



**TARGET SHEET**

**Board: Medicine**

**Licensee Full Name:**  
**AMNA IBRAHIM DERMISH**

**License No:**  
**MT187794**

**2376994\_LIC\_2\_01/12/2011**

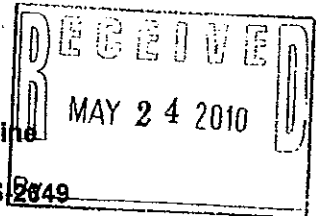
COMMONWEALTH OF PENNSYLVANIA  
DEPARTMENT OF STATE  
BUREAU OF PROFESSIONAL AND OCCUPATIONAL AFFAIRS  
STATE BOARD OF MEDICINE

MT187794  
DERMISH

RENEWAL APPLICATION

AMNA IBRAHIM DERMISH 9849  
PENNSYLVANIA HOSPITAL  
MARY MARTINO COORDINATOR  
ACADEMIC AFFAIRS OFFICE  
800 SPRUCE STREET  
PHILADELPHIA PA 19107

State Board of Medicine  
PO Box 2649  
Harrisburg, PA 17105-2649



☒ I will not be participating in graduate training in Pennsylvania after the expiration date indicated below and request inactive status. No fee is required. YOU MUST SIGN, DATE AND RETURN THIS FORM.

THE FOLLOWING QUESTIONS MUST BE ANSWERED

YES	NO	If YES to 2-8 - provide details AND attach certified copies of legal document(s).
		1. Do you hold or have you ever held a license, certification, or registration (active or inactive, current or expired) to practice this profession in any other state or jurisdiction? List:
		2. Since your initial application or your last renewal, whichever is later, have you ever had disciplinary action taken against your license, certification, or registration issued to you in any profession in any other state or jurisdiction?
		3. Since your initial application or your last renewal, whichever is later, have you withdrawn an application for a license, certification, or registration, had an application denied or refused, or for disciplinary reasons agreed not to reapply for a license, certificate or registration in any profession in any state or jurisdiction?
		4. Since your initial application or your last renewal, whichever is later, have you been convicted, found guilty or pleaded nolo contendere, or received probation without verdict or accelerated rehabilitative disposition (ARD) as to any felony or misdemeanor, including any drug law violations, or do you have any criminal charges pending and unresolved in any state or jurisdiction? You are not required to disclose any ARD or other criminal matter that has been expunged by order of a court.
		5. Since May 19, 2002, have you been arrested for criminal homicide, aggravated assault, sexual offenses, or drug offenses in any state, territory, or country?
		6. Since your initial application or your last renewal, whichever is later, have you had practice privileges denied, revoked or restricted in a hospital or other health care facility?
		7. Since your initial application or your last renewal, whichever is later, have you had your DEA registration denied, revoked or restricted or have you had your provider privileges terminated by any medical assistance agency for cause?
		8. Since May 19, 2002, have any malpractice complaints been filed against you? If yes, the Board requires that you submit a copy of the <u>entire Civil Complaint</u> , which must include the <u>filing date</u> and <u>the date you were served</u> . If the Civil Complaint was previously submitted, provide a statement, which lists the docket number.

Please review and update, as necessary, the following information regarding your license:

	Beginning Date	Ending Date	Level	Specialty	Hospital #	Hospital Name
Current	06/18/2009	06/17/2010	Level 4	Obstetrics and Gynecology	HS000181L	PENNSYLVANIA HOSPITAL
Renewal						

Signature of Licensee (Mandatory):

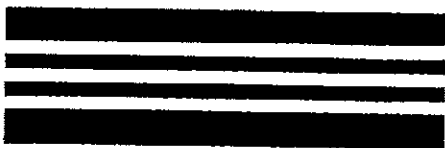
Date: 4/13/10

Medical School Graduation Date:

SSN:

ATTACHMENTS FOR RENEWING:

- FEE - \$15.00 check payable to "COMMONWEALTH OF PENNSYLVANIA". Write your license number on your payment. A \$20.00 fee will be assessed for a returned payment.
- LATE FEE - \$5.00 per month, or part of a month. Late renewal fee will be assessed if postmarked after the expiration date.
- NAME CHANGE DOCUMENT - Submit a photocopy of a legal document verifying name change (i.e., marriage certificate, divorce decree, etc.)
- PGY 2 LEVEL - Copy of your USMLE Step 1 and 2 scores OR FLEX I scores OR National Board Part 1 and 2 scores OR an acceptable combination as indicated in the regulations.
- PGY 3 LEVEL or above - Copy of your USMLE Step 3 scores OR FLEX I and II scores OR National Board Parts 1-3 scores OR an acceptable combination as indicated in the regulations OR a copy of your unrestricted license WHICH SHOWS THE CURRENT EXPIRATION DATE.



TARGET SHEET

Board: Medicine

Licensee Full Name:  
AMNA IBRAHIM DERMISH

License No:  
MT187794

2376994\_LIC\_2\_01/24/2011

\*Please leave  
renew sheet in  
Amna's mailbox,  
MT187794  
DERMISH

COMMONWEALTH OF PENNSYLVANIA  
DEPARTMENT OF STATE  
BUREAU OF PROFESSIONAL AND OCCUPATIONAL AFFAIRS  
STATE BOARD OF MEDICINE

### RENEWAL APPLICATION

AMNA IBRAHIM DERMISH 9849  
PENNSYLVANIA HOSPITAL  
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**THE FOLLOWING QUESTIONS MUST BE ANSWERED**

YES	NO	If YES to 2-8 - provide details AND attach certified copies of legal document(s).
	<input checked="" type="checkbox"/>	1. Do you hold or have you ever held a license, certification, or registration (active or inactive, current or expired) to practice this profession in any other state or jurisdiction? List:
	<input checked="" type="checkbox"/>	2. Since your initial application or your last renewal, whichever is later, have you ever had disciplinary action taken against your license, certification, or registration issued to you in any profession in any other state or jurisdiction?
	<input checked="" type="checkbox"/>	3. Since your initial application or your last renewal, whichever is later, have you withdrawn an application for a license, certification, or registration, had an application denied or refused, or for disciplinary reasons agreed not to reapply for a license, certificate or registration in any profession in any state or jurisdiction?
	<input checked="" type="checkbox"/>	4. Since your initial application or your last renewal, whichever is later, have you been convicted, pleaded guilty or entered a plea of nolo contendere, or received probation without verdict, accelerated rehabilitative disposition (ARD) or received any other disposition (excluding acquittal or dismissal) of any criminal charges, felony or misdemeanor, including any DUI/DWI, drug law violations, or are there any criminal charges pending and unresolved in any state or jurisdiction?
	<input checked="" type="checkbox"/>	5. Since May 19, 2002, have you been arrested for criminal homicide, aggravated assault, sexual offenses, or drug offenses in any state, territory, or country?
	<input checked="" type="checkbox"/>	6. Since your initial application or your last renewal, whichever is later, have you had practice privileges denied, revoked or restricted in a hospital or other health care facility?
	<input checked="" type="checkbox"/>	7. Since your initial application or your last renewal, whichever is later, have you had your DEA registration denied, revoked or restricted or have you had your provider privileges terminated by any medical assistance agency for cause?
	<input checked="" type="checkbox"/>	8. Since May 19, 2002, have any malpractice complaints been filed against you? If yes, the Board requires that you submit a copy of the <u>entire Civil Complaint</u> , which must include the <u>filing date</u> and the <u>date you were served</u> . If the Civil Complaint was previously submitted, provide a statement, which lists the docket number.

Please review and update, as necessary, the following information regarding your license:

	Beginning Date	Ending Date	Level	Specialty	Hospital #	Hospital Name
Current	06/18/2008	06/17/2009	Level 3	Obstetrics and Gynecology	HS000181L	PENNSYLVANIA HOSPITAL
Renewal	06/18/2009	06/17/2010	4	OB-Gyn	HS000181L	PA Hospital

Signature of Licensee (Mandatory): \_\_\_\_\_

Date: 4/6/09

Medical School Graduation Date: 5/2006

SSN: \_\_\_\_\_

**ATTACHMENTS FOR RENEWING:**

- **FEE** -- \$15.00 check payable to "COMMONWEALTH OF PENNSYLVANIA". Write your license number on your payment. A \$20.00 fee will be assessed for a returned payment.
- **LATE FEE** - \$5.00 per month, or part of a month. Late renewal fee will be assessed if postmarked after the expiration date.
- **NAME CHANGE DOCUMENT** - Submit a photocopy of a legal document verifying name change (i.e., marriage certificate, divorce decree, etc.)
- **PGY 2 LEVEL** - Copy of your USMLE Step 1 and 2 scores OR FLEX I scores OR National Board Part 1 and 2 scores OR an acceptable combination as indicated in the regulations.
- **PGY 3 LEVEL or above** - Copy of your USMLE Step 3 scores OR FLEX I and II scores OR National Board Parts 1-3 scores OR an acceptable combination as indicated in the regulations OR a copy of your unrestricted license WHICH SHOWS THE CURRENT EXPIRATION DATE.

