

PA 100 (REV. 5/89)



Regular Mailing Address
STATE BOARD OF MEDICINE
P.O. BOX 2640
HARRISBURG, PA 17105-2640
717-783-5885
717-787-2381

Counter Delivery Address

STATE BOARD OF MEDICINE
ROOM 612 TRANSPORTATION & SAFETY BLDG.
COMMONWEALTH AVE. & FORSTER STREET
HARRISBURG, PA 17120

Note: A processing fee of \$20.00 will be charged for any check or money order returned unpaid by your bank, regardless of the reason for non-payment.

**APPLICATION FOR A LICENSE TO PRACTICE
MEDICINE WITHOUT RESTRICTION**
For Graduates of **ACCREDITED** Medical Schools

Official Use Only

Amount

20

Date

2/1/90

Application Fee: \$20.00 *not refundable*
Make check payable to the "Commonwealth of Pennsylvania."

Please Print or Type

NAME:

PETIT

CRISTINA

M

Permanent Address:

BALTIMORE

MD

21209

Date of Birth:

Social Security Number:

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

LIST MEDICAL SCHOOL(S) ATTENDED:

WASHINGTON UNIVERSITY IN ST. LOUIS

DATES OF ATTENDANCE

From: 08-86

to 05-87

Date of Graduation:

May 18, 1990

List all states, territories and countries in which you have ever possessed a license to practice medicine and surgery (active or inactive, current or expired). If no license, write "NONE."

NONE

Check licensing examination(s) passed:

- () FLEX - indicate state where taken: _____ Date taken: _____
() FLEX COMPONENT 1 - indicate state where taken: _____ Date taken: _____
() FLEX COMPONENT 2 - indicate state where taken: _____ Date taken: _____
() NATIONAL BOARD - PART I 6-88 PART II 4-90 PART III 3-91
() USMLE - STEP 1 _____ STEP 2 _____ STEP 3 _____
() LMCC - Canadian _____
() STATE BOARD - indicate state where taken: _____

Post Graduate Education:

PGY1 Hospital: JOHNS HOPKINS From: 7/1/90 to: 6/30/91
PGY2 Hospital: JOHNS HOPKINS From: 7/1/91 to: 6/30/92

Answer the following questions, if "YES" to any of them, provide complete details on a separate sheet as well as certified copies of relevant documents. Sign and date below.

- | | YES | NO |
|---|-------|----------|
| 1. Has any disciplinary action been taken against your license in another state, territory or country? | _____ | <u>✓</u> |
| 2. Have you been convicted, found guilty, or pleaded guilty or nolo contendere, or received probation without verdict as to any felony or misdemeanor, including any drug law violation, in any state or federal court? | _____ | <u>✓</u> |
| 3. Have you had practice privileges denied, revoked or restricted in a hospital or other health care facility? | _____ | <u>✓</u> |
| 4. Have you had your DEA registration denied, revoked or restricted or have you had your provider privileges terminated by any medical assistance agency for cause? | _____ | <u>✓</u> |
| 5. Are you, or have you ever been, addicted to the intemperate use of alcohol or to the habitual use of narcotics or other habit-forming drugs? (Note: You may answer "NO" if you are currently a participant in or have successfully completed the requirements of the Board's Impaired Professional Program.) | _____ | <u>✓</u> |

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

Signature of Applicant _____

Date: 8-16-93

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

Certification of Moral Character

To be completed by two physicians with a license without restriction in good standing in the United States or Canada.

Name of Applicant: CRISTINA M PETIT

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

I have been personally acquainted with the applicant for 3 year(s) 2 month(s)

SIGNATURE [Redacted] Date: 8-10-93

Print or type name as signed above: J. Courtland Robinson, MD

State in which licensed: MD License Number: D 071116

Name of Applicant: CRISTINA M PETIT

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

I have been personally acquainted with the applicant for 4 year(s) 0 month(s)

SIGNATURE [Redacted] Date: 8/16/93

Print or type name as signed above: EDWARD E. WALLACH, MD

State in which licensed: Maryland License Number: D 30704
Pennsylvania 8196-E

Return Completed form to Applicant

Request/Change Address
State Board of Medical Examiners
P.O. Box 240
Harrisburg, PA 17105-0240

ACGME

VERIFICATION OF ACGME APPROVED GRADUATE MEDICAL TRAINING

Accredited Medical School Graduate

TO BE COMPLETED BY APPLICANT

Name: PETIT CRISTINA IA
Address: [REDACTED] #TL
BALTIMORE MD 21209
City State Zip Code

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

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

Name of Hospital: Johns Hopkins Hospital
Located in: Baltimore Md
City State

1st Year from 07/01/90 To 6/30/91 Specialty Ob/Gyn Level 1
2nd Year from 07/01/91 To 6/30/92 Specialty Ob/Gyn Level 2

I certify that Cristina Petit successfully completed
(Name of Applicant)
successfully complete this graduate medical training and that there was/is no disciplinary action outstanding against this applicant. If this applicant does not complete this training, the Board will be notified.

