STATE OF CONNECTICUT

DEPARTMENT OF PUBLIC HEALTH

February 13, 2015

LICENSURE VERIFICATION

Please be advised that Connecticut General Statutes, certain matters involving the investigation and rehabilitation of Physician/Surgeon remain confidential. Therefore, in response to your inquiry regarding the status of the Physician/Surgeon identified below, at this time we are providing only publically disclosable information. In order for this office to confirm or deny whether there is any confidential information relevant to your inquiry, a release form from such Physician/Surgeon must be provided.

IF YOU WISH TO ESTABLISH WHETHER CONFIDENTIAL INFORMATION EXISTS CONCERNING THIS Physician/Surgeon, PLEASE HAVE HIM/HER SIGN THE REVERSE SIDE OF THIS FORM, WHICH CONSTITUTES A RELEASE FOR SUCH INFORMATION, AND RETURN IT TO THIS OFFICE. PLEASE NOTE THAT ONLY THIS DEPARTMENT'S RELEASE FORM WILL BE ACCEPTED.

This is to certify that the records of the Connecticut Department of Public Health indicate that:

NIKKI COLODNY MD

Was issued Connecticut:	Physician/Surgeon License
Date of Issuance:	08/07/2007
License Number:	45745
Expiration Date:	04/30/2016
Status of License:	APPROVED, PRINT LICENSE
Past or Pending Disciplinary History:	No

Sincerely,

Stephen B. Carragher

Stephen B. Carragher
Public Health Services Manager
Office of Practitioner Licensing and Investigation

Printed by: Meghan Bennett

Phone: (860) 509-7603
Telephone Device for the Deaf (860) 509-7191
410 Capitol Avenue - MS # 12 APP
P.O. Box 340308 Hartford, CT 06134
An Equal Opportunity Employer

Renewal - 1.045745

Name	NIKKI COLODNY MD
Credential	1.045745

Fee Details

Renewal Application Fee	$570.00
	$570.00

Demographic Information-Renewal

1. First Name
   NIKKI

2. Middle Initial

3. Last Name
   COLODNY

4. Maiden Name

5. Please provide your Date of Birth.
   04/01/1948

6. Gender
   Female

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

8. Race:
   Unknown

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

9. What is your current work status in Medicine?
   Part-time (less than 30 hours per week)

Workforce Survey

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

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

12. 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.

19

13. 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.
1

14. 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.
1

15. 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.

16. 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.

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

Enter comments if "Other" is selected.

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.

18. Address 1
345 Whitney Ave

19. Address 2

20. City
New Haven

21. State
CT

22. Zip Code
06511-2348

Primary Source of Payment

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

23. Medicare
None

24. Medicaid
26 - 50%

25. Self-Pay
26 - 50%

26. Private Insurance

26 - 50%

27. Other
None

Connecticut Prescription Monitoring and Reporting System

All prescribing practitioners possessing a Connecticut controlled substance registration (CSP) issued by the Connecticut Department of Consumer Protection (DCP) must register with the Connecticut Prescription Monitoring and Reporting System (CPMRS) online at www.ctpmp.com.

After you have completed this transaction, please visit the DCP's website at www.ct.gov/dcp and select 'Programs & Services' then 'Prescription Monitoring Program' for information regarding registration.

28. I acknowledge that I have read the information regarding registration in the Connecticut Prescription Monitoring and Reporting System.
02/11/2015

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

33. **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.**
02/11/2015

34. 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.
02/11/2015

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 - 1.045745

Name	NIKKI COLODNY MD
Credential	1.045745

Fee Details

Renewal Application Fee	$570.00
	$570.00

Demographic Information

1. First Name
   NIKKI

2. Middle Initial

3. Last Name
   COLODNY

4. Maiden Name

5. Please provide your Date of Birth.
   04/01/1948

6. Gender
   Female

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

8. 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

9. What is your current work status in Medicine?
   Part-time (less than 30 hours per week)

Workforce Survey

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

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

12. 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.

16

13. 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

14. 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.
0.2

15. 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

16. 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.

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

Enter comments if "Other" is selected.
Outpatient Surgical Facility

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.

