FORM 1
MEDICINE

THE UNIVERSITY OF THE STATE OF NEW YORK
THE STATE EDUCATION DEPARTMENT
DIVISION OF PROFESSIONAL LICENSING SERVICES

APPLICATION FOR LICENSE AND FIRST REGISTRATION

(For Graduates of American or Canadian Medical Schools Only)
(If you hold a New York State Medical License do not complete this form)

Department Use Only
CAP. DEPOSIT ONLY NESLG
CASH NO. : W

[redacted] 24 60
270 LX
205 [redacted] ER
60 PR

License Number
163110
JUL 08 1985

QUALS. .....
APPROVED .....

1. PRINT FULL NAME
Last: HAJAR
First: MARILYN
Middle: ANN

2. ADDRESS
Street: [redacted]
[redacted]
City: ALBANY
State: NEW YORK
ZIP Code: [redacted]

3. BIRTH DATE: [redacted]
month day year

4. Social Security Number: [redacted]

5. TELEPHONE
At home: [redacted] area code [redacted] number
At work: 518 area code 445 3111 number

6. CITIZENSHIP: [redacted] United States [redacted] Alien lawfully admitted for permanent residence in the United States.
Citizen of [redacted]

7. Have you previously applied for a New York State Medical License? ☐ Yes* ■ No *Give date _____

8. Professional school(s):

INSTITUTION	LOCATION	COMPLETION DATE	DEGREE RECEIVED
ALBANY MEDICAL COLLEGE	ALBANY, NEW YORK	MAY, 1984	M.D.

9. Present employer: ALBANY MEDICAL CENTER HOSPITAL ALBANY, N.Y. Telephone No. 518 445 3125
Name Address

10. Have you ever been convicted of a crime (felony or misdemeanor) in any state or country? [redacted] Yes [redacted] No
11. Are charges pending against you for a crime (felony or misdemeanor) in any state or country? [redacted] Yes [redacted] No
12. Have you ever been found guilty of professional misconduct, unprofessional conduct or negligence in any state or country? [redacted] Yes [redacted] No
Are charges pending against you for professional misconduct, unprofessional conduct or negligence in any state or country? [redacted] Yes [redacted] No
If the answer to any of the above questions is "Yes," submit a letter giving a complete explanation, include copies of court records, and if you possess one, a copy of the "Certificate of Relief from Disabilities" or your "Certificate of Good Conduct."

14. APPLICATION FOR LICENSURE BY: (Please check the appropriate item)
☐ Endorsement of our valid medical license prior to January 1, 1972.
☐ Endorsement of Licensure Certificate of the Medical Council of Canada (MCC).
■ Acceptance of Examination of National Board of Medical Examiners.
☐ Acceptance of Examination of National Board of Examiners for Osteopathic Physicians and Surgeons.
☐ Acceptance of Federation Licensing Examination (FLEX) taken outside of New York State.
☐ Admission to New York State Licensing Examination (FLEX).
If applying for admission to New York State examination please indicate:
Time of examination requested: ☐ June ☐ December
Place of examination requested: ☐ New York Area ☐ Albany Area
[redacted] ☐ BUFFALO

NOTE: ALL APPLICANTS SHOULD READ CAREFULLY THE ATTACHED CIRCULAR OF INSTRUCTION BEFORE CONTINUING TO COMPLETE APPLICATION.

BL-7093

15. **POST GRADUATE HOSPITAL TRAINING AND PROFESSIONAL PRACTICE**
(LIST CHRONOLOGICALLY FROM GRADUATION TO THE PRESENT)

DESCRIPTION	NAME OF INSTITUTION	DATES From	DATES To	LOCATION
PGY-1 OBSTETRICS AND GYNECOLOGY	ALBANY MEDICAL CENTER	7/1/84	6/30/85	ALBANY, NY

16. I hold diplomas or certificates from the following specialty boards:

17. I am licensed by written examination in the following states or countries:

State or Country	Dates of License	License Number	Name/Dates of Written Examination Passed for License	Any limitations on license
			/	
			/	
			/	

The University of the State of New York
THE STATE EDUCATION DEPARTMENT
Division of Professional Licensing Services
Cultural Education Center
Albany, New York 12230

Marilyn Mayer
[redacted]
Albany, NY [redacted]

Date: June 17, 1985

Profession: MEDICINE

Dear Applicant:

In connection with your application, you should note the items checked, or follow the instructions indicated:

- [ ] Please complete the enclosed Form I and return for the following reasons:
  - [ ] Affix your signature on Page 2.
  - [ ] Affix date application was completed on Page 2.
  - [ ] Obtain signature of ___ licensed physicians recommending applicant.
- [x] Please request the National Board of Medical Examiners to send directly to this office the original Certification of Record (including marks of individual subjects).
- [ ] Request the Secretary of the State Board of Medical Examiners of the state in which you are licensed to submit a certification including your scores, state seal, and original signature.
- [ ] Request the Federation of State Medical Boards, 2626 - 5 West Freeway, Suite 200 Fort Worth, Texas 76102 to send directly to this office the official transcript of your examination scores.
- [ ] Enclosed Form _____

- [ ] Please submit the enclosed 3" x 5" card, properly completed and signed.

Sincerely,

Margaret Ann Newton
PRINCIPAL CLERK

PLS 66
9/81

17. PRINT YOUR NAME EXACTLY AS YOU WISH IT TO APPEAR ON YOUR LICENSE, IF DETERMINED ELIGIBLE.

(IMPORTANT: A request that contains only initials and the surname cannot be honored).

MARILYN ANN MAJOR

Under penalties of perjury, I declare and affirm that the statements made in the foregoing application, including accompanying statements and transcripts are true, complete and correct. I understand that any false or misleading information in, or in connection with my application may be cause for denial or loss of licensure.

Signature of applicant

May 14, 1985
Date

Date of Photograph May 19, 1985

18. **CERTIFICATION BY MEDICAL SCHOOL**
(Items (1) and (2) must be completed)

It is hereby certified that the applicant named herein: Marilyn Ann Major

(1) Satisfactorily completed, prior to matriculation in professional school, all of the required premedical education

Yale University
(Premedical school(s))

(2) Was graduated from this professional school after the completion of not less than 32 months with the degree

of Doctor of Medicine on May 24, 1984

Name: Sara J. Kremer
(Original signature)

Official position: Registrar

Medical school: Albany Medical College

(COLLEGE SEAL)

Date: May 22, 1985

Certification is not acceptable unless dated after graduation.
Please return this form to the applicant for further processing.

