5/17/01
Inc
CK# 149542

Application #: 8727
Date Approved: 5/17/01

**Commonwealth of Massachusetts - Board of Registration in Medicine**
**10 West Street, Third Floor, Boston, Massachusetts 02111 - www.massmedboard.org**

# RENEWAL APPLICATION - LIMITED LICENSE

**IMPORTANT:** Please read the accompanying instructions before completing this form, and print legibly or type your answers.

**SECTIONS "A"AND "C" ON PAGE 2 ARE TO BE COMPLETED BY APPLICANT.**

**SECTION A:**

1. Name: (Last) MOSKIN (First) AVA (MI) R
2. Mailing Address: _____ Telephone Number: _____
   City: _____ State: _____ Zip: _____
3. Name of Training Hospital: Lawrence General Hospital
4. Current Limited License Number: 99-8727-02
5. Other states (abbreviations) where you are now licensed to practice medicine. Indicate whether full license (F) or residency or training license (L). _____ ☐(F) ☐(L) _____ ☐(F) ☐(L) _____ ☐(F) ☐(L)

**SECTION B: To be completed by program director.**

Has the physician been subject to past or pending disciplinary action in this program? ☐ Yes ☒ No

I hereby certify that the above-named physician is in good standing in the training program.

Print Name: Scott Early Date: 4/27/01

Signature of Program Director: X [signature] Telephone: (978) 725-7410

**To be completed and signed by the designated official of the institution at which the applicant has received an appointment.**

This certifies that AVA Moskin (Name of Applicant) has been appointed

to the position of: ☐ Intern ☒ Resident ☐ Fellow as a PGY 3

Hospital Name: Lawrence Family Practice Residency Specialty: Family Practice

Beginning Date: 6/17/99 Anticipated Completion Date of Training: 6/21/02

Is the program accredited by the ACGME: ☒ Yes ☐ No

If no, is there an approved ACGME program in applicant's specialty? ☐ Yes ☐ No

Designated Official: Scott Early M.D. Program Director Telephone: (978) 725-7410
(Print Name) (Title)

Designated Official's Signature: X [signature] Date: 4/27/01

NAME: Ava Moskin



**SECTION C: Read the instructions. Check either YES or NO to each question. Do not answer N/A. If you answer YES to any of these questions, you must provide details on Limited Supplement attached.**

| THESE QUESTIONS APPLY ONLY SINCE YOUR LAST RENEWAL | YES | NO |
|---|---|---|
| 16. Have you been terminated, granted a leave of absence, withdrawn or had to repeat a year in a postgraduate-training program? | | |
| 17. Have you been denied the privilege of taking or finishing an examination or have you been accused of cheating and/or improper conduct during an examination? | | |
| 18. Have you, for any reason, been denied a medical license, whether full, limited or or temporary or have you withdrawn an application for medical licensure? | | |
| 19. Have you voluntarily surrendered a license to practice medicine or any healing art? | | |
| 20. Are any formal disciplinary charges pending against you, or do you have knowledge of any pending investigation into your professional competence or conduct by any governmental authority, health care facility, group practice or professional medical society or association (international, national, state or local)? (See definition). | | |
| 21. Has any disciplinary action been taken against you for violation of laws, rules, by-laws or standards of practice by any governmental authority, health care facility, group practice, or professional medical society or association (international, national, state or local)? (see definition). | | |
| 22. Have you been denied medical staff membership, or advancement in medical staff status, or has such denial been recommended by a standing medical staff committee or governing body? | | |
| 23. Have you, for any reason, withdrawn an application for hospital privileges or appointment? | | |
| 24. Have you voluntarily relinquished medical staff membership? | | |
| 25. Has your medical staff membership, medical privileges or medical staff status at any hospital been limited, suspended, revoked, not renewed or subject to probationary conditions or has processing toward any of those ends been instituted or recommended by a medical staff committee or governing board? | | |
| 26. Have you been charged with any criminal offense, other than a minor traffic offense? | | |
| 27. Has your privilege to possess, dispense or prescribe controlled substances been suspended, revoked, denied, restricted or surrendered, or have you been called before or warned by any state or other jurisdiction including a federal agency regarding such privileges? | | |
| 28. Has any medical malpractice claim been made against you, whether or not a lawsuit was filed in relation to the claim? | | |
| 29. Has any lawsuit, other than a medical malpractice suit, which is related to your competency to practice medicine, or your professional conduct in the practice of medicine, been filed against you or has such a suit been settled, adjudicated or otherwise resolved? | | |

