266393

REDACTED COPY

Board of Registration in Medicine
200 Harvard Mill Square, Suite 330 - Wakefield, MA 01880
Telephone: (781) 876-8210 Fax: (781) 876-8383 www.mass.gov/massmedboard

FULL LICENSE APPLICATION

Application Fee: Please enclose a check or money order in the amount of $600.00 made payable to the Commonwealth of Massachusetts. The application fee is non-refundable.

Type of License ☑ Initial Full License ☐ Administrative License ☐ Volunteer License

Check One: ☐ U.S./Canadian Graduate ☐ International Graduate

Legal Name (do not use nicknames or initials, unless they are part of your legal name)

LIEF	AMY	ELIZABETH	
Last Name (type or print clearly)	First	Middle	Suffix (Jr., etc.)

☑ M.D. ☐ D.O. ☐ PhD ☐ Other degree _____ ☐ Male ☑ Female

Other Name(s) Used - List any other name(s) you have used which may appear on your identifying documents, such as medical education and examination records. If not applicable, check here. ☐

Entire Last Name (type or print clearly) First Middle Suffix (Jr., etc.)

Social Security Number: [redacted] Date of Birth: [redacted] (Month Day Year)

NPI (National Provider Identifier) Number: 1295701753

Place of Birth: Bronx NY
City State/Province/Territory Country if not USA

*Mailing Address: [redacted] Telephone: [redacted]
Number and Street

[redacted]
City State/Province/Territory Zip (or postal) Code

Home Address: [redacted] Telephone: [redacted]
Number and Street

[redacted]
City State/Province/Territory Zip (or postal) Code

Business Address: 600 Mamaroneck Ave Suite 301 Telephone: 914-723-8100
Number and Street

Harrison NY 10528
City State/Province/Territory Zip (or postal) Code

E-mail Address: [redacted] Fax number: 914-989-1199

Are you applying for licensure through FCVS? ☐ Yes ☑ No

*** The Board will use your Mailing Address for all correspondence**

Pre-medical School

			From	To
Name: Yale University	Degree: BA		Year: 1991	Year: 1995
Street: PO Box 208218	City: New Haven	State: CT		
Name: Harvard University	Degree: —		Year: 1995	Year: 1996
Street: Massachusetts Hall	City: Cambridge	State: MA		

Medical School

Name: Albert Einstein College of Medicine Degree: MD

Street: 1300 Morris Park Avenue City: Bronx State: NY

Name: Degree:

Street: City: State:

Medical School Graduation Date: 6 / 2001
Month Year

Postgraduate Education:

List all postgraduate training in chronological order from medical school to the present. Include the name and address of the facility, your position, e.g. PGY 1, 2, fellow, etc. You must account for all periods of training or postgraduate work from the time you graduated from medical school. Enter month and year only.

			From	To
Facility: Children's Hospital At Montefiore	PGY Year: 1-3		7/01	6/04
Specialty: Pediatrics	City: Bronx	State: NY		
Facility: Children's Hospital At Montefiore	PGY Year: 4 (Chief)		7/04	6/05
Specialty: Pediatrics (Chief Resident)	City: Bronx	State: NY		
Facility: New York University School of Medicine	PGY Year: 5-6		7/05	6/07
Specialty: Fellow, M.S. degree program in Clinical Investigation ~~Attn: Patricia~~ exp	City: New York	State: NY		
Facility:	PGY Year:		/	/
Specialty:	City:	State:		
Facility:	PGY Year:		/	/
Specialty:	City:	State:		

Examination History

Please contact the appropriate examination entity and have the examination scores sent to you in a sealed envelope. If you are using FCVS, your examination scores will be sent to the Board with your credentials packet.

List each licensure examination, U.S. or international, you have taken (USMLE, NBME, NBOME, LMCC, FLEX, COMVEX, COMLEX or a state examination.