18. Address 1
345 Whitney Ave.

19. Address 2

20. City
New Haven

21. State
CT

22. Zip Code
06511

Primary Source of Payment

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

23. Medicare
None

24. Medicaid
11 - 25%

25. Self-Pay
26 - 50%

26. Private Insurance

26 - 50%

27. Other
None

Attestation

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

29. If yes, please provide details here

30. 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

31. 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.

32. 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.
03/16/2014

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

Credential Profile - 1.045745

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	NIKKI COLODNY MD
Credential	1.045745

Current Practice Locations

1. Are you currently practicing medicine in Connecticut?
   Yes

2. Are you actively involved in Patient Care?
   Yes

3. Enter your practice locations

Practice Name	Address 1	Address 2	Address 3	City	State	Zip Code	Primary Practice	Languages Spoken at this Location
26 Bleeker St.				New York City	New York	10012	No	
1039 E. Main St.				Stamford	Connecticut	06902	No	

Connecticut Staff Privileges

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

Facility Name	City	State

Medical School

5. Medical School
   Temple University Medical School

6. Enter the Year of Graduation from Medical School
   1981

Post Graduate Training

7. List your postgraduate training:

Site Name	City	State	Country	Start Date	End Date	Level	Type
McMaster University Faculty of Health Sciences	Hamilton	Ontario	CANADA	07/01/1981	12/31/1983	Resident	Family Practice

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?
   No

10. Select the state medical schools at which you are a member of the faculty.

11. Do you have current responsibility for graduate medical education?
No

Publications, Professional Services, Activities, and Awards

12. Publications, Professional Services, Activities, and Awards

Publisher/Issuer	Title/Award Name	Date
Canadian Medical Assoc. Journal (1996)		

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

New York	No
Ontario	No

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.
02/22/2011

Review

JEC

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

1. Biographical and Current Practice Information

CT License Number: 045745 Social Security No.: [redacted]

Last Name: Colodny First Name: Nikki MI:

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:

Address: 124 E. 40th St. Suite #702

City, State Zip: NY NY 10016

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

/	

Other Practice Location(s)-Name of Practice:

Address: 188 Montague St Suite #404

City, State Zip: Bklyn NY 11201

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
n/a	

2. Medical School

Medical School: Temple Univ. Medical School Year of Graduation 1981

****

3. *Post Graduate Training* (Please list your postgraduate training) Chedoke McMaster Hospitals

Site: McMaster Univ. Faculty of Health Sciences City: Hamilton Country: Canada

Inclusive Dates: From: 7 / / 81 To: 12 / / 83 ☑ Intern ☑ Resident ☐ Fellowship (Please check one)

Type of Training (i.e. Pediatrics, Internal Medicine): Family Medicine (Maternity leave 1/82 - 6/82)

****

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): ________

****

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? ☐ Yes ☒ No

If Yes, Please indicate which one.

☐ Yale University Medical School ☐ University of Connecticut School of Medicine

Do you have current responsibility for graduate medical education? ☐ 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:

• Publications: Include name of journal, title of article and date published.

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

1. Canadian Medical Assoc. Journal (1996)
2.
3.
4.
5.
6.
7.
8.
9.
10.

7. Medical Malpractice History

Date Resolved	Amount Paid	Practice Specialty Related To Payment

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

Hospital, City, State, Country	Date	Disciplinary Action
None		

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

Date of Conviction	Conviction
None	

****

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 or revocation of my license to practice medicine in Connecticut.

Signature

27 Oct 2007
Date

Please return as soon as possible, but no later than 60 days from the postmarked date of this survey by mail to:
(please use the enclosed, addressed envelope)

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

STATE OF CONNECTICUT

DEPARTMENT OF PUBLIC HEALTH

August 7, 2007

Nikki Colodny M.D.

[redacted]

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 **045745** 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, Office of Practitioner Licensing and Certification, 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
Practitioner Licensing and Investigations Section

SBC:CD

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

4.75

PHYSICIAN APPLICATION FOR:

✓ 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)
	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: Colodny First Name: Nikki MI: ____ Maiden Name: _____

Date of Birth: 04/01/1948 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 to the public pursuant to Freedom of Information requests.

