

**myLicense Renewal Question Responses**

**License Number:** MD425599

**Name:** AILEEN GARIEPY

**Online Submission Date :** 10/27/2006 8:08:02AM

<b>Renewal Question</b>	<b>Response</b>
Are you submitting a name change with this renewal?	N
Are you licensed in another licensing jurisdiction in this profession (any status)?	N
Since your last renewal, has a licensing jurisdiction taken any disciplinary action against you?	N
Since your last renewal, have you been convicted of a crime?	N
Since your last renewal, have you withdrawn an application for licensure in another licensing jurisdiction?	N
Have you met your current CE requirements?	Y
Since your last renewal, have your provider privileges been terminated by any medical assistance agency for cause?	N
Since your last renewal, have you had practice privileges denied, revoked or restricted in a hospital or health care facility?	N
Since your last renewal, have you had your DEA registration denied, revoked or restricted?	N
Since your last renewal, have you been arrested for criminal homicide, aggravated assault, sexual offenses or drug offenses in any state, territory or country?	N
Do you maintain current medical professional liability insurance in the Commonwealth?	Y
Medical Renewal - Since your last renewal, have you been the subject of a civil malpractice law suit?	N

**Online Submission Date :** 10/31/2008 8:02:43AM

<b>Renewal Question</b>	<b>Response</b>
Are you submitting a name change with this renewal?	N
Are you licensed in another licensing jurisdiction in this profession (any status)?	N
Since your last renewal, has a licensing jurisdiction taken any disciplinary action against you?	N
Since your last renewal, have you been convicted of a crime?	N
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Since your last renewal, have you been arrested for criminal homicide, aggravated assault, sexual offenses or drug offenses in any state, territory or country?	N
Do you maintain current medical professional liability insurance in the Commonwealth?	Y
Medical Renewal - Since your last renewal, have you been the subject of a civil malpractice law suit?	Y

**Online Submission Date :** 11/16/2010 12:15:22AM

<b>Renewal Question</b>	<b>Response</b>
Are you submitting a name change with this renewal?	N
Are you licensed in another licensing jurisdiction in this profession (any status)?	N
Since your last renewal, has a licensing jurisdiction taken any disciplinary action against you?	N
Since your last renewal, have you been convicted of a crime?	N
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Do you maintain current medical professional liability insurance in the Commonwealth? Y  
Medical Renewal - Since your last renewal, have you been the subject of a civil malpractice law suit? Y

**Online Submission Date :** 1/24/2013 12:15:47AM

<u>Renewal Question</u>	<u>Response</u>
Are you submitting a name change with this renewal?	N
Are you licensed in another licensing jurisdiction in this profession (any status)?	Y
Since your last renewal, has a licensing jurisdiction taken any disciplinary action against you?	N
Since your last renewal, have you been convicted of a crime?	N
Since your last renewal, have you withdrawn an application for licensure in another licensing jurisdiction?	N
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Name : AILEEN GARIEPY

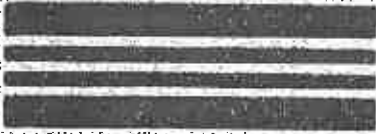
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Do you maintain current medical professional liability insurance in the Commonwealth?	N
Medical Renewal - Since your last renewal, have you been the subject of a civil malpractice law suit?	N

<b>Person Info</b> <b>Name:</b> AILEEN GARIEPY <b>Address Info</b> <b>Street Address:</b> [REDACTED] <b>Email:</b> [REDACTED]@hotmail.com <b>Phone</b> [REDACTED] <b>Fax</b> [REDACTED] <b>City:</b> New Haven <b>State:</b> CT <b>Zipcode:</b> 06515 <b>Country:</b> 82 <b>County:</b> New Haven	
Survey Response Summary Question Response Summary	
Are you submitting a name change with this renewal?	N
Do you hold a license/certificate (active, inactive or expired) to practice in any other state or jurisdiction?	Y
Since your initial application or last renewal, whichever is later, have you had disciplinary action taken against your license, certificate or registration issued to you in any profession in any other state or jurisdiction?	N
Since your initial application or last renewal, whichever is later, have you been convicted, found guilty or pleaded nolo contendere, or received probation without verdict, or accelerated rehabilitative disposition(ARD) as to any felony or misdemeanor, including any drug law violations, or do you have any criminal charges pending and unresolved in any state or jurisdiction? You are not required to disclose any ARD or other criminal matter that has been expunged by order of a court.	N
Since your initial application or last renewal, whichever is later, have you withdrawn an application for a license, certificate or registration, had an application denied or refused, or for disciplinary reasons agreed not to reapply for a license, certificate or registration in any profession in any other state or jurisdiction?	N
Since your initial application or last renewal, whichever is later, have you been arrested for criminal homicide, aggravated assault, sexual offenses or drug offenses in any state, territory or country?	N
Since your last renewal, have you been the subject of a civil malpractice law suit? If yes, please submit a copy of the entire Civil Complaint which must include the filing date and the date you were served. If you previously reported the complaint, email or fax the docket number to the Board. (email at st-medicine@state.pa.us or fax at 717-787-7769)	N

