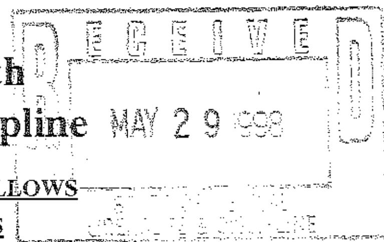
Rhode Island Department of Health
Board of Medical Licensure and Discipline



TEMPORARY LICENSE FOR INTERNS, RESIDENTS, FELLOWS
IN BROWN UNIVERSITY AFFILIATED HOSPITALS
-VALID FOR ONE YEAR-

Instructions:
1. Application must be completed in full and signed.
2. A $25. fee must accompany this application.
3. Make check payable to: General Treasurer, State of R.I.
4. Work outside of training program is not permitted with this license.
5. International Medical graduates must provide a notarized copy of valid ECFMG Certificate.

TO BE COMPLETED BY APPLICANT ONLY - PLEASE TYPE OR PRINT

IDENTIFYING INFORMATION

Previous Temporary License in R.I.? Yes ______ No X

Name: Jamshidi (last) ______ (gen'l suffix) Roxanne (first) Marie (middle) MD ☒ DO ☐

Other Names Used: ______

If name change, provide written explanation and certified copy of supporting documents

Residence: [redacted] (street-P.O. Boxes not accepted) Telephone: [redacted] (Mandatory) Sex: M ☐ F ☒

City: [redacted] State: [redacted] Zip code: [redacted]

Date Of Birth: [redacted] / [redacted] / [redacted] (month / day / year) Place Of Birth: [redacted] (city) [redacted] (state) [redacted] (nation)

UNDERGRADUATE/GRADUATE EDUCATION

Name Of College/ Univ	City/State/ Country	From	To	Major/Minor Course of Study	Grad Year	Degree Rec'D
Princeton University	Princeton, NJ, USA	89	93	Psychology/ Public Policy	1993	BA

PROFESSIONAL/MEDICAL EDUCATION E.G. MD, DO, JD, ED.D., PH.D., RN, PA, DDS, ETC

List in chronological order all Professional/Medical Schools attended:

Name Of School/Univ.	City/State/ Country	From	To	Graduation Year	Degree Received
Vanderbilt University	Nashville, TN USA	94	98	1998	MD

1) During any Professional/Medical Education, were you ever dismissed, suspended, restricted, put on probation, or otherwise acted against or did you take a leave of absence for medical reasons? Yes ______ No X

If "Yes", provide written explanation, to include dates, name and address of Professional/Medical school.

2) During any Professional/Medical Education, were you ever requested to leave or did you leave, temporarily or permanently, prior to completion of training? Yes ______ No X

If "Yes", provide written explanation, to include dates, name and address of Professional/Medical school.

Postgraduate Training

List in chronological order from date of graduation from medical school all professional/postgraduate training (Internship, Residency, Fellowship) to the present.

Program Name & Address	Specialty Area	Month/Year From	Month/Year To	Credit Rec'D? Yes	Credit Rec'D? No
N/A					

1) During any postgraduate training, were you ever dismissed, suspended, restricted, put on probation, or otherwise acted against or did you take a leave of absence for medical reasons? (explain "otherwise" actions) Yes ______ No __X__

If "Yes", provide written explanation with certified copies of supporting documents.

2) During any postgraduate training, were you ever requested to leave, temporarily or permanently, prior to completion of training? Yes ______ No __X__

If "Yes", provide written explanation with certified copies of supporting documents.

3) Are there any investigations pending against you? Yes ______ No __X__

If "Yes", provide written explanation with certified copies of supporting documents.

Other

Have you ever been arrested and charged with a violation of, or pled Nolo Contendere to any Federal, State or local statute, regulation or ordinance, or entered into a plea bargain. Yes ______ No __X__

If "Yes", provide written explanation with certified copies of supporting documents.