Examination	Number of attempts	Passed (P) or Failed (F)
USMLE Step I	one	☑ P ☐ F
USMLE Step II	one	☑ P ☐ F
USMLE Step III	one	☑ P ☐ F
NBME Part I		☐ P ☐ F
NBME Part II		☐ P ☐ F
NBME Part III		☐ P ☐ F
FLEX Component 1		☐ P ☐ F
FLEX Component 2		☐ P ☐ F
FLEX Pre-1985		☐ P ☐ F
NBOME Part I		☐ P ☐ F
NBOME Part II		☐ P ☐ F
NBOME Part III		☐ P ☐ F
COMLEX Level 1		☐ P ☐ F
COMLEX Level 2		☐ P ☐ F
COMLEX Level 3		☐ P ☐ F
COMVEX		☐ P ☐ F
LMCC – Single		☐ P ☐ F
LMCC – Part I		☐ P ☐ F
LMCC – Part II		☐ P ☐ F
State Board Exam	(State of examination and year)	☐ P ☐ F

Hospital Affiliations and Employment

List hospital appointments, in chronological order by month and year where you ever had medical staff privileges. Include the name and address of the facility, your position and dates of affiliation. Also include periods of unemployment or employment outside of medicine. Attach a separate sheet of paper if necessary.

		From	To
Facility: Children's Hospital At Montefiore	Position: Covering Attending, Emergency Department	9/04	7/10
Street: 3415 Bainbridge Ave.	City: Bronx	State: NY	
Facility: New York University Hospital	Position: Instructor	8/05	6/07
Street: 550 First Avenue	City: New York	State: NY	
Facility: Bellevue Hospital Center	Position: Clinical Assistant	8/05	6/07
Street: 462 First Avenue	City: New York	State: NY	

see next page

1. List other states (abbreviations) where you are currently or have ever had a full license: NY CT
2. a) Are you certified by the American Board of Medical Specialties? ☑ Yes ☐ No
   b) Are you certified by the American Board of Osteopathic Medicine? ☐ Yes ☐ No
3. List Board Certification(s): Pediatrics
4. List your practice specialt(ies): Pediatrics
5. Have you completed the Opioid and Pain Management training? (See Instructions) ☑ Yes ☐ No
6. Have you completed training to recognize and report suspected child abuse or neglect? ☑ Yes ☐ No
   (Your license will not be processed until you complete the required training – see instructions.)
7. Reason for requesting a Massachusetts medical license: I plan to work as the camp doctor at Camp Taconic in Hinsdale, MA
8. Name of Facility: Camp Taconic
   Address: 770 New Windsor Road City: Hinsdale
9. Anticipated starting date in Massachusetts: 7/30/16
10. Curriculum vitae (CV) listing activities by month and year must be enclosed with your application.

Under the penalties of perjury, I declare that I have examined this full application and all its accompanying instructions, forms and statements, and to the best of my knowledge and belief, the information contained herein is true, correct and complete.

Signature of Applicant

01 / 14 / 2016
Month Day Year

Hospital Affiliations and Employment, Continued:

			From	To
Facility: New York Presbyterian Hospital/ Columbia University Medical Center	Position: Assistant Clinical Professor		9/67	6/11
Street: 630 West 168th Street	City: New York	State: NY		
Facility: Stamford Hospital	Position: Staff Pediatrician		9/11	8/15
Street: 30 Shelburne Road	City: Stamford	State: CT		
Facility: Greenwich Hospital	Position: Staff Pediatrician		/	present
Street: 5 Perryridge Road	City: Greenwich	State: CT		

Amy Ried MD
Amy Ried

ELECTRONIC HEALTH RECORDS (EHR) PROFICIENCY FORM

Pursuant to M.G.L. c. 112, § 2, an applicant for licensure must demonstrate proficiency in the use of electronic health records (EHR). This is a one-time requirement.

Complete Section 1 (Demonstrating Proficiency) OR Section 2 (Claiming an Exemption) and Sign in Section 3.

SECTION 1. DEMONSTRATING PROFICIENCY

1. I have demonstrated proficiency in the use of EHR in one of the following ways:

___ Participation in a Meaningful Use program as an eligible professional;
✓ Employment with, credentialed to provide patient care at, or in a contractual agreement with an eligible hospital or critical access hospital with a CMS Meaningful Use program;
___ Participation as either a Participant or an Authorized User in the Massachusetts Health Information Highway.
___ Completion of 3 hours of a Category 1 EHR-related CPD course that discusses, at a minimum, the core and menu objectives and the Clinical Quality Measures ("CQMs") for Meaningful Use.

SECTION 2. CLAIMING AN EXEMPTION (Exemptions must be claimed each licensing cycle, if applicable. If you are exempted from the EHR proficiency requirement, please select the appropriate exemption.)