APR 23 2009

**USMLE**

United States

Medical

Licensing

Examination

**UNITED STATES MEDICAL LICENSING EXAMINATION™**

Students and graduates of U.S. and Canadian medical schools are registered for Step 1 by the  
**NATIONAL BOARD OF MEDICAL EXAMINERS® (NBME)**  
3750 Market Street, Philadelphia, Pennsylvania 19104-3190  
Telephone: (215) 590-9700

**STEP 1 SCORE REPORT**

Amish, Anna L

Test Date: June 4, 2004

USMLE ID: 5-144-656-5

The USMLE Step 1 examination program, consisting of three steps, is designed to assess an examinee's understanding of and ability to apply concepts and principles that are important in health and disease and that constitute the basis of safe and effective patient care. Step 1 is designed to assess whether an examinee understands and can apply important concepts of the sciences basic to the practice of medicine, with special emphasis on principles and mechanisms underlying health, disease, and modes of therapy. The inclusion of Step 1 in the USMLE sequence is intended to ensure mastery of not only the sciences underlying the safe and competent practice of medicine in the present, but also the scientific principles required for maintenance of competence through lifelong learning. Results of the examination are reported to medical licensing authorities in the United States and its territories for use in granting an initial license to practice medicine. The two numeric scores shown below are equivalent; each state or territory may use either score in making licensing decisions. These scores represent your results for the administration of Step 1 on the test date shown above.

**PASS**

This result is based on the minimum passing score set by USMLE for Step 1. Individual licensing authorities may accept the USMLE recommended pass/fail result or may establish a different passing score for their own jurisdiction.

**132**

This score is determined by your overall performance on Step 1. For recent administrations, the mean and standard deviation for first-time examinees from U.S. and Canadian medical schools are approximately 121 and 21, respectively, with most scores falling between 114 and 238. A score of 132 is set by USMLE to pass Step 1. The standard error of measurement (SEM) for this score is six points.

**75**

This score is also determined by your overall performance on the examination. A score of 75 on this scale, which is equivalent to a score of 132 on the scale described above, is set by USMLE to pass Step 1. The SEM for this scale is two points.

Your score is influenced both by your general understanding of the basic biomedical sciences and the specific set of items selected for this Step 1 examination. The Standard Error of Measurement (SEM) provides an index of the variation in scores that would be expected to occur if an

APR 26 2009



Students and graduates of U.S. and Canadian medical schools are registered for Step 2 by the  
NATIONAL BOARD OF MEDICAL EXAMINERS (NBME)  
1750 Market Street, Philadelphia, Pennsylvania 19104-3190  
Telephone: (215) 590-9700

**STEP 2 CLINICAL KNOWLEDGE (CK) SCORE REPORT**

Dermish, Anna L

Test Date: August 15, 2005

USMLE ID: S144-686-6

The USMLE is a single examination program consisting of three steps designed to assess an examinee's understanding of and ability to apply concepts and principles that are important in health and disease and that constitute the basis of safe and effective patient care. Step 2 is designed to assess whether an examinee has the medical knowledge, skills, and understanding of clinical science essential for the provision of patient care under supervision, including emphasis on health promotion and disease prevention. The inclusion of Step 2 in the USMLE is intended to ensure that the attention is devoted to principles of clinical science and basic patient-centered skills that provide the foundation for the safe and competent practice of medicine. There are two components to Step 2: a Clinical Knowledge (CK) examination and a Clinical Skills (CS) examination. This report represents results for the Step 2 CK examination only. Results of the examination are reported to medical licensing authorities in the United States and its territories for use in granting an initial license to practice medicine. The two numeric scores shown below are equivalent; each state or territory may use either score in making licensing decisions. These scores represent your results for the administration of Step 2 CK on the test date shown above.

<b>PASS</b>	This result is based on the minimum passing score set by USMLE for Step 2 CK. Individual licensing authorities may accept the USMLE recommended pass/fail result or may establish a different passing score for their own jurisdictions.
<b>225</b>	This score is determined by your overall performance on Step 2 CK. For recent administrations, the mean and standard deviation for first-time examinees from U.S. and Canadian medical schools are approximately 218 and 21, respectively, with most scores falling between 140 and 260. A score of 182 is set by USMLE to pass Step 2 CK. The standard error of measurement (SEM) for this scale is eight points.
<b>94</b>	This score is also determined by your overall performance on the examination. A score of 94 on this scale, which is equivalent to a score of 182 on the scale described above, is set by USMLE to pass Step 2 CK. The SEM for this scale is three points.

Your score is influenced both by your general understanding of clinical science and the specific set of items selected for this Step 2 CK examination. The Standard Error of Measurement (SEM) provides an index of the variation in scores that would be expected to occur if an examinee were tested repeatedly using different sets of items covering similar content.

**USMLE**

United States

Medical

Licensing

Examination

UNITED

STATES MEDICAL LICENSING

EXAMINATION

Students and graduates of U.S. and Canadian medical schools are registered for Step 2 by the  
NATIONAL BOARD OF MEDICAL EXAMINERS (NBME)  
3750 Market Street, Philadelphia, Pennsylvania 19104-3190  
Telephone: (215) 390-9700

**STEP 2 CLINICAL SKILLS (CS) SCORE REPORT**

Name: Dermish, Anna I

Test Date: October 10, 2005

USMLE ID: 5-144-656-5

The USMLE is a single examination program consisting of three Steps designed to assess an examinee's understanding of and ability to apply concepts and principles that are important in health and disease and that constitute the basis of safe and effective patient care. Step 2 is designed to assess whether an examinee can apply medical knowledge, skills, and understanding of clinical science essential for the provision of patient care under supervision, including emphasis on health promotion and disease prevention. The inclusion of Step 2 in the USMLE sequence is intended to ensure that due attention is devoted to principles of clinical sciences and basic patient-centered skills that provide the foundation for the safe and competent practice of medicine. There are two components to Step 2: a Clinical Knowledge (CK) examination and a Clinical Skills (CS) examination. This report represents results for the Step 2 CS examination only. Results of the examination are reported to medical licensing authorities in the United States and its territories for use in granting an initial license to practice medicine. The overall Pass/Fail outcome provided below represents your result for the administration of the Step 2 CS on the test date shown above. For examinees who failed the test, a graphical performance profile is provided on the second page of this report.

Overall  
Pass/Fail Outcome  
**PASS**

The overall outcome for Step 2 CS, reported above, is based upon the minimum passing levels set by USMLE for the three Step 2 CS subcomponents. The three subcomponents are Integrated Clinical Encounter (ICE), Communication and Interpersonal Skills (CIS), and Spoken English Proficiency (SEP). It is necessary to pass all three subcomponents in order to obtain an overall passing outcome on the Step 2 CS. Results for the three Step 2 CS subcomponents are reported below.

ICE	CIS	SEP
PASS	PASS	PASS



## UNITED STATES MEDICAL LICENSING EXAMINATION™

Federation of State Medical Boards of the U.S., Inc.

P.O. Box 619850, Dallas, Texas 75261-9850

Telephone: (817) 868-4041

## STEP 3 SCORE REPORT

Dermish, Anna

Test Date: May 9, 2007

USMLE ID: 5-144-656-5

The USMLE is a single examination program for all applicants for medical licensure in the United States. It replaced the Federation Licensing Examination (FLBX) and the certifying examinations of the National Board of Medical Examiners (NBME Parts I, II and III). The program consists of three Steps designed to assess an examinee's understanding of and ability to apply concepts and principles that are important in health and disease and that constitute the basis of safe and effective patient care. Step 3 is designed to assess whether an examinee possesses the medical knowledge and understanding of clinical science considered essential for the unsupervised practice of medicine, with an emphasis on patient management in ambulatory care settings. Results of the examination are reported to medical licensing authorities in the United States and its territories for use in granting an initial license to practice medicine. The two numeric scores shown below are equivalent; each state or territory may use either score in making licensing decisions. These scores represent your results for the administration of Step 3 on the test date shown above.

