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11/07/2016 1,179.00
ID: 131016 Type: F
BT: 3007062
R#: 916016352

MEDICAL DOCTOR
APPLICATION FOR LICENSURE
Apply for your license online at www.flboardofmedicine.gov

Choose your application type:

[X] Endorsement (1021) [ ] Examination (1024)

[ ] Military Veterans Fee Waiver

If you were honorably discharged from the U.S. armed services within 24 months of your application you will qualify for a waiver of the application fee and the initial licensure fee. In order to qualify, please check the box above indicating that you are seeking a waiver and submit **a DD-214 or NGB-22 form as proof of honorable discharge.**

[ ] I plan to dispense medicinal drugs in the State of Florida for a fee or other remuneration and hereby register as required by Section 465.0276, F. S. I understand that the fee for the Dispensing Practitioner is $100.00 in addition to the required initial license fee and will submit it along with the license fee.

1. PERSONAL INFORMATION

Name: Philippides (Last/Surname) Stephanie (First) _____ (Middle) **Date of Birth:** 04/03/1977 (MM/DD/YYYY)

Mailing Address: (The address where mail and your license should be sent)

506 Mission Ave NE (Street/ PO Box) _____ (Suite/Apt. No) Albuquerque (City)

New Mexico (State) 87107 (Zip) United States (Country) 505 659-9956 (Phone Number)

Physical Location: A Post Office Box is not acceptable. This address will be posted on the Department of Health's website. *If you do not have a current practice address, your mailing address will be used. When you obtain a practice address, you will be required to update your online practitioner profile.*

4640 Jefferson Lane NE (Street/ P.O. Box) _____ (Suite/Apt. No) Albuquerque (City)

New Mexico (State) 87109 (Zip) United States (Country) _____ (Alternate Phone Number)

Email Address: SPhilippides@wsnm.org

Under Florida law, email addresses are public records. If you do not want your e-mail address released in response to a public records request, do not provide an email address or send electronic mail to our office. Instead contact the office by phone or in writing.

Equal Opportunity Data: We are required to ask that you furnish the following information as part of your voluntary compliance with Section 2, Uniform Guidelines on Employee Selection Procedure (1978) 43 CFR 38296 (August 25, 1978). This information is gathered for statistical and reporting purposes only and does not in any way affect your candidacy for licensure.

SEX: [ ] Male [X] Female **RACE:** [ ] White [ ] Black [ ] Asian/Pacific Islander [X] Hispanic [ ] Other _____

[ ] Yes [X] No **Availability for Disaster:** Will you be available to provide health care services in special needs shelters or to help staff disaster medical assistance teams during times of emergency or major disaster?

WL

CONFIDENTIAL AND EXEMPT FROM PUBLIC RECORDS DISCLOSURE*

9. HEALTH HISTORY

If you answer "Yes" to any of the questions in this section, you are required to send the following items:

- A self-explanation providing accurate details that include name of all physicians, therapists, counselors, hospitals, institutions, and/or clinics where you received treatment and dates of treatment.
- A report directed to the Florida Board of Medicine from each treatment provider about your treatment, medications, and dates of treatment. If applicable, include all DSM III R/DSM IV/DSM IV-TR Axis I and II diagnosis(es) code(s), and admission and discharge summary(s).

[redacted]

In the last five years, have you been enrolled in, required to enter into, or participated in any drug or alcohol recovery program or impaired practitioner program for treatment of drug or alcohol abuse that occurred within the past five years?

In the last five years, have you been admitted or referred to a hospital, facility or impaired practitioner program for treatment of a diagnosed mental disorder or impairment?

During the last five years, have you been treated for or had a recurrence of a diagnosed mental disorder that has impaired your ability to practice medicine within the past five years?

During the last five years, have you been treated for or had a recurrence of a diagnosed physical disorder that has impaired your ability to practice medicine?

In the last five years, were you admitted or directed into a program for the treatment of a diagnosed substance-related (alcohol/drug) disorder or, if you were previously in such a program, did you suffer a relapse within the last five years?

During the last five years, have you been treated for or had a recurrence of a diagnosed substance-related (alcohol/drug) disorder that has impaired your ability to practice medicine within the past five years?

Name: Philippides (Last) Stephanie (First) _____ (Middle)

Social Security Number [redacted]

Social Security Information - * Under the Federal Privacy Act, disclosure of Social Security numbers is voluntary unless specifically required by federal statute. In this instance, Social Security numbers are mandatory pursuant to Title 42 United States Code, Sections 653 and 654; and Section 456.013(1), 409.2577 and 409.2598, Florida Statutes. Social Security numbers are used to allow efficient screening of applicants and licensees by a Title IV-D child support agency to ensure compliance with child support obligations. Social Security numbers must also be recorded on all professional and occupational license applications and will be used for license identification pursuant to the Personal Responsibility and Work Opportunity Reconciliation Act of 1996 (Welfare Reform Act. 104 Pub.L. Section 317) Clarification of the SSA process may be reviewed at **www.ssa.gov** or by calling 1-800-772-1213.

2. MEDICAL EDUCATION HISTORY

Federal Credentials Verification Services (FCVS) is not a requirement for licensure. FCVS will primary source verify and provide a copy of the medical school transcript(s), medical school diploma, medical school verification, name change document(s), national examination score report, ECFMG certificate, ECFMG verification and postgraduate training verifications. For more information about FCVS, visit their web-site at www.fcvs.org/.

☐ Yes ☒ No Are you using the FCVS to verify your core credentials?

☒ Yes ☐ No Have you completed the equivalent of 2 academic years of preprofessional, postsecondary education including, courses in anatomy, biology and chemistry prior to entering medical school?

Medical Education:
List in chronological order all medical schools attended, whether completed or not. Submit on a separate sheet if needed.

