

## Details for AMNA IBRAHIM DERMISH

### License Information

Name: AMNA IBRAHIM DERMISH  
City, State, Zip, Country: SALT LAKE CITY, UT 84101, UNITED STATES  
Profession: PHYSICIAN  
License Type: PHYSICIAN & SURGEON  
License Number: 7894043-1205  
Obtained By: APPLICATION  
License Status: EXPIRED  
Original Issue Date: 04/19/2011  
Expiration Date: 01/31/2014  
Agency and Disciplinary Action\*: NONE  
Docket Number: N/A

Controlled Substance License Yes View Controlled Substance License

### Education:

School Name	Major	Graduation Date	Degree
UNIVERSITY OF COLORADO SCHOOL OF MEDICINE		2006-05-26	DOCTORATE OF MEDICINE

This information is accurate as far as is contained in the Division's official records. It does not reflect whether an entity required to maintain a current registration with the Division of Corporations is current in that registration. You can verify such status at <https://secure.utah.gov/bes/bes>. Additionally, this verification does not show a complete license history or interruptions of licensure. Original issue dates listed as 01/01/1910 and 01/01/1911 were unknown at the time the Division implemented its first electronic licensing database.

\*NOTE: The disciplinary documents linked to this website include final orders issued by DOPL, with the exception of citations. [Click here for citations.](#)

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Profession: PHYSICIAN  
License Type: PHYSICIAN/SURGEON CS  
SCHEDULE 2-5  
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State of Utah

Date: 01/26/2011

Receipt Number: 3459160

DIVISION OF OCCUPATIONAL & PROFESSIONAL LICENSING

160 East 300 South, P.O. Box 146741  
Salt Lake City, Utah 84114-6741  
Telephone (801) 530-6628  
www.dopl.utah.gov

License(s) Applying For:

- PHYSICIAN AND SURGEON (\$200.00 Non Refundable Application Fee)
- OSTEOPATHIC PHYSICIAN AND SURGEON (\$200.00 Non Refundable Application Fee)
- TEMPORARY LICENSE (\$50.00 Non Refundable Application Fee)
- CONTROLLED SUBSTANCE (\$100.00 Non Refundable Application Fee)
- CONTROLLED SUBSTANCE TEMPORARY (\$50.00 Non Refundable Application Fee)

NOTE: You cannot apply for a temporary license separately.

(Note: Microsoft Word users can fill in the blanks, print the form and save it for their records)

\*\*\*Please list your full legal name as it appears on your driver's license, Social Security Card, etc.\*\*\*

Last Name: Dermish		First Name: Amna		Middle Name: Ibrahim	
Social Security Number: [REDACTED]			Maiden Name:		
Select One	<input checked="" type="checkbox"/>	Driver License or State ID Number:	[REDACTED]	State of Issuance:	[REDACTED]
	<input type="checkbox"/>	I am a citizen of the United States and do not have a drivers license or state ID number.			
	<input type="checkbox"/>	I am <u>not</u> a citizen of the United States <u>and</u> do not have a Drivers License or State ID. I understand that I am required to visit DOPL's offices and present government issued photo ID and one of the following: Alien ID Number: _____ I-94 Number: _____			
Mailing Address: [REDACTED]		City: [REDACTED]		State: [REDACTED]	ZIP: [REDACTED]
<input type="checkbox"/> Male	Date of Birth: [REDACTED]	Phone #: [REDACTED]	E-Mail: [REDACTED]		
<input checked="" type="checkbox"/> Female					
All other licenses, registrations, or certifications issued by any other state which you now hold or have ever held in any health care profession. (Use additional sheets if necessary.)					
Profession: MD		Issuing State: Pennsylvania			
License Number: MD439505		License Status: active		Issue Date: 3/17/2010	
Profession: MD		Issuing State: New Jersey			
License Number: Z5MAD8848500		License Status: active		Issue Date: 10/4/2010	
Profession:		Issuing State:			
License Number:		License Status:		Issue Date:	
Profession:		Issuing State:			
License Number:		License Status:		Issue Date:	
Profession:		Issuing State:			
License Number:		License Status:		Issue Date:	
Profession:		Issuing State:			
License Number:		License Status:		Issue Date:	

DO NOT WRITE IN THIS SECTION - FOR DIVISION USE ONLY

License/Certificate Number: 7894043-1205-8905 ms.