PASS

This result is based on the minimum passing score recommended by USMLE for Step 3. Individual licensing authorities may accept the USMLE recommended pass/fail result or may establish a different passing score for their own jurisdictions.

217

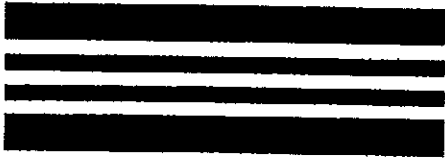
This score is determined by your overall performance on Step 3. For recent administrations, the mean and standard deviation for first-time examinees from U.S. and Canadian medical schools were approximately 213 and 17, respectively, with most scores falling between 140 and 260. A score of 184 is recommended by USMLE to pass Step 3. The standard error of measurement (SEM)<sup>1</sup> for this scale is approximately six points.

89

This score is also determined by your overall performance on the examination. A score of 75 on this scale, which is equivalent to a score of 184 on the scale described above, is recommended by USMLE to pass Step 3. The SEM<sup>1</sup> for this scale is approximately three points.

<sup>1</sup>Your score is influenced both by your general understanding of clinical medicine and by the specific set of items selected for this Step 3 examination. The Standard Error of Measurement (SEM) provides an index of the variation in scores that would be expected to occur if an examinee were tested repeatedly using different sets of items covering similar content.





**TARGET SHEET**

**Board: Medicine**

**Date Created:**

**03/17/2010**

**Licensee Full Name:**

**AMNA IBRAHIM DERMISH**

**License No:**

**MD439505**

**APPL**

**2767868**

**Regular Mailing Address**

STATE BOARD OF MEDICINE  
P.O. BOX 2649  
HARRISBURG, PA 17105-2649  
717-783-1400/717-787-2381  
Email: [st-medicine@state.pa.us](mailto:st-medicine@state.pa.us)

**Courier Delivery Address**  
STATE BOARD OF MEDICINE  
2801 NORTH THIRD STREET  
HARRISBURG, PA 17110

**APPLICATION FOR A LICENSE TO PRACTICE MEDICINE WITHOUT RESTRICTION**  
For Graduates of ACCREDITED Medical Schools (SCHOOLS IN THE U.S. AND CANADA)

**Application Fee:** \$35.00 not refundable. Make check payable to the "Commonwealth of Pennsylvania."  
**Note:** A processing fee of \$20.00 will be charged for any check or money order returned unpaid by your bank, regardless of the reason for non-payment.

**Please Print or Type**

NAME: Dermish Amna Ibrahim  
Last First Middle

Permanent Address:

All correspondence  
and the license will  
be mailed to this  
address unless the  
Board is notified of a  
change.

Street

Philadelphia PA 19106  
City State Zip Code

Email address:

[REDACTED]@gmail.com

Date of Birth:

MM DD YYYY

Social Security Number:

[REDACTED]

If your medical/licensure records are listed under another name or names list below:

Are you applying using credentials verification from FCVS? YES NO

Have you previously held a Pennsylvania graduate training license?

X YES; My license number is MT187794 NO

**LIST MEDICAL SCHOOL(S) ATTENDED:**

University of Colorado

**DATES OF ATTENDANCE:**

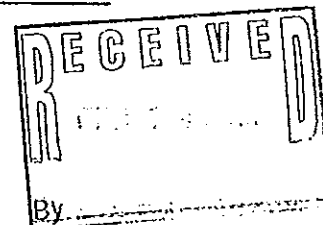
From: 08/2002 to 05/2006  
MM/YYYY MM/YYYY

From:          to           
MM/YYYY MM/YYYY

Date of Graduation: 05/26/2006  
MM/DD/YYYY

**Check licensing examination(s) passed:**

- ( ) FLEX - indicate state where taken:          Date taken: Component 1          Component 2           
( ) NATIONAL BOARD - PART I          PART II          PART III           
(X) USMLE - STEP 1 ✓ STEP 2 ✓ STEP 3 ✓  
( ) LMCC - Canadian  
( ) STATE BOARD - indicate state where taken:



204216

44558170

## ACGME Post Graduate Training:

PGY1 Hospital: Pennsylvania HospitalFrom: 6/18/06 to: 6/17/07PGY2 Hospital: Pennsylvania HospitalFrom: 6/18/07 to: 6/17/08

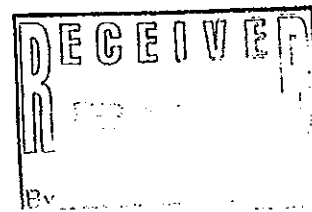
Answer the following questions. If "YES" is answered to #2 through #9, provide complete details on a separate sheet as well as certified copies of relevant documents. Sign and date below.

	Yes	No
1) Do you hold or have you ever held an unrestricted license, certification, or registration (active or inactive, current or expired) to practice medicine and/or surgery in another jurisdiction? <u>If yes, list the jurisdiction(s) here:</u>		X
2) Have you withdrawn an application for a license, certificate or registration, had an application for a license denied or refused, or for any disciplinary reason agreed not to reapply for a license, certificate or registration in any profession in any state or jurisdiction?		X
3) Have you had disciplinary action taken against your license, certificate or registration issued to you in any profession in any other state or jurisdiction?		X
4) Have you been convicted, pleaded guilty or entered a plea of nolo contendere, or received probation without verdict, accelerated rehabilitative disposition (ARD) or received any other disposition (excluding acquittal or dismissal) of any criminal charges, felony or misdemeanor, including any DUI/DWI, drug law violations, or are there any criminal charges pending and unresolved in any state or jurisdiction?		X
5) Since May 19, 2002, have you been arrested for criminal homicide, aggravated assault, sexual offenses or drug offenses in any state, territory or country?		X
6) Have you had practice privileges denied, revoked or restricted in a hospital or other health care facility, or have you been charged by a hospital, university, or research facility with violating research protocols, falsifying research, or engaging in other research misconduct?		X
7) Have you had your DEA registration denied, revoked or restricted or have you had your provider privileges terminated by any medical assistance agency for cause?		X
8) Are you, or have you ever been, addicted to the imtemperate use of alcohol or to the habitual use of narcotics or other habit-forming drugs? Note: You may answer "NO" if you are currently a participant in or have successfully completed the requirements of the Board's Professional Health Monitoring Program.)		
9) Since May 19, 2002, have any malpractice complaints been filed against you? If yes, the Board requires that you submit a copy of the <u>entire Civil Complaint</u> which must include the <u>docket number</u> , <u>filing date</u> , and the <u>date you were served</u> .		X

## SIGNED STATEMENT

Note that disclosing your social security number on this application is mandatory in order for the State Board of Medicine to comply with the requirements of the federal Social Security Act pertaining to child support enforcement, as implemented in the Commonwealth of Pennsylvania at 23 Pa. C.S. 4304.1(a). In order to enforce domestic child support orders, the Commonwealth's licensing boards must provide to the Department of Public Welfare Information prescribed by DPW about the licensee, including the social security number. Additionally, disclosing the number is mandatory in order for this board to comply with the reporting requirements of the federal National Practitioner Data Bank and the Healthcare Integrity and Protection Data Bank. Reports to the NPDB/HIPDB must include the licensee's social security number.

I verify that the statements in this application are true and correct to the best of my knowledge, information and belief. I understand that false statements are made subject to the penalties of 18 Pa. C.S. Section 4904 relating to unsworn falsification to authorities and may result in the suspension or revocation of my license. I hereby authorize all hospitals, institutions or organizations, my references, personal physicians, employers (past and present), and all governmental agencies and instrumentalities (local, state, federal or foreign) to release to the Pennsylvania State Board of Medicine any information requested.

Signature of Applicant: [Signature]Date: 2/5/10



### Certification of Moral Character

To be completed by two physicians who hold an unrestricted license in good standing in the United States or Canada and have known you for at least six months. ORIGINAL SIGNATURES ARE REQUIRED.

Name of Applicant: Amna Dermish

I hereby certify that I know the applicant to be of good moral character and to the best of my knowledge, he/she is not addicted to the imtemperate use of alcohol or to the habitual use of a narcotic or other habit forming drug. I recommend the applicant for a license to practice medicine in the Commonwealth of Pennsylvania.

I have been personally acquainted with the applicant for 3 year(s) 7 month(s).

SIGNATURE: [Redacted] Date: 1/8/10

Print or type name as signed above: Rima Mehita, M.D.