Medical School Name and Address:	From: (mm/yy)	To: (mm/yy)	Date Degree Received:
University of New Mexico School of Medicine 1 University of New Mexico Bldg 177 Albuquerque, New Mexico 87131	**08 / 2001**	**05 / 2005**	**05/14/2005**

Fifth Pathway Certificate Holders:

If you answer "yes" to any of the following questions, you must request verifications to be sent directly to the Board office.

****N/A to all of the Following; NOT a Fifth Pathway****

☐ Yes ☐ No Did you attend an international medical school and do not possess a valid ECFMG Certificate?

☐ Yes ☐ No Did you receive a bachelor's degree from an accredited United States college or University?

☐ Yes ☐ No Did you study at a medical school which is recognized by the World Health Organization?

☐ Yes ☐ No Did you complete all of the formal requirement of the International medical school, except the internship or social service requirements, and pass part I of the National board of Medical examination or the Education Commission for Foreign Medical Graduates Examination equivalent?

☐ Yes ☐ No Did you complete an academic year of supervised clinical training in a hospital affiliated with a medical school approved by the Council on Medical Education of the American Medical Association and upon completion passed part II of the National Board of Medical Examiners examination or the Education Commission for Foreign Medical Graduates examination Equivalent?

Postgraduate Training:

Provide the following documentation to support your postgraduate training:

☐ Post-Graduate Training Form

In the table below list, in chronological order, all postgraduate training from the date you graduated from medical school to the present. Start with your first program and end with your last or current program. List all programs you began, whether you completed or received credit for the training.

Program Name and Full Mailing Address:	Specialty Area:	From: (mm/yy)	To: (mm/yy)	Did you receive credit? (Y/N)
HonorHealth-Scottsdale Osborn MC 7301 E Second Street, Suite 210 Scottsdale, Arizona 85251	**Family Medicine**	**07 / 2005**	**06 / 2006**	**Yes**
Univ. of NM School of Medicine 1 University of New Mexico Albuquerque, New Mexico 87131	**Obstetrics and gynecology**	**07 / 2006**	**06 / 2010**	**Yes**

Prevention of Medical Errors:

The education must meet requirements defined in § 456.013(7), Florida Statutes and be completed prior to the issuance of your license number. Please contact the Florida Medical Association (FMA) at (850) 224-6496 or www.flmedical.org for a list of providers of CME. Other resources for CME are the American Medical Association (AMA) at (312) 464-5000 or Medical Education Group Learning Systems (MEGLAS) at 800-547-0308 or www.informed.cme.edu.

☐ I have completed a minimum of two (2) hours of Prevention of Medical Errors continuing medical education as defined by s. 456.013(7), Florida Statutes.

Loan History:

☐ Yes ☒ No Are you currently in default on any health education loan or scholarship obligation? (If "yes", explain on a separate sheet providing accurate details.)

3. EXAMINATION HISTORY

State Board (prior to 1974), State Board (after 1974) & SPEX, LMCC & SPEX, NBME, FLEX, USMLE III, or Combination (prior to 2000)

Request that the score report be sent directly to the Board of Medicine. NOTE: If you took a state Board examination and are not currently licensed in three other states, you must also request your SPEX score be sent.

Exam taken: **USMLE Step 3** Date passed: **03/25/08** mm/dd/yy

4. LICENSURE HISTORY

Request verification of licensure status directly from the licensing entity or www.veridoc.org. Request international license verification(s) if you have practiced outside of the U.S. for at least two of the previous four years.

☒ Yes ☐ No Do you now hold or have you ever held a license to practice medicine or any other profession in any US State or territory, or foreign country? Please list in table below.

Jurisdiction	Profession	License number
New Mexico	**Medical Doctor**	**MD2010-0195**
New Mexico	**Physician in Training**	**RS2006-0333**

If you answer "yes" to any of the questions in this section, you are required to send an explanation and supporting documentation.

☐ Yes ☒ No Have you had any application for a medical license or professional license denied by any state board or other governmental agency of any state, territory, or country?

☐ Yes ☒ No Are you currently under investigation in any jurisdiction for an act or offense that would constitute a violation of Section 458.331, Florida Statutes?

☐ Yes ☒ No Have you ever had any professional license or license to practice medicine revoked, suspended, placed on probation, or other disciplinary action taken in any state, territory or country?

5. PRACTICE/EMPLOYMENT HISTORY

List the year you legally first began to practice medicine, **2005** (yyyy). This would be the year you began practicing medicine and could be the date you began your postgraduate training.

☒ Yes ☐ No Have you practiced medicine in another jurisdiction for two of the last four years **or** completed a board approved post-graduate training program within the last two years?

☐ Yes ☐ No If your answer to the question above was "No," have you passed a board approved clinical competency exam within the last year? If yes, then submit supporting documentation.

List in chronological order all employment for the last four (4) years.

Name and address of practice or employment	Type of employment	From: mm/yy	To: mm/yy
Women's Specialists of New Mexico 4640 Jefferson Lane NE Albuquerque, New Mexico 87109	**Physician in Group Practice**	**08 / 2010**	**Present**

☒ Yes ☐ No Do you currently hold staff privileges in any hospital, health institution, clinic or medical facility? List each facility below.

Name of facility
Lovelace Women's Hospital
Kaseman Hospital
Presbyterian Hospital

If you answer "yes" to the following questions, you are required to send an explanation and supporting documentation.

☐ Yes ☒ No Have you ever had any staff privileges denied, suspended, revoked, modified, restricted, not renewed, or placed on probation, or have you been asked to resign or take a temporary leave of absence or were otherwise acted against by any facility?

☒ Yes ☐ No Do you currently, or have you had, responsibility for graduate medical education within the last 10 years?

In the table below, list all institutions where you have had responsibility for graduate medical education or faculty appointment(s) at any medical school.