Since your initial application or last renewal, whichever is later, have you had your DEA registration denied, revoked or restricted?	N
Since your initial application or last renewal, whichever is later, have you had practice privileges denied, revoked or restricted in a hospital or health care facility?	N
Since your initial application or last renewal, whichever is later, have your provider privileges been denied, revoked or restricted by any medical assistance agency for cause?	N
Do you maintain current medical professional liability insurance in the Commonwealth of Pennsylvania?	N
Have you met your current CE requirements?	Y
Education Information	
No education records	
Employment Information	
No employment records	
remarks	
Remarks:	
Continuing Education Information	
No CE Course records	



**TARGET SHEET**

**Board: Medicine**

**Date Created:**  
01/06/2005

**License Full Name:**  
AILEEN GARIEPY

**License No:**  
MD425599

**APPL**

**2245632**

Regular Mailing Address  
STATE BOARD OF MEDICINE  
P.O. BOX 2649  
HARRISBURG, PA 17105-2649  
717-783-1400/717-787-2381  
st-medicine@state.pa.us  
Courier Delivery Address  
STATE BOARD OF MEDICINE  
2601 NORTH THIRD STREET  
HARRISBURG, PA 17110

MD 425599  
APPL

OFFICIAL USE ONLY

Amount \_\_\_\_\_

Date \_\_\_\_\_

35683

APPLICATION FOR A LICENSE TO PRACTICE MEDICINE WITHOUT RESTRICTION  
For Graduates of ACCREDITED Medical Schools

MT049735T

Ham

Application Fee: \$35.00 *not refundable*. Make check payable to the "Commonwealth of Pennsylvania."  
Note: A processing fee of \$20.00 will be charged for any check or money order returned unpaid by your bank, regardless of the reason for non-payment.

Please print or type

NAME: GABERY AILEEN M.  
Last First Middle

Permanent Address: \_\_\_\_\_

All correspondence and the license will be mailed to this address unless the Board is notified of a change.

Philadelphia PA 19147  
City State Zip Code

Email address: \_\_\_\_\_@hotmail.com

Date of Birth: \_\_\_\_\_ Social Security Number: \_\_\_\_\_

If your medical/licensure records are listed under another name or names list below:

NA

LIST MEDICAL SCHOOL(S) ATTENDED:

MCP Hahnemann School of Medicine

DATES OF ATTENDANCE

From: 8/97 to 5/01  
Mo & Yr Mo & Yr

From: \_\_\_\_\_ to \_\_\_\_\_  
Mo & Yr Mo & Yr

Date of Graduation: 5/2001

Check licensing examination(s) passed:

- ( ) FLEX - indicate state where taken: \_\_\_\_\_ Date taken: Component 1 \_\_\_\_\_ Component 2 \_\_\_\_\_
- ( ) NATIONAL BOARD - PART I \_\_\_\_\_ PART II \_\_\_\_\_ PART III \_\_\_\_\_
- USMLE - STEP 1  STEP 2  STEP 3
- ( ) LMCC - Canadian
- ( ) STATE BOARD - indicate state where taken: \_\_\_\_\_



**ACGME Post Graduate Training:**

PGY1 Hospital: Thomas Jefferson Univ. Hospital From 6 20 01 to 6 20 02

PGY2 Hospital: Thomas Jefferson Univ. Hospital From 6 21 02 to 6 20 03

Answer the following questions. If "YES" is answered to #1 through #8, provide complete details on a separate sheet as well as certified copies of relevant documents. Sign and date below.

