Martha J. Chamers, MD
(P) 716-220-8542

710 03 0596

FORM 1.	RECEIVED
MEDICINE	

2001 MAY 29

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

FOR DEPARTMENT USE ONLY

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APPLICATION FOR LICENSE AND FIRST REGISTRATION

1 SOCIAL SECURITY NUMBER: [redacted]
(Leave this blank if you have no U.S. Social Security Number)

2 BIRTH DATE: [redacted] mo. day yr.

3 PRINT FULL NAME AS YOU WISH IT TO APPEAR ON YOUR LICENSE:

Last: Chalmers
First: Martha
Middle: Jean

NYS License Number
221542 6/21/01
6/21/01

4 MAILING ADDRESS CHECK ONE: ☐ HOME ADDRESS ☒ WORK ADDRESS

Care of: Family Medicine
Street: 885 South Avenue
City: Rochester
State: NY Zip Code: 14620
Province/Country If not U.S.:

The above address is: ☐ permanent address of record ☒ temporary mailing address

IMPORTANT: The applicant is responsible for notifying the Department of any name or address changes.

5 TELEPHONE
HOME [redacted]
Area Code Number
WORK
716-442-7470
Area Code Number

E-Mail Address: martha_chalmers@urmc.rochester.edu
Pager # = [redacted]

6 Name as it appears on diploma or other credentials (if different from above): Martha Jean Williams

7 Citizenship. ■ United States ■ Alien lawfully admitted for permanent residence in the United States. (Attach a copy of the front and back of the alien registration card) ■ Other Immigration

8 Mother's Maiden Name (family name before her marriage): [redacted]

9 I wish to become licensed on the basis of: ☒ acceptable examination scores (see page 3 of this form) ☐ endorsement of another license (See Pg. 11.)

I am using FCVS to collect my credentials: ☒ YES ☒ NO

10 Have you previously applied for a New York State license or a limited permit to practice medicine? ☐ YES ☒ NO

11 Have you ever been convicted of a crime (felony or misdemeanor) in any state or country? YES (See note) NO

12 Have you ever been charged with a crime (felony or misdemeanor) in any state or country, the disposition of which was other than by acquittal or dismissal? YES (See note) NO

13 Have you ever surrendered your license or been found guilty of professional misconduct, unprofessional conduct, incompetence or negligence in any state or country? YES (See note) NO

14 Are charges pending against you for professional misconduct, unprofessional conduct, incompetence or negligence in any state or country? YES (See note) NO

15 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 measures? YES (See note) NO

NOTE: If any answer to any question 11-15 is "Yes," submit a letter giving complete explanation. Include copies of any court records, and if you possess one, a copy of the "Certificate of Relief from Disabilities" or your "Certificate of Good Conduct."

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16 In the space below, give a complete record of your education preparation. Attach additional sheets if necessary.

SCHOOLS ATTENDED AND LOCATION (including country) List schools in original language and translate.	Number of Years Attended	Diploma or Degree Obtained *List diploma or degree titles in original language and translate. Indicate year obtained*	If no diploma or degree, number of credits earned
Medical Education (Professional) (List all medical schools attended) The George Washington University School of Medicine	4	M.D.	—

17 If you completed clinical clerkships in a country other than where your medical school is located, give the dates and location of these clerkships. Attach additional sheets if necessary.

Inclusive Clerkship Dates	Clinical Area	Name of Health Care Facility And Address	Medical School with which Clerkship Affiliated and Address

18 Provide a chronological list of all activities since graduation from professional school to the present. Include vacation periods and periods of employment. Attach additional sheets if necessary.

DATE (mm/dd/yy) From	To	Type of Activity, Beginning with Date of Graduation from Professional School. Include Name and Address of Employers.
5/17/98	6/21/98	study for boards / taking boards / vacation
6/22/98	present	Family Medicine Residency, U of Rochester
		885 South Avenue, Rochester, NY 14620

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(?) 714-220-8542

19 **Complete item 19 only if you are a graduate of a program not registered by New York State or LCME or AOA accredited.**

Have you completed all portions of the examination requirements for ECFMG certification? ☐ Yes ☐ No

Do you currently hold a valid ECFMG certificate? ☐ Yes ☐ No

Please complete and forward the ECFMG form enclosed with this application packet.

20 Are you applying for licensure on the basis of a Fifth Pathway program? ☐ Yes ☒ No

If Yes, list name and location of medical school or hospital and the inclusive dates of attendance.