Name of institution
University of New Mexico School of Medicine

☒ Yes ☐ No Are you certified by any specialty board recognized by the American Board of Medical Specialties or specialty board approved by the Florida Board of Medicine?

Board Name	Certification/ Specialty/Sub-Specialty	Date of Certification (mm/yy)
American Board of Obstetrics and Gynecology	**Obstetrics and gynecology**	**2012**

If you answer "yes" to any of the following questions, please explain on a separate sheet providing accurate details.

☐ Yes ☒ No Have you ever had any final disciplinary action taken against you by a specialty board or other similar national organization?

☐ Yes ☒ No Have you ever been denied or surrendered a DEA registration?

6. CRIMINAL HISTORY

If you answer "Yes" to the following question you are required to send the following items:

- Self-explanation describing in detail the circumstances surrounding each offense, including dates, city and state, charges and final results.
- Final Dispositions and Arrest Records for all offenses. The Clerk of the Court in the arresting jurisdiction will provide you with these documents. Unavailability of these documents must come in the form of a letter from the Clerk of the Court.
- Completion of Sentence Documents. You may obtain documentation from the Department of Corrections. The report must include the start date, end date and that the conditions were met.

☐ Yes ☒ No Have you ever been convicted of, or entered a plea of guilty, nolo contendere, or no contest to, a crime in any jurisdiction other than a minor traffic offense? You must include all misdemeanors and felonies, **even if adjudication was withheld. Driving under the influence (DUI) or driving while impaired (DWI) are not minor traffic offenses for purposes of this question.**

☒ Yes ☐ No I have been provided and read the statement from the Florida Department of Law Enforcement regarding the sharing, retention, privacy and right to challenge incorrect criminal history records and the "Privacy Statement" document from the Federal Bureau of Investigation.

7. MILITARY HISTORY

A. ☐ Yes ☒ No Have you ever been in the United States Military and/or Public Health Service?

B. ☐ Yes ☒ No Have you ever been disciplined by any branch of the United States Armed Services or Public Health Services? If you answered "yes" please provide a detailed explanation and supporting documentation

8. CRIMINAL AND MEDICAID/MEDICARE FRAUD QUESTIONS

Applicants for licensure, certification or registration and candidates for examination may be excluded from licensure, certification or registration if their felony conviction falls into certain timeframes as established in Section 456.0635(2), Florida Statutes. If you answer "Yes" to any of the following questions, please provide a written explanation for each question. Supporting documentation includes court dispositions or agency orders where applicable.

1. ☐ Yes ☒ No Have you been convicted of, or entered a plea of guilty or nolo contendere to, regardless of adjudication, a felony under Chapter 409, F.S. (relating to social and economic assistance), Chapter 817, F.S. (relating to fraudulent practices), Chapter 893, F.S. (relating to drug abuse prevention and control) or a similar felony offense(s) in another state or jurisdiction?

If you responded "No" to the question above, skip to question 2.

a. ☐ Yes ☐ No If "yes" to 1, for the felonies of the first or second degree, has it been more than 15 years from the date of the plea, sentence and completion of any subsequent probation?

b. ☐ Yes ☐ No If "Yes" to 1, for felonies of the third degree, has it been more than 10 years from the date of the plea, sentence and completion of any subsequent probation? (This question does not apply to felonies of the third degree under Section 893.13(6)(a), Florida Statutes)

c. ☐ Yes ☐ No If "Yes" to 1, for the felonies of the third degree under Section 893.13(6)(a), Florida Statutes, has it been more than 5 years from the date of the plea, sentence and completion of any subsequent probation?

d. ☐ Yes ☐ No If "Yes" to 1, have you successfully completed a drug court program that resulted in the plea for the felony offense being withdrawn or charges dismissed?

2. ☐ Yes ☒ No Have you been convicted of, or entered a plea of guilty or nolo contendere to, regardless of adjudication, a felony under 21 U.S.C. ss. 801-970 (relating to controlled substances) or 42 U.S.C. ss. 1395-1396 (relating to public health, welfare, Medicare and Medicaid issues)?

If you responded "No" to the question above, skip to question 3.

a. ☐ Yes ☐ No If "Yes" to 2, has it been more than 15 years before the date of application since the sentence and any subsequent period of probation for such conviction or plea ended?

3. ☐ Yes ☒ No Have you ever been terminated for cause from the Florida Medicaid Program pursuant to Section 409.913, Florida Statutes?

If you responded "No" to the question above, skip to question 4.

a. ☐ Yes ☐ No If you have been terminated but reinstated, have you been in good standing with the Florida Medicaid Program for the most recent five years?

4. ☐ Yes ☒ No Have you ever been terminated for cause, pursuant to the appeals procedures established by the state, from any other state Medicaid Program?

If you responded "No" to the question above, skip to question 5.

a. ☐ Yes ☐ No Have you been in good standing with a state Medicaid program for the most recent five years?

b. ☐ Yes ☐ No Did the termination occur at least 20 years before the date of this application?

5. ☐ Yes ☒ No Are you currently listed on the United States Department of Health and Human Services Office of Inspector General's List of Excluded Individuals and Entities?

6. ☐ Yes ☐ No **If "Yes" to any of the questions 1 through 5 above,** on or before July 1, 2009, were you enrolled in an educational or training program in the profession in which you are seeking licensure that was recognized by the Board of Medicine or the Department of Health? **(If "Yes", please provide official documentation verifying your enrollment status.)**

If you answer "Yes" to the questions below, you are required to send the following items:

- **A statement indicating the date of each incident and the number for each case.**
- **An explanation of details for each case and your involvement for each case.**
- **Submit the enclosed Exhibit 1 form.**
- **A copy of the complaint, judgments and/or settlements for each case.**
- **Submit a complete copy of the trial record(s) of each case, including the trial transcript, evidentiary exhibits and final judgment in electronic format.**

☐ Yes ☒ No Have you ever had a judgment entered against you for medical malpractice where the incident(s) of malpractice occurred after November 2, 2004?

