FORM 1
MEDICINE

ALL CANDIDATES MUST COMPLETE THIS FORM

THE UNIVERSITY OF THE STATE OF NEW YORK
THE STATE EDUCATION DEPARTMENT
DIVISION OF PROFESSIONAL LICENSING SERVICES

APPLICATION FOR LICENSE AND FIRST REGISTRATION

COMPLETE BOTH SIDES OF THIS APPLICATION

Department Use

RECEIVED
MAY 21 1992
LICENSURE SECTION

6 0
500 LX
375 ER

Diploma

N.Y.S. License Number TC
190753 10/30/92

QUALS. . . . . .

APPROVED . . . . . .

1. 384-84-9479 Social Security Number
2. ROT First 3 letters of Last Name
3. BIRTH DATE 04 29 66 (mo day yr)

4. PRINT FULL NAME EXACTLY AS YOU WISH IT TO APPEAR ON YOUR LICENSE, IF DETERMINED ELIGIBLE. (IMPORTANT: A request that contains only initials and the surname cannot be honored.)

Last ROTH
First HARVEY
Middle CRAIG

5. ADDRESS (check only one) ☐ permanent address of record ☐ temporary mailing address*

Care of
Misc. (Bldg. & Apt., etc.)
Street 39 WILLOW PLACE
City BROOKLYN
State NEW YORK ZIP Code 11201

6. TELEPHONE
At home 718 - 624 6204 (area code / number)
At work 718 - 780 1000 (area code / number)

7. CITIZENSHIP ☒ United States ☐ Alien Lawfully admitted for permanent residence in the United States.

Alien Registration Number _____
Citizen of _____

8. Name as it appears on diploma or other credentials. Harvey Craig Roth

	☐ Yes	☒ No
9. Have you previously applied for a New York medical license or a limited permit?		[redacted]
10. Have you ever been convicted of a crime (felony or misdemeanor) in any state or country?		[redacted]
11. Have you ever been charged with a crime (felony or misdemeanor) in any state or country, the disposition of which was other than by acquittal or dismissal?		[redacted]
12. Have you ever surrendered your license or been found guilty of professional misconduct, unprofessional conduct, incompetence or negligence in any state or country?		[redacted]
13. Are charges pending against you for professional misconduct, unprofessional conduct, incompetence or negligence in any state or country?		[redacted]
14. Has any hospital or licensed facility restricted or terminated your professional training, employment, or privileges or have you ever voluntarily or involuntarily resigned or withdrawn from such association to avoid imposition of such measures?		[redacted]

- If the answer to questions 10–14 is "Yes," submit a letter giving a complete explanation as applicable, also include copies of your court records and a copy of the "Certificate of Relief from Disabilities" or your "Certificate of Good Conduct."

15. I wish to be licensed in New York State on the basis of:
- ☒ National Board Examination (See Licensure Requirements – Sec. IV)
- ☐ National Board Examination/Osteopath (See Licensure Requirements – Sec. IV)
- ☐ Admission to the licensing examination in New York State (See Licensure Requirements – Sec. IV)

Give Date of Flex examination requested (Month and Year) _____
Requested exam center: ☐ New York City Area, (Incs. Long Island) ☐ Albany Area ☐ Buffalo Area

Acceptance of Federation Licensing Examination (FLEX) taken outside New York State.
Give dates and locations of all FLEX examinations taken. _____

My FLEX identification Number (FIN) is: _____

☐ Endorsement of license from another State or Country.
Name State or Country _____

Other _____

☐ 5th Pathway (Section 6528 of the Education Law.)

16. I am a graduate of the following medical program:

Name of Medical School Attended and Location	Number of Years Attended	Class Completed	ATTENDANCE		Diploma or Degree Obtained (if school is located Outside the United States, attach a copy)
			Entrance Date	Leaving Date	
School University of Michigan Medical School - Ann Arbor, MI 48104	4	MD 1991	Aug 1987	May 1991	M. D.

17. I am a licensed physician in the following states or countries:

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

AFFIDAVIT

I hereby certify that I have read the statutory provisions, Rules of the Board of Regents and Regulations of the Commissioner of Education distributed to me by the State Education Department.