PART B: ORIGINAL LIMITED PERMIT OR RENEWAL

1a. ORIGINAL PERMIT APPLICANTS EDUCATED IN THE UNITED STATES OR CANADA:

The original limited permit in medicine authorizes the graduate of a medical school in the United States or Canada to practice as a physician under the supervision of a physician licensed in New York State in an approved hospital or nursing home for up to two years.

I satisfactorily completed a curriculum in medicine covering at least 32 months leading to the degree of M.D.

on (date) 5/24/84; in the following medical school(s): ALBANY MEDICAL COLLEGE

ALBANY, NEW YORK

(Location)

I possess (check one): Medical license from another state by written examination.

Name state _____ Licensure Date _____;

☐ FLEX certificate ☐ Certification of National Board of Medical Examiners.

☐ Other: _____

- YOU MUST SUBMIT COPY OF DIPLOMA.
- ATTACH COPY OF CERTIFICATION CHECKED.

1b. ORIGINAL PERMIT APPLICANTS EDUCATED OUTSIDE THE UNITED STATES OR CANADA. You must complete Part C, submit ECFMG standard certificate, transcript, and diploma for proof of degree. The original limited permit in medicine authorizes the graduate of a medical school outside the United States or Canada to practice as a physician under the supervision of a physician licensed in New York State in an approved hospital or nursing home for up to two years.

RENEWAL OF ORIGINAL LIMITED PERMIT

For renewal of the limited permit in medicine for additional time, the Department may accept, satisfactory evidence of personal or family illness or extenuating circumstances requiring absence from the State licensing examination in medicine or satisfactory performance of a significant part of the State licensing examination. Such limited permit renewals may be issued for up to, but not exceeding, an additional two years of practice. If additional approved hospital training is required for admission to the New York State licensing examination, your training should be completed within the time validity of the limited permit. Please explain the basis for your request:

_____

_____

_____

THE UNIVERSITY OF THE STATE OF NEW YORK
THE STATE EDUCATION DEPARTMENT
DIVISION OF PROFESSIONAL LICENSING SERVICES

Department Use Only

FOR DEPOSIT ONLY NISED
CASH NO.

[redacted] 5125 60

60 PR

APPR. [illegible] DATE 7/9/84
PMT. # [illegible]
ISD 7/10/84 EXP. 7/10/86

APPLICATION FOR LIMITED PERMIT AUTHORIZATION TO PRACTICE MEDICINE

(Pursuant to Section 6525 of the Education Law and Section 60.7 of the Commissioner's Regulations)

APPLICANT MAY NOT BEGIN OR RESUME PRACTICE UNTIL LIMITED PERMIT HAS BEEN APPROVED.

PART A: INFORMATION REQUIRED OF ALL APPLICANTS.

1. I am applying for:
   - ☑ ORIGINAL PERMIT
   - ☐ RENEWAL OF ORIGINAL LIMITED PERMIT #

2. PRINT FULL NAME: Last HAJAR; First MARILYN; Middle ANN

3. ADDRESS: Street [redacted]; City ALBANY; State NEW YORK [redacted]

4. BIRTH DATE: [redacted] (mo. day yr.)

5. SOCIAL SECURITY NUMBER: [redacted]

6. TELEPHONE: At home [redacted] (area code / number); At work (area code / number)

7. Maiden NAME: HAJAR (Last) MARILYN (First) ANN (Middle)

8. I hereby request limited permit authorization to practice medicine as a member of the staff of ALBANY MEDICAL CENTER Hospital.

9. Has your medical license ever been revoked or suspended?	[redacted] Yes	[redacted] No.
10. Have you ever been expelled from any professional society?	[redacted] Yes	[redacted] No
11. Have your ever been convicted of a crime (felony or misdemeanor) in any state or country?	[redacted] Yes	[redacted] No
12. Are charges now pending against you for a crime (felony or misdemeanor) in any state or country?	[redacted] Yes	[redacted] No
13. Have you ever been found guilty of unprofessional conduct, professional misconduct or negligence in any state or country?	[redacted] Yes	[redacted] No
14. Are charges now pending against you for unprofessional conduct, professional misconduct or negligence in any state or country?	[redacted] Yes	[redacted] No

If the answers to any of the preceding questions is "Yes", submit a letter giving a complete explanation, include copies of court records, and if you possess one a copy of the "Certificate of Relief from Disabilities" or your "Certificate of Good Conduct".

15. Have your applied for a New York State medical license?	☐ Yes	☒ No
OR		
16. Do you intend to apply for a New York State medical license?	☒ Yes	☐ No

PART D: EMPLOYER CERTIFICATION

1 I hereby certify that I am the Administrator or Appointing officer of:

Albany Medical Center Hospital
New Scotland Ave Albany, NY 12208
Official Name & Address of Hospital

2 Which is a:

- [x] General hospital, as defined by the public health law.
- [ ] Nursing home.
- [ ] State-operated psychiatric, developmental, or alcohol treatment center.
- [ ] Incorporated, non-profit institution for the treatment of the chronically ill.

3 I certify that the physician named in this application is being appointed as a member of the staff of this hospital. The appointment is to be for 3 years as (Please check appropriate title and indicate field or specialty):

(✓) Resident ( ) Assistant ( ) Fellow ( ) Staff Physician in Obstetrics + Gynecology under the supervision of a licensed physician in New York State.

[redacted]
Signature of Official

4/17/84
Dated

Adm. Dir. for House Staff Affairs
Title of Official

445-3593
Telephone

PART II APPLICANT AFFIRMATION

Under penalty of perjury I declare and affirm that all statements made in the foregoing application, including accompanying statements and certifications are true, complete and correct. I understand that any false or misleading information in, or in connection with my application may be cause for denial or loss of permit and licensure, if applicable.

[redacted]
Signature of Applicant

Dec 9, 1984
Date

Important: Do not send cash.
Education Departm
ment, Division of I
NOTE: Payment s
States bank and in
be returned.