☐ Yes ☒ No Within the last 10 years have you had any liability claim(s) or action(s) for damages for personal injury settled or finally adjudicated in an amount that exceeds $100,000.00?

10. FINANCIAL RESPONSIBILITY

The Financial Responsibility options are divided into two categories, coverage and exemptions. Check only one option of the ten provided as required by s. 458.320, Florida Statutes.

Category I: Financial Responsibility Coverage

☐1. I do not have hospital staff privileges, I do not perform surgery at an ambulatory surgical center and I have established an irrevocable letter or credit or an escrow account in an amount of $100,000/$300,000, in accord with Chapter 675, F. S., for a letter of credit and s. 625.52, F. S., for an escrow account.

☐2. I have hospital staff privileges or I perform surgery at an ambulatory surgical and I have established an irrevocable letter of credit or escrow account in an amount of $250,000/$750,000, in accord with Chapter 675, F. S., for a letter of credit and s. 625.52, F. S., for an escrow account.

☐3. I do not have hospital staff privileges, I do not perform surgery at an ambulatory surgical center and I have obtained and maintain professional liability coverage in an amount not less than $100,000 per claim, with a minimum annual aggregate of not less than $300,000 from an authorized insurer as defined under s. 624.09, F. S., from a surplus lines insurer as defined under s. 626.914(2), F. S., from a risk retention group as defined under s. 627.942, F. S., from the Joint Underwriting Association established under s. 627.351(4), F. S., or through a plan of self-insurance as provided in s. 627.357, F. S.

☐4. I have hospital staff privileges or I perform surgery at an ambulatory surgical and I have professional liability coverage in an amount not less than $250,000 per claim, with a minimum annual aggregate of not less than $750,000 from an authorized insurer as defined under s. 624.09, F. S., from a surplus lines insurer as defined under s. 626.914(2), F. S., from a risk retention group as defined under s. 627.942, F. S., from the Joint Underwriting Association established under s. 627.351(4), F. S., or through a plan of self-insurance as provided in s. 627.357, F. S.

☐5. I have elected not to carry medical malpractice insurance however, I agree to satisfy any adverse judgments up to the minimum amounts pursuant to s. 458.320(5)(g)1, F. S. I understand that I must either post notice in a sign prominently displayed in my reception area or provide a written statement to any person to whom medical services are being provided that I have decided not to carry medical malpractice insurance. I understand that such a sign or notice must contain the wording specified in s. 458.320(5)(g), F. S.

Category II: Financial Responsibility Exemptions

☐6. I practice medicine exclusively as an officer, employee, or agent of the federal government, the state, or its agencies or subdivisions.

☐7. I hold a limited license issued pursuant to s. 458.317, F. S., and practice only under the scope of the limited license.

☒8. I do not practice medicine in the State of Florida.

☐9. I meet all of the following criteria:

(a) I have held an active license to practice in this state or another state or some combination thereof for more than 15 years;

(b) I am retired or maintain part time practice of no more than 1000 patient contact hours per year;

(c) I have had no more than two claims resulting in an indemnity exceeding $25,000 within the previous five-year period;

(d) I have not been convicted of or pled guilty or nolo contendere to any criminal violation specified in Chapter 458, F. S. or the medical practice act in any other state; and

(e) I have not been subject, within the past ten years of practice, to license revocation, suspension, or probation for a period of three years or longer, or a fine of $500 or more for a violation of Chapter 458, F. S., or the medical practice act of another jurisdiction. A regulatory agency's acceptance of a relinquishment of license, stipulation, consent order, or other settlement offered in response to or in anticipation of filing of administrative charges against a license is construed as action against a license. I understand if I am claiming an exception under this section that I must either post notice in a sign prominently displayed in my reception area or provide a written statement to any person to whom medical services are being provided that I have decided not to carry medical malpractice insurance. See Section 458.320(5)(f), Florida Statutes, for specific notice requirements.

☐10. I practice only in conjunction with my teaching duties at an accredited medical school or its teaching hospitals. (Interns and residents do not qualify for this exemption).

If you select an exemption based on number 9, you must also complete the affidavit on the following page.

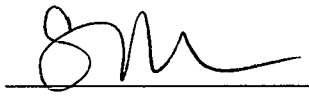
11. FLORIDA BIRTH RELATED NEUROLOGICAL COMPENSATION ASSOCIATION

You must choose one of the three options described below. Please be sure to view the information about each exemption at www.nica.com. Check only one.

☐	☒	☐	
$5,000	$250	$0	**$250**
Participating	Non-participating	Exempt	Amount enclosed

If you choose "$0 Exempt" provide appropriate documentation to the Board of Medicine and to NICA.

I have read the explanatory information provided by NICA, and I choose the option above.



Signature

10/27/16
Date

Stephanie Philippides
Name
506 Mission Ave NE
Street Address
Albuquerque, New Mexico 87107
City, State, Zip

If you are a participating or non-participating physician, or a physician claiming exemption, you must complete, sign and date this form and return it with your payment to this address.

Board of Medicine
4052 Bald Cypress Way, #C-03
Tallahassee, FL 32399-3253

If you are a physician claiming exemption, you must also send a copy of your completed, signed, and dated form with proof of your exemption to:

NICA
2360 Christopher Place
Tallahassee, FL 32308

If you have any questions about NICA or this form, please contact NICA at www.nica.com or (850) 488-8191.

12. STATEMENT OF APPLICANT

I state that these statements are true and correct. I recognize that providing false information may result in denial of licensure, disciplinary action against my license, or criminal penalties pursuant to Sections 456.067, 775.083, and 775.084, Florida Statutes. I state that I have read Chapters 456, 458 and 766.301-.316, Florida Statutes and Chapter 64B8, Florida Administrative Code.

