education?
o.			Has your employment by any hospital, HMO, other health care facility or institution, or military entity been terminated for disciplinary reasons?
p.			Have you voluntarily resigned from any hospital, HMO, other health care facility or institution, or military entity while under investigation by that institution for disciplinary reasons?
q.			Has the use of drugs and/or alcohol ever resulted in an impairment of your ability to practice your profession?
r.			Have you surrendered your license or allowed it to lapse while you were under investigation by any licensing or disciplinary board of any jurisdiction or any entity of the armed services?

»»» **If you answered "YES" to any of the questions in item 17, on the following page please list all adverse actions taken against you and provide a complete explanation. Attach any supporting documentation that applies (copies of all complaints, malpractice claims, adverse or disciplinary actions, arrests, pleadings, judgements, or final orders). Sign and date all pages submitted.**

Initial Medical Licensure Character/Fitness Details 09/2003 INT	Print Your Name: TESSA E MADDEN	Date: 2/7/05

18 a. If you answered "YES" to any of the questions in item 17, please provide an explanation below and a complaints, pleadings and judgments. Attach additional signed and dated pages as needed.

18 b. If you answered yes to 17L - answer the following questions:

1. Total number of malpractice claims ever filed in which you were named as a defendant?_____
2. Total number of malpractice claims ever paid (settlement / judgment) in which you were named as defendant? _____
3. Within the last 60 months (5 years) provide the following:
   Total number of medical malpractice claims filed _____ ; paid (settlement / judgment) _____ or dismissed_____; in which you were named as a defendant.
4. For a claim filed at any time, but paid (settlement / judgment) within the last 60 months (5 years), li claim by claimants name; describe the disposition of each claim; and provide a copy of the compl pleading, and judgment of each medical malpractice claim.

I have attached the following number of pages to this application:_____

19. CHECKLIST

Please review the checklist before signing page 12. A few minutes spent in review now may save days or weeks of delay in the processing your application.

- [x] I have provided all the personal information requested on this application (page 1)
- [x] My chronology of activities after graduating medical school is le
- [ ] (If applicable) I have enclosed additional sheets for my chronolc
- [x] I have provided all the information about my medical education.
- [x] I have indicated how I have met Maryland's requirement for English proficiency.(Item 11, page 4)

Control No: 94036 03/02/2005 11:58
Madden, Tessa Elaine
Application Form (Standard)
Received: Daniele Worsley
Analyst: Carol Johnson

Graduates of Foreign Medical School

- [ ] My English proficiency requirements were satisfied somewhere other than medical school, so I have requested that documentation of both written and oral proficiency be sent to the Board. (See item 11 on page 4)

I have also enclosed the following documents:

- [ ] A copy of my valid ECFMG certificate (You must take the TOEFL if ECFMG English exam was before January 1, 1974)
- [ ] A copy of my medical school diploma and a certified translation.
- [ ] If applicable a copy of the Certificate of Medical Education and Examinations Taken or Good Conduct or Intern Certificate showing my name, the name of the medical school, and the name of the affiliated university; and a certified translation. (See page 4)

- [x] I have completed Part 1 of form IML2 (follows page 4 of the application) and sent a copy to the institution from which I received my medical degree and, if different, to the institution at which I received English instruction that meets the Maryland requirements.
- [x] I have listed all postgraduate training I have undertaken in the U.S., Canada, or Puerto Rico (page 5); completed Part 1 of form IML3; signed Part 2; printed my name on side B; and sent a form IML3 to the director of each program in which I participated.
- [ ] I have listed all hospitals at which I have had privileges or provided services since the completion of postgraduate training and during the five year period prior to filing my application (page 6). N/A
- [x] I have listed all medical licensing examinations I have ever taken (page 7) and sent a copy of the request for transcripts and any fee that may be required to the appropriate administering authority of each exam (see instructions after exam listed on pages 7 and 8).
- [x] I have listed every license/registration I have ever been issued in the U.S., its territories, Puerto Rico, or Canada.(page 8) and have sent a copy of IML7 to each medical board / issuing authority.
- [x] I do not have to take the Special Purpose Exam (page 9) [ ] I must take the SPEX and have made arrangements to do so.
- [x] I have answered all character and fitness questions (page 9), explained all "yes" answers and, if applicable, enclosed all supporting documents (copies of all complaints, malpractice claims, adverse or disciplinary actions, arrests, pleadings, judgments, final orders, etc.)
- [x] I have attached a 2"x 2" passport quality photograph to the last page (page 12) of this application.
- [x] I have read the statements on page 12 of this application; signed and dated items 20, 21 (if applicable), 22 and 23; and arranged to have the application notarized.
- [x] I have enclosed my check made out to "Maryland Board of Physicians" (or "MBP") in the amount of either $817.00 (Graduates of LCME-accredited American and Canadian medical schools) or $917.00 (Graduates of International Medical Schools).
- [ ] I have attached the following number of pages of documentation to support this application: N/A

STOP! This is not the last page of your application. Please complete page 12 and have it notarized.