State in which licensed: PA License Number: MD426922

Name of Applicant: Amna Dermish

I hereby certify that I know the applicant to be of good moral character and to the best of my knowledge, he/she is not addicted to the imtemperate use of alcohol or to the habitual use of a narcotic or other habit forming drug. I recommend the applicant for a license to practice medicine in the Commonwealth of Pennsylvania.

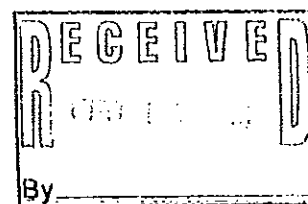
I have been personally acquainted with the applicant for 3 year(s) 7 month(s).

SIGNATURE: [Redacted] Date: 1/11/10

Print or type name as signed above: Stephanie Ewing

State in which licensed: PA License Number: MD056899L

**Return Completed Form to Applicant**





**Regular Mailing Address**

RECEIVED  
By \_\_\_\_\_

**Courier Delivery Address**  
**STATE BOARD OF MEDICINE**  
**2601 NORTH THIRD STREET**  
**HARRISBURG, PA 17110**

NAME: Dermish Amna Ibrahim  
Last First Middle

1. If training began before July 1, 1987, one year of approved training at a first (PGY 1) or second (PGY 2) year level must be verified. If the training began on or after July 1, 1987, two (2) years of approved training are required, one at first (PGY 1) year level and one at second (PGY 2) year level.
2. Training at a first (PGY 1) year must be ACGME approved entry level (training which requires no previous training). Training at a second (PGY 2) year must be ACGME approved and can be any specialty.
3. If training was completed at more than one hospital, duplicate this form and submit to each hospital.

**This Section to be completed by the program director at the hospital where the graduate training occurred.**

If training was in Pennsylvania, information must coincide with data on graduate license. For applicants still in the second year of training, this form may be completed and signed by the program director fifteen (15) days prior to the completion of the approved training. Forms postmarked or signed prior to the fifteen days will not be accepted.

NAME OF HOSPITAL WHERE TRAINING WAS COMPLETED: Pennsylvania Hospital

NAME OF SPONSORING INSTITUTION: \_\_\_\_\_

LOCATED IN: Philadelphia PA  
City State

1st Year from 06/18/06 To 06/17/07 Specialty Ob/Gyn Level (PGY) 1

2nd Year from 06/18/07 To 06/17/08 Specially Ob/Gyn Level (PGY) 2

**"I certify that the above named applicant successfully completed/will successfully complete this graduate medical training and that there was/is no disciplinary action outstanding against this applicant. If this applicant does not complete this training, the Board will be notified."**

The hospital has no seal or stamp to affix to this document. Therefore, I will have this form notarized to verify that this form was completed by this hospital.

Program Director's Signature  
2/5/10

Date: \_\_\_\_\_

[Seal of Hospital]

[ notary seal ]

Notary's Signature: \_\_\_\_\_

Notary's Commission expires on: \_\_\_\_\_

**RETURN COMPLETED FORM DIRECTLY TO THE BOARD IN OFFICIAL HOSPITAL ENVELOPE.**





Licensee - AMNA BRAHIM DERMISH ( Medicine )

General		Licenses	Education	Employment	Public Info	Supp. Info.																									
License #	Type	Status	Probation?	Limited?																											
<not issued>	Medical Physician and Surgeon	Pending	<input type="checkbox"/>	<input type="checkbox"/>																											
MT197784	Graduate Medical Trainee: Obstetrics and Gynecology		<input type="checkbox"/>	<input type="checkbox"/>																											
<table border="1"> <thead> <tr> <th>Address</th> <th>Specialties</th> <th>Issue Date</th> <th>Expiration Date</th> <th>Primary</th> </tr> </thead> <tbody> <tr> <td>Detail</td> <td>Level 1</td> <td>06/18/2008</td> <td>06/17/2009</td> <td><input type="checkbox"/></td> </tr> <tr> <td>Specialties</td> <td>Level 2</td> <td>06/18/2007</td> <td>06/17/2008</td> <td><input type="checkbox"/></td> </tr> <tr> <td>Supp. Info.</td> <td>Level 3</td> <td>06/18/2008</td> <td>06/17/2009</td> <td><input type="checkbox"/></td> </tr> <tr> <td>Additional</td> <td>Level 4</td> <td>06/18/2008</td> <td>06/17/2010</td> <td><input checked="" type="checkbox"/></td> </tr> </tbody> </table>							Address	Specialties	Issue Date	Expiration Date	Primary	Detail	Level 1	06/18/2008	06/17/2009	<input type="checkbox"/>	Specialties	Level 2	06/18/2007	06/17/2008	<input type="checkbox"/>	Supp. Info.	Level 3	06/18/2008	06/17/2009	<input type="checkbox"/>	Additional	Level 4	06/18/2008	06/17/2010	<input checked="" type="checkbox"/>
Address	Specialties	Issue Date	Expiration Date	Primary																											
Detail	Level 1	06/18/2008	06/17/2009	<input type="checkbox"/>																											
Specialties	Level 2	06/18/2007	06/17/2008	<input type="checkbox"/>																											
Supp. Info.	Level 3	06/18/2008	06/17/2009	<input type="checkbox"/>																											
Additional	Level 4	06/18/2008	06/17/2010	<input checked="" type="checkbox"/>																											
<div> <input type="button" value="New"/> <input type="button" value="Edit"/> <input type="button" value="Delete"/> <input type="button" value="Save"/> </div>																															

213465

48-101 (REV. 02-09)  
State Board of Medicine  
717-783-1400  
717-787-2381

## RECEIVED DIRECT

### VERIFICATION OF MEDICAL EDUCATION For Graduates of Accredited Medical Schools

#### SECTION 1: To be completed by applicant:

Name: Dermish Amna Ibrahim  
Last First Middle  
Name of medical school: University of Colorado  
Location: Denver, CO

SUBMIT THE VERIFICATION OF MEDICAL EDUCATION FORM TO YOUR MEDICAL SCHOOL AND REQUEST YOUR SCHOOL TO RETURN THE COMPLETED FORM DIRECTLY TO THE BOARD IN AN OFFICIAL SCHOOL ENVELOPE.

#### SECTION 2: To be completed by Dean or Registrar of medical school:

Name of medical student: Amna I Dermish  
Date student began to attend this medical school: 08/26/2002  
MM/DD/YYYY  
Date of graduation: 05/26/2006  
MM/DD/YYYY

I certify that all of the above information is correct.

[Seal of School]

Signature of Dean or Registrar:

Farid Meen  
Date: 2-5-10

Upon completion, school must return this completed form directly to the Pennsylvania State Board of Medicine in an official school envelope.

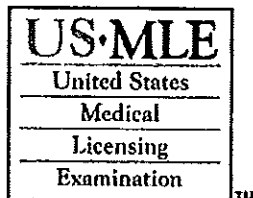
**DO NOT RETURN TO APPLICANT**

Regular Mailing Address  
State Board of Medicine  
P.O. Box 2649  
Harrisburg, PA 17105-2649

Courier Delivery Address  
State Board of Medicine  
2801 North Third Street  
Harrisburg, PA 17110

FEB 12 2010

2/3465



# United States Medical Licensing Examination™ (USMLE™) Certified Transcript of Scores

This document was prepared by the  
Federation of State Medical Boards of the United States, Inc.  
Federation Place, PO Box 619850, Dallas, TX 75261-9850 -- Telephone (817) 868-4041

Date: 02/04/2010

**Recipient:**

Pennsylvania State Board of Medicine  
ATTN: Tammy Radel  
2601 N Third Street  
Harrisburg, PA 17110

RECEIVED DIRECT

**Examinee:** Dermish, Amna  
**Alt Name(s):** Dermish, Amna I

**Examinee ID#:** 5-144-656-5  
**Date of Birth:** [REDACTED]

Results for Steps taken by this examinee (and for which results have been reported to date) are shown below. For Steps that span more than one day, the test date reflects the day on which the examination began. Where numeric scores are reported, there are two scales used and the recommended minimum passing score ("MP") on each scale is shown in parentheses.

