Planned Parenthood®
of the Rocky Mountains

The mission of Planned Parenthood of the Rocky Mountains is to improve the quality of life by enabling all people to exercise individual choice in their own reproductive health.

November 11, 2005

New Mexico Medical Board
2055 S. Pacheco St.
Building 400
Santa Fe, NM 87505

To Whom It May Concern:

I am applying for a medical license in New Mexico. This letter is to explain why American University of the Caribbean responded "Yes" to the leave of absence or break from their education in the Unusual Circumstances Section of the Verification of Medical Education

I took a leave of absence in May 1995 for a semester (right after basic sciences) to study for the usmle.

Please do not hesitate to contact me at if you have any questions or concerns.

Sincerely,

Savita Y. Ginde, MD
PPRM Medical Director

American Medical Association

Physicians dedicated to the health of America

Division of Database Products and Licensing
515 North State Street
Chicago, Illinois 60610
http://www.ama-assn.org/go/amaprofiles

AMA Physician Profile

Name and Mailing Address:

SAVITA YESHAWANT GINDE MD

Primary Office Address:

SAME AS MAILING ADDRESS

Phone: UNKNOWN

Birthdate: '1970
Birthplace: UNKNOWN

Physician's Major Professional Activity: OFFICE BASED PRACTICE

Practice Specialties Self Designated by the Physician*:

Primary Specialty: FAMILY MEDICINE

Secondary Specialty: UNSPECIFIED

**Self-Designated Practice Specialties/Areas of Practice (SDPS) listed on the AMA Physician Profile do not imply "recognition" or "endorsement" of any field of medical practice by the Association, nor does it imply, certification by a Member Medical Specialty Board of the American Board of Medical Specialties, or that the physician has been trained or has special competence to practice the SDPS.*

AMA membership: NON MEMBER

All Information from this Point Forward is Provided by the Primary Source

Current and/or Historical Medical School:

AMERICAN UNIV OF THE CARIBBEAN, SCH OF MED, ST MAARTEN, NETHERLANDS ANTILLE

Degree Awarded: Yes

Reported Year of Graduation 1997

American Medical Association

Physicians dedicated to the health of America

Division of Database Products and Licensing
515 North State Street
Chicago, Illinois 60610
http://www.ama-assn.org/go/amaprofiles

AMA Physician Profile

Federal Drug Enforcement Administration:

** Only the last three characters of active DEA number(s) are displayed.*

DEA Number *	Schedule	Expiration Date	Last Reported
XXXXXX615	22N 33N 4 5	09/30/2006	07/11/2005

Note: Many states require their own controlled substances registration/license. Please check with your state licensing authority for requirement information as the AMA does not maintain this information.

Specialty Board Certification(s)*:

Specialty Board Certification(s) by one or more of the 24 boards recognized by the American Board of Medical Specialties (ABMS) and the American Medical Association (AMA) through the Liaison Committee on Specialty Boards, as reported by the ABMS:

The AMA Physician Profile has been designated by the ABMS as an official "display agent" of the ABMS Specialty Board Certification data Therefore, the ABMS Board Certification information on the AMA Physician Profile is considered a designated equivalent source in regard to credentialing standards set forth by accrediting bodies such as the Joint Commission on the Accreditation of Healthcare Organizations (JCAHO) and National Committee for Quality Assurance (NCQA).

Certifying Board: AMERICAN BOARD OF FAMILY MEDICINE
Certificate: FAMILY PRACTICE
Certificate Type: GENERAL

Duration	Effective	Expiration	Occurrence	Last Reported
TIME LIMITED	07/12/2002	12/31/2009	INITIAL	06/10/2005

Note: For certification dates, a default value of "01" appears in the day or month field if data were not provided to AMA. Please contact the appropriate specialty board directly for this information. (**) Indicates an expired certificate.

Medicare/Medicaid Sanction(s):

TO DATE, THERE HAVE BEEN NO SUCH SANCTIONS REPORTED TO THE AMA BY THE DEPARTMENT OF HEALTH AND HUMAN SERVICES

Other Federal Sanction(s):

TO DATE, THERE HAVE BEEN NO FEDERAL SANCTIONS REPORTED TO THE AMA BY ANY BRANCH OF THE US MILITARY, THE VETERAN'S ADMINSTRATION OR THE US PUBLIC HEALTH SERVICE

American Medical Association

Physicians dedicated to the health of America

Division of Database Products and Licensing
515 North State Street
Chicago, Illinois 60610
http://www.ama-assn.org/go/amaprofiles

AMA Physician Profile

Additional Information:

TO DATE, THERE IS NO ADDITIONAL INFORMATION FOR THIS PHYSICIAN ON FILE.

The content of the AMA Physician Profile is intended to assist with credentialing. Appropriate use of the AMA Physician Masterfile data contained on this Profile by an organization would meet the primary source verification requirements of the Joint Commission on Accreditation of Healthcare Organizations (JCAHO) and the American Accreditation HealthCare Commission/URAC. The Physician Masterfile meets the National Committee for Quality Assurance (NCQA) standards for verification of medical education, post graduate medical training, board certification, DEA status, and Medicare/Medicaid sanctions.

If you note any discrepancies, please log onto our web site and go to the order detail page, select the D following the physician's name and enter the data in question. Or you can mark the issues on a copy of the profile and mail or fax to:

Division of Database Products and Licensing
Attn: Credentialing Products
515 N. State Street
Chicago, IL 60610
800- 665-2882
312 464-5900 (fax)

AMA Files Checked 7/19/05 13:01:23

Profile for: Savita Yeshawant Ginde MD

New Mexico Medical Board
2055 S. Pacheco St.
Building 400
Santa Fe, NM 87505
(505) 476-7220

RECEIVED
JUL 22 2005
NM BOARD OF
MEDICAL EXAMINERS

PROFESSIONAL RECOMMENDATION

The New Mexico Medical Board requires the completion of this Professional Recommendation by a physician or a Chief of Staff or a Department Chief with whom I have worked and who has personal knowledge of my character and competence to practice medicine. This form is required as part of my application for licensure. ***All*** elements in the section below ***must*** be completed. The lower half of the form may be used for narrative comment. This is my authorization to release all information in your files, favorable or otherwise, DIRECTLY to the NMMB, 2055 S. Pacheco St., Bldg. 400, Santa Fe, NM 87505.

Applicant's Name: SAVITA GINDE Date of Birth ___

Applicant' Signature: [signature] Date: 6/20/05

Address: [redacted] City Denver State CO

ALL ELEMENTS IN THIS SECTION MUST BE COMPLETED BY THE RECOMMENDING PHYSICIAN
The information on this form is NOT a public document.

1. Date and type of service: This individual served with me as fellow in reproductive health
from 7/02 (Month/Year) to 6/04 (Month/Year) at University of Rochester (Location)

2 Please evaluate:

	(Please indicate with check mark) Poor	Fair	Good	Superior
Professional knowledge				✓
Clinical judgment				✓
Relationship with patients				✓
Ethical/professional conduct				✓
Ability to communicate				✓
Clinical skills				✓

3 Recommendation: (please indicate with a check mark)

1 Recommend highly and without reservation ✓
2. Recommend as qualified and competent
3. Recommend with some reservation (explain)
4. Concerns (explain)

4. Of particular value in evaluating the candidate is information regarding any notable strengths and weaknesses (including personal demeanor) We would appreciate your comments.

High integrity - Excellent Clinician

5 The above report is based on: (please indicate with check mark)

1. Close personal observation ✓ 3. A composite of evaluations
2 General impression 4. Other

Name (Please Print): Eric Schaff Title: Fellowship Director Phone: 585 275 2129

Signature: [signature] Date: 7/18/05

Revised 10/04

New Mexico Medical Board

New Mexico Medical Board
2055 S. Pacheco St.
Building 400
Santa Fe, NM 87505
(505) 476-7220

PROFESSIONAL RECOMMENDATION

The New Mexico Medical Board requires the completion of this Professional Recommendation by a physician or a Chief of Staff or a Department Chief with whom I have worked and who has personal knowledge of my character and competence to practice medicine. This form is required as part of my application for licensure. ***All*** elements in the section below ***must*** be completed. The lower half of the form may be used for narrative comment. This is my authorization to release all information in your files, favorable or otherwise, DIRECTLY to the NMMB, 2055 S. Pacheco St., Bldg. 400, Santa Fe, NM 87505.

Applicant's Name: SAVITA GINDE Date of Birth ___

Applicant' Signature: [signature] Date: 6/20/05

Address: ___ City Denver State CO

ALL ELEMENTS IN THIS SECTION MUST BE COMPLETED BY THE RECOMMENDING PHYSICIAN
The information on this form is NOT a public document.

1. Date and type of service: This individual served with me as Fellow (post graduate) Reproductive Medicine / Colleague / Co-Investigator

from 6/02 (Month/Year) to 6/04 (Month/Year) at Univ. of Rochester (Location)

2 Please evaluate:

	(Please indicate with check mark) Poor	Fair	Good	Superior
Professional knowledge				✓
Clinical judgment				✓
Relationship with patients				✓
Ethical/professional conduct				✓
Ability to communicate				✓
Clinical skills				✓

3 Recommendation: (please indicate with a check mark)

1 Recommend highly and without reservation ✓
2. Recommend as qualified and competent ___
3. Recommend with some reservation (explain) ___
4. Concerns (explain) ___

4. Of particular value in evaluating the candidate is information regarding any notable strengths and weaknesses (including personal demeanor). We would appreciate your comments
Highly qualified in all areas

5 The above report is based on: (please indicate with check mark)

1. Close personal observation ✓ 3 A composite of evaluations ___
2. General impression ___ 4. Other ___

Name (Please Print): Lawrence B. Steenburg Title: MD / FACOG Phone: 585-425-5266

Signature: Lawrence B. Steenburg MD Date: 11/17/05

STATE OF COLORADO

DIVISION OF REGISTRATIONS
OFFICE OF SUPPORT SERVICES
Joann Crouse, Office Director

1560 Broadway, Suite 1350
Denver, Colorado 80202-5146
Phone (303) 894-7800
Fax (303) 894-7693

Department of Regulatory Agencies
Tambor Williams
Executive Director

Division of Registrations
Rosemary McCool
Director

Bill Owens
Governor

June 23, 2005

NM Medical Board
2055 S Pacheco St, Building 400
Santa Fe, NM 87505

LICENSE VERIFICATION

Savita Y Ginde

Profession: Physician
License number: 42050
Licensee Status: Active

Original Date of Issue: 10/09/2003
Basis of: International
Last renewed on 05/17/2005
Expiration date: 05/31/2007

Disciplinary action(s): None

If there is disciplinary action(s) against this licensee and you need additional information, please send a written request to the Board at the address above or email medical@dora.state.co.us. Or, you can view Registrations Online Disciplinary Documents (RODD) at www.dora.state.co.us/doraimages. This online system makes certain scanned documents related to disciplinary actions taken on all Colorado licensees available to the public via the Internet. Stipulations, Final Agency Orders, and Suspensions that were in effect in February 2000, plus any that became effective since that date, are among the documents that are now available.

The licensee provided documentation of successful completion of a recognized national exam and met all of the educational or examination requirements as set forth by the Colorado Revised Statutes and the Rules and Regulations of the Colorado Board of Medical Examiners in effect at the time of licensure. This information is the only certification information provided by this department. If further information is needed, it MUST be obtained from the licensee.

For future reference, you may verify the current status at any time through ALISON, the Automated Licensure System Online, at http://www.dora.state.co.us/registrations

FOR THE COLORADO BOARD OF MEDICAL EXAMINERS

Richard A. Ramirez
Customer Support Representative

THE STATE EDUCATION DEPARTMENT
DIVISION OF PROFESSIONAL LICENSING SERVICES
CERTIFICATION & VERIFICATION UNIT
89 WASHINGTON AVENUE
ALBANY, NEW YORK 12234

THIS IS TO CERTIFY THAT ACCORDING TO THE RECORDS OF THE DIVISION OF PROFESSIONAL LICENSING SERVICES, NEW YORK STATE EDUCATION DEPARTMENT, ALBANY, NEW YORK, GINDE SAVITA YESHAWANT
WAS ISSUED LICENSE/CERTIFICATE NUMBER 222915 FOR THE PRACTICE OF MEDICINE ON 09/28/01.

OUR RECORDS ALSO INDICATE THE FOLLOWING INFORMATION:
DATE OF BIRTH:
SCHOOL ATTENDED: AMER UNIV CARIBBEAN MED
DATE OF GRADUATION: 06/07/97
DEGREE EARNED: MD

PROGRAM WAS ACCEPTABLE IN ACCORDANCE WITH THE NYS REGULATIONS OF THE COMMISSIONER OF EDUCATION. REQUIREMENTS MET AT THE TIME OF LICENSURE.

BASIS OF LICENSURE:

DATE	EXAMINATION	SCORE	
09/00	USMLE STEP3	81	TAKEN IN OH 00081 OOSOH
03/97	USMLE STEP2	75	
09/95	USMLE STEP1	75	

EXMS TAKEN=03

A LICENSE IS VALID DURING THE LIFE OF THE HOLDER UNLESS REVOKED, ANNULLED OR SUSPENDED BY THE BOARD OF REGENTS. A LICENSEE MUST REGISTER PERIODICALLY WITH THIS DEPARTMENT TO PRACTICE IN THIS STATE

CURRENTLY REGISTERED: NO REG PERIOD ENDS:
ADDRESS:
[redacted] 14618-5635
DEROGATORY INFORMATION: NO CHARGES HAVE BEEN PREFERRED AGAINST THIS LICENSEE.
COMMENTS:

I LINDA GALEY, HEAD CLERK, DIVISION OF PROFESSIONAL LICENSING SERVICES OF THE NEW YORK STATE EDUCATION DEPARTMENT, DO HEREBY STATE THAT AS HEAD CLERK OF SAID DIVISION, I HAVE LEGAL CUSTODY OF THE OFFICIAL RECORDS OF THE DIVISION OF PROFESSIONAL LICENSING SERVICES AND TO THE BEST OF MY KNOWLEDGE, THE AFORESAID INFORMATION IS TRUE AND CORRECT.

SEAL

Linda Galey 07/29/05
HEAD CLERK

OP026 056

OHIO License CENTER

Identification Information	[back]
Name	Dr. SAVITA YESHAWANT GINDE Birth Date: Birth Place: TOLEDO OH Birth Country:
Practice	HIGHLAND HOSPITAL 1000 SOUTH AVE SUITE N 348 ROCHESTER, NY 14618
Residence	YOUNGSTOWN, OH 44511 County: Mahoning
Professional Education	School: 654010-School of Medicine, American University of the Caribb Graduated: 06/07/97

License and Registration Information

Credential	License Type	Initial Licensure Date	Expiration Date	Status
35.079132	Doctor of Medicine	03/09/2001	01/01/2005	INACTIVE

Specialties

FAMILY PRACTICE

Specialty listings are voluntarily provided by the physician. They are not verified by the State Medical Board and do not confirm that the physician is Board certified by a professional specialty organization. To find out if a physician is certified by a specialty board, you should contact that board. Information and links to specialty boards can be found by clicking this green box.

Formal Action Information

No formal action exists.

The above is an accurate representation of information currently maintained by the State Medical Board of Ohio as of 8/31/2005. The JCAHO and the NCQA have informed the Board that they consider this on-line license status information as fulfilling the primary source requirement for verification of licensure in compliance with their respective credentialing standards. This information is otherwise provided as a public service and no user may claim detrimental reliance thereon.

The State Medical Board utilizes the Federation Credentials Verification Service (FCVS) as an agent and partner in licensing physicians in Ohio. Physicians initially licensed in Ohio after February 1st, 1997 have had their medical education, post-graduate training and examination history primary source verified by FCVS. Therefore, the use of this website for documentation of primary source verification (PSV) of education and training meets current NCQA guidelines for those licensed after February 1, 1997. This statement, affirming that primary source verification of medical education and post-graduate training has been performed as part of the licensure process, should be printed out and retained in your files. Prior to February 1, 1997, the State Medical Board prime source verified the post-graduate training and examination history.

New Mexico Medical Board
2055 S. Pacheco St.
Building 400
Santa Fe, NM 87505
(505) 476-7220

WORK EXPERIENCE VERIFICATION

I am applying for a medical license in the State of New Mexico. The New Mexico Medical Board requires this form to be completed by the Chief of Staff or facility's administrative staff. I hereby authorize release of all information in your files, favorable or otherwise, DIRECTLY to the NMMB, 2055 S. Pacheco St., Bldg. 400, Santa Fe, NM 87505.

Savita Y. Ginde
Applicant Name

Applicant Signature

Address
Denver, CO 80203
City/State/Zip

10/03 - Present
*Dates of Privilege/Employment mm/yy to mm/yy (must be provided)

Telephone Number

The section below should be completed by the chief of staff or facility's administrative staff.
Letters of Recommendation are ***NOT*** accepted in lieu of this form.