RECEIVED
FEB 25 2002
BOARD OF REGISTRATION IN MEDICINE

Application #: 213854
Date of Issue: _____

**Commonwealth of Massachusetts - Board of Registration in Medicine**
**10 West Street, 3rd Floor**
**Boston, MA 02111 - (617) 727-3086**

# FULL LICENSE APPLICATION

**Application Fee:** Please enclose a check or money order in the amount of $350 made payable to the Commonwealth of Massachusetts.

**Check One:** ☒ U.S./Canadian Graduate ☐ International Graduate

**Legal Name** (do not use nicknames or initials, unless they are part of your legal name)

| MOSKIN | AVA | ROSALIND | |
|---|---|---|---|
| Last Name (type or print clearly) | First | Middle | Suffix (Jr., etc.) |

☒ M.D. ☐ D.O. ☐ Ph.D ☐ Other degree_____

**Other Name(s) Used** - List any other name(s) you have used which may appear on your identifying documents, such as medical education and examination records. If not applicable, check here ☒

| | | | |
|---|---|---|---|
| Entire Last Name (type or print clearly) | First | Middle | Suffix (Jr., etc.) |

Date of Birth: ____ ____ ____ (Month Day Year) Social Security Number: _____

Place of Birth: NEW YORK (City) NEW YORK (State/Province/Territory) (Country if not USA)

Home Address: _____ (Number and Street)

_____ (City) _____ (State/Province/Territory) _____ (Zip (or postal) Code)

Business Address: 34 Haverhill St (Number and Street)

Lawrence (City) MA (State/Province/Territory) 01841 (Zip (or postal) Code)

Business Telephone: (978) 686-0090, ext. 560 Home Telephone: (____) _____

Preferred Mailing Address: ☒ Business Address ☐ Home Address

#732
01/03
(A10)

PRINT NAME: AVA | MOSKIN PAGE 2 OF 3

**Pre-medical School**

| | | | | From | To |
|---|---|---|---|---|---|
| Facility: College of the Atlantic | Degree: BA | | | 9/ /92 | 6/ /95 |
| Street: 105 Eden street | City: Bar Harbor | State: ME | | | |
| Facility: Brown University | Degree: none | | | 9/ /90 | 12/ /91 |
| Street: | City: Providence | State: RI | | | |

**Medical School**

| | | | From | To |
|---|---|---|---|---|
| Facility: Albert Einstein | Degree: MD | | 9/ /95 | 6/03/99 |
| Street: 1300 Morris park Ave | City: Bronx | State: NY | | |
| Facility: | Degree: | | / / | / / |
| Street: | City: | State: | | |

Date of medical school graduation: 6/3/99

Note: U.S. graduates must include a written explanation for the duration of medical education longer than four (4) years, and for any breaks in medical education. International graduates must provide a written explanation for the duration of medical education longer than six (6) years and any breaks in medical education.