## USMLE STEP 1

Test Date	Pass/Fail	Three-Digit Score		Two-Digit Score		Comments
		Total	MP	Total	MP	
06/04/2004	Pass	184	182	75	75	

## USMLE STEP 2

### Clinical Knowledge (CK)

Test Date	Pass/Fail	Three-Digit Score		Two-Digit Score		Comments
		Total	MP	Total	MP	
08/15/2005	Pass	225	182	91	75	

### Clinical Skills (CS)\*

Test Date	Pass/Fail	Three-Digit Score		Two-Digit Score		Comments
		Total	MP	Total	MP	
10/10/2005	Pass					

## USMLE STEP 3

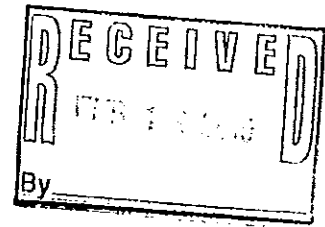
	Test Date	Pass/Fail	Three-Digit Score		Two-Digit Score		Comments
			Total	MP	Total	MP	
PENNSYLVANIA	05/09/2007	Pass	217	184	89	75	

NOTE: A search of the Board Action Data Bank of the Federation of State Medical Boards (FSMB) reveals no reported information on this examinee.

RECEIVED  
FEB 05 2010  
BY \_\_\_\_\_

# Amna Dermish

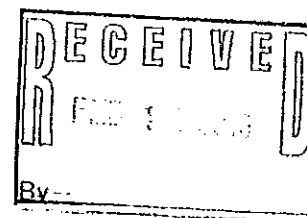
Philadelphia, PA 19106  
@uphs.upenn.edu



<b>Residency Training</b>	<p><i>Pennsylvania Hospital</i> Department of Obstetrics and Gynecology Philadelphia, PA Anticipated Graduation June 2010</p>	June 2006-present
<b>Education</b>	<p><i>University of Colorado Health Sciences Center</i> Denver, CO Doctor of Medicine <i>University of Pittsburgh, Pittsburgh PA</i> BSc Psychology</p> <ul style="list-style-type: none"> <li>Summa Cum Laude</li> <li>Phi Beta Kappa</li> </ul>	<p>2002 - 2006</p> <p>1997-2001</p>
<b>Professional &amp; Volunteer Experience</b>	<p><i>American Medical Student Association</i></p> <ul style="list-style-type: none"> <li>President, University of Colorado chapter</li> <li>Coordinator, Region 10 Conference</li> </ul> <p>"Treating all sides of the problem: Medicine on Capitol Hill" Keynote speaker US Congressman Mark Udall Oversaw recruitment of vendors for the residency/exhibitor fair. Also managed all aspects of organizing the conference, from developing programming to negotiating hotel and catering contracts. Topics included a debate on access to health insurance, patient advocacy, the role of pharmaceutical companies, cultural competency, and reproductive health.</p> <ul style="list-style-type: none"> <li>Region 10 Associate Trustee</li> </ul> <p>Acted as a liaison between the national leadership and local chapters, assisting with program development at the local level.</p> <p><i>Medical Students For Choice</i></p> <ul style="list-style-type: none"> <li>Coordinator/Founder, University of Colorado chapter</li> </ul> <p>Our goal was to increase campus dialogue about reproductive health and cover gaps in our 1st and 2nd year curriculum. We were also able to establish a close relationship with multiple organizations including NARAL Pro-Choice Colorado &amp; the Religious Coalition for Reproductive Choice, putting together a variety of lectures and community events.</p> <p><i>NARAL Reproductive Health Access Committee</i></p> <ul style="list-style-type: none"> <li>Medical Student Liaison</li> </ul> <p>Member of a group of women's health advocates and health professionals that met monthly, with a goal of preserving and improving access to reproductive health services. Projects completed include a comprehensive reproductive health guide for Colorado women and a teen sex guide, as well as a series of outreach and informational events.</p> <p><i>Reproductive Health Elective</i></p> <p>This course was offered each spring, and consists of a lecture series entirely run and planned by 2nd year medical students. The topics covered included birth control, abortion, GLBT youth issues &amp; infertility. A workshop on taking a sexual history was our biggest success.</p> <p><i>Vote 2004 Coordinator</i></p> <p>Registered over 300 new voters in collaboration with multiple student organizations.</p>	<p>2003-2004 October 2003</p> <p>2004-2005</p> <p>2003-2006</p> <p>2004-2006</p> <p>2003-2004</p> <p>April-November 2004</p>



<b>Research</b>	<i>Analysis of Implanon use in an Inner City Population</i>	In Progress
	Primary Investigator <i>Learning Research &amp; Development Center, University of Pittsburgh</i>	2000-2002
<b>Presentations</b>	Research Assistant/Lab Coordinator I was involved in several research projects using functional MRI to study at areas of the cerebral cortex involved in using feedback learning and other forms of visual learning. My principle role was subject recruitment, test administration and assistance in data analysis.	
	Myomectomy complicated by Splenic Injury	May 2008
	Acute Appendicitis in the 1 <sup>st</sup> Trimester	December 2008
<b>International Experience</b>	Conservative Management of Cornual Ectopic Pregnancy	March 2009
	<i>Harrison Fellowship</i> Mater Dei Hospital, Malta	May-June 2009
	Observational attachment in the Department of OB/Gyn <i>Adventure Education School</i> Dominical, Costa	Summer 2003
	Month-long Spanish immersion course <i>Semester at Sea</i>	February-May 1999
	During the 100 day voyage we visited 10 countries, including Cuba, South Africa, India, Vietnam & Shanghai. The shipboard curriculum was created to relate to each of the countries visited.	
<b>Professional Memberships</b>	<i>American College of Obstetrics &amp; Gynecology</i> Junior Fellow	
	<i>Association of Reproductive Health Professionals</i>	





National Practitioner Data Bank  
Healthcare Integrity and Protection  
Data Bank  
P.O. Box 10832  
Chantilly, VA 20153-0832

<http://www.npdb-hipdb.hrsa.gov>

5500000060542558

Process Date: 02/16/2010

Page: 1 of 1

To: DERMISH, AMNA IBRAHIM

PHILADELPHIA, PA 19107

From: National Practitioner Data Bank / Healthcare Integrity and Protection Data Bank

Re: Response to Your Self-Query

The enclosed information is released by the National Practitioner Data Bank (NPDB) for restricted use under the provisions of Title IV of Public Law 99-660, the Health Care Quality Improvement Act of 1986, as amended, and the Healthcare Integrity and Protection Data Bank (HIPDB) for restricted use under the provisions of Section 1128E of the Social Security Act.

Title IV established the NPDB as an information clearinghouse to collect and release certain information related to malpractice payment history and professional competence or conduct of physicians, dentists, and other licensed health care practitioners. Regulations governing the NPDB are codified at 45 CFR part 60. Responsibility for operating the NPDB resides with the Secretary of the U.S. Department of Health and Human Services (HHS), HRSA, Division of Practitioner Data Banks.

Section 1128E was established by Section 221(a) of Public Law 104-191, the Health Insurance Portability and Accountability Act of 1996, as amended. The statute established the HIPDB to combat fraud and abuse in health insurance and health care delivery and to improve the quality of patient care. The HIPDB serves as a source of final adverse action information on health care practitioners, providers, and suppliers. The HIPDB collects and releases information related to adverse licensure actions; health care-related convictions and judgments; exclusions from Federal and State health care programs; and other adjudicated actions or decisions. Regulations governing the HIPDB are codified at 45 CFR Part 61. Responsibility for operating the HIPDB resides with the Secretary of the U.S. Department of Health and Human Services (HHS), Office of Inspector General, and HRSA, Division of Practitioner Data Banks.

Reports from the NPDB and HIPDB contain limited summary information and should be used in conjunction with information from other sources in granting clinical privileges or making employment affiliation, contracting, or licensure decisions. The NPDB and HIPDB response may contain more than one report on a particular incident, if two or more actions were taken as a result of a single incident (e.g., an adverse licensure action and an exclusion from the Medicare and Medicaid programs). The NPDB and HIPDB is a flagging system and a report may be included for a variety of reasons that do not necessarily reflect adversely on the professional competence or conduct of the subject named in the report.

All information received from the NPDB and HIPDB is considered confidential and must be used solely for the purpose for which it was disclosed. ANY PERSON WHO VIOLATES THE CONFIDENTIALITY PROVISIONS AS SPECIFIED IN TITLE IV OF PUBLIC LAW 99-660, AS AMENDED, IS SUBJECT TO A CIVIL MONEY PENALTY OF UP TO \$11,000 FOR EACH VIOLATION. Subjects of reports who obtain information about themselves from the NPDB and/or HIPDB are permitted to share that information with anyone they choose.