FEE payable to the New York State
New York State Education Depart-
Albany, New York 12230. **PLEASE**
be by check or draft on a United
form will not be accepted and will

LICENSE 163110-1 REGISTRATION APPLICATION FOR PERIOD 01/01/86 - 12/31/88

REDELINE

$ 220
PAY THIS AMOUNT

1 SINCE YOU LAST REGISTERED HAVE YOU BEEN CONVICTED OF ANY CRIME FELONY OR MISDEMEANOR? [redacted]

2 SINCE YOU LAST REGISTERED WAS ANY STATE OTHER THAN NEW YORK REVOKED OR SUSPENDED A PROFESSIONAL LICENSE HELD BY YOU? [redacted]

3 WILL YOU BE PRACTICING IN NEW YORK STATE DURING THE PERIOD INDICATED BY YES NO

IF NO WHICH OTHER STATE?

4 LAST PRACTICED IN NYS 10/85

5 REGISTERED [redacted]

6 SIGN BELOW AND DATE:

X [redacted] 10/3/85

7 CHECK BOX IF NAME OR ADDRESS CHANGED → ☐

HAJAR MARILYN ANN
[redacted]
ALBANY NY [redacted]

OFFICE USE ONLY
09/26/85
LIC NO 163110
PROF CODE HAJ0
FEE 220
PD 60 OFF 1
YR 86 TYPE RR
DEN

163110HAJ0000D22002206018 6RR0000

You must complete all appropriate items on the registration application, sign it, and return it in the enclosed envelope. A response to the application is necessary even if you do not intend to register for the registration period indicated. Please make check or money order payable to the **NEW YORK STATE EDUCATION DEPARTMENT**. Be sure payment is for the correct fee and print your license number and profession on the check or money order. **U.S. FUNDS ONLY. DO NOT SEND CASH!**

ITEM 1 If you answer "yes" to this item you must submit a certified copy of the court records for each conviction. Do not check "yes" for minor traffic violations.

ITEM 2 If you answer "yes" to this item you must submit, on a separate sheet of paper, a listing of professional licenses revoked or suspended and the statutes involved. Give reasons for such action.

ITEM 3 Registration in your profession is required if you anticipate practicing your profession in New York State at any time during the period indicated. If you will not be practicing in New York State, you may **WITHOUT FEE**, let your registration lapse by checking the appropriate box in Item 3 below. [illegible] affect your license. However, if you become inactive and [illegible] registration certificate **WILL NOT** be issued [illegible] you **REACTIVATE** your registration [illegible] **WITH REQUEST.**

If you have not been in practice since your last registration and do want to reactivate, complete the registration application, sign it, and remit the basic registration fee. The Fee amount is shown in the "OFFICE USE ONLY" box on the reverse side.

REGISTRATION APPLICATION

PROFESSION MEDICINE

01/01/90 - 12/31/91

5 220

PAY THIS AMOUNT

1. Since you last registered has any state other than New York instituted charges against you for unprofessional conduct, unprofessional conduct, incompetence or negligence or revoked, suspended, or [illegible] a professional license held by you? [redacted]

2. Since you last registered have you been convicted of any crime (felony or misdemeanor) in any state, country, or any criminal charge now pending against you in any state or country, or have [illegible] been dismissed, or which has other than a hospital or dismissal? [illegible]

3. Will you be practicing in New York State during the period registered?

☒ Yes ☐ No

If No: ☐ Inactive ☐ Retired

4. Date Admitted to NYS: [illegible]

5. SIGN BELOW AND DATE:

X [illegible] 10/2/98

Signature Date

6. If the data shown above is not correct, please check box and indicate Data Change Form below ☐

[redacted]

HAJAR MARILYN ANN

[redacted]

ALBANY NY [redacted]

OFFICE USE ONLY

09/09/88

LIC NO 163110

IM CHK HAJO

DOB [redacted]

SSN

FEE 220

FR 80 OFF 1

YR 88 TYPE RR

PEN

[illegible] 710 00 460 5

FO[redacted] HYSED

The University of the State of New York
THE STATE EDUCATION DEPARTMENT
Division of Professional Licensing Services
Cultural Education Center
Albany, New York 12230

REGISTRATION INSTRUCTIONS

Please complete all appropriate items on the registration application printed on the reverse side, sign it, and return it in the enclosed envelope. You should return the application even if you do not intend to register for the registration period indicated. If you are registering, submit with the application a check or money order (U.S. FUNDS ONLY) payable to the NEW YORK STATE EDUCATION DEPARTMENT. Be sure payment is for the correct fee shown in the "OFFICE USE ONLY" box and print your license number and profession on the check or money order. DO NOT SEND CASH.

REGISTRATION APPLICATION PERIOD: 01/01/91 - 12/31/93

PROFESSION: MEDICINE

$ 330.00
PAY THIS AMOUNT

SEE INSTRUCTIONS ON REVERSE SIDE

1. (a) [illegible] charge payment for professional [illegible] or professional license held by you? [redacted]

(b) Since you last registered have you been convicted of a felony or misdemeanor in any state or territory? [illegible] [redacted]

(c) [illegible] [redacted]

2. (a) Will you be practicing in NYS during the period indicated? Yes ☐ No ☐

(b) If NO: ☐ INACTIVE ☐ RETIRED

3. Last address in NYS: 1 2 15 [redacted]

4. Date of birth: [redacted]

5. Social Security: [redacted]

If Social Security has not been provided, check appropriate box below:
☐ Applied for or pending
☐ Other reasons

[redacted]
ALBANY NY [redacted]

PRIVACY NOTIFICATION: The authority to request personal information from you, including identifying numbers such as Federal Social Security and Federal Employer Identification Numbers, and the authority to maintain such information is found in Section [illegible] of Public Law [illegible]. Disclosure of this information by you is mandatory, and will be used [illegible] purposes.

OFFICE USE ONLY
08/27/90
LIC. NO163110
IM CHK HAJ0
DOB [redacted]
SSN [redacted]
FEE 330
PR 60 OFF 1
YR 91 TYPE KR
PEN

[illegible] [illegible]

If this child, you must provide [illegible]

3. If your name or address has changed, or is listed incorrectly, complete the appropriate items of the Data Change below.