JAN 26 2011

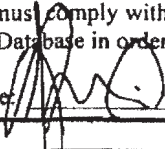
Date License/Certificate Approved/Denied: 1/19/11 by Julie B

Reason for Denial/Other Comments:

Supervisor Manager Review: QQ Yes answers or Education or Exam  Approve  Deny

**AFFIDAVIT and RELEASE AUTHORIZATION FOR APPLICANT**

1. I certify under penalty of perjury that I am a United States citizen, a qualified alien as defined in 8 U.S.C. Sec. 1641, or I am lawfully present in the United States.
2. I certify that am qualified in all respects for the license for which I am applying in this application.
3. I certify that to the best of my knowledge, the information contained in the application and its supporting document(s) is free of fraud, forgery, misrepresentation, omission of material fact; is truthful, correct, and complete; discloses all material facts regarding the applicant; and that I will update or correct the application as necessary, prior to any action on my application.
4. I authorize all persons, institutions, organization, schools, governmental agencies, employers, references, or any others not specifically included in the preceding characterization, which are set forth directly or by reference in this application, to release to the Division of Occupational and Professional Licensing, State of Utah, any files, records, or information of any type reasonably required for the Division of Occupational and Professional Licensing to properly evaluate my qualifications for licensure/certification/registration by the State of Utah.
5. I understand that it is the continuing responsibility of applicants and licensees to read, understand, and apply the requirements contained in all statutes and rules pertaining to the occupation or profession for which you are applying, and that failure to do so may result in civil, administrative, or criminal sanctions.
6. I understand that as holder of a Utah Controlled Substance licensee that I must comply with Utah Code Annotated §58-37f-401(3). This statute requires me to register with the Controlled Substance Database in order to hold a Utah Controlled Substance

Name: <sup>License</sup> Anna Dermish Position: Physician Signature:  Date: 1/14/11

- REDUCED -




## QUALIFYING QUESTIONNAIRE

**Read thoroughly, and answer the questions. Do not leave any question blank.**

(Note: If you have formally expunged a criminal record you do not need to disclose that criminal history.)