List all examinations taken since graduation from medical school (National Boards, FLEX, USMLE, Speciality Board Certification):

Exam Type	Date Taken	Pass	Fail
USMLE I	6/96	X	
USMLE II	3/97		

AFFIDAVIT OF APPLICANT:

I, Roxanne Jamshidi, being first duly sworn, depose and say that I am the person referred to in the foregoing application and supporting documents.

I hereby authorize all hospital(s), institution(s) or organization(s), my references, personal physicians, employers (past and present) and all governmental agencies and instrumentalities (local, state, federal or foreign) to release to the Rhode Island Board of Medical Licensure and Discipline any information which is material to my applicant for licensure.

I have read carefully the questions in the foregoing application and have answered them completely, without reservations of any kind, and I declare under penalty of perjury that my answers and all statements made by me herein are true and correct. Should I furnish any false information in this application, I hereby agree that such act shall constitute cause for denial, suspension or revocation of my license to practice medicine/surgery in the State of Rhode Island.

I understand that my records are protected under the Federal and State Regulations governing Mental Health Patient Records and cannot be disclosed without my written consent unless otherwise provided in the regulations. I understand that my records are protected under the Federal and State Regulations governing Confidentiality of Alcohol and Drug Abuse Patient Records, 42 CFR Part 2, and cannot be disclosed without my written consent unless otherwise provided in the regulations.

I understand that this is a continuing application and that I have an affirmative duty to inform the Board of Medical Licensure and Discipline of any change in the answers to these questions after this application and affidavit is signed.

Roxanne Jamshidi — SIGNATURE OF APPLICANT

4/6/98 — Date of Signature

The foregoing instrument was acknowledged before me this 6th day of April, 1998, by Roxanne Jamshidi, MD/DO, who is personally known to me or who has produced Tennessee Driver License as identification and did/did not take an oath.

Teresa A. Lyons — Signature of Notary

Notary No./ Commission No.

My Commission Expires: 3/25/2000

Notary Seal

Teresa A. Lyons — Name of Notary Typed, Printed or Stamped

TO BE CERTIFIED AND SIGNED BY THE ADMINISTRATOR OR CHIEF EXECUTIVE OFFICER OF THE HOSPITAL IN WHICH THE APPLICANT HAS RECEIVED AN APPOINTMENT

This certifies that the applicant named below has been appointed to the designated position for the period indicated (one year):

Roxanne Marie Jamshidi
First Middle Last

PG 1 Resident
Position and Year (Intern/Resident/Fellow)

Women & Infants Hospital
Name of Hospital

6/24/98
Beginning Date At Hospital

6/23/99
Ending Date At Hospital

This institution was duly incorporated as a hospital under the laws of the State of Rhode Island on

29 February 1884
Day Month Year

Constance A. Howes
Original Signature of Hospital Administrator Date of Signature or Chief Executive Officer (no substitutes) EVP/COO

5-9-98
Date of Signature

TO BE CERTIFIED AND SIGNED BY THE DEAN OF THE MEDICAL SCHOOL OF GRADUATION - FOR FIRST TEMPORARY LICENSURE IN RHODE ISLAND ONLY

The certifies that the applicant named below has creditably completed not less than two years of clinical clerkship studies (last two years) in the designated school during the period indicated:

Roxanne Marie Jamshidi
First Middle Last

Vanderbilt University School of Medicine
Name of Medical School

Nashville, TN 37232-0685
Medical School City, State, Country

From: 8/22/94 To: 4/24/98
Dates of Attendance

School Seal

Teresa Lyons-Oten
Signature of ~~Dean~~ Registrar, School of Medicine

April 6, 1998
Date of Signature

BMLD OFFICE USE ONLY ☒ NEW ☐ RE-NEW

License # 17853

Start Date 6-24-98

Category I PG 1

End Date 6-23-99

Received by [signature]

ECFMG Valid Indefinitely#

Administrator OK

ECFMG Expiration Date

Check #/ MO # 307726

980624_2_3_11 11-12-123 $25.00CK

Roxanne Jamshidi