Under penalties of perjury, I declare and affirm that the statements made in the application, including accompanying statements and transcripts are true, complete and correct. I understand that any false or misleading information in, or in connection with my application may be cause for denial or loss of licensure.

[redacted] 5/6/92

Signature of candidate *Date*

• DO NOT STAPLE •

M
to) pho-

Date of Photograph 6/30/91

• **RETURN TO: Fee Section, Division of Professional Licensing Service**
Cultural Education Center, Albany, New York 12230

REGISTRATION APPLICATION

PERIOD 01/01/93 - 12/31/94

$ 350 00
PAY THIS AMOUNT

PROFESSION MEDICINE

NAME AND ADDRESS DATA CHANGE (PLEASE PRINT)

Last Name
First Name
Middle
Care of
Street City
State Zip -

ROTH HARVEY CRAIG
39 WILLOW PLACE
BROOKLYN NY [redacted]

IF YOUR NAME AND OR ADDRESS HAS CHANGED, PLEASE INDICATE CHANGE IN SPACES PROVIDED

SEE INSTRUCTIONS ON REVERSE SIDE AND IMPORTANT INFORMATION BELOW

1 (A) **Since you last registered,** has any state other than New York instituted charges against you for professional misconduct, unprofessional conduct, incompetence or negligence or revoked, suspended, or accepted surrender of a professional license held by you? ☐ Yes ☒ No

(B) **Since you last registered,** have you been convicted of any crime (felony or misdemeanor) in any state or country or have you been charged with any crime the disposition of which was other than by acquittal or dismissal? ☐ Yes ☒ No

(C) FOR HEALTH PROFESSIONALS ONLY: Since you last registered, has any hospital or licensed facility restricted or terminated your professional training, employment or privileges or have you ever voluntarily or involuntarily resigned or withdrawn from such association to avoid imposition of such action due to professional misconduct, unprofessional conduct, incompetence or negligence? ☐ Yes ☒ No

2 (A) Will you be practicing in NYS during the period indicated? ☒ Yes ☐ No

(B) IF NO, ARE YOU ☐ INACTIVE ☐ RETIRED

3 Last practiced in NYS 12 12 (Mo Yr)

4 Date of Birth [redacted] (Mo Day Yr)

5 Attached is proof of the required coursework regarding child abuse (check one) ☐ Certificate of Completion (See Number 8 Below) ☐ Certificate of Exemption

6 Social Security # [redacted]

• If Social Security # has not been provided, check appropriate box below.
☐ # applied for or pending ☐ Other (explain) _____

7 Federal Employer Identification # ☐☐-☐☐☐☐☐☐☐
(If you have a Federal Employer Identification #, you must provide)

OFFICE USE ONLY
DATE: 03/05/93
LIC. NO.: [redacted]
NM CHK: ROT3
DOB: [redacted]
SSN: [redacted]
FEE: 350
PR: 60 OFF: 1
YR: 93 TYPE: RR
PEN: 20
CHILD ABUSE REQ. CODE: Y

RE 6 & 7 • **PRIVACY NOTIFICATION:** The authority to request Federal Social Security and Federal Employer Identification Numbers, and the authority to maintain such information, is found in Section 5 of the Tax Law. These numbers will be used for tax administration purposes.

It is required that you answer the questions pertaining to Social Security Number (6) and Federal Employer Identification Number (7) on this Registration Application.

• **DECEASED NOTIFICATION:** If the above named person is deceased, please check box ☐ and complete the information on the reverse side.

PLEASE NOTE: Section 29.2 of the Rules of the Board of Regents describes Health Professionals as those listed below:

acupuncture	massage	ophthalmic dispensing	podiatry
audiology	medicine	optometry	psychology
chiropractic	nursing (registered professional nurse	pharmacy	social work
dental hygiene	licensed practical nurse)	physical therapy	specialist's assistant
dentistry	occupational therapy	physician's assistant	speech-language pathology

If your profession is listed above, you must answer question 1(c). If you do not, an application will be returned to you and you will not be registered until a completed application is received.