I hereby authorize all hospitals, institutions or organizations, my references, personal physicians, employers (past and present), and all governmental agencies and instrumentalities (local, state, federal, or foreign) to release to the Florida Board of Medicine information which is material to my application for licensure.

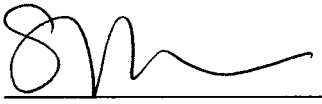
I have carefully read the questions in the foregoing application and have answered them completely, without reservations of any kind. I state that my answers and all statements made by me herein are true and correct.

Should I furnish any false information in this application, I hereby agree that such act constitutes cause for denial, suspension, or revocation of my license to practice medicine in the State of Florida. If there are any changes to my status or any change that would affect any of my answers to this application I must notify the board within 30 days.

I understand that my records are protected under federal and state regulations governing Confidentiality of 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 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 also understand that I may revoke this consent at any time except to the extent that action has been taken in reliance upon it.

Stephanie Philippides

Print name



Signature

10/27/16

Date

Confirmation of Receipt

Name: **Stephanie Philippides** File # (if known) _____

Profession: **MD** Date of Birth: **04/03/1977**
(MM/DD/YYYY)

Other last names: **Padilla; Julian**

I have been provided and read the statement from the Florida Department of Law Enforcement regarding the sharing, retention, privacy and right to challenge incorrect criminal history records and the "Privacy Statement" document from the Federal Bureau of Investigation.

☒ **Yes** ☐ **No**

Signature: _____ Date: 10/27/16
(MM/DD/YYYY)

LIMITED POWER OF ATTORNEY

Florida Medical Licensing Service, Inc.
1331 East Lafayette Street, Suite D
Tallahassee, FL 32301
(850) 942-0080 fax (850) 877-6417
email: license@floridamedlicense.com

I, **Stephanie Philippides**, hereby name and appoint KATHRINE BERTOLDI, MICHELE BERTOLDI, SUPRIYA PAWAR, LANCE BARDEN and/or any other representatives of FLORIDA MEDICAL LICENSING SERVICE, to represent my interests and to assist me in the administrative proceeding of my application for licensure with the State of Florida, Board of Registration in Medicine, by which I am governed and regulated. This Power of Attorney extends to authorize Mr. Bertoldi, et al., to: access all of my records and information contained within my application/licensure; access necessary documents from other governmental agencies; access correspondence to/from the State of Florida regarding my application/licensure; have authority to serve as my agent for delivery and collection of fees, receipts, and licenses; perform all required activities to attain proper licensure (initial and/or renewal) within the State of Florida. This will also include access to my account/USER ID and password for the Florida Board's online status check. If done so in writing, this Power of Attorney may be revoked, at my discretion, at any point in time.

In addition to the appointment of Mr. Bertoldi, et al., with this Power of Attorney, I request that the Florida Board of Medicine grant the same courtesy and cooperation as you have and would show to me.

10/28/16
DATE

SIGNATURE

The foregoing was acknowledged before me this 28th day of October, 2016 by Stephanie L Philippides who is/is not personally known to me and did take an oath.

Notary Public

State of New Mexico

Commission Number N/A

Commission Expiration Jan 24 2017

OFFICIAL SEAL
Allison Pitts
NOTARY PUBLIC - STATE OF NEW MEXICO
My Commission Expires Jan 24 2017

fieldprint

Registration # **3229930** for **Stephanie Philippides** is scheduled for:

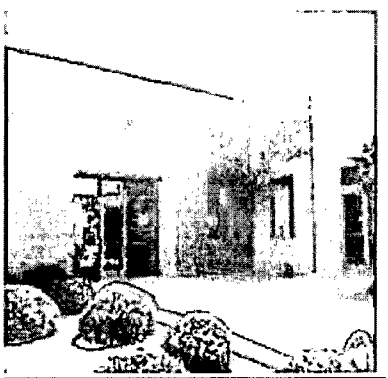
October 28, 2016 at 9:00 AM

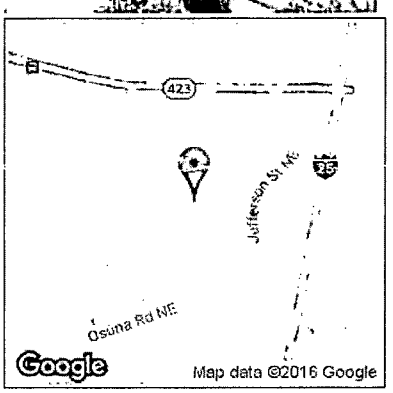
Reason for fingerprinting is ORI # EDOH2014Z - Physician/Medical Doctor

Your appointment information will also be emailed to you for additional reference. If an email is not received within one hour, please contact Fieldprint® at 877-614-4364.

Your Appointment Location

Fieldprint Site - Demand Printing Solutions
3900 Rutledge Road NE
Albuquerque, NM 87109





Please note: Once an appointment is made, you may not make a change or cancel less than 24 hours before the appointment time without incurring a charge.

Please call us at 800-799-1067 to rate your experience. We would appreciate feedback on your appointment and our site.

If you decide to reschedule your appointment in the future, please return to florida.fieldprint.com, sign in as an existing user, and click on the red Reschedule link to make a new appointment. .

What identification to bring?

You must print this appointment confirmation and bring it with you to your appointment.

All documents must be unexpired.

If you do not bring two valid, unexpired, acceptable forms of ID, your appointment cannot be completed. The name provided for the appointment must match both forms of identification and the date of birth must be on the primary form of ID, and must match exactly.

