Renewal - 1.041525

Name	ANNA K SFAKIANAKI MD
Credential	1.041525

Fee Details

Renewal Application Fee	$570.00
	$570.00

Demographic Information-Renewal

1. First Name
   ANNA

2. Middle Initial
   K

3. Last Name
   SFAKIANAKI

4. Maiden Name

5. Please provide your Date of Birth.
   11/14/1975

6. U.S. Social Security Number
   [redacted]

7. Gender
   Female

8. Ethnicity: Please choose one:
   Not Hispanic or Latino

9. Race:
   White

Workforce Survey Introduction

Dear Licensee:

Thank you for renewing your license online.

The purpose of the next several questions is to allow the Department of Public Health to collect valuable workforce data that is currently unavailable but critical in identifying and addressing healthcare workforce shortage issues.

Thank you for assisting the Department in this important initiative.

Current Workforce Status in Medicine

10. What is your current work status in Medicine?
    Full Time - (30 hours or more per week)

Workforce Survey

11. In the next 12 months, do you plan to (please mark all that apply):

12. If you are **NOT** working in your licensed profession, please indicate your plans for returning to work in your licensed field.

13. Please provide the number of hours per week that you provide DIRECT PATIENT CARE in your primary professional position.

If you do not provide hours in this category, please indicate 0.
40

14. Please provide the number of hours per week that you work as an ADMINISTRATOR/MANAGER in your primary professional position.

If you do not provide hours in this category, please indicate 0.
5

15. Please provide the number of hours per week that you work as an EDUCATOR/FACULTY in your primary professional position. If you do not provide hours in this category, please indicate 0.
5

16. Please provide the number of hours per week that you work as a RESEARCHER in your primary professional position. If you do not provide hours in this category, please indicate 0.
0

17. If your primary profesional position is in a category other than those above, please provide that category in the box below and indicate the number of hours per week.

If you do not provide hours in this category, please indicate 0.
0

18. Please indicate the setting of your primary professional employment.

Enter comments if "Other" is selected.
Other
Comments: Inpatient and outpatient academic center

Practice Location

If you are providing direct patient care, please identify the location of the primary site where you spend the most time providing direct patient care.

19. Address 1
1 Long Wharf Drive

20. Address 2

21. City
New Haven

22. State
CT

23. Zip Code
06520

Primary Source of Payment

What percent of your patients have the following source of Payment?

24. Medicare
None

25. Medicaid
26 - 50%

less than 10%

27. Private Insurance
51 - 75%

28. Other
less than 10%

Attestation

29. Within the last year, have you been convicted of a felony?
No

30. If yes, please provide details here

31. Within the last year, have you had any disciplinary action taken against you or any such actions pending by another State's licensing/certification authority?
No

32. If yes, please provide details here

By completing this renewal online, I verify that all the information I have provided is accurate and that I satisfy the renewal requirements that apply to my license.

33. I attest that on this date I completed this renewal application online and that all of the statements made by me on this renewal are accurate.
10/29/2014

Important Note

To continue processing your renewal, please click "Next" below (read the rest of this information first).

On the review screen, click **"Add to Invoice."**

On the top right of the invoice screen, select **"Pay Invoice".**

PLEASE NOTE THAT WHEN ENTERING YOUR CREDIT CARD NUMBER, DO NOT ENTER SPACES OR DASHES AS IT WILL RESULT IN A FAILED TRANSACTION.

Please note that you will receive your new licensing documents (2 wallet-sized cards and 1 suitable for posting) during the third week of next month.

Thank you for processing your renewal online.

Review

Renewal - 1.041525

Name	ANNA K SFAKIANAKI MD
Credential	1.041525

Fee Details

Fee Increase Effective 7/12/13	$5.00
Renewal Application Fee	$565.00
	$570.00

Demographic Information

1. Please provide your Date of Birth.
   11/14/1975

Workforce Survey Introduction

Dear Licensee:

Thank you for renewing your license online.

The purpose of the next several questions is to allow the Department of Public Health to collect valuable workforce data that is currently unavailable but critical in identifying and addressing healthcare workforce shortage issues.

Thank you for assisting the Department in this important initiative.

Current Workforce Status in Medicine

2. What is your current work status in Medicine?
   Full Time - (30 hours or more per week)

Workforce Survey

3. In the next 12 months, do you plan to (please mark all that apply):

4. If you are **NOT** working in your licensed profession, please indicate your plans for returning to work in your licensed field.

5. Please provide the number of hours per week that you provide DIRECT PATIENT CARE in your primary professional position.

If you do not provide hours in this category, please indicate 0.
40

6. Please provide the number of hours per week that you work as an ADMINISTRATOR/MANAGER in your primary professional position.

If you do not provide hours in this category, please indicate 0.
0

7. Please provide the number of hours per week that you work as an EDUCATOR/FACULTY in your primary professional position. If you do not provide hours in this category, please indicate 0.
10

8. Please provide the number of hours per week that you work as a RESEARCHER in your primary professional position. If you do not provide hours in this category, please indicate 0.
5

9. If your primary profesional position is in a category other than those above, please provide that category in the box below and indicate the number of hours per week.

If you do not provide hours in this category, please indicate 0.

0

10. Please indicate the setting of your primary professional employment.

Enter comments if "Other" is selected.
Other
Comments: University-based practice

11. Gender
Female

12. Race:
White

13. Ethnicity: Please choose one:
Not Hispanic or Latino

Practice Location

If you are providing direct patient care, please identify the location of the primary site where you spend the most time providing direct patient care.

