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THE NEW MEXICO MEDICAL SOCIETY

NMHHSA New Mexico Hospitals & Health Systems Association

RECEIVED MAY 16 2012 NM MEDICAL BOARD

The New Mexico Statewide Application for Physician/Practitioner Appointment©

(USING FCVS)

Date of Application: 5/4/12

Application Fee: 400.00
Background Check Fee: 36.00
TOTAL COST: $ 436.00

Demographics

Name	LANDAU (Last)	CARMEN (First)	SWITZER (Middle)
Other Names Used			

Will you be applying by endorsement Yes ____ No ✓ Dyam
(See page 2 of the application instructions for requirements)

Gender M (F)	**Place of Birth** WASHINGTON DC	**Citizenship**	US
Immigration Status	US CITIZEN	**INS Certification #**	
***Social Security Number**	[redacted]	**Date of Birth**	[redacted]-77
***NM Tax ID#** (if applicable)		Pending ☑	
***Fed. Tax ID#** (if applicable)		Pending ☑	
Current Practice Name	UNM Family Medicine Residency		
Practice Limited to: (Clinical Specialty)			
Street			
City		State	Zip Code
Telephone Number		Facsimile	
*Office Manager or Contact Person:			
Foreign Languages (spoken fluently by practitioner)	SPANISH		
Foreign Languages (spoken fluently at Practice)			
***E-Mail Address** (confidential)	[redacted]@gmail.com		
***Current Mailing Address** (if different from above -confidential unless no practice address indicated)			
*Street	[redacted]		
*City			
Telephone Number	505-241-9342	Facsimile	
What are your immediate or future Practice Plans in New Mexico?	Southwestern Womens Options		
Home Address (Required)	*Telephone Number	[redacted]	
Street	[redacted]		
*City			

*Information Confidential

Practice Associates in NM (If Applicable)	Call Coverage in NM (If Applicable)
N/A	

Other Practice Locations (If Applicable)					
Practice Name					
Street					
City		State		Zip Code	
Telephone Number		Facsimile			
Answering Service		Effective Date			

Education (Please attach a separate sheet, if necessary.)

Undergraduate Education N/A					
College or University					
City		State/Country		Zip Code:	
Dates Attended	From: To:	Degree		Graduation Date	
College or University					
City		State/Country		Zip Code:	
Dates Attended	From: To:	Degree		Graduation Date	
Professional / Medical Education					
College or University					
City		State/Country		Zip Code:	
Dates Attended	From: To:	Degree		Graduation Date	
College or University					
City		State/Country		Zip Code:	
Dates Attended	From: To:	Degree		Graduation Date	
Graduate Education					
College or University					
City		State/Country		Zip Code:	
Dates Attended	From: To:	Degree		Graduation Date	
College or University					
City		State/Country		Zip Code:	
Dates Attended	From: To:	Degree		Graduation Date	

Internship/ Residency/ Fellowship					
Institution Name	UNM H Family + Community Medicine Residency				
City	Albuquerque	State/Country	NM	Zip Code:	87106
Dates Attended	From: 07/09 To: present	Field	Family Medicine		
Institution Name					
City		State/County		Zip Code	
Dates Attended	From: To:	Field			
Institution Name					
City		State/Country		Zip Code:	
Dates Attended	From: To:	Field			
Institution Name					
City		State/Country		Zip Code:	
Dates Attended	From: To:	Field			

Applicant Name Carmen Switzer Landau Date 5/4/12

Work History Please list all previous practice experience for the last 15 years, **including military or government service**, listing the most recent first. If military service, state type of discharge and rank achieved **and attach copy of discharge or separation documents.** Attach separate page, if necessary. Please provide written explanation for any gaps in work history of 6 months or more.

Location	N/A	From		To	
Street		Phone Number			
City		State		Zip Code	
Type of Practice		Contact Person			
Type of Discharge		Rank Achieved			
Location		From		To	
Street		Phone Number			
City		State		Zip Code	
Type of Practice		Contact Person			
Type of Discharge		Rank Achieved			
Location		From		To	
Street		Phone Number			
City		State		Zip Code	
Type of Practice		Contact Person			
Type of Discharge		Rank Achieved			
Location		From		To	
Street		Phone Number			
City		State		Zip Code	
Type of Practice		Contact Person			
Type of Discharge		Rank Achieved			

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Hospital and Health Facility Affiliation History (other than postgraduate training) ☑ **N/A**

Please list hospital staff membership and/or healthcare organization affiliations in the past fifteen (15) years. If an institution is no longer in existence, please provide an alternative source of verification. Use separate page, if necessary. **Providers who do NOT have admitting privileges, please explain your procedures or the arrangements you make in instances when patients require admission to a hospital. If you are applying with a health plan, should arrangements include admitting coverage by another provider, a signed letter from the covering provider, including their primary admitting facility, is to be included with this application.**

(1) Current Primary Admitting Facility (Hospital Name)					
Street					
City		State		Zip Code	
Telephone Number		Facsimile			
Appointment Dates	**From:**	**To:**			
Type of Appointment					
Privileges Assigned					
(2) Facility Name					
Street					
City		State		Zip Code	
Telephone Number		Facsimile			
Appointment Dates	**From:**	**To:**			
Type of Appointment					
Privileges Assigned					
(3) Facility Name					
Street					
City		State		Zip Code	
Telephone Number		Facsimile			
Appointment Dates	**From:**	**To:**			
Type of Appointment					
Privileges Assigned					

Applicant Name Carmen Switzer Landau **Date** 5/4/12

(4) Facility Name					
Street					
City		State		Zip Code	
Telephone Number		Facsimile			
Appointment Dates	**From:**	**To:**			
Type of Appointment					
Privileges Assigned					
(5) Facility Name					
Street					
City		State		Zip Code	
Telephone Number		Facsimile			
Appointment Dates	**From:**	**To:**			
Type of Appointment					
Privileges Assigned					
(6) Facility Name					
Street					
City		State		Zip Code	
Telephone Number		Facsimile			
Appointment Dates	**From:**	**To:**			
Type of Appointment					
Privileges Assigned					
(7) Facility Name					
Street					
City		State		ZIP Code	
Telephone Number		Facsimile			
Appointment Dates	**From:**	**To:**			
Type of Appointment					
Privileges Assigned					
(8) Facility Name					
Street					
City		State		Zip Code	
Telephone Number		Facsimile			
Appointment Dates	**From:**	**To:**			
Type of Appointment					
Privileges Assigned					

Professional References F
past 5 years, (not including current or i

professional performance in the

(1) Name and Title	
Address	
City	
Telephone Number	
(2) Name and Title	
Address	
City	
Telephone Number	
(3) Name and Title	
Address	
City	
Telephone Number	

2 professional recommendations were already received and should be on file.

Applicant Name Carmen Switzer Landau **Date** 5/4/12

Licensure-Registration-Certification Information

ECFMG Number (if applicable)	O-656-186-4						
State Professional License/Certification Number							
State		Issue Date		Expiration Date		Pending ☐	
All Other State License Numbers (regardless of status - attach separate list if necessary.)							
State	**Number**		**Issue Year**		**Expiration Date**		
***Federal Drug Enforcement Admin. (DEA) Registration**						N/A ☐	
Number	[redacted]	Exp. Date	07/12			Pending ☐	
***State Controlled Substance Registration** (CSR)						N/A ☐	
Number		State		Exp. Date		Pending ☐	
***Medicare Unique Physician Identification Number (UPIN)**							
Pending ☐							
***State Medicaid Provider Number**							
Pending ☐							
***National Provider Identification Number**							
Pending ☐	1609003797						

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Specialty Board Certifications ☑ N/A

Are you Board Certified? ☐ Yes ☐ No **Note:** If you are not Board certified by a Board recognized by the American Board of Medical Specialties, the American Osteopathic Association, the National Commission on Certification of Physician Assistants, the American Nurses' Credentialing Center, or the National Certification Commission, or accepted for examination in your specialty, please give a brief explanation on an attached sheet.

Certified/Recertified by the:					
1.					
Date Certified		Date Last Recertified		Expiration Date	
2.					
Date Certified		Date Last Recertified		Expiration Date	
3.					
Date Certified		Date Last Recertified		Expiration Date	
Accepted for Examination by the:					
Until (expiration date)		If not accepted, have you made application?	Yes No		
Certified/Recertified by the Subspecialty Board of					
1.					
Date Certified		Date Last Recertified		Expiration Date	
2.					
Date Certified		Date Last Recertified		Expiration Date	
Accepted for Examination by the Subspecialty Board of					

Professional Liability Insurance (confidential information)

Do you have current liability insurance? ☑ Yes ☐ No

Current Carrier	UNM Residency	Current ☑	Pending ☐
Address			
Dates Insured	From 07/2009	To current	Policy # / Coverage Limits

Applicant Name Carmen Switzer Landau **Date** 5/4/12

Licensing Exam: **Please check all that apply:**

☐ **State Board Exam (Prior to 1973)** Which state? _____ Date(s) passed? _____

☐ **FLEX** ☐ **LMCC** ☐ **National Board (NBME)** ☑ **USMLE**

Part/Step 1 Date Passed 08/04 (Month/Year) Part/Step 2 Date Passed 06/08 (Month/Year) Part/Step 3 Date Passed 06/11 (Month/Year)

Professional Practice Questions Please answer all of the following Yes or No questions. If you answer YES to any question, please give details including name, address, and telephone number of significant parties on a separate sheet of paper.

1. Has your professional liability coverage ever been terminated by action of the insurance company except as a result of the company ceasing to offer insurance to physicians?	Yes ☐	No ☑
2. Have you ever been denied professional liability insurance coverage?	Yes ☐	No ☑
3. Has your professional liability carrier ever excluded any specific procedures from your coverage?	Yes ☐	No ☑
4. Have you ever been denied membership or renewal thereof, or been subject to disciplinary action in any professional organization?	Yes ☐	No ☑
5. Have you ever been excluded from or sanctioned by Medicare and/or Medicaid?	Yes ☐	No ☑
6. Have you ever been arrested? If so explain the circumstance, regardless of the outcome (i.e. expunged, dismissed, sealed, vacated).	Yes ☐	No ☑
7. Have you ever been named as a defendant in any criminal proceedings?	Yes ☐	No ☑
8. Have you ever been subject to investigation by a governmental entity or Board that either could have resulted or did result in licensure sanction or other adverse actions, irrespective of the outcome?	Yes ☐	No ☑
9. Have you ever been named in any formal requests for corrective actions filed by any healthcare entity where you have had an appointment (a request which could result in either formal or informal proceedings).	Yes ☐	No ☑
10. a. Have your privileges at any healthcare entity ever been voluntarily or involuntarily suspended, restricted, diminished, revoked, surrendered, or not renewed, except for medical records delinquency?	Yes ☐	No ☑
b. Have you ever agreed not to exercise your clinical privileges while under investigation?	Yes ☐	No ☑
11. Have you ever resigned from a healthcare entity to avoid modification, suspension, or termination of privileges, or while under investigation?	Yes ☐	No ☑
12. a. Has your application for licensure or license to practice in any jurisdiction ever been investigated, voluntarily or involuntarily limited, suspended, revoked, surrendered or denied?	Yes ☐	No ☑
b. Are any currently held licenses pending investigation or being challenged?	Yes ☐	No ☑
13. Have you ever been notified to appear before any licensing agency for a hearing or complaint of any nature?	Yes ☐	No ☑
14. Has your federal or state narcotics registration certificate in any jurisdiction ever been voluntarily or involuntarily limited (stipulations), suspended, revoked, restricted, or are there currently challenges to any of these items?	Yes ☐	No ☑

Applicant Name Carmen Switzer Landau **Date** 5/4/12

15. Have you ever been involved in a settlement, medical malpractice claim or suit, or have you ever received written notice of intent to file such a suit? **If yes, please provide the following information on the attached Malpractice History form for each case:** • Name, age, sex of patient/claimant. • Date(s) and type of treatment and/or surgery, which led to the allegations against you. • Nature of allegations in claims/suits. Specify whether a suit was ever filed. • Names of other practitioners and hospital, if any, involved in claims or suit. • Disposition or current status of claim or suit (be specific). • Name of insurance carrier defending you. • Name of defense attorney.	Yes ☐	No ☑
16. Have you ever been reported to the National Practitioner Data Bank?	Yes ☐	No ☑
17. Are you now, or were you in the past, addicted to, abusive of, or in treatment for abuse of any controlled substances, habit-forming drugs, illegal drugs, prescription medication or alcohol?	Yes ☐	No ☑
18. In the five (5) years prior to this application, have you had any physical injury or disease, or mental illness or impairment, which you are currently under treatment for or could reasonably be expected to affect your on-going ability to practice medicine safely and competently? **If yes, please have your treating physician send the NM Medical Board a letter regarding your diagnosis and treatment.**	Yes ☐	No ☑
19. Have you ever, for any reason:		
a) Resigned from a medical school or postgraduate training (PGT) program?	Yes ☐	No ☑
b) Withdrawn from a medical school or postgraduate training program?	Yes ☐	No ☑
c) Been suspended, dismissed, or expelled from a medical school or PGT program?	Yes ☐	No ☑
d) Been placed on probation or remediation, including academic probation or remediation, by a medical school or PGT program?	Yes ☐	No ☑
e) Taken a leave of absence or break from, or had any interruptions or extensions in, a medical school or PGT program for any personal or professional reason (including illness or disability, pregnancy or maternity, any academic issue, etc)?	Yes ☐	No ☑

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If you answer YES to any question, please give details including name, address, and telephone number of significant parties on a separate sheet of paper.

Applicant Name Carmen Switzer Landau **Date** 5/4/12

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

APPLICANT'S OATH

I, _____, hereby certify that I am the person pictured below and named in this application for a license to practice as a Physician in the State of New Mexico; that all statements I have made herein are true; that I am the original and lawful possessor and person named in the various forms and credentials furnished to the New Mexico Medical Board (Board) with my application.

I acknowledge and state that I have read the Information and Instructions that accompanied this application and I have answered all questions truthfully. I understand that the fee I submitted is not refundable.

I authorize and request every person, hospital, clinic, community, governmental agency, court, association, institution or other organization having control of any documents, records, and other information pertaining to me, to furnish to the Board any such information, including documents, records regarding charges or cc ... me formal or informal, pending or closed, or any other pertinent data and to ...tatives to inspect and make copies of such document ...on with this application.

Applicant oath
This was already sent in and should be on file

I hereby release, discharge, ar ...epresentatives, and any person furnishing information, ... kind arising out of the furnishing or inspection of suc ...he investigation made by the Board. I authorize the Boa ...nts, orders, or the like relating to me or to this applic ...w Mexico or the appropriate licensing agency ...States or any agency of the United States government.