If you require additional assistance, visit the NPDB-HIPDB web site (<http://www.npdb-hipdb.hrsa.gov>) or contact the NPDB-HIPDB Customer Service Center at 1-800-767-6732 (TDD: 1-703-802-9395). Information Specialists are available to speak with you weekdays from 8:30 a.m. to 6:00 p.m. (5:30 p.m. on Fridays) Eastern Time. The NPDB-HIPDB Customer Service Center is closed on all Federal holidays.

MAR 16 2010

CONFIDENTIAL DOCUMENT - FOR AUTHORIZED USE ONLY

## SELF-QUERY RESPONSE

This self-query was processed under the provisions of:

☒ Title IV (NPDB)

☒ Section 1128E (HIPDB)

### A: SEARCH RESULT (Based on the subject identification information provided, the reports found are listed below.)

Medical Malpractice Payment Report(s):	No Reports	Health Plan Action(s):	No Reports
State Licensure Action(s):	No Reports	Professional Society Action(s):	No Reports
Exclusion or Debarment Action(s):	No Reports	DEA/Federal Licensure Action(s):	No Reports
Government Administrative Action(s):	No Reports	Judgment or Conviction Report(s):	No Reports
Clinical Privileges Action(s):	No Reports		

### B: SUBJECT IDENTIFICATION INFORMATION

Subject Name: **DERMISH, AMNA IBRAHIM**  
Gender: **FEMALE**  
Date of Birth: **[REDACTED]**  
Other Name(s) Used:  
Organization Name: **PENNSYLVANIA HOSPITAL**  
Organization Type: **GENERAL/ACUTE CARE HOSPITAL (301)**  
Home or Work Address: **[REDACTED]**  
City, State, ZIP: **PHILADELPHIA, PA 19107**  
Telephone: **[REDACTED]**  
Social Security Numbers (SSN): **[REDACTED]**  
Individual Taxpayer Identification Numbers (ITIN): **[REDACTED]**  
Professional School(s) & Year of Graduation: **UNIVERSITY OF COLORADO (2006)**  
Occupation/Field of Licensure (Code): **PHYSICIAN INTERN/RESIDENT (MD) (015)**  
State License Number, State of Licensure: **MT187794, PA**  
Specialty: **OBSTETRICS & GYNECOLOGY (50)**  
Drug Enforcement Administration (DEA) Numbers:  
National Provider Identifiers (NPI): **1457417271**  
Federal Employer Identification Numbers (FEIN):  
Unique Physician Identification Numbers (UPIN):

### C: PAYMENT INFORMATION

Credit Card Number:	<b>[REDACTED]</b>	Expiration Date:	<b>08/2012</b>
Additional Paper Copies Requested:	<b>0</b>		
NPDB Charge:	<b>\$8.00*</b>	NPDB Bill Reference Number:	<b>N22190979</b>
HIPDB Charge:	<b>\$8.00*</b>	HIPDB Bill Reference Number:	<b>H22190979</b>
* Each charge will appear separately on your credit card statement.		Transaction Date:	<b>02/16/2010</b>

Copies of these reports are enclosed for restricted/limited use as prescribed by Title IV of Public Law 99-660, as amended, and by Section 1128E of the Social Security Act. Information from the NPDB and HIPDB is confidential and must be used solely for the purpose for which it was disclosed. ANY PERSON WHO VIOLATES THE CONFIDENTIALITY PROVISIONS AS SPECIFIED IN TITLE IV IS SUBJECT TO A CIVIL MONEY PENALTY OF UP TO \$11,000 FOR EACH VIOLATION. Subjects of reports who obtain information about themselves from the NPDB and/or HIPDB are permitted to share that information with anyone they choose.

MAR 16 2010

**The Federation of State Medical Boards  
of the United States, Inc**  
PO Box 619850  
Dallas, Texas 75261-9850  
Telephone: (817)868-4000  
FAX (817)868-4099

**BOARD ACTION CLEARANCE REPORT**

February 23, 2010

Attn: Tammy Radel, Administrator  
Pennsylvania State Board of Medicine  
PO Box 2649  
Harrisburg, PA 17105

Re: Board Action Query Dated: February 23, 2010  
Your Reference Number: SB  
FSMB Batch Number: BQ1725404

The following is a report of the search results from the Board Action Data Bank as of February 23, 2010 for practitioners submitted as part of the above-referenced batch for which NO board actions were identified.

Practitioners Cleared with No Actions as of February 23, 2010

Item	Name	DOB	School	Yr/Grad	Request ID
5	DELGADO, KRISTIAN	[REDACTED]		2006	21951003
		<b>LICENSE HISTORY</b> <u>State Board</u> No License Information Available			
3	DERMISH, AMNA	[REDACTED]		2006	21950994
		<b>LICENSE HISTORY</b> <u>State Board</u> No License Information Available			
4	NGAN, ROSE	[REDACTED]		2006	21950999
		<b>LICENSE HISTORY</b> <u>State Board</u> No License Information Available			
2	RENTSCHLER, STACEY	[REDACTED]		2004	21950989
		<b>LICENSE HISTORY</b> <u>State Board</u> No License Information Available			
1	TUREK, JOSEPH	[REDACTED]		2002	21950983
		<b>LICENSE HISTORY</b> <u>State Board</u> NORTH CAROLINA			

PLEASE NOTE: The licensure history information contained in these reports is not considered licensure verification but rather an indicator of known states of historical licensure for these individuals. Use of this information should be limited to cross-reference purposes.



COMMONWEALTH OF PENNSYLVANIA  
STATE BOARD OF MEDICINE  
P. O. BOX 2849  
HARRISBURG, PENNSYLVANIA 17105  
[st-medicine@state.pa.us](mailto:st-medicine@state.pa.us)  
[www.dos.state.pa.us/med](http://www.dos.state.pa.us/med)  
February 23, 2010

AMNA IBRAHIM DERMISH 9849  
[REDACTED]  
PHILADELPHIA PA 19106

Telephone: 717-783-1400/787-2381  
Fax: 717-787-7769

EVALUATOR: SANDY B

**RE: DISCREPANCY NOTICE – Unrestricted (American)**

Dear Doctor:

The Board has received your application for an unrestricted medical license. The items listed below are needed to complete your application. A license cannot be issued until all items are received, approved and the application is complete. **You may not practice in the Commonwealth of Pennsylvania as a Physician and Surgeon until a license has been issued by the Board.**

- **BOTH** the National Practitioner Data Bank AND the Healthcare Integrity and Protection Data Bank self query disclosure information ([www.npdb-hipdb.com](http://www.npdb-hipdb.com)) – **NPDB & HIPDB** reports are required. **Must provide original documents of both reports.**

**APPLICATIONS NOT COMPLETED WITHIN SIX MONTHS  
WILL REQUIRE UPDATES OF CERTAIN DOCUMENTS.**

**You may check the status of your application online at [www.mylicense.state.pa.us](http://www.mylicense.state.pa.us). Click on the link duplicate licenses/address changes/application status. First time users will be required to register and create a user ID and password. Your registration code to register is: 22418614**

Sincerely,

Pennsylvania State Board of Medicine

## Person Info

Name:AMNA IBRAHIM DERMISH

## Address Info

Street Address: [REDACTED] Email: [REDACTED]@gmail.com

Phone [REDACTED]

Fax [REDACTED]