**Postgraduate Education:**

List all postgraduate training chronologically from medical school to the present, the name and address of the facility, your position, e.g. PGY 1, 2, fellow, etc. and dates of affiliation. You must account for all periods of training or postgraduate work from the time you graduated from medical school.

| | | | | From | To |
|---|---|---|---|---|---|
| Facility: Lawrence Family Practice | Position: PGY 1 | | | 6/17/99 | 6/23/00 |
| Street: 34 Haverhill st | City: Lawrence | State: Ma | | | |
| Facility: Lawrence Family Practice | Position: PGY 2 | | | 6/24/00 | 6/22/01 |
| Street: 34 Haverhill st | City: Lawrence | State: Ma | | | |
| Facility: Lawrence Family Practice | Position: PGY 3 | | | 6/23/01 | 6/21/02 |
| Street: 34 Haverhill st | City: Lawrence | State: Ma | | | |
| Facility: | Position: | | | / / | / / |
| Street: | City: | State: | | | |
| Facility: | Position: | | | / / | / / |
| Street: | City: | State: | | | |

PRINT NAME: AVA MOSKIN 

**Hospital Affiliations and Employment**

List hospital appointments where you had active staff privileges, including the name and address of the facility, your position and dates of affiliation in postgraduate training, in chronological order. Also include periods of unemployment or employment outside of medicine. Attach a separate sheet of paper if necessary.

| | | | From | To |
|---|---|---|---|---|
| Facility: Lawrence General Hospital | Position: Resident | | 6/17/99 | 6/21/02 |
| Street: 100 General St | City: Lawrence | State: MA | | |
| Facility: | Position: | | __/__/__ | __/__/__ |
| Street: | City: | State: | | |
| Facility: | Position: | | __/__/__ | __/__/__ |
| Street: | City: | State: | | |
| Facility: | Position: | | __/__/__ | __/__/__ |
| Street: | City: | State: | | |

1. List other states (abbreviations) where you are currently or have ever been licensed: ME VT
2. Are you certified by the American Board of Medical Specialties? ☐ Yes ☒ No
3. List Board Certification(s): _____
4. Have you attached an up-to-date copy of your curriculum vitae? ☒ Yes ☐ No
5. Reason for requesting a Massachusetts medical license: Will be practicing Family Medicine in Lawrence 9/02
6. Name of Facility: Greater Lawrence Family Health Center
7. Address: 34 Haverhill St City: Lawrence
8. Anticipated starting date in Massachusetts: 9/15/02

**Affidavit of Applicant**

I, the undersigned applicant, hereby certify that all information included in this application for licensure constitutes a true statement made under the penalties of perjury.

AVA MOSKIN MD
Signature of Applicant

2/22/02
Date

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MAR 22 2000
Board of Registration in Medicine

DATE 3/30
INITIAL: LdF
FEE: $50.00 CHECK 14223

Application #: 8727
Date Approved: 5/25/00

**Commonwealth of Massachusetts - Board of Registration in Medicine**
**Ten West Street, Third Floor, Boston, Massachusetts 02111**

# RENEWAL APPLICATION - LIMITED LICENSE

**IMPORTANT:** Please read the accompanying instructions before completing this form, and print legibly or type your answers.

**SECTIONS "A"AND "C" ON PAGE 2 ARE TO BE COMPLETED BY APPLICANT.**

**SECTION A:**

1. Name: (Last) Moskin (First) Ava (MI) R.
2. Mailing Address: _____ Telephone Number: _____
   City: _____ State: _____ Zip: _____
3. Name of Training Hospital: Lawrence General Hospital
4. Current Limited License Number: 99-8727-02
5. Other states (abbreviations) where you are now licensed to practice medicine. Indicate whether full license (F) or residency or training license (L). ____ ☐(F) ☐(L) ____ ☐(F) ☐(L) ____ ☐(F) ☐(L)

**SECTION B: To be completed by program director.**

Has the physician been subject to past or pending disciplinary action in this program? ☐ Yes ☑ No

I hereby certify that the above-named physician is in good standing in the training program.