Ann Hetrick, RNC
Type or Print Name of person completing this form

Director of Quality Management
Title

Planned Parenthood of the Rocky Mountains
Name of Institution

Address

Denver, CO 80203
City / State / Zip

1. This evaluation is based on: ✓ Observation of applicant ___ Review of personnel file
2. In your estimation, is there any reason why this applicant should not be licensed to practice? ___ Yes ✓ No
3. To your knowledge, is there any mental or physical reason why this applicant should not be licensed? ___ Yes ✓ No
4. To your knowledge, is there any derogatory/disciplinary information regarding this applicant? ___ Yes ✓ No
5. Are the dates of privilege/employment provided by the applicant on this form accurate?* ✓ Yes ___ No

**If not, please provide correct dates:* Beginning _____ (Month/Year) Ending _____ (Month/Year)

If you answered "YES" to questions 2, 3, and/or 4, please provide a written explanation and/or any supporting documentation that may be relevant.

KELLIE R. BLACK NOTARY PUBLIC STATE OF COLORADO
Please affix hospital or notary seal here
My Commission Expires 09/12/2007

Ann Hetrick, RNC — Ann Hetrick, RNC — 1/10/06
Printed name of person completing this form — Signature — Date

Signature of Notary (if applicable) — 1/10/06
Date

My commission expires: 9/12/2007

Please note on this form if there is no hospital or notary seal available.
Please return this form directly to the address above
Thank you for your cooperation

Revised 10/04

rec'd 7/5/05 J.M.

New Mexico Medical Board
2055 S. Pacheco St.
Building 400
Santa Fe, NM 87505
(505) 476-7220

WORK EXPERIENCE VERIFICATION

I am applying for a medical license in the State of New Mexico. The New Mexico Medical Board requires this form to be completed by the Chief of Staff or facility's administrative staff. I hereby authorize release of all information in your files, favorable or otherwise, DIRECTLY to the NMMB, **2055 S. Pacheco St., Bldg. 400, Santa Fe, NM 87505.**

SAVITA GINDE
Applicant Name

Applicant Signature

Address

Denver, CO 80203
City/State/Zip

4/04 - present
*Date of Privilege/Employment mm/yy to mm/yy (must be provided)

Telephone Number

The section below should be completed by the chief of staff or facility's administrative staff.
Letters of Recommendation are ***NOT*** accepted in lieu of this form.

CHAS C RICHARDS
Type or Print Name of person completing this form

CREDENTIALING SPECIALIST
Title

UNIVERSITY OF COLORADO HOSPITAL
Name of Institution

4200 E 9th Ave Campus Box A042
Address

DENVER CO 80262
City / State / Zip

1. This evaluation is based on: ___Observation of applicant ___Review of personnel file
2. In your estimation, is there any reason why this applicant should not be licensed to practice? ___Yes ___No
3. To your knowledge, is there any mental or physical reason why this applicant should not be licensed? ___Yes ___No
4. To your knowledge, is there any derogatory/disciplinary information regarding this applicant? ___Yes ___No
5. Are the dates of privilege/employment provided by the applicant on this form accurate?* ___Yes ___No

**If not, please provide correct dates*: Beginning _____ (Month/Year) Ending _____ (Month/Year)

If you answered "YES" to questions 2, 3, and/or 4, please provide a written explanation and/or any supporting documentation that may be relevant.

CHAS C RICHARDS — 6/29/05
Printed name of person completing this form — Signature — Date

Regina C. Green — 6/29/05
Signature of Notary (if applicable) — Date

NOTARY PUBLIC
REGINA C. GREEN
STATE OF COLORADO

Please affix hospital or notary seal here

My commission expires: 2/13/09

Please note on this form if there is no hospital or notary seal available.
Please return this form directly to the address above
Thank you for your cooperation

Revised 10/04

UNIVERSITY OF COLORADO HOSPITAL

June 27, 2005

RE: Savita Y Ginde, MD

Dear Sir/Madam:

This letter serves as verification of medical staff membership and clinical privileges at the University of Colorado Hospital for Savita Y Ginde, MD:

DEPARTMENT:	**Family Medicine**
DIVISION:	**NA**
CATEGORY:	**Clinical**
ORIGINAL APPOINTMENT:	**8/10/2004**
CURRENT APPOINTMENT DATES:	8/10/2004 to 2/28/2006
STATUS:	**Current**

Member is in good standing.

Please note that although Academic category members do not have admitting or clinical privileges, they are members of the Medical Staff Please do not hesitate to contact me if you need further information. I can be reached at 303-372-5925

Cordially,

Chas Richards

Chas Richards
Credentialing Specialist
Medical Staff Office CARE Team

MEDICAL STAFF OFFICE
4200 East Ninth Avenue
Mail Stop Campus Box A042 • Denver, Colorado 80262 • Phone 303-372-5926 • Fax 303-372-5927
University of Colorado at Denver and Health Sciences Center

The Federation of State Medical Boards of the U.S., Inc.
Federation Credentials Verification Service
Federation Place
400 Fuller Wiser Road, Suite 300
Euless, TX 76039-3855
Tel: (817) 868–5000
Fax: (817) 868–5099

November 7, 2005

Charlotte Kinney, Executive Director
New Mexico State Board of Medical Examiners
2055 S. Pacheco Street, Bldg. 400
Santa Fe, NM 87505

ATTN: Barbara Mohler

RE: **Name:** **Dr. Savita Yeshawant Ginde**
SSN:
DOB:

The Federation Credentials Verification Service (FCVS) was retained by the above referenced physician to verify core medical credentials for submission to your state medical board. The FCVS Physician Information Profile for Dr Ginde was forwarded on August 22, 2005.

Please find enclosed exact reproduction of sealed primary source clarification of medical education and follow up on unusual circumstances from American University Of The Caribbean St. Maarten, Netherlands Antilles

If you have any questions regarding the information in this profile, please do not hesitate to contact me at (817) 868-5000. We appreciate the opportunity to assist your state board with its credentialing needs

Sincerely,
Deborha L Reed
Manager
Federation Credentials Verification Service

Enclosures
/kbr

FEDERATION CREDENTIALS VERIFICATION SERVICE (FCVS)

VERIFICATION OF MEDICAL EDUCATION

(This form must be completed by the medical school)

INSTRUCTIONS TO THE DEAN

The individual identified on the attached Authorization For Release of Information, Documents and Records form has authorized your medical school to provide to the Federation Credentials Verification Service (FCVS) any and all information pertaining to their education at your institution **Please complete this form and forward it to FCVS in the enclosed self-addressed envelope.**

Please note: If your institution processes transcript requests through another office, FCVS has likely made such a request under separate cover. **If your office also processes transcript requests, please attach the individual's official transcript (which indicates courses taken, dates and hours of attendance, and scores, grades, or evaluation).**

VERIFICATION OF MEDICAL EDUCATION

Name of Institution: American University Of The Caribbean

Complete Address: 1 University Drive

Street Address: Cupecoy

City: St Maarten **State:** NA **ZIP Code (Postal Code):** _____

If name of institution was different when this individual attended, please note this name below:

_____

Premedical Education:

Years of education required for admission to your medical school: 90 semester hours college

Credential/degree presented by the applicant for admission to your medical school: BS

Enrollment and Participation: Our records indicate that Gunde, Savita V.
(type/print individual's name: Last First, Middle, Suffix)

attended our medical school for total of 144 weeks of medical education on the following dates (mm/dd/yy):

From 8 / 30 / 93 (Month / Date / Year) **To** 6 / 7 / 97 (Month / Date / Year)

This individual (check one):

☒ was conferred/issued the degree of Doctor of Medicine on 6 / 7 / 97 (Month / Date / Year)

☐ was NOT conferred/issued a degree (please attach an explanation)

Certification: By my signature, I, Melia King (type/print name), certify that the above information is an accurate account of the above named individual's official records maintained at this institution and is true and correct to my knowledge.

Affix Institutional Seal Here. If no seal is available this form must be notarized.

SEAL VERIFIED

Signature: M. King

Title: Graduate Certification

Date of Signature: 7/13/05

Phone: (305) 4460000 **Fax:** (305) 444 6791

Email: gradcert@aucmed.edu

VERIFICATION OF MEDICAL EDUCATION

Unusual Circumstances: The following questions apply to unusual circumstances that occurred during any part of the individual's medical education Please check the appropriate response and provide dates and requested information "Yes" responses to any of these questions require a copy of explanatory records or a written explanation (attach additional pages as necessary).

1 Do this individual's official records reflect (an) interruption(s) or extension(s) in his/her medical education?
Response YES ☑ NO ☐

If YES, please select the reason(s) for, indicate the dates of the interruption(s) or extension(s) and check whether the interruption/extension was approved or unapproved

	From Mo/Yr	To Mo/Yr	Approved	Unapproved
Personal/Family			☐	☐
Academic remediation			☐	☐
Health			☐	☐
Financial			☐	☐
Participation in joint degree Program (e.g., MD/PhD)			☐	☐
Participation in non-research special study (e g., fellowship, international experience)			☐	☐
Participation in non-degree research			☐	☐
Other	5/95	8/95	☐	☐

Please Specify: Study leave

2. Do this individual's official records reflect that he/she was ever placed on academic or disciplinary probation during his/her medical education? Response YES ☐ NO ☑

If YES, please select the reason(s) for the probation, indicate the date(s) of placement on and removal from probation and attach additional documentation to this report

	From Mo/Yr	To Mo/Yr
Academic Probation		
Probation for unprofessional conduct/behavioral		
Probation for other reason		

Please specify reason: _____

3. Do this individual's official records reflect that he/she was ever disciplined for unprofessional conduct/behavioral reasons by the medical school or parent university? Response YES ☐ NO ☑

If YES, please provide detailed documentation/information about the circumstances and outcome(s):

_____

_____

4. Do this individual's official records reflect that he/she was ever the subject of negative reports or an investigation by the medical school or parent university? Response YES ☐ NO ☑

If YES, please provide detailed documentation/information about the circumstances and outcome(s):

_____

_____

5. Do this individual's official records reflect that there were any limitations or special requirements imposed on the individual because of questions of academic incompetence disciplinary problems, or any other reason?
Response YES ☐ NO ☑

If YES, please provide detailed documentation/information about the nature of the limitations or special requirements

_____

_____

The Federation of State Medical Boards of the United States, Inc.
Federation Credentials Verification Service
P O. Box 619850
Dallas, TX 75261-9850
Telephone (817) 868-5043
FAX: (817) 868-4275

PLEASE EXPEDITE
DOCUMENTS CRITICAL
FOR MEDICAL LICENSURE

Fax Cover Sheet

TO: Office of the Dean
American University Of The Caribbean[654010]
305-444-6791

Follow Up Requested

DATE: September 1, 2005

FROM: Monica Stanfield
mstanfield@fsmb.org
MLS

Packet ID: 9437
Request ID: 15833788

The form you recently submitted to FCVS for Dr. Savita Yeshawant Ginde was either incomplete or requires further clarification. Please address these items listed below and return by fax to the above number.

2. Unusual Circumstances:

The Verification Form indicates that there was (an) interruption(s) or extension(s) in the applicant's medical education but omitted an explanation. **Please provide an explanation**

Reason for interruption(s) or extension(s).
Study leave

If not enough room is provided please include and attachment.

Completion of the following is certification that the information above is an accurate account of the individual's records and is true and correct. This section MUST be signed by an authorized representative.

Mellie Lung — Signature
Graduate Certification — Title
9/23/05 — Date

Number of Pages Sent:
[654010]

SEAL
VERIFIED

9437

The Federation of State Medical Boards of the United States, Inc.
Federation Credentials Verification Service
P O Box 619850
Dallas, Texas 75261-9850
Telephone: (817) 868-4000
Fax: (817) 868-4099

Physician Information Profile

This report is compiled exclusively for:

Name:	**Savita Yeshawant Ginde**
SSN:	
DOB:	
Packet ID:	9437
Recipient:	**New Mexico Medical Board**

NOTICE:

The Federation Credentials Verification Service (FCVS) was retained by the above referenced physician to verify his/her medical credentials for submission to your agency/organization. Unless noted otherwise, all documents contained in this report were received directly from the issuing institution per written request made by FCVS. All documents bearing the official FCVS seal are certified to be an exact reproduction of the original. Where required, original documents are provided according to the agreements with the institution issuing such document. FCVS maintains all original documents (excluding third-party examination transcripts) in the physician's source file.

Physician Information Profile is compiled and published by the Federation of State Medical Boards of the United States, Inc. as a reference source for its member boards and other authorized entities. Physician Information Profile may not be republished, sold, resold or duplicated, in whole or in part, for commercial or any other purposes, or for purposes of compiling lists or files without the express written consent of the Federation's Executive Vice President as authorized by its Board Of Directors. The use of this Physician Information Profile to establish independent data files or compendiums or information is strictly prohibited.

Table of Contents

Section I

FCVS Reports

FEDERATION CREDENTIALS VERIFICATION SERVICE

Physician Information Report

Identity:

Name:	**Savita Yeshawant Ginde**	
Other Name Used:	**N/A**	
Gender:	**Female**	
Date of Birth:		
Place of Birth:	**Toledo, OH USA**	
SSN:		
Current Address:	**Denver, CO 80203**	
Permanent Address:	**Same**	
Telephone Numbers:	Bus:	**303-813-7630**
	Fax:	**303-813-7673**
	Home:	
	Other:	**N/A**
Physical Description:	Height:	**5' 08"**
	Weight:	**130 lbs**
	Eye Color:	**Dark Brown**
	Hair Color:	**Dark Brown**
Physical Marks:	Description:	**Dark Brown Nevus**
	Location:	**Right Forehead**

Premedical Education (Reported by physician Not verified by FCVS):

Institution:	**University of Pennsylvania, Philadelphia, PA 19104-6291**
Dates of Attendance:	**08/1988 - 05/1992**
Degree Conferred/Issued:	**Bachelor of Arts**
Institution:	**University of Cincinnati, Cincinnati, OH 45221**
Dates of Attendance:	**09/1992 - 06/1993**
Degree Conferred/Issued:	**N/A**

Medical Education:

Current, valid ECFMG	**Yes**
ECFMG Number:	
Date Issued:	**08/22/1997**
Medical School:	**American University Of The Caribbean** **Office of the Dean** **St Maarten, Netherlands Antilles**
Dates of Attendance:	**08/30/1993 - 06/07/1997**
Date Degree Conferred/Issued:	**06/07/1997**

Degree Conferred/Issued:	**Doctor of Medicine**
Unusual Circumstance:	**Leave** **See Form**

Post Graduate Medical Education:

Institution:	**Mt Sinai Medical Center/Closed** **Graduate Medical Education** **One Mt Sinai Drive** **Cleveland, OH 44106-4198**
Post Graduate Year:	**1**
Program Type:	**Transitional**
Department:	**Internal Medicine**
Dates of Attendance:	**07/01/1998 - 06/30/1999**
Completion:	**Yes**
Accreditation:	**ACGME**
Unusual Circumstance:	**None**
Institution:	**New Hampshire Dartmouth Family Practice Residency-Concord** **Department of Family Practice** **250 Pleasant Street** **Concord, NH 03301**
Post Graduate Year:	**2-3**
Program Type:	**Residency**
Department:	**Family Practice**
Dates of Attendance:	**06/28/1999 - 06/30/2001**
Completion:	**Yes**
Accreditation:	**ACGME**
Unusual Circumstance:	**None**
Institution:	**Highland Family Medicine** **Department of Family Practice** **777 South Clinton Avenue** **Rochester, NY 14620-2399**
Post Graduate Year:	**Not Reported by the Primary Source**
Program Type:	**Fellowship**
Department:	**Women's Health**
Dates of Attendance:	**07/01/2001 - 09/30/2003**
Completion:	**Yes**
Accreditation:	**NONE**
Unusual Circumstance:	**None**

Fifth Pathway:

N/A

Examination History:

Transcripts Enclosed For:	**USMLE Step 1** **USMLE Step 2** **USMLE Step 3**

Board Action:

A Report of the results from a search of the Board Action Data Bank is enclosed.

Credentials Analysis Report

The Credentials Analysis Report is a comparative report of a physician's credentials as reported to FCVS by the physician applicant and the primary source (Medical School, PGT program, etc.). It will also list particular missing documentation, if any, as outlined in the FCVS Policies and Procedures.

Physician Identification:

Name:	Savita Yeshawant Ginde
DOB:	
SSN:	
Packet ID:	9437
Request ID:	15833788

OMISSIONS

There are none identified.