2. I am exempt from the EHR Proficiency requirement because I am an applicant

___ who will not be engaged in the practice of medicine as defined in 243 CMR 2.01(4);
___ for an Administrative License;
___ for a Volunteer License;
___ on active duty as a member of the National Guard or of a uniformed service called into service during a national emergency or crisis; or
___ for an Emergency Restricted License.

SECTION 3. SIGNATURE

I, the undersigned applicant, hereby certify that all information included in this EHR Proficiency Form constitutes a true statement made under penalties of perjury.

NAME: Mary E. Lee DATE: 1/19/16

Amy E. Lief, M.D., M.S.

Education and Training

8/91-5/95 **Yale University,** New Haven, CT
B.A., **History,** May 1995

8/95-5/96 **Harvard University,** Cambridge, MA
Post-Baccalaureate, **Premedical Sciences**

8/97-6/01 **Albert Einstein College of Medicine**, Bronx, NY
M.D., School of Medicine, June 2001

7/01-6/04 **Children's Hospital at Montefiore**, Albert Einstein College of Medicine, Bronx, NY
Intern and Resident, Department of Pediatrics

7/04-6/05 **Children's Hospital at Montefiore**, Albert Einstein College of Medicine, Bronx, NY
Chief Resident, Department of Pediatrics

7/05-6/07 **New York University School of Medicine,** New York, NY
Fellowship in Medicine and Public Health Research (CDC-funded)
M.S. in Clinical Investigation, June 2007

Licensure and Certification

6/11-present **Connecticut State** medical license

6/04-present **New York State** medical license

10/04-present Board Certified, **American Board of Pediatrics**

Membership

7/01-present Fellow, **American Academy of Pediatrics**

Employment

9/15-present **Scarsdale Medical Group**, Harrison, NY
Pediatrician in multi-provider private practice.

7/11-8/15 **Stamford Pediatric Associates**, Stamford and Darien, CT
Pediatrician in multi-provider private practice.

9/07-6/11 **New York-Presbyterian Hospital/Columbia University Medical Center**, New York, NY.
Pediatrician in hospital-based primary care clinic.

HOSPITAL APPOINTMENTS

11/15-present **Greenwich Hospital**, Greenwich CT
Attending pediatrician for neonates in newborn nursery.

9/11-8/15 **Stamford Hospital**, Stamford CT
Attending pediatrician for neonates in newborn nursery.

9/07-6/11 **New York-Presbyterian Hospital Columbia University Medical Center**, New York, NY
Assistant Clinical Professor

9/04-7/10 **Pediatric Emergency Department, Children's Hospital at Montefiore**, Albert Einstein College of Medicine, Bronx, NY
Covering Attending, Emergency Department

8/05-6/07 **Bellevue Hospital Center**, New York, NY
Clinical Assistant, Department of Pediatrics

8/05-6/07 **New York University Hospital**, New York, NY
Instructor, Department of Pediatrics

TEACHING EXPERIENCE

4/08-6/11 **Preceptor of Pediatric Residents**, Ambulatory Care Network, New York-Presbyterian Hospital, Columbia University Medical Center, New York, NY
Supervisor of pediatric residents in all aspects of patient care.

10/05-5/06 **Seminar leader**, "Physician, Patient and Society" Course, NYU School of Medicine, New York, NY
Served as seminar leader for first year medical student course about doctor-patient interaction.

DEPARTMENT COMMITTEES

7/04-5/05 **Residency Acceptance Committee**, Department of Pediatrics, Children's Hospital at Montefiore, Albert Einstein College of Medicine, Bronx, NY
Interviewed applicants and served on rank committee for the pediatric residency program.

7/04-5/05 **Quality Improvement (QI) Committees**, Children's Hospital at Montefiore, Albert Einstein College of Medicine, Bronx, NY
Participated in QI for the Departments of Pediatrics and Pediatric Radiology.

GRANT SUPPORT

6/06-4/08 Lief, A., Mendelsohn, A., Foltin, G., Kalet, A.: **"Increasing Access to the Medical Home,"** American Academy of Pediatrics (AAP) CATCH grant-funded implementation project. Investigated the barriers to families gaining and maintaining public health insurance for their children.

PUBLICATIONS AND ABSTRACTS

9/04-5/05 Lief, A., Ozuah, P.: **"Sources of Fluoride Intake Among Inner-City Children."** Abstract presented at the **Eastern Society for Pediatric Research** annual meeting, March 2005 and at the **Pediatric Academic Societies'** annual meeting, May 2005.