Check this box to indicate change. ☐

4. • **IMPORTANT NOTICE** Section 29.1 of the Rules of the Board of Regents describes health professions as follows.

acupuncture	massage	optometry	podiatry
audiology	medicine	pharmacy	psychology
chiropractic	nursing (registered professional nurse)	physical therapy	social work
dental hygiene	licensed practical nurse)	physician's assistant	specialist in [illegible]
dentistry	occupational therapy		speech-language pathology

If your profession is listed, you must answer question 1 (c). If you do not, an application will be returned to you and you will not be registered until a completed application is received.

5. Under penalties of perjury, I declare and affirm that the statements above are accurate, complete and correct. I understand that any false or misleading information or statements in, or in connection with, my application may be cause for disciplinary action, including the loss of my license.

[redacted]
(Signature)

12/11/90
(Date)

REGISTRATION APPLICATION

PROFESSION MEDICINE

PERIOD 01/01/93 - 12/31/94 $ 330

PAY THIS AMOUNT

BEFORE COMPLETING THIS FORM READ ENCLOSED INSTRUCTIONS

HAJAR MARILYN ANN

[redacted]

CASTLETON NY [redacted]

OFFICE USE ONLY

DATE: 08/11/92
LIC. NO: 163110
NM: HAJO
DOB: [redacted]
SSN: [redacted]
FEE: 330
PR. 60 OFF: 1
YR: 93 TYPE: RR
PEN:

CHILD ABUSE Y

Since you last registered, [illegible] state [illegible] have instituted charges against you for professional misconduct, unprofessional conduct, incompetence or [redacted]

(b) **Since you last registered** have you been convicted of any crime (felony or misdemeanor) in any state or country, or have you been charged with any crime the disposition of which was other than by acquittal or dismissal?

(c) **FOR HEALTH PROFESSIONALS ONLY:** Since you last registered, has any hospital or licensed facility restricted or terminated your professional training, employment, or privileges or have you ever voluntarily or involuntarily resigned or withdrawn from such association to avoid imposition of such action due to professional misconduct, unprofessional conduct, incompetence or negligence?

[redacted]

2 (a) Will you be practicing in NYS during the period indicated? [X] Yes [ ] No

(b) If NO, specify: [ ] INACTIVE [ ] RETIRED [ ] PRACTICING OUTSIDE NYS

3 Last practiced in NYS: 10 92 (Mo. Yr.)

4 DATE OF BIRTH: [redacted] (Mo. Da. Yr.)

5 Attached documentation regarding child abuse coursework: [ ] Certificate of Completion [ ] Certificate of Exemption

6 Social Security # [redacted]

If Social Security # has not been provided, check appropriate box below:
[ ] SS # applied for or pending
[ ] Other (explain) _____

7 Federal Employer Identification # [ ][ ] [ ][ ][ ][ ][ ][ ][ ]
(If you have Federal Employer Identification Number, you must provide)

8 Under penalties of perjury, I believe and affirm that the statements above are an accurate representation and that such statements, including my accompanying documentation and explanations, are true, complete and correct. I understand that any false or misleading information or statement on or in connection with my application may be cause for disciplinary action, including the loss of my license.

SIGNATURE [signature] DATE: 10/24/92

Fold Line

REGISTRATION APPLICATION

PROFESSION: MEDICINE

PERIOD: 01/01/95 - 10/31/97

$ 468
PAY THIS AMOUNT

OFFICE USE ONLY

DATE: 08/01/94
LIC NO: 163110
NM: HAJO
DOB: [redacted]
SSN: [redacted]
FEE: 468
PR: 60 OFF: 1
YR: 95 TYPE: RR
PY:
CA: Y

[redacted]

THE STATE EDUCATION DEPARTMENT
Office of Professional Credentialing
Professional Licensing Services
Cultural Education Center
Albany, NY 12230
518 474-3817

READ INSTRUCTIONS ON REVERSE SIDE BEFORE COMPLETING THIS FORM

HAJAR MARILYN ANN
[redacted]
CASTLETON NY [redacted]

7

This application may ONLY be used by the person whose name appears above.

1. (a) Since you last registered, has any state other than New York imposed charges against you for professional misconduct, unprofessional conduct, incompetence or negligence or revoked, suspended, or accepted surrender of a professional license held by you?

(b) Since you last registered, have you been convicted of any crime (felony or misdemeanor) in any state or country or have you been charged with any crime the disposition of which was other than acquittal or dismissal?

(c) Since you last registered, has any hospital or licensed facility restricted or terminated your professional training, employment, or privileges, or have you voluntarily, or involuntarily resigned or withdrawn from such association to avoid imposition of such action due to professional misconduct, unprofessional conduct, incompetence or negligence?

[redacted]

2. Do you wish to register in New York State for the period indicated? ☑ Yes ☐ No

3. Are you currently practicing in New York State? ☑ Yes ☐ No
If no, provide month and year last practiced / Mo Yr

4. Date of Birth [redacted] Mo Day Yr

5. Social Security #: [redacted]
If Social Security # has not been provided, check appropriate box below
☐ number applied for or pending ☐ explanation attached

6. Federal Employer Identification Number

7. Your profession must comply with a one-time requirement for two hours of coursework or training in the recognition and reporting of child abuse and maltreatment. Your registration will not be processed until this requirement has been satisfied. Your current status with regard to the requirement is noted to the right. SEE REVERSE SIDE

CA: Y

8. You must comply with the mandatory requirement for completion of approved course work in infection control and barrier precautions to prevent the transmission of HIV and HBV in healthcare settings. Questions may be referred to the Infection Control Occupational Health Unit of the NYS Department of Health at 518 473 6819.

9. Under penalties of perjury I declare and affirm that the statements above are an accurate representation and that such statements, including any accompanying documentation and explanations, are true, complete and correct. I understand that any false or misleading information or statement in connection with this application may be cause for disciplinary action including the loss of my license.

Signature of Applicant 7/15/94
Date

DECEASED NOTIFICATION

If you are aware that the licensee is deceased, please complete and sign the following statement in order to permit us to change our records and to prevent future correspondence from being mailed.