14. Address 1
Yale University School of Medicine, Dept. OB/GYN, Maternal-Fetal Medicine

15. Address 2
150 Sargent Drive, 2nd Floor

16. City
New Haven

17. State
CT

18. Zip Code
06510

Primary Source of Payment

What percent of your patients have the following source of Payment?

19. Medicare
less than 10%

20. Medicaid
26 - 50%

21. Self-Pay
less than 10%

22. Private Insurance
26 - 50%

23. Other
less than 10%

Attestation

24. Have you been convicted of a felony since your last application?
No

25. Have you had any disciplinary action taken against you or any such actions pending by another State's licensing/certification authority since your last application?

No

By completing this renewal online, I verify that all the information I have provided is accurate and that I satisfy the renewal requirements that apply to my license.

Important Note

Please note that you will receive your new licensing documents (2 wallet-sized cards and 1 suitable for posting) during the third week of next month.

To continue processing your renewal, please click "Next" below.

On the review screen, click **"Add to Invoice."**

On the top right of the invoice screen, you will be given the option to **"Pay Invoice"** or **"Print Invoice."** When you are ready to pay the renewal fee due, choose **"Pay Invoice"** to process your credit card payment.

Thank you for processing your renewal online.

Review

Credential Profile - 1.041525

This profile contains information that may be used as a starting point in evaluating a health care provider. This profile should not, however, be the sole basis for selecting a health care provider. Please direct questions and comments about this profile to: Connecticut Department of Public Health, Physician Profiles, 410 Capitol Ave., M.S. 12 APP, P.O. Box 340308, Hartford, CT 06134-0308, oplc.dph@ct.gov.

Name ANNA K SFAKIANAKI MD
Credential 1.041525

Current Practice Locations

1. Are you currently practicing medicine in Connecticut?
   Yes

2. Are you actively involved in Patient Care?
   No

3. Enter your practice locations

Practice Name	Address 1	Address 2	Address 3	City	State	Zip Code	Primary Practice	Languages Spoken at this Location
Yale-New Haven Hospital	333 Cedar Street			New Haven	Connecticut	06520	Yes	

Connecticut Staff Privileges

4. Indicate the Connecticut Hospitals or Nursing Homes for which you have Staff privileges.

Facility Name	City	State
YALE-NEW HAVEN HOSPITAL, INC.		

Medical School

5. Medical School
   University of Miami School of Medicine

6. Enter the Year of Graduation from Medical School
   1999

Post Graduate Training

7. List your postgraduate training:

Site Name	City	State	Country	Start Date	End Date	Level	Type
Yale University School of Medicine	New Haven	Connecticut	UNITED STATES	07/01/2003	06/30/2004	Fellowship	Maternal/Fetal Medicine
NYU Medical Center	New York	New York	UNITED STATES	07/01/1999	06/30/2003	Resident	OB/GYN

Specialty Area/American Board Certification

This physician has reported the Certification information below. For more information regarding Board Certification please contact:

- *The American Board of Medical Specialties at www.abms.org, or*
- *The American Osteopathic Association at www.am-osteo-assn.org.*

8. Please indicate practice specialties, subspecialties and the date you were certified by ABMS or ABOMS.

Specialty	Subspecialty	Certifying Board	Certification Date

Medical Education Responsibilities

9. Are you a member of the faculty of a Connecticut medical school?
   Yes

10. Select the state medical schools at which you are a member of the faculty.
Yale University Medical School

11. Do you have current responsibility for graduate medical education?
Yes

Publications, Professional Services, Activities, and Awards

12. Publications, Professional Services, Activities, and Awards

Publisher/Issuer	Title/Award Name	Date

Medical Malpractice Information

13. Indicate your malpractice insurance carrier:

14. Indicate the Medical Malpractice Payments you have made within the past ten years.
Some studies have shown that there is no significant correlation between malpractice history and a physician's competence. At the same time, consumers should have access to malpractice information. This profile contains information about the malpractice payment history of the physician. Payment amounts have been placed into three statistical categories: below average, average and above average. To make the best health care decisions, you should view this information in perspective. You could miss an opportunity for high quality care by selecting a doctor based solely on malpractice history.

When considering malpractice data, please keep in mind:

- *Malpractice histories tend to vary by specialty. Some specialties are more likely than others to be the subject of litigation. This report compares physicians only to the members of their specialty, not all physicians, in order to make an individual physician's history more meaningful.*
- *This malpractice information reflects data for the last 10 years of the physician's practice. For physicians practicing less than 10 years, the data covers their total years of practice. You should take into account how long the doctor has been in practice when considering malpractice averages.*
- *The incident causing the malpractice claim may have happened years before payment is finally made. Sometimes it takes a long time for a malpractice lawsuit to move through the legal system.*
- *Some physicians work primarily with high-risk patients. These physicians may have malpractice histories that are higher than average because they specialize in cases or patients who are at very high risk of problems.*
- *Settlement of a claim may occur for a variety of reasons that do not necessarily reflect negatively on the professional competence or conduct of the physician. A payment in settlement of a medical malpractice action or claim should not be construed as creating a presumption that medical malpractice has occurred. For example, an insurer may choose to settle a case even if the physician opposes such settlement.*

You may wish to discuss the information provided in this report, and malpractice generally, with your physician.

Payments made by or on behalf of this healthcare provider:

Resolved Date	Payment Category	Specialty

Connecticut Hospital Discipline

This section contains categories disciplinary actions taken by hospitals during the past ten years which are specifically required by law to be released in the physician's profile.

