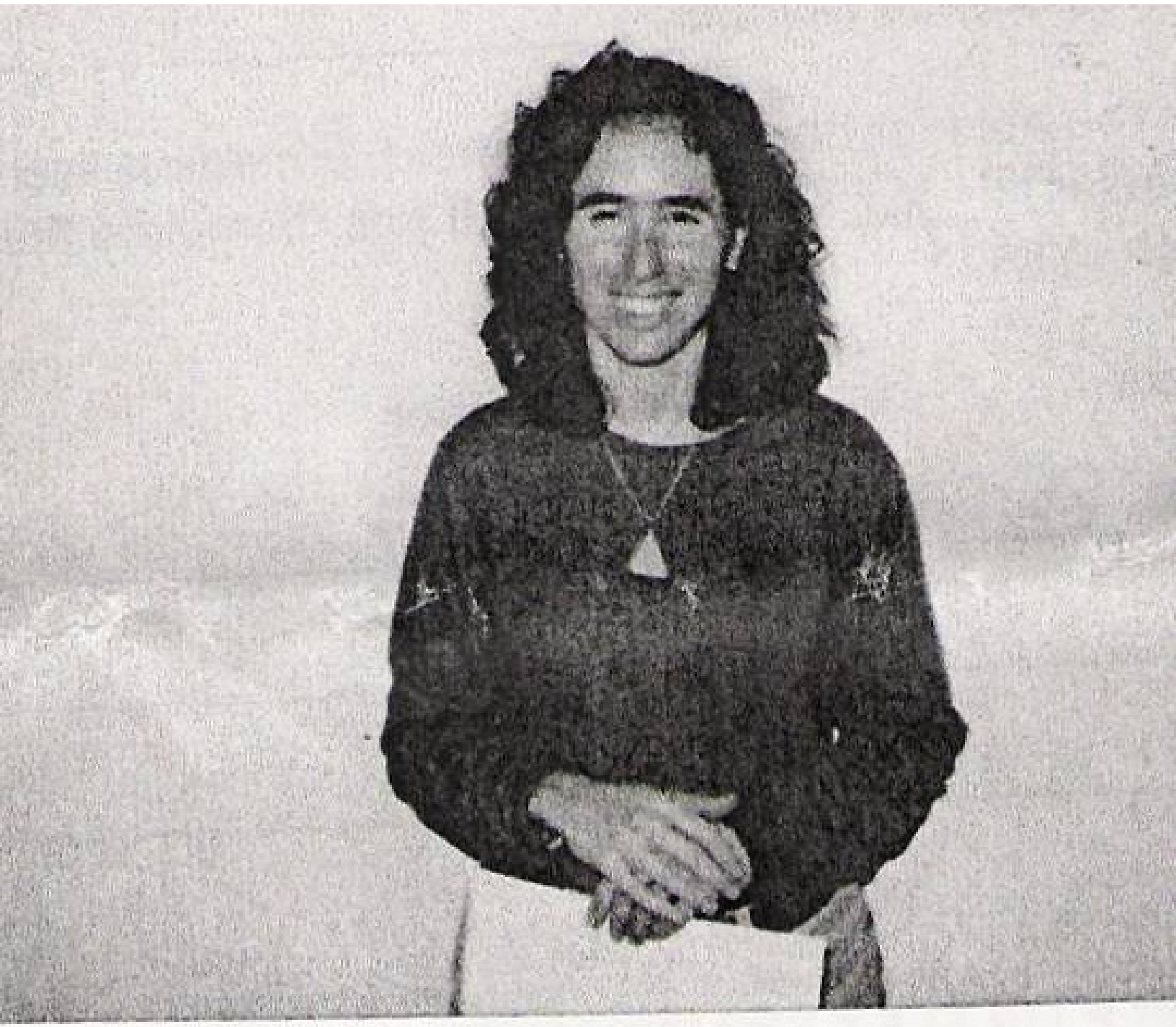
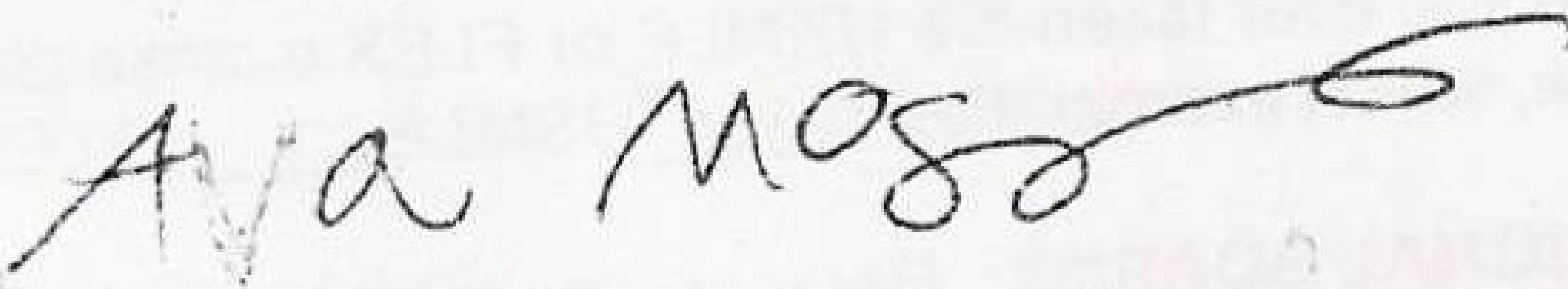