Print Name: Scott C. Early, MD Date: 3/7/00

Signature of Program Director: [signature] Telephone: (978) 725-7410

**To be completed and signed by the designated official of the institution at which the applicant has received an appointment.**

This certifies that Ava R. Moskin (Name of Applicant) has been appointed

to the position of: ☐ Intern ☑ Resident ☐ Fellow as a PGY 2

Hospital Name: Lawrence General Hospital Greater Lawrence Family Health Center Specialty: Family Practice

Beginning Date: 6/24/00 Anticipated Completion Date of Training: 6/22/01

Is the program accredited by the ACGME: ☑ Yes ☐ No
If no, is there an approved ACGME program in applicant's specialty? ☐ Yes ☐ No

Designated Official: Scott C. Early, MD (Print Name) Program Director (Title) Telephone: (978) 725-7410

Designated Official's Signature: [signature] Date: 3/7/00

NAME: Ava R. Moskin

**SECTION C: Read the instructions. Check either YES or NO to each question. Do not answer N/A. If you answer YES to any of these questions, you must provide details on Limited Supplement attached.**

| | YES | NO |
|---|---|---|

## SINCE YOUR LAST RENEWAL

***Note: These questions apply only since your last renewal.***

16. Have you been terminated, granted a leave of absence, withdrawn or had to repeat a year in a postgraduate-training program?

17. Have you been denied the privilege of taking or finishing an examination or have you been accused of cheating and/or improper conduct during an examination?

18. Have you, for any reason, been denied a medical license, whether full, limited or or temporary or have you withdrawn an application for medical licensure?

19. Have you voluntarily surrendered a license to practice medicine or any healing art?

20. Are any formal disciplinary charges pending against you, or do you have knowledge of any pending investigation into your professional competence or conduct by any governmental authority, health care facility, group practice or professional medical society or association (international, national, state or local)? (See definition).

21. Has any disciplinary action been taken against you for violation of laws, rules, by-laws or standards of practice by any governmental authority, health care facility, group practice, or professional medical society or association (international, national, state or local)? (See definition).

22. Have you been denied medical staff membership, or advancement in medical staff status, or has such denial been recommended by a standing medical staff committee or governing body?

23. Have you, for any reason, withdrawn an application for hospital privileges or appointment?

24. Have you voluntarily relinquished medical staff membership?

25. Has your medical staff membership, medical privileges or medical staff status at any hospital been limited, suspended, revoked, not renewed or subject to probationary conditions or has processing toward any of those ends been instituted or recommended by a medical staff committee or governing board?

26. Have you been charged with any criminal offense, other than a minor traffic offense?

27. Has your privilege to possess, dispense or prescribe controlled substances been suspended, revoked, denied, restricted or surrendered, or have you been called before or warned by any state or other jurisdiction including a federal agency regarding such privileges?

28. Has any medical malpractice claim been made against you, whether or not a lawsuit was filed in relation to the claim?

29. Has any lawsuit, other than a medical malpractice suit, which is related to your competency to practice medicine, or your professional conduct in the practice of medicine, been filed against you or has such a suit been settled, adjudicated or otherwise resolved?

NAME: AVA R MOSKIN



**SECTION C: TO BE COMPLETED AND SIGNED BY THE DESIGNATED OFFICIAL OF THE INSTITUTION AT WHICH THE APPLICANT HAS RECEIVED AN APPOINTMENT.**

This certifies that Ava R. Moskin has been appointed
(Name of Applicant)

to the position of ☑ Intern ☑ Resident ☐ Fellow

in the specialty of Family Medicine as a PGY 1

at Greater Lawrence Family Health Center / Lawrence General Hospital
(Name of Hospital)

beginning 6 / 28 / 99 (month / day / year) to anticipated completion of training: 6 / 30 / 02 (month / day / year)

| | YES | NO |
|---|---|---|
| Is the program accredited by the ACGME? | ☑ | ☐ |
| If no, is there an ACGME-approved training program in the applicant's specialty? | ☐ | ☐ |

Designated Official's Signature: [signature]

Type or Print Name: Scott C. Early, MD

Official Title: Program Director

Date: 4 / 19 / 99 Telephone Number: 978-725-7410

Commonwealth of Massachusetts Board of Registration in Medicine
560 Harrison Avenue, Suite #G-4, Boston, MA 02118 – (617) 654-9810 http://www.massmedboard.org