Initial Medical Licensure
Supplemental Form
MBP IML-2
09/2003 INT

STATE OF MARYLAND
MARYLAND BOARD OF PHYSICIANS
4201 Patterson Avenue ■ P.O. Box 2571
Baltimore, Maryland 21215-0095
Telephone: 410-764-4777 or toll free 1-800-42-6836

Follows page ___ of the application

DW

VERIFICATION OF EDUCATION AND ENGLISH LANGUAGE INSTRUCTION

Part 1 **APPLICANT: Complete Part 1 and send to the institution which issued your medical degree. If you satisfied Maryland's English language competency requirements somewhere other than your medical school, also send a copy of this form to that institution and ask them to return the completed form directly to the Board.**

Name: MADDEN (Print last name and generational indicator (Jr., Sr., II, III, etc.)) TESSA (First name) ELAINE (Middle name)

Date of Birth: Month Day Year [redacted] **Social Security Number:** [redacted]

School Attended WASHINGTON UNIV SCHOOL OF MEDICINE
Only medical school, undergraduate school, or high school

Affiliated with (if applicable): _____
Name of institution that conferred your degree, if different from medical college attended

Attended from: 08/97 **to** 05/01 **Date of Graduation:** 5/18/01

Part 2 **REGISTRAR, DEAN, PRINCIPAL or OTHER AUTHORIZED OFFICIAL: Please complete this form and mail it to the above address.**

I hereby certify that the above-named individual attended this institution during the inclusive dates from

Month 08 Day 13 Year 97 to Month 05 Day 18 Year 01 ; that all academic studies were taught in the language(s) of English ; that all clinical clerkships were taught in the language(s) of English ; and that he/she was conferred the degree of

☑ M.D. ☐ D.O. ☐ M.D./Ph.D ☐ M.B.B.S. ☐ M.B.B.Ch ☐ Other: _____ (specify)

on Month 05 Day 18 Year 01 after he/she had satisfied all prerequisite obligations.

DEBORAH A. MONOLO, REGISTRAR
ASSISTANT DEAN FOR ACADEMIC AFFAIRS
SCHOOL OF MEDICINE
WASHINGTON UNIVERSITY
660 SOUTH EUCLID AVENUE, BOX 8021
ST. LOUIS, MO 63110

Printed Name of Authorized Official _____ Name of Institution

Title of Authorized Official 314-362-6858 Telephone Number 314-362-4658 Fax Number

Signature of Authorized Official _____ Date 2/10/05

SEAL OF THE INSTITUTION

Initial Medical Licensure
Supplemental Form
MBP IML3
09/2003 INT

MARYLAND BOARD OF PHYSICIANS
4201 Patterson Avenue ■ P.O.Box 2571
Baltimore, Maryland 21215-0095

Side 1
Follows page
of the application

VERIFICATION OF POSTGRADUATE MEDICAL EDUCATION

Part 1 **APPLICANT:** Complete Part 1 and sign where indicated in the Part 2 instructions. Print your name on top of the reverse page, and send a form to the director of each postgraduate training program you attended. Be sure to copy both sides.

a. **Applicant's Name:** MADDEN (Last Name and Generational Indicator (Jr., Sr., II, III, etc.)) TESSA (First Name) ELAINE (Middle Name)

Address: [redacted]

City: [redacted] **State:** [redacted]

Date of Birth: Month Day Year [redacted] **Social Security Number:** [redacted]

b. **Name of Institution:** NEW YORK-PRESBYTERIAN HOSP/COLUMBIA CAMPUS

Department and Area of Training: OBSTETRICS & GYNECOLOGY

Complete Address: 622 WEST 168TH ST, PH 16-29

City: NEW YORK **State:** NY

FROM: Month 07 Year 01 **TO** Month 06 Year 05 **Applicant's Signature:** [signature]

Part 2 **POSTGRADUATE TRAINING PROGRAM DIRECTOR:** Please complete Part 2 according to the records available and send directly to the Maryland Board of Physicians at the above address. Please do not send original or copies to me.

