Th 6/20/02 NDS 2/2PGT/SCRS BLR

FORM 1
MEDICINE

The University of the State of New York
THE STATE EDUCATION DEPARTMENT
Office of the Professions
Division of Professional Licensing Services
Cultural Education Center
Albany, NY 12230

DEPARTMENT USE ONLY

60

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APPLICATION FOR LICENSE AND FIRST REGISTRATION

NYS License Number 226134 8/26/02

1 SOCIAL SECURITY NUMBER: [redacted]
(Leave this blank if you have no U.S. Social Security Number)

2 BIRTH DATE: [redacted] *mo. day yr.*

3 PRINT FULL NAME AS YOU WISH IT TO APPEAR ON YOUR LICENSE:

Last EVANS
First MARK
Middle IRA

4 MAILING ADDRESS CHECK ONE: ☒ HOME ADDRESS ☐ WORK ADDRESS

Care of
Street [redacted]
City MEDIA
State PA Zip Code [redacted]
Province/Country If not U.S.

The above address is: ☒ permanent address of record ☐ temporary mailing address

5 TELEPHONE
HOME [redacted] 8/23/02
Area Code Number
WORK [redacted]
Area Code Number
[redacted]
E-Mail Address

IMPORTANT: The applicant is responsible for notifying the Department of any name or address changes.

6 Name as it appears on diploma or other credentials (if different from above): _____

7 Citizenship: ☒ United States ☐ Alien lawfully admitted for permanent residence in the United States. (Attach a copy of the front and back of the alien registration card) ☐ Other Immigration _____

8 Mother's Maiden Name *(family name before her marriage)*: SILVERSTEIN

9 I wish to become licensed on the basis of: ☒ acceptable examination scores *(see page 3 of this form)* ☐ endorsement of another license *(See Pg. 11.)*

I am using FCVS to collect my credentials: ☐ YES ☒ NO

10	Have you previously applied for a New York State license or a limited permit to practice medicine?	[redacted] YES	[redacted] NO
11	Have you ever been convicted of a crime (felony or misdemeanor) in any state or country?	[redacted] YES *See note*	[redacted] NO
12	Have you ever been charged with a crime (felony or misdemeanor) in any state or country, the disposition of which was other than by acquittal or dismissal?	[redacted] YES *See note*	[redacted] NO
13	Have you ever surrendered your license or been found guilty of professional misconduct, unprofessional conduct, incompetence or negligence in any state or country?	[redacted] YES *See note*	[redacted] NO
14	Are charges pending against you for professional misconduct, unprofessional conduct, incompetence or negligence in any state or country?	[redacted] YES *See note*	[redacted] NO
15	Has any hospital or licensed facility restricted or terminated your professional training, employment, or privileges or have you ever voluntarily or involuntarily resigned or withdrawn from such association to avoid imposition of such measures ?	[redacted] YES *See note*	[redacted] NO

NOTE: If any answer to any question 11-15 is "Yes," 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."

November 99

16 In the space below, give a complete record of your education preparation. Attach additional sheets if necessary.

SCHOOLS ATTENDED AND LOCATION (including country) List schools in original language and translate.	Number of Years Attended	Diploma or Degree Obtained *List diploma or degree titles in original language and translate. Indicate year obtained*	If no diploma or degree, number of credits earned
High School or Secondary POLY PREP C.D.S BROOKLYN, NY	4	H.S.	
Postsecondary Preprofessional (Exclusive of Medical School) NEW YORK U. BRONX, NY TUFTS U. MEDFORD, MASS	1 3	B.S. MASSACHUSETTS	30
Medical Education (Professional) (List all medical schools attended) SUNY - DOWNSTATE MEDICAL CENTER - BROOKLYN, NY	4	M.D. - DISTINCTION IN RESEARCH	

17 If you completed clinical clerkships in a country other than where your medical school is located, give the dates and location of these clerkships. Attach additional sheets if necessary.

Inclusive Clerkship Dates	Clinical Area	Name of Health Care Facility And Address	Medical School with which Clerkship Affiliated and Address

18 Provide a chronological list of all activities since graduation from professional school to the present. Include vacation periods and periods of employment. Attach additional sheets if necessary.