The following professionals must comply with item (5) if the child abuse requirement code status listed in the OFFICE USE box above is 'X' or 'N'

physicians	dentists	optometrists
chiropractors	registered nurses	psychologists
dental hygienists	podiatrists	

'X' or 'N' = Requirement has not been met
'Y' = Yes, requirement is complete
'E' = Exemption

If your child abuse requirement code status is 'Y' or 'E', disregard item (5).

9 Under penalties of perjury, I declare and affirm that the statements above are an accurate representation and that such statements, including any accompanying documentation and explanations, are true, complete, and correct. I understand that any false or misleading information or statement in, or in connection with, my application may be cause for disciplinary action, including the loss of my license.

Signature _____ Date 3, 11, 93

REGISTRATION APPLICATION — OFFICE USE ONLY

PROFESSION: MEDICINE

PERIOD 01/01/95 - 03/31/96 $ 206 PAY THIS AMOUNT

DATE: 08/01/94
LIC NO: [redacted]
NM: ROT3
DOB: [redacted]
SSN: [redacted]
FEE: 206
PR: 60 OFF: 1
YR: 95 TYPE: RR
PY:
CA: Y

Make [illegible] New York State Education Department

215781

The University of the State of New York
THE STATE EDUCATION DEPARTMENT
Office of Professional [illegible]
Professional [illegible]
[illegible]
Albany, NY [illegible]
518 474 [illegible]

READ INSTRUCTIONS ON REVERSE SIDE BEFORE COMPLETING THIS FORM

ROTH HARVEY CRAIG
[redacted]
BROOKLYN NY [redacted]

7

This application may ONLY be used by the person whose name appears above

1 (a) Since you last registered, has any state [illegible] New York [illegible] charges against you for professional [illegible] professional conduct, incompetence or negligence or revoked, suspended [illegible] accepted surrender of a professional license held by you? [redacted] X

(b) Since you last registered, have you been [illegible] of any crime [illegible] misdemeanor in any state or [illegible] been charged with any crime the disposition of which was other than a [illegible] dismissal? [redacted] X

(c) Since you last registered, has any hospital [illegible] licensed facility restricted or terminated your professional training, employment, or privileges, or have you [illegible] or involuntarily resigned or withdrawn from such association to avoid imposition of such action due to professional misconduct, unprofessional [illegible] incompetence or negligence? [redacted] X

2 [illegible] register in New York State for the period indicated [illegible] X Yes [illegible]

3 Are you currently practicing in New York State? [illegible] month and year last practiced [illegible] / X Yes [illegible]

4 Date of Birth [redacted] Mo Day Yr

5 Social Security # [redacted]
If Social Security # has not been provided, check appropriate box below
☐ number applied for or pending ☐ explanation attached

6 Federal Employer Identification Number

7 Your profession must comply with a one-time requirement for two hours of coursework or training in the recognition and reporting of child abuse and maltreatment. Your registration will not be processed until this requirement has been satisfied. Your current status with regard to the requirement is noted to the right. SEE REVERSE SIDE
- [illegible] or N Requirement has not been satisfied. You must submit either a Certificate of Completion or Exemption. CA: Y
- Y Requirement has been satisfied. You do not have to submit any additional information.
- E Exemption has been granted. You do not have to submit any additional information.

8 You must comply with the statutory requirement for completion of approved course work in infection control and barrier precautions to prevent the transmission of HIV and HBV in healthcare settings. Questions may be referred to the Infection Control/Occupational Health Unit of the NYS Department of Health at (518) 473-8815

9 Under penalties of perjury, I declare and affirm that the statements above are an accurate representation and that such statements, including any accompanying documentation and explanations, are true, complete and correct. I understand that any false or misleading information or statement in or in connection with my application may be cause for disciplinary action, including the loss of my license.

(Signature) 9 / 14 / 94 (Date)

DECEASED NOTIFICATION

If you are aware that the licensee is deceased, please complete and sign the following statement in order to permit us to change our records and to prevent future correspondence from being mailed.