CitySalt Lake

City

StateUT

Zipcode84111

Country82

CountySalt lake

Survey Response Summary  
Question Response Summary

Are you submitting a name change with this renewal?	N
Do you hold a license/certificate (active, inactive or expired) to practice in any other state or jurisdiction?	Y
Since your initial application or last renewal, whichever is later, have you had disciplinary action taken against your license, certificate or registration issued to you in any profession in any other state or jurisdiction?	N
Since your initial application or last renewal, whichever is later, have you been convicted, found guilty or pleaded nolo contendere, or received probation without verdict, or accelerated rehabilitative disposition(ARD) as to any felony or misdemeanor, including any drug law violations, or do you have any criminal charges pending and unresolved in any state or jurisdiction? You are not required to disclose any ARD or other criminal matter that has been expunged by order of a court.	N
Since your initial application or last renewal, whichever is later, have you withdrawn an application for a license, certificate or registration, had an application denied or refused, or for disciplinary reasons agreed not to reapply for a license, certificate or registration in any profession in any other state or jurisdiction?	N
Since your initial application or last renewal, whichever is later, have you been arrested for criminal homicide, aggravated assault, sexual offenses or drug offenses in any state, territory or country?	N
Since your last renewal, have you been the subject of a civil malpractice law suit? If yes, please submit a copy of the entire Civil Complaint which must include the filing date and the date you were served. If you previously reported the complaint, email or fax the docket number to	Y

the Board. (email at st-medicine@state.pa.us or fax at 717-787-7769)													
Since your initial application or last renewal, whichever is later, have you had your DEA registration denied, revoked or restricted?	N												
Since your initial application or last renewal, whichever is later, have you had practice privileges denied, revoked or restricted in a hospital or health care facility?	N												
Since your initial application or last renewal, whichever is later, have your provider privileges been denied, revoked or restricted by any medical assistance agency for cause?	N												
Do you maintain current medical professional liability insurance in the Commonwealth of Pennsylvania?	N												
Have you met your current CE requirements?	Y												
<b>Education Information</b>													
<table border="1"> <tr> <td colspan="4"><u>Edit</u></td> </tr> <tr> <td>Profession: Medicine</td> <td>School: UNIVERSITY OF COLORADO</td> <td>Credit Hours:</td> <td>Education Type:</td> </tr> <tr> <td>From: 8/26/2002</td> <td>To: 5/26/2006</td> <td></td> <td></td> </tr> </table>		<u>Edit</u>				Profession: Medicine	School: UNIVERSITY OF COLORADO	Credit Hours:	Education Type:	From: 8/26/2002	To: 5/26/2006		
<u>Edit</u>													
Profession: Medicine	School: UNIVERSITY OF COLORADO	Credit Hours:	Education Type:										
From: 8/26/2002	To: 5/26/2006												
<b>Employment Information</b>													
No employment records													
remarks Remarks: Continuing Education Information													
No CE Course records													



**myLicense Renewal Question Responses**

**License Number:** MD439505

**Name :** AMNA IBRAHIM DERMISH

**Online Submission Date :**

<b>Renewal Question</b>	<b>Response</b>
Are you submitting a name change with this renewal?	N
Are you licensed in another licensing jurisdiction in this profession (any status)?	Y
Since your last renewal, has a licensing jurisdiction taken any disciplinary action against you?	N
Since your last renewal, have you been convicted of a crime?	N
Since your last renewal, have you withdrawn an application for licensure in another licensing jurisdiction?	N
Have you met your current CE requirements?	Y
Since your last renewal, have your provider privileges been terminated by any medical assistance agency for cause?	N
Since your last renewal, have you had practice privileges denied, revoked or restricted in a hospital or health care facility?	N
Since your last renewal, have you had your DEA registration denied, revoked or restricted?	N
Since your last renewal, have you been arrested for criminal homicide, aggravated assault, sexual offenses or drug offenses in any state, territory or country?	N
Do you maintain current medical professional liability insurance in the Commonwealth?	Y
Medical Renewal - Since your last renewal, have you been the subject of a civil malpractice law suit?	N

**Online Submission Date :** 9/29/2012 12:16:00AM

<b>Renewal Question</b>	<b>Response</b>
Are you submitting a name change with this renewal?	N
Are you licensed in another licensing jurisdiction in this profession (any status)?	Y
Since your last renewal, has a licensing jurisdiction taken any disciplinary action against you?	N
Since your last renewal, have you been convicted of a crime?	N
Since your last renewal, have you withdrawn an application for licensure in another licensing jurisdiction?	N
Have you met your current CE requirements?	Y
Since your last renewal, have your provider privileges been terminated by any medical assistance agency for cause?	N
Since your last renewal, have you had practice privileges denied, revoked or restricted in a hospital or health care facility?	N
Since your last renewal, have you had your DEA registration denied, revoked or restricted?	N
Since your last renewal, have you been arrested for criminal homicide, aggravated assault, sexual offenses or drug offenses in any state, territory or country?	N
Do you maintain current medical professional liability insurance in the Commonwealth?	N
Medical Renewal - Since your last renewal, have you been the subject of a civil malpractice law suit?	Y

ORIGINAL MUST BE ATTACHED  
TO BE COMPLETED BY APPLICANT  
HOSPITAL NAME: PENNSYLVANIA HOSPITAL  
HIS #

ORIGINAL MUST BE ATTACHED  
TO BE COMPLETED BY APPLICANT  
HOSPITAL NAME: PENNSYLVANIA HOSPITAL  
HIS #

HOSPITAL NAME  
TO BE COMPLETED BY APPLICANT

Hospital Name: PENNSYLVANIA HOSPITAL

HIS #

Receipt #

1/17/89 779

THIS APPLICATION IS TO BE USED FOR INITIAL GRADUATE  
LICENSE - DO NOT USE TO RENEW  
THIS APPLICATION MUST BE SUBMITTED AT LEAST 60 DAYS  
PRIOR TO THE START OF TRAINING

APPLICATION FOR A GRADUATE LICENSE  
FOR GRADUATES OF ACCREDITED MEDICAL SCHOOLS

Application Fee: \$30.00 not refundable. Make check payable to the "Commonwealth of Pennsylvania." NOTE: A processing fee of  
\$20.00 will be charged for any check or money order returned unpaid by your bank, regardless of the reason for non-payment.

TO BE COMPLETED BY APPLICANT:  
PLEASE PRINT OR TYPE

NAME: Hermesh Anna Ibrahim

ADDRESS: [REDACTED]

Denver CO 80206

SOCIAL SECURITY # [REDACTED] DATE OF BIRTH: [REDACTED]

NAME & ADDRESS OF MEDICAL SCHOOL: UNIV. OF CO. 5011

1200 E 9th Ave Denver CO 80202

NAME & ADDRESS OF HOSPITAL: [REDACTED]

TO BE COMPLETED BY HOSPITAL LOCATED IN PENNSYLVANIA:

NAME OF HOSPITAL: Pennsylvania Hospital

ADDRESS OF HOSPITAL: 350 Spruce St Phila. PA 19104

YEAR IN TRAINING: 1 SPECIALTY: OB Gyn

DATES OF TRAINING REQUESTED: 6/1/89 to 6/1/90

NAME OF PROGRAM DIRECTOR: David M. [REDACTED]

SIGNATURE OF PROGRAM DIRECTOR: [REDACTED]

APPLICANT'S SIGNATURE \_\_\_\_\_  
DATE OF SIGNATURE \_\_\_\_\_  
HOSPITAL'S SIGNATURE \_\_\_\_\_  
DATE OF SIGNATURE \_\_\_\_\_

HOSPITAL'S ONLY  
TO BE COMPLETED FOR HOSPITAL USE ONLY

Hospital Name \_\_\_\_\_

Address \_\_\_\_\_

Receipt # \_\_\_\_\_

\* THIS APPLICATION IS TO BE USED FOR INITIAL GRADUATE  
LICENSE - DO NOT USE TO RENEW  
\* THIS APPLICATION MUST BE SUBMITTED AT LEAST 60 DAYS  
PRIOR TO THE START OF TRAINING

9/18/2006

APPLICATION FOR A GRADUATE LICENSE  
FOR GRADUATES OF ACCREDITED MEDICAL SCHOOLS

1/16/07  
M M

Application Fee: \$30.00 - not refundable. Make check payable to the Commonwealth of Pennsylvania. NOTE: A processing fee of \$20.00 will be charged for any check or money order returned unpaid by your bank, regardless of the reason for non-payment.

TO BE COMPLETED BY APPLICANT  
PLEASE PRINT OR TYPE

NAME: Dermot A. Anna Breckin

ADDRESS: [REDACTED]

CITY: Denver STATE: CO ZIP: 80106

HOSPITAL: [REDACTED] CITY: [REDACTED]

NAME & ADDRESS OF PREVIOUS SCHOOL: Univ of CO, 301

DATE OF ATTENDANCE: 6/02 TO 7/06 DEGREE: MD

NAME & ADDRESS OF PREVIOUS HOSPITAL: Rocky Mountain Denver CO 80202

TO BE COMPLETED BY HOSPITAL LOCATED IN PENNSYLVANIA

NAME OF HOSPITAL: Pennsylvania Hospital

ADDRESS OF HOSPITAL: 34th & Locust St, Philadelphia, PA 19106

DATE OF TRAINING REQUESTED: 10/16/06 TO 10/16/07

SIGNATURE OF HOSPITAL DIRECTOR: [REDACTED]



State Board of Medicine  
717-783-1400  
717-787-2381

8/26/06  
RECEIVED DIRECT

VERIFICATION OF MEDICAL EDUCATION  
For Graduates of Accredited Medical Schools

SECTION 1: To be completed by applicant

Name: Derrin Anna Ibrahim  
Last First Middle  
Name of medical school: University of Colorado Sch. of Medicine  
Location: DENVER, CO

SUBMIT THIS VERIFICATION OF MEDICAL EDUCATION FORM TO YOUR MEDICAL SCHOOL AND  
REQUEST YOUR SCHOOL TO RETURN COMPLETED FORM DIRECTLY TO THE BOARD IN OFFICIAL  
SCHOOL ENVELOPE.