ATTACH RECENT PASSPORT-QUALITY* PHOTOGRAPH THAT WILL FIT IN THIS SPACE

A _____

Date _____

*Passport-quality color photograph taken within six months prior to filing the application, approximate size 2 x 2 inches, head and shoulders only, full face, front view, plain white or off-white background, standard photo stock paper, scanned or computer-generated photographs should have no visible pixels or dots.

Applicant Name _____ **Date** _____

N/A

Malpractice History

Provider Name: _____

Please DUPLICATE this form and complete for EACH case.

1. **Patient Name:** _____
2. **Diagnosis:**

   _____

   _____

   _____
3. **Your involvement in the case, i.e... Attending, Consulting, Etc.:**

   _____
4. **Allegation(s):**

   _____

   _____
5. **Clinical Case Summary:**

   _____

   _____

   _____

   _____

   _____
6. **Patient Outcome:** _____
7. **Other pertinent details:**

   _____

   _____

   _____
8. **Date of incident:** _____ **Date filed:** _____
   Date closed: _____
9. **Resolution of case, i.e. Dismissed, Settled Out of Court, Litigated, Pending, Other:**

   _____

   _____
10. **Settlement amount paid on your behalf (if any):**

    _____
11. **Professional liability insurer involved:** _____
    a. **Name of Insurer:** _____
    b. **Address of Insurer:** _____
12. **Defense attorney:** _____

_____ _____

Signature **Date**

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

PROFESSIONAL RECOMMENDATION

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

Applicant's Name:_____ Date of Birth ___/___/___

Applicant' Signature: _____ Date:_____

Address: _____ City _____ State_____

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

1. Date and type of service: Th

   from _____
   Month/Year

These were completed and are on file

2. Please evaluate:

	...r	Fair	Good	Superior
Professional knowle				
Clinical judgment				
Relationship with p				
Ethical/professiona				
Ability to communi				
Clinical skills				

(...indicate with check mark)

3. Recommendation: (plea...

2. Recommend...
3. Recommend with some reservation (explain)
4. Concerns (explain)

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

_____

_____

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

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

Name (Please Print): _____ Title: _____ Phone:_____

Signature: _____ Date: _____

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

N/A

WORK EXPERIENCE VERIFICATION

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

Carmen Switzer Landau
Applicant Name

[redacted]

Applicant Signature

07/09 - current
***Dates of Privilege/Employment mm/yy to mm/yy (must be provided)**

[redacted]

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

Type or Print Name of person completing this form

Title

Name of Institution

Address

City / State / Zip

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

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

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

Please affix hospital or notary seal here

Printed name of person completing this form | Signature | Date

Signature of Notary (if applicable) | Date

My commission expires: _____

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

Revised 8/08

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

VERIFICATION OF LICENSURE

I am applying for medical licensure in the State of New Mexico. The New Mexico Medical Board requires that your Board complete this form or its equivalent so that I may be considered for licensure. This is my authorization to release all information in your files, favorable or otherwise, to the NMMB, **2055 S. Pacheco St., Bldg. 400, Santa Fe, NM 87505**

Print/Type Full Name _____ Signature _____ Date _____

License Number _____ Date Issued _____

State _____ Zip Code _____

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THE MEDICAL BOARD

I think this is for people who have licenses in other states. If I am wrong please let me know!

Name of Licensing Authorit _____

Name of Licensee: _____

License Number: _____ piration Date: _____

1. Is license current? ___Yes _____

2. Did you receive source docu _____No
_____No
_____No

3. Has licensee ever been discip
   If "Yes": Revoked ___ Suspended ___Yes ___No
   Stipulated ___ ___No On Probation ___Yes ___No
   Dates: _____

4. Has his licensee's license ever been:
   Allowed to lapse for non-payment of fees? ___Yes ___No
   Placed on Retired or Inactive status? ___Yes ___No
   Surrendered Voluntarily ? ___Yes ___No

5. Are there any formal charges pending against this license? ___Yes ___No

6. Has licensee ever been investigated or requested to appear before your Board for any serious matter? ___Yes ___No

If you answered "YES" to questions 3-6 please provide a written explanation below, and attach a copy of all supporting documentation (e.g., Board order, complaint, etc.).

_____

_____

Please Affix Board Seal Here

Signature of Board Official _____ Date _____

Title _____ Phone Number _____

Revised 8/08

AMA AMERICAN MEDICAL ASSOCIATION

AMA Physician Profile

Name and Mailing Address:

CARMEN SWITZER LANDAU MD
812 GEORGIA ST SE
ALBUQUERQUE NM 87108-4946

Primary Office Address:

915 CAMINO DE SALUD
ALBUQUERQUE NM 87131-0001

Phone: UNKNOWN

Birthdate: [redacted]1977

Physician's Major Professional Activity: HOSPITAL BASED RESIDENTS - ALL YEARS

Practice Specialties Self Designated by the Physician*:

Primary Specialty: FAMILY MEDICINE

Secondary Specialty: UNSPECIFIED

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

AMA membership: NON MEMBER

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

Current and/or Historical Medical School:

ESCUELA LATINOAMERICANA DE MED, INST SUP DE CIENCIAS MED DE LA HABANA, CUBA

Degree Awarded: Yes

Degree Year: 2007

AMA AMERICAN MEDICAL ASSOCIATION

AMA Physician Profile

Current and/or Historical Post Graduate Medical Training Programs Accredited by the Accreditation Council for Graduate Medical Education (ACGME):

Beginning with the 2010 cycle of the National GME Census, post-graduate training segments will include the name of the program attended in addition to the sponsoring institution. Program-level information prior to 2010 will not be available for reporting. Future training dates, as reported by the program, should be interpreted as "in progress" or "current" with the projected date of completion.

Post-graduate training performed at accredited osteopathic institutions or in Canada are updated on the AMA Physician Masterfile only upon verification by the program. US licensing authorities accept graduate medical education from both entities as equivalent to training performed in a US program accredited by ACGME.

Sponsoring Institution: UNIV OF NM SCH OF MED
Sponsoring State: NEW MEXICO
Program Name: UNIVERSITY OF NEW MEXICO PROGRAM
Specialty: FAMILY MEDICINE
Dates: 06/2009 - 06/2012 (VERIFIED)

Note: If you have discrepant information, please submit a Request for Investigation to the AMA so that we may verify the information with the primary source(s). See the last page of this Profile for instructions on how to report a data discrepancy.

Current and/or Historical Medical Licensure:

Jurisdiction	MD/ DO	Date Granted	Expiration Date	Status	License Type	Last Reported
NEW MEXICO	MD	06/25/2009	06/30/2012	ACTIVE	RESIDENT	05/03/2012

Current and/or Historical NPI Information:

NPI Number	Enumeration Date	Deactivation Date	Reactivation Date	Replacement Number	Last Reported Date
1063655595	04/14/2009	NOT RPTD	NOT RPTD	NOT RPTD	05/04/2012

ECFMG Certfication:

Applicant Number: 06561864

Note: The Educational Commission for Foreign Medical Graduates (ECFMG) applicant identification number does not imply current ECFMG certification status. To verify ECFMG status, contact the ECFMG Certification Verification Service in writing at P.O. Box 13679, Philadelphia, PA 19101.

AMA AMERICAN MEDICAL ASSOCIATION

AMA Physician Profile

Federal Drug Enforcement Administration:

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

DEA Number *	Schedule	Expiration Date	Last Reported
None	Reported		

Address:

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

Specialty Board Certification(s)*:

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

The AMA Physician Profile has been designated by the ABMS as an Official ABMS Display Agent of Member Board Certification data. Therefore, the ABMS Board certification information on the AMA Physician Profile is considered a designated equivalent source in regard to credentialing standards set forth by Joint Commission. The AMA is also an NCQA-approved source for verification of medical school, postgraduate medical training, ABMS Board certification, and Federal DEA registration.

Certifying Board: TO DATE, THERE HAVE BEEN NO BOARD CERTIFICATIONS REPORTED.
Certificate:
Certificate Type:

Duration	Effective	Expiration	Reverification	Occurrence	Last Reported

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

Medicare/Medicaid Sanction(s):

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

AMA AMERICAN MEDICAL ASSOCIATION

AMA Physician Profile

Other Federal Sanction(s):

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

Additional Information:

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

The content of the Physician Profile is intended to assist with credentialing. Appropriate use of the data contained in the AMA Physician Masterfile by an organization meets selected primary source verification requirements of the Joint Commission, the Accreditation Association for Ambulatory Health Care (AAAHC), and the American Accreditation Health Care Commission (AAHCC)/Utilization Review Accreditation Commission (URAC). The AMA is also an NCQA-approved source for verification of medical school, postgraduate medical training, ABMS Board certification and Federal DEA registration.

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

Division of Database Products and Licensing
Attn: Credentialing Products
515 N. State Street
Chicago, IL 60654
800- 665-2882
312 464-5900 (fax)

If you have questions or need additional information, please call the AMA Profile Service customer support line at 800-665-2882.

The Federation of State Medical Boards
of the United States, Inc
PO Box 619850
Dallas, Texas 75261-9850
Telephone: (817)868-4000
FAX (817)868-4099

BOARD ACTION CLEARANCE REPORT

May 17, 2012

Attn: Lynn S. Hart
New Mexico Medical Board
Lynn S. Hart
2055 S. Pacheco St, Ste 400
Santa Fe, NM 87505-0503

Re: Board Action Query Dated: May 17, 2012
Your Reference Number:
FSMB Batch Number: BQ2078623

The following is a report of the search results from the Board Action Data Bank as of May 17, 2012 for practitioners submitted as part of the above-referenced batch for which NO board actions were identified.

Practitioners Cleared with No Actions as of May 17, 2012

Item	Name	DOB	School	Yr/Grad	Request ID
1	Landau, Carmen	[redacted]/1977	032010	2005	25265523

LICENSE HISTORY
State Board
NEW MEXICO
TEXAS

PLEASE NOTE: The licensure history information contained in these reports is not considered licensure verification but rather an indicator of known states of historical licensure for these individuals. Use of this information should be limited to cross-reference purposes.

Carmen Landau, MD

Licensed Physician #MD2012-0687

Issue Date	Expiration Date
08/31/2012	07/01/2015

Signature of Holder

The bearer is prohibited by law from using this identification card to give the impression that they are in any way connected with a governmental agency.

New Mexico Medical Board

Triennial Renewal Certificate

This is to certify that

Carmen Landau, MD

License Number: MD2012-0687

Having complied with the provisions of the Medical Practice Act is hereby granted a license to practice in the State of New Mexico as a Physician.

Issue Date: 08/31/2012 Date Expires: 07/01/2015*

**A New Mexico medical license that has not been renewed by July 1 of the renewal year will remain temporarily active with respect to medical practice until September 30 of the renewal year at which time, the status will be changed to lapsed. A lapsed license is not valid for practice in New Mexico.*

This License Must Be Conspicuously Posted In Each Practice Location

1st Derm Dic

THE NEW MEXICO MEDICAL SOCIETY

NMH&HSA
New Mexico Hospitals & Health Systems Association

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NM MEDICAL BOARD

The New Mexico Statewide Application for Physician/Practitioner Appointment©

(USING FCVS)

Date of Application: 5/4/12

Application Fee: 400.00
Background Check Fee: 36.00
TOTAL COST: $ 436.00

Demographics

Name	LANDAU (Last)	CARMEN (First)	SWITZER (Middle)
Other Names Used			

Will you be applying by endorsement Yes ____ No ✓ Dylan
(See page 2 of the application instructions for requirements)

Gender M (F)	**Place of Birth** WASHINGTON DC	**Citizenship**	US
Immigration Status	US CITIZEN	**INS Certification #**	
***Social Security Number**	[redacted]	**Date of Birth**	[redacted]-77
***NM Tax ID# (if applicable)**		Pending ☑	
***Fed. Tax ID# (if applicable)**		Pending ☑	
Current Practice Name	UNM Family Medicine Residency		
Practice Limited to: (Clinical Specialty)			
Street			
City	State	Zip Code	
Telephone Number	Facsimile		
*Office Manager or Contact Person:			
Foreign Languages (spoken fluently by practitioner)	SPANISH		
Foreign Languages (spoken fluently at Practice)			
***E-Mail Address** (confidential)	[redacted]@gmail.com		
***Current Mailing Address** (if different from above -confidential unless no practice address indicated)			
*Street	[redacted]		
*City			
Telephon			
What are your immediate or future Practice Plans in New Mexico?	Southwestern Womens Options		
Home Ad	[redacted]		
Street			
*City			

*Information Confidential

Practice Associates in NM (If Applicable)	Call Coverage in NM (If Applicable)
N/A	

Other Practice Locations (If Applicable)					
Practice Name					
Street					
City		State		Zip Code	
Telephone Number		Facsimile			
Answering Service		Effective Date			

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Education (Please attach a separate sheet, if necessary.)

Undergraduate Education N/A					
College or University					
City		State/Country		Zip Code:	
Dates Attended	From: To:	Degree		Graduation Date	
College or University					
City		State/Country		Zip Code:	
Dates Attended	From: To:	Degree		Graduation Date	
Professional / Medical Education					
College or University					
City		State/Country		Zip Code:	
Dates Attended	From: To:	Degree		Graduation Date	
College or University					
City		State/Country		Zip Code:	
Dates Attended	From: To:	Degree		Graduation Date	
Graduate Education					
College or University					
City		State/Country		Zip Code:	
Dates Attended	From: To:	Degree		Graduation Date	
College or University					
City		State/Country		Zip Code:	
Dates Attended	From: To:	Degree		Graduation Date	

Internship/ Residency/ Fellowship					
Institution Name	UNM H Family + Community Medicine Residency				
City	Albuquerque	State/Country	NM	Zip Code:	87106
Dates Attended	From: 07/09 To: present	Field	Family Medicine		
Institution Name					
City		State/County		Zip Code	
Dates Attended	From: To:	Field			
Institution Name					
City		State/Country		Zip Code:	
Dates Attended	From: To:	Field			
Institution Name					
City		State/Country		Zip Code:	
Dates Attended	From: To:	Field			

Applicant Name Carmen Switzer Landau Date 5/4/12

To whom it may concern:

Per request I am submitting this information which was evidently missing from my original paper application for an initial physician's license.

Medical School: Latin American Medical School (ELAM for its Spanish acronym, Escuela Latinoamericana de Medicina) from August 2001 until graduation in July 2007.