10/05-5/07 Lief, AL., Mendelsohn, AL., Foltin, G., Wolff, MM, Kalet, AL.: **"Parents' Perspectives on Gaining and Maintaining Children's Public Health Insurance."** Abstract presented at the **Pediatric Academic Societies'** meeting, May 2007.

5/09 Brellochs, C., King, K., Vanneman, M., Lief, A., Fryer, E., Aguayo, S., Cadogan, M., Platt, R., Barbot, O.: **"The Access to Coverage and Care Project: An Analysis of Health Insurance Enrollment and Retention by Students in Selected NYC Public Schools."** Published at "http://www.nyc.gov/html/hra/downloads/pdf/Access to Coverage and Care Report.pdf"

PRINT NAME: Amy E. Lief DATE: 01 / 14 / 16

FULL LICENSE APPLICATION SUPPLEMENT

IMPORTANT NOTE: If you answer "yes" to any of these questions, you must provide the additional information on pages 5-11.

QUESTIONS		YES	NO
1.	While enrolled in college, medical school, graduate school or postgraduate training were you ever the subject of any disciplinary action? (This includes action that was formal or informal, oral or written, voluntary or involuntary. A confidentiality agreement does not absolve you of your requirement to answer this question.)		
2-A.	Have you ever been terminated or granted a leave of absence by a medical school or any postgraduate training program or have you ever withdrawn from a medical school or any postgraduate training program or had to repeat a year of postgraduate training?		
2-B.	Have you ever been placed on probation or remediation by a medical school, graduate school or any postgraduate training program?		
3.	If you are a US or Canadian graduate, did you take more than four (4) years to complete medical school; or if you are an international medical graduate, did you take more than six (6) years to complete medical school?		
4.	Since your enrollment in college, have you been denied the privilege of taking or finishing an examination or been accused of or found to have cheated or engaged in improper conduct during an examination?		
5.	Have you ever been denied a medical license, whether full, limited, temporary, or have you withdrawn an application for medical licensure?		
6.	Have you ever surrendered a license to practice medicine or any professional license or has your license or certificate ever been revoked? (You do not need to report a lapsed license.)		
7.	Have you been denied American Board of Medical Specialties or American Board of Osteopathic Medicine certification or has your certification ever been suspended or revoked?		
8-A.	Are you aware of any pending investigation or inquiry into your professional conduct by any entity or are any disciplinary charges pending against you?		
8-B.	Since your completion of postgraduate training, has any disciplinary action ever been taken against you? (A confidentiality agreement does not absolve you of your requirement to answer this question.)		

PRINT NAME: Amy E. Lief DATE: 01 / 19 / 16

		YES	NO
9-A.	Have you ever relinquished any medical staff membership or association with a health care facility?		
9-B.	Has your medical staff membership, medical privileges, medical staff status or association with a health care facility ever been limited, suspended, revoked, not renewed or subject to probationary conditions or has processing toward any of those ends been instituted or recommended by a medical staff committee, administration or governing board?		
9-C.	Have you ever withdrawn an application for hospital privileges or appointment, or have you ever been denied medical staff membership, advancement in medical staff status or association with a health care facility, or has such denial been recommended by a medical staff committee, administration or governing body?		
10.	Have you ever been charged with any criminal offense? (You must report being arrested, arraigned, indicted or convicted, even if the charges against you were dropped, filed, dismissed, expunged or otherwise discharged. A charge of operating under the influence or its equivalent is reportable. A medical malpractice claim is a civil, not a criminal, matter and need not be reported for purposes of this question.)		
11.	Has your privilege to manufacture, distribute, administer, possess, dispense or prescribe controlled substances ever been suspended, revoked, denied, restricted or surrendered, or have you ever been called before or warned by any state or other jurisdiction including a federal agency regarding such privileges?		
12.	Has any professional liability insurance provider ever restricted, limited, terminated, imposed a surcharge or co-payment, or placed any condition on your coverage or have you ever voluntarily restricted, limited or terminated your insurance coverage in response to any inquiry by a professional liability insurance provider?		
13.	Have you ever had an application for membership as a participating provider denied by any third-party payor, Medicare or Medicaid (any state) or have you ever been the subject of any termination, suspension or probation proceedings instituted by any third-party payor, Medicare or Medicaid (any state) or have you ever been restricted from receiving payments from any third-party payor, Medicare, Medicaid (any state)?		
14-A.	Has any medical malpractice claim ever been made against you, whether or not a lawsuit was filed in relation to the claim or has such a suit been settled, adjudicated or otherwise resolved?		
14-B.	Has any lawsuit, other than a medical malpractice suit, ever been filed against you which is related to your practice of medicine or has such a suit been settled, adjudicated or otherwise resolved?		