DATE (mm/dd/yy) From	To	Type of Activity, Beginning with Date of Graduation from Professional School. Include Name and Address of Employers.
6/25/78	6/30/82	OB/GYN Residency U. Chicago 5841 S. MARYLAND Ave Chicago, IL
7/1/82	6/30/84	Genetics Fellowship - NIH 5000 Rockville Pk, Bethesda, MD
7/1/82	6/30/83	Genetics Fellowship - George Washington U. 2150 PENN Ave NW DC
7/1/83	6/30/84	Instructor OB/GYN George Washington U. 2150 Penn Ave, NW DC
7/1/84	12/31/00	Prof OB/GYN WAYNE STATE UNIVERSITY, Detroit Hospital
		4707 ST ANTOINE DETROIT, MI 48201
1/1/00	Present	Prof & Chairman OB/GYN MCP Hahnemann University
		245 N 15TH ST, Philadelphia, PA

19 Complete item 19 only if you are a graduate of a program not registered by New York State or LCME or AOA accredited.

Have you completed all portions of the examination requirements for ECFMG certification? ☐ Yes ☐ No

Do you currently hold a valid ECFMG certificate? ☐ Yes ☐ No

Please complete and forward the ECFMG form enclosed with this application packet.

20 Are you applying for licensure on the basis of a Fifth Pathway program? ☐ Yes ☒ No

If Yes, list name and location of medical school or hospital and the inclusive dates of attendance.

Name and Location of Medical School or Hospital	Inclusive Dates of Attendance

21 List in English, all specialty qualifications you have earned. (i.e., Board Specialty Certification or Diplomate Certificate)

Name of Qualifications	Name and location of organization issuing credential
Ob Gyn Board Certified	Am Bd. Ob Gyn Dallas TX
Clinical Genetics Board Certified	Am Bd. Medical Genetics. Bethesda. MD

22 ☐ I will be applying for USMLE Step 3

OR

☒ I have successfully completed the examination combination indicated below:

EXAMINATION COMBINATIONS

- ☐ USMLE Steps 1, 2, and 3
- ☐ FLEX Parts I, II, and III
- ☐ FLEX Components I and II
- ☒ NBME Parts I, II, and III
- ☐ NBME Parts I and II and USMLE Step 3
- ☐ NBME Part I, USMLE Step 2 and NBME Part III
- ☐ NBME Part I, and USMLE Steps 2 and 3
- ☐ USMLE Step 1, and NBME Parts II and III
- ☐ USMLE Step 1, NBME Part II, and USMLE Step 3
- ☐ USMLE Steps 1 and 2 and NBME Part III
- ☐ USMLE Step 1, NBME Part II, and FLEX Component II
- ☐ NBME Part I, USMLE Step 2, and FLEX Component II
- ☐ USMLE Steps 1 and 2 and FLEX Component II
- ☐ NBME Parts I and II and FLEX Component II
- ☐ FLEX Component I and USMLE Step 3
- ☐ NBOME Parts I, II, and III
- ☐ Other: _____

Date examination sequence was completed March 1979

23 Are you licensed or have you ever been licensed as a physician in any other state or country? ☒ Yes ☐ No

If yes, list each jurisdiction. In addition, you must have a Form 3A or 3B, as appropriate, submitted. See pages 14 - 15.

State or Country	Date License Issued	Number	Basis of Licensure			Any Limitations on License
			Examination (Date passed)	Endorsement	Other	
ILLINOIS	1979	036-058892	NBME 79			NO
CALIFORNIA	1981	G45178	"			
D.C.	1982	013346	"			
MARYLAND	1982	D28119	"			
VIRGINIA	1982	0101034107	"			
MICHIGAN	1984	4301047149	"			
OHIO	1990	35060460-E	"			
PENNSYLVANIA	2000	MD071935L	"			

24 If you hold a New York State license in another profession, indicate the profession, your license number and date of licensure below.

Profession	License Number	Date of Initial Licensure (mm/dd/yy)
		___/___/___
		___/___/___
		___/___/___
		___/___/___

25 **CHILD SUPPORT OBLIGATION:**

New York State General Obligations Law, section 3-503, requires every applicant for a professional license, permit, or registration, or any renewal there of, to file a written statement that, as of the date of the filing, he or she is, or is not, under an obligation to pay child support. Individuals who are four months or more in arrears in child support may be subject to suspension of their business, professional and/or drivers licenses. The intentional submission of false written statements for the purpose of frustrating or defeating the lawful enforcement of support obligations is punishable pursuant to section 175.35 of the Penal Law.

You must complete this section before we can issue the credential for which you have applied. Individuals who are under an obligation to pay child support but are not in compliance with the General Obligations Law can be issued a credential for no more than six months to discharge child support obligations consistent with that law.

Check only A or B below. If you check B, you must check one of the five statements listed below it.

A ☒ I am not under an obligation to pay child support:

OR

B ☐ I am under an obligation to pay child support *and* (please check only one of the following)

- ☐ I am current and am not four months or more in arrears in the payment of child support: or,
- ☐ I am making payments by income execution or by court agreed payment plan or by a plan agreed to by the parties; or,
- ☐ The child support obligation is the subject of a pending court proceeding; or,
- ☐ I am receiving public assistance or supplemental security income; or,
- ☐ None of the above four statements apply.