16. Hospital Discipline

Hospital Name	City	State	Country	Discipline Date	Disciplinary Action

Other State License

18. Indicate States outside of CT where licenses are held.

State	Disciplinary Action

Connecticut Licensure Disciplinary Actions

19. The following lists any past disciplinary actions taken against this licensee. If there is no data present, there have been no disciplinary action taken.

Date of Action	Action	License Status

Felony Convictions

20. Felony Convictions within the previous ten years.

Conviction Date	Conviction

Profile Attestation

I hereby certify that to the best of my knowledge, the information contained in this profile is true and accurate and understand that providing false information may be grounds for sanction, which may include suspension revocation of my license to practice medicine in Connecticut.

21. Enter the date.

Review

Physician Profile Survey
Please Print or Type and Provide All Information Requested in Each Section

1. Biographical and Current Practice Information

CT License Number: 041525 Social Security No.: [redacted]

Last Name: Sfakianaki First Name: Anna MI: K

Telephone No. (Where you may be reached, 8:30 a.m.-4:30 p.m. [redacted]

Are you currently practicing medicine in Connecticut? ☒ YES ☐ NO

Primary Practice Location-Name of Practice: Yale-New Haven Hospital

Address: 333 Cedar Street

City, State Zip: New Haven, CT 06520

List of languages, other than English, spoken at practice location:

Spanish	

Other Practice Location(s)-Name of Practice:

Address:

City, State Zip:

List of Languages, other than English, spoken at practice location:

Please list the Connecticut hospitals/nursing homes at which you have staff privileges:

Name/City, State	Name/City, State
Yale New Haven Hospital	New Haven, CT

2. Medical School

Medical School: university of miami Year of Graduation 1999

****

3. Post Graduate Training (Please list your postgraduate training)

Site: New York University City: New York Country: USA

Inclusive Dates: From: 07 / 01 / 99 To: 06 / 23 / 03 [X] Intern [X] Resident [ ] Fellowship (Please check one)

Type of Training (i.e. Pediatrics, Internal Medicine): Obstetrics & Gynecology

****

Site: Yale University City: New Haven Country: USA

Inclusive Dates: From: 07 / 01 / 03 To: present [ ] Intern [ ] Resident [X] Fellowship (Please check one)

Type of Training (i.e. Pediatrics, Internal Medicine): Maternal Fetal Medicine

****

Site: ______ City: ______ Country: ______

Inclusive Dates: From: ___/___/___ To: ___/___/___ [ ] Intern [ ] Resident [ ] Fellowship (Please check one)

Type of Training (i.e. Pediatrics, Internal Medicine): ______

****

Site: ______ City: ______ Country: ______

Inclusive Dates: From: ___/___/___ To: ___/___/___ [ ] Intern [ ] Resident [ ] Fellowship (Please check one)

Type of Training (i.e. Pediatrics, Internal Medicine): ______

****

Site: ______ City: ______ Country: ______

Inclusive Dates: From: ___/___/___ To: ___/___/___ [ ] Intern [ ] Resident [ ] Fellowship (Please check one)

Type of Training (i.e. Pediatrics, Internal Medicine): ______

****

Site: ______ City: ______ Country: ______

Inclusive Dates: From: ___/___/___ To: ___/___/___ [ ] Intern [ ] Resident [ ] Fellowship (Please check one)

Type of Training (i.e. Pediatrics, Internal Medicine): ______

****

4. Specialty Area/American Board Certification

Practice Specialty: ______ Practice Sub-Specialty: ______
(Please use the attached table of specialties and sub-specialties for a list of acceptable specialties)

Practice Specialty: ______ Practice Sub-Specialty: ______
(Please use the attached table of specialties and sub-specialties for a list of acceptable specialties)

Please list current certifications held by the American Board of Medical Specialties or the American Board of Osteopathic Medical Specialties

American Board of: ______ Date Certified: ___/___/___

American Board of: ______ Date Certified: ___/___/___

American Board of: ______ Date Certified: ___/___/___

****

5. Medical Educational Responsibilities (This Section is Voluntary)

Are you a member of the faculty of a Connecticut medical school? [X] Yes [ ] No

If Yes, Please indicate which one.

[X] Yale University Medical School [ ] University of Connecticut School of Medicine

Do you have current responsibility for graduate medical education? [X] Yes [ ] No

****

6. Publications in Peer Reviewed Journals/Professional Services Offered/Activities and Awards (This Section is Voluntary, but provides you an opportunity to highlight accomplishments, ABMS Board Eligible status or special interests.)

If you include publications or awards, please use the following format:

For publications: Include name of journal, title of article and date published.

awards: Include name of entity issuing award, title of award, and date received.

_____

_____

_____

_____

_____

_____

_____

_____

_____

_____

). _____

Medical Malpractice History

ate Resolved	Amount Paid	Practice Specialty Related To Payment

Hospital Discipline Within Last Ten (10) Years - In Any State

Hospital, City, State, Country	Date	Disciplinary Action

Felony Convictions Within Last Ten (10) Years - In Any State

te of Conviction	Conviction

****

ATTESTATION

reby certify that to the best of my knowledge, the information contained in this profile is true and accurate and understand that providing e information may be grounds for sanction, which may include suspension or revocation of my license to practice medicine in nnecticut.