PRINT NAME: Amy E. Lief DATE: 01/19/16

CERTIFICATIONS

- Pursuant to M.G.L. c. 112, § 2 and 243 CMR 2.07(15), I certify that I will not charge to or collect from a Medicare beneficiary more than the Medicare "reasonable charge" for services, in compliance with Chapter 475 of the Acts of 1985. (*Note:* Signing this certification does not imply that you will participate in the Medicare program).
- Pursuant to M.G.L. c. 62C, § 49A, I certify under the penalties of perjury that, to the best of my knowledge and belief, I have filed any Massachusetts state tax returns and paid any Massachusetts state taxes that are required under law. (*Note:* This applies even if you reside out of the state or out of the country.)
- Pursuant to G.L.c. 62C, § 49A, to the best of my knowledge and belief, I am in compliance with G.L.c. 119A relating to withholding and remitting child support.
- Pursuant to M.G.L. c. 119, § 51A, I certify under the penalties of perjury that I will fulfill my obligation to report abuse or neglect of children.
- I will read the Board's regulations, 243 CMR 1.00 through 3.00.

I certify under the penalties of perjury that all information on this form, and all attached pages, is true, to the best of my knowledge.

Applicant's Signature: Amy E Lief Date: 01/19/16

Board of Registration in Medicine, 200 Harvard Mill Square, Suite 330, Wakefield, MA 01880
Telephone: (781) 876-8210 Fax: (781) 876-8383 www.mass.gov/massmedboard

MEDICAL EDUCATION VERIFICATION

APPLICANT INSTRUCTIONS: Please complete the waiver for release of information and forward this form to your university/medical school(s) or university of graduation for verification. **Please note: Fourth year medical students must include the letter to the medical school registrar and Form B.**

Waiver for Release of Information

I authorize the medical school/university listed below to provide any and all information pertaining to my medical education at your institution.

Applicant's Signature: Amy E. Lief Date of Birth: [redacted]

Print or Type Name: Lief (Last Name) Amy (First Name) E (Middle Initial) U.S. Social Security No: [redacted]

Other Name(s): _____ (Please type or print.)

Name of Medical School: Albert Einstein College of Medicine

Address: 1300 [redacted] Morris Park Avenue City: Bronx State or Province: NY

INSTRUCTIONS TO THE DEAN OR DESIGNATED OFFICIAL OF MEDICAL SCHOOL

Please complete Form A and complete Form B if the above-named applicant has not been awarded a degree. Please include a copy of the official transcript (which indicates courses taken, dates and hours of attendance, scores, grades, or evaluations) and return to the applicant in a sealed envelope. Please sign or stamp across the seal on the envelope.

APPLICANT'S EDUCATIONAL HISTORY

If name of institution was different from the above-named institution when applicant attended, please enter name below:

_____

Premedical Education: Does your school have a premedical school education requirement? ☐ Yes ☒ No

If yes, indicate where the applicant completed premedical school.

Applicant's Undergraduate School: _____

Undergraduate School Address: _____

Enrollment and Participation: Our records indicate that (print the applicant's name): Lief (Last Name) Amy (First Name) E (Middle Initial)

attended our medical school on the following dates (indicate the *month, day and year* separately **for each academic year** in the section below):

ATTENDANCE DATES:	FROM	TO	FROM	TO
8/25/97	6/17/98	5/30/00	5/30/01	
8/24/98	5/14/99	/ /	/ /	
6/14/99	5/28/00	/ /	/ /	

Graduation Date (month/year): 6/01

The applicant attended 176 **total weeks or** _____ **total months (must be included) of not less than 32 weeks in each academic year of continuing on-campus education.**

Unusual Circumstances: The following questions apply to unusual circumstances that occurred during any part of the applicant's medical education. All questions must be answered. **If you answer "YES" to any of the questions below, please enclose an explanation.**

	YES	NO
1. Was the medical school training more than four (4) years for U.S. graduates or six (6) years for international medical graduates?		
2. Did the applicant take any leaves of absence (i.e., for research, public service, participation in an M.D./Ph.D. program, or for any "personal reasons")?		
3. Was the applicant ever placed on probation?		
4. Was the applicant ever disciplined or under investigation?		
5. Were any negative reports ever filed by instructors regarding the applicant?		