26 **STUDENT LOAN DISCLOSURE:**

(a) Do you have any outstanding loans made or guaranteed by the New York State Higher Education Services Corporation? ☐ Yes ☒ No

(b) If you have such a loan(s), is any part in default? ☐ Yes ☐ No

NOTE: Education Law (Section 6501-a) requires the State Education Department to ask the questions above and forward any "yes" responses to question (b) to the New York State Higher Education Services Corporation. Your license application is not complete without this information.

27 **GENDER AND ETHNICITY: (This item is optional. See note below.)**

NOTE: Information on gender and ethnicity is sought solely to allow the Education Department to collect and analyze data concerning representation in the licensed professions. The ethnic and gender data you provide will be used only for statistical, research, and program evaluation purposes. It will not be released to the public. This information has absolutely no bearing on your qualification for licensure.

ETHNICITY: [redacted] White (not Hispanic) [redacted] Black (not Hispanic) [redacted] Asian [redacted] Hispanic [redacted] Native American

GENDER: [redacted] Male [redacted] Female

28 **CHILD ABUSE IDENTIFICATION AND REPORTING: (check only one of the following.)**

☐ I graduated from a New York State medicine program after September 1, 1990.

☐ I completed the child abuse coursework and have enclosed a certificate of completion from an approved provider.

☐ I am filing for an exemption to the requirement and have enclosed the exemption form.

29 **PHOTOGRAPH REQUIREMENT:** ⟶

I give permission to the New York State Education Department to release my examination results to my professional school for the confidential purposes of program review and institution research and planning. I may rescind this authority at any time by notifying, in writing, the Division of Professional Licensing Services.

☒ Yes ☐ No Please initial: [redacted]

Under penalties of perjury, 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.

Signature of applicant: [redacted] *Date:* 5/30/02

[redacted]

Date of photo: 5/23/02

Mail this form and appropriate fee to: New York State Education Department, Office of the Professions, Fee Section, Division of Professional Licensing Services, Cultural Education Center, Albany, NY 12230. DO NOT SEND CASH. Make check or money order payable to the New York State Education Department.

file
Mg 6/24/02

FORM 2
MEDICINE

The University of the State of New York
THE STATE EDUCATION DEPARTMENT
Office of the Professions
Division of Professional Licensing Services
Cultural Education Center
Albany, NY 12230

CERTIFICATION OF PROFESSIONAL AND PREPROFESSIONAL EDUCATION

APPLICANT INSTRUCTIONS

1. Complete Section I. Enter your name as it appears on your New York State Licensure Application (Form 1).
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.
3. If you attended a medical school that has been closed, send this form to the official repository of the records for that school (e.g., CONES).
4. This form must be signed by the Registrar, Dean, Rector, or Principal of the medical school and sent back directly to the Office of the Professions by that school official in an official school envelope. Forms sent back by the applicant or other parties will not be accepted.

SECTION I: APPLICANT INFORMATION

1 SOCIAL SECURITY NUMBER [redacted]
(Leave this blank if you have no U.S. Social Security Number)

2 BIRTH DATE [redacted]
Month Day Year

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

Last EVANS
First MARK
Middle IRA
Maiden or Previous name

4 MAILING ADDRESS:
Apt./Bldg.
Street [redacted]
City MEDIA
State PA Zip Code [redacted]
Province/Country If not U.S.

(check only one) ☒ permanent address of record ☐ temporary mailing address until: ___/___/___ *mo. day. yr.*

5 TELEPHONE: WORK [redacted] HOME [redacted]
Area Code Number *Area Code Number*

6 Print name under which your degree or diploma was awarded *(if different from above)*: _____

7 Preprofessional School Attended: TUFTS UNIVERSITY BS 1973

8 Professional School Attended: SUNY DOWNSTATE MD 1978
Address: _____

9 Name of Degree/Diploma: M.D. Date awarded: 5/25/78

SECTION II : CERTIFICATION OF PROFESSIONAL EDUCATION

INSTRUCTION TO SCHOOL: Please complete this section, sign certifying statement, attach the information 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 Applicant's Entrance date: 05 / 08 / 74 Completion/Withdrawal Date: 05 / 25 / 78

2 Degree/diploma conferred: Doctor of Medicine Date of conferral: 05 / 25 / 78

3 Did the applicant receive advanced standing based on prior academic work? ☐ YES ☑ NO
If Yes, indicate when the prior work was completed below.
Name of institution: _____ Dates of attendance: _____ to _____

Submit with this form: (1) An official transcript of studies at your institution, and
(2) Copies of documentation in your file to support the granting of transfer credit.