1. Did the applicant participate in postgraduate training in your department during the period listed above?*
   ☒ YES ☐ NO If "No," please enter exact dates: _____ to _____
   Program Specialty: _____
   ***If training was part-time, please explain the training schedule after item 8 of this form.**

2. During the time of the applicant's participation, was the postgraduate training program accredited? ☒ YES ☐ NO
   Accredited by: ☒ **ACGME: Program #** 2203521201 ☐ **AOA: ID #:** _____ ☐ **RCPS**

3. Did the applicant participate in all of the components of the training as required by the accrediting body?
   ☒ YES ☐ NO Comments (attach signed and dated additions as needed): _____

4. Did the applicant successfully complete all requirements of each year of training?
   ☒ YES ☐ NO Comments (attach signed and dated additions as needed): _____

5. During the applicant's year(s) of training, did the applicant have any break in training?
   ☒ NO ☐ YES Comments (attach signed and dated additions as needed): _____

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FEB 14
MARYLAND BOARD OF PHYSICIANS

(Continued on reverse side)

Initial Medical Licensure
Supplemental Form
MBP IML3
09/2003 INT

MARYLAND BOARD OF PHYSICIANS
VERIFICATION OF POSTGRADUATE MEDICAL EDUCATION

Side B

Applicant's Name (print): Tessa E Madden

6. Did the applicant have any physical or mental problem that affected the applicant's ability to practice medicine during the period of training?

☒ NO ☐ YES If "Yes," please give a detailed explanation* _____

7. Was any action taken against the applicant by any training program, hospital, medical board, licensing authority, or court ? Such actions include, but are not limited to investigations, limitations of privileges or special conditions, requirements imposed for academic incompetence, disciplinary actions, probationary actions, etc.

☒ NO ☐ YES If "Yes," please give a detailed explanation* _____

8. In each year of training, did the applicant demonstrate sufficient academic and clinical ability to qualify for advancement without conditional or probationary status to the next year and next progressive level of responsibility in a designated specialty program?

☒ YES ☐ NO Comments:*

Excellent all around physician!

Control No: 94036
Madden, Tessa Elaine
IML3-Accredited Training Programs
Received: Daniele Worsley
Analyst: Carol Johnson

03/02/2005 11:58

RECEIVED
FEB 14 2005
MARYLAND BOARD OF PHYSICIANS

*** If space is not sufficient,**

Attestation: I attest that the information I have provided regarding the applicant is true, accurate, and complete according to all available records.

Jodi P. Lerner MD
Printed Name of Program Director or Authorized Official

Residency Program Direc
Title

NY Presbyterian Columbia
Hospital

622 W 168 St NY NY
Address

Obstetrics / Gynecology
Department

212 305 2376
Telephone Number

Jodi P Lerner MD
Signature

2/8/05
Date

THE UNIVERSITY OF THE STATE OF NEW YORK
THE STATE EDUCATION DEPARTMENT
DIVISION OF PROFESSIONAL LICENSING SERVICES
CERTIFICATION & VERIFICATION UNIT
89 WASHINGTON AVENUE
ALBANY, NEW YORK 12234

THIS IS TO CERTIFY THAT ACCORDING TO THE RECORDS OF THE DIVISION OF PROFESSIONAL LICENSING SERVICES, NEW YORK STATE EDUCATION DEPARTMENT, ALBANY, NEW YORK, MADDEN TESSA E
WAS ISSUED LICENSE/CERTIFICATE NUMBER 234443 FOR THE PRACTICE OF MEDICINE ON 11/09/04.

OUR RECORDS ALSO INDICATE THE FOLLOWING INFORMATION:
DATE OF BIRTH: [redacted]
SCHOOL ATTENDED: WASHINGTON UNIVERSITY
DATE OF GRADUATION: 05/18/01
DEGREE EARNED: MD

PROGRAM WAS ACCEPTABLE IN ACCORDANCE WITH THE NYS REGULATIONS OF THE COMMISSIONER OF EDUCATION. REQUIREMENTS MET AT THE TIME OF LICENSURE.