The licensee whose name appears above is deceased. Approximate date of death was ____ / ____ / ____

(Signature) (Relationship to deceased) ____ / ____ / ____ (Date)

PLS CAT 7 5/94

THE UNIVERSITY OF THE STATE OF NEW YORK
THE STATE EDUCATION DEPARTMENT
DIVISION OF PROFESSIONAL LICENSING SERVICES
CULTURAL EDUCATION CENTER
ALBANY, NEW YORK 12230

M84176 $20 RC

ROTH HARVEY CRAIG
39 WILLOW PLACE
BROOKLYN NY [redacted]

WHEN RESPONDING, PLEASE INCLUDE NAME, ADDRESS, PROFESSION, SSN, AND A DAY PHONE#.
DATE: 06/30/92
PROFESSION: SO
SOC SEC NO: 384849479

DEAR APPLICANT:

OUR RECORDS INDICATE THAT YOUR APPLICATION IS INCOMPLETE BECAUSE WE HAVE NOT RECEIVED YOUR ENDORSEMENT FEE OF $465. NO FURTHER ACTION CAN BE TAKEN ON YOUR APPLICATION UNTIL WE HAVE RECEIVED THIS FEE.

PLEASE MAKE YOUR CHECK OR MONEY ORDER PAYABLE TO THE NEW YORK STATE EDUCATION DEPARTMENT. NOTE: PAYMENT SUBMITTED FROM OUTSIDE THE UNITED STATES MUST BE MADE BY CHECK OR DRAFT PAYABLE ON A UNITED STATES BANK AND IN UNITED STATES DOLLARS. NO OTHER FORM CAN BE ACCEPTED. DO NOT SEND CASH.

TO ASSURE PROMPT CREDITING TO YOUR RECORD, PLEASE RETURN THIS FORM ALONG WITH YOUR FEE TO THE ADDRESS SHOWN BELOW:

FEE SECTION
DPLS - CEC
ALBANY, NEW YORK 12230

IF YOU HAVE QUESTIONS REGARDING YOUR FEE OR YOUR APPLICATION, YOU MAY WRITE TO THE ADDRESS ABOVE OR CALL 1-800-342-9729, AND ASK FOR THE APPLICATION PROCESSING UNIT FOR YOUR PROFESSION.

60

ROTH HARVE

465 ER

SINCERELY YOURS,

JOAN BUTLER
HEAD CLERK

1. 2
DICINE

THE UNIVERSITY OF THE STATE OF NEW YORK
THE STATE EDUCATION DEPARTMENT
DIVISION OF PROFESSIONAL LICENSING SERVICES

CANDIDATE EDUC. TRAINING RECORD

ALL CANDIDATES MUST COMPLETE THIS FORM.

1. 385-84-9479 Social Security Number
2. RUT First 3 letters of Last Name
3. BIRTH DATE 04 17 66 (mo. day yr.)

4. PRINT FULL NAME EXACTLY AS YOU WISH IT TO APPEAR ON YOUR LICENSE, IF DETERMINED ELIGIBLE. (IMPORTANT: A request that contains only initials and the surname cannot be honored.)

Last RUTH
First HARVEY
Middle CRAIG

5. ADDRESS Misc (Bldg & Apt etc)
Street 39 WILLOW [redacted]
City BROOKLYN
State NEW YORK ZIP Code [redacted]

6. Basis of licensure sought (Form 1, #15) ☒ National Board, ☐ N.Y.S. Exam.; ☐ FLex Outside NYS; ☐ Endorsement

7. In the spaces below, give an accurate record of your educational preparation.

SCHOOLS ATTENDED-Location **Write names of schools in original language and translate.**	NUMBER OF YEARS ATTENDED	ATTENDANCE				Diploma or degree obtained Quote titles in original language and translate.
		Entrance		Leaving		
		Class	Date	Class Completed	Date	
Elementary or Primary School Detroit Country Day School	4	Sept 5th grade	Sept 1975	8th grade	June 1979	(Proof of completion need not be submitted
Secondary or High School Detroit Country Day School	4	9th grade	Sept 1979	12th grade	June 1983	(Proof of completion need not be submitted
Postsecondary PreProfessional (Exclusive of Medical School) Brown University	4	freshman	Sept 1983	Senior	May 1987	Candidates using Form 2A need not verify preprofessional training. Candidates using Form 2N must arrange that verification of preprofessional training be submitted directly from the school.
Medical Education (Professional) (List *all* Medical Schools Attended) University of Michigan Medical School	4	M-1	May 1987	M-4	May 1991	(See Form 2A or 2N for verification requirements)

December 1989

• COMPLETE OTHER SIDE •

8. * If clinical clerkships were completed in a country other than where your medical school is located, give the dates and location of those clerkships.