4 ***For Applicants from N.Y.S. Registered or LCME/AOA Accredited Medical Schools:***
Applicant met LCME/AOA requirements for admission to medical/osteopathic school? ☑ YES ☐ NO

If No, number of preprofessional postsecondary credit hours completed by applicant prior to admission to medical school _____ semester hours or _____ quarter hours.

5 ***For All Other Applicants:***

Years of education required for admission into your medical school: _____

Preprofessional credential/degree submitted by applicant for admission into your medical school: _____

Was Social Service required? ☐ YES ☐ NO If Yes, give inclusive dates and name of institution in which requirement was met.

Institution: _____ Dates: _____ to _____

Was a pre-graduation internship required? ☐ YES ☐ NO If Yes, give inclusive dates and name of institution in which requirement was met.

Institution: _____ Dates: _____ to _____

Submit with this form:

A. An official transcript (course record, index, or marksheets) showing courses taken at your institution and accepted from other institutions for transfer of credit or convalidation.
The transcript must bear the original signature of the dean, principal, rector, or registrar 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: [redacted]
Type or Print Name: Joyce Christoforou
Title: Assistant Dean and Registrar (SEAL)
Medical School: _____
Address: Office of the Registrar
SUNY Health Science Center at Brooklyn
450 Clarkson Avenue, Box 98
Brooklyn, NY 11203
Telephone: (718) 270-4555 *E-mail address:* _____
Date: Oct 13 02 **CERTIFICATION IS NOT ACCEPTABLE UNLESS DATED AFTER GRADUATION.**

Return this Form and material requested above to: New York State Education Department, Office of the Professions, Division of Professional Licensing Services, Medicine Licensing Unit, Cultural Education Center, Albany, NY 12230.

7

FORM 2PGT
MEDICINE

The University of the State of New York
THE STATE EDUCATION DEPARTMENT
Office of the Professions
Division of Professional Licensing Services
Cultural Education Center
Albany, NY 12230

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 for U.S. and Canadian approved postgraduate training programs)

APPLICANT INSTRUCTIONS

1. Complete Section 1. Enter your name as it appears on your Licensure Application (Form 1).
2. Please send this form to the director of medical education of the hospital(s) in which you completed postgraduate training. One form must be submitted to verify each residency. If you have completed more than one residency, you may photocopy this form.
3. This form must be sent directly to the Department by the hospital in which you did your residency. If the hospital in which you did your residency does not have a director of medical education, the forms may be completed by the department chair. If the Department cannot determine that this verification came directly from the hospital, the postgraduate hospital training will not be credited.

SECTION I: APPLICANT INFORMATION

1 SOCIAL SECURITY NUMBER: [redacted]
(Leave this blank if you have no U.S. Social Security Number)

2 BIRTH DATE: [redacted] *Month Day Year*

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

Last EVANS
First MARK
Middle ALAN

8/3/02
Reg PG4 1-

4 MAILING ADDRESS:
Apt/Bldg.
Street [redacted]
City MEDIA
State PA Zip Code [redacted]
Province/Country If not U.S.

5 Print name under which postgraduate training was completed: MARK I EVANS MD

6 Hospital in which postgraduate training was completed: WARREN G. MAGNUSON CLINICAL CENTER
Address: NIH 9000 Rockville Pike
Bethesda, MD 20892

SECTION II : CERTIFICATION OF POSTGRADUATE TRAINING

INSTRUCTION TO HOSPITAL: Please complete this section, sign certifying statement, and return the form *directly* to the Division of Professional Licensing Services at the address shown below. This form will not be accepted if returned by the applicant.

This is to certify that Mark Ira Evans
(Physician's Name)

a graduate of SUNY Downstate Medical Center
(Medical school)

was enrolled in a postgraduate training program(s) approved by the Accreditation Council on Graduate Medical Education, the American Osteopathic Association, or Royal College of Physicians and Surgeons of Canada at University of Chicago Lying In Hospital from July 1978 to June 1982.
(Name and location of Hospital)

Level of Training (example PGY-1)	Clinical Area	Inclusive dates (mm/dd/yy)	Successfully completed
Medical Genetics Fellowship	Medical Genetics	July 1, 1982 to June 30, 1984	☑ YES ☐ NO ☐ In progress; satisfactory to date
		/ / to / /	☐ YES ☐ NO ☐ In progress; satisfactory to date
		/ / to / /	☐ YES ☐ NO ☐ In progress; satisfactory to date
		/ / to / /	☐ YES ☐ NO ☐ In progress; satisfactory to date
		/ / to / /	☐ YES ☐ NO ☐ In progress; satisfactory to date

If this physician did not successfully complete the postgraduate training program, please attach a letter of explanation with this form.

☐ Explanation is attached

I am the director of medical education or department chair of the clinical area. I was the program director for the physician named above during the postgraduate training indicated and have carefully read and completed this form and hereby attest that the statements made herein are strictly true in every respect and are supported by hospital records.