[Seal of Hospital] Signature of Program Director: [Signature]
Date: 5/3/93

If the hospital has no seal complete the following section and have this form notarized:
I hereby certify that this hospital has no seal or stamp and that this form was completed by this hospital.

Program Director's Signature: _____
Date: _____
RETURN COMPLETED FORM DIRECTLY TO THE BOARD IN OFFICIAL HOSPITAL ENVELOPE

Com
Bureau of PI
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HAI



Entry Level Specialties:

Anesthesiology
Dermatology
Diagnostic Radiology
Emergency Medicine
Family Practice
General Surgery
Internal Medicine
Neurology



The following specialties are listed in the
prior to entry and would not be consid

Adult Reconstructive Surgery
Aerospace Medicine
Allergy and Immunology
Blood Banking
Cardiovascular Disease
Chemical Pathology
Child Neurology
Child and Adolescent Psychiatry
Colon and Rectal Surgery
Critical Care
Dermatopathology
Diagnostic Laboratory Immunology
Endocrinology and Metabolism
Forensic Pathology
Gastroenterology
Geriatrics
Hand Surgery
Hematology
Immunopathology
Infectious Diseases
Medical Microbiology
Medical Oncology
Musculoskeletal Oncology
Neonatal-Perinatal Medicine
Nephrology
Neurosurgery
Neuropathology

School of Medicine

500 N. Wolfe Street
Baltimore MD 21287

Department of Gynecology and Obstetrics

JOHNS HOPKINS
UNIVERSITY

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

training

Board adopted April 22, 1986
State Board of Medicine

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

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						E	D	U	C

VERIFICATION OF MEDICAL EDUCATION

For Graduates of Accredited Medical Schools

SECTION 1: To be completed by applicant:

Name: PETIT CRISTINA LA
Last First Middle
Name of medical school: WASHINGTON UNIVERSITY
Location: ST LOUIS, MO

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

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

Name of medical student: Cristina M. Petit

Date student began to attend this medical school: 08 20 86
Month Day Year

Date of graduation: 05 18 90
Month Day Year

[Seal of School]

JOHN L. SCHULTZ, REGISTRAR
ASSISTANT DEAN
SECRETARY TO THE EXECUTIVE FACULTY
SCHOOL OF MEDICINE
WASHINGTON UNIVERSITY
869 SOUTH EURLID AVENUE
ST. LOUIS, MISSOURI 63110

I certify that all of the above information is correct.

Signature of John L. Schultz
Dean or Registrar: John L. Schultz, Assistant Dean

09/01/93

Date:

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

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

Carrier Delivery Address
State Board of Medicine
Room 602, Transportation & Safety Bldg.
Commonwealth Ave. & Foster St.
Harrisburg, PA 17120 U.S.A.



WASHINGTON UNIVERSITY IN ST. LOUIS

School of Medicine

Office of the Dean
Academic Administration
Campus Box 8107
660 S. Euclid Ave.
St. Louis, MO 63110-1093

FORWARD AND ADDRESS CORRECTION

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

new in



NATIONAL BOARD OF MEDICAL EXAMINERS

DOCUMENT OF CERTIFICATION

Note: The enclosed card of the National Board of Medical Examiners (NBME) in the lower left corner contains the authenticity of this document.

RECEIVED

Diplomate Name: Cristina M. Petit, MD

Date of Birth: [REDACTED]

Certification Date: 07/01/1991

Certification #: 199107

It is certified that the physician named above has successfully completed the examination, education, and training requirements for certification by the NBME as of the certification date shown above.