Inclusive Clerkship Dates	Clinical Area	Name of Health Care Facility and Address	Medical School In Which Taken/Addr

9. * Provide a chronological list of all activities since graduation from professional school to the present. Include vacation periods and periods of employment.

FROM		TO		Type of Professional Activity, Including Name and Address of Employer, Beginning with Date of Graduation from Professional School
Month	Year	Month	Year	
July	1991	Present	—	OB/GYN Residency Program Long Island College Hospital 340 Henry Street Brooklyn, NY 11201

10. Professional Certificates/Other Examinations

MSKP	Date:	Score:	Certificate No.:	
Proficiency Examination	Name:	Date Medicine Passed	Date English Passed	Certificate No.
Specialty Boards (if more space is needed attach on separate sheet).				
Fifth Pathway	Name and Location of Medical School	Name and Location of Hospital	Inclusive Dates of Attendance	

* If more space is needed, please attach additional sheets of paper.

- Return this Form *Together* with Form 1, Form 1D, and fee to:

Fee Section, Division of Professional Licensing Services,
Cultural Education Center, Albany, New York 12230

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

26,912

CERTIFICATION OF COMPLETION

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

PART A — TRAINEE INFORMATION

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

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

Last: ROTH
First: HARVEY
Middle: CRAIG

2 Print your address:

Care of:
Misc (Bldg. & Apt., etc.):
Street: [redacted]
City: ROCKLYN
State: NY Zip Code: [redacted]

3 Date of Birth: 04/29/66 (Mo. Day Yr)

4 Social Security number: [redacted]

5 Complete information below if you hold, or are applying for, a professional license or permit:

Profession: Physician/President
N.Y.S License Number: [redacted]
Permit #:

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

Certificate Title(s):

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

Trainee's Signature: [signature] **Date:** 4/30/92

PART B — CERTIFICATION BY APPROVED PROVIDER

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

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

BERNICE N. GORDON, MA, RN
Name of Authorized Certifying Officer (Print or Type)

[signature]
Signature of Authorized Certifying Officer

LONG ISLAND COLLEGE HOSPTIAL
Approved Provider Name

40085
Identification Number

4/30/92
Date(s) of Coursework or Training

PR 2 (II) - 5/90

[illegible] SL

STUDENT LOAN DISCLOSURE

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

ALL CANDIDATES ARE REQUIRED TO COMPLETE THIS FORM

Chapter 78 of the laws of 1991 has added a new section 6501-a to the Education Law. That provision requires that the State Education Department ask the questions below regarding any student loans made or guaranteed by the New York State Higher Education Services Corporation. The effective date of this legislation was September 1, 1991. **Your license application is not complete until this information has been received.**

Please complete the information below. If you have already filed your license application, please return it to the above address. If you will be applying for licensure, enclose it with your application, Form 1.

INSTRUCTIONS FOR COMPLETING AND SUBMITTING THIS FORM

1. **Complete Items 1-5 by printing all information clearly in the boxes provided. For Item 2 state your professional title from the list on back.**
2. **Complete Items 6 & 7 by placing an (X) in the appropriate box.**
3. **Complete Item 8 by dating and signing.**

1 [redacted] SOCIAL SECURITY NUMBER

2 Pharmacist + Osteopathy PROFESSION (see list on back)

3 BIRTH DATE 04 29 56 (mo. day yr.)

4 PRINT FULL NAME EXACTLY AS IT APPEARS ON YOUR APPLICATION.

Last RUTH
First HARVEY
Middle CRAIG

5 ADDRESS

Care of HARVEY RUTH
Misc. (Bldg. & Apt., etc.)
Street 39 [illegible]
City [illegible]
State NY Zip Code [redacted]

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

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

8 Under penalty of perjury, I declare and affirm that the above information is true, complete, and correct.

[redacted] SIGNATURE

7/1/92 DATE

PLS 246 - 3/92

FORM 2A
MEDICINE

THE UNIVERSITY OF THE STATE OF NEW YORK
THE STATE EDUCATION DEPARTMENT
DIVISION OF PROFESSIONAL LICENSING SERVICES

Graduates of N.Y.S. Registered or LCME Accredited Programs must complete this Form.