_____ 07/02/03

nature Date

se return as soon as possible, but no later than 60 days from the postmarked date of this survey. You may send it via facsimile to ysician Profiles" at (860) 509-8457 or by mail (please use the enclosed, addressed envelope) to:

Department of Public Health
Physician Profiles
410 Capitol Ave., MS # 12 APP
PO Box 340308
Hartford, CT 06134-0308

ou have questions, please contact this office at (860) 509-7557.

STATE OF CONNECTICUT

DEPARTMENT OF PUBLIC HEALTH

May 30, 2003

Anna K. Sfakianaki MD
Yale University School of Medicine
OB/GYN, MFM 333 Cedar Street, P.o.Box 208063
New Haven, CT 06520

Dear Licensee:

I am pleased to inform you that you have met all requirements for licensure as **a Physician/Surgeon** in Connecticut. Your license number is **041525** and is effective as of the date of this letter. Your formal license will be mailed to you in the near future. Your name will appear on your license as shown above unless you notify us otherwise.

It is your responsibility to notify the Department of Public Health, Division of Health Systems Regulation, in writing, of any changes of name, residence address or business address, either within or outside Connecticut. Such notification to the Department of Public Health is required by law; failure to provide same may jeopardize the status of your license.

Please note that your license must be renewed annually during your month of birth. Renewal will be required in the first birth month which immediately follows the issuance of licensure. Failure to renew your license within ninety (90) days of the due date will result in your license becoming void. In that event, re-licensure would require a new application to the department and a review of all credentials to determine whether you satisfy current licensing requirements.

Should you have any questions or concerns regarding the renewal of your license, please contact the renewal staff at (860) 509-7603.

Respectfully,

Stephen B. Carragher

Stephen B. Carragher
Health Program Supervisor
Office of Practitioner Licensing and Certification

SBC:MM

Phone: (860) 509-7603
Telephone Device for the Deaf (860) 509-7191
410 Capitol Avenue - MS # 12MQA
P.O. Box 340308 Hartford, CT 06134
An Equal Opportunity Employer
Website for licensure verification http://www.ct-clic.com

STATE OF CONNECTICUT
DEPARTMENT OF PUBLIC HEALTH

PHYSICIAN APPLICATION FOR: $5.00

✓ Initial licensure ($450)

Reinstatement (Fee $450) CT License No.: _____ Date Granted: _____

PLEASE INDICATE (X) THE EXAMINATION(S) YOU COMPLETED:

	National Board of Medical Examiners (NBME)		Federation Licensing Examination (FLEX)
	State Board Licensing Exam _____(State) Year Taken: _____		Licentiate of the Medical Council of Canada (LMCC)
X	United States Medical Licensing Examination (USMLE) Was Step 3 taken in CT? If yes, what date? _____		Combination of Segments (please specify)
	National Board of Osteopathic Examiners (NBOME)		

Last Name: SFAKIANAKI First Name: ANNA MI: K Maiden Name: _____

Date of Birth: 11 / 14 / 75 Social Security No [redacted] Gender: F

Name and Mailing Address: This will be how your name and address will appear on your official license, your address of record for all mailings from this office and releasable pursuant to Freedom of Information requests.

Name on License: ANNA K. SFAKIANAKI

Address: Yale University School of Medicine, Dept OB/GYN, MFM
333 Cedar Street ; P.O. Box 208063

City, State, Zip: New Haven, CT 06520-8063

Daytime Phone Number: [redacted] E-mail: [redacted]

MEDICAL EDUCATION:

List name and location of medical school(s) attended Dates of Attendance

University of Miami School of Medicine (FL) 8/95 - 5/99

M.D. DEGREE AWARDED BY: University of Miami (Name of school) **DATE AWARDED:** 5/99

MEDICAL LICENSURE:

List all states in which you have ever been licensed to practice medicine:

STATE	LIC. NUMBER	DATE ISSUED	LICENSED BY: EXAM	LICENSED BY: ENDORSEMENT
NY	222604	8/2001	USMLE	

SPECIALTY:

If certified by a specialty board approved by the American Board of Medical Specialties (ABMS), indicate name of American Board:

AMERICAN BOARD OF: _____ **DATE CERTIFIED:** _____

MEDICAL PRACTICE:

List all medical practice you have engaged in since graduation from medical school (identify internship and residency):

Hospitals Associated With	Location		Dates
NYU Medical Center	NYC, NY	Internship	7/99 - 7/00
NYU Medical Center	NYC, NY	Residency	7/00 - 6/03

Answer only if applying for endorsement of the Medical Council of Canada license. Have you requested a "certificate of good standing" with scores from the Medical Council of Canada? _____ **(Yes or No)**

If you are a foreign medical graduate, do you hold current Educational Commission for Foreign Medical Graduates (ECFMG) certification or have you completed a Fifth Pathway Program? _____ **(Yes or No)**

STATEMENT OF PROFESSIONAL HISTORY

Please answer the following questions referring to the instructions, if applicable.

YES (NO)

1. Have you ever been censured, disciplined, dismissed or expelled from, had admissions monitored or restricted, had privileges limited, suspended or terminated, been put on probation, or been requested to resign or withdraw from any of the following:

-Any hospital, nursing home, clinic, or similar institution;
-Any health maintenance organization, professional partnership, corporation, or similar health practice organization, either private or public;
-Any professional school, clinical clerkship, internship, externship, preceptorship or postgraduate training program;-Any third party reimbursement program, whether governmental or private?

If your answer is "yes", give full details, names, addresses, etc. on separate notarized statement.

2. Have you ever had your membership in or certification by any professional society or association suspended or revoked for reasons related to professional practice?