Exam	Test Date	Total Test	Min. Pass	Pass/Fail	Anat	Phys	Bioc	Path	Micro	Plant
NBME PART I	Jun 1988	425	380	PASS	440	435	315	410	450	500
		76	75		77	76	69	75	78	80
NBME PART II	Apr 1990	480	290	PASS	365	400	575	560	500	500
		81	75		76	77	85	84	80	80
NBME PART III	Mar 1991	405	290	PASS						
		78	75							

SEE OTHER SIDE FOR SCORE INFORMATION

PAGE: 1 of 1

The NBME Endorsement of Certification may include scores for Step 1 and Step 2 of the United States Medical Licensing Examination™ (USMLE™). The USMLE, established by the Federation of State Medical Boards and the NBME, is a single, uniform medical licensure examination system comprised of three Step examinations. USMLE will replace both the current Federation Licensing Examination (FLEX) and the NBME Parts I, II and III. Implementation of USMLE began with the administration of Steps I and 2 in 1992. The first administration of Step 3 will occur in June 1994. The NBME accepts passing scores on Parts I, II, and III as meeting the examination requirements for its certification program and the following combinations of passing scores on NBME examinations and USMLE: Part I or Step 1 plus Part II or Step 2 plus Part III or Step 3.

INTERPRETATION OF SCORES

NBME Part I and Part II Examinations Prior to June 1991

The most recent total test and subject scores are reported. The total test score is based on the total number of questions answered correctly on the entire examination and is not the average of the subject scores. There are no minimum pass requirements for individual subjects within a Part. Scores are on a three-digit scale with a mean of 500 and a standard deviation of 100, in increments of 5.

NBME Part I and Part II Examinations June 1991 and Thereafter

The most recent total test score is reported. This score is on a three-digit scale with a mean of 200 and a standard deviation of 20, in increments of 1.

Step 1 and Step 2 of the United States Medical Licensing Examination (USMLE)

The complete USMLE examination history is given. A total test score is reported on a three-digit scale with a mean of 200 and a standard deviation of 20, in increments of 1.

All NBME Part III Examinations

The most recent total test score is reported. This score is on a three-digit scale with a mean of 500 and a standard deviation of 100, in increments of 5.

Two-Digit Scores

For all examinations, an equivalent value scale score on a two-digit scale is also provided. The scale score mean is 82 and the minimum pass total scale score is 75. Scale scores are reported in increments of 1.

EXPLANATION OF COMMENTS

For USMLE Step 1 and Step 2, this document is annotated to reflect special circumstances regarding the score report.

If you wish to obtain further information about individual examinees who have notations under "Comments," please write the NBME Supervisor of Examinee Records.

Indeterminate - Results that cannot be certified as representing a valid measure of the examinee's knowledge or competence as sampled by the examination. Decisions to classify results as indeterminate may be made on the basis of factors that include, but are not limited to, inconsistency of performance within the examination or between administrations within the same Step. No score is reported.

Incomplete - The examinee sat for some but not all of the scheduled test books. No score is reported.

Irregular Behavior - Determination was made by the USMLE Committee on Irregular Behavior that the examinee engaged in such behavior. Irregular behavior includes all actions on the part of applicants and/or examinees, or by others when solicited by an applicant and/or examinee, that subvert or attempt to subvert the examination process.

Score Not Yet Available - Score not available pending further review and/or analysis.

Special Testing Accommodations - Following review and approval of a request from the examinee, special testing accommodations were provided in the administration of the examination.

CRISTINA M. PETIT, M.D.

[REDACTED]
Baltimore, Maryland 21209

home [REDACTED]
work (410) 955-6070 beeper 2033

RESIDENCY

Department of Gynecology and Obstetrics
The Johns Hopkins Hospital
Baltimore, Maryland 21205

July 1990 to June 1994

APPOINTMENTS

Administrative Chief Resident

July 1993 to June 1994

EDUCATION

Washington University School of Medicine
St. Louis, Missouri
M.D. received May 1990

University of Pittsburgh
Pittsburgh, Pennsylvania
B.S. Chemistry, Summa Cum Laude, received April 1986

CERTIFICATION

Medical Board Examinations
Parts I, II and III successfully completed March 1991

AWARDS AND HONORS:

Phi Beta Kappa	1986
University of Pittsburgh	
Chancellor's Scholar	1982-1986
Silverman Chemistry Prize	1986
University Scholar	1985

PERSONAL

Birth date: [REDACTED]
Marital status: [REDACTED]
Citizenship: U.S.A.