Professional Referances:

1- Jennifer K. Phillips, MD
Medical Director
UNM Southeast Heights Clinic
505-272-5885
8200 Central SE
Albuquerque, NM 87108

2- Felisha Rohan-Minjares, MD
UNM Southeast Heights Clinic
505-272-5885
8200 Central SE
Albuquerque, NM 87108

2- Arthur Kaufman, MD
UNM Family Medicine Clinic
2400 Tucker St. NE
Albuquerque, NM 87106
505-272-1734

Thank you and please do let me know of any further clarification needed.

Sincerely,
Carmen Landau, MD

Work History Please list all previous practice experience for the last 15 years, **including military or government service**, listing the most recent first. If military service, state type of discharge and rank achieved **and attach copy of discharge or separation documents.** Attach separate page, if necessary. Please provide written explanation for any gaps in work history of 6 months or more.

Location	N/A	From		To	
Street		Phone Number			
City		State		Zip Code	
Type of Practice		Contact Person			
Type of Discharge		Rank Achieved			
Location		From		To	
Street		Phone Number			
City		State		Zip Code	
Type of Practice		Contact Person			
Type of Discharge		Rank Achieved			
Location		From		To	
Street		Phone Number			
City		State		Zip Code	
Type of Practice		Contact Person			
Type of Discharge		Rank Achieved			
Location		From		To	
Street		Phone Number			
City		State		Zip Code	
Type of Practice		Contact Person			
Type of Discharge		Rank Achieved			

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Hospital and Health Facility Affiliation History (other than postgraduate training) ☑ **N/A**

Please list hospital staff membership and/or healthcare organization affiliations in the past fifteen (15) years. If an institution is no longer in existence, please provide an alternative source of verification. Use separate page, if necessary. **Providers who do NOT have admitting privileges, please explain your procedures or the arrangements you make in instances when patients require admission to a hospital. If you are applying with a health plan, should arrangements include admitting coverage by another provider, a signed letter from the covering provider, including their primary admitting facility, is to be included with this application.**

(1) Current Primary Admitting Facility (Hospital Name)					
Street					
City		State		Zip Code	
Telephone Number		Facsimile			
Appointment Dates	**From:**	**To:**			
Type of Appointment					
Privileges Assigned					
(2) Facility Name					
Street					
City		State		Zip Code	
Telephone Number		Facsimile			
Appointment Dates	**From:**	**To:**			
Type of Appointment					
Privileges Assigned					
(3) Facility Name					
Street					
City		State		Zip Code	
Telephone Number		Facsimile			
Appointment Dates	**From:**	**To:**			
Type of Appointment					
Privileges Assigned					

Applicant Name Carmen Switzer Landau **Date** 5/4/12

(4) Facility Name					
Street					
City		State		Zip Code	
Telephone Number		Facsimile			
Appointment Dates	**From:**	**To:**			
Type of Appointment					
Privileges Assigned					
(5) Facility Name					
Street					
City		State		Zip Code	
Telephone Number		Facsimile			
Appointment Dates	**From:**	**To:**			
Type of Appointment					
Privileges Assigned					
(6) Facility Name					
Street					
City		State		Zip Code	
Telephone Number		Facsimile			
Appointment Dates	**From:**	**To:**			
Type of Appointment					
Privileges Assigned					
(7) Facility Name					
Street					
City		State		ZIP Code	
Telephone Number		Facsimile			
Appointment Dates	**From:**	**To:**			
Type of Appointment					
Privileges Assigned					
(8) Facility Name					
Street					
City		State		Zip Code	
Telephone Number		Facsimile			
Appointment Dates	**From:**	**To:**			
Type of Appointment					
Privileges Assigned					

Professional References

past 5 years, (not including current or i

professional performance in the

(1) Name and Title	
Address	
City	
Telephone Number	
(2) Name and Title	
Address	
City	
Telephone Number	
(3) Name and Title	
Address	
City	
Telephone Number	

2 professional recommendations were already received and should be on file.

[redacted]

Applicant Name Carmen Switzer Landau **Date** 5/4/12

Licensure-Registration-Certification Information

ECFMG Number (if applicable)	0-656-186-4						
State Professional License/Certification Number							
State		Issue Date		Expiration Date		Pending ☐	
All Other State License Numbers (regardless of status - attach separate list if necessary.)							
State	**Number**		**Issue Year**		**Expiration Date**		
***Federal Drug Enforcement Admin. (DEA) Registration**						N/A ☐	
Number [redacted]		Exp. Date	07/12			Pending ☐	
***State Controlled Substance Registration** (CSR)						N/A ☐	
Number	State		Exp. Date			Pending ☐	
***Medicare Unique Physician Identification Number (UPIN)**							
Pending ☐							
***State Medicaid Provider Number**							
Pending ☐							
***National Provider Identification Number**							
Pending ☐	1609003797						

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NM MEDICAL BOARD

Specialty Board Certifications ☑ N/A

Are you Board Certified? ☐ Yes ☐ No **Note:** If you are not Board certified by a Board recognized by the American Board of Medical Specialties, the American Osteopathic Association, the National Commission on Certification of Physician Assistants, the American Nurses' Credentialing Center, or the National Certification Commission, or accepted for examination in your specialty, please give a brief explanation on an attached sheet.

Certified/Recertified by the:					
1.					
Date Certified		Date Last Recertified		Expiration Date	
2.					
Date Certified		Date Last Recertified		Expiration Date	
3.					
Date Certified		Date Last Recertified		Expiration Date	
Accepted for Examination by the:					
Until (expiration date)		If not accepted, have you made application?	Yes No		
Certified/Recertified by the Subspecialty Board of					
1.					
Date Certified		Date Last Recertified		Expiration Date	
2.					
Date Certified		Date Last Recertified		Expiration Date	
Accepted for Examination by the Subspecialty Board of					

Professional Liability Insurance (confidential information)

Do you have current liability insurance? ☑ Yes ☐ No

Current Carrier	UNM Residency			Current ☑	Pending ☐
Address					
Dates Insured	From 07/2009	To current	Policy # / Coverage Limits		

Applicant Name Carmen Switzer Landau **Date** 5/4/12

Licensing Exam: Please check all that apply:

☐ **State Board Exam (Prior to 1973)** Which state? _____ Date(s) passed? _____

☐ **FLEX** ☐ **LMCC** ☐ **National Board (NBME)** ☑ **USMLE**

Part/Step 1 Date Passed 08/04 (Month/Year) Part/Step 2 Date Passed 06/08 (Month/Year) Part/Step 3 Date Passed 06/11 (Month/Year)

Professional Practice Questions Please answer all of the following Yes or No questions. If you answer YES to any question, please give details including name, address, and telephone number of significant parties on a separate sheet of paper.

1. Has your professional liability coverage ever been terminated by action of the insurance company except as a result of the company ceasing to offer insurance to physicians?	Yes ☐	No ☑
2. Have you ever been denied professional liability insurance coverage?	Yes ☐	No ☑
3. Has your professional liability carrier ever excluded any specific procedures from your coverage?	Yes ☐	No ☑
4. Have you ever been denied membership or renewal thereof, or been subject to disciplinary action in any professional organization?	Yes ☐	No ☑
5. Have you ever been excluded from or sanctioned by Medicare and/or Medicaid?	Yes ☐	No ☑
6. Have you ever been arrested? If so explain the circumstance, regardless of the outcome (i.e. expunged, dismissed, sealed, vacated).	Yes ☐	No ☑
7. Have you ever been named as a defendant in any criminal proceedings?	Yes ☐	No ☑
8. Have you ever been subject to investigation by a governmental entity or Board that either could have resulted or did result in licensure sanction or other adverse actions, irrespective of the outcome?	Yes ☐	No ☑
9. Have you ever been named in any formal requests for corrective actions filed by any healthcare entity where you have had an appointment (a request which could result in either formal or informal proceedings).	Yes ☐	No ☑
10. a. Have your privileges at any healthcare entity ever been voluntarily or involuntarily suspended, restricted, diminished, revoked, surrendered, or not renewed, except for medical records delinquency?	Yes ☐	No ☑
b. Have you ever agreed not to exercise your clinical privileges while under investigation?	Yes ☐	No ☑
11. Have you ever resigned from a healthcare entity to avoid modification, suspension, or termination of privileges, or while under investigation?	Yes ☐	No ☑
12. a. Has your application for licensure or license to practice in any jurisdiction ever been investigated, voluntarily or involuntarily limited, suspended, revoked, surrendered or denied?	Yes ☐	No ☑
b. Are any currently held licenses pending investigation or being challenged?	Yes ☐	No ☑
13. Have you ever been notified to appear before any licensing agency for a hearing or complaint of any nature?	Yes ☐	No ☑
14. Has your federal or state narcotics registration certificate in any jurisdiction ever been voluntarily or involuntarily limited (stipulations), suspended, revoked, restricted, or are there currently challenges to any of these items?	Yes ☐	No ☑

15. Have you ever been involved in a settlement, medical malpractice claim or suit, or have you ever received written notice of intent to file such a suit? **If yes, please provide the following information on the attached Malpractice History form for each case:** • Name, age, sex of patient/claimant. • Date(s) and type of treatment and/or surgery, which led to the allegations against you. • Nature of allegations in claims/suits. Specify whether a suit was ever filed. • Names of other practitioners and hospital, if any, involved in claims or suit. • Disposition or current status of claim or suit (be specific). • Name of insurance carrier defending you. • Name of defense attorney.	Yes ☐	No ☑
16. Have you ever been reported to the National Practitioner Data Bank?	Yes ☐	No ☑
17. Are you now, or were you in the past, addicted to, abusive of, or in treatment for abuse of any controlled substances, habit-forming drugs, illegal drugs, prescription medication or alcohol?	Yes ☐	No ☑
18. In the five (5) years prior to this application, have you had any physical injury or disease, or mental illness or impairment, which you are currently under treatment for or could reasonably be expected to affect your on-going ability to practice medicine safely and competently? **If yes, please have your treating physician send the NM Medical Board a letter regarding your diagnosis and treatment.**	Yes ☐	No ☑
19. Have you ever, for any reason:		
a) Resigned from a medical school or postgraduate training (PGT) program?	Yes ☐	No ☑
b) Withdrawn from a medical school or postgraduate training program?	Yes ☐	No ☑
c) Been suspended, dismissed, or expelled from a medical school or PGT program?	Yes ☐	No ☑
d) Been placed on probation or remediation, including academic probation or remediation, by a medical school or PGT program?	Yes ☐	No ☑
e) Taken a leave of absence or break from, or had any interruptions or extensions in, a medical school or PGT program for any personal or professional reason (including illness or disability, pregnancy or maternity, any academic issue, etc)?	Yes ☐	No ☑

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NM MEDICAL BOARD

If you answer YES to any question, please give details including name, address, and telephone number of significant parties on a separate sheet of paper.

AMA AMERICAN MEDICAL ASSOCIATION

AMA Physician Profile

Name and Mailing Address:

CARMEN SWITZER LANDAU MD
812 GEORGIA ST SE
ALBUQUERQUE NM 87108-4946

Primary Office Address:

915 CAMINO DE SALUD
ALBUQUERQUE NM 87131-0001

Phone: UNKNOWN

Birthdate: [redacted]1977

Physician's Major Professional Activity: HOSPITAL BASED RESIDENTS - ALL YEARS

Practice Specialties Self Designated by the Physician*:

Primary Specialty: FAMILY MEDICINE

Secondary Specialty: UNSPECIFIED

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

AMA membership: NON MEMBER

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

Current and/or Historical Medical School:

ESCUELA LATINOAMERICANA DE MED, INST SUP DE CIENCIAS MED DE LA HABANA, CUBA

Degree Awarded: Yes

Degree Year: 2007

AMA AMERICAN MEDICAL ASSOCIATION

AMA Physician Profile

Current and/or Historical Post Graduate Medical Training Programs Accredited by the Accreditation Council for Graduate Medical Education (ACGME):

Beginning with the 2010 cycle of the National GME Census, post-graduate training segments will include the name of the program attended in addition to the sponsoring institution. Program-level information prior to 2010 will not be available for reporting. Future training dates, as reported by the program, should be interpreted as "in progress" or "current" with the projected date of completion.

Post-graduate training performed at accredited osteopathic institutions or in Canada are updated on the AMA Physician Masterfile only upon verification by the program. US licensing authorities accept graduate medical education from both entities as equivalent to training performed in a US program accredited by ACGME.

Sponsoring Institution: UNIV OF NM SCH OF MED
Sponsoring State: NEW MEXICO
Program Name: UNIVERSITY OF NEW MEXICO PROGRAM
Specialty: FAMILY MEDICINE
Dates: 06/2009 - 06/2012 (VERIFIED)

Note: If you have discrepant information, please submit a Request for Investigation to the AMA so that we may verify the information with the primary source(s). See the last page of this Profile for instructions on how to report a data discrepancy.

Current and/or Historical Medical Licensure:

Jurisdiction	MD/ DO	Date Granted	Expiration Date	Status	License Type	Last Reported
NEW MEXICO	MD	06/25/2009	06/30/2012	ACTIVE	RESIDENT	05/03/2012

Current and/or Historical NPI Information:

NPI Number	Enumeration Date	Deactivation Date	Reactivation Date	Replacement Number	Last Reported Date
1063655595	04/14/2009	NOT RPTD	NOT RPTD	NOT RPTD	05/04/2012

ECFMG Certfication:

Applicant Number: 06561864

Note: The Educational Commission for Foreign Medical Graduates (ECFMG) applicant identification number does not imply current ECFMG certification status. To verify ECFMG status, contact the ECFMG Certification Verification Service in writing at P.O. Box 13679, Philadelphia, PA 19101.

AMA AMERICAN MEDICAL ASSOCIATION

AMA Physician Profile

Federal Drug Enforcement Administration:

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

DEA Number *	Schedule	Expiration Date	Last Reported
None	Reported		

Address:

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

Specialty Board Certification(s)*:

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

The AMA Physician Profile has been designated by the ABMS as an Official ABMS Display Agent of Member Board Certification data. Therefore, the ABMS Board certification information on the AMA Physician Profile is considered a designated equivalent source in regard to credentialing standards set forth by Joint Commission. The AMA is also an NCQA-approved source for verification of medical school, postgraduate medical training, ABMS Board certification, and Federal DEA registration.