Name on License: Nikki Colodny

Address: [redacted]

City, State, Zip: [redacted]

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

MEDICAL EDUCATION:

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

Temple University Medical School — 6/1976 - 6/1978
6/1979 - 5/1981 *

M.D. DEGREE AWARDED BY: Temple Univ. Med. Schl. (Name of school) **DATE AWARDED:** 28 May 1981

* Maternity Leave 6/78 - 6/79

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	219718	Nov 9 2000	NMBE	
ONTARIO	50281	1984	NMBE	

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:** _____

D1

MEDICAL PRACTICE:

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

Hospitals Associated With	Location	Dates
Self Employed Family Physician	Toronto ON Canada	Jan 1984 – Apr. 2000
Privileges: Womens College Hospital, Peterborough Civic Hosp., Kitchener Waterloo Hosp.		
Staff Physician Dr. I. Fleischman Family Medicine	Bklyn NY	Jul 2001 to present
Privileges Long Island College Hospital; Bklyn Hospital		

STATEMENT OF PROFESSIONAL HISTORY

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

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.

Yes ☐ No ☑

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.

Yes ☐ No ☑

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.

Yes ☐ No ☑

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.

Yes ☐ No ☑

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.

Yes ☐ No ☑

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.

Yes ☐ No ☑

STATEMENT OF PROFESSIONAL HISTORY (continued)

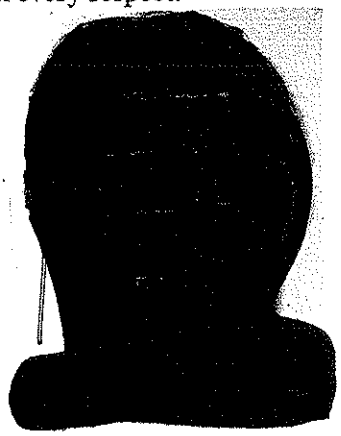
7. Have you ever been found guilty or convicted as a result of an act which constitutes a felony under the laws of this state , federal law or the laws of another jurisdiction and which, if committed within this state, would have a felony under the laws of this state? Yes ☐ No ☑

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? Yes ☐ No ☑

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

On this _____ day of _____ (month/ year) Nikki Colodny **(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 11th day of April (month/year) 2007.

CHANTÉ A. SLATER
No. 01SL6116476
Notary Public, State of New York
Qualified in Kings County
My Commission Expires Oct. 4 2008

Notary Public Signature_____ My Commission Expires_____

PLEASE RETURN THIS APPLICATION, THE FEE FOR $450 (CERTIFIED CHECK OR MONEY ORDER) AND A SEPARATE CERTIFED BANK CHECK OR MONEY ORDER FOR $4.75 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

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: Nikki Coladny Date of Birth: April 1, 1948

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: McMaster University; Faculty of Health Sciences; Hamilton ON Canada

Dates of Residency: From July 1, 1981 (month/day/year) To Dec 31, 1983 (month/day/year)

In what specialty was the residency training completed: Family Medicine

At what level(s) was this residency completed (PGY1, PGY2, etc.)? PG1 + PG2

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, Dr. Marc Walter, being duly sworn, do depose and certify that I am the Chief of Staff/Program Director at:

Name of Facility: McMaster University - Post Graduate Medical Program.

Address: 1200 Main street W.
Hamilton, Ontario

Telephone Number: (905) 525-9140 ext. 22118

Email: mcniversb@mcmaster.ca

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

Marc Walter
Signature of Chief of Staff/Program Director

Subscribed and sworn to me this 27 day of July (month/ year) 2007.

No[illegible] My Commission Expires

P[illegible]

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

-905-527-2707

McMaster University

Faculty of Health Sciences
Office of Postgraduate Medical Education

MDCL-3113
1200 Main Street West
Hamilton, Ontario, Canada
L8N 3Z5

Phone 905.525.9140
Ext. 22118 or 22116
Fax 905.527.2707

July 27, 2007

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

Dear Sir or Madam;

Re: Nikki Colodny, MD

This will confirm that Dr. Colodny was registered as a Postgraduate student for the period July 1, 1981 to December 31, 1983, in the Family Medicine Program, Faculty of Health Sciences, McMaster University. Dr. Colodny successfully completed this residency training program.

Sincerely,

Sharon Cameron
Program Administrator
Postgraduate Education

SC/sm