	YES	NO
1) Do you hold licensure or certification (active or inactive, current or expired) to practice in any other jurisdiction? If yes, list each one.		X
2) Have you ever withdrawn an application for a license, had a license denied or refused, or applied for a license in another state, territory or country? A license includes a registration or certification.		X
3) Has any disciplinary action been taken against your license or certification in another state, territory or country?		X
4) Have you been convicted, found guilty, or pleaded guilty to any criminal offense or received probation without success in any federal, state or territory, including any drug law violation, in any state or federal court?		X
5) Since May 19, 2002, have you been arrested for criminal offenses, including assault, sexual offenses or drug offenses in any state, territory or country?		X
6) Have you had practice privileges denied, revoked or restricted at a hospital or other health care facility, or been excluded from a hospital, university, or research facility, with violation of research or falsifying research, or cheating in other research situations?		X
7) Have you had your DEA registration denied, revoked or found void, or have had your provider privileges terminated by any medical society, state or country?		X
8) Are you, or have you ever been, addicted to the use of alcohol, or to the habitual use of controlled substances in your work or private life? (Note: You may answer "NO" if you are currently a participant in or have successfully completed the requirements of the Board's Professional Health Monitoring Program.)		X
9) Since May 19, 2002, have any malpractice complaints been filed against you? If yes, the Board requires that you submit a copy of the complaint and Complaint which must include the filing information and date you last received the complaint.		X

**SIGNED STATEMENT**

Note that disclosing your social security number on this application is mandatory in order for the State Board of Medicine to comply with the requirements of the Federal Social Security Act pertaining to child support enforcement, as mandated in the Commonwealth of Pennsylvania at 24 Pa. C.S. 4914. You are hereby notified that child support orders, the Commonwealth's licensing board must provide to the Department of Public Welfare information contained on this form, which includes the social security number. Additionally, disclosure of the number is required in order for you to be eligible for the "moving to compliance" of the Federal National Practitioner Data Bank and the Healthcare Integrity and Protection Data Bank. Reports to the NPI/DIPEDB must include the licensee's actual ID number.

I verify that the statements in this application are true and correct to the best of my knowledge, information and belief. I understand that any statements or omissions subject to the penalties of 18 Pa. C.S. Section 4914 relating to unsworn falsification of statements and may result in the suspension or revocation of my license. I hereby authorize all hospitals, institutions or organizations, my references, personal physicians, employers (past and present), and all governmental agencies and state or federal (state, federal or foreign) practice or the Pennsylvania State Board of Medicine any information files or records requested by the Board.

[Redacted Signature]

11/17/04  
DATE

State Board of Medicine  
P.O. Box 2649  
Harrisburg, PA 17105-2649


**Certification of Moral Character**

To be completed by two physicians with a license without restriction in good standing in the United States or Canada.

Name of Applicant: Aileen M. Gariepy, M.D.

I hereby certify that I know the applicant to be of good moral character and to the best of my knowledge, he/she is not addicted to the intemperate use of alcohol or to the habitual use of a narcotic or other habit forming drug. I recommend the applicant for a license to practice medicine in the Commonwealth of Pennsylvania.

I have been personally acquainted with the applicant for 3 year(s) 5 month(s).

SIGNATURE:  Date: 11/23/04


Print or type name as signed above: CARMEN SUTANA MD

State in which licensed: PA License Number: MD0391966

Name of Applicant: Aileen M. Gariepy, M.D.

I hereby certify that I know the applicant to be of good moral character and to the best of my knowledge, he/she is not addicted to the intemperate use of alcohol or to the habitual use of a narcotic or other habit forming drug. I recommend the applicant for a license to practice medicine in the Commonwealth of Pennsylvania.

I have been personally acquainted with the applicant for 3 year(s) 5 month(s).