<input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	1. Have you ever applied for or received a license, certificate, permit, or registration to practice in a regulated profession under any name other than the name listed on this application?
<input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	2. Have you ever been denied the right to sit for a licensure examination?
<input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	3. Have you ever had a license, certificate, permit, or registration to practice a regulated profession denied, conditioned, curtailed, limited, restricted, suspended, revoked, reprimanded, or disciplined in any way?
<input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	4. Have you ever been permitted to resign or surrender your license, certificate, permit, or registration to practice in a regulated profession while under investigation or while action was pending against you by any health care profession licensing agency, hospital or other health care facility, or criminal or administrative jurisdiction?
<input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	5. Are you currently under investigation or is any disciplinary action pending against you now by any licensing agency?
<input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	6. Have you ever had hospital or other health care facility privileges denied, conditioned, curtailed, limited, restricted, suspended, or revoked in any way?
<input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	7. Have you ever been permitted to resign or surrender hospital or other health care facility privileges, while under investigation or while action was pending against you by any licensing agency, hospital or other health care facility, or criminal or administrative jurisdiction?
<input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	8. Is any action related to your conduct or patient care pending against you now at any hospital or health care facility?
<input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	9. Have you ever had rights to participate in Medicaid, Medicare, or any other state or federal health care payment reimbursement program denied, conditioned, curtailed, limited, restricted, suspended, or revoked in any way?
<input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	10. Have you ever been permitted to resign from Medicaid, Medicare, or any other state or federal health care payment reimbursement program while under investigation or while action was pending against you by any licensing agency, hospital, or other health care facility, or criminal or administrative jurisdiction?
<input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	11. Is any action pending against you now by Medicaid, Medicare, or any other state or federal health care payment reimbursement program?
<input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	12. Have you ever had a federal or state registration to sell, possess, prescribe, dispense, or administer controlled substances denied, conditioned, curtailed, limited, restricted, suspended or revoked in any way by either the federal Drug Enforcement Administration or any state drug enforcement agency?
<input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	13. Have you ever been permitted to surrender your registration to sell, possess, prescribe, dispense, or administer controlled substances while under investigation or while action was pending against you by any health care profession licensing agency, hospital or other health care facility, or criminal or administrative jurisdiction?
<input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	14. Is any action pending against you now by either the Federal Drug Enforcement Administration or any state drug enforcement agency?
<input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	15. Have you been named as a defendant in a malpractice suit?
<input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	16. Have you ever had office monitoring, practice curtailments, individual surcharge assessments based upon specific claims history, or other limitations, restrictions or conditions imposed by any malpractice carrier?
<input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	17. Have you ever had any malpractice insurance coverage denied, conditioned, curtailed, limited, suspended, or revoked in any way?
<input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	18. If you are licensed in the occupation/profession for which you are applying, would you pose a direct threat to yourself, to your patients or clients, or to the public health, safety, or welfare because of any circumstance or condition?
<input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	19. Have you ever been declared by any court of competent jurisdiction incompetent by reason of mental defect or disease and not restored?
<input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	20. Have you been terminated, suspended, reprimanded, sanctioned, or asked to leave voluntarily from a position because of drug use or abuse within the past five (5) years?
<input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	21. Have you ever had a documented case in which you were involved as the abuser in any incident of verbal, physical, mental, or sexual abuse?
<input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	22. Are you currently using or have you recently ( <i>within 90 days</i> ) used any drugs ( <i>including recreational drugs</i> ) without a valid prescription, the possession or distribution of which is unlawful under the Utah Controlled Substances Act or other applicable state or federal law?
<input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	23. Do you currently have any criminal action pending?
<input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	24. Have you pled guilty to, no contest to, entered into a plea in abeyance or been convicted of a misdemeanor in any jurisdiction within the past ten (10) years? Motor vehicle offenses such as driving while impaired or intoxicated must be disclosed but minor traffic offenses such as parking or speeding violations need not be listed.
<input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	25. Have you ever pled guilty to, no contest to, or been convicted of a felony in any jurisdiction?
<input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	26. Have you, in the past ten (10) years, been allowed to plea guilty or no contest to any criminal charge that was later dismissed ( <i>i.e. plea-in-abeyance or deferred sentence</i> )?

<input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	27. Have you ever been incarcerated for any reason in any federal, state or county correctional facility or in any correctional facility in any other jurisdiction or on probation/parole in any jurisdiction?
<input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	28. Has any owner, officer, manager, pharmacist, pharmacy technician or medical practitioner associated with or employed by the applicant ever had a license, certificate, permit, registration to practice a regulated profession denied, conditioned, curtailed, limited, restricted, suspended, revoked, reprimanded, or disciplined in any way?
	If you answered "yes" to any of the above questions, enclose with this application complete information with respect to all circumstances and the final result, if such has been reached. If you answered "yes" to Questions 23, 24, 25, 26, 27, 28 or 29 you must submit a complete narrative of the circumstances that occurred for EACH and EVERY conviction, plea in abeyance, and/or deferred sentence. You must also attach copies of all applicable police report(s), court record(s), and probation/parole officer report(s).
	If you are unable to obtain any of the records required above, you must submit documentation on official letterhead from the police department and/or court indicating that the information is no longer available.
	If you have formally expunged a criminal record as evidenced by a court order signed by a judge, you do not need to disclose that criminal history. Expungement orders must be sent to the Bureau of Criminal Identification and the FBI to enable the expungement to be completed and the criminal history eliminated from the records.
	A "Yes" answer does not necessarily mean you will not be granted a license; however, DOPL may request additional documentation if the information submitted is insufficient.

**DESIGNATION OF CONTACT PERSON FOR ACCESS TO MEDICAL RECORDS**

In accordance with Subsection 58-67-302(1)(j) of the Utah Code and the Federal HIPAA Regulations every physician licensed in Utah must designate a contact person and an alternate contact person for access to his/her patients' medical records and provide such information to the DOPL. Each applicant is also required to establish a method of notifying patients of the identity and location of the contact persons (i.e. a phone number or address where patients can obtain their medical records).