If your answer is "yes", give names of professional society or association, date and reasons your membership or certification was suspended or revoked on a separate notarized statement.

3. Has any professional licensing or disciplinary body in any state, the District of Columbia, a United States possession or territory, or a foreign jurisdiction, limited, restricted, suspended or revoked any professional license, certificate, or registration granted to you, or imposed a fine or reprimand, or taken any other disciplinary action against you?

If your answer is "yes", give full details, names, addresses, etc. on a separate notarized statement.

4. Have you ever, in anticipation or during the pendency of an investigation or other disciplinary proceeding, voluntarily surrendered any professional license, certificate or registration issued to you by any state, the District of Columbia, a United States possession or territory, or a foreign jurisdiction?

If your answer is "yes" give full details, names, addresses, etc. on a separate notarized statement.

5. Have you ever been subject to, or do you currently have pending, any complaint, investigation, charge, or disciplinary action by any professional licensing or disciplinary body in any state, the District of Columbia, a United States possession or territory, or a foreign jurisdiction or any disciplinary board/committee of any branch of the armed services? You need not report any complaints dismissed as without merit.

If your answer is "yes" give full details, names, addresses, etc. on a separate notarized statement.

6. Have you ever entered into, or do you currently have pending, a consent agreement of any kind, whether oral or written, with any professional licensing or disciplinary body in any state, the District of Columbia, a United States possession or territory, any branch of the armed services or a foreign jurisdiction?

If your answer is "yes" give full details on a separate notarized statement and submit notarized copy of agreement.

STATEMENT OF PROFESSIONAL HISTORY (continued)

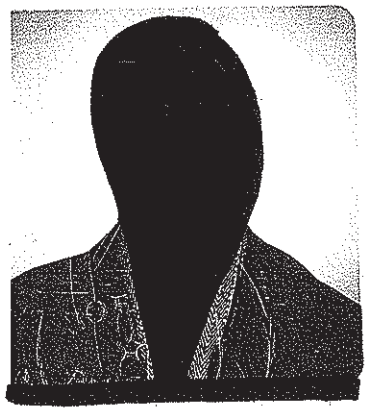
7. Have you ever been found guilty or convicted as a result of an act which constitutes a felony under the laws of this state , federal law or the laws of another jurisdiction and which, if committed within this state, would have a felony under the laws of this state? NO

If your answer is "yes" give full details on a separate notarized statement and furnish a Certified Court Copy (with court seal affixed) of the original complaint, the answer, the judgment, the settlement, and/or the disposition of the case.

8. Have you ever been denied or surrendered a state or federal controlled substance registration, had it revoked or restricted in any way, or been warned, reprimanded or fined by the responsible agency? NO

If your answer is "yes", give full details, dates, etc., on a separate notarized statement.

On this 4th day of February, 2003 (month/ year) ANNA KATERINA SFAKIANAKI **(applicant's name)** personally appeared before me, who being duly sworn says that she/~~he~~ is the person referred to in the foregoing application and that the photograph attached hereto is a true picture of self and that the statements made herein are true in every respect.



All of the above statements contained herein are true and correct to the best of my knowledge and belief.

SIGNATURE OF APPLICANT

Sworn to me this 4th day of February (month/year) 2003.

Notary Public Signature RINA KUCASSIAN Notary Public, State of New York No. 01KU6018479 Qualified in Queens County Commission Expires January 11, 20 07

My Commission Expires January 11, 2007.

PLEASE RETURN THIS APPLICATION AND THE FEE FOR $450 (CERTIFIED CHECK OR MONEY ORDER) MADE PAYABLE TO, **"TREASURER, STATE OF CONNECTICUT"** TO:

DEPARTMENT OF PUBLIC HEALTH
PHYSICIAN LICENSURE
410 CAPITOL AVE., **MS# 12MQA**
P.O. BOX 340308
HARTFORD, CT 06134-0308

IMPORTANT: The application packet for this profession consists of 10 pages, including instructions and eligibility requirements. Do not send this form and fee unless you have read and understood all pertinent information. No fees are refundable should you not be eligible for licensure.

STATE OF CONNECTICUT
DEPARTMENT OF PUBLIC HEALTH
VERIFICATION OF RESIDENCY TRAINING

APPLICANT: Enter your full name and birth date on this form and forward it to the Chief of Staff or program director at the facility in which you completed your residency training. This form must be completed by the facility and returned directly to this office.

Applicant's name: ANNA K. SFAKIANAKI Date of Birth: 11-14-75

Dear Chief of Staff/Program Director:

Please provide the following verification of residency training for the above-named Connecticut physician licensure applicant.

Name of facility where residency training was completed: NYU medical Center

Dates of Residency: From 7/1/1944 (month/day/year) To 6/30/2003 (month/day/year)

In what specialty was the residency training completed: OB/GYN

At what level(s) was this residency completed (PGY1, PGY2, etc.)? PGY1 - PGY4

At the time of the applicant's training, was the residency training program in this specialty area accredited by the Accreditation Council for Graduate Medical Education? Yes (YES or NO)

Did the applicant satisfactorily complete this period of residency training? Yes (YES or NO)

Do you have any derogatory information regarding the competency or conduct of this applicant? No If yes, please attach any disclosable documents you may have on file regarding such information.

I, SCOTT W. SMILEN, MD, being duly sworn, do depose and certify that I am the Chief of Staff/Program Director at:

Name of Facility: NYU SCHOOL OF MEDICINE

Address: DEPARTMENT OF OB/GYN of
550 First Avenue, New York, NY 10016

Telephone Number: [redacted]

and that the information provided herein is true and correct to the best of my knowledge and belief.