Signature of Director/Chair: [redacted]

Type or Print Name of Director/Chair: Chief, Medical Genetics Branch, NHGRI/NIH

Title or Official position: Maximilian Muenke, M.D.

Institution: National Institutes of Health/NHGRI/MGB

(SEAL)

Address: 10 Center Drive, Bldg. 10/10C103

Bethesda, MD 20892-1851

Telephone: [redacted] Date: 7 / 22 / 02

E-mail Address: [redacted]

We have No Seal

Return this Form to: New York State Education Department, Office of the Professions, Division of Professional Licensing Services, Medicine Licensing Unit, Cultural Education Center, Albany, NY 12230.

FORM 2PGT

MEDICINE

8/21 bdc

Pull for Review

The University of the State of New York
THE STATE EDUCATION DEPARTMENT
Office of the Professions
Division of Professional Licensing Services
Cultural Education Center
Albany, NY 12230

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 for U.S. and Canadian approved postgraduate training programs)

APPLICANT INSTRUCTIONS

1. Complete Section 1. Enter your name as it appears on your Licensure Application (Form 1).
2. Please send this form to the director of medical education of the hospital(s) in which you completed postgraduate training. One form must be submitted to verify each residency. If you have completed more than one residency, you may photocopy this form.
3. This form must be sent directly to the Department by the hospital in which you did your residency. If the hospital in which you did your residency does not have a director of medical education, the forms may be completed by the department chair. If the Department cannot determine that this verification came directly from the hospital, the postgraduate hospital training will not be credited.

SECTION I: APPLICANT INFORMATION

1 SOCIAL SECURITY NUMBER: [redacted]

(Leave this blank if you have no U.S. Social Security Number)

2 BIRTH DATE: [redacted] *Month Day Year*

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

Last: EVANS
First: MARK
Middle: IRA

4 MAILING ADDRESS:

Apt./Bldg.:
Street: [redacted]
City: MEDIA
State: PA Zip Code: [redacted]
Province/Country If not U.S.:

5 Print name under which postgraduate training was completed: MARK IRA EVANS MD

6 Hospital in which postgraduate training was completed: U. Chicago Chicago Lying In Hospital

Address: 5841 S. MARYLAND AVE

Chicago, IL 60637

SECTION II : CERTIFICATION OF POSTGRADUATE TRAINING

INSTRUCTION TO HOSPITAL: Please complete this section, sign certifying statement, and return the form *directly* to the Division of Professional Licensing Services at the address shown below. This form will not be accepted if returned by the applicant.

This is to certify that MARK I. EVANS
(Physician's Name)

a graduate of SUNY - HLTH-SCIENCE - BROOKLYN COLL OF MED
(Medical school)

was enrolled in a postgraduate training program(s) approved by the Accreditation Council on Graduate Medical Education, the American Osteopathic Association, or Royal College of Physicians and Surgeons of Canada at

University of Chicago, Dept. of OB/GYN 5841 S Maryland Chicago, IL 60637
(Name and location of Hospital)

Level of Training (example PGY-1)	Clinical Area	Inclusive dates (mm/dd/yy)	Successfully completed
PGY1	OB/GYN	6/24/78 to 6/30/79	☑ YES ☐ NO ☐ In progress; satisfactory to date
PGY2	OB/GYN	7/1/79 to 6/30/80	☑ YES ☐ NO ☐ In progress; satisfactory to date
PGY3	OB/GYN	7/1/80 to 6/30/81	☑ YES ☐ NO ☐ In progress; satisfactory to date
PGY4	OB/GYN	7/1/81 to 6/30/82	☑ YES ☐ NO ☐ In progress; satisfactory to date
		__/__/__ to __/__/__	☐ YES ☐ NO ☐ In progress; satisfactory to date

8/12/02

If this physician did not successfully complete the postgraduate training program, please attach a letter of explanation with this form.

☐ Explanation is attached

I am the director of medical education or department chair of the clinical area. I was the program director for the physician named above during the postgraduate training indicated and have carefully read and completed this form and hereby attest that the statements made herein are strictly true in every respect and are supported by hospital records.

Signature of Director/Chair: [redacted]

Type or Print Name of Director/Chair: Atef Moawad, M.D

Title or Official position: Interim Chair, Dept. of OB/GYN

Institution: University of Chicago

(SEAL)

Address: 5841 S. Maryland Ave, MC 2050
Chicago, IL 60637

Telephone: [redacted] Date: 8/12/02

E-mail Address: [redacted]

Return this Form to: New York State Education Department, Office of the Professions, Division of Professional Licensing Services, Medicine Licensing Unit, Cultural Education Center, Albany, NY 12230.