SECTION 2: To be completed by Dean or Registrar of medical school

Name of medical student: Scott M. A. Alexander  
Date student began to attend this medical school: 8/30/2003  
Date of graduation: May 2006

(Seal of School)

I certify that all of the above information is correct.

Signature of

Dean or Registrar

Date

Upon completion, school must return this completed form directly to the Pennsylvania State Board of Medicine  
in official school envelope. DO NOT RETURN TO APPLICANT.

Regular Mailing Address  
State Board of Medicine  
P.O. Box 2609  
Harrisburg, PA 17105-2609

Courier Delivery Address  
State Board of Medicine  
2601 North Third Street  
Harrisburg, PA 17110



**AMNA DERMISH**

Denver, CO 80202

@gmail.com

**EDUCATION**

Resident - Department of Obstetrics & Gynecology  
Pennsylvania Hospital  
Philadelphia, PA

Starting: June 2006

University of Colorado Health Sciences Center  
School of Medicine, Denver, CO  
MD

August 2002 - May 2006

University of Pittsburgh, Pittsburgh, PA  
BSc Psychology  
Summa Cum Laude

August 1997 - April 2001

**CERTIFICATION**

NBME Step 1 - passed June 2004

NBME Step 2 CK - passed August 2005

NBME Step 2 CS - passed October 2005

**EMPLOYMENT**

Research Assistant  
Learning Research & Development Center  
University of Pittsburgh, Pittsburgh, PA

October 2000 - July 2002

Assisted graduate students in Cognitive Neuroscience studies conducted by the lab used functional MRI to look at areas of the cerebral cortex are involved in visual learning. Duties included assisting in study design, subject recruitment, literature searches, & running & analyzing studies.

Research Assistant  
Department of Pharmacology  
University of Colorado, Denver, CO

June 2000 - August 2000

Assisted in the isolation of the LUSH protein, an olfactory binding protein in the *Drosophila* fruit fly used to recognize short chain alcohols. The goal of the project was to use the protein to determine the structure of alcohol binding sites and thus gain better understanding of the biochemistry of alcohol.

Office Assistant  
Institute for Shipboard Education  
University of Pittsburgh, Pittsburgh, PA

September 1997 - October 2000

Assisted Alumni Office with data entry, mailing, and fund raising efforts.



## HONORS

Phi Beta Kappa, 2001

## AFFILIATIONS

American Medical Student Association

Medical Students for Choice

*References are available upon request*



SUBMIT A COPY OF A CURRENT  
UNRESTRICTED PRACTICE EXAM  
SCORES, RECORDED SCORES ARE  
BASED ON THE PRACTICE  
REQUIREMENTS AND BEHOLDING  
THE RENEWAL INSTRUCTIONS

COMMONWEALTH OF PENNSYLVANIA  
DEPARTMENT OF STATE  
HEALTH PROFESSIONAL AND OCCUPATIONAL AFFAIRS  
STATE BOARD OF MEDICINE

RENEWAL APPLICATION

MAINA BOGANNI, DERM. II, DPM  
PENNY VANAT, DPM  
MARY MARTINO, COORDINATOR  
ACADEMIC AFFAIRS OFFICE  
HOSPITALS, STAFF  
PHILADELPHIA, PA 19104

State Board of Medicine  
PO Box 2649  
Harrisburg, PA 17105-2649

I will not be a participant in a medical practice until I have received a license from the State Board of Medicine. No fee is required. QUESTIONS MUST STILL BE ANSWERED

THE FOLLOWING QUESTIONS MUST BE ANSWERED

YES	NO	QUESTIONS MUST BE ANSWERED
		1. Do you hold or have you ever held a license to practice medicine in any other state or country?
		2. Since your initial application or your last renewal, have you been arrested for any criminal offense?
		3. Since your initial application or your last renewal, have you been convicted of any criminal offense?
		4. Since your initial application or your last renewal, have you been involved in any civil or criminal litigation?
		5. Since May 19, 2002, have you been arrested for sexual abuse, aggravated assault, sexual offenses or drug offenses in any state, territory, or country?
		6. Since your initial application or your last renewal, have you been involved in a lawsuit or other legal action?
		7. Since your initial application or your last renewal, have you been involved in a lawsuit or other legal action?
		8. Since May 19, 2002, have any malpractice complaints been filed against you? If yes, the filer requires that you submit a copy of the entire Civil Complaint. Which must include the third date and the date you were served. If the Civil Complaint was previously submitted, provide a statement which lists the date and number.

Please review and update, as necessary, the following information regarding your license:

Beginning Date	Ending Date	Level	Specialty	Hospital #	Hospital Name	
Current	06/15/2011	06/15/2012	Level 1	Specialty	000000	Hospital Name
Renewal	06/15/2012	06/15/2013	Level 1	Specialty	000000	Hospital Name

Signature of Licensee (Mandatory)

Medical School Graduation Date

ATTACHMENTS FOR RENEWAL

- 1. FEE: \$15.00 (Current) and \$15.00 (Renewal) (Total \$30.00)
- 2. STATE FEE: \$15.00 (Current) and \$15.00 (Renewal) (Total \$30.00)
- 3. NAME CHANGE DOCUMENT: Sign a document of a legal document, which must include the third date and the date you were served. If the Civil Complaint was previously submitted, provide a statement which lists the date and number.
- 4. COPY 2 LEVEL: Copy 2 Level 1 (Current) and Copy 2 Level 1 (Renewal) (Total \$30.00)
- 5. COPY 3 LEVEL: Copy 3 Level 1 (Current) and Copy 3 Level 1 (Renewal) (Total \$30.00)



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MLT

# UNITED STATES MEDICAL EDUCATION BOARD

1900 L Street, N.W.

NATIONAL BOARD OF MEDICAL EXAMINERS

(U.S. Department of Health and Human Services)

## STEP 2 CLINICAL SKILLS TESTING REPORT

Name: **Dorinda Ann**

Test Date: **October 10, 2004**

USMLE ID: **341444565**

The USMLE Step 2 Clinical Skills Testing Report provides information on the performance of candidates on the Step 2 Clinical Skills Testing. The report is divided into two main sections: the Overall Clinical Skills Testing Results and the Individual Clinical Skills Testing Results. The Overall Clinical Skills Testing Results section provides information on the performance of candidates on the Step 2 Clinical Skills Testing, including the number of candidates who passed the test, the number of candidates who failed the test, and the number of candidates who were not tested. The Individual Clinical Skills Testing Results section provides information on the performance of candidates on the Step 2 Clinical Skills Testing, including the number of candidates who passed the test, the number of candidates who failed the test, and the number of candidates who were not tested. The report also includes information on the number of candidates who were not tested on the Step 2 Clinical Skills Testing, including the number of candidates who were not tested on the Step 2 Clinical Skills Testing, the number of candidates who were not tested on the Step 2 Clinical Skills Testing, and the number of candidates who were not tested on the Step 2 Clinical Skills Testing.

Overall  
Clinical Skills Testing  
Results

The overall clinical skills testing results for the Step 2 Clinical Skills Testing are as follows: The number of candidates who passed the test was 1,000, the number of candidates who failed the test was 1,000, and the number of candidates who were not tested was 1,000. The overall clinical skills testing results for the Step 2 Clinical Skills Testing are as follows: The number of candidates who passed the test was 1,000, the number of candidates who failed the test was 1,000, and the number of candidates who were not tested was 1,000.

Overall Clinical Skills Testing Results	Individual Clinical Skills Testing Results	Number of Candidates Who Passed the Test	Number of Candidates Who Failed the Test	Number of Candidates Who Were Not Tested
Overall Clinical Skills Testing Results	Individual Clinical Skills Testing Results	Number of Candidates Who Passed the Test	Number of Candidates Who Failed the Test	Number of Candidates Who Were Not Tested

Overall Clinical Skills Testing Results



RECEIVED  
MAY 28 1961



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