The licensee whose name appears above is deceased. Approximate date of death was ___/___/___

Signature Relationship to deceased ___/___/___
Date

PLS CAT. 7 2 94

This is your application to register your professional license for the period indicated in the upper left corner of the application. Registration is required if you practice your profession or use your professional title within New York State.

If you do not expect to practice or use your professional title within New York State during the period indicated, you may voluntarily place your license on inactive status by checking "NO" to Item 2 and returning the completed application without fee by the beginning of the new period. Please note: If you become inactive, a registration certificate will not be issued and future notices will not be sent to you until you reactivate your registration. Should you later decide to register for practice within New York, you will not be assessed delayed or late registration fees for the period your license was inactive.

If you do not return this application, either to register or to claim inactive status, your license will be automatically declared not registered. Should you later attempt to register for practice within the State, you may be assessed delayed or late registration fees for each month your license was not registered.

INSTRUCTIONS FOR COMPLETING THE APPLICATION

1. Answer all questions. A response of "YES" to any question will not prevent or delay your reregistration.

   (a) If you answer "YES", submit a list of charges involved for each state and give a brief explanation of each action.

   (b) If you answer "YES", submit a certified copy of the court records for each conviction. Do not check "YES" for minor traffic violations, charges that were dismissed or acquittals.

   For purposes of Item 1(c), section 29.2 of the Rules of the Board of Regents identifies this profession a health profession.

   (c) If you answer "YES", submit a statement describing the details of the separation.

2. Check "YES" if you plan to practice in New York State during the period. Registration is required if you practice your profession or use your professional title within New York State. If you do not plan to practice in the State and wish to claim inactive status, check "NO" and return the application without a fee. (see above box for more information.)

3. If you are not currently practicing, enter the month and year you last practiced in New York State.

4. Please provide your date of birth.

5. Enter your Social Security Number in Item 5. If you do not have a Social Security Number, you must provide an explanation as indicated.

6. If you are an employer and hold a Federal Employer Identification Number, you must enter your employer identification number in the boxes provided.

   (The authority to collect this information is contained in Section 5 of the New York State Tax Law; it will be used for tax administration purposes.)

7. Licensees who complete, on or after September 1, 1990 an academic program registered by the State Education Department as fulfilling the educational requirements for licensure are credited with completion of the coursework and do not have to submit a Certificate of Completion nor file for an exemption. The coursework or training must be specifically approved for that purpose by the New York State Education Department; only approved providers can furnish the Certificate of Completion form required for reregistration. You should return the copy marked **STATE EDUCATION DEPARTMENT COPY** with your reregistration application. If you need to locate a provider, you should call Professional Licensing Services for assistance.

   Section 59.12 of the Regulations of the Commissioner of Education provides for exemption from the course requirement in cases where the nature of an individual's practice precludes any contact with children. If you believe you may qualify for such an exemption, call Professional Licensing Services to request an exemption application.

8. Please read the important information on the reverse side regarding a HIV/HBV requirement in your profession

9. Read the affirmation, sign and date the application. If you are registering, the fee must be paid with a check or money order made payable to the **NEW YORK STATE EDUCATION DEPARTMENT** in U.S. funds only. **DO NOT SEND CASH.** Section 6502(7) of the Education Law requires a $25.00 penalty fee be charged, in addition to the original fee owed, to anyone who submits a bad check for registration or licensure. Such replacement fees must be paid by certified check, bank check, or money order. If replacement fees are not submitted within 60 days of the notice of a bad check, section 59.8(g) of the Regulations of the Commissioner of Education stipulates that the registration may be voided.

- **DECEASED NOTIFICATION:** If you are aware that the licensee named on the application is deceased, please complete the appropriate information on the front and return using the enclosed envelope.
- **NAME AND ADDRESS CHANGE:** Use the enclosed card **ONLY** if you are reporting a change of name and/or address.
- **When returning the application, please do not staple, tape or clip any of the materials together. Please print your profession and profession code on the front of the return envelope. The professions and codes are listed on page 4.**

1631104A0006000267197

REGISTRATION REMITTANCE DOCUMENT

The University of the State of New York
THE STATE EDUCATION DEPARTMENT
Professional Licensing Services
Cultural Education Center
Albany, NY 12230

[redacted] 1235

08/02/97
LIC: 183110
NME: HAJO
YR: 97
OFF: 1
DOB: [redacted]
SSN: [redacted]
EIN:

HAJAR MARILYN ANN
[redacted]
CASTLETON NY [redacted]

PROFESSION: 80 MEDICINE
PERIOD: 11/01/97 - 10/31/99

$ 600
AMOUNT DUE

Complete and sign reverse side of this application

1. Do you wish to register for the period indicated? X Yes ___ No

2. Since you last filed a registration application,

a. Have you been convicted or charged with any crime (felony or misdemeanor) in any state or country, the disposition of which was other than acquittal or dismissal?

[redacted]

b. Have any formal or informal charges been filed against you for professional misconduct, unprofessional conduct, incompetence or negligence, or revoked, suspended, or accepted surrender of a professional license held by you?

c. Has any hospital or licensed facility restricted or terminated your professional training, employment, or privileges, or have you voluntarily or involuntarily resigned or withdrawn from such association to avoid the imposition of such action due to professional misconduct, unprofessional conduct, incompetency, or negligence?

3. a. Are you under an obligation to pay child support?

b. If you are under such an obligation, do you meet one of the four requirements listed in the Child Support Law section below?

Under penalties of perjury, I certify that the statements in this application and any accompanying documentation are true, complete and correct. I understand that any misrepresentation made in connection with my application may be cause for disciplinary action, including the loss of my license, and that willful failure to register while continuing to practice my profession constitutes professional misconduct.