Certifying Board: TO DATE, THERE HAVE BEEN NO BOARD CERTIFICATIONS REPORTED.
Certificate:
Certificate Type:

Duration	Effective	Expiration	Reverification	Occurrence	Last Reported

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

Medicare/Medicaid Sanction(s):

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

AMA
AMERICAN
MEDICAL
ASSOCIATION

AMA Physician Profile

Other Federal Sanction(s):

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

Additional Information:

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

The content of the Physician Profile is intended to assist with credentialing. Appropriate use of the data contained in the AMA Physician Masterfile by an organization meets selected primary source verification requirements of the Joint Commission, the Accreditation Association for Ambulatory Health Care (AAAHC), and the American Accreditation Health Care Commission (AAHCC)/Utilization Review Accreditation Commission (URAC). The AMA is also an NCQA-approved source for verification of medical school, postgraduate medical training, ABMS Board certification and Federal DEA registration.

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

Division of Database Products and Licensing
Attn: Credentialing Products
515 N. State Street
Chicago, IL 60654
800- 665-2882
312 464-5900 (fax)

If you have questions or need additional information, please call the AMA Profile Service customer support line at 800-665-2882.

The Federation of State Medical Boards
of the United States, Inc
PO Box 619850
Dallas, Texas 75261-9850
Telephone: (817)868-4000
FAX (817)868-4099

BOARD ACTION CLEARANCE REPORT

May 17, 2012

Attn: Lynn S. Hart
New Mexico Medical Board
Lynn S. Hart
2055 S. Pacheco St, Ste 400
Santa Fe, NM 87505-0503

Re: Board Action Query Dated: May 17, 2012
Your Reference Number:
FSMB Batch Number: BQ2078623

The following is a report of the search results from the Board Action Data Bank as of May 17, 2012 for practitioners submitted as part of the above-referenced batch for which NO board actions were identified.

Practitioners Cleared with No Actions as of May 17, 2012

Item	Name	DOB	School	Yr/Grad	Request ID
1	Landau, Carmen	[redacted]/1977	032010	2005	25265523

LICENSE HISTORY
State Board
NEW MEXICO
TEXAS

PLEASE NOTE: The licensure history information contained in these reports is not considered licensure verification but rather an indicator of known states of historical licensure for these individuals. Use of this information should be limited to cross-reference purposes.

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

APPLICANT'S OATH

I, Carmen Switzer Landau, **hereby certify that I am the person pictured below and named in this application for a license to practice as a Physician in the State of New Mexico; that all statements I have made herein are true; that I am the original and lawful possessor and person named in the various forms and credentials furnished to the New Mexico Medical Board (Board) with my application.**

I acknowledge and state that I have read the Information and Instructions that accompanied this application and I have answered all questions truthfully. I understand that the fee I submitted is not refundable.

I authorize and request every person, hospital, clinic, community, governmental agency, court, association, institution or other organization having control of any documents, records, and other information pertaining to me, to furnish to the Board any such information, including documents, records regarding charges or complaints filed against me, formal or informal, pending or closed, or any other pertinent data and to permit the Board or their agents or representatives to inspect and make copies of such documents, records and other information, in connection with this application.

I hereby release, discharge, and exonerate the Board, and their agents or representatives, and any person furnishing information, from any and all liability of every nature and kind arising out of the furnishing or inspection of such documents, records, other information, or the investigation made by the Board. I authorize the Board to release information, material, documents, orders, or the like relating to me or to this application to any other agency of the State of New Mexico or the appropriate licensing agency of any other state or Territory of the United States or any agency of the United States government.

Applicant Signature — Date: 4/2/12

*Passport-quality color photograph taken within six months prior to filing the application, approximate size 2 x 2 inches, head and shoulders only, full face, front view, plain white or off-white background, standard photo stock paper, scanned or computer-generated photographs should have no visible pixels or dots.

Applicant Name Carmen Switzer Landau **Date** 4/2/12

Breen, Samantha, BME

From: carmen landau[redacted]@gmail.com]
Sent: Wednesday, August 15, 2012 9:10 AM
To: Breen, Samantha, BME
Subject: Bonita House job description

Hi Samantha,

As promised, my job description at Bonita House from June 2008 through April 2009.

Medical Project Assistant
Approximately 20 hours/week.
Provided coordination and organizational assistance to a non-profit agency which provided housing, psychiatric and medical care, job training, legal aide and case management for homeless individuals with mental illness. Obtained, consolidated and reviewed medical and psychiatric records in order to allow for improved care. Interviewed patients regarding health history and medications lists.

Supervisor: Britta Nelson, PA
6333 Telegraph Ave # 102 Oakland, CA 94609
(510) 923-1099

Thank you so much for your time,
Carmen

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

POSTGRADUATE TRAINING VERIFICATION

I am applying for a license to practice medicine in New Mexico and the Medical Board requires this form to be completed by each hospital where I participated in an approved postgraduate training program in the United States or Canada. This is your authorization to release any information in your files of record, favorable or otherwise, DIRECTLY to the NMMB, 2055 S. Pacheco St., Bldg. 400, Santa Fe, NM 87505. Your prompt response will be appreciated.

Name: Carmen Switzer Landau M.D.

Signature 5/15/12 Date (Month/Day/Year)

(DO NOT DETACH)

This section to be completed by the office of the Administrator of the institution or program wherein the applicant satisfactorily completed (or will complete) an approved postgraduate training program in the United States or Canada.

This is to certify that Carmen Switzer Landau, M.D. undertook and satisfactorily completed a full term approved program of 36? (number) months in the UNM Family Medicine Residency Program, MSC09 5040 (Full name and complete address of facility) in the field of Family Medicine from 6/25/2009 (Date: Mo/Day/Yr) to 06/30/2012 (Date/Anticipated Date).

1. Was this program approved for postgraduate training during that period by the Accreditation Council for Graduate Medical Education, or the Royal College of Physicians and Surgeons of Canada? X **Yes** ___ **No**
2. Was applicant ever placed on probation, restricted, or limited? ___ **Yes** X **No** If ***yes***, please attach written explanation.
3. Was there any reason not to continue applicant in the training program? ___ **Yes** X **No** If ***yes***, please attach written explanation.
4. Did the applicant have any medical condition, which in any way impaired or limited his/her ability to safely practice any field of medicine? ___ **Yes** X **No** If ***yes***, please attach written explanation.

   Ability to practice medicine is to be construed to include all of the following:

   The cognitive capacity to make appropriate clinical diagnoses and exercise reasoned medical judgments and to learn and keep abreast of medical developments; and

   The ability to communicate those judgments and medical information to patients and health care providers, with or without the use of aids or devices, such as voice amplifiers; and

   The physical capability to perform medical tasks such as physical examination and surgical procedures, with or without the use of aids or devices, such as corrective lenses or hearing aids

   "Medical condition" includes physiological, mental or psychological conditions or disorders, such as, but not limited to orthopedic, visual speech, and hearing impairments, cerebral palsy, epilepsy, muscular dystrophy, multiple sclerosis, cancer, heart disease, diabetes, mental retardation, emotional or mental illness, specific learning disabilities, HIV disease, tuberculosis, drug addition and alcoholism.

5. Was the applicant ever diagnosed with or treated for bipolar disorder, schizophrenia, paranoia, or any psychotic disorder? ___ **Yes** X **No** If ***yes***, please attach written explanation.
6. Were applicant's final evaluations in every category rated satisfactory? X **Yes** ___ **No** If ***no***, please attach written explanation.

James Wilterding, MD — 5-17-12
Printed name of person completing this form — Signature — Date

OFFICIAL SEAL
DOLORES L. GARCIA
NOTARY PUBLIC
STATE OF NEW MEXICO
My Commission Expires 6/23/13

Affix hospital or notary seal here — Signature of Notary (if applicable) — 5/17/12 Date

My commission expires: 6/23/13

If there is no hospital or notary seal, this form is unacceptable.
Please return this form directly to the address above
Thank you for your cooperation.

New Mexico Medical Board
2055 S. Pacheco, Building 400
Santa Fe, NM 87505
505-476-7220 fax 505-476-7237
(toll free within New Mexico 800-945-5845)

General Information

Licensee	Carmen Landau	License Type	Resident
Business address	MSC11-6093	License Number	RS2009-0278
Business address	1 University of New Mexico	License Status	Active
Business city state zip	Albuquerque NM 871310001	License Date	06/25/2009
Business phone	505-272-6225	**License Expires	06/30/2012

Medical School	Escuela Colombrana de Medica
Graduation Date	07/17/2007

* The Board does not verify current specialties. For more information please see the American Board of Medical Specialties website at: www.abms.org to determine if the physician has earned a specialty certification from this private agency.

** A New Mexico medical license that has not been renewed by July 1 of the renewal year will remain temporarily active with respect to medical practice until September 30 of the renewal year at which time, the status will be changed to lapsed.A lapsed license is not valid for practice in New Mexico.

PUBLIC ACTIONS:None
(while licensed in New Mexico)
New Search

This Board's data has been searched 7566065 times since 05/08/2001
Date information last updated: 05/18/12

Please read the AIM **Disclaimer**

TEXAS MEDICAL BOARD

PUBLIC VERIFICATION / PHYSICIAN PROFILE

PHYSICIAN IN TRAINING PERMIT

NAME: CARMEN LANDAU MD **DATE:** 08/30/2012

THE INFORMATION IN THIS BOX HAS BEEN VERIFIED BY THE TEXAS MEDICAL BOARD

Date of Birth: 1977
Permit Number: BP10038786
Permit Type: PHYSICIAN IN TRAINING PERMIT
Permit Status: PERMIT TERMINATED
Permit Status Date: 8/30/2010
Begin Date: 08/03/2010
Expiration Date: 08/30/2010
End Date: 08/30/2010
Terminated Date: 08/30/2010

Mailing Address
4456 AVENIDA DEL SOL NE
ALBUQUERQUE , NM 87110

Board Action (includes all actions regardless of license/permit type)
NONE

THE INFORMATION IN THIS BOX WAS REPORTED BY THE LICENSEE AND HAS NOT BEEN VERIFIED BY THE TEXAS MEDICAL BOARD

Gender: FEMALE

Current Primary Practice Address:
NOT GIVEN

Education

Graduation Year: 2007
Medical School: UNASSIGNED
Program Type: RESIDENT
Training Institution: UNIV OF NEW MEXICO
Program Specialty: FAMILY MEDICINE

Summary of all License/Permit Types

Issue Date:	Type:
08/03/2010	PHYSICIAN IN TRAINING PERMIT

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

WORK EXPERIENCE VERIFICATION

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

Carmen Landau
[redacted]

Applicant Signature

06/08 - 04/09
*Dates of Privilege/Employment mm/yy to mm/yy (must be provided)

[redacted]
Telephone Number

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

Britta Nelson
Type or Print Name of person completing this form

Physician Assistant
Title

Bonita House, Inc.
Name of Institution

6333 Telegraph Avenue #102
Address

Oakland / CA / 94609
City / State / Zip

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

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

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

Britta Nelson, PA
PA# 18211
DEA# MN1353894

Please affix hospital or notary seal here

Britta Nelson, PA-C — 5/20/12
Printed name of person completing this form — Signature — Date

@ hospital or notary seal available. BN
Signature of Notary (if applicable) — Date

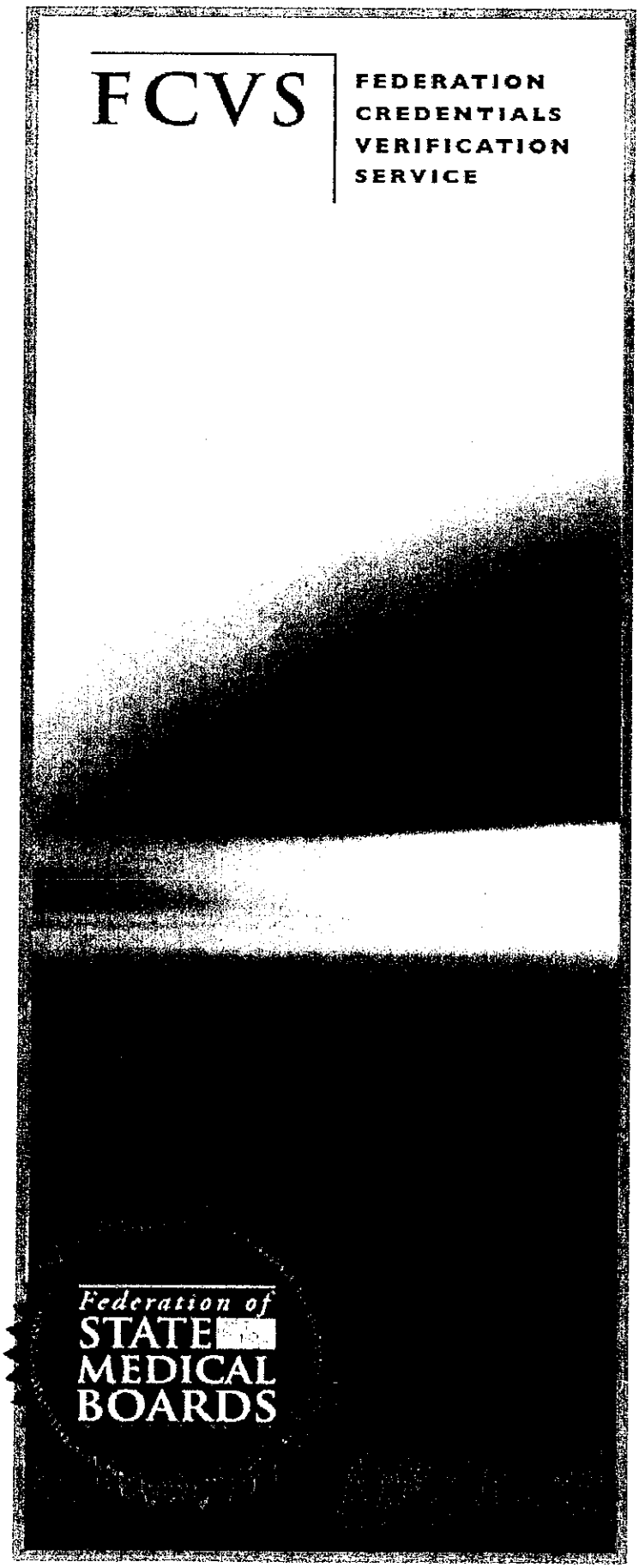
My commission expires: _____

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

Revised 10/04

FCVS

FEDERATION
CREDENTIALS
VERIFICATION
SERVICE



Medical Professional Information Profile

This report provides credentialing information for

Name: **Carmen Switzer Landau**

Social Security: Number: **XXX-XX-1571**

Date of Birth: **May 14, 1977**

FID#: **202954061**

Recipient: **NM - New Mexico Medical Board**

ABOUT THIS PROFILE

The Federation Credentials Verification Service (FCVS) was retained by the above referenced medical professional to verify his/her medical credentials for submission to your agency/organization. Unless noted otherwise, all documents contained in this report were received directly from the issuing institution per written request made by FCVS.