Ava Moss



Social Security #* 058 / 50 / 0563

YESHIVA UNIVERSITY

IN RECOGNITION OF THE SATISFACTORY FULFILLMENT
OF THE REQUIRED COURSE OF STUDY AT THE

ALBERT EINSTEIN COLLEGE OF MEDICINE

AND UPON THE RECOMMENDATION OF THE FACULTY,
THE TRUSTEES OF YESHIVA UNIVERSITY BY VIRTUE OF THE
AUTHORITY VESTED IN THEM HAVE CONFERRED UPON

AVA ROSALIND MOSKIN

THE DEGREE OF

DOCTOR OF MEDICINE

WITH ALL THE RIGHTS, PRIVILEGES, AND HONORS THEREUNTO PERTAINING
IN TESTIMONY WHEREOF THIS DIPLOMA IS GRANTED IN THE CITY OF
NEW YORK ON THE THIRD DAY OF JUNE, 1999.

CHAIRMAN, BOARD OF TRUSTEES

CHAIRMAN, BOARD OF OVERSEERS

PRESIDENT

VICE PRESIDENT FOR MEDICAL AFFAIRS AND DEAN

STATE OF VERMONT - BOARD OF MEDICAL PRACTICE
APPLICATION FOR LIMITED TEMPORARY LICENSE, PAGE FOUR OF SEVEN

What has been your physical residence (City, State) in the past ten years?:

Providence, RI 9/90 – 8/92

Bar Harbor, ME 8/92 – 6/95

NY, NY 6/95 – 6/99

Lawrence, Ma 6/99 – Present

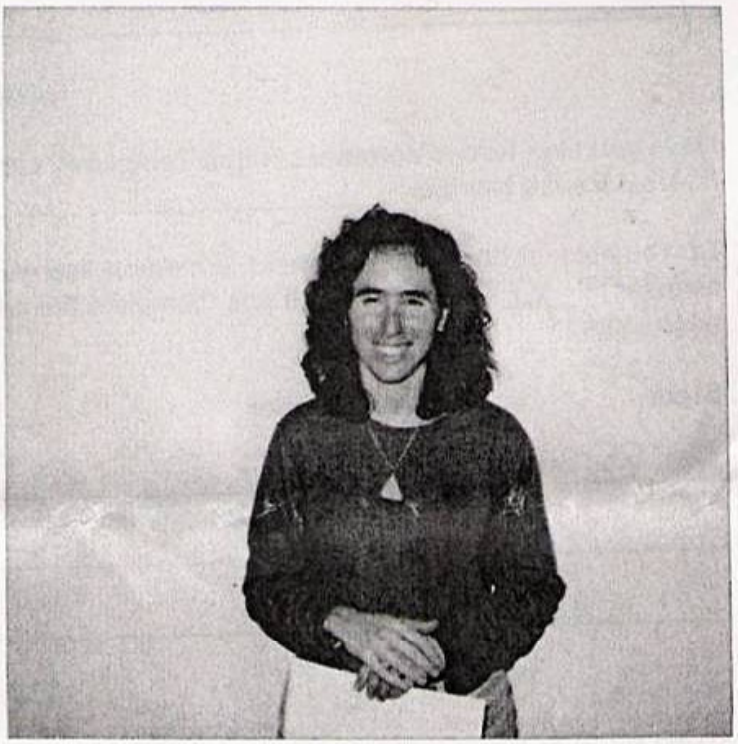
INTERNATIONAL MEDICAL GRADUATES

ECFMG Standard Certificate Number:_____ Date Issued: _____
Attach a copy of your ECFMG Certificate

Are you a graduate of a fifth pathway program? ___ Yes ___ No
If yes, attach a copy of your fifth pathway certificate.

SECTION II

PROVIDE A PHOTOGRAPH: Attach a photograph taken within the last 60 days (head and shoulders). Proofs not acceptable. **Sign the front of the photograph.**



Aya Moss

SECTION IV
APPLICANT'S STATEMENT REGARDING CHILD SUPPORT, TAXES, UNEMPLOYMENT COMPENSATION CONTRIBUTIONS

You must answer questions 1, 2, and 3.

Regarding Child Support

Title 15 § 795 requires that: A professional license or other authority to conduct a trade or business may not be issued or renewed unless the person certifies that he or she is in g standing with respect to or in full compliance with a plan to pay any and all child support payable under a support order as of the date the application is filed. **"Good standing"** me that less than one-twelfth of the annual support obligation is overdue; or liability for any support payable is being contested in a judicial or quasi-judicial proceeding; or he or she i compliance with a repayment plan approved by the office of child support or agreed to by the parties; or the licensing authority determines that immediate payment of support would imp an unreasonable hardship. (15 V.S.A. § 795)

1. **You must check one of the two statements below regarding child support regardless whether or not you have children:**

✓ I hereby certify that, as of the date of this application: (a) I am not subject to any support order or (b) I am subject to a support order and I am in g standing with respect to it, or (c) I am subject to a support order and I am in full compliance with a plan to pay any and all child support due under t order.

or

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2. **You must check one of the two statements below regarding taxes:**

✓ I hereby certify, under the pains and penalties or perjury, that I am in good standing with respect to or in full compliance with a plan to pay any and taxes due to the State of Vermont as of the date of this application. (The maximum penalty for perjury is fifteen years in prison, a $10,000.00 fin both).

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Regarding Unemployment Compensation Contributions

Title 21 § 1378 requires that: No agency of the state shall grant, issue or renew any license or other authority to conduct a trade or business (including a license to practice a profes to, or enter into, extend or renew any contract for the provision of goods, services, or real estate space with any employing unit unless such employing unit shall first sign a wr declaration, under the pains and penalties of perjury, that the employing unit is in good standing with respect to or in full compliance with a plan to pay any and all contributio payments in lieu of contributions due as of the date such declaration is made. For the purposes of this section, a person is in good standing with respect to any and all contributio payments in lieu of contributions payable if: (1) no contributions or payments in lieu of contributions are due and payable; (2) the liability for any contributions or payments in li contributions due and payable is on appeal; (3) the employing unit is in compliance with a payment plan approved by the Commissioner; or (4) in the case of a licensee, the agency f that requiring immediate payment of contributions or payments in lieu of contributions due and payable would impose an unreasonable hardship.

3. **You must check one of the three statements below regarding unemployment contributions or payments in lieu of unemployment contributi**

✓ I hereby certify, under the pains and penalties or perjury, that I am in good standing with respect to or in full compliance with a payment plan appr by the Commissioner of Employment and Training to pay any and all unemployment contributions or payments in lieu of unemployment contribut to the Vermont Department of Employment and Training due as of the date of this application. (The maximum penalty for perjury is 15 years in pri a $10,000.00 fine or both.)