DISCREPANCIES

Discrepancy 1:

Section of Profile:	**Medical Education**
Discrepancy:	The applicant responded No to all of the questions in the Unusual Circumstances Section of the application for attendance at Amer U of The Caribbean. The institution responded Yes to the Leave question in the Unusual Circumstances Section of the Verification of Medical Education form.
Follow-Up:	See Comments on Verification of Medical Education Form. A copy of the FCVS Medical Education application page completed by the applicant is included

MISCELLANEOUS INFORMATION

Miscellaneous 1:

Section of Profile:	**Post-Graduate Education**
Issue:	The attendance dates reported for Fellowship by Highland Family Medicine are irregular, ending in September.
Follow-Up:	Provided as information only. No follow up performed.

Miscellaneous 2:

Section of Profile:	**Continuity of Education**
Issue:	There is a gap of approximately 1 year between graduation from medical school at American U Of Caribbean (06/07/1997) and entrance into the postgraduate training program at Mt Sinai Medical Center of Cleveland (begins 07/01/1998).

Follow-Up:	A written explanation from the applicant is included immediately following the Credentials Analysis Report

End of report for Savita Yeshawant Ginde

Packet Id: 9437 Request Id: 15833788 Report Created By: AZS

EXPLANATION OF GAPS IN MEDICAL EDUCATION

Please provide a complete, specific explanation regarding any other training or breaks between the beginning of your medical education and the final year of your postgraduate training. Dates should be reported in mm/yyyy format.

From Date: 07/1997 (M M / Y Y Y Y)
To Date: 01/1998 (M M / Y Y Y Y)
Activity: Ophthalmology Research Extern
80% Clinical & 20% Administrative
Kresge Eye Institute, Wayne State University
Detroit MI 48201

From Date: 02/1998 (M M / Y Y Y Y)
To Date: 06/1998 (M M / Y Y Y Y)
Activity: Low Vision Rehabilitation Policy Research Extern
75% Clinical & 25% Administrative
American Foundation for the Blind
New York NY 10001

From Date: ☐☐/☐☐☐☐ (M M / Y Y Y Y)
To Date: ☐☐/☐☐☐☐ (M M / Y Y Y Y)
Activity:

From Date: ☐☐/☐☐☐☐ (M M / Y Y Y Y)
To Date: ☐☐/☐☐☐☐ (M M / Y Y Y Y)
Activity:

From Date: ☐☐/☐☐☐☐ (M M / Y Y Y Y)
To Date: ☐☐/☐☐☐☐ (M M / Y Y Y Y)
Activity:

Signature *(Physician Applicant)* [signature] MD

Date of Signature 6.10.2005

FCVS Packet ID Number 9437

Board Action Databank Search

As of: 8/15/05

State Queried For:	**New Mexico Medical Board**
Physician's Name	**Gindc, Savita Yeshawant**
Date of Birth:	
Medical School:	**654010 - American University Of The Caribbean**
Year of Graduation:	**1997**
Social Security Number:	
ECFMG Number:	

Results:

WE HAVE NO UNFAVORABLE INFORMATION
REGARDING THE ABOVE NAMED PHYSICIAN

AUG 18 2005

DALE L. AUSTIN
SENIOR VICE PRESIDENT
AND CHIEF OPERATING OFFICER

AMERICAN BOARD OF MEDICAL SPECIALTIES
VERIFICATION OF CERTIFICATION

As of: 8/15/05

State Queried For:	New Mexico Medical Board
Physician Name:	Savita Yeshawant Ginde
Date of Birth:	
Year of Graduation:	1997 (Doctor of Medicine)
Social Security Number:	
ABMSU ID:	721257

Certification:

Board:	Family Practice
Specialty:	Family Practice
Status:	ACTIVE
Initial Certification:	07/12/2002

Section II

Identity

AFFIDAVIT AND RELEASE

I, the undersigned, hereby certify under oath that I am the person named in this application, that all statements I have or shall make are true, that I am the person named in the various forms and credentials furnished or to be furnished with respect to my application and that all documents, forms or copies I furnish with my application are strictly true.

I acknowledge that I have read and understand the "INSTRUCTIONS FOR COMPLETING THE FCVS APPLICATION" and have answered all questions contained in the application truthfully and completely. I further acknowledge that failure on my part to answer questions truthfully and completely may lead to my being prosecuted under appropriate federal and state laws.

I authorize every person, hospital, clinic, government agency (local, state, federal or foreign), institution or law enforcement agency having custody or control of any documents, records and other information pertaining to me to furnish to the Federation Credentials Verification Service any such information, or true and correct copies of documents or records.

I hereby release, discharge and hold harmless the Federation Credentials Verification Service, its agents or representatives and any person furnishing information, records or documents of any and all liability. I authorize the Federation Credentials Verification Service to release information, material, documents, orders or the like relating to me or this application to any entity at my request.

[signature]
Applicant's Signature (must be signed in the presence of a notary)

GUPTE
Applicant's Printed Last Name

SAVITA, YESHWANT
Applicant's Printed First Name, Middle Initial, and Suffix (e.g., Jr.)

FEB 1 2020
Date of Signature (must correspond to date of notarization)

State of Pennsylvania, County of Delaware

I certify that on the date set forth below the individual named above did appear personally before me and that I did identify this applicant by: (a) comparing his/her physical appearance with the photograph on the identifying document presented by the applicant and with the photograph affixed hereto, and (b) comparing the applicant's signature made in my presence on this form with the signature on his/her identifying document. The statements on this document are subscribed and sworn to before me by the applicant on this 21st day of January, 2020.

Notary Public signature: [signature]

KATHLEEN A. CESERA, Notary Public
My commission expires: My Commission Expires November 20, 2021

Notary:
The physician has been instructed to sign the front of the photograph. Your seal (or stamp) must be partly upon the photo and partly upon the signature of the applicant.

PACKET ID:

Section III

Medical Education

FEDERATION CREDENTIALS VERIFICATION SERVICE (FCVS)

VERIFICATION OF MEDICAL EDUCATION

(This form must be completed by the medical school)

INSTRUCTIONS TO THE DEAN

The individual identified on the attached Authorization For Release of Information, Documents and Records form has authorized your medical school to provide to the Federation Credentials Verification Service (FCVS) any and all information pertaining to their education at your institution. **Please complete this form and forward it to FCVS in the enclosed postage-paid, self-addressed envelope.**

Please note: If your institution processes transcript requests through another office, FCVS has likely made such a request under separate cover. **If your office also processes transcript requests, please attach the individual's official transcript (which indicates courses taken, dates and hours of attendance, and scores, grades, or evaluation).**

VERIFICATION OF MEDICAL EDUCATION

Name of Institution: School of Medicine, American University of the Caribbean

Complete Address: Post Office Box 400
Street Address
Plymouth Montserrat
Street Address
British West Indies
City State Zip Code(Postal Code)

If name of institution was different when this individual attended, please note this name below:

Enrollment and Participation: Our records indicate that Ginde, Savita Yeshawant
(type/print individual's name: Last, First, Middle, Suffix)

attended our medical school for total of 144 weeks of continuous on-campus education on the following dates (mm/dd/yy):

From	To
08 / 30 / 93	05 / 01 / 94
05 / 02 / 94	01 / 01 / 95
01 / 02 / 95	04 / 30 / 95
08 / 28 / 95	04 / 26 / 96
04 / 27 / 96	01 / 05 / 97
01 06 97	06 07 97

This individual (check one):

_____ was awarded the degree of Doctor of Medicine on 06 / 07 / 97 (mm/dd/yy)

_____ was NOT awarded a degree (please attach an explanation)

VERIFICATION OF MEDICAL EDUCATION (continued)

Unusual Circumstances: The following questions apply to unusual circumstances that occurred during any part of the individual's medical education. Please circle the appropriate response. **"Yes" responses to any of these questions requires a written explanation.**

Questions	Response
Did this individual ever take a leave of absence or break from their medical education?	(Yes) No
Was this individual ever placed on probation?	Yes (No)
Was this individual ever disciplined or under investigation?	Yes (No)
Were any negative reports regarding this individual ever filed by instructors?	Yes (No)
Were any limitations or special requirements imposed on the individual because of questions or academic incompetence, disciplinary problems or any other reason?	Yes (No)

Premedical Education: Does your school have a premedical education requirement? (Yes) No

If yes, include where your records indicate the individual completed his/her premedical education and the basic science courses taken (attach additional pages if necessary):

Premedical Institution(s): University of Pennsylvania
University of Cincinnati

Check Courses Taken: X Physics ✓ Biology/Zoology
✓ Organic Chemistry ✓ Inorganic Chemistry

Certification: By my signature, I, Yife Tien (type/print name), certify that the above information is an accurate account of the above named individual's official records maintained in this and is true and correct to my knowledge

AFFIX INSTITUTIONAL SEAL HERE

(If your institution does not have an official seal, this form must be notarized).

SEAL VERIFIED

Signature: Yife Tien

Title: Director

Date of Signature: 5/26/99

Telephone: (305) 446 0600

PROVIDED BY APPLICANT

Applicant: Print your complete last name: GONDE

14. Medical Education Outside the U.S or Canada

Complete this page only if you have attended a medical school located outside the U.S. or Canada.

List all of the medical schools you attended. You may photocopy this page to report more than one (1) institution, if necessary.

DOCUMENTATION:

You must include a legible photocopy of your medical school diploma.

AMERICAN UNIVERSITY OF THE CARIBBEAN

Complete Name of Medical School (Do not abbreviate)

Complete Name of Affiliated University or College (Do not abbreviate)

MEDICAL EDUCATION INFORMATION

Address Line 1

OFFICE 901 PONCE DE LEON BLVD

Address Line 2

CORAL GABLES

City

Province

33134036

Zip/Postal Code

USA

Country

Duration of medical degree program: From: Month 08 Year 1993 To: Month 06 Year 1997

Duration of additional clinical training (if applicable): From: Month Year To: Month Year
(i.e., training required before degree is conferred)

Degree (as it appears on your diploma): ☐ MBBS ☐ MBBCh ☑ Other: MD

☐ Did Not Graduate

Exact Date Degree was Conferred: Month 06 Day 07 Year 1997

Unusual Circumstances (circle Yes or No):

If necessary, you may continue your explanation of Unusual Circumstances on a separate 8½ x 11 sheet of paper. Your response may not exceed 100 words per question.

Did you take a leave(s) of absence or break(s) from your medical education?	YES	(NO)
Were you ever placed on probation?	YES	(NO)
Were you ever disciplined or placed under investi	YES	(NO)
Were any negative reports ever filed against you?	YES	(NO)
Were any limitations or special requirements impc academic incompetence, disciplinary problems.	YES	(NO)

03-08/95 Study USMLE 1

Please explain any "Yes" response from above:

15. Fifth Pathway

Complete this section only if you participated in a Fifth Pathway Program.

DOCUMENTATION:

You must include a legible photocopy of your Fifth Pathway Certificate.

N/A

Complete Name of Medical School that Awarded Fifth Pathway Certification (Do not abbreviate)

City

State

From: Month Year To: Month Year

Exact Date Certificate was Awarded: Month Day Year

AMERICAN UNIVERSITY OF THE CARIBBEAN - SCHOOL OF MEDICINE

TRANSCRIPT OF ACADEMIC RECORDS
P.O. BOX 400, PLYMOUTH, MONTSERRAT, WEST INDIES

Student Number	Student Name	Citizenship	Sex
43172	GINDE, Savita Yeshawant	USA	Female

Address	Date of Birth	Place of Birth
		Toledo, Ohio

Entrance Date	Graduation Date	Degree Conferred	
September 1993	June 7,1997	DOCTOR OF MEDICINE	Master of Science April 21, 1995

Course #	Title	Sem. Hrs.	Grade
	September 1993 Semester		
100	Anatomy	10	P
108	Cell Biology and Histology	7	P
109	Embryology	2	H
	January 1994 Semester		
210	Medical Terminology	2	H
212	Biochemistry	5	H
220	Biostatistics	1	H
221	Physiology I	5	H
252	Medical Microbiology I	3	H
360	Medical Psychology	5	H
	May 1994 Semester		
323	Physiology II	5	P
354	Medical Microbiology II	6	P
329	Neuroscience I	6	P
	September 1994 Semester		
415	Pharmacology	4	P
419	Genetics	4	H
444	Pathology	8	P
447	Neuroscience II	2	P
471	Preventive Medicine	1	H
	January 1995 Semester		
534	Introduction to Clinical Medicine	8	H
546	Clinical Pathology	7	P
591	Biological Basis of Clinical Medicine	5	P

Course #	Title	Sem. Hrs.	Grade
	September 1995 Semester		
	Medicine (Family Practice)	6 weeks	P
	January 1996 Semester		
	Psychiatry	6 weeks	H
	Internal Medicine	11 weeks	H
	May 1996 Semester		
	Internal Medicine	1 week	H
	Medicine (Oncology/Hematology)	4 weeks	P
	(Neurology)	4 weeks	H
	Surgery	4 weeks	P
	September 1996 Semester		
	Surgery	8 weeks	P
	Obstetrics/Gynecology	6 weeks	H
	Pediatrics	3 weeks	P
	January 1997 Semester		
	Pediatrics	3 weeks	P
	Medicine (Infectious Diseases)	4 weeks	P
	Surgery (Pathology)	4 weeks	H
	(Anesthesiology)	4 weeks	P
	May 1997 Semester		
	Medicine (Opthamology)	4 weeks	H

SEAL VERIFIED

Dorothy M. Chanok, Registrar

SEAL

Key: H-Honors (100-90%, P-Pass 89-70%, F-Fail 69-0%, R-Repeat, W-Withdraw. This transcript is printed on a pink color safety paper and does not require a raised seal.

EDUCATIONAL COMMISSION for FOREIGN MEDICAL GRADUATES

PHILADELPHIA OFFICE
3624 MARKET STREET PHILADELPHIA PENNSYLVANIA 19104-2685 U S A
TELEPHONE: 215-386-5900 • FAX: 215-386-3185 • INTERNET: www ecfmg org

Your **organization number** is: **V-02735**
Please include this number on all requests

Date: July 19, 2005 *

To: KEVIN CALDWELL
MANAGER
FEDERATION CREDENTIALS VERIFICATION SERVICE
400 FULLER WISER ROAD
SUITE 300
EULESS, TX 76039-3855

CONFIRMATION OF ECFMG® CERTIFICATION

USMLE™/ECFMG Identification Number: 0-533-589-8 **Physician Name:** Savita Yeshawant Ginde **Date of Birth:**	This is the information found in ECFMG computer records that correlates with the USMLE/ECFMG Identification Number provided It is the responsibility of the requesting organization to obtain appropriate documentation (e g , marriage license, record of official name change, birth certificate, etc.) from the physician to validate any discrepancy with the name and/or date of birth as they appear in ECFMG records
Date Standard ECFMG Certificate was Issued: 08/22/1997	Physicians who are ECFMG-certified have passed the requisite examinations and have had their medical education credentials verified by ECFMG
English Test is Valid Through: Valid Indefinitely	Effective June 14, 2004 physicians who have passed an English test will not be required to revalidate expired English test dates in order to enter graduate medical education (GME) in the United States; all passing performances on the English test will be valid for the purpose of entry into GME, regardless of the length of time that has passed since the test date
Clinical Skills Assessment is Valid Through: Not Applicable	Physicians who have passed the ECFMG CSA during the 3-year period before the implementation of USMLE Step 2 Clinical Skills (Step 2 CS) on June 14, 2004 will not be required to revalidate expired CSA dates before entering GME These individuals may enter GME regardless of the length of time that has passed between their passing performance on the CSA and their program start date If the physician's most recent passing performance on CSA was prior to June 14, 2001 and the physician entered an ACGME-accredited residency program on or before the CSA valid through date, the CSA is no longer subject to expiration and the physician may request permanent validation of the CSA Otherwise, the physician must revalidate the CSA by passing USMLE Step 2 CS before entering GME

* Information is current as of this date

Important Note:

Requesting organizations must secure and retain the physician's signed authorization to obtain certification information Organizations may not resell the information or make it available to any party beyond the initial request as authorized by the physician The information may only be used to confirm ECFMG certification for the purpose for which the physician provided authorization

ECFMG® is an organization committed to promoting excellence in international medical education

EDUCATIONAL COMMISSION
for
FOREIGN MEDICAL GRADUATES

CERTIFIES THAT

SAVITA YESHAWANT GINDE

HAS SATISFIED ALL THE REQUIREMENTS OF THE COMMISSION,

SUCCESSFULLY PASSED ITS EXAMINATIONS

AND HAS BEEN AWARDED THIS CERTIFICATE.