NOTICE: All documents bearing an original Official FCVS seal are certified to be an exact reproduction of the original. Where required, original documents are provided according to the agreements with the institution issuing such document. FCVS maintains all original documents (excluding third-party examination transcripts) in the physician's source file.

400 FULLER WISER ROAD | SUITE 300 | EULESS, TX 76039 TEL(817)868-5000 FAX(817)868-5099

FCVS FEDERATION CREDENTIALS VERIFICATION SERVICE

Credentials Analysis Summary Report

Federation of STATE MEDICAL BOARDS

Note: *Your board may wish to review the unresolved items below marked by an "X"*
Please review the Credentials Analysis report for further details on the unresolved items

Medical Professional Name: **Carmen Switzer Landau**
Date of Birth: [redacted]**1977**
Social Security Number: **XXX-XX-1571**
FID: **202954061**

I. FCVS Reports

II. FSMB and Other Reports

III. Identity

A. Certified Birth Certificate

IV. Medical Education

A. Pre-medical Schools

B. Medical Schools

Escuela LatinoAmericana De Medicina
X 1. Medical Education Form
2. Medical Education Transcript
X 3. Medical Education Diploma

C. Fifth Pathway Program

D. ECFMG Certification

1. ECFMG Status Report

V. Graduate Medical Education

University of New Mexico
1. GME Form

VI. Licensure Examination History

A. FSMB Exams

End of report for: Carmen Switzer Landau

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FCVS FEDERATION CREDENTIALS VERIFICATION SERVICE

Medical Professional Profile

Federation of STATE MEDICAL BOARDS

Table of Contents

400 FULLER WISER ROAD | SUITE 300 | EULESS, TX 76039 | TEL(817)868-5000 | FAX(817)868-5099

Section I

FCVS Reports

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FCVS FEDERATION CREDENTIALS VERIFICATION SERVICE

Medical Professional Information Report

Federation of STATE MEDICAL BOARDS

Identity

Medical Professional Name:	**Carmen Switzer Landau**
	Documentation: Certified Birth Certificate
Gender:	Female
Date of Birth:	[redacted] 1977
Place of Birth:	Washington, DC, UNITED STATES
Social Security Number:	XXX-XX-1571
FID:	202954061
Physical Description:	Height: 5 ft. 5 in.
	Weight: 130 lbs.
	Eye Color: Brown
	Hair Color: Brown

Contact Information

Mailing Address:	[redacted]
Permanent Address:	
Telephone Numbers:	Primary: [redacted]
	Secondary: N/A
	Fax: N/A
	Other: N/A

Premedical Education

There are none identified or not applicable.

ECFMG

ECFMG Number: 06561864
Issue Date: 08/13/2008

Medical Education

Medical School: **Escuela LatinoAmericana De Medicina**
Address: Carretera Panamericana
Km 3 1/2 Santa Fe, Playa
Havana,
CUBA

Dates of Attendance: 02/19/2001 to 07/12/2007
Date Certificate Issued: 07/24/2007
Degree Conferred/Issued: Doctor en Medicina

Unusual Circumstances
Leave of Absence/Extension: **No**
Probation: **No**
Disciplined: **No**
Negative Reports: **No**
Limitations: **No**

Fifth Pathway

There are none identified or not applicable.

Graduate Medical Education

Institution: **University of New Mexico**
Address: Geriatric Division MSC10 5550
1 University of New Mexico
Albuquerque, NM 87131
UNITED STATES

Training Level: 1
Program Type: Internship
Specialty: Family Medicine
Dates of Attendance: 06/30/2009 To 06/30/2010
Completed Successfully: Yes
Accreditation: ACGME

Training Level: 2
Program Type: Residency
Specialty: Family Medicine
Dates of Attendance: 07/01/2010 To 06/30/2011
Completed Successfully: Yes
Accreditation: ACGME

Training Level: 3
Program Type: Residency
Specialty: Family Medicine
Dates of Attendance: 07/01/2011 To 06/30/2012
Completed Successfully: Yes
Accreditation: ACGME

Unusual Circumstances
Leave of Absence/Extension: **No**
Probation: **No**
Disciplined: **No**
Negative Reports: **No**
Limitations: **No**

Licensure Examinations

FSMB Transcript USMLE Step 1	Date: 8/2004	Passed the Exam
FSMB Transcript USMLE Step 2 CK	Date: 09/2006	Passed the Exam
FSMB Transcript USMLE Step 2 CS	Date: 6/2008	Passed the Exam
FSMB Transcript USMLE Step 3	Date: 6/2011	Passed the Exam

ABMS Verification

A report of the result from a search of the data provided by the American Board of Medical Specialties is enclosed.

Board Action

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

End of report for Carmen Switzer Landau FID: 202954061

FCVS FEDERATION CREDENTIALS VERIFICATION SERVICE

Credentials Analysis Report

Federation of STATE MEDICAL BOARDS

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

Medical Professional Identification

Medical Professional Name: **Carmen Switzer Landau**
Date of Birth: **[redacted] 1977**
Social Security Number: **XXX-XX-1571**
FID: **202954061**

Omissions

There are no omissions identified.

Discrepancies

Discrepancy 1:

Section of Profile: **Medical Education**

Discrepancy: **FCVS has identified discrepant information relating to the medical education graduation date for Escuela LatinoAmericana De Medicina**

Verification of Medical Education Form - 07/12/2007
Medical School Diploma - 07/24/2007
Applicant - 07/24/2007

Action Taken: **FCVS has defined "graduation date" as the date the diploma was issued to the applicant by the medical school.**

Discrepancy 2:

Section of Profile: **Medical Education**

Discrepancy: **FCVS has identified discrepant information relating to the medical degree type for the Escuela LatinoAmericana De Medicina.**

Verification of Medical Education Form - Doctor en Medicina
Medical School Diploma - Doctor en Medicina
Applicant - Bachelor of Medicine

Action Taken: **FCVS reports the degree type listed on the medical school diploma. This information is reported on the Medical Professional Information Report.**

Discrepancy 3:

Section of Profile: **Medical Education**

Discrepancy: **The applicant reports attendance at Escuela LatinoAmericana De Medicina from 08/--/2001 to 07/--/2007. The institution reports attendance from 02/19/2001 to 07/12/2007**

Action Taken: **FCVS does not follow up with the applicant or the institution for resolution of discrepant attendance dates less than one year.**

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Miscellaneous Information

There is no miscellaneous information identified.

End of report for: Carmen Switzer Landau

FCVS FEDERATION CREDENTIALS VERIFICATION SERVICE

Chronology of Activities

Federation of STATE MEDICAL BOARDS

The Chronology of Activities is a comprehensive report of a medical professional's activities as reported to FCVS by the medical-professional applicant.

Medical Professional Name: **Carmen Switzer Landau**
Date of Birth: [redacted]1977
Social Security Number: **XXX-XX-1571**
FID#: **202954061**

Start Date	End Date	Activity	Location	Overlap Explanation	Program Length Explanation
8/2001	07/2007	Medical Education Record	Escuela LatinoAmericana De Medicina,Carretera Panamericana Havana, CUBA		
10/2007	02/2008	Employment	Needle Exchange Emergency Distribution,2339 Durant St. Berkeley, CA 94704 UNITED STATES		
3/2008	05/2008	Medical Leave	maternity leave, ,		
6/2008	04/2009	Employment	Bonita House,6333 Telegraph Ave. Oakland, CA 94609 UNITED STATES		
6/2009	06/2012	GME Record	University of New Mexico,Geriatric Division MSC10 5550 Albuquerque, NM 87131 UNITED STATES		

End of report for Carmen Switzer Landau

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Section II

FSMB and Other Reports

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FPDC | FEDERATION PHYSICIAN DATA CENTER

Board Action Clearance Report

July 30, 2012

Attn: Tracy Bevers
FCVS
400 Fuller Wiser Rd., #209
Euless, TX 76039

Re: Board Action Query Dated: July 30, 2012
FSMB Batch Number: BQ2116663

The following is a report of the search results from the Board Action Data Bank as of July 30, 2012 for practitioners submitted as part of the above-referenced batch for which NO board actions were identified.

Provider cleared with No Actions as of July 30, 2012

Name	DOB	School	Yr/Grad	Provider ID
Carmen Switzer Landau	[redacted]/1977	275095	2007	229360

License History

Licensing Entity
NEW MEXICO
TEXAS

PLEASE NOTE: The licensure history information contained in these reports is not considered licensure verification but rather an indicator of known states of historical licensure for these individuals. Use of this information should be limited to cross-reference purposes.

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Section III

Identity

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Federation of STATE MEDICAL BOARDS

Affidavit and Release and Authorization for Release of Information, Documents and Records

I, the undersigned, being duly sworn, hereby certify under oath that I am the person named in this application, that all statements I have or shall make with respect thereto are true, that I am the original and lawful possessor and person named in the various forms and credentials furnished or to be furnished with respect to my application and that all documents, forms or copies thereof furnished or to be furnished with respect to my application are strictly true in every aspect.

I acknowledge that I have read and understand the "Instructions for Completing the FCVS Application" and have answered all questions contained in the application truthfully and completely. I further acknowledge that failure on my part to answer questions truthfully and completely may lead to my being prosecuted under appropriate federal and state laws.

I waive confidentiality, authorize and request every person, hospital, clinic, government agency (local, state, federal or foreign), court, association, institution or law enforcement agency having custody or control of any documents, records and other information pertaining to me to furnish to the Federation Credentials Verification Service (FCVS) any such information, including documents, records regarding charges or complaints filed against me, formal or informal, pending or closed, my examination grades, or any other pertinent data and to permit FCVS or any of its agents or representatives to inspect and make copies of such documents, records, and other information in connection with this application that can subsequently be provided to professional licensing boards, hospitals and other entities when I apply for licensure, staff membership, employment or other privileges.

I hereby release, discharge and exonerate FCVS, its agents or representatives and any person, hospital, clinic, government agency (local, state, federal or foreign), court, association, institution or law enforcement agency having custody or control of any documents, records and other information pertaining to me of any and all liability of every nature and kind arising out of investigation made by FCVS.

I will immediately notify FCVS in writing of any changes to the answers to any questions contained in this application if such a change occurs at any time prior to my FCVS Physician Information Profile being mailed.

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

Landau
Applicant's Printed Last Name

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

5/15/12 [redacted]/77
Date of Signature Date of Birth

[redacted]
Applicant SSN

NOTARY

Your seal or stamp must be partly upon the photograph.

State of New Mexico County of Bernalillo

SUBSCRIBED AND SWORN TO before me this 15 day of May, 20 12

My commission expires: 6/23/13

(NOTARY PUBLIC SIGNATURE & SEAL)

Notary Public signature

I certify that on the date set forth above the individual named above did appear personally before me and that I did identify this applicant by: (a) comparing his/her physical appearance with the photograph on the identifying document presented by the applicant and with the photograph affixed hereto, and (b) comparing the applicant's signature made in my presence on this form with the signature on his/her identifying document.

Federation Credentials Verification Service

229360

DISTRICT OF COLUMBIA
DEPARTMENT OF HUMAN SERVICES
WASHINGTON, D.C.

284533

CERTIFICATE OF BIRTH

This is to certify that the following information has been taken from the original record of birth.

Name CARMEN SWITZER LANDAU

Date of Birth [redacted]-1977 Sex FEMALE Certificate Number 108-77-008290

Name of Father SAUL IRWIN LANDAU

Maiden Name of Mother REBECCA SWITZER

Date Issued 06-25-1986 Date Recorded 06-16-1977

DHS 1610 (3/83)

John H. Crandall
JOHN H. CRANDALL
REGISTRAR

21960

SEAL
VERIFIED

Section IV

Medical Education

400 FULLER WISER ROAD | SUITE 300 | EULESS, TX 76039 | TEL(817)868-5000 | FAX(817)868-5099

ECFMG™

Educational Commission for Foreign Medical Graduates (ECFMG®)
VERIFICACIÓN DE EDUCACIÓN MÉDICA
(Este formulario tiene que ser completado por la escuela de medicina)

INSTRUCCIONES PARA EL DECANO

El individuo identificado en la *Solicitud de Divulgación de la Escuela de Medicina* adjunta o en la Declaración de Certificación en la solicitud al ECFMG ha autorizado que su escuela de medicina provea al Comité Educativo para Graduados Médicos Extranjeros (ECFMG) cualquiera y toda la información que pertenezca a su educación en su institución. **Por favor complete este formulario de VERIFICACIÓN DE EDUCACIÓN MÉDICA y devuélvalo al ECFMG con el diploma en medicina adjunto y el expediente académico final de la escuela de medicina en el sobre que se provee con dirección ya escrita.**

VERIFICACIÓN DE EDUCACIÓN MÉDICA

RE: Carmen Switzer Landau
0-656-186-4

ESCUELA LATINOAMERICANA DE MEDICINA
CARRETERA PANAMERICANA
KM. 3 1/2 SANTA FE, PLAYA
HABANA
HABANA, CUBA

RECEIVED
JAN 22 2008
ECFMG
MAILROOM BW

Si el nombre de la institución era diferente cuando este individuo asistió a ella, por favor escriba dicho nombre debajo:
Escuela Latinoamericana de Medicina

Educación Pre-médica:

Años de educación exigidos para admisión a su escuela de medicina: 12 años

Credenciales/título presentado por el solicitante para admisión en su escuela de medicina: Bachiller

Matriculación y Participación: Nuestro registro indica que **Carmen Switzer Landau** asistió a nuestra escuela de medicina por un total de 302 semanas de educación médica en las fechas siguientes:

Del 19/2/2001 (día/mes/año) **Al** 12/07/2007 (día/mes/año)

Este individuo (por favor marque uno):

(X) Se le confirió/recibió la titulación de Doctor en Medicina el 12/07/2007 (día/mes/año)

( ) No recibió titulación (por favor adjunte una explicación)

Por favor marque uno:

(X) Por la presente certifico que la titulación médica adjunta del individuo nombrado anteriormente es auténtica y correcta y que estoy autorizado para certificar esto en nombre de esta institución.

O

( ) No puedo certificar que la titulación médica del individuo nombrado anteriormente sea auténtica y correcta porque:

_____

_____

(adjunte folios adicionales si es necesario)

Certificación: Con mi firma, Yo, Juan Domingo Carrizo Estévez certifico que la información anterior es
(escriba el nombre a máquina o con letra de imprenta)
un informe preciso del expediente del individuo nombrado anteriormente mantenido en esta escuela de medicina y es verdadera y correcta según mi conocimiento.