# Physician Registration Renewal Application

**Before proceeding, *please read the instruction booklet*. Copy this form and all attachments for your own records; you will need copies for credentialing and other purposes. This completed renewal form with attachments must be returned in the *green* envelope *at least 4 weeks* before your renewal date.**

- **Remit $400.00 for renewal fee (non-refundable).**
- **Add late fee of $25.00, if necessary.**
- **Return renewal application in GREEN envelope.**
- **Enclose check with coupon in BLUE envelope.**

***Please review carefully the following information for accuracy and completeness. Make any corrections or alterations as required. All questions must be answered or your renewal will be delayed.***

1. Current Status: Active Registration No.: 213854 Renewal Date: 04/07/2003

If you want to change your current status, please check *one* of the following boxes to indicate your *new* status: (Check only one)

☐ Active ☐ Retiring (see instructions) ☐ Inactive (see instructions) ☐ Do not wish to renew

2. Other Name(s), if any, under which you were licensed:

3. Ava R Moskin

A) Mailing/Business Address:

B) Home Address:

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Board of Registration in Medicine

Home Phone:

Business Phone: (978)387-5736

**Please make corrections** (print)

☐ Other Name(s) ☐ Name Change (enter name below)

Mailing Address: 34 HAVERHILL ST
City/Town: LAWRENCE State: MA
Zip: 01841 Country: USA

Business Address: same
City/Town: State:
Zip: Country:
Business Telephone: (978) 689-6560

Home Address:
City/Town: State:
Zip: Country:
Home Telephone: (

**PLEASE NOTE: Only one address can be a P.O. box. The mailing address cannot be a P.O. Box.**

4. a) Date of Birth: b) Sex: F
c) SS#:

5. a) Name of Medical School: Albert Einstein College of Medicine Yeshiva Univ
b) Year Graduated: 1999 c) Degree: M.D.

6. Specialty Code(s) (See Table 1)

| Code(s) | Hours per Week in Mass. |
|---|---|
| FP | 20 |
| 0 | |
| 0 | |

7. Current American Board of Medical Specialties Certification (See Table 2)
Code: FP Code:

8. Drug License Numbers, if any:
a) Federal (DEA):
b) Massachusetts:

9. a) Other states where you are now licensed to practice (Abbr.)
ME
b) States where you were previously licensed (Abbr.)

10. List all current health care facilities at which you are affiliated or have completed the credentialing process for the provision of patient care. (Supply the codes from Table 3 and place a check mark next to those health care facilities where you have admitting privileges (AP). Next to each facility, write the approximate percentage of patient care hours that you provide in each facility). ___ No affiliations.

Facility Code: 099/✓ (AP) 0 % Facility Code: 996/ (AP) 100 % Facility Code: / (AP) %
Facility Code: / (AP) % Facility Code: / (AP) % Facility Code: / (AP) %
If 999, print name(s):

PRINT YOUR LAST NAME: MOSKIN LICENSE NUMBER: 213854

11. My medical malpractice insurance is covered by ☐ Insurance Carrier ☐ Letter of Credit

Insurer's name. (Required): FTCA - See Attached Policy dates: From: / / To: / /

Alternatively, indicate as follows: I am registering with Active status but I am not covered by medical malpractice insurance because I am: Check One: ☐ Not involved in direct/indirect patient care in Massachusetts ☐ A government employee.

☐ Otherwise exempt Please explain exemption: _____

12. What is your principal work setting? (See Table 4) 2 5 If you are affiliated with a healthcare facility or credentialed for the provision of patient care you must complete question #10 on page 1 and list your affiliations.