(Signature) _____ (Date) _____

163110HAJ0006000[illegible]149

REGISTRATION REMITTANCE DOCUMENT

The University of the State of New York
THE STATE EDUCATION DEPARTMENT
Professional Licensing Services
Cultural Education Center
Albany, NY 12230

08/01/99
LIC: 163110
NME: HAJO
YR: 99
OFF: 1
DOB: [redacted]
SSN: [redacted]
EIN:

HAJAR MARILYN ANN
[redacted]
CASTLETON NY 1[redacted]

PROFESSION: 80 MEDICINE
PERIOD: 11/01/99 - 10/31/01

Complete and sign reverse side of this application

Name/address change
Complete only if change has occurred

Name
[redacted]
Street
[illegible] PATZ
City
[redacted]
State/Zip

$ 800
AMOUNT DUE

1. Do you wish to register for the period indicated? ✓ Yes ___ No

2. Since you last filed a registration application

a. Have you been convicted or charged with any crime (felony or misdemeanor) in any state or country, the disposition of which was other than acquittal or dismissal?

b. Has any other state or country instituted charges against you for professional misconduct, unprofessional conduct, incompetence or negligence, or revoked, suspended, or accepted surrender of a professional license held by you?

c. Has any hospital or licensed facility restricted or terminated your professional training, employment, or privileges, or have you voluntarily and involuntarily resigned or withdrawn from such association to avoid the imposition of such action due to professional misconduct, unprofessional conduct, incompetency, or negligence?

3. a. Are you under an obligation to pay child support?

b. If you are under such an obligation, do you meet one of the four requirements listed in the Child Support Law section below?

4. Are you a U.S. citizen or a qualified alien as defined below?

[redacted]

222259628 01 0000260000

001 08241999

DO NOT WRITE IN THIS BOX
FOR OFFICIAL USE ONLY

Under penalties of perjury, I certify that the statements in this application and any accompanying documentation are true, complete, and correct. I understand that any false or misleading statement made in connection with my application may be cause for disciplinary action, including the loss of my license, and that willful failure to pay child support while continuing to practice my profession constitutes professional misconduct.

Signature _____ Business phone ( ) _____ Date _____

✓ Yes ___ No

15311041J0006000060101

REGISTRATION REMITTANCE DOCUMENT

The University of the State of New York
THE STATE EDUCATION DEPARTMENT
Professional Licensing Services
89 Washington Avenue
Albany, NY 12234-1237

08/12/01
LIC: 103110
RNK: NAJO
V2: 01
DT: 1
DOB: [redacted]
SSN: [redacted]
EIN:

NAJAR MARILYN ANN
[redacted]
NEW PALTZ NY [redacted]

PROFESSION: 60 MEDICINE
PERIOD: 11/01/01 - 10/31/03

Complete and sign reverse side of this application

Name/address change
Complete only if change has occurred

Name

Street

City

State/Zip

$ 600
AMOUNT DUE

[redacted]

DO NOT WRITE IN THIS BOX
FOR OFFICIAL USE ONLY

Business phone (845) 255-6450 Date 9/27/01

163110HAJ0006000060103

REGISTRATION RENEWAL DOCUMENT
THE STATE EDUCATION DEPARTMENT
Professional Licensing Services
89 Washington Avenue
Albany, NY 12234 1000

06/02/03
LIC: 163110
NME: HAJO
YR: 03
OFF: 1
DOB: [redacted]
SSN: [redacted]
EIN:

HAJAR MARILYN ANN
[redacted]
NEW PALTZ NY [redacted]

Name/address change
Complete only if change has occurred

MARILYN ANNE HAJAR
Name
[redacted]
Street
BEACON
City
NY [redacted]
State/Zip

PROFESSION: 60 MEDICINE
PERIOD: 11/01/03 - 10/31/05

$ 600
AMOUNT DUE

Complete and sign reverse side of this application

Cat 6 - 1001

1. Do you wish to register for the period indicated? ..... X Yes ___ No

2. Since your last registration application,
   a. Have you been found guilty after trial, or pleaded guilty, no contest, or nolo contendere to a crime (felony or misdemeanor) in any court? .....
   b. Has any licensing or disciplinary authority revoked, annulled, cancelled, accepted surrender of, suspended, placed on probation, or refused to issue or renew a professional license or certificate held by you now or previously, or fined, censured, reprimanded or otherwise disciplined you?
   c. Are criminal charges pending against you in any court? .....
   d. Are charges pending against you in any jurisdiction for any sort of professional misconduct? .....
   e. Has any hospital or licensed facility restricted or terminated your professional training, employment, or privileges, or have you voluntarily or involuntarily resigned or withdrawn from such association to avoid the imposition of such action due to professional misconduct, unprofessional conduct, incompetency, or negligence? .....

3. a. Are you under an obligation to pay child support? .....
   b. If you are under such an obligation, do you meet one of the four requirements listed in the Child Support Law section below? .....

4. Are you a U.S. citizen or a qualified alien as defined below? .....

[redacted]

32944259 [illegible]
015 09032003

DO NOT WRITE IN THIS BOX
FOR OFFICIAL USE ONLY

I certify that the statements made in this application and any accompanying documentation are true, complete and correct. I understand that any misrepresentation or any false or misleading information made in connection with my application may **result in criminal prosecution and** may be cause for disciplinary action, including the loss of my license; and that the willful failure to register while continuing to practice my profession constitutes professional misconduct.

Signature _____ Business phone (845) 831-0130 Date 9/2/03

Cat 6A - 0503

163110HAJ0006000060105

REGISTRATION RENEWAL DOCUMENT
THE STATE EDUCATION DEPARTMENT
Professional Licensing Services
89 Washington Avenue
Albany, NY 12234-1000

06/01/05
LIC: 163110
NME: HAJO
YR: 05
OFF: 1
EIN:

HAJAR MARILYN ANN
[redacted]
BEACON NY [redacted]

Name/address change
Complete only if change has occurred

Name

Street

City

State/Zip

PROFESSION: 60 MEDICINE
PERIOD: 11/01/05 - 10/31/07

$ 600
AMOUNT DUE

Complete and sign reverse side of this application

1. Do you wish to register for the period indicated? ..... X Yes ___ No

2. Since your last registration application,

a. Have you been found guilty after trial, or pleaded guilty, no contest, or nolo contendere to a crime (felony or misdemeanor) in any court? .....

b. Has any licensing or disciplinary authority revoked, annulled, cancelled, accepted surrender of, suspended, placed on probation, or refused to issue or renew a professional license or certificate held by you now or previously, or fined, censured, reprimanded or otherwise disciplined you? .....

c. Are criminal charges pending against you in any court? .....

d. Are charges pending against you in any jurisdiction for any sort of professional misconduct? .....

e. Has any hospital or licensed facility restricted or terminated your professional training, employment, or privileges, or have you voluntarily or involuntarily resigned or withdrawn from such association to avoid the imposition of such action due to professional misconduct, unprofessional conduct, incompetency, or negligence? .....