IDENTIFICATION REQUIRED FOR FINGERPRINTING

Primary ID

- State-issued drivers license
- State-issued non-driver identity
- U.S. Passport/U.S. Passport Card
- Military Identification Card
- Work Visa w/ Photo
- Foreign Passport
- DOD Common Access Card
- Foreign Drivers License

Secondary ID

- State-issued drivers license
- State-issued non-driver identity
- U.S. Passport/U.S. Passport Card
- Military Identification Card
- Social Security Card
- Bank Statement/Paycheck Stub
- Utility bill
- Credit/Debit Card
- Marriage Certificate
- Vehicle Registration/Title
- State Government Issued Certificate of Birth
- School ID w/ Photograph
- Voter Registration Card
- Draft Record
- Native American Tribal Document
- Transportation Worker Identification Credential (TWIC Card)
- Foreign Passport
- Certificate of Citizenship
- Certificate of Naturalization
- INS I-551 Permanent Resident Card

Payment Information

Date	Payment Description	Payment Type	Total
10/27/2016	Fieldprint Scheduling Fee	MasterCard	$79.00

November 14, 2016

Stephanie Philippides, M.D.
506 Mission Ave Ne
Albuquerque, NM 87107

Dear Dr. Philippides:
File: 131016

Thank you for considering Florida for physician licensure. Your application for medical licensure has been received. The application is incomplete for the reasons set out in the attached deficiency notice. Please address these deficiencies as soon as possible to avoid delay in processing your application.

Information received by this office may require additional explanation or documentation to determine licensure eligibility. After all requested documentation is received, your application will be submitted for supervisory review. We will notify you if additional information is required.

Applicants with a history of malpractice, criminal activity, discipline, physical or mental impairment, unfavorable evaluations, or other matters that need explanation may require a personal appearance before the Board of Medicine Credentials Committee for determination of licensure eligibility. If your appearance is required, you will be notified in writing once your application is complete.

You can check the status of your application online at www.FlHealthSource.com

1. Click on Licensee/Provider.
2. Click on Practitioner Login from the left sidebar.
3. Choose your profession from the Profession drop down list.
4. Your user ID is: [redacted]. Your password is: [redacted]
5. Click on “Check Application Status” from left side of page.
6. Click on the listed application.
7. Click on “Supporting Documents”.

THIS IS IMPORTANT: Your application will remain incomplete until all deficiencies are completed. In addition, you are required to notify the Board office immediately in writing of any occurrence(s) that would in any way change or affect any answer given in the application or an answer provided in response to any of our direct questions to you.

If I can be of further assistance, contact me at 850-245-4131 ext. 3453, fax me at (850) 412-1295 or e-mail at Christopher.Roberts@flhealth.gov.

Sincerely,

Christopher Roberts
Regulatory Specialist II

Enclosure(s)

Stephanie Philippides **Date: November 14, 2016**

REMINDER: Chapter 456.013(1)(a), Florida Statutes, provides that an incomplete application shall expire one year after initial filing with the department.

YOUR APPLICATION'S EXPIRATION DATE IS 11/7/17

APPLICATION SUBMITTED REMAINS DEFICIENT FOR LACK OF THE FOLLOWING:

Your Postgraduate Training Verification Forms have not been received.

- ☆ Honorhealth Scottsdale Osborn Medical Center

We await your USMLE exam scores, direct from the Federation of State Medical Boards, which must be requested by the applicant.

If I can be of any assistance, please contact me at (850) 245-4131 ext. 3453, fax me at (850) 412-1295 or email me at Christopher.Roberts@flhealth.gov. The Florida Board of Medicine has assigned **131016** as your **tracking number**. Please indicate this number if you leave a message, and try to ensure that other sources include it on their communications to us as well.

3077245

POST-GRADUATE TRAINING VERIFICATION FORM

MEDICINE BOARD
10 NOV 10 PM 2:54

Please have this form completed by the Chairman/Director of the post-graduate training program you attended. Please note that if you are using FCVS, do not submit these items.

The form should be mailed or faxed to:

FLORIDA BOARD OF MEDICINE
4052 BALD CYPRESS WAY, BIN C-03
TALLAHASSEE, FLORIDA 32399-3253
(850) 412-1268 Facsimile

Univ. of NM School of Medicine
Name of School

Obstetrics and gynecology
Department

1 University of New Mexico
Address

Albuquerque, New Mexico 87131
City, State, Zip

1. Name of Resident: **Stephanie Philippides**

2. Internship/Residency/Fellowship: From: **2006** To: **2010**

3. Matriculation Date: 7/1/2006

4. Completion Date: 6/30/2010

5. Specialty: OB/Gyn

6. Levels completed (check all that apply):

PGY I ☒ PGY II ☒ PGY III ☒ PGY IV ☒ PGY V ☐

ORIGINAL

Signed: _____
Chairman or Program Director Only
(No stamped signatures please).

3077247

B1016
Chris

Medical Degree Verification Form

MEDICINE BOARD
16 NOV 10 PM 4:28

FLORIDA BOARD OF MEDICINE
4052 BALD CYPRESS WAY, BIN # C03
TALLAHASSEE, FL 32399-3253
FAX (850) 412-1268

Applicant completes number 1 through 3. Please note that if you are using FCVS, do not submit this item.

1. TO: University of New Mexico School of Medicine
Name of medical school

1 University of New Mexico Bldg 177
Street address

Albuquerque, New Mexico 87131 United States
City - State - Zip - Country

ORIGINAL

2. Name: Stephanie Philippides

3. Date of Birth: 04/03/1977

4. Type of Degree: Doctor of Medicine Date Degree Received: 05/14/2005

Authenticate by signature and school seal.

Verified by

Davette D. Sandoval
Name

Academic Program Manager
Title

SEAL

64B8-1.007 & 64B8-4.009, F.A.C. DH-MQA 1000
Revised 12/2014

3077249

The University of New Mexico

has conferred upon

Stephanie L. Philippides

the degree of

Doctor of Medicine

with all the rights and privileges appertaining to that degree,
in testimony whereof the Regents of the University upon recommendation
of the Faculty have granted this diploma bearing the seal of the University
this fourteenth day of May, two thousand and five.