Name and Location of Medical School or Hospital	Inclusive Dates of Attendance

21 List in English, all specialty qualifications you have earned. (i.e., Board Specialty Certification or Diplomate Certificate)

Name of Qualifications	Name and location of organization issuing credential

22 ☒ error I will be applying for USMLE Step 3

OR

☒ I have successfully completed the examination combination indicated below:

EXAMINATION COMBINATIONS

- ☒ USMLE Steps 1, 2, and 3
- ☐ FLEX Parts I, II, and III
- ☐ FLEX Components I and II
- ☐ NBME Parts I, II, and III
- ☐ NBME Parts I and II and USMLE Step 3
- ☐ NBME Part 1, USMLE Step 2 and NBME Part III
- ☐ NBME Part I, and USMLE Steps 2 and 3
- ☐ USMLE Step 1, and NBME Parts II and III
- ☐ USMLE Step 1, NBME Part II, and USMLE Step 3
- ☐ USMLE Steps 1 and 2 and NBME Part III
- ☐ USMLE Step 1, NBME Part II, and FLEX Component II
- ☐ NBME Part I, USMLE Step 2, and FLEX Component II
- ☐ USMLE Steps 1 and 2 and FLEX Component II
- ☐ NBME Parts I and II and FLEX Component II
- ☐ FLEX Component I and USMLE Step 3
- ☐ NBOME Parts I, II, and III
- ☐ Other: ____________

Date examination sequence was completed 3/26/01

Martha J. Chalmers, MD
(?) 716-220-8542

23 Are you licensed or have you ever been licensed as a physician in any other state or country? ☐ Yes ☒ No
If yes, list each jurisdiction. In addition, you must have a Form 3A or 3B, as appropriate, submitted. See pages 14 - 15.

State or Country	Date License Issued	Number	Basis of Licensure			Any Limitations on License
			Examination (Date passed)	Endorsement	Other	

24 If you hold a New York State license in another profession, indicate the profession, your license number and date of licensure below.

Profession	License Number	Date of Initial Licensure (mm/dd/yy)
		/ /
		/ /
		/ /
		/ /

25 **CHILD SUPPORT OBLIGATION:**

New York State General Obligations Law, section 3-503, requires every applicant for a professional license, permit, or registration, or any renewal there of, to file a written statement that, as of the date of the filing, he or she is, or is not, under an obligation to pay child support. **Individuals who are four months or more in arrears in child support may be subject to suspension of their business, professional and/or drivers licenses.** The intentional submission of false written statements for the purpose of frustrating or defeating the lawful enforcement of support obligations is punishable pursuant to section 175.35 of the Penal Law.

You must complete this section before we can issue the credential for which you have applied. Individuals who are under an obligation to pay child support but are not in compliance with the General Obligations Law can be issued a credential for no more than six months to discharge child support obligations consistent with that law.

Check only A or B below. If you check B, you must check one of the five statements listed below it.

A ☐ I am not under an obligation to pay child support:

OR

B ☐ I am under an obligation to pay child support *and* (please check only one of the following)

- ☐ I am current and am not four months or more in arrears in the payment of child support: or,
- ☐ I am making payments by income execution or by court agreed payment plan or by a plan agreed to by the parties; or,
- ☐ The child support obligation is the subject of a pending court proceeding; or,
- ☐ I am receiving public assistance or supplemental security income; or,
- ☐ None of the above four statements apply.

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26 **STUDENT LOAN DISCLOSURE:**

(a) Do you have any outstanding loans made or guaranteed by the New York State Higher Education Services Corporation? ☐ Yes ☐ No

(b) If you have such a loan(s), is any part in default? ☐ Yes ☐ No

NOTE: Education Law (Section 6501-a) requires the State Education Department to ask the questions above and forward any "yes" responses to question (b) to the New York State Higher Education Services Corporation. **Your license application is not complete without this information.**

27 **GENDER AND ETHNICITY: (This item is optional. See note below.)**

NOTE: Information on gender and ethnicity is sought solely to allow the Education Department to collect and analyze data concerning representation in the licensed professions. The ethnic and gender data you provide will be used only for statistical, research, and program evaluation purposes. It will not be released to the public. This information has absolutely no bearing on your qualification for licensure.