226134EVA4005290060104

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

06/14/04
LIC: 226134
NME: EVA4
YR: 04
OFF: 1
DOB: [redacted]
SSN:
EIN:

EVANS MARK IRA
[redacted]
FT LEE NJ [redacted]

Name/address change
Complete only if change has occurred

Name
Street
City
State/Zip

PROFESSION: 80 MEDICINE
PERIOD: 08/01/04 - 04/30/06

$ 529
AMOUNT DUE

Complete and sign reverse side of this application

Cat 5 - 1001

	Yes	No
1. Do you wish to register for the period indicated?	✓	
2. Since your last registration application,		
a. Have you been found guilty after trial, or pleaded guilty, no contest, or nolo contendere to a crime (felony or misdemeanor) in any court?	[redacted]	
b. Has any licensing or disciplinary authority revoked, annulled, cancelled, accepted surrender of, suspended, placed on probation, or refused to issue or renew a professional license or certificate held by you now or previously, or fined, censured, reprimanded or otherwise disciplined you?		
c. Are criminal charges pending against you in any court?		
d. Are charges pending against you in any jurisdiction for any sort of professional misconduct?		
e. Has any hospital or licensed facility restricted or terminated your professional training, employment, or privileges, or have you voluntarily or involuntarily resigned or withdrawn from such association to avoid the imposition of such action due to professional misconduct, unprofessional conduct, incompetency, or negligence?		
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 requirements listed in the Child Support Law section below?		
4. Are you a U.S. citizen or a qualified alien as defined below?		

3247313
153 07152084

DO NOT WRITE IN THIS BOX
FOR OFFICIAL USE ONLY

I certify that the statements made in this application and any accompanying documentation are true, complete and correct. I understand that any misrepresentation or any false or misleading information made in connection with my application may **result in criminal prosecution and** *may be cause for disciplinary action, including the loss of my license; and that the willful failure to register while continuing to practice my profession constitutes professional misconduct.*

Signature [redacted] Business phone (248) 361 0837 Date 7/1/04

226134EVA4006000060106

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

12/01/05
LIC: 226134
NME: EVA4
YR: 08
OFF: 1
EIN:

EVANS MARK IRA
[redacted]
FT LEE NJ [redacted]

Name/address change
Complete only if change has occurred

Name
Street
City
State/Zip

$ 600
AMOUNT DUE

PROFESSION: 60 MEDICINE
PERIOD: 05/01/06 - 04/30/08

Complete and sign reverse side of this application

Cst ZIP:

1. Do you wish to register for the period indicated? . . . . [redacted]

2. Since your last registration application,
   a. Have you been found guilty after trial, or pleaded guilty, no contest, or nolo contendere to a crime (felony or misdemeanor) in any court? . . . . .
   b. Has any licensing or disciplinary authority revoked, annulled, cancelled, accepted surrender of, suspended, placed on probation, or refused to issue or renew a professional license or certificate held by you now or previously, or fined, censured, reprimanded or otherwise disciplined you? .
   c. Are criminal charges pending against you in any court? . . . .
   d. Are charges pending against you in any jurisdiction for any sort of professional misconduct? . . . .
   e. Has any hospital or licensed facility restricted or terminated your professional training, employment, or privileges, or have you voluntarily or involuntarily resigned or withdrawn from such association to avoid the imposition of such action due to professional misconduct, unprofessional conduct, incompetency, or negligence? . . . .

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 requirements listed in the Child Support Law section below? . . . .

4. Are you a U.S. citizen or an alien admitted for permanent residence in the U.S.? . . . .

DO NOT WRITE IN THIS BOX
FOR OFFICIAL USE ONLY

I certify that the statements made in this application and any accompanying documentation are true, complete and correct. I understand that any misrepresentation or any false or misleading information made in connection with my application may result in criminal prosecution and may be cause for disciplinary action, including the loss of my license; and that the willful failure to register while continuing to practice my profession constitutes professional misconduct.

Signature [redacted] Daytime phone [redacted] Date 3/17/06

OFFICE OF THE PROFESSIONS
NEW YORK STATE EDUCATION DEPARTMENT
89 Washington Avenue
Albany, NY 12234
518-474-3817

Registration Renewal - Transaction Summary

License Number : 226134
Profession : MEDICINE
Renewal Period : 05/01/2008 through 04/30/2010

We recommend that you print and keep this transaction summary. Thank you for using OP Registration Online.