References available upon request

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

Official Use Only

027539

MD - 051384 - L
HAMIL RNEW

THIS IS YOUR RENEWAL NOTICE

STATE BOARD OF MEDICINE
P.O. BOX 8414
HARRISBURG, PA. 17105-8414

CRISTINA PETIT HAMIL
[REDACTED]
NEWTOWN SQUARE, PA 19073

YOUR CURRENT LICENSE TO PRACTICE MEDICINE AND SURGERY IN PENNSYLVANIA WILL EXPIRE ON DECEMBER 31, 1994. TO RENEW THROUGH DECEMBER 31, 1996 PLEASE COMPLETE THE QUESTIONS BELOW AND SUBMIT A CHECK OR MONEY ORDER IN THE AMOUNT OF \$80.00, MADE PAYABLE TO THE "COMMONWEALTH OF PA." RECORD YOUR LICENSE NUMBER ON THE FRONT OF YOUR PAYMENT. A LATE PENALTY FEE OF \$5.00 PER MONTH WILL BE CHARGED FOR RENEWALS POSTMARKED AFTER DECEMBER 31, 1994. A PROCESSING FEE OF \$20.00 WILL BE CHARGED FOR ANY CHECK OR MONEY ORDER RETURNED UNPAID BY YOUR BANK, REGARDLESS OF THE REASON. IF YOU HAVE A CHANGE IN NAME AND/OR ADDRESS, INDICATE THE CHANGE NEXT TO THE PRE-PRINTED NAME AND ADDRESS ABOVE.

YOU ARE HEREBY NOTIFIED THAT IF YOU ARE PRACTICING IN THIS COMMONWEALTH, YOU ARE REQUIRED TO FURNISH SATISFACTORY PROOF TO THE OFFICE OF THE MEDICAL PROFESSIONAL LIABILITY CATASTROPHE LOSS FUND THAT YOU ARE IN COMPLIANCE WITH THE HEALTH CARE SERVICES MALPRACTICE ACT.

IF, SINCE YOUR LAST RENEWAL, YOU HAVE EXPERIENCED DIFFICULTIES AS A RESULT OF ALCOHOL OR OTHER DRUGS SUCH AS DIAGNOSIS OF/ TREATMENT FOR CHEMICAL DEPENDENCY OR ABUSE OR ARRESTS FOR CHEMICAL-USE-RELATED OFFENSES, YOU MAY CONTACT THE BUREAU'S IMPAIRED PROFESSIONAL PROGRAM FOR CONFIDENTIAL INFORMATION AND ASSISTANCE AT 1-800-554-3428.

ANY DISCIPLINARY ACTION TAKEN IN ANOTHER STATE, TERRITORY OR COUNTRY SHALL BE REPORTED TO THE BOARD ON THE BIENNIAL RENEWAL NOTICE OR WITHIN 30 DAYS OF FINAL DISPOSITION, WHICHEVER IS SOONER.

IF YOU ANSWER "YES" TO QUESTIONS 2, 3, 4, OR 5 BELOW, PLEASE PROVIDE COMPLETE DETAILS ON 8 1/2 X 11 SHEETS OF PAPER AND INCLUDE COPIES OF LEGAL DOCUMENTS, IF ANY.

THE FOLLOWING QUESTIONS MUST BE ANSWERED AND YOU MUST SIGN BELOW.

- | | YES | NO |
|---|-------------------------------------|-------------------------------------|
| 1. DO YOU HOLD A LICENSE TO PRACTICE MEDICINE AND SURGERY IN ANY OTHER JURISDICTION? IF YES, LIST EACH ONE. | ☒ | ☐ |
| 2. SINCE YOUR LAST RENEWAL, HAS ANY DISCIPLINARY ACTION BEEN TAKEN AGAINST YOUR LICENSE IN ANOTHER STATE, TERRITORY OR COUNTRY? | ☐ | ☒ |
| 3. SINCE YOUR LAST RENEWAL, HAVE YOU BEEN CONVICTED, FOUND GUILTY OR PLEADED GUILTY OR NOLU CONTENDERE, OR RECEIVED PROBATION WITHOUT VERDICT AS TO ANY FELONY OR MISDEMEANOR, INCLUDING ANY DRUG LAW VIOLATION, IN ANY STATE OR FEDERAL COURT? | ☐ | ☒ |
| 4. SINCE YOUR LAST RENEWAL, HAVE YOU HAD PRACTICE PRIVILEGES DENIED, REVOKED OR RESTRICTED IN A HOSPITAL OR OTHER HEALTH CARE FACILITY? | ☐ | ☒ |
| 5. SINCE YOUR LAST RENEWAL, HAVE YOU HAD YOUR DEA REGISTRATION DENIED, REVOKED OR RESTRICTED OR HAVE YOU HAD YOUR PROVIDER PRIVILEGES TERMINATED BY ANY MEDICAL ASSISTANCE AGENCY FOR CAUSE? | ☐ | ☒ |

IF YOU WANT TO HAVE YOUR LICENSE PLACED ON "INACTIVE" STATUS, CHECK HERE.