3. a. Are you under an obligation to pay child support? .....

b. If you are under such an obligation, do you meet one of the four requirements listed in the Child Support Law section below? .....

4. Are you a U.S. citizen or an alien admitted for permanent residence in the U.S.? .....

[redacted]

32450473 029 09202005	60000	DO NOT WRITE IN THIS BOX FOR OFFICIAL USE ONLY

I certify that the statements made in this application and any accompanying documentation are true, complete and correct. I understand that any misrepresentation or any false or misleading information made in connection with my application may **result in criminal prosecution and** may be cause for disciplinary action, including the loss of my license; and that the willful failure to register while continuing to practice my profession constitutes professional misconduct.

Signature [redacted] Daytime phone (518) 732-4211 Date 9/10/05

163110HAJ0006000060107

REGISTRATION RENEWAL DOCUMENT
THE STATE EDUCATION DEPARTMENT
Professional Licensing Services
89 Washington Avenue
Albany, NY 12234-1000

Address change
Complete only if change has occurred

06/01/07
LIC: 163110
NME: HAJO
YR: 07
OFF: 1
EIN:

HAJAR MARILYN ANN
[redacted]
BEACON NY [redacted]

Street

City

State/Zip

5482402

PROFESSION: 60 MEDICINE
PERIOD: 11/01/07 - 10/31/09

$ 600
AMOUNT DUE

Complete and sign reverse side of this application

1. Do you wish to register for the period indicated? ..... [X] Yes ___ No

2. Since your last registration application,
   a. Have you been found guilty after trial, or pleaded guilty, no contest, or nolo contendere to a crime (felony or misdemeanor) in any court? .....
   b. Has any licensing or disciplinary authority revoked, annulled, cancelled, accepted surrender of, suspended, placed on probation, or refused to issue or renew a professional license or certificate held by you now or previously, or fined, censured, reprimanded or otherwise disciplined you? .....
   c. Are criminal charges pending against you in any court? .....
   d. Are charges pending against you in any jurisdiction for any sort of professional misconduct? .....
   e. Has any hospital or licensed facility restricted or terminated your professional training, employment, or privileges, or have you voluntarily or involuntarily resigned or withdrawn from such association to avoid the imposition of such action due to professional misconduct, unprofessional conduct, incompetency, or negligence? .....

3. a. Are you under an obligation to pay child support? .....
   b. If you are under such an obligation, do you meet one of the four requirements listed in the Child Support Law section below? .....

4. Are you a U.S. citizen or an alien admitted for permanent residence in the U.S.? .....

[redacted]

~~[illegible]~~ ~~[illegible]~~
084 09182007

DO NOT WRITE IN THIS BOX
FOR OFFICIAL USE ONLY

I certify that the statements made in this application and any accompanying documentation are true, complete and correct. I understand that any misrepresentation or any false or misleading information made in connection with my application may **result in criminal prosecution and** may be cause for disciplinary action, including the loss of my license; and that the willful failure to register while continuing to practice my profession constitutes professional misconduct.

Signature [signature] Daytime phone (518) 732-4214 Date 9/16/07

163110HAJ0000200060107

NEW YORK STATE PROFESSIONAL PHOTO IDENTIFICATION CARD APPLICATION

The University of the State of New York
THE STATE EDUCATION DEPARTMENT
Office of the Professions
Division of Professional Licensing Services

09/18/07
LIC: 163110
NME: HAJO
YR: 07
OFF: 1

HAJAR MARILYN ANN
[redacted]
BEACON NY [redacted]

Your address CANNOT be updated by the NYS Education Department or the NYS Department of Motor Vehicles by changing the address on this form. Please see the reverse side for information on how to update your address.

PIN:

PROFESSION: 60 MEDICINE
PERIOD: 11/01/07 - 10/31/09

$ 20
AMOUNT DUE

Read Instructions on Reverse Side of this Application

PHOT1c062507

Carefully read the **Information and Instructions for Completing and Returning the New York State Professional Photo Identification Card Application** below before filling out and returning this portion of the form.

1. New York State (NYS) Driver License or Non-Driver ID Number:
   [redacted]

2. Please Provide Your Daytime Telephone, Fax and E-mail:
   Home [redacted] Fax (845) 831-0133
   Work/Cell (845) 831-0130 E-mail [redacted]

3. Authorization:

3256681 2000
019 11062007

I (Print Name) MARILYN HAJAR, authorize New York State to produce a professional photo identification card bearing my NYS Driver License or Non-Driver ID card photograph. I understand that this card will be sent to the address indicated on the front of this application form. I also understand that I am required to pay the stated fee before an ID card can be issued to me and if I need to replace the ID card or obtain a new card, I will be required to provide a new application form and fee. I know that I may withdraw my consent to use my NYS Driver License photograph and cancel this ID at any time.

Signature [redacted] Date 11 / 5 / 07

PHOT 1B 062507 SS

OP Renewal Online Payment - By Registration Period

For different Selection.

Professions	: **MEDICINE**	**Address:**
Name	: HAJAR MARILYN ANN	136 LAKE STREET SUITE 11
Date of Birth	: 11/02/1951	NEWBURGH
License Number	: 163110 Coupon ID : [redacted]	NY - 12550
Registration Period	: 11/01/2009 through 10/31/2011	US
Payment Date	: 09/12/2009	
E-mail	: [redacted]	
Phone	:	
Renewal Status	: **Paid On-line - Renewal Complete**	

License Renewal Payment Details:

Evta Authorization Num	Evta Transaction Num	Date Paid	Office Number	Amount
[redacted]	[redacted]	09/12/2009	1	600

Photo Id Payment Details:

No Data Available

Response to Questions:

Question Type	Question Text	Response Ind
Moral Character	Since your last registration application, are charges pending against you in any jurisdiction for any sort of professional misconduct?	[redacted]
Moral Character	Since your last registration application, has any licensing or disciplinary authority revoked, annulled, cancelled, accepted surrender of, suspended, placed on probation, or refused to issue or renew a professional license or certificate held by you now or previously, or fined, censured, reprimanded or otherwise disciplined you?	
Moral Character	Since your last registration application, are criminal charges pending against you in any court?	
Moral Character	Since your last registration application, have you been found guilty after trial, or pleaded guilty, no contest, or nolo contendere to a crime (felony or misdemeanor) in any court?	
Child Support	Are you under an obligation to pay child support?	
Citizenship	Are you a U.S. citizen?	
Moral Character	Since your last registration application, has any hospital or licensed facility restricted or terminated your professional training, employment, or privileges, or have you voluntarily or involuntarily resigned or withdrawn from such association to avoid the imposition of such action due to professional misconduct, unprofessional conduct, incompetency, or negligence?	