13. Care of patients in Massachusetts (see instruction booklet).

1) Average weekly hours involved in: A) inpatient care 0 hrs/wk B) outpatient care 20 hrs/wk

2) What is the approximate percentage of your patient care hours in primary care? 100 %

## PART A – QUESTIONS REFER ONLY TO THE PAST TWO (2) YEARS (SEE INSTRUCTIONS)

**Questions 14 through 22 refer to the period since you signed your last renewal application. Check either YES or NO to each question. Provide details on Form R for all YES answers (except question 22). Refer to instructions for additional information and definitions. ALL questions in this section must be answered. Do not answer NA or the form will be incomplete and delay your renewal.**

| | YES | NO |
|---|---|---|
| 14. **CLAIMS MADE (New or Pending):** Has any medical malpractice claim been made against you that has not yet been finally settled or adjudicated, whether or not a lawsuit was filed in relation to the claim? | | |
| 15. **CLAIMS (Resolved):** Has any medical malpractice claim that has been made against you been settled, adjudicated, or otherwise resolved, whether or not a lawsuit was filed in relation to the claim? | | |
| 16. Has any lawsuit, other than a medical malpractice suit, which is related to your competency to practice medicine, or your professional conduct in the practice of medicine, been filed against you or been settled, adjudicated or otherwise resolved? | | |
| 17. Have you been charged with any criminal offense? | | |
| 18. Have you been charged with or disciplined for any violation of laws, rules, by-laws or standards of practice of any governmental authority, health care facility, group practice or professional society or association? | | |
| 19. Has your privilege to possess, dispense or prescribe controlled substances been suspended, revoked, denied, restricted by, or surrendered to any state or federal agency? | | |
| 20. Have you withdrawn an application for a medical license or been denied a medical license for any reason? | | |
| 21. Has any professional liability insurance provider restricted, limited, terminated, imposed a surcharge or co-payment, or placed any condition related to professional competency or conduct on your coverage, or have you voluntarily restricted, limited or terminated your insurance coverage in response to an inquiry by a professional liability insurance provider? | | |

22. **CME CERTIFICATION:** Have you completed your CME requirements preceding your renewal date? ☐ Yes ☐ No

☐ CME Waiver. CME waiver form must be submitted at least 30 days prior to license expiration date. Please see exemption below

**CME EXEMPTION:** Check one: ☐ Inactive status ☑ Residency/Fellowship training (See instructions).

**See Instructions for CME waiver or exemptions. Do not submit documentation of your CMEs with application.**

- Pursuant to G.L. c. 112, Sec 1A, I understand my obligations to report abuse or neglect of children under G.L. c. 119, Sec. 51A and the punishment for failure to comply.
- Pursuant to G.L. c. 112, Sec. 2, I will not charge to or collect from a Medicare beneficiary more than the Medicare fee schedule amount.
- Pursuant to G.L. c. 62C, 49A, I certify that I have complied with all laws of the Commonwealth related to the filing of Massachusetts state tax returns and payment of all Massachusetts state taxes; reporting of employees and contractors under G.L. c. 62E; and withholding and remitting child support pursuant to G.L. c. 119A. (See instructions).

**I hereby certify under the penalties of perjury that all information on this Renewal Application, Part B and Form R is true.**

Signature: [signature] Date: 2/27/03

**YOU MUST SIGN AND INCLUDE PART B, WITH YOUR RENEWAL APPLICATION**

***Board Regulations require that you notify the Board, in writing, of any change of address***

**MAKE A COPY OF YOUR APPLICATION AND ALL ATTACHMENTS BEFORE MAILING.**

REDACTED COPY

Application #: 99-8127-02
Date Approved: 5/12/99

**Commonwealth of Massachusetts**
**Board of Registration in Medicine**
**10 West Street, Boston, Massachusetts 02111**

# INITIAL LIMITED LICENSE APPLICATION

**IMPORTANT: Read the accompanying instructions before completing this form, and print legibly or type your answers. Please attach a $50 check payable to the Commonwealth of Massachusetts.**

**CHECK ONE:**

- [x] Graduate of a Medical School in the United States, Canada, or Puerto Rico (USMG)
- [ ] Graduate of an International Medical School (IMG)
- [ ] Graduate of an International Medical School applying under the Special Refugee Physician Program