NO FEE IS REQUIRED FOR INACTIVE STATUS. YOU ARE STILL REQUIRED TO ANSWER THE ABOVE QUESTIONS AND SIGN BELOW.

SIGNATURE

DATE

9.27.94

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

Official Use Only

029079

MD - 051364 - L

HAMIL RNEW

THIS IS YOUR RENEWAL NOTICE

STATE BOARD OF MEDICINE
P.O. BOX 8414
HARRISBURG, PA. 17105-8414

CRISTINA PETIT HAMIL

BRYN MAWR, PA 19010

YOUR CURRENT LICENSE TO PRACTICE MEDICINE AND SURGERY IN PENNSYLVANIA WILL EXPIRE ON DECEMBER 31, 1996. TO RENEW THROUGH DECEMBER 31, 1998 PLEASE COMPLETE THE QUESTIONS BELOW AND SUBMIT A CHECK OR MONEY ORDER IN THE AMOUNT OF \$80.00, MADE PAYABLE TO THE "COMMONWEALTH OF PA." RECORD YOUR LICENSE NUMBER ON THE FRONT OF YOUR PAYMENT. A LATE PENALTY FEE OF \$5.00 PER MONTH WILL BE CHARGED FOR RENEWALS POSTMARKED AFTER DECEMBER 31, 1996. A PROCESSING FEE OF \$20.00 WILL BE CHARGED FOR ANY CHECK OR MONEY ORDER RETURNED UNPAID BY YOUR BANK, REGARDLESS OF THE REASON. IF YOU HAVE A CHANGE IN NAME AND/OR ADDRESS, INDICATE THE CHANGE NEXT TO THE PRE-PRINTED NAME AND ADDRESS ABOVE AND ATTACH A COPY OF LEGAL DOCUMENTATION OF THE NAME CHANGE.

NOTICE: IF YOU PRACTICE IN PENNSYLVANIA, YOU MUST MAINTAIN THE REQUIRED AMOUNT OF PROFESSIONAL LIABILITY INSURANCE AND PAY THE REQUIRED FEE AND CAT FUND SURCHARGE. FAILURE TO DO SO WILL RESULT IN SUSPENSION OR REVOCATION OF YOUR LICENSE.

ANY DISCIPLINARY ACTION TAKEN IN ANOTHER STATE, TERRITORY OR COUNTRY SHALL BE REPORTED TO THE BOARD ON THE BIENNIAL RENEWAL NOTICE OR WITHIN 30 DAYS OF FINAL DISPOSITION, WHICHEVER IS SOONER.

THE FOLLOWING QUESTIONS MUST BE ANSWERED. IF YOU ANSWER "YES" TO QUESTIONS 2, 3, 4, OR 5 BELOW, PLEASE PROVIDE COMPLETE DETAILS IN 8 1/2 X 11 SHEETS OF PAPER AND INCLUDE COPIES OF LEGAL DOCUMENTS, IF ANY.

YES NO

1. DO YOU HOLD A LICENSE TO PRACTICE MEDICINE AND SURGERY IN ANY OTHER JURISDICTION? IF YES, LIST EACH ONE ON THE BACK.
2. SINCE YOUR LAST RENEWAL, HAS ANY DISCIPLINARY ACTION BEEN TAKEN AGAINST YOUR LICENSE IN ANOTHER STATE, TERRITORY OR COUNTRY?
3. SINCE YOUR LAST RENEWAL, HAVE YOU BEEN CONVICTED, FOUND GUILTY OR NOLO CONTENDERE, OR RECEIVED PROBATION WITHOUT VERDICT AS TO ANY FELONY OR MISDEMEANOR, INCLUDING ANY DRUG LAW VIOLATION, IN ANY STATE OR FEDERAL COURT?
4. SINCE YOUR LAST RENEWAL, HAVE YOU HAD PRACTICE PRIVILEGES DENIED, REVOKED OR RESTRICTED IN A HOSPITAL OR OTHER HEALTH CARE FACILITY?
5. SINCE YOUR LAST RENEWAL, HAVE YOU HAD YOUR DEA REGISTRATION DENIED, REVOKED OR RESTRICTED OR HAVE YOU HAD YOUR PROVIDER PRIVILEGES TERMINATED BY ANY MEDICAL ASSISTANCE AGENCY FOR CAUSE?