President of the Regents

Secretary of the Regents

THE UNIVERSITY OF NEW MEXICO · 1889 ·

President of the University

Provost of the University

Dean of the School

I certify this to be a true copy of the original:
Davette De La O-Sandoval
Academic Program Support Manager
11/3/14
Date

BOARD OF MEDICINE
2014 NOV 14 PM 3:16

LIMITED POWER OF ATTORNEY

Florida Medical Licensing Service, Inc.
1331 East Lafayette Street, Suite D
Tallahassee, FL 32301
(850) 942-0080 fax (850) 877-6417
email: license@floridamedlicense.com

I, **Stephanie Philippides**, hereby name and appoint KATHRINE BERTOLDI, MICHELE BERTOLDI, SUPRIYA PAWAR, LANCE BARDEN and/or any other representatives of FLORIDA MEDICAL LICENSING SERVICE, to represent my interests and to assist me in the administrative proceeding of my application for licensure with the State of Florida, Board of Registration in Medicine, by which I am governed and regulated. This Power of Attorney extends to authorize Mr. Bertoldi, et al., to: access all of my records and information contained within my application/licensure; access necessary documents from other governmental agencies; access correspondence to/from the State of Florida regarding my application/licensure; have authority to serve as my agent for delivery and collection of fees, receipts, and licenses; perform all required activities to attain proper licensure (initial and/or renewal) within the State of Florida. This will also include access to my account/USER ID and password for the Florida Board's online status check. If done so in writing, this Power of Attorney may be revoked, at my discretion, at any point in time.

In addition to the appointment of Mr. Bertoldi, et al., with this Power of Attorney, I request that the Florida Board of Medicine grant the same courtesy and cooperation as you have and would show to me.

10/28/16
DATE

SIGNATURE

The foregoing was acknowledged before me this 28th day of October, 2016 by Stephanie L Philippides, who is/is not personally known to me and did take an oath.

Notary Public

State of New Mexico

Commission Number N/A

Commission Expiration Jan 24 2017

OFFICIAL SEAL
Allison Pitts
NOTARY PUBLIC - STATE OF NEW MEXICO
My Commission Expires Jan 24 2017

BIDI6, Chris

3079262

POST-GRADUATE TRAINING VERIFICATION FORM

MEDICINE BOARD

16 NOV 15 AM 8:51

Please have this form completed by the Chairman/Director of the post-graduate training program you attended. Please note that if you are using FCVS, do not submit these items.

The form should be mailed or faxed to:

FLORIDA BOARD OF MEDICINE
4052 BALD CYPRESS WAY, BIN C-03
TALLAHASSEE, FLORIDA 32399-3253
(850) 412-1268 Facsimile

HonorHealth-Scottsdale Osborn MC
Name of School

Family Medicine
Department

ORIGINAL

7301 E Second Street, Suite 210
Address

Scottsdale, Arizona 85251
City, State, Zip

1. Name of Resident: **Stephanie Philippides**

2. Internship/Residency/Fellowship: From: **2005** To: **2006**

3. Matriculation Date: 7/1/2005

4. Completion Date: 6/30/2006

5. Specialty: Family Medicine

6. Levels completed (check all that apply):

PGY I ☑ PGY II ☐ PGY III ☐ PGY IV ☐ PGY V ☐

Signed: _____
Chairman or Program Director Only
(No stamped signatures please).

64B8-1.007 & 64B8-4.009, F.A.C. DH-MQA 1000
Revised 08/2014

3079264

Scottsdale Healthcare

Family Medicine Residency Program

The Board of Directors and Administration
of Scottsdale Healthcare
Scottsdale, Arizona
hereby certifies that

BOARD OF MEDICINE
2016 NOV 16 PM 12:59

Stephanie Lynn Julian, M.D.

has successfully completed the first year
of residency in the Family Medicine Program

Stephanie philipides

2005-2006

Chairman, Board of Directors

SCOTTSDALE
HEALTHCARE

Mission:
To protect, promote & improve the health of all people in Florida through integrated state, county & community efforts.

Rick Scott
Governor

Celeste Philip, MD, MPH
Interim State Surgeon General

Vision: To be the **Healthiest State** in the Nation

FLORIDA DEPARTMENT OF HEALTH

CONFIRMATION OF LICENSE

NAME:	**STEPHANIE PHILIPPIDES**
PROFESSION:	**MEDICAL DOCTOR**
LICENSE NUMBER:	**ME130682**
EFFECTIVE DATE:	12/14/2016
MAILING ADDRESS:	506 MISSION AVE NE
	ALBUQUERQUE, NM 87107
ATTENTION:	
PRACTICE ADDRESS:	4640 JEFFERSON LANE NE
	ALBUQUERQUE, NM 87109
ATTENTION:	

NOTE:
This document confirms receipt of an approved initial licensure application for the practitioner listed above. The practitioner should receive a license in the mail within 7-14 business days. Online licensure confirmation also can be obtained by visiting http://www.FLHealthsource.gov and accessing the Department's license verification screen.
This document, issued from a secure online site, authorizes practice until the practitioner receives the printed license.

Florida Department of Health
Division of Medical Quality Assurance
4052 Bald Cypress Way
Tallahassee, FL 32399-3260

Accredited Health Department
Public Health Accreditation Board

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)868-4000

Recipient: FLORIDA BOARD OF MEDICINE

Date: 10/31/2016

Examinee: Philippides, Stephanie Lynn

Examinee ID: 51283331

Alt Name(s): Julian, Stephanie Lynn

Date of Birth: 04/03/1977

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, the recommended minimum passing score ("MP") is shown in parentheses. Pass/fail outcomes are based upon the minimum passing level in place at the time of test administration and are not altered by subsequent revisions to the minimum passing level. Effective April 1, 2013, test results are reported on a three-digit scale only; two-digit scores reported for prior administrations will no longer be reported. Test results reported as passing represent an exam score of 75 or higher on a two-digit scoring scale.