ETHNICITY: ☐ White (not Hispanic) ☐ Black (not Hispanic) ☐ Asian ☐ Hispanic ☐ Native American

GENDER: ☐ Male ☐ Female

28 **CHILD ABUSE IDENTIFICATION AND REPORTING: (check only one of the following.)**

☐ I graduated from a New York State medicine program after September 1, 1990.

☒ I completed the child abuse coursework and have enclosed a certificate of completion from an approved provider.

☐ I am filing for an exemption to the requirement and have enclosed the exemption form.

29 **PHOTOGRAPH REQUIREMENT:** →

I give permission to the New York State Education Department to release my examination results to my professional school for the confidential purposes of program review and institution research and planning. I may rescind this authority at any time by notifying, in writing, the Division of Professional Licensing Services.

☑ Yes ☐ No Please initial: MJC

Under penalties of perjury, I declare and affirm that the statements made in this application, including accompanying documents, 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: [signature] Date: 2/1/01

Mail this form and appropriate fee to: New York State Education Department, Office of the Professions, Fee Section, Division of Professional Licensing Services, Cultural Education Center, Albany, NY 12230. DO NOT SEND CASH. Make check or money order payable to the New York State Education Department.

The University of the State of New York
THE STATE EDUCATION DEPARTMENT

Martha J. Chamers, MD (P) 716-220-8592

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CERTIFICATION OF COMPLETION

(Coursework/Training in Identification and Reporting of Child Abuse and Maltreatment)

PART A TRAINEE INFORMATION

1. Trainee must complete all items in Part A. Return to provider for completion of Part B, "Certification by Approved Provider".
2. The provider will return the Certification form, with Part B completed, to the trainee. It is the trainee's responsibility to submit the original copy of this Certification form to the New York State Education Department at the appropriate time. It should be submitted along with other relevant forms when the trainee applies initially for, or renews, a license, registration certificate, or permit.
3. Address for submitting form is as follows:
   - Professional License or Permit: New York State Education Department, Division of Professional Licensing Services, [give name of profession], Cultural Education Center, Albany, New York 12230.
   - Reregistering Licensees: Your certificate should be included with your reregistration application in the envelope provided with those materials.
   - Teacher Certification: New York State Education Department, Office of Teaching, Cultural Education Center, Albany, New York 12230.

1 Print name exactly as it currently appears on New York State Education Department records:

Last: Challmers
First: Martha
Middle: Jean

2 Print your address:

Care of: Dept of Family Medicine
Misc. (Bldg. & Apt., etc.):
Street: 885 South Ave
City: Rochester
State: NY Zip Code: 14620-

3 Date of Birth: [redacted] Mo. Day Yr.

4 Social Security number: [redacted]

5 Complete information below If you hold or are applying for, professional license(s) or a permit:

Name of Profession(s): Physician (MD)
N.Y.S License Number:
N.Y.S License Number:
Permit #:

6 Complete information below If you hold, or are applying for a teaching certificate:

Certificate Title(s):

N.Y.S. Certificate Number (other than Social Security Number, if any):

Trainee's Signature: Date: 2/5/01

PART B CERTIFICATION BY APPROVED PROVIDER

1. Provider must complete Part B.
2. The EDUCATION DEPARTMENT-ORIGINAL COPY and TRAINEE COPY should be returned to the trainee within ten calendar days of the completion of the coursework or training.
3. The provider of the coursework or training must retain the PROVIDER COPY. This copy must be retained in the provider's files for not less than five years from the date the course was completed.

Pursuant to Chapter 544 of the Laws of 1988, I certify that the person indicated in Part A has completed the required coursework or training regarding the identification and reporting of child abuse and maltreatment.

Patricia A. Huntington
Name of Authorized Certifying Officer (Print or Type)

Signature of Authorized Certifying Officer

Nazareth College
Approved Provider Name

30380
Identification Number

2/5/01
Date(s) of Coursework or Training

STATE EDUCATION DEPARTMENT COPY

FORM 2
MEDICINE

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

PROFESSIONAL LICENSING UNIT B
2001 JUN 13 PM 1:14

CERTIFICATION OF PROFESSIONAL AND PREPROFESSIONAL EDUCATION

APPLICANT INSTRUCTIONS

1. Complete Section 1. Enter your name as it appears on your New York State Licensure Application (Form 1).
2. Send this form to the professional school you attended to complete Section II. Be sure to include any fee required. If you graduated from a medical school that was not registered by New York State or accredited by LCME/AOA, notify the school that a transcript must accompany this form.
3. If you attended a medical school that has been closed, send this form to the official repository of the records for that school (e.g., CONES).
4. This form must be signed by the Registrar, Dean, Rector, or Principal of the medical school and sent back directly to the Office of the Professions by that school official in an official school envelope. Forms sent back by the applicant or other parties will not be accepted.