CERTIFICATION OF PROFESSIONAL EDUCATION: REGISTERED OR ACCREDITED PROGRAMS

CANDIDATE INSTRUCTIONS

1. Complete Section I. Enter your name as it appears on your Application (Form 1).
2. Send this form to the professional school you attended. See "Licensure Requirements" for additional instruction. Be sure to include any fee required.
3. Certification is not acceptable unless dated after graduation.

SECTION I: CANDIDATE INFORMATION

1. [redacted] Social Security Number

2. RUT First 3 letters of Last Name

3. BIRTH DATE 04 29 66 (mo. day yr.)

4. PRINT FULL NAME EXACTLY AS YOU WISH IT TO APPEAR ON YOUR LICENSE, IF DETERMINED ELIGIBLE. (IMPORTANT: A request that contains only initials and the surname cannot be honored.)

Last: RUTH
First: HARVEY
Middle: CRAIG

5. ADDRESS
Misc. Bldg. & Apt. etc.:
Street: 39 WILLOW PLACE
City: BROOKLYN
State: NEW YORK
ZIP Code: [redacted]

6. Basis of licensure sought (Form 1, #15) ☒ National Board ☐ N.Y.S. Exam.; ☐ FLex Outside NYS; ☐ Endorsement ☐ Limited Permit

7. Print name under which degree or diploma was awarded:
Harvey Craig Ruth
(Name)

8. High School Attended: Detroit Country Day School
(Name)

9. Professional school attended: University of Michigan Medical School
(Name)
Address Ann Arbor, MI 48109 Date degree was awarded May 1991

• CERTIFICATION BY PROFESSIONAL SCHOOL OFFICIAL •
IS TO BE MADE ON REVERSE SIDE

SECTION II: CERTIFICATION OF EDUCATION

INSTRUCT[illegible] SCHOOL: Please complete this section, sign the certifying statement, and return the form [illegible] Division [illegible] essional Licensing Service. **This form will not be accepted if returned by the applicant.**

CERTIFICATION BY N.Y.S. REGISTERED OR LCME ACCREDITED MEDICAL SCHOOL

Preprofessional Education:

(1) Satisfactorily completed, prior to matriculation in professional school the following preprofessional education:

Brown University
(Print Name of Institution)

August 1987 – May 1991
Dates of Attendence

B.S
Degree Granted

Professional Education

(1) Was admitted to University of Michigan Medical School
Print Name of Medical School

on August 31 1987
Month Day Year
and satisfactorily completed the program on

May 24 1991
Month Day Year
and was awarded the degree of

Medical Doctor
Degree

MAY 24, 1991
Date

- **If the applicant was credited with advanced standing based on prior academic work, give institution name and dates of attendence.**

Name of Institution: _____

Dates of Attendence _____

Attach the following to this form:

(1) Official transcript of studies at your institution.
(2) Copies of documentation in your file to support the granting of transfer credit.

Name [signature]
(original signature)

NANCY H. MCGLOTHLIN
(Type or print above name

(COLLEGE SEAL)

Title REGISTRAR

Medical School THE UNIVERSITY OF MICHIGAN MEDICAL SCHOOL

Location ANN ARBOR, MICHIGAN 48109

Telephone Number (313) 764-0219

Date MAY 18, 1992

Certification is not acceptable unless dated after graduation.

- RETURN TO: Division of Professional Licensing Services, Medical Unit, Cultural Education Center, Albany, New York 12230

F[illegible]PGT
[illegible]ICINE

THE UNIVERSITY OF THE STATE OF NEW YORK
THE STATE EDUCATION DEPARTMENT
DIVISION OF PROFESSIONAL LICENSING SERVICES

ALL CANDIDATES MUST COMPLETE THIS FORM.