OP Renewal Online Payment - By Registration Period

For Different Selection:

Professions	: **MEDICINE**
Name	: HAJAR MARILYN ANN
Date of Birth	: 11/02/1951
License Number	: 163110 Coupon ID : [redacted]
Registration Period	: 11/01/2011 through 10/31/2013
Payment Date	: 10/13/2011
E-mail	: [redacted]
Phone	:
Renewal Status	: **Paid On-line - Renewal Complete**

Address:
136 LAKE STREET SUITE 11
NEWBURGH
NY - 12550
US

License Renewal Payment Details:

Evta Authorization Num	Evta Transaction Num	Date Paid	Office Number	Amount
[redacted]	[redacted]	10/13/2011	1	600

Photo Id Payment Details:

No Data Available

Response to Questions:

Question Type	Question Text	Response Ind
Moral Character	Since your last registration application, are charges pending against you in any jurisdiction for any sort of professional misconduct?	[redacted]
Moral Character	Since your last registration application, has any licensing or disciplinary authority revoked, annulled, cancelled, accepted surrender of, suspended, placed on probation, or refused to issue or renew a professional license or certificate held by you now or previously, or fined, censured, reprimanded or otherwise disciplined you?	
Moral Character	Since your last registration application, are criminal charges pending against you in any court?	
Moral Character	Since your last registration application, have you been found guilty after trial, or pleaded guilty, no contest, or nolo contendere to a crime (felony or misdemeanor) in any court?	
Child Support	Are you under an obligation to pay child support?	
Citizenship	Are you a U.S. citizen?	
Moral Character	Since your last registration application, has any hospital or licensed facility restricted or terminated your professional training, employment, or privileges, or have you voluntarily or involuntarily resigned or withdrawn from such association to avoid the imposition of such action due to professional misconduct, unprofessional conduct, incompetency, or negligence?	

OP Renewal Online Payment - By Registration Period

For Different Selection:

Professions	: **MEDICINE**
Name	: HAJAR MARILYN ANN
Date of Birth	: 11/02/1951
License Number	: 163110 Coupon ID : [redacted]
Registration Period	: 11/01/2013 through 10/31/2015
Payment Date	: 09/25/2013
E-mail	: [redacted]
Phone	:
Renewal Status	: **Paid On-line - Renewal Complete**

Address:
136 LAKE STREET SUITE 11
NEWBURGH
NY - 12550
US

License Renewal Payment Details:

Evta Authorization Num	Evta Transaction Num	Date Paid	Office Number	Amount
[redacted]	[redacted]	09/25/2013	1	600

Photo Id Payment Details:

No Data Available

Response to Questions:

Question Type	Question Text	Response Ind
Moral Character	Since your last registration application, are charges pending against you in any jurisdiction for any sort of professional misconduct?	[redacted]
Moral Character	Since your last registration application has any licensing or disciplinary authority revoked, annulled, cancelled, accepted surrender of, suspended, placed on probation, or refused to issue or renew a professional license or certificate held by you now or previously, or fined, censured, reprimanded or otherwise disciplined you?	
Citizenship	Are you a U.S. citizen or qualified alien as defined above?	
Moral Character	Since your last registration application, are criminal charges pending against you in any court?	
Moral Character	Since your last registration application, have you been found guilty after trial, or pleaded guilty, no contest, or nolo contendere to a crime (felony or misdemeanor) in any court?	
Child Support	Are you under an obligation to pay child support?	
Moral Character	Since your last registration application, has any hospital or licensed facility restricted or terminated your professional training, employment, or privileges, or have you voluntarily or involuntarily resigned or withdrawn from such association to avoid the imposition of such action due to professional misconduct unprofessional conduct, incompetency, or negligence?	

OP Renewal Online Payment - By Registration Period

For Different Selection

Professions	: **MEDICINE**	**Address:**
Name	: HAJAR MARILYN ANN	136 LAKE STREET SUITE 11
Date of Birth	: 11/02/1951	NEWBURGH
License Number	: 163110 Coupon ID : [redacted]	NY - 12550
Registration Period	: 11/01/2015 through 10/31/2017	US
Payment Date	: 09/24/2015	
E-mail	[redacted]	
Phone		
Renewal Status	: **Paid On-line - Renewal Complete**	

License Renewal Payment Details:

Evta Authorization Num	Evta Transaction Num	Date Paid	Office Number	Amount
[redacted]	[redacted]	09/24/2015	1	600

Photo Id Payment Details:

No Data Available

Response to Questions:

Question Type	Question Text	Response Ind
Moral Character	Since your last registration application, are charges pending against you in any jurisdiction for any sort of professional misconduct?	[redacted]
Moral Character	Since your last registration application, has any licensing or disciplinary authority revoked, annulled, cancelled, accepted surrender of, suspended, placed on probation, or refused to issue or renew a professional license or certificate held by you now or previously, or fined, censured, reprimanded or otherwise disciplined you?	
Citizenship	Are you a U.S. citizen or qualified alien as defined above?	
Moral Character	Since your last registration application, are criminal charges pending against you in any court?	
Moral Character	Since your last registration application, have you been found guilty after trial, or pleaded guilty, no contest, or nolo contendere to a crime (felony or misdemeanor) in any court?	
Child Support	Are you under an obligation to pay child support?	
Moral Character	Since your last registration application, has any hospital or licensed facility restricted or terminated your professional training, employment, or privileges, or have you voluntarily or involuntarily resigned or withdrawn from such association to avoid the imposition of such action due to professional misconduct, unprofessional conduct, incompetency, or negligence?	