SECTION I: APPLICANT INFORMATION

1 SOCIAL SECURITY NUMBER [redacted]
(Leave this blank if you have no U.S. Social Security Number)

2 BIRTH DATE [redacted]
Month Day Year

3 PRINT FULL NAME EXACTLY AS IT APPEARS ON YOUR LICENSURE APPLICATION (FORM 1)

Last: Chalmers
First: Martha
Middle: Jean
Maiden or Previous name: Williams

4 MAILING ADDRESS:
Apt./Bldg.: C/O Family Medicine
Street: 885 South Avenue
City: Rochester
State: NY Zip Code: 14620
Province/Country if not U.S.:

(check only one) ☐ permanent address of record ☒ temporary mailing address until: 7 / 31 / 2002 (mo. day. yr.)

5 TELEPHONE: WORK 716-442-7470 (Area Code Number) HOME [redacted] (Area Code Number)

6 Print name under which your degree or diploma was awarded *(if different from above)*: ____________

7 Preprofessional School Attended: [redacted]

8 Professional School Attended: The George Washington University School of Medicine
Address: 2121 "Eye" Street, Washington DC 20052

9 Name of Degree/Diploma: M.D. Date awarded: 5/17/98

SECTION II : CERTIFICATION OF PROFESSIONAL

INSTRUCTION TO SCHOOL: Please complete this section, sign certifying statement, attach the information in Item 5 and send directly to the Office of the Professions at the address shown below. **This form will not be accepted if returned by the applicant or any other party.**

1 Applicant's Entrance date: 8 / 22 / 94 Completion/~~Withdrawal~~ Date: 5 / 8 / 98

2 Degree/~~diploma~~ conferred: Doctor of Medicine Date of conferral: 5 / 17 / 98

3 Did the applicant receive advanced standing based on prior academic work? ☐ YES ☒ NO
If Yes, indicate when the prior work was completed below.

Name of Institution: ______ Dates of attendance: ______ to ______

Submit with this form: (1) An official transcript of studies at your institution, and
(2) Copies of documentation in your file to support the granting of transfer credit.

4 *For Applicants from N.Y.S. Registered or LCME/AOA Accredited Medical Schools:*
Applicant met LCME/AOA requirements for admission to medical/osteopathic school? ☐ YES ☐ NO

If No, number of preprofessional postsecondary credit hours completed by applicant prior to admission to medical school ______ semester hours or ______ quarter hours.

5 *For All Other Applicants:*

Years of education required for admission into your medical school: 4

Preprofessional credential/degree submitted by applicant for admission into your medical school: BA

Was Social Service required? ☐ YES ☒ NO If Yes, give inclusive dates and name of institution in which requirement was met.

Institution: ______ Dates: ______ to ______

Was a pre-graduation internship required? ☐ YES ☒ NO If Yes, give inclusive dates and name of institution in which requirement was met.

Institution: ______ Dates: ______ to ______

Submit with this form:

A. An official transcript (course record, index, or marksheets) showing courses taken at your institution and accepted from other institutions for transfer of credit of convalidation.
The transcript must bear the original signature of the dean, principal, rector, or registrar and original seal of the school.

B. A copy of documentation from your files to support the granting of transfer credit or convalidated course and clerkships.

C. List of clinical clerkship completed outside jurisdiction where medical school is located, including (for each): area or specialty, starting and ending dates of clerkship, and name and address of hospital where clerkship was performed.

FOR ATTENDEES OF CIFAS, CETEC, AND UTESA, this list must include all clerkships completed, both inside and outside the jurisdiction where the medical school is/was located.

I certify that to the best of my knowledge and belief the foregoing is a true statement of the record of the individual named on this form.

Signature: [signature]

Type or Print Name: ANTHONY L. WHITE

Title: EXECUTIVE COORDINATOR FOR STUDENT SERVICES AND REGISTRAR

Medical School: THE GEORGE WASHINGTON UNIV

Address: 2300 I St NW ROSS 713W
WASHINGTON DC 20037

Telephone: 202/994-3501 *E-mail address:* MSDALW@GWUMC.EDU

Date: 6 / 7 / 01 **CERTIFICATION IS NOT ACCEPTABLE UNLESS DATED AFTER GRADUATION.**

(SEAL)

Return this Form and material requested above to: New York State Education Department, Office of the Professions, Division of Professional Licensing Services, Medicine Licensing Unit, Cultural Education Center, Albany, NY 12230.