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Social Security #* 058 / 50 / 0563 Date of Birth 04 / 07 / 71

*** The disclosure of your social security number is mandatory, it is solicited by the authority granted by 42 U.S.C. § 405 (c)(2)(C), and will be used by Department of Taxes and the Department of Employment and Training in the administration of Vermont tax laws, to identify individuals affected by laws, and by the Office of Child Support.**

STATEMENT OF APPLICANT

I certify that the information stated by me in this application is true and accurate to the best of my knowledge and that providing false information or omissi information is unlawful and may jeopardize my license/certification/registration status.

Signature of Applicant [signature] Date 12/6/00

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I certify that the information stated by me in this application is true and accurate to the best of my knowledge and that providing false information or omissi information is unlawful and may jeopardize my license/certification/registration status.

Signature of Applicant [signature] Date 12/6/00

Albert Einstein College of Medicine
of Yeshiva University

Lillian Lombardi
Registrar

Jack and Pearl Resnick Campus
1300 Morris Park Avenue
Bronx, New York 10461

Phone: 718•430•2102
718•430•2104
FAX: 718•430•8825
email: lombardi@aecom.yu.edu

STATE OF VERMONT - BOARD OF MEDICAL PRACTICE
109 STATE STREET
MONTPELIER, VERMONT 05609-1106
(802) 828-2673

JAN 16 2001

APPLICATION FOR LIMITED TEMPORARY LICENSE - PAGE ONE OF SEVEN

Important:

- Please print legibly or type your answers.
- Answer all questions completely-it is not adequate to state that the Board already has the information. Use the **enclosed Form A** to provide explanations to "yes" answers in **Section III**.
- Incomplete applications will be returned.
- When space provided is insufficient, attach additional sheets.
- Make a copy of this form and all attachments for your own records.
- Carefully complete the application as false statements are grounds for unprofessional conduct.
- **Thank you for your cooperation.**

SECTION I

I hereby make application for a Limited Temporary License to practice medicine and surgery as an intern, resident, fellow or medical officer in the State of Vermont at the

Fletcher Allen Healthcare Hospital, Department of Orthopedics + Rehabilitation

under the supervision of Robert S. Johnson, M.D. and submit the following information:

Name: Moskin (Last) Ava (First) R (Middle) _____ (Former)

Mailing Address: 500 Lowell St (Street)

Lawrence (City) Ma (State) 01841 (Zip Code) (978) 738-0151 (Phone)

Present Address (if different): _____ (Street)

_____ (City) _____ (State) _____ (Zip Code) _____ (Phone)

Home Address: same

City, State, Zip Code: _____

Daytime Telephone Number: Area Code: (_____) same

Date of Birth: Month: April Day 7 Year 1971

Place of Birth: NYC Sex: _____ Male ✓ Female

STATE OF VERMONT - BOARD OF MEDICAL PRACTICE
109 STATE STREET
MONTPELIER, VERMONT 05609-1106
(802) 828-2673

LIMITED TEMPORARY LICENSE APPLICATION
STATEMENT OF PROGRAM DIRECTOR

This section must be completed by the Director of the residency program in which the applicant is currently engaged.

I certify that Ava Moskin is engaged as an intern, resident, fellow, or
Name of Applicant

medical officer at:

Hospital: Greater Lawrence Family Health Center

Department: Lawrence Family Residency

Address: 34 Haverhill St.

City, State, Zip Code: Lawrence MA 01841

for the period 6-95 to 6-2002.

I further state that Ava Moskin is scheduled to participate in an away
Name of Applicant

rotation at:

Hospital: Fletch Allen Healthcare

Department: Dept. of Orthopoedic & Rehab

Address: _____

City, State, Zip Code: _____

for the period _____ to _____. This is an approved

rotation within the framework of the residency program.