CHAIRMAN, BOARD OF TRUSTEES

PRESIDENT, CHIEF EXECUTIVE OFFICER

DATE ISSUED AUGUST 22, 1997

CERTIFICATE NUMBER	
MEDICAL EXAMINATION	
BASIC SCIENCE	SEPTEMBER 28, 1995
CLINICAL SCIENCE	MARCH 05, 1997
ENGLISH EXAMINATION	MARCH 05, 1997
VALID THROUGH	

CERTIFICATE NUMBER

ENGLISH EXAMINATION
March 5, 1997
VALID INDEFINITELY

Section IV

Postgraduate Training

FEDERATION CREDENTIALS VERIFICATION SERVICE (FCVS)

RECEIVED
JUL 09 1999
By Documents and Records

VERIFICATION OF POSTGRADUATE MEDICAL EDUCATION

(This form must be completed by the Program Director)

INSTRUCTIONS TO THE PROGRAM DIRECTOR

The individual identified on the attached Authorization For Release of Information, D[illegible] form has authorized your postgraduate training program to provide to the Federation Credentials Verification Service (FCVS) any and all information pertaining to their education at your institution. **Please complete this form and forward it, together with an official copy of the individual's record (indicating rotations, dates, and hours of training, scores, grades or evaluations), to FCVS in the enclosed postage-paid, self-addressed envelope.**

POSTGRADUATE MEDICAL EDUCATION HISTORY

Name of Institution: Mount Sinai Medical Center of Cleveland

Complete Address: DEPARTMENT OF INTERNAL MEDICINE
Street Address
ONE Mt. SINAI DRIVE
Street Address
CLEVELAND OH 44106-4198
City State Zip Code(Postal Code)

If name of institution was different when this individual attended, please note this name below:

Name and complete address of affiliated university/college: CASE WESTERN RESERVE UNIVERSITY
Institution
10900 EUCLID AVENUE
Street Address
Street Address
CLEVELAND OH 44106
City State Zip Code(Postal Code)

Enrollment and Participation: Our records indicate that GINDE, SAVITA Y.
(type/print individual's name: Last, First, Middle, Suffix)

participated in the following:

Program Type (Internship, Residency, Fellowship)	PGY (1,2,3,4)	Department (Pathology, Internal Medicine, etc.)	Dates Attended (month/day/year) From	To	Completed (Yes/No)	Accredited By (ACGME, RSC, AOA or Not Accredited)
TRANSITIONAL	1	INT. MED.	07/01/98	06/30/99	YES	ACGME
			/ /	/ /		
			/ /	/ /		
			/ /	/ /		
			/ /	/ /		

VERIFICATION OF POSTGRADUATE MEDICAL EDUCATION (continued)

Unusual Circumstances: The following questions apply to unusual circumstances that occurred during any part of the individual's medical education. Please circle the appropriate response.

Questions	Response	
Did this individual ever take a leave of absence or break from their medical education?	Yes	(No)
Was this individual ever placed on probation?	Yes	(No)
Was this individual ever disciplined or under investigation?	Yes	(No)
Were any negative reports regarding this individual ever filed by instructors?	Yes	(No)
Were any limitations or special requirements imposed on the individual because of questions or academic incompetence, disciplinary problems or any other reason?	Yes	(No)

"Yes" responses to any of the questions above concerning unusual circumstances require a written explanation.

Certification: By my signature below, I, D. ROY FERGUSON, M.D. (type/print name), certify that the information contained in this report is an accurate account of the above named individual's official records maintained by this institution and is true and correct to my knowledge.

AFFIX INSTITUTIONAL SEAL HERE

(If your institution does not have an official seal, this form must be notarized.)

SEAL VERIFIED

Signature: D R Ferguson

Title: PROGRAM DIRECTOR

Date of Signature: 07/06/99

Telephone: (216) 421-3983

July 2, 1999

TO WHOM IT MAY CONCERN:

RE: SAVITA GINDE, M.D.

PHS

Mt. Sinai
Medical Campus
University Circle

Neighborhood
Commitment Specialized
Care

INTERNAL MEDICINE
RESIDENCY TRAINING
PROGRAM

This will verify that Savita Ginde, M.D. was a Transitional Resident at Mt. Sinai Medical Center in Cleveland, Ohio from July 1, 1998 to June 30, 1999. Dr. Ginde's rotation is as follows:

July 1998	Urology
August 1998	Ophthalmology
September 1998	General Medicine
October 1998	General Medicine
November 1998	Emergency Services
December 1998	Ophthalmology
January 1999	Medical Intensive Care
February 1999	Radiology
March 1999	Surgery
April 1999	Infectious Disease
May 1999	Obstetrics/Gynecology
June 1999	Obstetrics/Gynecology

If further information is needed, please do not hesitate to call.

Sincerely,

D. Roy Ferguson, M.D
Program Director

ONE MT SINAI DRIVE
CLEVELAND OHIO
44106-4198

216.421 5768 *phone*
216 421 4833 *fax*

PROVIDED BY APPLICANT

Applicant: Print your complete last name: GINDE

12. Postgraduate Medical Education

You are provided one page in this application to report this information.

Use one page per institution. If you attended more than one institution, you must make a photocopy(ies) of this page

IMPORTANT

List training in chronological order.

Report incomplete postgraduate years (PGY) separate from those that were successfully completed.

Use one (1) page per institution. This page represents 1 of 3 institution(s).

MT. SINAI MEDICAL CENTER

Complete name of hospitals where training was conducted (do not abbreviate).

CASE WESTERN RESERVE UNIVERSITY

Complete name of affiliated university or college (do not abbreviate):

11100 EUCLID AVENUE

Address line 1

MAILSTOP LKS5029

Address line 2

CLEVELAND — City

OH — State/Province

USA — Country

44106 – ZIP/Postal Code

PGY: 1
- ☑ Internship
- ☐ Residency
- ☐ Chief Residency
- ☐ Fellowship
- ☐ Research

INTERNAL MEDICINE
Specialty/subspecialty
From: 07 (Month) 1998 (Year) To: 06 (Month) 1999 (Year)
Successfully Completed? ☑ Yes ☐ No ☐ In progress

PGY: ____
- ☐ Internship
- ☐ Residency
- ☐ Chief Residency
- ☐ Fellowship
- ☐ Research

Specialty/subspecialty
From: Month Year To: Month Year
Successfully Completed? ☐ Yes ☐ No ☐ In progress

PGY: ____
- ☐ Internship
- ☐ Residency
- ☐ Chief Residency
- ☐ Fellowship
- ☐ Research

Specialty/subspecialty
From: Month Year To: Month Year
Successfully Completed? ☐ Yes ☐ No ☐ In progress

PGY: ____
- ☐ Internship
- ☐ Residency
- ☐ Chief Residency
- ☐ Fellowship
- ☐ Research

Specialty/subspecialty
From: Month Year To: Month Year
Successfully Completed? ☐ Yes ☐ No ☐ In progress

Unusual Circumstances (circle Yes or No):

Did you take a leave(s) of absence or break(s) from your medical education?	Yes (No)
Were you ever placed on probation?	Yes (No)
Were you ever disciplined or placed under investigation?	Yes (No)
Were any negative reports ever filed against you?	Yes (No)
Were any limitations or special requirements imposed on you because of academic incompetence disciplinary problems, or for any other reason?	Yes (No)

Please explain any 'yes' responses from above:

9437 FCVS Packet ID Number

Federation Credentials Verification Service (FCVS)

Federation Place, P.O. Box 619850, Dallas, TX 75261-9850
Tel: (817) 868-5000 Fax: (817) 868-5099

Verification of Postgraduate Medical Education

Institution: **New Hampshire Dartmouth Family Practice Residency-Concord**
Address: Department of Family Practice
Concord, NH 03301

Attention: Program Director

Affiliated University: _____

RECEIVED AUG 18 2003 By _____

Verification For: Name: **Ginde, Savita Yeshawant**
SSN:
DOB:
Individual's Name on Record (if different from above): _____

Program Participation:
Important:
Report incomplete postgraduate years (PGY) separate from those that were successfully completed.

If the postgraduate year is currently in progress report the expected completion date in the "To" field.

Report Internships, Residencies and Fellowships separately

Use one section per Department/Specialty. If the Department/Specialty is rotating or transitional, please provide a schedule of rotations.

PGY: _____
___ Internship
___ Residency
___ Fellowship
___ Research
Department/Specialty: _____
From: ___/___/_____ To: ___/___/_____
Successfully Completed?: ___Yes ___No ___In Progress
Accredited by: __ACGME __AOA __LCGME __RSC __CFPC __RCPSC __APPAP __None of these

PGY: 2
___ Internship
✓ Residency
___ Fellowship
___ Research
Department/Specialty: NH-Dartmouth Family Practice Residency
From: 06/28/1999 To: 06/30/2000
Successfully Completed?: ✓Yes ___No ___In Progress
Accredited by: ✓ACGME __AOA __LCGME __RSC __CFPC __RCPSC __APPAP __None of these

PGY: 3
___ Internship
✓ Residency
___ Fellowship
___ Research
Department/Specialty: NH-Dartmouth Family Practice Residency
From: 07/01/2000 To: 06/30/2001
Successfully Completed?: ✓Yes ___No ___In Progress
Accredited by: ✓ACGME __AOA __LCGME __RSC __CFPC __RCPSC __APPAP __None of these

Unusual Circumstances:
Circle the correct response. Omitted responses require written explanation.

If necessary, you may continue your explanation on a separate sheet of paper

Did this individual ever take a leave of absence or break from his/her training?	Yes (No)
Was this individual ever placed on probation?	Yes (No)
Was this individual ever disciplined or placed under investigation?	Yes (No)
Were any negative reports ever filed by instructors?	Yes (No)
Were any limitations or special requirements placed upon this individual because of questions of academic incompetence, disciplinary problems or any other reason?	Yes (No)

Please explain any "Yes" response from above:
_____
_____

Certification:
Affix your institutional seal in this space. If no seal is available you must have this form notarized.

SEAL VERIFIED

Completion of the following is certification that the information above is an accurate account of this individual's records and is true and correct. This section MUST be signed by the Program Director (M.D./D.O. only)

Name: Gail Sawyer, M.D. Signature: _____
Title: Program Director Date of Signature: 8/12/03
Tel: (603) 227-7000 Fax: (603) 228-7123 E-Mail: gsawyer@ccbhc.org

X7130 PA# 9437 Stacy

PROVIDED BY APPLICANT

Applicant: Print your complete last name: GINDE

12 Postgraduate Medical Education

You are provided one page in this application to report this information.

Use one page per institution. If you attended more than one institution, you must make a photocopy(ies) of this page.

IMPORTANT

List training in chronological order.

Report incomplete postgraduate years (PGY) separately from those that were successfully completed.

Use one (1) page per institution. This page represents 2 of 3 institution(s).

CAPITAL REGION HEALTH CARE CONCORD HOSPITAL

Complete name of hospitals where training was conducted (do not abbreviate).

DARTMOUTH COLLEGE

Complete name of affiliated university or college (do not abbreviate)

250 PLEASANT STREET

Address line 1

Address line 2

CONCORD — City

NH — State/Province

USA — Country

03301 — ZIP/Postal Code

PGY: 2

- ☐ Internship
- ☑ Residency
- ☐ Chief Residency
- ☐ Fellowship
- ☐ Research

FAMILY MEDICINE — Specialty/subspecialty

From: 07 (Month) 1999 (Year) To: 06 (Month) 2000 (Year)

Successfully Completed? ☑ Yes ☐ No ☐ In progress

PGY: 3

- ☐ Internship
- ☑ Residency
- ☐ Chief Residency
- ☐ Fellowship
- ☐ Research

FAMILY MEDICINE — Specialty/subspecialty

From: 07 (Month) 2000 (Year) To: 06 (Month) 2001 (Year)

Successfully Completed? ☑ Yes ☐ No ☐ In progress

PGY: _____

- ☐ Internship
- ☐ Residency
- ☐ Chief Residency
- ☐ Fellowship
- ☐ Research

Specialty/subspecialty

From: (Month) (Year) To: (Month) (Year)

Successfully Completed? ☐ Yes ☐ No ☐ In progress

PGY: _____

- ☐ Internship
- ☐ Residency
- ☐ Chief Residency
- ☐ Fellowship
- ☐ Research

Specialty/subspecialty

From: (Month) (Year) To: (Month) (Year)

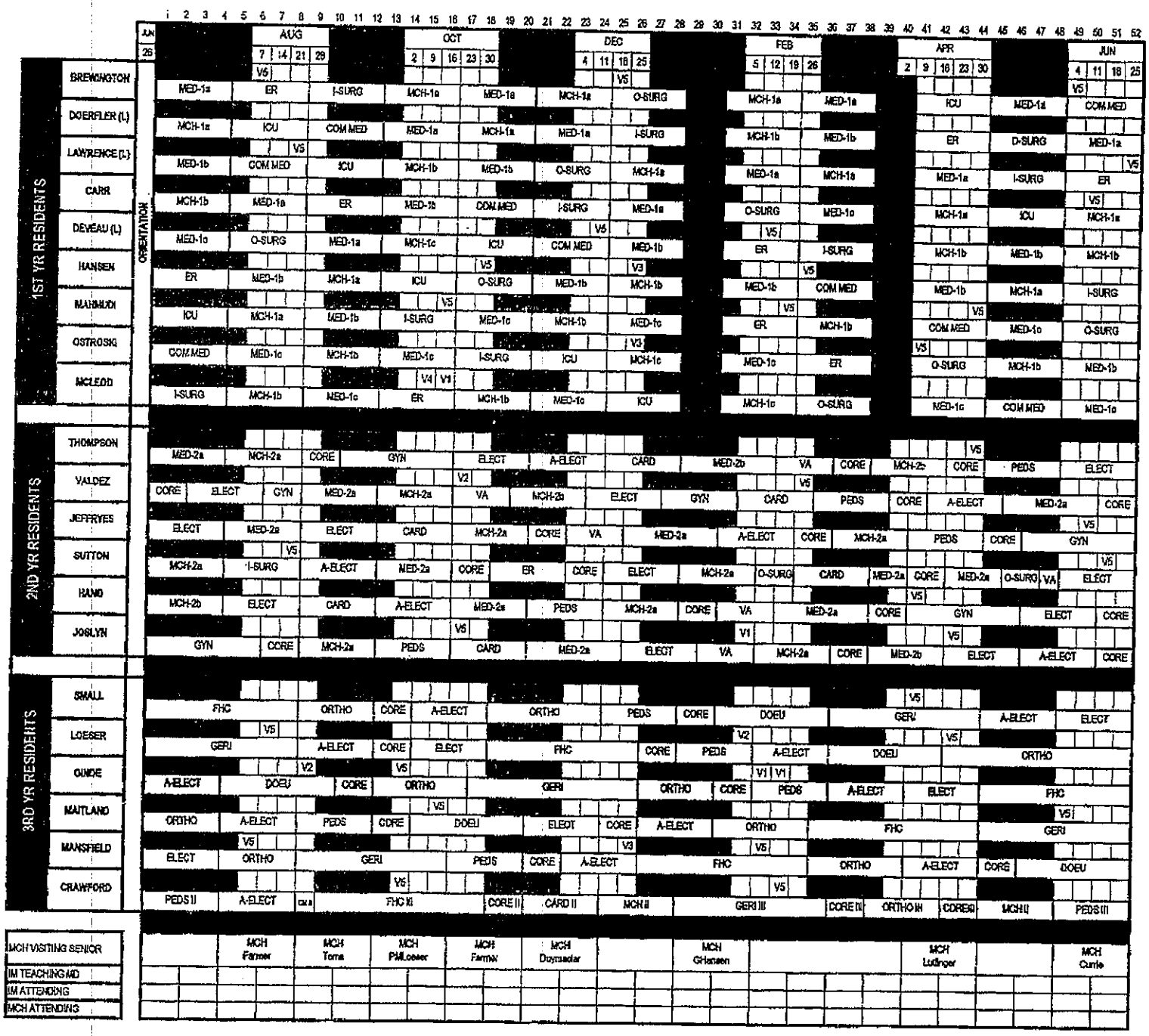
Successfully Completed? ☐ Yes ☐ No ☐ In progress

Unusual Circumstances (circle Yes or No):

Did you take a leave(s) of absence or break(s) from your medical education?	Yes (No)
Were you ever placed on probation?	Yes (No)
Were you ever disciplined or placed under investigation?	Yes (No)
Were any negative reports ever filed against you?	Yes (No)
Were any limitations or special requirements imposed on you because of academic incompetence, disciplinary problems, or for any other reason?	Yes (No)

Please explain any "yes" responses from above:

CURRICULUM ROTATIONS 2000-2001



MAJOR HOLIDAYS

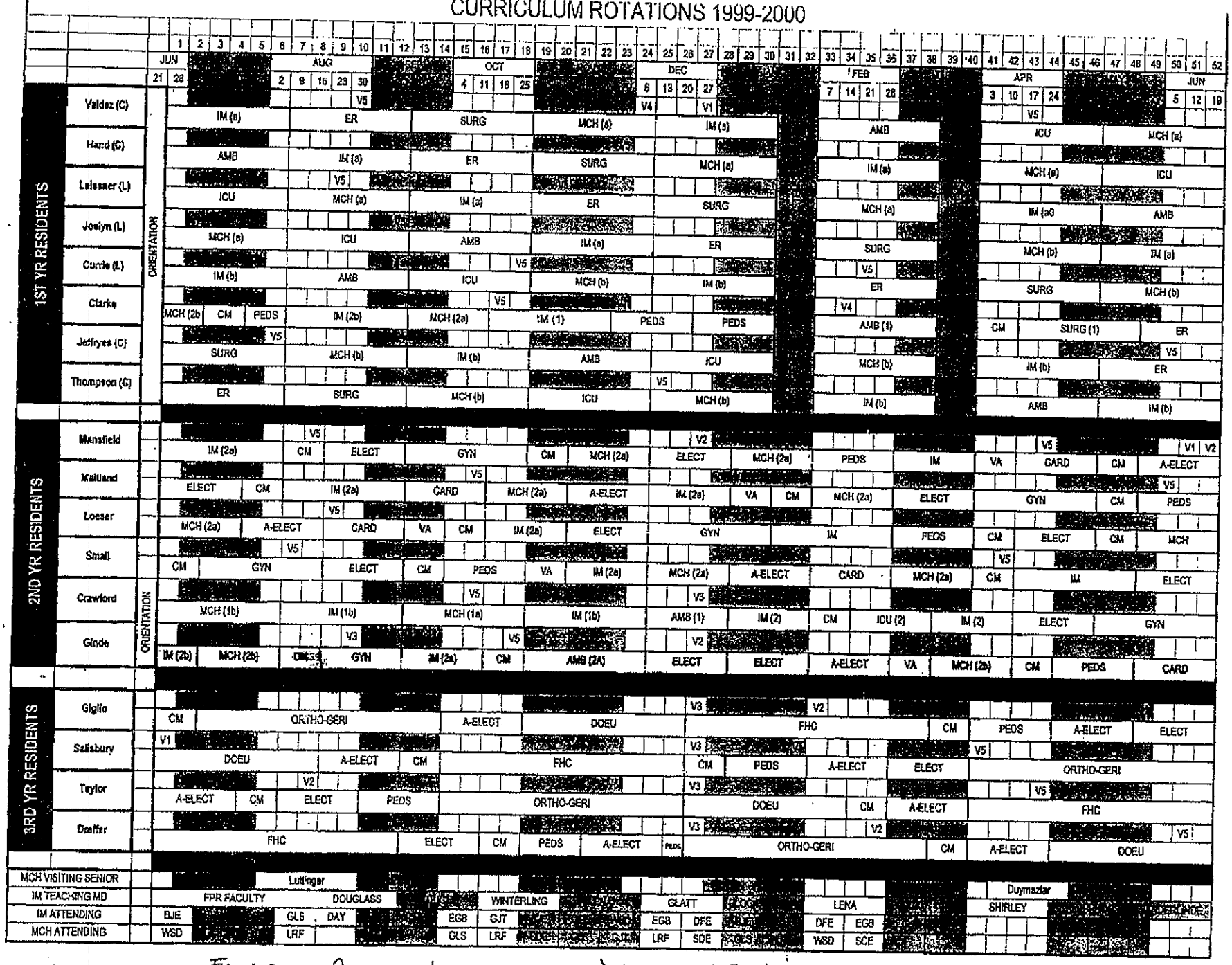
07/04/2000
09/04/2000
11/23/2000
12/25/2000
01/01/2001
05/29/2001

MINOR HOLIDAYS

10/09/2000
11/24/2000
01/15/2001
02/19/2001
05/28/2001

Revised 06/27/2000 3:01 PM

CURRICULUM ROTATIONS 1999-2000



FAMPRAC \ Curriculum 1999-2000\Resident Rotation Sched 99-00 REV A

Revised ~~03/31/2000~~

F\ ation Credentials Verification Service (FC\

Federation Place, P.O. Box 619850, Dallas, TX 75261-9850
Tel: (817) 868-5000 Fax: (817) 868-5099

Verification of Postgraduate Medical Education

Institution: **Highland Family Medicine**

Address: Department of Family Practice
Rochester, NY 14620-2399

Attention: Program Director

Affiliated University: UNIVERSITY OF ROCHESTER

Verification For:

Name: **Ginde, Savita Yeshawant**
SSN:
DOB:

Individual's Name on Record (If different from above):

RECEIVED
AUG 08 2005
BY:

Program Participation:

Important:
Report incomplete postgraduate years (PGY) separate from those that were successfully completed

If the postgraduate year is currently in progress report the expected completion date in the "To" field.

Report Internships, Residencies and Fellowships separately

Use one section per Department/Specialty. If the Department/Specialty is rotating or transitional please provide a schedule of rotations

PGY: _____
___ Internship
___ Residency
___ Chief Residency
X Fellowship
___ Research

Specialty/Subspecialty: Women's Health
From: 07/01/2001 To: 09/30/2003
Successfully Completed?: ✓ Yes ___ No ___ In Progress
Accredited by: __ ACGME __ AOA __ LCGME __ RSC __ CFPC __ RCPSC __ APPAP ✓ None of these

PGY: _____
___ Internship
___ Residency
___ Chief Residency
___ Fellowship
___ Research

Specialty/Subspecialty: _____
From: ___/___/_____ To: ___/___/_____
Successfully Completed?: ___ Yes ___ No ___ In Progress
Accredited by: __ ACGME __ AOA __ LCGME __ RSC __ CFPC __ RCPSC __ APPAP __ None of these

PGY: _____
___ Internship
___ Residency
___ Chief Residency
___ Fellowship
___ Research

Specialty/Subspecialty: _____
From: ___/___/_____ To: ___/___/_____
Successfully Completed?: ___ Yes ___ No ___ In Progress
Accredited by: __ ACGME __ AOA __ LCGME __ RSC __ CFPC __ RCPSC __ APPAP __ None of these

Unusual Circumstances:

Circle the correct response. Omitted responses require written explanation

If necessary, you may continue your explanation on a separate sheet of paper.

SEAL VERIFIED

Did this individual ever take a leave of absence or break from his/her training?	Yes (No)
Was this individual ever placed on probation?	Yes (No)
Was this individual ever disciplined or placed under investigation?	Yes (No)
Were any negative reports ever filed by instructors?	Yes (No)
Were any limitations or special requirements placed upon this individual because of questions of academic incompetence, disciplinary problems or any other reason?	Yes (No)

Please explain any "Yes" response from above:

Certification:

Affix your institutional seal in this space. If no seal is available you must have this form notarized

Completion of the following is certification that the information above is an accurate account of this individual's records and is true and correct. This section MUST be signed by the Program Director (M.D./D.O. only).

Name: Thomas L. Campbell, MD Signature: T. L. Campbell

Title: William Rocktaschel Chair + Professor of Family Medicine Date of Signature: 8/1/05

Tel: 585-279-4800 Fax: 585-442-8319 E-Mail: tom_campbell@urmc.rochester.edu

NEW YORK 'ALL-PURPOSE' ACKNOWLEDGMENT REAL PROPERTY LAW §309-a

State of New York
County of Monroe } SS

On the 1 (Day) day of August (Month) in the year 2005 (Year)
before me, the undersigned, a Notary Public in and for said state, personally appeared Thomas L. Campbell (Name of Signer), personally known to me or proved to me on the basis of satisfactory evidence to be the individual(s) whose name(s) is (are) subscribed to the within instrument and acknowledged to me that he/she/they executed the same in his/her/their capacity(ies), and that by his/her/their signature(s) on the instrument, the individual(s), or the person upon behalf of which the individual(s) acted, executed the instrument.

SEAL VERIFIED

EILEEN M. WEAVER
Notary Public, State of New York
No. 01WE5034318
Qualified in Monroe County
Commission Expires: December 12, 2006

Eileen M Weaver
Signature of Notary Public

OPTIONAL

Though the information in this section is not required by law, it may prove valuable to persons relying on the document and could prevent fraudulent removal and reattachment of this form to another document.

RIGHT THUMBPRINT OF SIGNER
Top of thumb here

Description of Attached Document Savita Yeshawant Ginde, MD
Title or Type of Document: Verification of Postgraduate Medical Education
Document Date: 8/1/05 Number of Pages: 3
Signer(s) Other Than Named Above: _____

PROVIDED BY APPLICANT

Applicant: Print your complete last name: GINDE

12. Postgraduate Medical Education

You are provided one page in this application to report this information.

Use one page per institution. If you attended more than one institution, you must make a photocopy(ies) of this page.

IMPORTANT

List training in chronological order.

Report incomplete postgraduate years (PGY) separate from those that were successfully completed.

Use one (1) page per institution. This page represents 3 of 3 institution(s).

HIGHLAND HOSPITAL

Complete name of hospitals where training was conducted (do not abbreviate).

UNIVERSITY OF ROCHESTER SCHOOL OF MEDICINE AND DENTISTRY

Complete name of affiliated university or college (do not abbreviate).

601 ELMWOOD AVENUE

Address line 1

Address line 2

ROCHESTER — City

NY — State/Province

USA — Country

14642 — ZIP/Postal Code

PGY: 4

☐ Internship ☐ Residency ☐ Chief Residency ☑ Fellowship ☐ Research

FAMILY PLANNING — Specialty/subspecialty

From: 07 (Month) 2001 (Year) To: 06 (Month) 2002 (Year)

Successfully Completed? ☑ Yes ☐ No ☐ In progress

PGY: 5

☐ Internship ☐ Residency ☐ Chief Residency ☑ Fellowship ☐ Research

FAMILY PLANNING — Specialty/subspecialty

From: 07 (Month) 2002 (Year) To: 09 (Month) 2003 (Year)

Successfully Completed? ☑ Yes ☐ No ☐ In progress

PGY: ____

☐ Internship ☐ Residency ☐ Chief Residency ☐ Fellowship ☐ Research

Specialty/subspecialty

From: (Month) (Year) To: (Month) (Year)

Successfully Completed? ☐ Yes ☐ No ☐ In progress

PGY: ____

☐ Internship ☐ Residency ☐ Chief Residency ☐ Fellowship ☐ Research

Specialty/subspecialty

From: (Month) (Year) To: (Month) (Year)

Successfully Completed? ☐ Yes ☐ No ☐ In progress

Unusual Circumstances (circle Yes or No):

Did you take a leave(s) of absence or break(s) from your medical education? Yes (No)

Were you ever placed on probation? Yes (No)

Were you ever disciplined or placed under investigation? Yes (No)

Were any negative reports ever filed against you? Yes (No)

Were any limitations or special requirements imposed on you because of academic incompetence, disciplinary problems, or for any other reason? Yes (No)

Please explain any "yes" responses from above:

Section V

Examination History/Score Transcripts

USMLE
United States Medical Licensing Examination™

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 : 07/08/2005

Recipient:
Federation Credentials Verification Service
ATTN: New Mexico

Packet ID: 9437

Examinee ID#:

Examinee: Ginde, Savita Yeshawant
Alt Name(s): Ginde, Savita

Date of Birth:

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 Total	Three-Digit Score MP	Two-Digit Score Total	Two-Digit Score MP	Comments
09/27/1995	Pass	179	176	75	75	
06/14/1995	Fail	175	176	74	75	

USMLE STEP 2

Clinical Knowledge (CK)

Test Date	Pass/Fail	Three-Digit Score Total	Three-Digit Score MP	Two-Digit Score Total	Two-Digit Score MP	Comments
03/03/1997	Pass	170	170	75	75	

USMLE STEP 3

Test Date	Pass/Fail	Three-Digit Score Total	Three-Digit Score MP	Two-Digit Score Total	Two-Digit Score MP	Comments
OHIO 09/25/2000	Pass	197	177	81	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.

Patent 5836874

SHS v5.00.01 15868185 Page 1 of 1 TouchSafe®

SEE REVERSE SIDE FOR EXPLANATION OF INFORMATION REPORTED ABOVE.

New Mexico Medical Board
2055 S. Pacheco St.
Building 400
Santa Fe, NM 87505
(505) 476-7220

WORK EXPERIENCE VERIFICATION

I am applying for a medical license in the State of New Mexico The New Mexico Medical Board requires this form to be completed by the Chief of Staff or facility's administrative staff. I hereby authorize release of all information in your files, favorable or otherwise, DIRECTLY to the NMMB, **2055 S. Pacheco St., Bldg. 400, Santa Fe, NM 87505**.

Savita Y. Gande
Applicant Name

950 Broadway
Address

Denver, CO 80203
City/State/Zip

Applicant Signature

10/03 → Present
*Dates of Privilege/Employment mm/yy to mm/yy (must be provided)

(303) 813-7630
Telephone Number

The section below should be completed by the chief of staff or facility's administrative staff.
Letters of Recommendation are ***NOT*** accepted in lieu of this form.

Ann Hetrick, RNC
Type or Print Name of person completing this form

Director of Quality Management
Title

Planned Parenthood of the Rocky Mountains
Name of Institution

950 Broadway
Address

Denver, CO 80203
City / State / Zip

1 This evaluation is based on: ✓ Observation of applicant ___ Review of personnel file

2. In your estimation, is there any reason why this applicant should not be licensed to practice? ___Yes ✓No

3 To your knowledge, is there any mental or physical reason why this applicant should not be licensed? ___Yes ✓No

4 To your knowledge, is there any derogatory/disciplinary information regarding this applicant? ___Yes ✓No

5 Are the dates of privilege/employment provided by the applicant on this form accurate?* ✓Yes ___No

***If not, please provide correct dates**: Beginning _____ (Month/Year) Ending _____ (Month/Year)

If you answered "YES" to questions 2, 3, and/or 4, please provide a written explanation and/or any supporting documentation that may be relevant.

KELLIE R. BLACK NOTARY PUBLIC STATE OF COLORADO
Please affix hospital or notary seal here
My Commission Expires 09/12/2007

Ann Hetrick, RNC — Ann Hetrick, RNC — 1/10/06
Printed name of person completing this form — Signature — Date

Kellie Black — 1/10/06
Signature of Notary (if applicable) — Date

My commission expires: 9/12/2007

Please note on this form if there is no hospital or notary seal available.
Please return this form directly to the address above
Thank you for your cooperation

Revised 10/04

400 –

RECEIVED
25429
MAY 25 2006
NM BOARD OF MEDICAL EXAMINERS

New Mexico Medical Board
2055 S Pacheco Street
Building 400
Santa Fe New Mexico 87505
Voice 505-476-7227 fax 505-476-7233 website http://nmmb state.nm.us/

Triennial Renewal 6/30/2006 – 7/01/2009 Renewal Fee $400

Current Information

Gender: ☐ Male ☒ Female License # MD2006-0025 DEA#:

Preferred Mailing Address:	Please make corrections below.
Savita Yeshawant Ginde, MD 950 Broadway Denver CO 80203	
Business Phone: 3038137630	
Fax #:	
E-Mail Address:	
Business Address:	
950 Broadway	
Denver CO 80203	

NM Physician Assistant(s) currently approved and registered with the Board under your supervision:

Your license will expire June 30, 2006

I request the following change in license status: (Check only one)

☒ **Active Status/$400 Fee:**

☐ **Inactive Status/$25 Fee:** I am not practicing medicine in New Mexico. I understand that a license in inactive status does not require payment of the triennial renewal fee or compliance with CME requirements. I further understand that I may not engage in the practice of medicine or write prescriptions as long as my license is inactive.

☐ **Retired Status/No Fee:** I am retired and no longer practice medicine in New Mexico I understand that I may not engage in the practice of medicine or write prescriptions

☐ **Voluntary Lapsed Status/No Fee:** I choose not to renew my New Mexico medical license. I understand that I may not engage in the practice of medicine or write prescriptions

LATE RENEWALS
All Renewals postmarked after July 1, 2006 will require documentation of 75 CME credit hours
Renewals postmarked after July 1, 2006 and before August 15, 2006, require payment of $500
Renewals postmarked after August 15, 2006 and before October 1, 2006 require payment of $550
YOUR LICENSE WILL BE SUSPENDED AFTER OCTOBER 1, 2006 IF IT IS NOT RENEWED!

Do not submit CME documentation unless you are renewing after JULY 1, 2006.