FORM 2PGT

MEDICINE

2011 FEB 12 10 51 57

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

Certification of completion of approved postgraduate training will be accepted only if it is signed no more than one month prior to the completion date of the training period in which credit is sought.

CERTIFICATION OF APPROVED POSTGRADUATE TRAINING

(To be used only for U.S. and Canadian approved postgraduate training programs)

APPLICANT INSTRUCTIONS

1. Complete Section 1. Enter your name as it appears on your Licensure Application (Form 1).
2. Please send this form to the director of medical education of the hospital(s) in which you completed postgraduate training. One form must be submitted to verify each residency. If you have completed more than one residency, you may photocopy this form.
3. This form must be sent directly to the Department by the hospital in which you did your residency. If the hospital in which you did your residency does not have a director of medical education, the forms may be completed by the department chair. If the Department cannot determine that this verification came directly from the hospital, the postgraduate hospital training will not be credited.

SECTION I: APPLICANT INFORMATION

1 SOCIAL SECURITY NUMBER: [redacted]

(Leave this blank if you have no U.S. Social Security Number)

2 BIRTH DATE: [redacted]
Month Day Year

3 PRINT FULL NAME EXACTLY AS IT APPEARS ON YOUR APPLICATION (FORM 1):

Last: Chalmers
First: Martha
Middle: Jean

4 MA[redacted] ADDRESS:

Apt/Bldg: c/o Family Medicine
Street: 885 South Avene
City: Rochester
State: NY Zip Code: 14620
Province/Country if not U.S.:

5 Print name under which postgraduate training was completed: Martha J. Chalmers

6 Hospital in which postgraduate training was completed: Highland Hospital

Address: 1000 South Ave, Rochester, NY 14620

SECTION II : CERTIFICATION OF POSTGRADUATE TRAINING

INSTRUCTION TO HOSPITAL: Please complete this section, sign certifying statement, and return the form *directly* to the Division of Professional Licensing Services at the address shown below. **This form will not be accepted if returned by the applicant.**

This is to certify that Martha J Chalmers MD
(Physician's Name)

a graduate of George Washington Univ.
(Medical school)

was enrolled in a postgraduate training program(s) approved by the Accreditation Council on Graduate Medical Education, the American Osteopathic Association, or Royal College of Physicians and Surgeons of Canada at The Univ. Rochester / Highland Hospital Fam Med. 885 South Ave Rochester, NY 14620
(Name and location of Hospital)

Level of Training (example PGY-1)	Clinical Area	Inclusive dates (mm/dd/yy)	Successfully completed
PGY 1	Fam. Prac	6/22/98 to 6/27/99	☑ YES ☐ NO ☐ In progress; satisfactory to date
PGY 2	Fam. Prac	6/28/99 to 6/28/2000	☑ YES ☐ NO ☐ In progress; satisfactory to date
PGY 3	Fam. Prac	6/29/2000 to 6/27/2001	☐ YES ☐ NO ☑ In progress; satisfactory to date
		__/__/__ to __/__/__	☐ YES ☐ NO ☐ In progress; satisfactory to date
		__/__/__ to __/__/__	☐ YES ☐ NO ☐ In progress; satisfactory to date

If this physician did not successfully complete the postgraduate training program, please attach a letter of explanation with this form.

☐ Explanation is attached

I am the director of medical education or department chair of the clinical area. I was the program director for the physician named above during the postgraduate training indicated and have carefully read and completed this form and hereby attest that the statements made herein are strictly true in every respect and are supported by hospital records.

Signature of Director/Chair: [signature]

Type or Print Name of Director/Chair: Jeffrey J Harp, MD

Title or Official position: Residency Director

Institution: Univ. Rochester / Highland Hosp.

Address: 885 South Avenue
Rochester, NY 14620

Telephone: 716-442-7470 Date: 2/2/01

E-mail Address:

(SEAL)

Return this Form to: New York State Education Department, Office of the Professions, Division of Professional Licensing Services, Medicine Licensing Unit, Cultural Education Center, Albany, NY 12230.