**NOTE: GRADUATES OF INTERNATIONAL MEDICAL SCHOOLS MUST COMPLETE ADDITIONAL FORMS**

**SECTION A: Sworn Statement to be Completed by Applicant**

1-A. Name: (Last) MOSKIN (First) AVA (MI) R

1-B. Other Name(s): _____

| | YES | NO |
|---|---|---|
| 1) Have you ever been known under a different name or combination of names? | ☐ | ☒ |
| 2) Have you ever been licensed under a different name? | ☐ | ☒ |
| 3) Have you ever applied for licensure, or applied to sit for an examination, or taken an examination under a different name? | ☐ | ☒ |

If yes, you must provide additional information. (See instructions.)

2. Current Residence: _____ Telephone Number: (_____)

City: _____ State: _____ Zip: _____

3. Date of Birth: ___ ___ ___ (Month Day Year) Place of Birth: New York City

4. Sex: ☐ Male ☒ Female 5. Social Security Number: ___ - ___ - ____

6. Name of Massachusetts Training Hospital: Lawrence General Hospital / Greater Lawrence Family Health Center
34 Haverhill St. Lawrence
Street Address City

DATE 4/29
INITIAL LLS
FEE: $50.00 Check 7160

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7. Name of premedical school(s): Brown University, College of the Atlantic

Location: Providence, RI and Bar Harbor, Maine
(City, State, Country)

8. Name of medical school(s): Albert Einstein College of Medicine NY046

Location: Bronx, NY
(City, State, Country)

Year of Graduation: '99 Degree Received: ☒ M. D. ☐ D. O. Other(specify)_____

9. Have you had previous post-graduate training? ☒ No ☐ Yes ☐ U.S. or ☐ International

Name of Institution: _____

Address: _____

Name of Program: _____ Dates of Training: _____
(If additional space is needed, please continue your answer on a separate sheet of paper.)

10. List states (abbreviations) where you are currently licensed to practice medicine (include residency training licenses):

none _____ _____ _____ _____

11. List states (abbreviations) where you were previously licensed to practice medicine (include residency training licenses):

none _____ _____ _____ _____

12. Medical School Training:

| | YES | NO |
|---|---|---|
| a) If you are a USMG, have you taken more than 4 years to complete medical school? | | |
| b) If you are an IMG, have you taken more than 6 years to complete medical school? | | |

If yes, you must provide additional information. (See instructions.)

13. Has more than one year passed between the date of your graduation from medical school and the anticipated start date of your limited licensure in Massachusetts? If yes, you must provide additional information. (See instructions.)

NAME: AVA B MOSKIN



| | YES | NO |
|---|---|---|
| 14-A. Have you ever been enrolled in a residency program(s) where you were required to repeat a year of training? (See instructions). | | |
| 14-B. Have you ever been enrolled in a residency training program(s) that you did not complete, or where you transferred to another program, specialty or facility? | | |

**If you answered "yes" to question 14-A or 14-B, a letter from your program director is required.**

Explanation attached: ☐ Program Director's explanation requested: ☐

**SECTION B: Read the instructions. Check either YES or NO to each question. Do not answer N/A. If you answer YES to any of these questions, you must provide details on the Limited License Supplement.**

| | YES | NO |
|---|---|---|
| 15. Since your enrollment in college, have you been subject to any disciplinary action (see definition) at any academic institution? | | |
| 16. Have you ever been terminated or granted a leave of absence by a medical school or medical post-graduate training program or have you ever withdrawn from a medical school or medical post-graduate training program? | | |
| 17. Since your enrollment in college, have you been denied the privilege of taking or finishing an examination or have you been accused of cheating and/or improper conduct during an examination? | | |
| 18. Have you ever, for any reason, been denied a medical license, whether full, limited or temporary, or have you withdrawn an application for medical licensure? | | |
| 19. Have you ever voluntarily surrendered a license to practice medicine or any healing art? | | |
| 20. Are any formal disciplinary charges pending against you, or do you have knowledge of any pending investigation into your professional competence or conduct by any governmental authority, health care facility, group practice or professional medical society or association (international, national, state or local)? (See definition). | | |

YES NO

21. Has any disciplinary action ever been taken against you for violation of laws, rules, by-laws or standards of practice by any governmental authority, health care facility, group practice, or professional medical society or association (international, national, state or local)? (See definition).