Payment Information: Fee Submitted $400.00

Visa___ Master Card___ Check X Money Order___

Credit Card No_____ Expiration Date_____

1. Since your last renewal, has your professional liability coverage been terminated by action of the insurance company? ☐ Yes ☒ No

2. Since your last renewal, have you been denied professional liability insurance coverage? ☐ Yes ☒ No

3. Since your last renewal, has your professional liability carrier excluded any specific procedures from your coverage? ☐ Yes ☐ No

4. Since your last renewal, have you been denied membership or renewal thereof, or been subject to disciplinary action in any professional organization? ☐ Yes ☒ No

5. Since your last renewal, have you been excluded from or sanctioned by Medicare and/or Medicaid? ☐ Yes ☒ No

6. Since your last renewal, have you been charged with, arrested for, convicted of, or pled no contest to a misdemeanor or felony, or have you been named as a defendant in any criminal proceedings or subject to investigation by a governmental entity that could result in sanctions or licensure adverse actions? ☐ Yes ☒ No

7. Since your last renewal, have you been named in any formal requests for corrective actions filed by any healthcare entity where you have had an appointment (a request which could result in either formal or informal proceedings)? ☐ Yes ☒ No

8. Since your last renewal, have your privileges at any healthcare entity been voluntarily or involuntarily suspended, restricted, diminished, revoked or not renewed, except for medical records? ☐ Yes ☒ No

9. Since your last renewal, have you resigned from a healthcare entity to avoid investigation, modification, suspension, or termination of privileges? ☐ Yes ☒ No

10. Since your last renewal, has your application for licensure in any jurisdiction been investigated or denied, or are any current applications pending investigation or being challenged? ☐ Yes ☒ No

11. Since your last renewal, has your license to practice in any jurisdiction been investigated, voluntarily or involuntarily limited, suspended, revoked, denied or are any currently held licenses pending investigation or being challenged? ☐ Yes ☒ No

12. Since your last renewal, have any complaints been filed against you with any licensing agency? ☐ Yes ☒ No

13. Since your last renewal, have you been notified to appear before any licensing agency for a hearing or complaint of any nature? ☐ Yes ☒ No

14. Since your last renewal, has your DEA or Controlled Substance license in any jurisdiction been investigated, voluntarily or involuntarily limited (stipulations), suspended, revoked, restricted, or are there currently challenges to any of these items? ☐ Yes ☒ No

15. Since your last renewal, have you been involved in a settlement, medical malpractice claim or suit, or have you received written notice of intent to file such a suit? If yes, please provide the following information for each claim or suit. Please type on a separate sheet of paper for each case.

- Name, age, sex of patient/claimant.
- Date(s) and type of treatment and/or surgery, which led to the allegations against you
- Nature of allegations in claims/suits. Specify whether a suit was ever filed
- Names of other practitioners and hospital, if any, involved in claims or suit.
- Disposition or current status of claim or suit (be specific).
- Name of insurance carrier defending you
- Name of defense attorney.

☐ Yes ☒ No

16. Have you been treated for mental or significant medical illness during the past five years? If yes, please have your treating physician provide the NM Medical Board with a letter regarding your diagnosis and treatment. ☐ Yes ☒ No

17. Have you had personal or legal problems with narcotics, alcohol or other dangerous drugs during the past 5 years? (If you are currently a voluntary participant in a Board approved monitoring program you may answer "no"). ☐ Yes ☒ No

18. Are you currently more than a month in arrears in court-ordered child support payments in New Mexico or in any other state? ☐ Yes ☒ No

19. Since your last renewal, have you been reported to the National Practitioner Data Bank? ☐ Yes ☒ No

20. I certify that I have completed a minimum of 75 AMA Category I hours of Continuing Medical Education as required by 16.10 4 NMAC ☒ Yes ☐ No

If you answered "Yes" to any of the above, please provide a complete written explanation with this application.

Practice Information:

1. Do you practice full-time in New Mexico? ☐ Yes ☒ No
   If yes, estimate the % of time you spend in the following areas (total = 100): Direct patient care _____%
   Administration _____%; Teaching _____%; Research _____%; other _____%
2. Do you practice part-time in New Mexico? ☐ Yes ☒ No
   If yes, estimate the % of time you spend in the following areas (total = <100): Direct patient care _____%
   Administration _____%; Teaching _____%; Research _____%; other _____%
3. Are you retired but maintain an active license? ☐ Yes ☒ No
4. Please indicate number of work location(s)
   Office(s): 1 2 3 4 5 6 (≥7) Clinic(s): 1 2 3 4 5 6 ≥7 Hospital(s): 1 2 3 4 ≥5
   City(s)/Town(s): 1 2 3 4 (≥5) Rural: 1 2 3 4 ≥5

Physician Practice Information data will not be identified to any other person or institution.

☐ I have not completed a minimum of 75 CME hours as required by 16.10.4 NMAC and I am requesting an emergency deferral, of up to 90 days, as allowed under 16.10.4.15 NMAC. I understand I will be assessed a late renewal penalty fee of $100 between 7/1/06-8/15/06 or $150 between 8/16/06-10/1/06 if my CME is not completed and submitted to the Board by July1.

[signature] MD April 27, 2006

Signature of Licensee (Signature stamp is not accepted) **Date**

By signing above you are certifying, under penalty of perjury, that all information on this form is currently accurate.

****Your Triennial Renewal will be returned if you DO NOT:**

- **Enclose correct renewal fee**
- **Indicate fee to be charged to credit card**
- **Sign check**
- ✓ **Sign and date renewal form**
- ✓ **Answer all questions and provide complete written explanations to any "yes" answers to questions 1-20**
- ✓ **Indicate CME status**
- ✓ **Submit acceptable documentation of CME** ***(if renewing late)***
- ✓ **Complete backside of renewal**

New Mexico Medical Board
2055 S Pacheco Street
Building 400
Santa Fe New Mexico 87505
Voice 505-476-7227 fax 505-476-7233 website http://nmmb.state.nm.us/

Ref: 10/2012

Triennial Renewal 7/01/2009 – 7/01/2012 Renewal Fee $600

Current Information

Gender: ☐ Male ☑ Female License # MD2006-0025 DEA#:

Preferred Mailing Address:	Please make corrections below.
Savita Yeshawant Ginde, MD 7155 East 38th Avenue Denver CO 80207	SAVITA YESHWANT GINDE MD
Business Phone: 3038137630	
Fax #: 3038137673 fax	
E-Mail Address:	
Business Address:	
7155 East 38th Avenue	
Denver CO 80207	

NM Physician Assistant(s) currently approved and registered with the Board under your supervision:

Your license will expire July 1, 2009

I request the following change in license status: (Check only one)

☑ **Active Status/$600 Fee:**

☐ **Inactive Status/$25 Fee:** I am not practicing medicine in New Mexico. I understand that a license in inactive status does not require payment of the triennial renewal fee or compliance with CME requirements. I further understand that I may not engage in the practice of medicine or write prescriptions as long as my license is inactive.

☐ **Retired Status/No Fee:** I am retired and no longer practice medicine in New Mexico. I understand that I may not engage in the practice of medicine or write prescriptions.

☐ **Voluntary Lapsed Status/No Fee:** I choose not to renew my New Mexico medical license. I understand that I may not engage in the practice of medicine or write prescriptions.

LATE RENEWALS
All Renewals postmarked after July 1, 2009 will require documentation of 75 CME credit hours.
Renewals postmarked after July 1, 2009 and before August 15, 2009, require payment of $700.
Renewals postmarked after August 15, 2009 and before October 1, 2009 require payment of $800.
YOUR LICENSE WILL BE SUSPENDED AFTER OCTOBER 1, 2009 IF IT IS NOT RENEWED!

Do not submit CME documentation unless you are renewing after JULY 1, 2009.

PAYMENT INFORMATION PAGE ATTACHED

ALL QUESTIONS MUST BE ANSWERED

1. Since your last renewal has your professional liability coverage been terminated by action of the insurance company except as a result of the company ceasing to offer insurance to physicians?	☐ Yes	☑ No
2. Since your last renewal have you been denied professional liability insurance coverage?	☐ Yes	☑ No
3. Since your last renewal has your professional liability carrier excluded any specific procedures from your coverage?	☐ Yes	☑ No
4. Since your last renewal have you been denied membership or renewal thereof, or been subject to disciplinary action in any professional organization?	☐ Yes	☑ No
5. Since your last renewal have you been excluded from or sanctioned by Medicare and/or Medicaid?	☐ Yes	☑ No
6. Have you ever been arrested? If so explain the circumstance, regardless of the outcome (i.e. expunged, dismissed, sealed, vacated).	☐ Yes	☑ No
7. Have you ever been named as a defendant in any criminal proceedings?	☐ Yes	☑ No
8. Have you ever been subject to investigation by a governmental entity or Board that either could have resulted or did result in licensure sanction or other adverse actions, irrespective of the outcome?	☐ Yes	☑ No
9. Since your last renewal have you been named in any formal requests for corrective actions filed by any healthcare entity where you have had an appointment (a request which could result in either formal or informal proceedings).	☐ Yes	☑ No
10. a. Since your last renewal have your privileges at any healthcare entity been voluntarily or involuntarily suspended, restricted, diminished, revoked, surrendered, or not renewed, except for medical records delinquency?	☐ Yes	☑ No
b. Since your last renewal have you agreed not to exercise your clinical privileges while under investigation?	☐ Yes	☑ No
11. Since your last renewal have you resigned from a healthcare entity to avoid modification, suspension, or termination of privileges, or while under investigation?	☐ Yes	☑ No
12. a. Since your last renewal has your application for licensure or license to practice in any jurisdiction been investigated, voluntarily or involuntarily limited, suspended, revoked, surrendered or denied?	☐ Yes	☑ No
b. Since your last renewal are any currently held licenses pending investigation or being challenged?	☐ Yes	☑ No
13. Since your last renewal have you been notified to appear before any licensing agency for a hearing or complaint of any nature?	☐ Yes	☑ No
14. Since your last renewal has your federal or state narcotics registration certificate in any jurisdiction been voluntarily or involuntarily limited (stipulations), suspended, revoked, restricted, or are there currently challenges to any of these items?	☐ Yes	☑ No
15. Since your last renewal have you been involved in a settlement, medical malpractice claim or suit, or have you received written notice of intent to file such a suit? If yes, please provide the following information on the attached Malpractice History form for each case: Name, age, sex of patient/claimant. • Date(s) and type of treatment and/or surgery, which led to the allegations against you. • Nature of allegations in claims/suits. Specify whether a suit was ever filed. • Names of other practitioners and hospital, if any, involved in claims or suit. • Disposition or current status of claim or suit (be specific). • Name of insurance carrier defending you. • Name of defense attorney.	☐ Yes	☑ No
16. Since your last renewal have you been reported to the National Practitioner Data Bank?	☐ Yes	☑ No
17. Are you now, or were you in the past, addicted to, abusive of, or in treatment for abuse of any controlled substances, habit-forming drugs, illegal drugs, prescription medication or alcohol?	☐ Yes	☑ No
18. Since your last renewal have you had any physical injury or disease, or mental illness or impairment, which you are currently under treatment for or could reasonably be expected to affect your on-going ability to practice medicine safely and competently? If yes, please have your treating physician send the NM Medical Board a letter regarding your diagnosis and treatment.	☐ Yes	☑ No
19. a. Are you currently ABMS Certified?	☑ Yes	☐
b. Do you hold lifetime certification?	☐ Yes	☑ No
c. Do you hold time limited certification?	☑ Yes	☐
20. I certify that I have completed a minimum of 75 AMA Category 1 hours of Continuing Medical Education as required by 16.10.4 NMAC?	☑ Yes	☐

If you answered "Yes" to any of the above questions 1-18, please provide a complete written explanation with this application.

Jaime Chace, MD

QUESTION ID	QUESTION TEXT	ANSWER	CREATE DATE	UPDATE DATE
1.	Since your last renewal has your professional liability coverage been terminated by action of the insurance company except as a result of the comp	N		5/31/2012
2.	Since your last renewal have you been denied professional liability insurance coverage?	N		5/31/2012
3.	Since your last renewal has your professional liability carrier excluded any specific procedures from your coverage?	N		5/31/2012
4.	Since your last renewal have you been denied membership or renewal thereof, or been subject to disciplinary action in any professional organizatic	N		5/31/2012
5.	Since your last renewal have you been excluded from or sanctioned by Medicare and/or Medicaid?	N		5/31/2012
6.	Since your last renewal, have you been arrested? If so explain the circumstance, regardless of the outcome (i.e. expunged, dismissed, sealed, vacat	N		5/31/2012
7.	Since your last renewal, have you been named as a defendant in any criminal proceedings?	N		5/31/2012
8.	Since your last renewal, have you been subject to investigation by a governmental entity or Board that either could have resulted or did result in lic	N		5/31/2012
9.	Since your last renewal have you been named in any formal requests for corrective actions filed by any healthcare entity where you have had an ap	N		5/31/2012
10.	a. Since your last renewal have your privileges at any healthcare entity been voluntarily or involuntarily suspended, restricted, diminished, revoke	N		5/31/2012
10.	b. Since your last renewal have you agreed not to exercise your clinical privileges while under investigation?	N		5/31/2012
11.	Since your last renewal have you resigned from a healthcare entity to avoid modification, suspension, or termination of privileges, or while under	N		5/31/2012
12.	a. Since your last renewal has your application for licensure or license to practice in any jurisdiction been investigated, voluntarily or involuntaril	N		5/31/2012
12.	b. Are any currently held licenses pending investigation or being challenged?	N		5/31/2012
13.	Since your last renewal have you been notified to appear before any licensing agency for a hearing or complaint of any nature?	N		5/31/2012
14.	Since your last renewal has your federal or state narcotics registration certificate in any jurisdiction been voluntarily or involuntarily limited (stipu	N		5/31/2012
15.	Since your last renewal have you been involved in a settlement, medical malpractice claim or suit, or have you ever received written notice of inte	N		5/31/2012
16.	Since your last renewal have you been reported to the National Practitioner Data Bank?	N		5/31/2012
17.	Are you now, or were you in the past, addicted to, abusive of, or in treatment for abuse of any controlled substances, habit-forming drugs, illegal	N		5/31/2012
18.	In the five (5) years prior to this application, have you had any physical injury or disease, or mental illness or impairment, which you are currentl	N		5/31/2012
19.	I certify that I have completed a minimum of 75 AMA Category I hours of Continuing Medical Education as required by 16.10.4 NMAC?	Y		5/31/2012
20.	Are you ABMS (American Board of Medical Specialties) Board Certified?	Y		5/31/2012
21.	If yes do you hold Lifetime Certification?	N		5/31/2012
22.	If yes do you hold Time Limited Certification?	Y		5/31/2012

NMMB 2012 CME AUDIT FORM

REQUIRED INFORMATION
PLEASE PRINT

***NAME:** SAVITA Y. GINDE ***LICENSE NUMBER:** MD 2006-002

***SPECIALTY:** FAMILY MEDICINE

***SUB-SPECIALTIES:** FAMILY PLANNING

***ARE YOU AMERICAN BOARD OF MEDICAL SPECIALTIES (ABMS) CERTIFIED?** YES ✓ NO

***IF YES, IS THE CERTIFICATION TIME LIMITED OR LIFETIME?** Time Limited to 10 years
last recertified 2011

Date	CME Course	Hours	Staff Use Only
	Please See Attached Spreadsheet		
	128+ (after 7/1/09)		

Savita Y. Ginde MD				
CME				
Course	Location	Dates	# Credits	
MeDC 5th Annual Update on Reproductive Health and Medical Leadership	Big Sky, MT	Feb 26 -Mar 1 2009	12.00	
UCSF Fellowship Fam Planning Psychosocial Issues in AB Care Workshop	San Francisco, CA	April 3-4 2009	12.50	
NAF 33rd Annual Meeting- Post-graduate Seminar	Portland, OR	April 26, 2009	6.00	
NAF 33rd Annual Meeting	Portland, OR	April 25-28, 2009	9.25	
American Society for Microbiology	Philadelphia, PA	May 17-21 2009	8.50	
ARHP/NMC Annual Meeting	Los Angeles, CA	Oct 1-3 2009	9.00	
NAF Risk Management Seminar	Denver, CO	Oct 18-19 2009	12.00	
Fellowship in Family Planning Leadership Conference	Chicago, IL	Nov 5-7 2009	10.00	
COEC student precepting		Jan 19-Feb 1 2009	80.00	Category 2 [student precepting]
MeDC 6th Annual Update on Reproductive Health and Medical Leadership	Utah	Feb 25-Feb 28 2010	12.00	
NAF 34th Annual Meeting	Philadelphia, PA	April 26-27 2010	12.00	
Education Testing Service LLC, Family Medicine Board Review	Las Vegas, NV	June 10-13 2010	42.50	
KCUMB student precepting		Mar-Jun 2010	280.00	Category 2 [student precepting]
NAF 2010 Risk Mgmt Seminar	Newport Beach, CA	Oct 17-18 2010	10.50	
AHEC Southern NV Safe Injection Practices	Online	October 18, 2010	2.00	
Medical Ethics Today: A CME Update Course #7E013	Online	November 22, 2010	2.00	
ASCCP Advanced Colposcopy & Lower Genital Tract Dermatology	Scottsdale, AZ	Dec 10-12 2010	19.25	
MeDC 7th Annual Update on Reproductive Health and Medical Leadership	Las Vegas, NV	March 10-13 2011	14.00	
NAF 35th Annual Meeting	Chicago, IL	April 11-12 2011	6.00	
The National Family Medicine Board Review Course	Dallas, TX	June 2-5 2011	41.00	
COEC Student Precepting	2-week rotations=80h; 4 week rotations 160h	12/2009 - 6/2011; 8 2-week precepting blocks = 640 precepting hours	640.00	Category 2 [student precepting]
NAF Risk Management Seminar 2011	New Orleans, LA	October 16-17 2011	13.00	
North American Forum on Family Planning 2011	Washington DC	Oct 21-24 2011	22.50	
MeDC 8th Annual Update on Reproductive Health and Medical Leadership	Snowbird, UT	Feb 24-27 2012	12.50	
National Procedures Institute Office-based Hysteroscopy & Hysteroscopic Sterilization	Snowbird, UT	February 23, 2012	8.50	
		2009 Total CME	79.25	
		2010 Total CME	100.25	
		2011 Total CME	96.50	
		2012 YTD CME	21.00	
		CME Total + 30h precepting	327.00	

The UNIVERSITY of VERMONT
Continuing Medical Education

The University of Vermont College of Medicine
certifies that

Savita Ginde, MD

has participated in the educational activity entitled

Update on Reproductive Health and Medical Leadership
5thAnnual Clinical Conference
February 26-March 1, 2009

The University of Vermont College of Medicine
is accredited by the Accreditation Council for Continuing Medical Education
to provide continuing medical education for physicians.