SIGNATURE:  Date: 11/22/04

Print or type name as signed above: JORGE E. TOLOSA

State in which licensed: PA, OREGON License Number: PA M0065192L

Return Completed Form to Applicant

353680

Regular Mailing Address  
State Board of Medicine  
P.O. Box 2649  
Harrisburg, PA 17105-2649

Courier Delivery Address  
State Board of Medicine  
2601 North Third Street  
Harrisburg, PA 17110

RECEIVED DIRECT

**VERIFICATION OF ACGME APPROVED GRADUATE MEDICAL TRAINING**  
Accredited Medical School Graduates  
**TO BE COMPLETED BY APPLICANT**

NAME: Gariely Aileen M.  
Last First Middle

1. If training began before July 1, 1987, one year of approved training at a first (PGY 1) or second (PGY 2) year level must be verified. If the training began on or after July 1, 1987, two (2) years of approved training are required, one at first (PGY 1) year level and one at second (PGY 2) year level.
2. Training at a first (PGY 1) year must be ACGME approved entry level (training which requires no previous training). Training at a second (PGY 2) year must be ACGME approved and can be any specialty. See listing on back.
3. If training was completed at more than one hospital, duplicate this form and submit to each hospital.

*To be completed by the program director at the hospital where the graduate training occurred. If training was in Pennsylvania, information must coincide with data on graduate license. For applicants still in the second year of training, this form may be completed and signed by the program director fifteen (15) days prior to the completion of the approved training. Forms postmarked or signed prior to the fifteen days will not be accepted.*

NAME OF HOSPITAL WHERE TRAINING WAS COMPLETED: Thomas Jefferson University Hospital

NAME OF SPONSORING INSTITUTION: Thomas Jefferson University

LOCATED IN: Philadelphia PA  
City State

1st Year from 6/20/2002 To 6/19/2003 Specialty Ob-Gyn Level (PGY) 1

2nd Year from 6/20/2003 To 6/19/2004 Specialty Ob-Gyn Level (PGY) 2

"I certify that Aileen Gariely, M.D. successfully completed/will successfully complete this graduate medical training and that there was/is no disciplinary action outstanding against this applicant. If this applicant does not complete this training, the Board will be notified."

"I further certify that the above program was ACGME accredited at the time Aileen Gariely, M.D. completed the training."

Signature of Program Director: [Signature]  
Date: 11/22/04

If the hospital has no seal complete the following section and have this form notarized:

I hereby certify that this hospital has no seal or stamp and that this form was completed by this hospital

Program Director's Signature: \_\_\_\_\_  
Date: \_\_\_\_\_ [notary seal]

RETURN COMPLETED FORM DIRECTLY TO THE BOARD IN OFFICIAL HOSPITAL ENVELOPE.

STATE BOARD OF MEDICINE  
P.O. BOX 2649  
HARRISBURG, PA 17105-2649

**Entry Level Specialties:**

Anesthesiology  
Dermatology  
Diagnostic Radiology  
Emergency Medicine  
Family Practice  
General Surgery  
Internal Medicine  
Neurology

Obstetrics & Gynecology  
Pathology  
Pediatrics  
Physical Medicine & Rehab  
Preventive Medicine  
Psychiatry  
Transitional Year

The following specialties are listed in the Directory of Residency Training Programs and *require training prior to entry* and would not be considered entry-level specialties:

Adult Reconstructive Surgery  
Aerospace Medicine  
Allergy and Immunology  
Blood Banking  
Cardiovascular Disease  
Chemical Pathology  
Child Neurology  
Child and Adolescent Psychiatry  
Colon and Rectal Surgery  
Critical Care  
Dermatopathology  
Diagnostic Laboratory Immunology  
Endocrinology and Metabolism  
Forensic Pathology  
Gastroenterology  
Geriatrics  
Hand Surgery  
Hematology  
Immunopathology  
Infectious Diseases  
Medical Microbiology  
Medical Oncology  
Musculoskeletal Oncology  
Neonatal-Perinatal Medicine  
Nephrology  
Neurosurgery  
Neuropathology

Neuroradiology  
Nuclear Medicine  
Nuclear Radiology  
Occupational Medicine  
Ophthalmology  
Orthopaedic Surgery  
Otolaryngology  
Pediatric Cardiology  
Pediatric Endocrinology  
Pediatric Hematology/Oncology  
Pediatric Nephrology  
Pediatric Orthopaedics  
Pediatric Pulmonology  
Pediatric Radiology  
Pediatric Surgery  
Plastic Surgery  
Preventive Medicine/Public Health  
Public Health  
Pulmonary Diseases  
Rheumatology  
Selective Pathology  
Sports Medicine  
Thoracic Surgery  
Trauma Orthopedics  
Urology  
Vascular Surgery  
Radiation Oncology