If a hospital clinic or other medical facility is the owner of your patients' medical records the facility's records department could be listed as the primary contact. You may list yourself as the primary contact but you must also provide an alternate contact.

Please note that this statute became law in 2005 due to complaints from patients who could not gain access to their medical records. DOPL's responsibility is to collect each physician's contact information and to provide it to patients upon request. If you have not provided accurate information to DOPL you could be investigated for unprofessional conduct.

<b>Contact Person:</b> Health Information	Telephone: 801-581-2704
Address of Contact Person: 50 N. Medical Drive	
City: Salt Lake City	State: UT Zip: 84132
<b>Alternate Contact Person:</b> Dept Obtain Medical Records	Telephone: 801-585-3855
Address of Contact Person: 30 N 1900 E	
City: Salt Lake City	State: UT Zip: 84132
Method of Notifying Patients of Location of Records: (check all that apply)	
<input type="checkbox"/> Phone	
<input checked="" type="checkbox"/> Mail	
<input type="checkbox"/> In Person	

**AFFIDAVIT IF APPLYING FOR LICENSURE FOR RESIDENCY TRAINING IN UTAH**

I have successfully completed 12 months of resident training in an ACGME approved program after receiving a degree of doctor of medicine. I am successfully participating in an ACGME progressive residency program within Utah with no disciplinary action. I agree to surrender my license to DOPL without any proceedings under the Administrative Procedures Act and DOPL will automatically revoke my license as a physician and surgeon if I fail to continue in good standing in the ACGME approved residency program within Utah.

Signature of Applicant: \_\_\_\_\_ Date: \_\_\_\_\_



<b>MEDICAL SCHOOL</b> (Use additional sheets if necessary.)			
School Name: <u>University of Colorado</u>		Dates Attended: <u>8/2002</u> to <u>5/2006</u>	
Location: <u>Denver, CO</u>			
Degree Received: <u>MD</u>		Date of Graduation: <u>5/2006</u>	
School Name:		Dates Attended: to	
Location:			
Degree Received:		Date of Graduation:	

<b>GRADUATE MEDICAL EDUCATION OR TRAINING</b> - Complete the information below and account for all periods of training or postgraduate work from the time you graduated from medical school. (Use additional sheets if necessary.)			
Name of Hospital: <u>Pennsylvania Hospital</u>		Position (intern, resident, fellow): <u>intern + resident</u>	
Address of Hospital: <u>800 Spruce St</u>			
City: <u>Philadelphia</u>		State: <u>PA</u>	Zip: <u>19107</u>
Department: <u>Ob/Gyn</u>		Date Began: <u>6/18/2004</u>	Date Ended: <u>6/17/2010</u>
Name of Hospital:		Position (intern, resident, fellow):	
Address of Hospital:			
City:		State:	Zip:
Department:		Date Began:	Date Ended:

<b>PROFESSIONAL EXAMINATION REQUIREMENT</b>		
# Attempts	Examination	Date(s) Taken
1	USMLE Step 1	<u>6/2004</u>
1	USMLE Step 2	<u>8/2005</u>
1	USMLE Step 3	<u>3/2007</u>
	NBOME Part I	
	NBOME Part II	
	NBOME Part III	
	FLEX Component 1	
	FLEX Component 2	
	LMCC Part 1	
	LMCC Part 2	
	SPEX Examination	
<b>List Tests Taken if Not Listed Above:</b>		
# Attempts	Examination	Date(s) Taken

<b>SPECIALTY BOARD CERTIFICATION</b> - List your ABMS or AOA specialty board certification(s) and date(s) of specialty certification(s). (Use additional sheets if needed.)	
Board:	Date:
Board:	Date:
Board:	Date:
Board:	Date:



CHRIS CHRISTIE  
Governor

KIM GUADAGNO  
Lt. Governor

## New Jersey Office of the Attorney General

Division of Consumer Affairs  
State Board of Medical Examiners  
P.O. Box 183, Trenton, NJ 08625-0183



PAULA T. DOW  
Attorney General

THOMAS R. CALCAGNI  
Acting Director

February 8, 2011

Utah Department of Commerce  
P.O. Box 146741  
Salt Lake City, UT 84114-6741

**For overnight deliveries:**  
140 East Front St.  
PO Box 183, 3<sup>rd</sup> Floor  
Trenton, NJ 08608  
(609) 826-7100  
(609) 826-7101 FAX

To Whom It May Concern:

The New Jersey State Board of Medical Examiners has been requested by Amna I Dermish to forward a letter of good standing regarding the Medical Doctor's license to practice in the State of New Jersey.