Signature of Chief of Staff/Program Director

Subscribed and sworn to me this 6th day of February, (month/ year) 2003

Notary Public's Signature

January 11, 2007
My Commission Expires

Please return this form directly to:

RINA KUCASSIAN
Notary Public, State of New York
No. 01KU6018479
Qualified in Queens County
Commission Expires January 11, 20 07

Department of Public Health
410 Capitol Ave., MS # 12 APP
P.O. Box 340308
Hartford, CT 06134-0308

Website: www.dph.state.ct.us

The Federation of State Medical Boards of the United States, Inc.
Federation Credentials Verification Service
P.O. Box 619850
Dallas, Texas 75261-9850
Telephone: (817) 868-4000
Fax: (817) 868-4099

Physician Information Profile

This report is compiled exclusively for:

Name: **Anna Katerina Sfakianaki**
[redacted]
DOB: **11/14/1975**
Recipient: **Connecticut Medical Examining Board**

NOTICE:

The Federation Credentials Verification Service (FCVS) was retained by the above referenced physician to verify his/her medical credentials for submission to your agency/organization. Unless noted otherwise, all documents contained in this report were received directly from the issuing institution per written request made by FCVS. All documents bearing the official FCVS seal are ceritified to be an exact reproduction of the original. Where required, original documents are provided according to the agreements with the institution issuing such document. FCVS maintains all original documents (excluding third-party examination transcripts) in the physician's source file.

Table of Contents

Section I

FCVS Reports

FEDERATION CREDENTIALS VERIFICATION SERVICE

Physician Information Report

Identity:

Name:	**Anna Katerina Sfakianaki**
Other Name Used:	**N/A**
Gender:	**Female**
Date of Birth:	**11/14/1975**
Place of Birth:	**Columbus, OH USA**
SSN:	[redacted]
Current Address:	[redacted]
Permanent Address:	**Same**
Telephone Numbers:	Bus: [redacted]
	Fax: **N/A**
	Home: [redacted]
	Other: **N/A**
Physical Description:	Height: **5' 2"**
	Weight: **120 lbs**
	Eye Color: **Brown**
	Hair Color: **Brown**
Physical Marks:	Description: **N/A**
	Location: **N/A**

Premedical Education (Reported by physician. Not verified by FCVS)**:**

Institution:	**University of Miami, Coral Gables, FL 33124**
Dates of Attendance:	**08/1993 - 05/1996**
Degree Awarded:	**Bachelor of Science**

Medical Education:

Current, valid ECFMG	**N/A**
ECFMG Number:	**N/A**
Date Issued:	**N/A**
Medical School:	**University of Miami School of Medicine** **PO Box 0169600 Northwest R-128** **Miami, FL 33101**
Dates of Attendance:	**08/18/1995 - 05/09/1999**
Graduation Date:	**05/14/1999**
Degree Awarded:	**Doctor of Medicine**
Unusual Circumstance:	**None**

Post Graduate Medical Education:

Institution:	**New York University Medical Center** **Department of Obstetrics/Gynecology** **550 First Avenue** **New York, NY 10016**
Post Graduate Year:	**1**
Program Type:	**Internship**
Department:	**Obstetrics and Gynecology**
Dates of Attendance:	**07/01/1999 - 06/30/2000**
Completion:	**Yes**
Accreditation:	**ACGME**
Post Graduate Year:	**2**
Program Type:	**Residency**
Department:	**Obstetrics and Gynecology**
Dates of Attendance:	**07/01/2000 - 06/30/2003**
Completion:	**To Be Completed On 06/30/2003**
Accreditation:	**ACGME**
Unusual Circumstance:	**None**

Fifth Pathway:

N/A

Examination History:

Transcripts Enclosed For:	**USMLE Step 1** **USMLE Step 2** **USMLE Step 3**

Board Action:

A Report of the results from a search of the Board Action Data Bank is enclosed.

Omission / Discrepancy Report

Physician Identification:

Name:	Anna Katerina Sfakianaki
DOB:	11/14/1975
SSN:	[redacted]
Packet ID:	15818
Request ID:	10616449

REPORT OF OMISSIONS

There are none identified.

REPORT OF DISCREPANCIES

Discrepancy 1:

Section of Profile:	**Identity**
Discrepancy:	The documented name is Anna Katerina Sfakianaki. The Postgraduate Medical Education form completed by New York University Medical Center indicates the name Anna Katerina Sfakianakis.
Follow-Up:	This was a typographical error in the FCVS database at the time the form was generated and has since been corrected.

MISCELLANEOUS INFORMATION

Miscellaneous 1:

Section of Profile:	**Continuity of Education**
Issue:	The attendance dates reported for University of Miami and University of Miami School of Medicine overlap from 08/1995 to 05/1996.
Follow-Up:	A written explanation from the institution is included immediately following the Medical Education Form.

End of report for Anna Katerina Sfakianaki

Board Action Databank Search

State Queried For:	**Connecticut Medical Examining Board**
Physician's Name:	**Sfakianaki, Anna Katerina**
Date of Birth:	**11/14/1975**
Medical School:	**010020 - Univ Miami Sch Med**
Year of Graduation:	**1999**
Social Security Number:	[redacted]
ECFMG Number:	N/A

Results:

WE HAVE NO UNFAVORABLE INFORMATION
REGARDING THE ABOVE NAMED PHYSICIAN

MAY 27 2003

DALE L. AUSTIN
DEPUTY EXECUTIVE VICE PRESIDENT
AND CHIEF OPERATING OFFICER

Section II

Identity

AFFIDAVIT AND RELEASE

I, the undersigned, hereby certify under oath that I am the person named in this application, that all statements I have or shall make are true, that I am the person named in the various forms and credentials furnished or to be furnished with respect to my application and that all documents, forms or copies I furnish with my application are strictly true.