IF YOU WANT YOUR LICENSE PLACED ON "INACTIVE" STATUS PLACE AN "X" IN THE BLANK TO THE RIGHT.
NO FEE IS REQUIRED. YOU ARE STILL REQUIRED TO ANSWER THE QUESTIONS ABOVE.

SIGN AND DATE BELOW AND PROVIDE THE REQUESTED INFORMATION:

SOCIAL SECURITY NUMBER:

DATE OF BIRTH:

NAME OF MEDICAL SCHOOL:

Washington University, St. Louis MO

YEAR OF GRADUATION

1990

CERTIFY THAT THE INFORMATION CONTAINED IN THIS APPLICATION IS TRUE AND CORRECT UNDER 18 PA. C.S. SECTION 4904 RELATING TO
HONOR FALSIFICATION TO AUTHORITIES

SIGNATURE

DATE

10.7.96

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

Official Use Only

025640

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H A M I L R N E W

THIS IS YOUR RENEWAL NOTICE - REQUIRED FEE - \$125.00

STATE BOARD OF MEDICINE
P.O. BOX 8414
HARRISBURG, PA. 17105-8414

CRISTINA PETIT HAMIL

BRYN MAWR, PA. 19010

YOUR CURRENT LICENSE TO PRACTICE MEDICINE AND SURGERY IN PENNSYLVANIA WILL EXPIRE ON DECEMBER 31, 1998. TO RENEW YOUR LICENSE THROUGH DECEMBER 31, 2000, COMPLETE THE QUESTIONS BELOW AND RETURN WITH A CHECK OR MONEY ORDER IN THE AMOUNT OF \$125.00 MADE PAYABLE TO THE COMMONWEALTH OF PA. WRITE YOUR LICENSE NUMBER ON THE FRONT OF THE PAYMENT. A LATE FEE OF \$5.00 PER MONTH WILL BE CHARGED FOR RENEWALS POSTMARKED AFTER DECEMBER 31, 1998. A PROCESSING FEE OF \$20.00 WILL BE CHARGED FOR ANY CHECK OR MONEY ORDER UNPAID BY YOUR BANK, REGARDLESS OF THE REASON. IF YOU HAVE A CHANGE IN NAME AND/OR ADDRESS, INDICATE THE CHANGE NEXT TO THE PRE-PRINTED NAME AND ADDRESS ABOVE. A NAME CHANGE REQUIRES SUBMISSION OF A COPY OF A COURT ORDER, MARRIAGE CERTIFICATE, DIVORCE DECREE OR OTHER OFFICIAL DOCUMENT.

NOTICE: IF YOU PRACTICE IN PENNSYLVANIA, YOU MUST MAINTAIN THE REQUIRED AMOUNT OF PROFESSIONAL LIABILITY INSURANCE AND PAY THE REQUIRED FEE AND CAT FUND SURCHARGE. FAILURE TO DO SO WILL RESULT IN SUSPENSION OR REVOCATION OF YOUR LICENSE.

ANY DISCIPLINARY ACTION TAKEN IN ANOTHER STATE, TERRITORY OR COUNTRY SHALL BE REPORTED TO THE BOARD ON THE BIENNIAL RENEWAL NOTICE OR WITHIN 30 DAYS OF FINAL DISPOSITION, WHICHEVER IS SOONER.

THE FOLLOWING QUESTIONS MUST BE ANSWERED. IF YOU ANSWER "YES" TO QUESTIONS 2, 3, 4, OR 5 BELOW, YOU MUST PROVIDE COMPLETE DETAILS ON 8 1/2 X 11 SHEETS OF PAPER AND INCLUDE COPIES OF LEGAL DOCUMENTS, IF ANY. FAILURE TO PROVIDE DOCUMENTS WILL DELAY THE PROCESS.