A review of the Board's files indicates that Amna I Dermish was issued a New Jersey license 25MA08848500 on or about 10/04/2010 and is currently Active with an expiration date of 06/30/2011. A review of the Board's files further indicates that no public disciplinary action has been taken against this Medical Doctor.

Very truly yours,

BOARD OF MEDICAL EXAMINERS

William V. Roeder  
Executive Director

WVR/dd/mac

FEB 14 2011

DIVISION OF CONSUMER AFFAIRS  
& PROFESSIONAL LICENSING



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**COMMONWEALTH OF PENNSYLVANIA**  
**DEPARTMENT OF STATE**  
**BUREAU OF PROFESSIONAL AND OCCUPATIONAL AFFAIRS**  
P. O. Box 2649  
Harrisburg, PA 17105-2649  
[www.dos.state.pa.us](http://www.dos.state.pa.us)

January 18, 2011

## CERTIFICATION OF LICENSE

This is to certify that the individual or business named below is licensed by the Department of State, Bureau of Professional and Occupational Affairs:

<b>NAME:</b>	AMNA IBRAHIM DERMISH
<b>LICENSE TYPE:</b>	Medical Physician and Surgeon
<b>LICENSE NUMBER:</b>	MD439505
<b>ORIGINAL LICENSURE DATE:</b>	03/17/2010
<b>EXPIRATION DATE:</b>	12/31/2012
<b>STATUS:</b>	Active

  
**JAN 24 2011**  
DIVISION OF OCCUPATIONAL  
& PROFESSIONAL LICENSING

The license is in good standing and the records indicate no derogatory information.

SEAL



Deputy Commissioner  
Bureau of Professional and Occupational Affairs

license: 7894043-1205		
Question	Answer	Date Answered
Citizenship question	citizen	12/01/2011
Physician Specialty Question	2580	12/01/2011
Is the licensee currently under investigation or is any disciplinary, administrative, or criminal action pending against the licensee now by any agency?	q4no	12/01/2011
Since the last renewal or issuance of this license has the licensee surrendered or had any disciplinary action taken against a license to practice in a regulated profession?	q3no	12/01/2011
Since the last renewal or issuance of this license has the licensee been charged with or arrested for any felony or misdemeanor in any jurisdiction?	q2no	12/01/2011
Since the last renewal or issuance of this license has the licensee pled guilty to, pled no contest to, been convicted of, made a plea in abeyance to, or entered into a deferred sentence with respect to any felony or misdemeanor in any jurisdiction?	q1no	12/01/2011

<p>Do you perform elective abortions in Utah in a location other than a hospital?</p>	<p>yes,515 S 400 E,Salt Lake City,Utah Women's Clinic,8015319192,UT,84111,160 S 1000 E,Salt Lake City,Planned Parenthood Association of Utah,8012576789,UT,84102</p>	<p>12/01/2011</p>
<p>Renewal Requirements Question</p>	<p>continue</p>	<p>12/01/2011</p>
<p>Signature</p>		
<p>I am the licensee described and identified in this application for licensure renewal/reinstatement, or I have legal power of attorney, court appointment, or similar legal authority to act on behalf of the holder of the license being renewed.</p>		
<p>I am qualified in all respects for the renewal or reinstatement of this license.</p>		
<p>To the best of my knowledge, the information contained in this application is complete and correct, and is free of fraud, misrepresentation, or omission of material fact.</p>		
<p>I understand that this application will be classified as a public record and will be available for inspection by the public, except with regard to the release of information which is classified as controlled, private, or protected under the Government Records Access and Management Act or restricted by other law.</p>		
<p>Electronic Signature of</p>		

Authorized Authority: (type  
name here ->) Amna  
Dermish

Close