NOV 3 8 2004

RECEIVED

Board adopted April 22, 1986 (State Board of Medicine)

Home  File  Edit  View  Format  Tools  Window  Help

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**General** | **Contents** | **Equation** | **Environment** | **Field Info** | **Help Info**

**License #**:  **Product**:  **Product Number**:

**Manufacturer**:  **Part No.**:  **Rev. No.**:

---

**Address**

**Date**:  **Location**:  **Start Date**:  **Stop Date**:  **Priority**:

**Description**:

**Level 1**:

**Level 2**:

**Level 3**:

**Level 4**:

**Accession**:

Level	Start Date	Stop Date	Priority
Level 1	10/1/2001	10/1/2001	<input type="checkbox"/>
Level 2	10/1/2001	10/1/2001	<input type="checkbox"/>
Level 3	10/1/2001	10/1/2001	<input type="checkbox"/>
Level 4	10/1/2001	10/1/2001	<input checked="" type="checkbox"/>

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Home  File  Edit  View  Format  Tools  Window  Help

Level 1 | Level 2 | Level 3 | Level 4 | Date: 10/1/2001

HTH813

APPLICANT - INQUIRY

1/06/05 10:11:13

Applicant Number MT 049735 T

Name GARIEPY, AILEEN

Address NO STREET ADDRESS

Business Name Code N

Entry Date 05 / 02 / 2001

Completion Date 05 / 05 / 2001

Beginning Date 05 / 20 / 2001

Ending Date 06 / 19 / 2002

Birth Date 03 / 30 / 1974

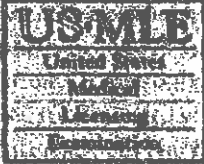
City NO CITY State \_\_\_\_\_ Zip 00000 0000

SSN/Tax-ID 109540891 Level I Specialty OBG

Related License Number HS 000240 L THOMAS JEFFERSON UNIVERSITY

Date Reported	Description	A/R/N	Comments
<u>00 / 00 / 0000</u>	<u>ECFMS</u>	-	-
<u>00 / 00 / 0000</u>	<u>EXAM SCORES</u>	-	-
<u>00 / 00 / 0000</u>	<u>UNREST LICENSE</u>	-	-
<u>05 / 05 / 2001</u>	<u>MEDICAL EDUCATION</u>	X	<u>HCP HANNEMANN 97/01 DIRECT</u>
<u>00 / 00 / 0000</u>	<u>OFFICIAL DOCUMENT/TRANS</u>	-	-

F3=Exit F10=Next



# 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.  
Federalist Plaza, PO Box 61928, Dallas, TX 75261-9998 - Telephone (817) 548-4041

Date: 11/13/2004

**Recipient:**

Pennsylvania State Board of Medicine  
ATTN: Cindy L. Warner, Administrator  
PO Box 2649  
Harrisburg, PA 17105-2649

**RECEIVED DIRECT**

**Examinee:** Gorlepy, Aileen  
**Alt Name(s):** Gorlepy, Aileen Maray

**Examinee ID#:** 4-011-675-1  
**Date of Birth:** [REDACTED]

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

Test Date	Pass/Fail	Three-Digit Score		Two-Digit Score		Comments
		Total	MP	Total	MP	
06/04/1990	Pass	207	170	84	75	

### USMLE STEP 2

Clinical Knowledge (CK)						
Test Date	Pass/Fail	Three-Digit Score		Two-Digit Score		Comments
		Total	MP	Total	MP	
08/24/2000	Pass	217	174	86	75	

### USMLE STEP 3

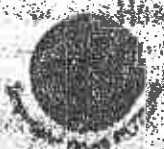
Test Date	Pass/Fail	Three-Digit Score		Two-Digit Score		Comments
		Total	MP	Total	MP	
03/23/2002	Pass	214	182	87	75	

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

RECEIVED

NOV 13 2004

Form 5030274



### Authenticity of USMLE Transcripts

An original, certified transcript of United States Medical Licensing Examination results is printed using black ink on blue safety paper and is produced only by the Educational Commission for Foreign Medical Graduates, Federation of State Medical Boards, or National Board of Medical Examiners. The Tamper Safe Histogram in the lower left corner certifies the authenticity of this document. Alteration or forgery of a USMLE transcript may result in appropriate legal action and/or a determination of irregular behavior, as described below.