I acknowledge that I have read and understand the "INSTRUCTIONS FOR COMPLETING THE FCVS APPLICATION" and have answered all questions contained in the application truthfully and completely. I further acknowledge that failure on my part to answer questions truthfully and completely may lead to my being prosecuted under appropriate federal and state laws.

I authorize every person, hospital, clinic, government agency (local, state, federal or foreign), institution or law enforcement agency having custody or control of any documents, records and other information pertaining to me to furnish to the Federation Credentials Verification Service any such information, or true and correct copies of documents or records.

I hereby release, discharge and hold harmless the Federation Credentials Verification Service, its agents or representatives and any person furnishing information, records or documents of any and all liability. I authorize the Federation Credentials Verification Service to release information, material, documents, orders or the like relating to me or this application to any entity at my request.

Applicant's Signature (must be signed in the presence of a notary)

SFAKIANAKI

Applicant's **Printed** Last Name

ANNA K.

Applicant's **Printed** First Name, Middle Initial, and Suffix (e.g., Jr.)

June 13 2000

Date of Signature (must correspond to date of notarization)

SEAL VERIFIED

State of New York, County of New York,

I certify that on the date set forth below the individual named above did appear personally before me and that I did identify this applicant by: (a) comparing his/her physical appearance with the photograph on the identifying document presented by the applicant and with the photograph affixed hereto, and (b) comparing the applicant's signature made in my presence on this form with the signature on his/her identifying document. The statements on this document are subscribed and sworn to before me by the applicant on this 13 day of June, ~~19~~ 2000

Notary Public signature: Sandra Burke

SANDRA BURKE
Notary Public, State of New York
No. 01BU4694384
Qualified in Westchester County
Commission Expires Aug. 31, ~~1997~~ 2001

My commission expires: 8/31/2001

Notary:
The physician has been instructed to sign the front of the photograph. Your seal (or stamp) must be partly upon the photo and partly upon the signature of the applicant.

PACKET ID: 0015818

Federation ~~Credentials~~ Verification Service

FEDERATION CREDENTIALS VERIFICATION SERVICE (FCVS)

VERIFICATION OF MEDICAL EDUCATION

(This form must be completed by the medical school)

RECEIVED
SEP 13 2000
By

INSTRUCTIONS TO THE DEAN

The individual identified on the attached Authorization For Release of Information, Documents and Records form has authorized your medical school to provide to the Federation Credentials Verification Service (FCVS) any and all information pertaining to their education at your institution. **Please complete this form and forward it to FCVS in the enclosed postage-paid, self-addressed envelope.**

Please note: If your institution processes transcript requests through another office, FCVS has likely made such a request under separate cover. **If your office also processes transcript requests, please attach the individual's official transcript (which indicates courses taken, dates and hours of attendance, and scores, grades, or evaluation).**

VERIFICATION OF MEDICAL EDUCATION

Name of Institution: University of Miami School of Medicine

Complete Address:

Associate Dean/Student Affairs R129
Street Address: U/Miami School of Medicine
P. O. Box 016960
Street Address: Miami, Florida 33101

City State Zip Code(Postal Code)

If name of institution was different when this individual attended, please note this name below:

ANNA SFAKIANAKIS

Enrollment and Participation: Our records indicate that ANNA SFAKIANAKIS
(type/print individual's name: Last, First, Middle, Suffix)

attended our medical school for total of _____ weeks of continuous on-campus education on the following dates (mm/dd/yy):

From	To
8 / 18 / 95	5 / 9 / 99
/ /	/ /
/ /	/ /
/ /	/ /
/ /	/ /

This individual (check one):

✓ was awarded the degree of DOCTOR OF MEDICINE on 5 / 14 / 99 (mm/dd/yy)

_____ was NOT awarded a degree (please attach an explanation)

SJJ

VERIFICATION OF MEDICAL EDUCATION (continued)

Unusual Circumstances: The following questions apply to unusual circumstances that occurred during any part of the individual's medical education. Please circle the appropriate response. **"Yes" responses to any of these questions requires a written explanation.**

Questions	Response	
Did this individual ever take a leave of absence or break from their medical education?	Yes	(No)
Was this individual ever placed on probation?	Yes	(No)
Was this individual ever disciplined or under investigation?	Yes	(No)
Were any negative reports regarding this individual ever filed by instructors?	Yes	(No)
Were any limitations or special requirements imposed on the individual because of questions or academic incompetence, disciplinary problems or any other reason?	Yes	(No)

Premedical Education: Does your school have a premedical education requirement? (Yes) No

If yes, include where your records indicate the individual completed his/her premedical education and the basic science courses taken (attach additional pages if necessary):

Premedical Institution(s): UNIV. OF MIAMI

Check Courses Taken: N/A Physics _____ Biology/Zoology

_____ Organic Chemistry _____ Inorganic Chemistry

Certification: By my signature, I, _____, certify that the above
(type/print name)
information is an accurate account of the above named individual's official records maintained in this and is true and correct to my knowledge.

AFFIX INSTITUTIONAL SEAL HERE

(If your institution does not have an official seal, this form must be notarized).