EVANS MARK IRA
[redacted]
FT LEE NJ [redacted]

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

Offices Selected for Renewal:

	Address	Fee
1)	[redacted] FT LEE, NJ, [redacted]	$ 600

Response to Questions :

Question	Response
1) Have you been found guilty after trial, or pleaded guilty, no contest, or nolo contendere to a crime (felony or misdemeanor) in any court?	[redacted]
2) Has any licensing or disciplinary authority revoked, annulled, cancelled, accepted surrender of, suspended, placed on probation, or refused to issue or renew a professional license or certificate held by you now or previously, or fined, censured, reprimanded or otherwise disciplined you?	
3) Are criminal charges pending against you in any court?	[redacted]
4) Are charges pending against you in any jurisdiction for any sort of professional misconduct?	
5) Has any hospital or licensed facility restricted or terminated your professional training, employment, or privileges, or have you voluntarily or involuntarily resigned or withdrawn from such association to avoid the imposition of such action due to professional misconduct, unprofessional conduct, incompetency, or negligence?	
6) Are you under an obligation to pay child support?	[redacted]
7) Are you a U.S. citizen?	

License Renewal Payment Details:

Receipt No [redacted]
Payment Date : 02/24/2008
Amount Paid : $ 600

OFFICE OF THE PROFESSIONS
NEW YORK STATE EDUCATION DEPARTMENT
89 Washington Avenue
Albany, NY 12234
518-474-3817

Registration Renewal - Transaction Summary

Main Page | Logout

License Number : 226134
Profession : MEDICINE
Renewal Period : 05/01/2010 through 04/30/2012

We recommend that you print and keep this transaction summary. Thank you for using OP Registration Online.

EVANS MARK IRA
[redacted]
FT LEE NJ [redacted]

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

Offices Selected for Renewal:

	Address	Fee
1)	[redacted] FT LEE, NJ [redacted] S	$ 600

Response to Questions :

Question	Response
1) Have you been found guilty after trial, or pleaded guilty, no contest, or nolo contendere to a crime (felony or misdemeanor) in any court?	[redacted]
2) Has any licensing or disciplinary authority revoked, annulled, cancelled, accepted surrender of, suspended, placed on probation, or refused to issue or renew a professional license or certificate held by you now or previously, or fined, censured, reprimanded or otherwise disciplined you?	[redacted]
3) Are criminal charges pending against you in any court?	[redacted]
4) Are charges pending against you in any jurisdiction for any sort of professional misconduct?	[redacted]
5) Has any hospital or licensed facility restricted or terminated your professional training, employment, or privileges, or have you voluntarily or involuntarily resigned or withdrawn from such association to avoid the imposition of such action due to professional misconduct, unprofessional conduct, incompetency, or negligence?	[redacted]
6) Are you under an obligation to pay child support?	[redacted]
7) Are you a U.S. citizen?	[redacted]

License Renewal Payment Details:

Receipt No [redacted]
Payment Date :03/29/2010
Amount Paid :$ 600

OFFICE OF THE PROFESSIONS
NEW YORK STATE EDUCATION DEPARTMENT
89 Washington Avenue
Albany, NY 12234
518-474-3817

Registration Renewal - Transaction Summary

License Number : 226134
Profession : MEDICINE
Renewal Period : 05/01/2012 through 04/30/2014

We recommend that you print and keep this transaction summary. Thank you for using OP Registration Online.

EVANS MARK IRA
[redacted]
FT LEE NJ [redacted]

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

Offices Selected for Renewal:

	Address	Fee
1)	[redacted] FT LEE, NJ, [redacted] US	$ 600

Response to Questions :

Question	Response
1) Have you been found guilty after trial, or pleaded guilty, no contest, or nolo contendere to a crime (felony or misdemeanor) in any court?	[redacted]
2) Has any licensing or disciplinary authority revoked, annulled, cancelled, accepted surrender of, suspended, placed on probation, or refused to issue or renew a professional license or certificate held by you now or previously, or fined, censured, reprimanded or otherwise disciplined you?	[redacted]
3) Are criminal charges pending against you in any court?	[redacted]
4) Are charges pending against you in any jurisdiction for any sort of professional misconduct?	[redacted]
5) Has any hospital or licensed facility restricted or terminated your professional training, employment, or privileges, or have you voluntarily or involuntarily resigned or withdrawn from such association to avoid the imposition of such action due to professional misconduct, unprofessional conduct, incompetency, or negligence?	[redacted]
6) Are you under an obligation to pay child support?	[redacted]
7) Are you a U.S. citizen?	[redacted]

License Renewal Payment Details:

Receipt No	:4242662922
Payment Date	:03/14/2012
Amount Paid	:$ 600

NATIONAL BOARD OF MEDICAL EXAMINERS® (NBME®)

Endorsement of Certification

This document was prepared by
National Board of Medical Examiners® (NBME®)
3750 Market Street, Philadelphia, PA 19104-3190 - Telephone (215) 590-9592

Recipient: New York State Education Department
Medical Processing Unit
Div Prof Licensing Services, Room 3023
Cultural Education Ctr, Empire Plaza
Albany, NY 12230

Date: 06/18/2002

Examinee: Mark Ira Evans **Examinee ID:** [redacted]

Date of Birth: [redacted]

NBME Certification Date: 07/02/1979 **Certificate#:** [redacted]

It is certified that the physician named above successfully completed the examination, education and training requirements for certification by the NBME as of the certification date shown above. This record shows only passing scores for each NBME Part examination reported on this document. If applicable, results for all USMLE Steps taken by this examinee (and for which scores have been reported to date) are also shown.