To Test for Authenticity: Touch, rub or breathe on Tamper Safe Histogram and the word **VALID** will appear. When liquid bleach is applied to the face of the document, the paper will turn brown. Also, when photocopied, a security watermark containing the words **UNOFFICIAL COPY, NOT AN ORIGINAL DOCUMENT**, will appear prominently across the face of the entire document.

### 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. If a 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 CS updates, available at the USMLE website ([www.usmle.org](http://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 of 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 inconsistencies 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 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 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 of the individual physician, and the existence of such an action may be indicated on the USMLE transcript by a "Note."



**Alleen M. Garlsey, M.D.**

Philadelphia, Pennsylvania 19147

E-mail: [redacted]@hotmail.com

#### **EDUCATION**

**THOMAS JEFFERSON UNIVERSITY HOSPITAL** - Philadelphia, Pennsylvania  
Resident, Department of Obstetrics & Gynecology- Expected date of graduation June 2005

**MCP HAHNEMANN SCHOOL OF MEDICINE**- Philadelphia, Pennsylvania.  
Doctor of Medicine, May 2001

**CORNELL UNIVERSITY**- Ithaca, New York.  
Bachelor of Arts, Magna Cum Laude - Biology and Society, May 1996

#### **HONORS and AWARDS**

##### **RESIDENCY HONORS**

2004-2005 Chief Resident, Department of Obstetrics & Gynecology, Thomas Jefferson University Hospital  
Gold Foundation Humanism & Excellence in Teaching Award- selected by Jefferson Medical College Class of 2005  
CREOG Achievement Award, Thomas Jefferson University Hospital- 2003  
Excellency in Teaching awards

##### **MEDICAL SCHOOL HONORS**

1998-1999 Program for Integrated Learning Scholarship for student with highest GPA

##### **UNDERGRADUATE HONORS**

Quill and Dagger Senior Honor Society  
Cornell Tradition Senior Recognition Award, 1996  
Cornell Tradition Fellowship, 1992-1996  
Dean's List, Spring 1994, Fall 1994, Spring 1995

##### **EMPLOYMENT**

Research Associate - Northeast Regional Cancer Institute (NRCI), 1996-1997  
Student Coordinator, Volunteer Orientation Coordinator - Public Service Center, 1992-1996  
Student Extern - Ob-Gyn Consultants, Ltd., Summer 1995  
Research Assistant - Virginia Utermohlen, M.D., Cornell University, Summer 1994  
Counselor- Camp Archbald Girl Scout Camp and Boys & Girls Club of Scranton, Summers 1990-1993

##### **RESEARCH**

*Prior Cone Biopsy: Prediction of Preterm birth By Cervical Ultrasound*  
Poster presentation at the Society for Maternal Fetal Medicine, 2004  
Accepted for publication, *The American Journal of Obstetrics & Gynecology*, Fall 2004

*The Impact of Community Prostate Cancer Screening Programs*  
Advisor: Timothy Rebbeck, PhD, University of Pennsylvania

*Decision-Making in Obstetrics and Gynecology: Are Women Are Satisfied With the Amount of Control They Have*  
Cornell University Senior Honors Thesis, 1995-1996

##### **PUBLIC SERVICE**

Ex Officio Member- Philadelphia Family Planning Council, 2001-2001  
Co-Coordinator and Founding Member- Medical Students for Choice (MSFC) chapter, MCP-Hahnemann

School of Medicine, 1997-2001  
Co-President and Member- Physicians for Social Responsibility chapter, 1997-2001  
Co-President and Member- Cleveland/Williamson Society (Ob-Gyn Interest Group), 1997-2001  
Clinical Assistant -MCP Hahnemann School of Medicine Homeless Clinic, 1997-1999  
Director, Assistant Director and Team Leader- Into the Streets, Cornell University, 1992-1996

**PROFESSIONAL MEMBERSHIPS**

American College of Obstetrics and Gynecology, 1999-present  
American Medical Women's Association (AMWA), 1997-present  
American Medical Student Association, 1997-2001

**LANGUAGE**

Proficient in Spanish.