_____ 12/4/00
Signature of Program Director — Date

Scott Early
Program Director's Name Printed

STATE OF VERMONT - BOARD OF MEDICAL PRACTICE
APPLICATION FOR LIMITED TEMPORARY LICENSE, PAGE THREE OF SEVEN

TRAINING

List chronologically residency or other postgraduate training. Give names, addresses of hospitals, exact dates (month, day, year), and type of training.

Name	Address	From/To	Training
Lawrence Family Practice	34 Haverhill st Lawrence, Ma 01841	6/99 - Present	Family Practice

PRACTICE

List all hospitals where you have, or previously have had, staff privileges. Include name, address, and dates.

Name	Address	From/To	Specialty/Subspecialty

OTHER LICENSES

Have you ever held a Vermont Limited Temporary License? ____ Yes X No
If Yes, License Number: _____

Do you hold, or have you ever held, a medical license in any other state (either training permits or permanent licenses)? X Yes ____ No If yes, complete the section below and send a Certificate of Medical Licensure to each state.

State	License Number	Date Issued	Status (Active or Inactive)
Mass	8727	5/28/99	Active

EXAMINATIONS

USMLE OR FLEX EXAMINATION:
Have you ever taken the USMLE or FLEX examination? ✓ Yes ____ No
If yes, which examination? ✓ USMLE _____ FLEX

NATIONAL BOARDS: Have you ever taken the National Boards? ____ Yes ✓ No

STATE EXAMINATION: Have you ever taken a State Medical Board Examination? ____ Yes ✓ No

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

(617) 727-3086
Fax: (617) 451-9568
An Agency within the Office of Consumer Affairs and Business Regulation

JL CELLUCCI
ERNOR

SWIFT
T GOVERNOR

IN SULLIVAN
E DIRECTOR

VERIFICATION OF LIMITED LICENSE

Date: 12-11-2000

To whom It May Concern:

This is to certify that Cara R. Hoskin has/had been granted a limited license number 99-8727-02 to serve as Resident with authority to practice medicine only in Greater Lawrence hospital. Service at the hospital begins/~~began~~ on 6-28-99 and will ~~expire~~/expired on 6-30-2002

Our files contain no derogatory information on this physician.

Peter N. Madras, M.D., Chairman

Seal

Please be advised that the above information is based entirely on examination of our open and closed complaint file. It is not based on a review of the application for licensure, renewal of licensure or any reports that the Board is required to receive by statute (from courts, insurers, hospitals, etc...).

[e/share/verifications/Limited-No]

(Limited License Status Sheet Continued)

10) X Applicant's Signature Required in:

X Photograph in Section II;

X Tax and Child Support Statement - end of Section IV.

11) _____ Internal Federation Disciplinary Check by computer

STATE OF VERMONT - BOARD OF MEDICAL PRACTICE
109 STATE STREET
MONTPELIER, VERMONT 05609-1106
(802) 828-2673

LIMITED TEMPORARY LICENSE APPLICATION
STATEMENT OF SUPERVISING PHYSICIAN

This section must be completed by the physician who will be supervising your work while in Vermont. This licensed physician will be responsible and liable for all negligent and wrongful acts or omissions of the limited temporary license holder. Termination of appointment as an intern, resident, fellow or medical officer of such designated hospital or institution shall operate as a revocation of such limited temporary license. Such limited temporary license shall be revoked upon the death or legal incompetency of the licensed physician or upon ten days written notice of the licensed physician.

I certify that Ava Moskin is engaged as an intern, resident, fellow or medical
Name of Applicant

officer at:

Hospital: _____

Department: _____

Address: _____

City, State, Zip Code: _____

for the period _____ to _____.

I state that the above applicant is under my direct supervision and control. I further state that I shall be legally responsible and liable for all negligent or wrongful acts or omissions of this limited temporary license holder.

_____ _____
Signature of Supervising Physician Supervising Physician's License Number

_____ _____
Supervising Physician's Name Printed Date

_____
Address

_____
City, State, Zip Code

Please mail completed form to the Board's address listed above. Thank you.