SEAL VERIFIED

Signature: Thomas E Crowder

Title: THOMAS E. CROWDER, B.D.
Associate Dean for Student Affairs

Date of Signature: AUG 29 2000

Telephone: ((305) 243-6811

Fax: (____) _____

Email: _____

MAY 16 2003

URGENT

The Federation of State Medical Boards of the United States, Inc.
Federation Credentials Verification Service
P.O. Box 619850
Dallas, TX 75261-9850
Telephone (817) 868-5000
FAX: (817) 868-4106

URGENT

3rd REQUEST

Fax Cover Sheet

TO: Department of Student Affairs
1600 N.W. 10th Avenue
[010020] University of Miami School of Medicine
305-243-6757

Document critical for medical licensure.

PLEASE EXPEDITE.

DATE: May 2, 2003

FROM: Susan Hyde
shyde@fsmb.org

Packet ID: 15818
Request ID: 10616449
Anna Katerina Sfakianaki, MD

The form you recently submitted to FCVS for **Dr. Sfakianaki** was either incomplete or requires further clarification. Please address these items listed below and return by fax to the above number.

1. The **premedical education** attendance dates that Dr. Spakianaki reported were from **08/1993 to 05/1996.** The attendance dates that your institution reported for Dr. Spakianaki's **medical education** were from **08/18/1995 to 05/09/1999.** There is a one-year overlap between the dates reported for premedical education and for medical education. Please specify if this was an accelerated program. Please clarify the attendance dates and offer an explanation below.

Dates reported correctly ✓ Explanation:

DR SFAKIANAKI was enrolled in the Honors Program in Medicine (6-year program). She entered the medical school after two years of undergrad and was awarded the undergrad degree (BS) after completion of the first year of medical school.

Dates reported incorrectly ____
Correct attendance dates for the University of Miami:
Premedical Education: from _____ to _____

Correct attendance dates for the University of Miami:
Medical Education: from _____ to _____

Completion of the following is certification that the information above is an accurate account of the individual's records and is true and correct. This section MUST be signed by the Program Director (MD/DO only) or an appropriate representative.

Signature

Thomas E. Crowder, B.D.
Associate Dean for Student Administration
Title

MAY 16 2003
Date

Number of Pages Sent: 2
[010020]

Section IV

Postgraduate Training

Federation Credentials Verification Service (FCVS)
Federation Place, 400 Fuller Wiser Road, Suite 300, Euless, TX 76039
Tel: (817) 868-5000 Fax: (817) 868-5099

Verification of Postgraduate Medical Education

Institution: New York University Medical Center

Address: 550 First Avenue
New York, NY 10016

Attention: Department of Obstetrics/Gynecology

Affiliated University: _____

Verification For:

Name: Sfakianakis, Anna Katerina
SSN: [redacted]
DOB: 11/14/1975
Physician's Name on Record (If different from above): _____

Program Participation:

Important:
Report incomplete postgraduate years (PGY) separate from those that were successfully completed.

If the postgraduate year is currently in progress, report the *expected* completion date in the "To" field.

Report Internships, Residencies and Fellowships separately.

Use one section per department. If the department is rotating or transitional, please provide a schedule of rotations.

PGY: 1	___ Internship	Department: OB/GYN			
		From: 7/1/99	To: 6/30/00		
	___ Residency	Successfully Completed?: ✓ Yes	___ No	___ In Progress	
	___ Fellowship	Accredited by: ✓ ACGME	__ AOA	__ Not Accredited	Other: _____
	___ Research				
PGY: 2	___ Internship	Department: OB/GYN			
		From: 7/1/00	To: 6/30/03		
	✓ Residency	Successfully Completed?: ___ Yes	___ No	✓ In Progress	
	___ Fellowship	Accredited by: ✓ ACGME	__ AOA	__ Not Accredited	Other: _____
	___ Research				
PGY: _____	___ Internship	Department: _____			
		From: ___/___/_____	To: ___/___/_____		
	___ Residency	Successfully Completed?: ___ Yes	___ No	___ In Progress	
	___ Fellowship	Accredited by: __ ACGME	__ AOA	__ Not Accredited	Other: _____
	___ Research				

Unusual Circumstances:

Circle the correct response. Omitted responses require written explanation.

If necessary, you may continue your explanation on a separate sheet of paper.

Did this individual ever take a leave of absence or break from their training?	Yes	No
Was this individual ever placed on probation?	Yes	No
Was this individual ever disciplined or placed under investigation?	Yes	No
Were any negative reports ever filed by instructors?	Yes	No
Were any limitations or special requirements placed upon this individual because of questions of academic incompetence, disciplinary problems or any other reason?	Yes	No

Please explain any "Yes" response from above:

_____

_____

Certification:

Affix your official seal in this space. If you do not have a seal, you must have this form notarized.

SEAL WAIVED

Completion of the following is certification that the information above is an accurate account of this individual's records and is true and correct. This section MUST be signed by the Program Director (M.D./D.O. only).

Name: Jim Stone Signature: _____

Title: MD / PROGRAM DIRECTOR Date of Signature: 8/31/00

Tel: 212-263-7886 Fax: 212-263-8261 E-Mail: _____

Anna Kucassian 8/31/00

ANNA KUCASSIAN
Notary Public, State of New York
No. 01KU6018479
Qualified in Queens County
Commission Expires January 11, 20 01

Rev. 8/10/00 Packet ID: 15816 Request ID: 5219105 SJJ [16273]