BASIS OF LICENSURE:

DATE	FLEX1	NBME1	USML1	NBME2	FLEX2	USML2	NBME3	USML3	OTHER
06/04									[redacted]
03/01								[redacted]	
06/99		[redacted]							

EXMS TAKEN=03

A LICENSE IS VALID DURING THE LIFE OF THE HOLDER UNLESS REVOKED, ANNULLED OR SUSPENDED BY THE BOARD OF REGENTS. A LICENSEE MUST REGISTER PERIODICALLY WITH THIS DEPARTMENT TO PRACTICE IN THIS STATE

CURRENTLY REGISTERED: YES REG PERIOD ENDS: 10/31/06
ADDRESS: [redacted]

DEROGATORY INFORMATION: NO CHARGES HAVE BEEN PREFERRED AGAINST THIS LICENSEE.
COMMENTS:

I LINDA GALEY, HEAD CLERK, DIVISION OF PROFESSIONAL LICENSING SERVICES OF THE NEW YORK STATE EDUCATION DEPARTMENT, DO HEREBY STATE THAT AS HEAD CLERK OF SAID DIVISION, I HAVE LEGAL CUSTODY OF THE OFFICIAL RECORDS OF THE DIVISION OF PROFESSIONAL LICENSING SERVICES AND TO THE BEST OF MY KNOWLEDGE, THE AFORESAID INFORMATION IS TRUE AND CORRECT.

SEAL

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

March 1, 2005

Maryland Board of Phys. Q.A.
Attn: C Irving Pinder
PO Box 2571
4201 Patterson Ave, 3rd FL
Baltimore, MD 21215

Re: Board Action Query Dated: March 1, 2005
Your Reference Number:
FSMB Batch Number: [redacted]

The following is a report of the search results from the Board Action Data Bank as of March 1, 2005 for practitioners submitted as part of the above-referenced batch for which NO board actions were identified.

Practitioners Cleared with No Actions as of March 1, 2005

Item	Name	DOB	School	Yr/Grad	Request ID
1	[redacted]				
4					
2					
3					
5					
6					
7					
8					
9	Madden, Tessa Elaine	[redacted]	026060	2001	[redacted]

RELEASE AND CERTIFICATION

20. Release:

I agree that the Maryland Board of Physicians (the Board) may request any information necessary to process my application for medical licensure in Maryland from any person or agency, including but not limited to postgraduate program directors, individual physicians, government agencies, the National Practitioner Data Bank, the Healthcare Integrity and Protection Data Bank, the Federation of State Medical Boards, hospitals and other licensing bodies, and I agree that any person or agency may release to the Board the information requested. I also agree to sign any subsequent release for information that may be requested by the Board.

TESSA E MADDEN — Applicant's Name (Printed)

Applicant's Signature

2/7/05 — Date

21. (OPTIONAL) Third Party Release: Although the Board encourages you to complete all aspects of your application on your own, if you plan to use an intermediary to receive information about the status of your application, please complete this release.

I agree that the Maryland Board of Physicians may release any information pertaining to the status of my application to the following person:

Name: _____

Phone: _____

Applicant's Signature — Date

22. I agree that I will cooperate fully with any request for information or with any investigation related to my medical practice as a licensed physician in the State of Maryland, including the subpoena of documents or records or the inspection of my medical practice.

During the period in which my application is being processed, I shall inform the Board within 30 days of any change to any answer I originally gave in this application, any arrest or conviction, any change of address or any action that occurs based on accusations that would be grounds for disciplinary action under Md. Code Ann., Health Occ. § 14-404.

Applicant's Signature

2/7/05 — Date

23. Affidavit: To be completed by the applicant in the presence of a notary public after the applicant's picture has been attached below.

I certify that I have personally reviewed all the responses to items 1-23 of this application and that the information I have given is true and accurate to the best of my knowledge. I understand and agree that I may not practice, attempt to practice, or offer to practice medicine in Maryland unless licensed by the Board.

Applicant's Signature

2/16/05 — Date

STATE OF New York

CITY/COUNTY OF New York

I HEREBY CERTIFY that on this 16th day of February, 20 05, before me, a Notary Public of the State and City/County aforesaid, personally appeared the Applicant, Dr. Tessa Madden (print applicant's name), whose likeness is identifiable as that of the person in the photograph attached to this application and who has made oath in due form of law to be the person referred to in the above application for license to practice Medicine and Surgery in the State of Maryland, and to have stated the truth in all statements made in this application.

AS WITNESS my hand and notorial seal. Beverly Adams Black
Notary Public

My Commission expires: _____

BEVERLY ADAMS BLACK
Notary Public, State of New York
No. 01AD6074976
Qualified In Rockland County

SEAL