PO# 115 177

Regular Mailing Address  
State Board of Medicine  
P.O. Box 2649  
Harrisburg, PA 17105-2649  
717-783-1400  
717-787-2381

Courier Delivery Address  
State Board of Medicine  
124 Pine Street, 1st Floor  
Harrisburg, PA 17101

For ~~010400~~ 0096

MT 0497357

GARIE APPL

APPLICATION FOR A GRADUATE LICENSE  
FOR GRADUATES OF ACCREDITED MEDICAL SCHOOLS

THIS APPLICATION IS TO BE USED FOR INITIAL  
GRADUATE LICENSE - DO NOT USE TO RENEW

NOTE: A processing fee of \$20.00 will be charged for any check or money order returned unpaid by  
your bank, regardless of the reason for non-payment

FEES - \$15.00

Official Use Only

MAKE FEE PAYABLE TO COMMONWEALTH OF PENNSYLVANIA

FEES NOT REFUNDABLE

THIS APPLICATION MUST BE SUBMITTED AT LEAST  
60 DAYS PRIOR TO START OF TRAINING

Amount  
Date

15.00  
5/2/01

41-1037201

TO BE COMPLETED BY APPLICANT:

Please PRINT or type

NAME: Gariepy Aileen Maray  
LAST FIRST MIDDLE MAIDEN

ADDRESS: [REDACTED]  
STREET

Philadelphia PA 19129  
CITY STATE ZIP CODE

SOCIAL SECURITY # [REDACTED] DATE OF BIRTH [REDACTED] TELEPHONE (WORK) [REDACTED] (HOME) [REDACTED]  
MONTH/DATE/YEAR NUMBERS

NAME & ADDRESS OF MEDICAL SCHOOL HCP Hahnemann School of Medicine, 3100 Locust St, Philadelphia, PA 19104 DATES OF ATTENDANCE 8/1/97 DATE OF GRADUATION 5/18/01

NAME & ADDRESS OF HOSPITAL(S) [REDACTED] DATES OF PREVIOUS TRAINING [REDACTED] SPECIALTY [REDACTED]

TO BE COMPLETED BY HOSPITAL LOCATED IN PENNSYLVANIA:

NAME OF HOSPITAL Thomas Jefferson University Hospital HS # 000240-1

ADDRESS OF HOSPITAL 111 South 10th Street, Philadelphia, PA 19107-5096

TRAINING 1 SPECIALTY Obstetrics and Gynecology LEVEL IN TRAINING (pgy) 1

DATES OF TRAINING REQUESTED June 20, 2001 TO June 20, 2002  
BEGINNING DATE MONTH-DAY-YEAR ENDING DATE MONTH-DAY-YEAR

NAME OF PROGRAM DIRECTOR Debra A. Cifelli, Director, House Staff Affairs

SIGNATURE OF PROGRAM DIRECTOR Debra A. Cifelli

Answer the following questions. If "YES" is answered to any of them, provide complete details on a separate sheet as well as certified copies of relevant documents. Sign and date below.

	YES	NO
Do you hold a license to practice medicine and surgery (active or inactive, current or expired) in any state, territory or country? If "yes" list all states below	<input type="checkbox"/>	<input checked="" type="checkbox"/>
Have you withdrawn an application for a license, had an application for a license denied or refused, or agreed not to reapply for a license in another state, territory or country?	<input type="checkbox"/>	<input checked="" type="checkbox"/>
Has any disciplinary action been taken against your license in another state, territory or country?	<input type="checkbox"/>	<input checked="" type="checkbox"/>
Have you been convicted, found guilty, or pleaded guilty or nolo contendere, or received probation without verdict as to any felony or misdemeanor, including any drug law violation, in any state or federal court?	<input type="checkbox"/>	<input checked="" type="checkbox"/>
Have you had practice privileges denied, revoked or restricted in a hospital or other health care facility?	<input type="checkbox"/>	<input checked="" type="checkbox"/>
Have you had your DEA registration denied, revoked or restricted or have you had your provider privileges terminated by any medical assistance agency for cause?	<input type="checkbox"/>	<input checked="" type="checkbox"/>
Are you, or have you ever been, addicted to the intemperate use of alcohol or to the habitual use of narcotics or other habit-forming drugs? (NOTE: You may answer "NO" if you are currently a participant in or have successfully completed the requirements of the Board's Health Monitoring Program)	<input type="checkbox"/>	<input checked="" type="checkbox"/>