STATE OF VERMONT, BOARD OF MEDICAL PRACTICE
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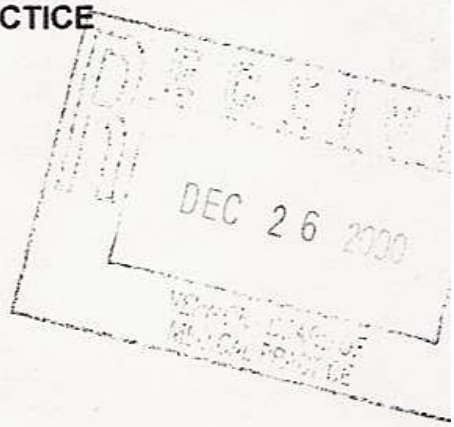

CERTIFICATE OF MEDICAL EDUCATION

To be completed by an officer of your School of Medicine

I hereby certify that AVA MOSKIN (Name) was admitted to the

ALBERT EINSTEIN COLLEGE OF MEDICINE School of Medicine

in BRONX, NY, (City and State) on AUGUST 16, 1995 (Date)

and completed all requirements for graduation on MAY 24, 1999 (Date).

A DOCTOR OF MEDICINE (Specify certificate/diploma/degree) was granted on JUNE 3, 1999 (Date).

(AFFIX SEAL)

Date: DECEMBER 21, 2000

Signed: _____
(Authorized Officer of the School)

PRINT NAME: LILLIAN LOMBARDI, REGISTRAR

STATE OF VERMONT - BOARD OF MEDICAL PRACTICE
APPLICATION FOR LIMITED TEMPORARY LICENSE, PAGE TWO OF SEVEN

SPECIALTY

Specialty: Family Practice

Subspecialty: _____

NAME FOR CERTIFICATE - NAME CHANGES - OTHER NAMES LICENSED

Name as it should appear on your license certificate: Ava Moskin

Have you ever legally changed your name? ____ Yes ✓ No
If Yes, enclose a certified copy of the legal document stating the change.

Other Name(s), if any, under which you were licensed elsewhere: _____

PREMEDICAL EDUCATION

(Name and location of Institution)	(From/To)	(Degree)
Brown University, Providence, RI	9/90 - 12/91	none
College of the Atlantic, Bar Harbor, Me	9/92 - 6/95	B.A.

MEDICAL EDUCATION-See also Certificate of Medical Education

(Name and location of Institution)	(From/To)	(Degree)
Albert Einstein College of Med, Bronx, NY	9/95 - 6/99	

(Name and location of Institution) (From/To) (Degree)

STATE OF VERMONT, BOARD OF MEDICAL PRACTICE
APPLICATION FOR LIMITED TEMPORARY LICENSE, PAGE FIVE OF SEVEN

A "Yes" answer to Questions 1 - 24 requires an explanation on the enclosed Form A.

1. Have you ever applied for and been denied a license to practice medicine or any healing art? ___Yes ___No

2. Have you ever withdrawn an application for a license to practice medicine or any healing art? ___Yes ___No

3. Have you ever voluntarily surrendered or resigned a license to practice medicine or any healing art in lieu of disciplinary action? ___Yes ___No

4. Are any formal disciplinary charges pending or has any disciplinary action ever been taken against you by any governmental authority, by any hospital or health care facility, or by any professional medical association (international, national, state or local)? ___Yes ___No

5. To your knowledge, are you the subject of an investigation by any **other** licensing board as of the date of this application? ___Yes___No

6. Have you ever been denied the privilege of taking an examination before any State Medical Examining Board? ___Yes ___No

7. Have you ever discontinued your education, training, or practice for a period of more than three months? ___Yes ___No

8. Have you ever been dismissed or asked to leave a residency training program(s) before completion? ___ Yes ___No

9. Have you ever had staff privileges, employment or appointment in a hospital or other health care institution denied, reduced, suspended or revoked; resigned from a medical staff in lieu of disciplinary action; or resigned from a medical staff after a complaint or peer review action has been initiated against you? ___Yes ___No