NBME PART I

Test Date	Pass/Fail	Score Scale	Total Score	(Min. Pass)	Individual Subject Scores: Anat	Phys	Bioc	Path	Micr	Phar	Beh Sci
06/15/1976	[redacted]	Three-Digit	[redacted]	[redacted]	[redacted]						
		Two-Digit									

NBME PART II

Test Date	Pass/Fail	Score Scale	Total Score	(Min. Pass)	Individual Subject Scores: Med	Surg	ObGyn	Prev	Peds	Psych
09/27/1977	[redacted]	Three-Digit	[redacted]	[redacted]	[redacted]					
		Two-Digit								

NBME PART III

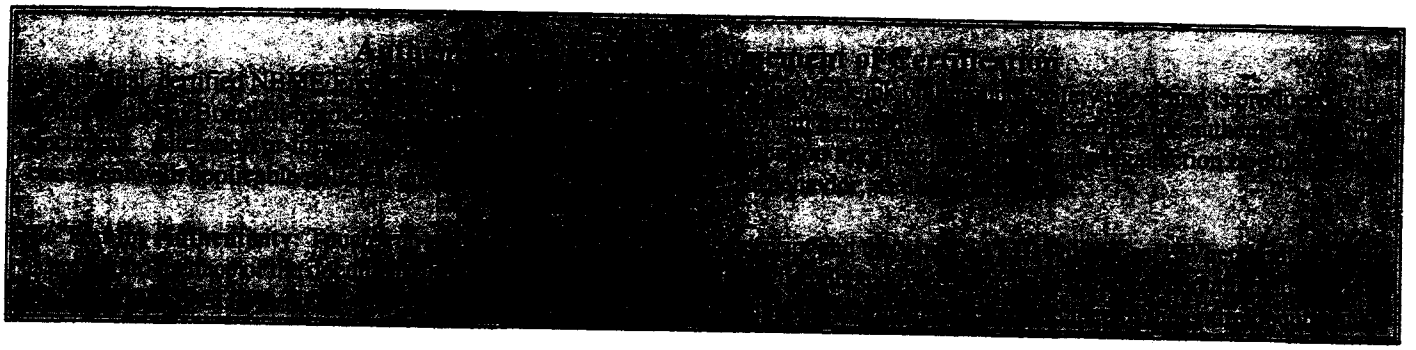
Test Date	Pass/Fail	Score Scale	Total Score	(Min. Pass)
03/07/1979	[redacted]	Three-Digit	[redacted]	[redacted]
		Two-Digit		

NY 1250

Patent 5636674

TouchSafe®

SEE REVERSE SIDE FOR EXPLANATION OF INFORMATION REPORTED ABOVE



INTERPRETATION OF SCORES

NBME Part I and Part II Examinations Prior to June 1991
The most recent total test and subject scores are reported. The total test score is based on the total number of questions answered correctly on the entire examination and is not the average of the subject scores. There are no minimum pass requirements for individual subjects within a Part. Scores are on a scale with a mean of 500 and a standard deviation of 100, in increments of 5. Most scores fall between 250 and 750.

NBME Part I and Part II Examinations June 1991 and Thereafter
The most recent total test score is reported. This score is on a scale with a mean of 200 and a standard deviation of 20, in increments of 1. Most scores fall between 145 and 260.

All NBME Part III Examinations
The most recent total test score is reported. This score is on a scale with a mean of 500 and a standard deviation of 100, in increments of 5. Most scores fall between 250 and 750.

Two-Digit NBME Scores
For all NBME scores, an equivalent value scale score on a two-digit scale is also provided. The scale score mean is 82 and the minimum pass total scale score is 75. Scale scores are reported in increments of 1.

USMLE Step 1, Step 2 and Step 3
If applicable, this document will include a complete score history and notations of any USMLE 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 145 and 260. 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 document 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 document, it may be obtained by contacting the NBME 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 document, it may be obtained by contacting the NBME or the USMLE Secretariat, 3750 Market Street, Philadelphia, PA 19104, telephone (215) 590-9700.

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

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

ANNOTATIONS APPEARING AS "NOTE"

Circumstances not in connection with an administration shown on this document 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 this document by a "Note".