22. Have you ever been denied medical staff membership, or advancement in medical staff status, or has such denial been recommended by a standing medical staff committee or governing body?

23. Have you ever, for any reason, withdrawn an application for hospital privileges or appointment?

24. Have you ever voluntarily relinquished medical staff membership?

25. Has your medical staff membership, medical privileges or medical staff status at any hospital been limited, suspended, revoked, not renewed or subject to probationary conditions or has processing toward any of those ends been instituted or recommended by a medical staff committee or governing board?

26. Have you ever been charged with any criminal offense, other than a minor traffic offense?

27. Has your privilege to possess, dispense or prescribe controlled substances ever been suspended, revoked, denied, restricted or surrendered, or have you ever been called before or warned by any state or other jurisdiction including a federal agency regarding such privileges?

28. In the past ten (10) years, has any medical malpractice claim been made against you, whether or not a lawsuit was filed in relation to the claim?

29. In the past ten (10) years, has any lawsuit, other than a medical malpractice suit, which is related to your competency to practice medicine, or your professional conduct in the practice of medicine, been filed against you or has such a suit been settled, adjudicated or otherwise resolved?

# Ava Moskin MD

## Academic

| | | |
|---|---|---|
| 1999 –2002 | **Lawrence Family Practice Residency** | Lawrence, Mass |
| | Community health center-based residency with an emphasis on serving an underserved and Spanish-speaking population. | |
| 12/2001 | **Department of Family Practice, University of Rochester,** NY | |
| | Completed one-month training elective in Reproductive Health | |
| 1995-1999 | **Albert Einstein College of Medicine** | Bronx, NY |
| 1992-1995 | **College of the Atlantic** | Bar Harbor, Maine |
| | BA in Human Ecology | |
| 1990-1991 | **Brown University** | Providence, RI |
| | Undergraduate study including classes in education and biology | |

## Work Experience

| | | |
|---|---|---|
| Summer 1996 | **Research Assistant** | San Francisco General Hospital |
| | Conducted interviews as part of Dr. Phillip Darney's 7 year study of Norplant acceptability in adolescents | |
| Summer 1995 | **Crew Boss** | Mountain School Organic Farm |
| | Led 12-person labor crew in garden and animal management on a one-hundred acre organic farm | |
| 1994-1995 | **Lab Technician** | Albert Einstein College of Medicine |
| | Worked with transgenic mice models to elucidate sickling mechanisms in Acute Chest syndrome of sickle cell disease | |
| Summer 1993 | **Family Planning Counselor** | Concord Feminist Health Center |
| | Provided reproductive health counseling | |

## Volunteer Experience

| | | |
|---|---|---|
| 2000-present | **Prenatal Class Coordinator** | Child Care Circuit |
| | Organize and teach bilingual 6-session course on health in pregnancy, labor and delivery, and parenting for pregnant women and their partners (3-4x/yr) | |
| 1996-1998 | **Sexual Assault Counselor** | Victims Assistance Services |
| | Participated in 12-week training program for certification in New York. Provided crisis intervention on telephone hotline | |
| 1995-1997 | **Volunteer** | Citiwide Harm Reduction |
| | Provided clean syringes, condoms, referrals to food and housing services to HIV+ IV drug users | |

## Awards and Memberships

| | |
|---|---|
| 1999-Present | Prenatal Task Force, Greater Lawrence Family Health Center |
| 1999 | Alpha Omega Alpha Society |
| 1999 | American Medical Women's Association Medical Student Achievement Award |

## Additional Training and Skills

- Fluent in medical Spanish
- Competent to do obstetrics as a family practitioner including early trimester ultrasound
- Planning to complete training in colposcopy.