The University of Vermont designates this educational activity for a maximum of 12 AMA PRA Category 1 Credits™. Physicians should only claim credit commensurate with the extent of their participation in the activity.

12 Actual Credits Earned

Mary C. Gagné
Regional Program Coordinator

University of Vermont College of Medicine Continuing Medical Education 128 Lakeside Avenue, Suite 100 Burlington, VT 05401
Phone (802) 656-2292 Fax (802) 656-1925 Website: http://cme.uvm.edu

Office of Continuing Medical Education
School Of Medicine
University of California San Francisco
ACCME Provider Number: 0000302
San Francisco, California
(415) 476-5808
www.cme.ucsf.edu

Savita Y. Ginde, MD, MPH

Denver, CO 80207

Certificate of Attendance

This is to certify that

Savita Y. Ginde, MD, MPH

has participated in:

MMC09029: Psychosocial Issues in Abortion Care Workshop

April 3 - 4, 2009

Salon Room, Hotel Rex, San Francisco

This CME activity is approved for a maximum of
12.5 AMA PRA Category 1 Credit(s) ™.
I have earned 12.5 credits.

The University of California, San Francisco School of Medicine (UCSF) is accredited by the Accreditation Council for Continuing Medical Education to provide continuing medical education for physicians.

UCSF designates this educational activity for 12.5 Category 1 Credit(s) ™ toward the AMA Physician's Recognition Award. Physicians should only claim credit commensurate with the extent of their participation in the activity.

This CME activity meets the requirements under California Assembly Bill 1195, continuing education and cultural and linguistic competency.

CERTIFICATE OF PHYSICIAN ATTENDANCE

NATIONAL ABORTION FEDERATION

Post-Graduate Seminar
A Decade of Progress: What's New in Abortion Care

April 26, 2009 **Portland, Oregon**

The National Abortion Federation (NAF) is accredited by the Accreditation Council for Continuing Medical Education to sponsor continuing medical education for physicians. NAF designates this educational activity for a maximum of 6 AMA PRA Category 1 Credits.™ Physicians should only claim credit commensurate with the extent of their participation in the activity.

NAF certifies that Savita Ginde, MD

(Name of physician)

has participated in the educational activity titled "Post-Graduate Seminar: A Decade of Progress-What's New in Abortion Care" at the Hilton Portland on April 26, 2009, and is awarded 6 AMA PRA Category 1 Credits.™

The American College of Obstetricians and Gynecologists (ACOG) has assigned 6 cognate credits to this program. This activity has been reviewed and is acceptable for up to 6 Prescribed credits by the American Academy of Family Physicians.

Vicki Saporta
Vicki Saporta
President and CEO

Sally Burgess
Sally Burgess, MBA
Chair of the Board of Directors

CERTIFICATE OF PHYSICIAN ATTENDANCE

NATIONAL ABORTION FEDERATION

NAF's 33rd Annual Meeting
Reaching New Heights in Reproductive Health

April 27–28, 2009 **Portland, Oregon**

The National Abortion Federation (NAF) is accredited by the Accreditation Council for Continuing Medical Education to sponsor continuing medical education for physicians. NAF designates this educational activity for a maximum of 13 AMA PRA Category 1 Credits.™ Physicians should only claim credit commensurate with the extent of their participation in the activity.

NAF certifies that

Savita Ginde

~~(Name of physician)~~

Has participated in the educational activity titled "NAF's 33rd Annual Meeting" at the Hilton Portland on April 27–28, 2009, and is awarded _9.25____ AMA PRA Category 1 Credits.™

The American College of Obstetricians and Gynecologists (ACOG) has assigned 13 cognate credits to this program. This activity has been reviewed and is acceptable for up to 9.25 Prescribed credits by the American Academy of Family Physicians.

Vicki Saporta
President and CEO

Sally Burgess, MBA
Chair of the Board of Directors

AMERICAN SOCIETY FOR MICROBIOLOGY

ACCME ID#0000159
California ID# 0035
Florida ID#JP0000530

109TH General Meeting Philadelphia May 17-21, 2009

CertificateNumber:
877954C_U2451_A2926_O1_T1

PHYSICIAN PARTICPANT CERTIFICATE OF CREDIT

109th General Meeting
Sunday, May 17, 2009 - Thursday, May 21, 2009, Philadelphia, Pennsylvania

Date	Session Title	Time	Max. Credits Designated	Credits Awarded
5/18/2009	Hot Topics in Point-of-Care Microbiology	07 AM - 08 AM	1	1
5/18/2009	Novel Approaches for Microbial Detection and Identification in Clinical Microbiology	02 PM - 05 PM	2.5	1.5
5/19/2009	21st Century Communications: The Key to Successful Public Health Investigations	08 AM - 10 AM	2.5	2
5/19/2009	Infectious Agents through the Food Chain: Farm, Feed, and Food Handler	05 PM - 07 PM	1.5	1.5
5/20/2009	Why Do You Hurt the Ones You Love? - Factors Promoting the Evolution of Microbial Virulence	08 AM - 10 AM	2.5	2.5
			Total Credits	8.5

I [signature] attest that I have attended the sessions listed above 8/5/09
Signature Date

The ASMÃ‚Â attests that **Savita Ginde** has participated in the educational activity titled **109th General Meeting, Sunday, May 17, 2009 - Thursday, May 21, 2009** and is awarded **8.5** *AMA PRA Category 1 Credit(s)*™. This activity was designated for a maximum of 24.5 *AMA PRA Category 1 Credit(s)*™.

The American Society for Microbiology (ASM) is accredited by the Accreditation Council for Continuing Medical Education (ACCME) to provide continuing medical education for physicians. ASM takes responsibility for the content, quality, and scientific integrity of the General Meeting and Workshop programs.

**ASM Preconference Workshops offered additional opportunities to earn AMA PRA Category 1 Credits™ and those will also appear on this statement if the individual participated in a workshop that offered AMA PRA Category 1 Credits™.*

Association of Reproductive Health Professionals

The Association of Reproductive Health Professi

Savita Ginde MD, MPH

has participated in the educational acti

Reproductive Health 2009 in Los Ang
on October 1-3, 2009

and is awarded 9.0 *AMA PRA Category*

The Association of Reproductive Health Professionals (ARHP) is accredited by the Accreditation Council for Continuing Medical Education to sponsor continuing medical education for physicians.

Physicians should only claim credit commensurate with the extent of their participation in this activity.

This activity was designated for 14.5 *AMA PRA Category 1 Credits™*.

Eve Espey, MD, MPH
Education Chair, ARHP
October 27, 2009

Association of Reproductive Health Professionals (ARHP)
1901 L Street, NW, Suite 300 | Washington, DC 20036
Phone: (202) 466-3825 E-mail: arhp@arhp.org Web: www.arhp.org

Ginde, Savita

From: Allison Tombros Korman [atombros@ARHP.org]
Sent: Tuesday, October 27, 2009 1:02 PM
To: Ginde, Savita
Subject: CE Certificate: Reproductive Health 2009
Follow Up Flag: Follow up
Flag Status: Red

Dear Savita Ginde,

Thank you for attending *Reproductive Health 2009*. Your continuing education certificate is below. If you have any questions about your certificate, please contact our education department at (202) 466-3825 or email me at atombros@arhp.org.

Please save the date for *Reproductive Health 2010*, September 22-25 in Atlanta, Georgia. We hope to see you there!

Sincerely,

Allison Tombros Korman
Associate Director of Education, ARHP

PHYSICIAN CME CERTIFICATE

NATIONAL ABORTION FEDERATION

2009 Risk Management Seminar

October 18–19, 2009 **Denver, Colorado**

The National Abortion Federation (NAF) is accredited by the Accreditation Council for Continuing Medical Education to sponsor continuing medical education for physicians. NAF designates this educational activity for a maximum of 12 AMA PRA Category 1 Credits.™ Physicians should only claim credit commensurate with the extent of their participation in the activity.

NAF certifies that

SAVITA Y EINDE

(Name of physician)

Has participated in the educational activity titled "NAF's 2009 Risk Management Seminar" in Denver, Colorado on October 18–19, 2009, and is awarded 12 AMA PRA Category 1 Credits.™

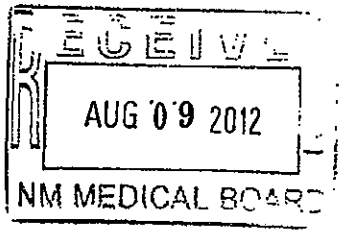
The American College of Obstetricians and Gynecologists (ACOG) has assigned 12 cognate credits to this program. This activity has been reviewed and is acceptable for up to 12 Prescribed credits by the American Academy of Family Physicians.

RECEIVED
AUG 09 2012
MEDICAL BOARD

Vicki Saporta
President and CEO

Sally Burgess, MBA
President, Board of Directors

Office of Continuing Medical Education
School Of Medicine
University of California San Francisco
ACCME Provider Number: 0000302
San Francisco, California
(415) 476-5808
www.cme.ucsf.edu



Savita Y. Ginde, MD, MPH

Denver, CO 80207

Certificate of Attendance

This is to certify that

Savita Y. Ginde, MD, MPH

has participated in:

MMC10015: Fellowship in Family Planning Leadership Workshop

November 5 - 7, 2009

Hotel Affinia, Chicago

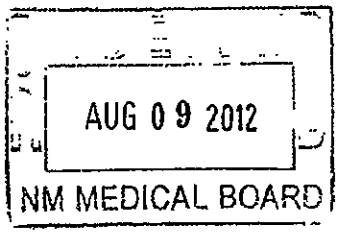
This CME activity is approved for a maximum of
17 AMA PRA Category 1 Credit(s) ™.
I have earned 10 credits.

The University of California, San Francisco School of Medicine (UCSF) is accredited by the Accreditation Council for Continuing Medical Education to provide continuing medical education for physicians.

UCSF designates this educational activity for 17 Category 1 Credit(s) ™ toward the AMA Physician's Recognition Award. Physicians should only claim credit commensurate with the extent of their participation in the activity.

This CME activity meets the requirements under California Assembly Bill 1195, continuing education and cultural and linguistic competency.

COLORADO OSTEOPATHIC EDUCATION CENTER



November 3, 2009

TO: Savita Ginde, MD

FROM: Ian R. Levenson, D.O., FACOFP
Chair, Colorado Osteopathic Education Center

RE: CME Credits for Precepting COEC students from July 1, 2007 – June 30, 2009

I appreciate your participation in the educational program of the Colorado Osteopathic Education Center (COEC). Your participation is what makes the program as successful as it is.

You are eligible for CME credits in AMA PRA Category 2 activities (precepting students) for serving as a preceptor in this program. The enclosed documentation is a summary of the students you have precepted over the past two years and can be used to apply for credit with the AMA.

Without your support COEC would not exist and none of this could be accomplished. Again, thank you for your interest in maintaining our Osteopathic medical education program.

encl.

8401 S. Chambers Road, Parker, CO 80134 Ph: 720-874-2456/7 Fax: 303-322-1956
~~600 South Cherry Street, Suite 510, Denver, Colorado 80246·303-322-1752·Fax 303-322-1956~~
A Branch of the Colorado Society of Osteopathic Medicine www.ColoradoDO.org

COLORADO OSTEOPATHIC EDUCATION CENTER

8401 S. Chambers Rd. • Parker, Colorado • 80134 Ph: (720) 874-2456/7 • Fx: (303) 322-1956

Preceptor / Students

School Years: 2008 / 2010
From 7/1/2007 to 6/30/2009

Physician Ginde, Savita MD

Student	School	Class of	Rotation	Start	End
Cross, Brieanna	TUCOM	2009	Gyn	9/3/2007	9/16/2007
Webb, Kimberly	TUCOM	2008	OB/GYN	1/28/2008	2/10/2008
Grooms, Heather	KCOM	2008	Gyn	2/18/2008	3/14/2008
Mont, Meghan	KCOM	2008	Gyn	3/17/2008	4/11/2008
Tran, Diem	TUCOM	2009	Gyn	11/10/2008	11/23/2008
Geiger, Scott	TUCOM	2009	Gyn	1/19/2009	2/1/2009

Association of Reproductive Health Professionals

The Association of Reproductive Health Professionals certifies that

Savita Ginde, MD

has participated in the educational activity titled

MeDC 6th Annual Update on Reproductive Health and Medical Leadership (February 25-28, 2010)

and is awarded 12 hour(s) of *AMA PRA Category 1 Credit* ™

on June 9, 2010

The Association of Reproductive Health Professionals (ARHP) is accredited by the Accreditation Council for Continuing Medical Education to sponsor continuing medical education for physicians.

Physicians should only claim credit commensurate with the extent of their participation in this activity.

ARHP designates this continuing medical education activity for up to 12.0 hour(s) of *AMA PRA Category 1™* credit.

Eve Espey, MD
Education Chair, ARHP
6/9/2010

Association of Reproductive Health Professionals (ARHP)
1901 L Street, NW, Suite 300 | Washington, DC 20036
Phone: (202) 466-3825 E-mail: arhp@arhp.org Web: www.arhp.org

CERTIFICATE OF PHYSICIAN ATTENDANCE

naf NATIONAL ABORTION FEDERATION

NAF's 34th Annual Meeting
Liberty, Justice and Abortion

April 26-27, 2010 **Philadelphia, Pennsylvania**

The National Abortion Federation (NAF) is accredited by the Accreditation Council for Continuing Medical Education to sponsor continuing medical education for physicians. NAF designates this educational activity for a maximum of 12 AMA PRA Category 1 Credits™. Physicians should only claim credit commensurate with the extent of their participation in the activity.

NAF certifies that

Savita Y. Cinde

(Name of physician)

Has participated in the educational activity titled "NAF's 34th Annual Meeting" at the Loews in Philadelphia, PA, 2010 and is awarded 12 AMA PRA Category 1 Credits™.

The American College of Obstetricians and Gynecologists (ACOG) has assigned 12 cognate credits to this program. This activity has been reviewed and is acceptable for up to 12 Prescribed credits by the American Academy of Family Physicians.

Vicki Saporta
President and CEO

Sally Burgess, MBA
Chair of the Board of Directors

Educational Testing Consultants, LLC Family Medicine Board Review
June 10-13, 2010 – Las Vegas, NV.
Continuing Medical Education Verification and Certificate

Educational Testing Consultants, LLC certifies that:

Savita Y. Ginde MD MPH

(Please **PRINT your name** and M.D. or D.O.)

"The Educational Testing Consultants, LLC designates this educational activity for up to 42.50 Prescribed credits by the American Academy of Family Physicians. Physicians should only claim credit commensurate with the extent of their participation in the activity."