Ponga sello de la institución aquí.
Si no hay sello disponible, este formulario debe ser notariado

Firma: Carrizo

Título: Rector

Fecha de Firma: 9 de Enero 2008

Teléfono: ( ) 209-82-25 **Fax:** ( )

Dirección de correo electrónico: carrizo@elacm.sld.cu

SEAL VERIFIED

ECFMG

Educational Commission for Foreign Medical Graduates (ECFMG®)
VERIFICACIÓN DE EDUCACIÓN MÉDICA
(continuación)

VERIFICACIÓN DE EDUCACIÓN MÉDICA

Circunstancias Extraordinarias: Las preguntas siguientes se aplican a circunstancias extraordinarias que ocurrieran durante cualquier parte de la educación médica del individuo. Por favor marque las respuestas apropiadas y provea las fechas e información requeridas. La respuesta afirmativa ("Sí")a cualquiera de estas preguntas exige una copia del expediente explicativo o una explicación escrita (adjunte páginas adicionales si es necesario).

1. ¿El expediente oficial de este individuo refleja una(s) interrupción(es) o extensión(es) en su educación médica? **SÍ ( ) NO (X)**

Si responde Sí, por favor seleccione la(s) razón(es), indique las fechas de la(s) interrupción(es) o extensión(es) y marque si la interrupción/extensión fue aprobada o no aprobada.

	De Mes/Año	A Mes/Año	Aprobada	No Aprobada
Personal/Familiar			( )	( )
Remedio Académico			( )	( )
Salud			( )	( )
Financiera			( )	( )
Participación en doble titulación (e.g., MD/PhD)			( )	( )
Participación en estudio especial que no sea de investigación (e.g., asociación, experiencia internacional)			( )	( )
Participación en investigación que no resulta en titulación			( )	( )
Otro			( )	( )

Por favor, especifique: _____

2. ¿El expediente de este individuo refleja que alguna vez haya sido puesto a prueba académica o disciplinaria durante su educación médica? **SÍ ( ) NO (X)**

Si responde SÍ, por favor seleccione la(s) razón(es) para la prueba, indique la(s) fecha(s) de inicio y conclusión del periodo de prueba y adjunte documentación adicional para este informe.

	De Mes/Año	A Mes/Año
Periodo de prueba académica		
Periodo de prueba por conducta/comportamiento no profesional		
Periodo de prueba por otra razón		

Por favor especifique la razón: _____

3. ¿El expediente de este individuo refleja que ha sido disciplinado/a por razones de conducta/comportamiento por la escuela de medicina o Universidad emoparentada con ella? **SÍ ( ) NO (X)**

Si responde SÍ, por favor provea documentación/información con detalles de las circunstancias y los resultados:

_____

_____

4. ¿El expediente de este individuo refleja que ha sido en algún momento el sujeto de reportes negativos o de una investigación por la escuela de medicina o por la Universidad emparentada con ella? SÍ ( ) NO (X)

Si responde SÍ, por favor provea documentación/información con detalles de las circunstancias y los resultados:

_____

_____

5. ¿El expediente de este individuo refleja que habia algún tipo de limitaciones o requisitos especiales impuestos en el individuo por cuestiones de incompetencia académica, problemas disciplinarios, o cualquier otra razón? SÍ ( ) NO (X)

Si responde SÍ, por favor provea documentación/información con detalles de las circunstancias y los resultado.

_____

_____

ECFMG®

Educational commission for Foreign Medical Graduates (ECFMG®)
VERIFICATION OF MEDICAL EDUCATION
(This form must be completed by the medical school)

INSTRUCTIONS TO THE DEAN

The individual identified on the attached Medical School Release Request Form has authorized your medical school to provide to the Educational Commission for Foreign Medical Graduates (ECFMG) on behalf of the Federal Credentials Verification Service (FCVS), a division of the Federation of State Medical Boards of the united States, Inc. (FSMB) any and all information pertaining to his/her education at your institution. **Please complete this Verification of Medical Education form and return it to ECFMG with the accompanying medical diploma endorsed with your medical institution's seal. If your institution also processes final medical school transcript requests, please attach the individual's final medical school transcript. If the transcript is not in English, please include an English translation, if possible. Enclosed is a self-addressed prepaid envelope.**

VERIFICATION OF MEDICAL EDUCATION

REF: Carmen Switzer Landau
0-656-186-4

Latin American School of Medicine
Carretera Panamericana
KM. 3 ½ Santa Fe, Playa
Havana
Havana, Cuba

If the name of institution was different when this individual attended, please note this name below:
Latin American School of Medicine

Premedical Education:

Years of education required for admission to your medical school: 12 years.

Credential/degree presented by the applicant for admission to your medical school: High School diploma

Enrollment and Participation: Our records indicate that attended our medical school for a total of 302 weeks of medical education on the following dates:

From 19 / 2 / 2001 (dd/mm/yy) **To** 12 / 07 / 2007 (dd/mm/yy)

This individual:

Was awarded the degree of Doctor in Medicine on 12 / 07 / 2007 (dd/mm/yy)

OR

Was NOT awarded a degree because _____

(Please explain – attach additional pages if necessary)

Certification: By my signature, I, Juan Domingo Carrizo Estévez (Please print name), certify that the above information is an accurate account of the above mentioned individual's official records maintained in this medical school and is true and correct to my knowledge.

{Seal:Latin American School of Medicine}

Signature:[illegible signature]

Title: Rector

Date of Signature: 09 / 01 / 2008 (dd/mm/yy)

Phone: ( ) 209-82-29 **Fax:** ( )

Email: carrizo@elacm.sld.cu

Educational commission for Foreign Medical Graduates (ECFMG®)
(continued)

VERIFICATION OF MEDICAL EDUCATION

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

1. Does this individual's official record reflect (an) interruption(s) or extension(s) in his/her medical education?
Response YES ☐ NO ☒

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

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

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

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

	From Mo/Yr	To Mo/Yr
Academic Probation		
Probation for unprofessional conduct/behavioral		
Probation for other reason		
Please specify the reason:		

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

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

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

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

5. Does this individual's official record reflect that there were any limitations or special requirements imposed on the individual because of questions of academic incompetence, disciplinary problems, or any other reason?

   Response YES ☐ NO ☒

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

Teneo
Linguistics
Company

CERTIFICATE OF ACCURATE TRANSLATION
No. 07122012-308

Teneo Linguistics Company, LLC, a translation company based in Tarrant County, state of Texas (TX state vendor ID: 120511285800), hereby certifies that the attached is a true and accurate translation of the original submitted, completed to the best of our knowledge, ability and belief by a qualified and certified translator of the Spanish and English languages.*

Original language:	Spanish
Target language:	English
No. of pages:	3
Type of document:	ECFMG Form (Landau)
Date of translation:	July 12, 2012

Kimberly Halpenny

Digitally signed by Kimberly Halpenny
DN: cn=Kimberly Halpenny, o=Teneo Linguistics Company, ou=Teneo Linguistics Company, email=klm@tlctranslation.com, c=US
Date: 2012.07.12 15:40:29 -06'00'

Kimberly Halpenny
Project Coordinator

* Teneo Linguistics Co. does not warrant the authenticity of the original document.

6000 Western Place
Ste 403
Fort Worth, TX 76107

Tel. (817) 441 9974
Fax.(817) 231 0052

www.tlctranslation.com

Applicant Reported Unusual Circumstances

Medical School

Medical Professional Name: Carmen Switzer Landau

Escuela LatinoAmericana De Medicina

Unusual Circumstances

Did you have any interruption(s) or extension(s) in your medical education?	Yes	**No**
Were you ever placed on probation?	Yes	**No**
Were you ever disciplined or placed under investigation?	Yes	**No**
Were any negative reports for behavioral reasons ever filed by instructors?	Yes	**No**
Were any limitations or special requirements imposed on you because of academic performance, incompetence, disciplinary problems or for any other reason?	Yes	**No**

End of report for Carmen Switzer Landau

PROVIDED BY APPLICANT

Carretera Panamericana
Km 3 ½, Santa Fe,
Playa Ciudad Habana.
Cuba.

ESCUELA LATINOAMERICANA DE MEDICINA

INGENIERO INOCENTE ALEJANDRO RUIZ MARTÍNEZ, SECRETARIO GENERAL DE LA ESCUELA LATINOAMERICANA DE MEDICINA, DE LA CIUDAD DE LA HABANA, REPÚBLICA DE CUBA

CERTIFICO: Que CARMEN SWITZER LANDAU

Procedente de ESTADOS UNIDOS

cursó y aprobó las asignaturas correspondientes al Plan de Estudio de la especialidad de MEDICINA, graduándose de Doctor(a) en Medicina en este centro de educación Médica Superior en el curso académico 2006 - 2007 con el aprovechamiento docente siguiente:

CURSO 2001- 2002 Primer Año

Introducción a la Medicina General Integral	5
Anatomía I	5
Histología I	4
Embriología I	4
Biología Celular y Molecular	4
Historia y Medicina I	3
Preparación Física y Deportes I	5
Anatomía II	4
Histología II	5
Fisiología I	4
Metabolismo Intermediario y su Regulación	3
Historia y medicina II	5
Informática Médica I	5
Preparación Física y Deportes II	5

CURSO 2002 - 2003 Segundo Año

Anatomía III	4
Histología III	4
Embriología II	4
Fisiología II	4
Preparación Física y Deportes III	5
Anatomía Patológica	5
Agentes Biológicos	4
Psicología Médica I	4
Informática Médica II	5
Introducción a la Clínica	5
Preparación Física y Deportes IV	5
Tiempo Electivo	5
Farmacología I	4
Farmacología II	5

CURSO 2003 - 2004 Tercer Año

Propedéutica Clínica y Semiología Médica	5
Psicología Médica II	5
Medicina Interna	4
Tiempo Electivo	5

Confrontado y revisado por ... Número 1290
Folio 53
Extractado Por ...
Anotado en el Libro 3

CARMEN SWITZER LANDAU

Cuarto Año

Medicina General Integral I	5
Cirugía General	5
Obstetricia y Ginecología	4
Inglés VII	Eximido
Medicina de Desastres I	4
Pediatría	5
Inglés VIII	5
Tiempo Electivo	5

Quinto Año

Salud Pública	5
Medicina General Integral II	5
Psiquiatría	5
Medicina de Desastres II	5
Inglés IX	4
Ortopedia y Traumatología	5
Urología	5
Otorrinolaringología	5
Oftalmología	5
Dermatología	5
Medicina Legal y Ética Médica	5
Inglés X	5
Tiempo Electivo	5

Sexto Año, Internado Rotatorio

Medicina Interna	5
Pediatría	4
Obstetricia y Ginecología	5
Cirugía	5
Medicina General Integral	5
EXAMEN ESTATAL	***Aprobado***
Índice académico	**4,63**

ASÍ MISMO CERTIFICO QUE: los resultados de las evaluaciones se ajustan a las equivalencias que se expresan en las siguientes categorías y símbolos, exceptuando el Examen Estatal

La calificación de 2 en tiempo electivo no invalida para promover de año.

EQUIVALENCIA DE NOTAS

				Escala de 0 a 100	
				Aprobado 60	*Aprobado 70*
Excelente	5	A	Sobresaliente	90 - 100	90 - 100
Bien	4	B	Aprovechado	80 - 89	80 - 89
Regular	3	C	Aprobado	60 - 79	70 - 79
Mal	2	D	Suspenso	0 - 59	0 - 69

Y para surtir efecto fuera del territorio nacional, se expide la presente en la Ciudad de la Habana, República de Cuba, a los veinticuatro días del mes de julio de dos mil siete.

"Año 49 de la Revolución".

Ingeniero Inocente Alejandro Ruiz Martínez
Secretario General de la ELAM

ESCUELA LATINOAMERICANA DE MEDICINA
Secretaría General

Dr. Nicolás Fernández Montoto, Lda. María de los Angeles Montalvo Carrió, Lda. Tania M. García Cabello, Asesores Jurídicos del Ministerio de Salud Pública, por la presente:

CERTIFICO: Que la firma del funcionario que antecede es auténtica por la semejanza que guarda con la que acostumbra a usar en sus actos oficiales

Dado en la Ciudad de La Habana a los 30

días del mes de agosto del 200 7

MINISTERIO DE SALUD PÚBLICA
SALUS POPULIS
SUPREMA LEX
DIRECCIÓN JURÍDICA

REPÚBLICA DE CUBA
MINISTERIO DE RELACIONES EXTERIORES
DIRECCIÓN DE ASUNTOS CONSULARES Y DE CUBANOS RESIDENTES EN EL EXTERIOR

LA HABANA 30 AGO. 2007

FUNCIONARIO AUTORIZADO PARA CERTIFICAR AUTENTICACIONES DE FIRMA EN DOCUMENTOS EXPEDIDOS PARA SURTIR EFECTOS EN EL EXTRANJERO.
CERTIFICO: QUE AL PARECER ES AUTÉNTICA DEL FUNCIONARIO AUTORIZANTE DE ESTE DOCUMENTO, LA FIRMA QUE ANTECEDE, POR SEMEJANZA QUE GUARDA CON LA QUE OBRA REGISTRADA EN ESTE CENTRO COMO LA QUE EL MISMO ACOSTUMBRA A USAR EN SUS ACTOS OFICIALES. EN FE DE LO CUAL AUTORIZO LA PRESENTE CON LA FIRMA Y EL SELLO DE ESTE MINISTERIO.

LATIN AMERICAN SCHOOL OF MEDICINE

Carretera Panamericana
Km 3½, Santa Fe,
Playa, Ciudad Habana
Cuba

INOCENTE ALEJANDRO RUIZ MARTINEZ, REGISTRAR OF THE LATIN AMERICAN SCHOOL OF MEDICAL SCIENCES, CIUDAD DE LA HABANA, REPUBLIC OF CUBA.