USMLE STEP 1

Test Date	Pass/Fail	Total	MP	Comments
4/19/2003	Pass	[redacted]	(182)	

USMLE STEP 2

Clinical Knowledge (CK)

Test Date	Pass/Fail	Total	MP	Comments
10/6/2004	Pass	[redacted]	(182)	

Clinical Skills (CS)*

Test Date	Pass/Fail	Total	MP	Comments
11/12/2004	Pass			

USMLE STEP 3

Test Date	Pass/Fail	Total	MP	Comments
3/25/2008	Pass	[redacted]	(184)	

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

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)868-4000

Examinee: Philippides, Stephanie Lynn

Examinee ID: 51283331

Date of Birth: 04/03/1977

INTERPRETATION OF RESULTS

USMLE transcripts include a complete examination history. On those Step examinations for which numeric scores are reported, a three-digit scale is used. Most scores fall between 140 and 260 on this scale. The recommended minimum passing score is shown on the front of the transcript next to the examinee's score for each administration along with a pass/fail outcome. Test results reported as passing represent an exam score of 75 or higher on a two-digit scoring scale. The level of proficiency required to meet the recommended minimum passing level for each USMLE Step is reviewed periodically and is subject to change. Such changes do not alter pass/fail outcomes from prior test administrations.

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.

STEP 2 CLINICAL SKILLS (CS)

Step 2 CS results are reported as pass or fail, with no numeric score. Had the two-digit reporting scale been used, examinees would have had to achieve a score of 75 or higher in order to pass.

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 are at or above the passing level but cannot be certified as representing a valid measure of the examinee's knowledge or competence as sampled by the examination. No score is reported. Information regarding the nature of the indeterminate score 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.

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

Irregular Behavior - The Committee for Individualized Review 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.

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.

PHYSICIAN DATA CENTER INFORMATION APPEARING AS "NOTE"

The Physician Data Center of the Federation of State Medical Boards (FSMB) contains actions reported to the FSMB by U.S. licensing and disciplinary boards, the U.S. Department of Health and Human Services, government regulatory entities and international licensing authorities. To be included in the Physician Data Center, 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 Physician Data Center 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 of the individual physician, and the existence of such an action may be indicated on the USMLE transcript by a Note.

03/2015

This document was printed from a secure website and accurately reflects score information maintained by the FSMB.

AC# **COPY**

STATE OF FLORIDA
DEPARTMENT OF HEALTH
DIVISION OF MEDICAL QUALITY ASSURANCE

DATE	LICENSE NO.	CONTROL NO.
12/15/2016	**ME 130682**	**558504**

The **MEDICAL DOCTOR**
named below has met all requirements of
the laws and rules of the state of Florida.
Expiration Date: **JANUARY 31, 2019**

STEPHANIE PHILIPPIDES
4640 JEFFERSON LANE NE
ALBUQUERQUE, NM 87109

AC#
STATE OF FLORIDA
DEPARTMENT OF HEALTH
DIVISION OF MEDICAL QUALITY ASSURANCE

DATE	LICENSE NO.	CONTROL NO.
12/15/2016	ME 130682	558504

The **MEDICAL DOCTOR**
named below has met all requirements of
the laws and rules of the state of Florida.
Expiration Date: **JANUARY 31, 2019**

COPY - NOT A VALID LICENSE - COPY
LICENSEE SIGNATURE

COPY - NOT A VALID LICENSE - COPY

GOVERNOR Surgeon General and Secretary

DISPLAY IF REQUIRED BY LAW

EXPIRATION DATE: **JANUARY 31, 2019**

Your license number is ME 130682. Please use it in all correspondence with your board/council. Each licensee is solely responsible for notifying the Department in writing of the licensee's current mailing address and practice location address. If you have not received your renewal notice 90 days prior to the expiration date shown on this license, please visit www.FLHealthSource.gov and click "Renew A License" to renew online.

Medical Quality Assurance has a new and improved Online Services Portal. In the new system, you have the ability to renew your license, update your mailing and practice location addresses, request a name change, request a duplicate license and update your profile information all from the convenience of your online account.

1. Go to www.FLHealthSource.gov .
2. Click on "Provider Services" and select "Manage Your License."
3. Select your profession and license type and click "Submit."
4. The question "Have you Registered in Our New Online Service S
   a. Click on "No" if you have not registered for an account in the new system and follow the instructions provided for new user registration.
   b. Click on "Yes" if you are a returning user. Enter the user ID and password you selected during the registration process, then select "Sign In" to access your MQA Online Services Portal account.

IMPORTANT ANNOUNCEMENTS

Are You Renewal Ready?

The Department of Health will now review your continuing education records at the time of license renewal.

To learn more, please visit www.FLHealthSource.gov/AYRR

Grounds for Discipline

You should be familiar with the Grounds for Discipline found in Section 456.072(1), Florida Statutes, and in the practice act for the profession in which you are licensed. Florida Statutes can be accessed at www.leg.state.fl.us/Statutes

DEPARTMENT OF HEALTH
DIVISION OF MEDICAL QUALITY ASSURANCE
LICENSURE SUPPORT SERVICES UNIT
4052 BALD CYPRESS WAY, BIN #C-10
TALLAHASSEE, FLORIDA 32399-3260

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********** **AUTO** **********

STEPHANIE PHILIPPIDES
506 MISSION AVE NE
ALBUQUERQUE, NM 87107

TFDDFAAFTFFFTFDFDFTADDAD

007_003_01539