10. Have you ever been denied the right to participate or enroll in any system whereby a third party pays all or part of a patient's bill? ___Yes ___No

11. Have you ever been notified as a responsible party of a confirmed quality concern (quality of hospital care provided to Medicare patients) by the Peer Review Organization (PRO) in Vermont or elsewhere? ___Yes ___No

12. Has any medical malpractice claim been made against you in the last ten years (whether or not a lawsuit was filed in relation to the claim/complaint/demand for damages)? ___Yes ___No

13. Have you ever been turned down for coverage by a malpractice insurance carrier? ___Yes ___No

14. Has your privilege to possess, dispense or prescribe controlled substances ever been suspended, revoked, denied, restricted or surrendered by any jurisdiction or federal agency at any time? ___Yes___No

15. Have you, at any time, been a defendant in any criminal proceeding other than minor traffic offenses (Note: DWI - Driving While Intoxicated - is NOT a minor offense)? ___Yes___No

16. To your knowledge, are you the subject of an investigation for a criminal act? ___Yes ___No

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Signature of Applicant [signature] Date 12/6/00

STATE OF VERMONT - BOARD OF MEDICAL PRACTICE
109 STATE STREET
MONTPELIER, VERMONT 05609-1106
(802) 828-2673

LIMITED TEMPORARY LICENSE APPLICATION
STATEMENT OF SUPERVISING PHYSICIAN

This section must be completed by the physician who will be supervising your work while in Vermont. This licensed physician will be responsible and liable for all negligent and wrongful acts or omissions of the limited temporary license holder. Termination of appointment as an intern, resident, fellow or medical officer of such designated hospital or institution shall operate as a revocation of such limited temporary license. Such limited temporary license shall be revoked upon the death or legal incompetency of the licensed physician or upon ten days written notice of the licensed physician.

I certify that Ava Moskin is engaged as an intern, resident, fellow or medical officer at:
Name of Applicant

Hospital: Sugarbush Ski Clinic

Department: FAHC Ortho/Rehab

Address: 792 College Parkway, Suite 107

City, State, Zip Code: Colchester, VT 05446

for the period 01/01 to 02/01.

I state that the above applicant is under my direct supervision and control. I further state that I shall be legally responsible and liable for all negligent or wrongful acts or omissions of this limited temporary license holder.

Signature of Supervising Physician

042-0008798
Supervising Physician's License Number

Michael Sargent
Supervising Physician's Name Printed

Date

FAHC Ortho/Rehab, 792 College Parkway, Suite 101
Address

Colchester, VT 05446
City, State, Zip Code

Please mail completed form to the Board's address listed above. Thank you.

STATE OF VERMONT-BOARD OF MEDICAL PRACTICE
For Office Use Only - Initial Limited Temporary License Checklist

Limited License Physician Status Sheet

Name of Applicant: Ava R. Moskin

Address: 500 Lowell St.
Lawrence, MA 01841

Telephone: 978-738-0151

Date Application Received: 1/16/01

X US Graduate ___ Canadian Graduate ___ International Medical Graduate

Institution: X Fletcher Allen ___ Dartmouth ___ Other ___

Program: Ortho/Rehab

* Unless noted, a copy of the original and English translation, if applicable, is required to be submitted:

1) X Fee of $50

2) X Completed "APPLICATION FOR LIMITED TEMPORARY LICENSE".

X Photograph Date of Birth 4/7/71

3) X Copy of Medical School Diploma Date of Graduation 6/99

Name of Medical School Albert Einstein College of Medicine

4) X Direct verification: "CERTIFICATE OF MEDICAL EDUCATION".

5) X Supervising Physician's Statement Name: Michael Sargent

6) X Supervising Director's Statement Name: Scott Early

7) X Direct Verification: "Certificate of Medical Licensure"

X Mass ___ ___ ___ ___

___ ___ ___ ___ ___

8) N/A If applicable, copy of:

___ ECFMG Certificate

___ or Fifth Pathway Certificate

9) N/A Completed Form A if applicant answered "Yes" in Section III.