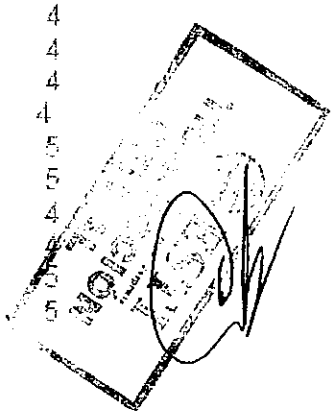
I CERTIFY: that **CARMEN SWITZER LANDAU**
From **UNITED STATES**
has taken and passed the subjects relevant to the Curriculum of the specialty of MEDICINE and graduated as MEDICAL DOCTOR in this Higher Medical Education Center during the 2006-2007 academic year with the following academic performance:----------

ACADEMIC YEAR: 2001- 2002, First Year

Introduction to General Comprehensive Medicine	5	
Anatomy I	5	
Histology I	4	
Embryology I	4	
Cell and Molecular Biology	4	
History and Medicine I		3
Physical Education I	5	
Anatomy II		4
Histology II	5	
Physiology I	4	
Intermediate Metabolism and its Regulation	3	
History and Medicine II	5	
Computer Science in Medicine I	5	
Physical Education II	5	

ACADEMIC YEAR: 2002- 2003, Second Year

Anatomy III	4
Histology III	4
Embryology II	4
Physiology II	4
Physical Education III	5
Pathological Anatomy	5
Biological Agents	4
Medical Psychology I	4
Computer Science in Medicine II	5
Introduction to the Clinical Medicine	5



Physical Education IV	5
Elective Time	5
Pharmacology I	4
Pharmacology II	5

ACADEMIC YEAR: 2003- 2004, Third Year

Clinic Propedeutics and Medical Semiology	5
Medical Psychology II	5
Internal Medicine	4
Elective Time	5

Fourth Year

General Comprehensive Medicine I	5
General Surgery	5
Gynecology and Obstetrics	4
English VII	Exempt
Medicine of Disasters I	4
Pediatrics	5
English VIII	5
Elective Time	5

Fifth Year

Public Health	5
General Comprehensive Medicine II	5
Psychiatry	5
Medicine of Disasters II	5
English IX	4
Orthopedics and Traumatology	5
Urology	5
Otolaryngology	5
Ophthalmology	5
Dermatology	5
Forensic Medicine and Medical Ethics	5
English X	5
Elective Time	5

Sixth Year, Rotation Internship

Internal Medicine	5
Pediatrics	4
Gynecology and Obstetrics	5
Surgery	5
General Comprehensive Medicine	5

STATE EXAM.....*Pass*
Grade Point Average 4.63

I LIKEWISE CERTIFY THAT: the above grades match with the equivalences expressed in the following categories and symbols, except for the State Exam. *The grade of 2 points obtained in Elective Time subject does not count to promote the year.*

KEY TO GRADE				0-100 Point Scale	
				Pass 60	Pass 70
Excellent	5	A	Outstanding	90-100	90-100
Good	4	B	Satisfactory	80-89	80-89
Fair	3	C	Pass	60-79	70-79
Bad	2	D	Fail	0-59	0-69

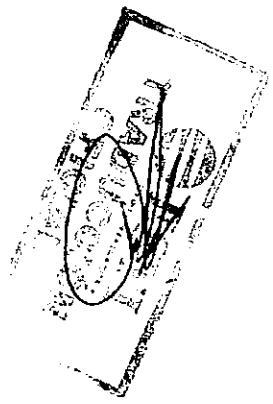
And so it may be officially recorded abroad, this document is issued in Ciudad de La Habana, Republic of Cuba, this twenty-fourth day of July of the year two thousand and seven. "YEAR 49 OF THE REVOLUTION."

(Signed)
Inocente Alejandro Ruiz Martínez, Eng.
Registrar
Latin-American School of Medical Sciences

(Stamp: Registrar, Latin American School of Medical Sciences)

LEFT MARGIN OF THE FIRST PAGE:

ABSTRACTED BY: (Signed) COLLATED AND CHECKED BY: (Signed)
REGISTERED IN VOLUME: 3 FOLIO: 53 NUMBER: 1290



NICOLAS E. FERNÁNDEZ MONTOTO, MARA DE LOS ANGELES MONTALVO CARRIO, TANIA M. GARCÍA CABELLO, LEGAL ADVISORS OF MINISTRY OF PUBLIC HEALTH

HEREBY CERTIFY: THAT THE SIGNATURE OF THE OFFICIAL AUTHORIZING THIS DOCUMENT SEEMS TO BE AUTHENTIC AND MATCHES THE ONE HE/SHE HAS REGISTERED IN THIS CENTER FOR USE IN HIS/HER OFFICIAL CAPACITY.

GIVEN IN CIUDAD DE LA HABANA, THIS 30TH DAY OF AUGUST, 2007

(SIGNED)
(STAMP: LEGAL ADVISORY, SALUS POPULUS, SUPREMA LEX, MINISTRY OF PUBLIC HEALTH)

REPUBLIC OF CUBA
MINISTRY OF FOREIGN AFFAIRS
DIVISION OF CONSULAR AFFAIRS
AND CUBAN RESIDENTS ABROAD

Jesús Fernández

Officials authorized to certify signature authentications on documents issued for use abroad,

CERTIFY: THAT THE ABOVE SIGNATURE OF THE OFFICIAL AUTHORIZING THIS DOCUMENT APPEARS TO BE AUTHENTIC AND MATCHES THE SIGNATURE HE/SHE HAS REGISTERED WITH THIS MINISTRY FOR USE IN HIS/HER OFFICIAL CAPACITY.
IN WITNESS WHEREOF, I AUTHORIZE THIS DOCUMENT WITH MY SIGNATURE AND THE SEAL OF THIS MINISTRY

HAVANA, AUGUST 30, 2007

(Signed)
(Seal: Ministry of Foreign Affairs, Republic of Cuba)

REPÚBLICA DE CUBA
MINISTERIO DE RELACIONES EXTERIORES
DIRECCIÓN DE ASUNTOS CONSULARES Y DE CUBANOS RESIDENTES EN EL EXTERIOR
LA HABANA 06 SET. 2007
FUNCIONARIO AUTORIZADO PARA CERTIFICAR AUTENTICACIONES DE FIRMA EN DOCUMENTOS EXPEDIDOS PARA SURTIR EFECTOS EN EL EXTRANJERO.
CERTIFICO: QUE AL PARECER ES AUTÉNTICA DEL FUNCIONARIO AUTORIZANTE DE ESTE DOCUMENTO, LA FIRMA QUE ANTECEDE, POR SEMEJANZA QUE GUARDA CON LA QUE OBRA REGISTRADA EN ESTE CENTRO COMO LA QUE EL MISMO ACOSTUMBRA A USAR EN SUS ACTOS OFICIALES. EN FE DE LO CUAL AUTORIZO LA PRESENTE CON LA FIRMA Y EL SELLO DE ESTE MINISTERIO.

This is a true translation of the original
OFFICIAL TRANSLATION: Equipo de Servicios de Traductores e Intérpretes (ETI)

REPÚBLICA DE CUBA
MINISTERIO DE EDUCACIÓN SUPERIOR

El Rector de la Escuela Latinoamericana de Medicina

en uso de las facultades que le están conferidas y a propuesta del Decano de la Facultad, expide el presente Título de

Doctora en Medicina

a favor de **Carmen Switzer Landau**

en atención a que la misma ha cumplido los requisitos establecidos para los estudios de la especialidad y ha realizado los ejercicios correspondientes para la culminación de los mismos, el día doce del mes de julio del dos mil siete.

En testimonio de lo cual, se suscribe en la Ciudad de La Habana, a los veinticuatro días del mes de julio del dos mil siete.

Decano

Rector

Refrendado:

Secretaria General

Registrado al Tomo 3 Folio 53 número 1296 del libro correspondiente a la Secretaría de este Centro de Educación Superior

Registrado al Tomo 1 Folio 191 número 1184 del libro correspondiente a la Facultad de Ciencias Médicas Dr. Salvador Allende

Nicolás Fernández Montoto, Lda. María de los Angeles Montalvo Carrió, Lda. Tania M. García Cabello, Asesores Jurídicos del Ministerio de Salud Pública, por la presente:

CERTIFICO: Que la firma del funcionario que antecede es auténtica por la semejanza que guarda con la que acostumbra a usar en sus actos oficiales

Dado en la Ciudad de La Habana a los 29

días del mes de Agosto del 200 7

MINISTERIO DE SALUD PÚBLICA
SALUS POPULIS
SUPREMA LEX
DIRECCIÓN JURÍDICA

REPÚBLICA DE CUBA
MINISTERIO DE RELACIONES EXTERIORES
DIRECCIÓN DE ASUNTOS CONSULARES Y DE CUBANOS RESIDENTES EN EL EXTERIOR

LA HABANA: 30 AGO. 2007

FUNCIONARIO AUTORIZADO PARA CERTIFICAR AUTENTICACIONES DE FIRMA EN DOCUMENTOS EXPEDIDOS PARA SURTIR EFECTOS EN EL EXTRANJERO.
CERTIFICO: QUE AL PARECER ES AUTÉNTICA DEL FUNCIONARIO AUTORIZANTE EN ESTE DOCUMENTO, LA FIRMA QUE ANTECEDE, POR SEMEJANZA QUE GUARDA CON LA QUE OBRA REGISTRADA EN ESTE CENTRO COMO LA QUE EL MISMO ACOSTUMBRA A USAR EN SUS ACTOS OFICIALES.
EN FE DE LO CUAL AUTORIZO LA PRESENTE CON LA FIRMA Y EL SELLO DE ESTE MINISTERIO.

REPUBLIC OF CUBA
MINISTRY OF HIGHER EDUCATION

THE RECTOR OF THE LATIN AMERICAN SCHOOL OF MEDICAL SCIENCES

by the authority vested in him, and at the instance of the Dean of the School, awards this Degree in

Doctor in Medicine

to

Carmen Switzer Landau

In consideration of the fact that he/she has met the established requirements and has fulfilled the relevant exercises for the completion of the same, on the twelfth day of July, two thousand and seven.

In witness whereof, we sign this document in the Ciudad de La Habana, this twenty-fourth day of July, two thousand and seven.

(Signed)
Dean

(Signed)
Rector

Countersigned:
(Signed)
Registrar

Recorded in volume 3 folio 53, number 1290 in the relevant register of the Registry of this Higher Education Center.
Recorded in volume 1 folio 198, number 4834 in the relevant register of Dr. Salvador Allende School of Medical Sciences.

I, NICOLAS E. FERNÁNDEZ MONTOTO, MARÍA DE LOS ANGELES MONTALVO CARRIO AND TANIA M. GARCÍA CABELLO, LEGAL ADVISORS OF MINISTRY OF PUBLIC HEALTH

HEREBY CERTIFY: THAT THE SIGNATURE OF THE OFFICIAL AUTHORIZING THIS DOCUMENT SEEMS TO BE AUTHENTIC AND MATCHES THE ONE HE/SHE HAS REGISTERED IN THIS CENTER FOR USE IN HIS/HER OFFICIAL CAPACITY.

GIVEN IN CIUDAD DE LA HABANA, THIS 30TH DAY OF AUGUST, 2007

(SIGNED)
(STAMP: LEGAL ADVISORY, SALUS POPULIS, SUPREMA LEX, MINISTRY OF PUBLIC HEALTH)

REPUBLIC OF CUBA
MINISTRY OF FOREIGN AFFAIRS
DIVISION OF CONSULAR AFFAIRS AND CUBAN RESIDENTS ABROAD

Jesús Fernández,

official authorized to certify signature authentication on documents issued for use abroad,
CERTIFIES: THAT THE ABOVE SIGNATURE OF THE OFFICIAL AUTHORIZING THIS DOCUMENT APPEARS TO BE AUTHENTIC AND MATCHES THE SIGNATURE HE/SHE HAS REGISTERED WITH THIS MINISTRY FOR USE IN HIS/HER OFFICIAL CAPACITY.
IN WITNESS WHEREOF, I AUTHORIZE THIS DOCUMENT WITH MY SIGNATURE AND THE SEAL OF THIS MINISTRY.

HAVANA, AUGUST 30, 2007

(Signed)
(Seal: Ministry of Foreign Affairs, Republic of Cuba)

REPÚBLICA DE CUBA
MINISTERIO DE RELACIONES EXTERIORES
DIRECCIÓN DE ASUNTOS CONSULARES Y DE CUBANOS RESIDENTES EN EL EXTERIOR
LA HABANA 06 SET. 2007
FUNCIONARIO AUTORIZADO PARA CERTIFICAR AUTENTICACIONES DE FIRMA EN DOCUMENTOS EXPEDIDOS PARA SURTIR EFECTOS EN EL EXTRANJERO
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This is a true translation of the original
OFFICIAL TRANSLATION: Equipo de Servicios de Traductores e Intérpretes (ESTI)

ECFMG®
EDUCATIONAL COMMISSION FOR
FOREIGN MEDICAL GRADUATES

3624 Market St
Philadelphia, PA 19104-2685 USA
215-386-5900 | 215-386-3185 FAX
www.ecfmg.org

NEW MEXICO MEDICAL BOARD
LICENSING MANAGER
c/o Federation Credentials Verification Service
2055 S. PACHECO ST., BLDG 400
SANTA FE, NM, 87505

State Board Code:
032
Please include this number on all requests

ECFMG® CERTIFICATION STATUS REPORT

USMLE™/ECFMG Identification Number: 0-656-186-4
Applicant's Name: Carmen Switzer Landau
Applicant's Date of Birth: 05/14/1977
ECFMG Certified:Yes
Certificate Issue Date: 08/13/2008
English Test Valid Through: Valid Indefinitely
Clinical Skills Assessment Valid Through: Valid Indefinitely

Passing Performance on Medical Science Examinations:

Examination	Date	Two Digit Score	Three Digit Score
USMLE Step 1	26 Aug 2004	*	*
USMLE Step 2 CK	06 Sep 2006	*	*

Most Recent Passing Performance on Clinical Skills Examination:

Examination	Date
USMLE Step 2 CS	04 Jun 2008

Name of Medical School and Country:Escuela Latinoamericana de Medicina, Habana, CUBA

Degree Year: 2007
† Medical Education Credentials Status: Complete
This information is reported directly from ECFMG computer records and is current as of 07/23/12.

How to Verify the Authenticity of this Report:

This report was issued to the named recipient on the date shown below. To verify the authenticity of this report, visit https://cvsonline2.ecfmg.org/verify/verify.aspx and enter the unique verification code at the bottom of the report. The information contained in this report is current as of the issue date. Any changes to the physician's status after the issue date will not be reflected, and you are encouraged to request an updated report.

The purpose of this Status Report is to indicate whether this individual is certified by ECFMG. It reflects only examinations that were used to fulfill requirements for ECFMG Certification. The most recent passing performance on the clinical skills examination is reflected, regardless of whether this individual was required to take a clinical skills examination for ECFMG Certification. This Status Report is not a complete score history of all examinations for this individual. This Status Report does not include examinations that were taken but not passed. Furthermore, if this individual passed examinations that were not used to fulfill the requirements for ECFMG Certification, these examinations are not included.
* To obtain a complete history of and scores for USMLE Step examination(s) that may have been taken by this individual, contact the appropriate registration entity to request a USMLE transcript.