Ira Lubell, M.D., M.P.H., Medical Director

Date	Time and Hours Earned	Session	Hours attended (please circle one)	Total Hours Attended
Thursday June 10, 2010	7:00 am-11:00 am (up to 4 hours)	Emergent/Urgent Care	.50 1.0 1.5 2.0 2.5 3.0 3.5 **(4.0)**	4.0
Thursday June 10, 2010	12:00 pm-4:00 pm (up to 4 hours)	Orthopedics Sports Medicine	.50 1.0 1.5 2.0 2.5 3.0 3.5 **(4.0)**	4.0
Thursday June 10, 2010	4:00 pm-7:00 pm (up to 3 hours)	Endocrinology	.50 1.0 1.5 2.0 2.5 **(3.0)**	3.0
Friday June 11, 2010	7:00 am.- 11:00 am (up to 4 hours)	Neurology	.50 1.0 1.5 2.0 2.5 3.0 3.5 **(4.0)**	4.0
Friday June 11, 2010	12:00 pm-4:00 pm (up to 4 hours)	Pediatrics	.50 1.0 1.5 2.0 2.5 3.0 3.5 **(4.0)**	4.0
Friday June 11, 2010	4:00 pm-6:00 pm (up to 2 hours)	Dermatology	.50 1.0 1.5 **(2.0)**	2.0
Saturday June 12, 2010	7:00 am-12:00 pm (up to 5 hours)	Cardiology	.50 1.0 1.5 2.0 2.5 3.0 3.5 4.0 4.5 **(5.0)**	5.0
Saturday June 12, 2010	1:00 pm-4:00 pm (up to 3 hours)	Hematology Oncology	.50 1.0 1.5 2.0 2.5 **(3.0)**	3.0
Saturday June 12, 2010	4:00 pm-7:30 pm (up to 3.5 hours)	Pulmonary	.50 1.0 1.5 2.0 2.5 3.0 **(3.5)**	3.5
Sunday June 13, 2010	7:00 am-11:00 am (up to 4 hours)	Women's Health	.50 1.0 1.5 2.0 2.5 3.0 3.5 **(4.0)**	4.0
Sunday June 13, 2010	12:00 pm-4:00 pm (up to 4 hours)	Gastroenterology	.50 1.0 1.5 2.0 2.5 3.0 3.5 **(4.0)**	4.0
Sunday June 13, 2010	4:00 pm-6:00 pm (up to 2 hours)	Nephrology	.50 1.0 1.5 **(2.0)**	2.0

I verify that I have attended the above programs. Signature _____

Total hours from above 42.50

Note: Please use only <u>one</u> form for all of the sessions attended. Please fill in your name and return this form to the ETC, LLC Registration Desk. Credit not valid unless signed by conference attendee and ETC, LLC staff.

ETC, LLC Approval: _____

Please turn in the original and keep the copy for your records.

Thank you for attending!

KCUMB

1750 Independence Avenue
Kansas City, MO 64106-1453

NON-PROFIT ORG.
U.S. POSTAGE
PAID
KANSAS CITY, MO
PERMIT NO. 4647

RECEIVED
AUG 09 2012
NM MEDICAL BOARD

Dear Dr. Ginde ,M.D.,

Thank you for your dedication to teaching Kansas City University of Medicine and Biosciences students. In accordance with the American Medical Association's CME Submission Guidelines, you have earned 280 credits/Category 2 for the reporting period of Mar. - Jun. 2010. (Please note: The reporting period represents the date the completed clerkship evaluation was received by KCUMB, not the clerkship dates.)

If you have any questions, please contact us at 1-800-234-4746 ext. 2541.

********** MIXED AADC 500
Savita Y. Ginde ,M.D.

PHYSICIAN CME CERTIFICATE

NATIONAL ABORTION FEDERATION

2010 Risk Management Seminar

October 17–18, 2010 **Newport Beach, CA**

The National Abortion Federation (NAF) is accredited by the Accreditation Council for Continuing Medical Education to sponsor continuing medical education for physicians. NAF designates this educational activity for a maximum of 12 AMA PRA Category 1 Credits.™ Physicians should only claim credit commensurate with the extent of their participation in the activity.

NAF certifies that

Savita Y. Girde MD MPH

(Name of physician)

Has participated in the educational activity titled "NAF's 2010 Risk Management Seminar" in Newport Beach, California on October 17–18, 2010, and is awarded 10.5 AMA PRA Category 1 Credits.™

The American College of Obstetricians and Gynecologists (ACOG) has assigned 12 cognate credits to this program. This activity has been reviewed and is acceptable for up to 12.5 Prescribed credits by the American Academy of Family Physicians.

NM MEDICAL BOARD AUG 09 2012

Vicki Saporta
President and CEO

Cassing Hammond, MD
Chair, Board of Directors

AHEC

Better Health Through Education

Area Health Education Center of Southern Nevada

DOCUMENTATION OF ATTENDANCE

Title: Safe Injection Practices

Date: October 18, 2010

Area Health Education Center of Southern Nevada certifies that:

Participant's Name: Savita Ginde

License Number: _____

CME Approval Number: SNAHEC-CME-94

Romanna Ferriter, M.Ed., CHES
Associate Director of Professional Education
Area Health Education Center of Southern Nevada
3014 W. Charleston Blvd., Suite 150
Las Vegas, NV 89102

(702) 318-8452
Toll Free: (877) 318-2432
www.snahec.org

Area Health Education Center of Southern Nevada is accredited by the Nevada State Medical Association to provide continuing medical education for physicians.

Area Health Education Center of Southern Nevada designates this education activity for a maximum of 2.0 AMA APR Category 1 Credit(s). Physicians should only claim credit commensurate with the extent of their participation in the activity.

The University of Oklahoma
College of Medicine
IRWIN H. BROWN OFFICE OF CONTINUING MEDICAL EDUCATION

Certificate of Completion

The University of Oklahoma College of Medicine certifies that

Savita Ginde, MD

Has completed the educational activity titled:

Medical Ethics Today: A CME Update

Course #7E013

November 22, 2010

This activity was designated for the *AMA PRA Category 1 Credits*™ below:

2 *AMA PRA Category 1 Credits*™

This activity has been planned and implemented in accordance with the Essential Areas and Policies of the Accreditation Council for Continuing Medical Education through the joint sponsorship of the University of Oklahoma College of Medicine and TIV, Inc. The University of Oklahoma College of Medicine is accredited by the ACCME to provide continuing medical education for physicians.

The University of Oklahoma College of Medicine designates this educational activity for a maximum of 2 *AMA PRA Category 1 Credits*™. Physicians should claim only credit commensurate with the extent of their participation in the activity.

Margie Miller

Margie Miller
Director, Continuing Medical Education

American Society for Colposcopy and Cervical Pathology

Founded 1964

Devoted to the Study of Early Cervical Neoplasia

The American Society for Colposcopy and Cervical Pathology (ASCCP) certifies that

Savita Y. Ginde, MD, MPH

has participated in the educational activity titled *Advanced Colposcopy & Lower Genital Tract Dermatology* at the Westin Kierland Resort and Spa in Scottsdale, Arizona on December 10-12, 2010.

This activity, Advanced Colposcopy & Lower Genital Tract Dermatology, with a beginning date of December 10, 2010, has been reviewed and is acceptable for up to 21.75 Prescribed credits by the American Academy of Family Physicians.

Actual AAFP Prescribed credits this participant claims: 19.25

PRESIDENT

ASCCP
AMERICAN SOCIETY FOR COLPOSCOPY AND CERVICAL PATHOLOGY

EDUCATION CHAIR

The Association of Reproductive Health Professionals certifies that

Savita Ginde, MD

has participated in the live activity material titled

Medical Directors - 7th Annual Update on Reproductive Health and Medical Leadership Conference

and is awarded 14 hours of *AMA PRA Category 1 Credit(s)™*

On March 10, 2011 – March 13, 2011

The Association of Reproductive Health Professionals (ARHP) is accredited by the Accreditation Council for Continuing Medical Education to provide continuing medical education for physicians.

ARHP designates this live activity for a maximum of 14 *AMA PRA Category 1 Credit(s)™*

Physicians should only claim credit commensurate with the extent of their participation in this activity.

Sandy Worthington, MSN, WHNP, CNM
Education Co-Chair, ARHP

David Turok, MD
Education Co-Chair, ARHP

6/16/2011

Association of Reproductive Health Professionals (ARHP)
1901 L Street, NW, Suite 300 | Washington, DC 20036
Phone: (202) 466-3825 E-mail: arhp@arhp.org Web: www.arhp.org

CERTIFICATE OF PHYSICIAN ATTENDANCE

NATIONAL ABORTION FEDERATION

NAF's 35th Annual Meeting
Honoring Our Past, Charting Our Future

April 11-12, 2011 Chicago, Illinois

The National Abortion Federation (NAF) is accredited by the Accreditation Council for Continuing Medical Education to sponsor continuing medical education for physicians. NAF designates this educational activity for a maximum of 12 *AMA PRA Category 1 Credits.™* Physicians should only claim credit commensurate with the extent of their participation in the activity.

NAF certifies that

Savita Gitade

(Name of physician)

Has participated in the educational activity titled "NAF's 35th Annual Meeting," beginning on April 11, 2011, and is awarded

6 *AMA PRA Category 1 Credits.™*

The American College of Obstetricians and Gynecologists (ACOG) has assigned 12 cognate credits to this program. NAF's 35th Annual Meeting, with a start date of April 11, 2011, has been reviewed and is acceptable for up to 12 Prescribed credits by the American Academy of Family Physicians.

Vicki Saporta
President and CEO

Cassing Hammond, MD
Chair of the Board of Directors

Certificate For Continuing Medical Education

This certificate is to acknowledge that

Savita Y. Ginde M.D.

was a registrant at the **Dallas, TX** presentation of

The National Family Medicine Board Review Course 2011

The "National Family Medicine Board Review" course was held June 2-5, 2011. This activity, the 10th Annual National Family Medicine Board Review, with a beginning date of May 21, 2011, has been planned and is acceptable for up to 41 Prescribed credits by the American Academy of Family Physicians.

AAFP Prescribed credit is accepted by the American Medical Association as equivalent to *AMA PRA Category 1 Credit*™ toward the AMA Physician's Recognition Award. When applying for the AMA PRA, Prescribed credit earned must be reported as Prescribed, not as Category 1.

CME activities approved for AAFP credit are recognized by the AOA as equivalent to AOA Category 2 credit.

Members of the College of Family Physicians of Canada who attend CME activities that have been accredited by the AAFP for Prescribed credit can claim MAINPRO-M1 credit for interactive activities (group, online, etc.) or MAINPRO-M2 credit for reading/testing.

AAFP Prescribed credit is classified as preapproved CME Category 1 credit by the National Commission on Certification of Physician Assistants (NCCPA).

W. Richard Bukata

W. Richard Bukata, M.D.
President, The Center for Medical Education, Inc.

COLORADO OSTEOPATHIC EDUCATION CENTER

July 7, 2011

TO: Savita Ginde, MD

FROM: Ian R. Levenson, D.O., FACOFP
Chair, Colorado Osteopathic Education Center

RE: CME Credits for Precepting COEC students
from July 1, 2009–June 30, 2011

We appreciate your participation in the educational program of the Colorado Osteopathic Education Center (COEC). Your participation is what made the program as successful as it has been.

You are eligible for CME credits in AMA PRA Category 2 activities (precepting students) for serving as a preceptor in this program. The enclosed documentation is a summary of the students you have precepted over the past two years and can be used to apply for credit with the AMA. Two-week rotations are 80 hours and four-week rotations are 160 hours.

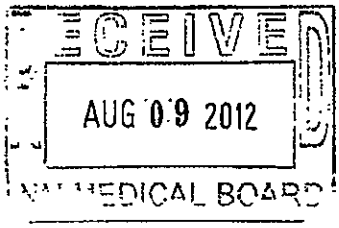
Without your support COEC would not have existed and none of this could have been accomplished. Again, thank you for your interest in maintaining our Osteopathic medical education program.
encl.

8401 S. Chambers Road, Parker, CO 80134 Ph: 720-874-2456/7 Fax: 303-322-1956
~~600 South Cherry Street, Suite 510, Denver, Colorado 80246 303-322-1752 Fax 303-322-1956~~
A Branch of the Colorado Society of Osteopathic Medicine www.ColoradoDO.org

COLORADO OSTEOPATHIC EDUCATION CENTER

8401 S. Chambers Rd. • Parker, Colorado • 80134 • Ph: (720) 874-2456/7 • Fx: (303) 322-1956

Preceptor Annual Report
7/1/09 - 6/30/11



Savita Ginde, MD

Student	School	Class of	Rotation	Start	End
Jennifer Jaskiewicz	TUCOM	2010	Gyn	12/7/2009	12/20/2009
Steven Leto	TUCOM	2010	Gyn	1/18/2010	1/31/2010
Hong Le	TUCOM	2010	Gyn	3/15/2010	3/28/2010
Heather Mack	TUCOM	2010	Gyn	4/26/2010	5/9/2010
Nancy Nguyen	TUCOM	2011	Gyn	3/28/2011	4/10/2011
Mackenzie Brown	TUCOM	2011	Gyn	4/11/2011	4/24/2011
Tracy Hume	TUCOM	2011	Gyn	4/25/2011	5/8/2011
Amanda Chan	TUCOM	2012	Gyn	6/6/2011	6/19/2011

June 27, 2011

PHYSICIAN CME CERTIFICATE

NATIONAL ABORTION FEDERATION

2011 Risk Management Seminar

October 16–17, 2011 New Orleans, LA

The National Abortion Federation (NAF) is accredited by the Accreditation Council for Continuing Medical Education to sponsor continuing medical education for physicians. NAF designates this educational activity for a maximum of 13 AMA PRA Category 1 Credits™. Physicians should only claim credit commensurate with the extent of their participation in the activity.

NAF certifies that

Sarita Gnade, MD, PhD

(Name of physician)

Has participated in the educational activity titled "NAF's 2011 Risk Management Seminar" in New Orleans, Louisiana on October 16–17, 2011 and is awarded 13 AMA PRA Category 1 Credits™.

The American College of Obstetricians and Gynecologists (ACOG) has assigned 13 cognate credits to this program. This activity has been reviewed and is acceptable for up to 13 Prescribed credits by the American Academy of Family Physicians.

Vicki Saporta
President and CEO

Cassing Hammond, MD
Chair, Board of Directors

NOV 09 2011

Albert Einstein College of Medicine

certifies that

Savita Ginde, MD

HAS PARTICIPATED IN THE
LIVE ACTIVITY TITLED

North American Forum on Family Planning 2011

at Hyatt Regency Capitol Hill, Washington, DC
on October 21-24, 2011 and is awarded 22.5
AMA PRA Category 1 Credit(s)™

Victor B. Hatcher, Ph.D.,
Associate Dean

Association of Reproductive Health Professionals

The Association of Reproductive Health Professionals certifies that

Savita Ginde, MD MPH

has participated in the live activity titled

Medical Directors Council – Update on Reproductive Health and Medical Leadership Conference

and is awarded 12.5 hours of *AMA PRA Category 1 Credit(s)™*

On 2/23/12 – 2/26/12

The Association of Reproductive Health Professionals (ARHP) is accredited by the Accreditation Council for Continuing Medical Education to provide continuing medical education for physicians.

ARHP designated this live activity for a maximum of 12.5 *AMA PRA Category 1 Credit(s)™*

Physicians should only claim credit commensurate with the extent of their participation in this activity.

Sandy Worthington, MSN, WHNP, CNM
Education Co-Chair, ARHP

David Turok, MD
Education Co-Chair, ARHP

6/27/2012

Association of Reproductive Health Professionals (ARHP)
1901 L Street, NW, Suite 300 | Washington, DC 20036
Phone: (202) 466-3825 E-mail: arhp@arhp.org Web: www.arhp.org

Ginde, Savita

From: Amy McKiernan [amckiernan@ARHP.org]
Sent: Wednesday, June 27, 2012 1:41 PM
To: Ginde, Savita
Subject: CME Certificate - Medical Directors Council

Dear Savita Ginde,

Your continuing education certificate is below. If you have any questions about your certificate, please contact our education department at (202) 466-3825, or education@arhp.org.

ARHP provides quality continuing medical education opportunities on a variety of topics, including free live and archived webinars and enduring materials. Visit our website to learn more: http://www.arhp.org.

If you are not already a member, please consider joining ARHP and contribute your voice to our diverse, multi-disciplinary network of physicians, nurse practitioners, physician assistants, nurse midwives, researchers, educators, and other reproductive health professionals. For more information, visit www.arhp.org/membership.

Sincerely,

Ellen

Ellen L. Cohen, Cert.Ed., Dip.Ed., CCMEP
Association of Reproductive Health Professionals (ARHP)
1901 L Street NW, Suite 300
Washington, DC 20036
202.466.3825 (office)
202.621.1436 (direct)
www.arhp.org

N·P·I

National Procedures Institute

Certifies that

Savita Ginde, MD

has participated in the educational activity entitled

Office-Based Hysteroscopy and Hysteroscopic Sterilization

held February 23, 2012 in Snowbird, UT

This activity has been planned and implemented in accordance with the Essentials and Standards of the Accreditation Council for Continuing Medical Education through the joint sponsorship of the Texas Academy of Family Physicians and National Procedures Institute. The Texas Academy of Family Physicians is accredited by the ACCME to provide continuing medical education for physicians. The Texas Academy of Family Physicians designates this educational activity for a maximum of **8.5** ***AMA PRA Category 1 Credits™***.

This live activity, **Office-Based Hysteroscopy and Hysteroscopic Sterilization**, has been reviewed and is acceptable for up to **8.8 Prescribed Credits** by the American Academy of Family Physicians (AAFP). AAFP Prescribed Credit is accepted by the AMA as equivalent to *AMA PRA Category 1 credit™* for the AMA Physician's Recognition Award. When applying for the AMA PRA, Prescribed Credits earned must be reported as Prescribed Credits, not as Category 1 credit.

Physicians should claim only the credit commensurate with the extent of their participation in the activity.