- YES NO
- () ☒ 1. DO YOU HOLD A LICENSE TO PRACTICE MEDICINE AND SURGERY IN ANY OTHER JURISDICTION? IF YES, LIST EACH ONE BELOW.
- () ☒ 2. SINCE YOUR LAST RENEWAL, HAS ANOTHER STATE, TERRITORY OR COUNTRY TAKEN ANY DISCIPLINARY ACTION (INCLUDES VOLUNTARY SURRENDER OF A LICENSE) AGAINST YOU OR FILED CHARGES AGAINST YOU THAT HAVE NOT BEEN RESOLVED IN YOUR FAVOR?
- () ☒ 3. SINCE YOUR LAST RENEWAL, HAVE YOU BEEN CONVICTED, FOUND GUILTY, PLEADED NOLO CONTENDERE, RECEIVED PROBATION WITHOUT VERDICT, OR RECEIVED ANY OTHER DISPOSITION (EXCLUDING ACQUITTAL OR DISMISSAL), WITH RESPECT TO ANY CRIMINAL OFFENSE, INCLUDING ANY DRUG LAW VIOLATIONS, OR DO YOU HAVE ANY CRIMINAL CHARGES PENDING AND UNRESOLVED IN ANY STATE OR FEDERAL COURT? (A SUMMARY TRAFFIC VIOLATION SHOULD NOT BE CONSIDERED AS A CRIMINAL OFFENSE.)
- () ☒ 4. SINCE YOUR LAST RENEWAL, FOR DISCIPLINARY REASONS HAVE YOU WITHDRAWN AN APPLICATION FOR A LICENSE, HAD AN APPLICATION FOR A LICENSE DENIED OR REFUSED, OR AGREED NOT TO REAPPLY FOR A LICENSE IN ANOTHER STATE, TERRITORY OR COUNTRY? A LICENSE INCLUDES A REGISTRATION OR CERTIFICATION.
- () ☒ 5. SINCE YOUR LAST RENEWAL, HAVE YOU HAD PRACTICE PRIVILEGES DENIED, REVOKED, SUSPENDED, RESTRICTED, SURRENDERED IN LIEU OF DISCIPLINE OR EMPLOYMENT TERMINATED IN A HOSPITAL OR ANY HEALTH CARE FACILITY?
- () ☒ 6. SINCE YOUR LAST RENEWAL, HAVE YOU HAD YOUR DEA REGISTRATION DENIED, REVOKED OR RESTRICTED OR HAVE YOU HAD YOUR PROVIDER PRIVILEGES TERMINATED BY ANY MEDICAL ASSISTANCE AGENCY FOR CAUSE?

IF YOU WANT YOUR LICENSE PLACED ON "INACTIVE" STATUS PLACE AN "X" IN THE BLANK TO THE RIGHT.
NO FEE IS REQUIRED. YOU ARE STILL REQUIRED TO ANSWER THE QUESTION, SIGN AND DATE BELOW.

MY REPRESENTATIONS AND RESPONSES IN THIS DOCUMENT ARE TRUE AND CORRECT TO THE BEST OF MY KNOWLEDGE. I UNDERSTAND THAT THEY ARE SUBJECT TO THE PENALTIES OF 18 PA. C.S. 4904 RELATING TO UNSWORN FALSIFICATION TO AUTHORITIES.

SIGNATURE

DATE

10 7 98

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

Official Use Only

032069

MD - 051384 - L

HAMIL RNEW

THIS IS YOUR RENEWAL NOTICE - REQUIRED FEE - \$125.00

STATE BOARD OF MEDICINE
P.O. BOX 8414
HARRISBURG, PA. 17105-8414

CRISTINA PETIT HAMILL

BRYN MAWR, PA. 19010

YOUR CURRENT LICENSE TO PRACTICE MEDICINE AND SURGERY IN PENNSYLVANIA WILL EXPIRE ON DECEMBER 31, 2000. TO RENEW YOUR LICENSE THROUGH DECEMBER 31, 2002, COMPLETE THE QUESTIONS BELOW AND RETURN WITH A CHECK OR MONEY ORDER IN THE AMOUNT OF \$125.00 MADE PAYABLE TO THE "COMMONWEALTH OF PA." WRITE YOUR LICENSE NUMBER ON THE FRONT OF THE PAYMENT. A LATE FEE OF \$5.00 PER MONTH WILL BE CHARGED FOR RENEWALS POSTMARKED AFTER DECEMBER 31, 2000. A PROCESSING FEE OF \$20.00 WILL BE CHARGED FOR ANY CHECK OR MONEY ORDER UNPAID BY YOUR BANK, REGARDLESS OF THE REASON. IF YOU HAVE A CHANGE IN NAME AND/OR ADDRESS, INDICATE THE CHANGE NEXT TO THE PRE-PRINTED NAME AND ADDRESS ABOVE. A NAME CHANGE REQUIRES SUBMISSION OF A COPY OF A COURT ORDER, MARRIAGE CERTIFICATE, DIVORCE DECREE OR OTHER OFFICIAL DOCUMENT.