† Since July 1986, ECFMG has verified medical school credentials directly with the medical schools, or through a reasonable alternative that has been approved by the ECFMG Medical Education Credentials Committee.

Important Note:

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

Report Verification Code: OS8NAUPUMY

Educational Commission for Foreign Medical Graduates

The ECFMG® certifies that

Carmen Switzer Landau

has successfully passed the required examinations, satisfied all the requirements of the Commission, and has been awarded this Certificate.

Chair, Board of Trustees

President & Chief Executive Officer

Date Issued August 13, 2008

Certificate Number	0-656-186-4
Medical Science	
USMLE Step 1	August 26, 2004
USMLE Step 2 CK	September 6, 2006
Clinical Skills	
USMLE Step 2 CS	June 4, 2008

0076186

Section V

Graduate Medical Education

400 FULLER WISER ROAD | SUITE 300 | EULESS, TX 76039 | TEL(817)868-5000 | FAX(817)868-5099

Federation of STATE MEDICAL BOARDS

Federation Credentials Verification Service (FCVS)

400 Fuller Wiser Road, Suite 300, Euless, TX 76039
Tel: (817) 868-5000 Fax: (817) 868-5099

Verification of Graduate Medical Education

Institution: University of New Mexico
Attention: FAMILY PRACTICE
Specialty: Family Practice
Affiliated University: _____
Address: Albuquerque, NM

Verification For:

Name: Landau, Carmen Switzer
DOB: [redacted]1977
Individual's Name on Record (If different from above):

Program Participation:

Important:
Report Incomplete Training Levels (years) separate from those that were successfully completed.

If the training level (year) is currently in progress report the expected completion date in the "To" field.

Report Internships, Residencies and Fellowships separately.

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

Training Level: 1 (e.g., 1, 2, 3, etc.)
☒ Internship ☐ Residency ☐ Chief Residency ☐ Fellowship ☐ Research
Specialty/Subspecialty: Family Medicine
From: 6/30/2009 **To:** 6/30/2010
Successfully Completed?: ☒ Yes ☐ No ☐ In Progress
Accredited by: ☒ ACGME ☐ AOA ☐ LCGME ☐ RSC ☐ CFPC ☐ RCPSC ☐ APPAP ☐ None of these

Training Level: 2 (e.g., 1, 2, 3, etc.)
☐ Internship ☒ Residency ☐ Chief Residency ☐ Fellowship ☐ Research
Specialty/Subspecialty: Family Medicine
From: 07/01/2010 **To:** 06/30/2011
Successfully Completed?: ☒ Yes ☐ No ☐ In Progress
Accredited by: ☒ ACGME ☐ AOA ☐ LCGME ☐ RSC ☐ CFPC ☐ RCPSC ☐ APPAP ☐ None of these

Training Level: 3 (e.g., 1, 2, 3, etc.)
☐ Internship ☒ Residency ☐ Chief Residency ☐ Fellowship ☐ Research
Specialty/Subspecialty: Family Medicine
From: 07/01/2011 **To:** 06/30/2012
Successfully Completed?: ☒ Yes ☐ No ☐ In Progress
Accredited by: ☒ ACGME ☐ AOA ☐ LCGME ☐ RSC ☐ CFPC ☐ RCPSC ☐ APPAP ☐ None of these

Unusual Circumstances:

Check the correct response. Omitted responses require written explanation.

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

1. Did this individual ever take a leave of absence or break from his/her training? ☐ Yes ☒ No
2. Was this individual ever placed on probation? ☐ Yes ☒ No
3. Was this individual ever disciplined or placed under investigation? ☐ Yes ☒ No
4. Were any negative reports for behavioral reasons ever filed by instructors? ☐ Yes ☒ No
5. Were any limitations or special requirements placed upon this individual because of questions of academic incompetence, disciplinary problems or any other reason? ☐ Yes ☒ No

Please explain any "Yes" response from above:

_____

_____

Certification:

Affix your institutional seal in this space. If no seal is available, you must have this verification certified

ELECTRONIC SEAL VERIFIED

Completion of the following is certification that the information above is an accurate account of this individual's records and is true and correct. The signature line must contain the original signature, or the electronic typed signature, of the program director (M.D./D.O. only).

Name: James Wilterding, MD
Signature: James Wilterding, MD
Title of Signatory: Program Director
Date of Signature: 7/12/12
Tel: 505-272-6607 Fax: (505)272-1348 E-Mail: jwilterding@salud.unm.edu

Rev. 07/03/2012

FCVS ID: 229360 FID: 202954061 FFF CODE: 114617

Applicant Reported Unusual Circumstances

Graduate Medical Education

Medical Professional Name: Carmen Switzer Landau
University of New Mexico
Family Practice

Unusual Circumstances

Did you have any interruption(s) or extension(s) in your medical education?	Yes	**No**
Were you ever placed on probation?	Yes	**No**
Were you ever disciplined or placed under investigation?	Yes	**No**
Were any negative reports for behavioral reasons ever filed by instructors?	Yes	**No**
Were any limitations or special requirements imposed on you because of academic performance, incompetence, disciplinary problems or for any other reason?	Yes	**No**

End of report for Carmen Switzer Landau

PROVIDED BY APPLICANT

Section VI

Licensure Examination History

(State Licensing Authorities Only)

400 FULLER WISER ROAD | SUITE 300 | EULESS, TX 76039 | TEL(817)868-5000 | FAX(817)868-5099

United States Medical Licensing Examination® (USMLE®)
Certified Transcript of Scores

This document was prepared by the
Federation of State Medical Boards of the United States, Inc.
Federation Place, 400 Fuller Wiser Road, Suite 300, Euless, TX 76039-3856 -- Telephone (817) 868-4041

Date: 07/02/2012

Recipient:

Federation Credentials Verification Service
ATTN: FCVS

Packet ID: 229360

Examinee: Landau, Carmen Switzer
Alt Name(s):

Examinee ID#: 0-656-186-4
Date of Birth: [redacted]1977

Results for Steps taken by this examinee (and for which results have been reported to date) are shown below. For Steps that span more than one day, the test date reflects the day on which the examination began. Where numeric scores are reported, there are two scales used and the recommended minimum passing score ("MP") on each scale is shown in parentheses.

USMLE STEP 1

			Three-Digit Score		Two-Digit Score		
	Test Date	Pass/Fail	Total	MP	Total	MP	Comments
	08/26/2004	Pass	197	182	80	75	
	09/02/2003	Fail	181	182	74	75	

USMLE STEP 2

Clinical Knowledge (CK)

			Three-Digit Score		Two-Digit Score		
	Test Date	Pass/Fail	Total	MP	Total	MP	Comments
	09/06/2006	Pass	237	182	96	75	

Clinical Skills (CS)*

			Three-Digit Score		Two-Digit Score		
	Test Date	Pass/Fail	Total	MP	Total	MP	Comments
	06/04/2008	Pass					

USMLE STEP 3

			Three-Digit Score		Two-Digit Score		
	Test Date	Pass/Fail	Total	MP	Total	MP	Comments
NEW MEXICO	06/27/2011	Pass	222	187	94	75	

NOTE: A search of the Board Action Data Bank of the Federation of State Medical Boards (FSMB) reveals no reported information on this examinee.

Interpretation of results

USMLE transcripts include a complete results history and notations of any examinations for which the examinee sat and no results were reported, e.g., "Incomplete." On those Step examinations for which numeric scores are reported, two different scales are used. The first is a three-digit score scale on which most scores fall between 140 and 280. The recommended minimum passing score is shown on the front of the transcript next to the examinee's score for each administration. The second is a two-digit scale on which a score of 75 is the recommended minimum passing score. The level of proficiency required to meet the recommended minimum passing level for each USMLE Step is reviewed periodically and is subject to change.

For examinations with reported scores, the Standard Error of Measurement (SEM) provides an index of the variation that would be expected to occur if an examinee were tested repeatedly using different sets of items covering similar content. The SEM is usually in the range of 4 to 8 points on the three-digit scale and 1 to 2 points on the two-digit scale.

STEP 2 CLINICAL SKILLS (CS)

The Clinical Skills (CS) component of Step 2 was introduced in 2004 and the USMLE transcript has been modified to reflect this change. The Step 2 examination that existed prior to the introduction of Step 2 CS continues to be administered as the Clinical Knowledge (CK) component of Step 2. The label "Step 2 CK" is used for this examination whether taken before or after the introduction of the Step 2 CS component.

Step 2 CS results are reported as pass or fail. Had the two-digit reporting scale been used, examinees would have had to achieve a score of 75 or higher in order to pass.

Some individuals may be required to take and pass Step 2 CS prior to registering for Step 3. Transcript users can find information on eligibility requirements for all USMLE examinations in the *USMLE Bulletin of Information* and from periodic Step 2 CS updates, available at the USMLE website (www.usmle.org).

ANNOTATIONS APPEARING UNDER "COMMENTS"

Circumstances in connection with an administration shown on this transcript may result in one or more annotations listed next to the score. A description of each "Comment" is provided below:

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, unexplained inconsistency of performance within the examination or between administrations of the same Step. **No score is reported.** Information regarding the nature of the indeterminate score and the determination of the Committee on Score Validity is available. If such information is not enclosed within this transcript, it may be obtained by contacting the organization from which you received the transcript or the USMLE Secretariat, 3750 Market Street, Philadelphia, PA 19104, telephone (215) 590-9700.

Incomplete - The examinee sat for some, but not all, of the scheduled examination. **No score is reported.**

Irregular Behavior - The Committee on Irregular Behavior determined that the examinee engaged in irregular behavior. Examples of irregular behavior are described in the current edition of the *USMLE Bulletin of Information*. Information regarding the nature of the irregular behavior and the determination of the Committee is available. If such information is not enclosed with this transcript, it may be obtained by contacting the organization from which you received the transcript or the USMLE Secretariat, 3750 Market Street, Philadelphia, PA 19104, telephone (215) 590-9700.

Score Not Available - The score is not available. Further review and/or analysis may be pending, or it may have been determined that the score cannot be reported.

Test Accommodations - Following review and approval of a request from the examinee, test accommodations were provided in the administration of the examination.

ANNOTATIONS APPEARING AS "NOTE"

Circumstances not in connection with an administration shown on this transcript may result in one or more annotations and an explanation or instructions to contact the appropriate individual or organization. The "Note" will appear at the end of the document.

BOARD ACTION DATA BANK INFORMATION APPEARING AS "NOTE"

The Board Action Data Bank of the Federation of State Medical Boards (FSMB) contains actions reported to the FSMB by U.S. licensing and disciplinary boards, Canadian licensing authorities, the U.S. Armed Forces, the U.S. Department of Health and Human Services, and other credentialing entities. To be included in the Data Bank, an action must be a matter of public record or be legally releasable to state medical boards or other entities with recognized authority to review physician credentials. Certain actions reported to and released by the Board Action Data Bank are not disciplinary or otherwise prejudicial in nature. Such actions are reported to ensure that records are complete and to assist in preventing misrepresentation or the use of lost or stolen credentials by unauthorized persons. Once reported to the FSMB, an action becomes part of the permanent record to the individual physician, and the existence of such an action may be indicated on the USMLE transcript by a "Note".

Landau, Carmen **Medical Doctor** **MD2012-0687**

1. Since your last renewal has your professional liability coverage been terminated by action of the insurance company except as a result of the company ceasing to offer insurance to physicians ?	N	06/17/2015
2. Since your last renewal have you been denied professional liability insurance coverage?	N	06/17/2015
3. Since your last renewal has your professional liability carrier excluded any specific procedures from your coverage?	N	06/17/2015
4. Since your last renewal have you been denied membership or renewal thereof, or been subject to disciplinary action in any professional organization?	N	06/17/2015
5. Since your last renewal have you been excluded from or sanctioned by Medicare and/or Medicaid?	N	06/17/2015
6. Since your last renewal, have you been arrested? If so explain the circumstance, regardless of the outcome (i.e. expunged, dismissed, sealed, vacated).	N	06/17/2015
7. Since your last renewal, have you been named as a defendant in any criminal proceedings?	N	06/17/2015
8. Since your last renewal, have you been subject to investigation by a governmental entity or Board that either could have resulted or did result in licensure sanction or other adverse actions, irrespective of the outcome?	N	06/17/2015
9. Since your last renewal have you been named in any formal requests for corrective actions filed by any healthcare entity where you have had an appointment (a request which could result in either formal or informal proceedings).	N	06/17/2015
10. a. Since your last renewal have your privileges at any healthcare entity been voluntarily or involuntarily suspended, restricted, diminished, revoked, surrendered, or not renewed, except for medical records delinquency?	N	06/17/2015
10. b. Since your last renewal have you agreed not to exercise your clinical privileges while under investigation?	N	06/17/2015
11. Since your last renewal have you resigned from a healthcare entity to avoid modification, suspension, or termination of privileges, or while under investigation?	N	06/17/2015
12. a. Since your last renewal has your application for licensure or license to practice in any jurisdiction been investigated, voluntarily or involuntarily limited, suspended, revoked, surrendered or denied?	N	06/17/2015
12. b. Are any currently held licenses pending investigation or being challenged?	N	06/17/2015
13. Since your last renewal have you been notified to appear before any licensing agency for a hearing or complaint of any nature?	N	06/17/2015
14. Since your last renewal has your federal or state narcotics registration certificate in any jurisdiction been voluntarily or involuntarily limited (stipulations), suspended, revoked, restricted, or are there currently challenges to any of these items?	N	06/17/2015
15. Since your last renewal have you been involved in a settlement, medical malpractice claim or suit, or have you ever received written notice of intent to file such a suit? If yes, please provide the following information for each claim or suit. Please type on a separate sheet	N	06/17/2015
16. Since your last renewal have you been reported to the National Practitioner Data Bank?	N	06/17/2015
17. Are you now, or were you in the past, addicted to, abusive of, or in treatment for abuse of any controlled substances, habit-forming drugs, illegal drugs, prescription medication or alcohol?	N	06/17/2015
18. In the five (5) years prior to this application, have you had any physical injury or disease, or mental illness or impairment, which you are currently under treatment for or could reasonably be expected to affect your on -going ability to practice medicine safely and	N	06/17/2015
19. I certify that I have completed a minimum of 75 AMA Category I hours of Continuing Medical Education as required by 16.10.4 NMAC?	Y	06/17/2015
19a. I certify that 5 hours of the required 75 hours of CME are in Pain Management, as required by 16.10.14. 11 NMAC OR I certify that I do NOT hold a NM Controlled Substance Registration.	Y	06/17/2015
20. I attest that I will limit my practice to areas in which I am competent to practice.	Y	06/17/2015