Please provide a detailed explanation if you answered "YES" to any of the above questions.

AFFIX INSTITUTIONAL SEAL HERE

(If the institution does not have a seal, this form must be notarized.)

INTERNATIONAL MEDICAL SCHOOLS MUST ATTACH A COPY OF THE MEDICAL SCHOOL DIPLOMA AND A TRANSCRIPT OR PROVIDE AN EXPLANATION.

Signature: Julie Schneider

Print Name: Julie Schneider

Title: Registrar

Date: 5/17/16 Telephone: (718) 430-2102

E-mail address: Registrar@einstein.yu.edu

Seal Verified
DATE: 5/24
INITIALS: PM

Board of Registration in Medicine
200 Harvard Mill Square, Suite 330 - Wakefield, MA 01880
Telephone: (781) 876-8210 Fax: (781) 876-8383

POSTGRADUATE TRAINING VERIFICATION

APPLICANT'S AUTHORIZATION: I authorize the release of information from my postgraduate training program listed below, as requested by the Massachusetts Board of Registration in Medicine.

Applicant's Signature: Amy E Lief, MD Date: 1/16/16

Print or Type Name: Amy E. Lief, MD

Name of Institution: Children's Hospital at Montefiore

INSTRUCTIONS TO THE PROGRAM DIRECTOR

Please complete this form and forward it to the applicant in a **sealed envelope, signed across the seal**. If the department was a "rotating" or "transitional" program, please submit documentation of the rotations, dates and hours of training.

Name of Institution: Childrens Hospital at Montefiore

If name of Institution was different when applicant attended, please enter name:

Enrollment and Participation: Our records indicate that Amy F Lief (Print applicant's name) participated in the following program:

(List each year separately with from and to dates)

Program Type (internship, residency, fellowship)	PGY (1,2,3,4)	Department or type of specialty training	Dates Attended (MONTH/DAY/YEAR) FROM	TO	Completed (YES/NO)	Accredited By (ACGME, RSC, AOA or not accredited
Internship	1	Pediatrics	7/1/01	6/30/02	YES	ACGME
Residency	2	Pediatrics	7/1/02	6/30/03	yes	ACGME
Residency	3	Pediatrics	7/1/03	6/30/04	yes	ACGME
Chief Residency	4	Pediatrics	7/1/04	6/30/05	yes	ACGME

(Continued on page 2)

APPLICANT'S NAME: Amy E. Lief

Unusual Circumstances: The following questions apply to unusual circumstances that occurred during any part of the applicant's medical education. Please circle the appropriate response. **If you answer yes to any of these questions, please enclose an explanation.**

QUESTIONS	YES	NO
1. Did the applicant take any leaves of absence or breaks from his/her post-graduate training?		
2. Was the applicant ever placed on probation?		
3. Was the applicant ever disciplined or under investigation?		
4. Were any negative reports ever filed by instructors regarding the applicant?		
5. Were any limitations or special requirements imposed on the applicant because of questions of academic incompetence or disciplinary problems?		

6. During the applicant's participation, our postgraduate medical training ☑ was accredited by: ☐ ACGME ☐ Other: _____

COMMENTS: _____

AFFIX INSTITUTIONAL SEAL HERE

(If the institution does not have a seal, this form must be notarized by a notary public).

Certification: I hereby certify that the above information is correct, to the best of my knowledge.

Program Director's Signature: _____

Print Name: Elizabeth Alderman, MD

Academic Title: Pediatric Residency Program Director

Institution: Children's Hospital at Montefiore

Telephone: (718-741-2453(P) 718-654-6692 (F)) Today's Date: 1/13/16

E-mail address: ealderma@montefiore.org

PLEASE RETURN THIS COMPLETED FORM TO THE APPLICANT IN A SEALED ENVELOPED WITH YOUR SIGNATURE ACROSS THE SEAL OF THE ENVELOPE.

Seal Verified
DATE: 3-1-16
INITIALS: KY