NOTICE: IF YOU PRACTICE IN PENNSYLVANIA, YOU MUST MAINTAIN THE REQUIRED AMOUNT OF PROFESSIONAL LIABILITY INSURANCE AND PAY THE REQUIRED FEE AND CAT FUND SURCHARGE. FAILURE TO DO SO WILL RESULT IN SUSPENSION OR REVOCATION OF YOUR LICENSE.

ANY DISCIPLINARY ACTION TAKEN IN ANOTHER STATE, TERRITORY OR COUNTRY SHALL BE REPORTED TO THE BOARD ON THE BIENNIAL RENEWAL NOTICE OR WITHIN 30 DAYS OF FINAL DISPOSITION, WHICHEVER IS SOONER.

THE FOLLOWING QUESTIONS MUST BE ANSWERED. IF YOU ANSWER "YES" TO QUESTIONS 2, 3, 4, OR 5 BELOW, YOU MUST PROVIDE COMPLETE DETAILS ON 8 1/2 X 11 SHEETS OF PAPER AND INCLUDE COPIES OF LEGAL DOCUMENTS, IF ANY. FAILURE TO PROVIDE DOCUMENTS WILL DELAY THE PROCESS.

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1. DO YOU HOLD A LICENSE TO PRACTICE MEDICINE AND SURGERY (ACTIVE OR INACTIVE, CURRENT OR EXPIRED) IN ANY OTHER JURISDICTION? IF YES, LIST EACH ONE.
2. SINCE YOUR LAST RENEWAL, HAS ANOTHER STATE, TERRITORY OR COUNTRY TAKEN ANY DISCIPLINARY ACTION (INCLUDES VOLUNTARY SURRENDER OF A LICENSE) AGAINST YOU OR FILED CHARGES AGAINST YOU THAT HAVE NOT BEEN RESOLVED IN YOUR FAVOR?
3. SINCE YOUR LAST RENEWAL, HAVE YOU BEEN CONVICTED, FOUND GUILTY, PLEADED NOLO CONTENDERE, RECEIVED PROBATION WITHOUT VERDICT, OR RECEIVED ANY OTHER DISPOSITION (EXCLUDING ACQUITTAL OR DISMISSAL), WITH RESPECT TO ANY CRIMINAL OFFENSE, INCLUDING ANY DRUG LAW VIOLATIONS, OR DO YOU HAVE ANY CRIMINAL CHARGES PENDING AND UNRESOLVED IN ANY STATE OR FEDERAL COURT? (A SUMMARY TRAFFIC VIOLATION SHOULD NOT BE CONSIDERED AS A CRIMINAL OFFENSE.)
4. SINCE YOUR LAST RENEWAL, FOR DISCIPLINARY REASONS HAVE YOU WITHDRAWN AN APPLICATION FOR A LICENSE, HAD AN APPLICATION FOR A LICENSE DENIED OR REFUSED, OR AGREED NOT TO REAPPLY FOR A LICENSE IN ANOTHER STATE, TERRITORY OR COUNTRY? A LICENSE INCLUDES A REGISTRATION OR CERTIFICATION.
5. SINCE YOUR LAST RENEWAL, HAVE YOU HAD PRACTICE PRIVILEGES DENIED, REVOKED, SUSPENDED, RESTRICTED, SURRENDERED IN LIEU OF DISCIPLINE OR EMPLOYMENT TERMINATED IN A HOSPITAL OR ANY HEALTH CARE FACILITY?
6. SINCE YOUR LAST RENEWAL, HAVE YOU HAD YOUR DEA REGISTRATION DENIED, REVOKED OR RESTRICTED OR HAVE YOU HAD YOUR PROVIDER PRIVILEGES TERMINATED BY ANY MEDICAL ASSISTANCE AGENCY FOR CAUSE?

IF YOU WANT YOUR LICENSE PLACED ON "INACTIVE" STATUS PLACE AN "X" IN THE BLANK TO THE RIGHT.

NO FEE IS REQUIRED. YOU ARE STILL REQUIRED TO ANSWER THE QUESTION, SIGN AND DATE BELOW.

MY REPRESENTATIONS AND RESPONSES IN THIS DOCUMENT ARE TRUE AND CORRECT TO THE BEST OF MY KNOWLEDGE. I UNDERSTAND THAT THEY ARE SUBJECT TO THE PENALTIES OF 18 PA. C.S. 4904, RELATING TO UNSWORN FALSIFICATION TO AUTHORITIES.

SIGNATURE

DATE

4.27.00