CERTIFICATION OF APPROVED POSTGRADUATE TRAINING

Any certification s[illegible] earlier then one month [illegible] completion of the training p[illegible] will be returned to the hospital by divi- sion without processing.

CANDIDATE INSTRUCTION

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

SECTION I: CANDIDATE INFORMATION

1. [redacted] Social Security Number
2. RUT First 3 letters of Last Name
3. BIRTH DATE [redacted] mo. day yr.

4. PRINT FULL NAME EXACTLY AS YOU WISH IT TO APPEAR ON YOUR LICENSE, IF DETERMINED ELIGIBLE. (IMPORTANT: A request that contains only initials and the surname cannot be honored.)

Last RUTH
First HARVEY
Middle CRAIG

OK for 2nd 12/14/92

SECTION II: CERTIFICATION OF POSTGRADUATE TRAINING

This is to certify that Harvey Craig Ruth
Physician's Name

a graduate of University of Michigan Medical School
Medical School

was enrolled in a residency training program approved by the Accreditation Council on Graduate Medical Education or the American Osteopathic Association at Long Island College Hospital
Name of Hospital

340 Henry Street Brooklyn N.Y. 11201
(Location of Hospital)

from 7/1 Date 19 91 thru 6/30 Date 19 92 in the clinical area of

Obstetrics and Gynecology
Clinical Area

and that the above named physician successfully completed this training on 6/30/92 Date (Internship)

December 1989

• COMPLETE OTHER SIDE •

If this ph[illegible]rd not successfully complete the postgraduate training program, please attach a letter of expl[illegible] form.

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

Signature of Director/Chief [signature] Date 9/18/92

Print Name of Director/Chief Jack Maidman, MD

Print Title Chairman - Department of OB/GYN Telephone Number: (718) 780 1647
(718) 780-1000 (General Info)

- RETURN TO: Division of Professional Licensing Services, Medical Unit, Cultural Education Center, Albany, New York 12230

NBME

NATIONAL BOARD OF MEDICAL EXAMINERS • 3930 CHESTNUT STREET, PHILADELPHIA, PA 19104

ENDORSEMENT OF CERTIFICATION

NATIONAL BOARD OF MEDICAL EXAMINERS
OF THE
UNITED STATES OF AMERICA

Harvey Craig Roth, M.D.

having satisfied all the requirements and having successfully passed the examinations is hereby declared a Diplomate of the National Board of Medical Examiners

Attest Edward J. Stemmler, MD
Chairman of the Board

SEAL L. Thompson Bowles, MD, PhD
President of the Board

Philadelphia, Pa
07/01/92

Certificate # 407844

It is certified that the above is a facsimile of the Diplomate Certificate which has been or will be* awarded to the physician named above, who graduated from University of Michigan Medical School in MAY 1991 and whose birth date is [redacted] This physician has successfully completed all examinations required for certification by the National Board of Medical Examiners. The scores obtained by this physician upon which his/her certification is based are as follows

	Standard Score	Scale Score
PART I passed 05/89		
Anatomy	455	79
Physiology	425	77
Biochemistry	460	79
Pathology	425	77
Microbiology	365	73
Pharmacology	535	84
Behavioral Sciences	580	87
TOTAL TEST(Minimum Passing Score 380/75)	455	79
PART II passed 02/90		
Medicine	365	76
Surgery	435	79
Obstetrics and Gynecology	545	83
Public Health and Preventive Medicine	550	84
Pediatrics	445	79
Psychiatry	480	81
TOTAL TEST(Minimum Passing Score 290/75)	460	80
PART III passed 03/92		
A General Test of Clinical Competence		
TOTAL TEST(Minimum Passing Score 315/75)	345	76
GENERAL AVERAGE (Parts, I, II, and III Scale Score)		79

*For those individuals who have not yet satisfactorily completed one full year of post-M.D. training the date shown on the facsimile is the date which has been certified by the physician's residency program director as the date on which this requirement for certification by the National Board will be fulfilled and such certification will be awarded.

SEE OTHER SIDE FOR SCORE INFORMATION

Melanie Valente
Secretary for Certification

SEAL

05/18/92
Date

NY0469