\*\*\*\*\*  
SIGNED STATEMENT

I verify that the statements in this application are true and correct to the best of my knowledge, information and belief. I understand that false statements are made subject to the penalties of 18 Pa. C.S. Section 4904 and that I am aware of the penalties of 18 Pa. C.S. Section 4904 for willful and knowing falsification to authorities and may result in the suspension or revocation of my license. 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 Pennsylvania State Board of Medicine any information, files or records requested by the Board.

Signature of Applicant   
Date 11/15/01

State Board of Medicine  
717-783-1400  
717-787-2381

4/1031/01  
18403 0396

**VERIFICATION OF MEDICAL EDUCATION**  
For Graduates of Accredited Medical Schools

						E	D	U	C

**SECTION 1: To be completed by applicant:**

Name: Janicoy Aileen Maray  
Last First Middle

Name of medical school: MCP Hahnemann School of Medicine

Location: Philadelphia, PA

**SUBMIT THIS VERIFICATION OF MEDICAL EDUCATION FORM TO YOUR MEDICAL SCHOOL AND REQUEST YOUR SCHOOL TO RETURN COMPLETED FORM DIRECTLY TO THE BOARD IN OFFICIAL SCHOOL ENVELOPE.**

**SECTION 2: To be completed by Dean or Registrar of medical school:**

Name of medical student: Aileen Maray Carney

Date student began to attend this medical school: August 1, 1997  
Month Day Year

Date of graduation: Anticipated date of graduation is May 15th 2001  
Month Day Year

[Seal of School]

I certify that all of the above information is correct.

Signature of Dean or Registrar: Jenice Simmons

Date: April 20, 2001

**Upon completion, school must return this completed form directly to the Pennsylvania State Board of Medicine in official school envelope. DO NOT RETURN TO APPLICANT.**

Regular Mailing Address  
State Board of Medicine  
P.O. Box 2649  
Harrisburg, PA 17105-2649 U.S.A.

Courier Delivery Address  
State Board of Medicine  
124 Pine Street, 1st Floor  
Harrisburg, PA 17101 U.S.A.

COMMONWEALTH OF PENNSYLVANIA  
DEPARTMENT OF STATE  
BUREAU OF PROFESSIONAL AND OCCUPATIONAL AFFAIRS  
STATE BOARD OF MEDICINE

511

MT049735T  
GARIEPY

**RENEWAL APPLICATION**

AILEEN GARIEPY  
THOMAS JEFFERSON UNIVERSITY  
HOUSE STAFF OFFICE  
111 SOUTH 11TH STREET  
SUITE 2170  
PHILADELPHIA PA 19107-6096

State Board of Medicine  
PO Box 2649  
Harrisburg, PA 17105-2649

**RECEIVED**

MAY 10 2004

Health Licensing Boards

I will not be participating in graduate training in Pennsylvania after the expiration date indicated below and request inactive status. No fee is required. QUESTIONS MUST STILL BE ANSWERED.

**THE FOLLOWING QUESTIONS MUST BE ANSWERED**

YES	NO	If YES to 2-8: provide details AND attach certified copies of legal document(s).
	X	1. Do you hold a license to practice this profession in any other state or jurisdiction? List:
	X	2. Since your initial application or your last renewal, have you had disciplinary action taken against your license in any state or jurisdiction?
	X	3. Since your initial application or your last renewal, have you withdrawn an application for a license, had an application for a license denied or refused, or agreed not to reapply for a license in any state or jurisdiction?
	X	4. Since your initial application or your last renewal, have you been convicted, found guilty or pleaded not contendere, or received probation without verdict as to any felony or misdemeanor, including any drug law violations, or any criminal charges pending and unresolved in any state or jurisdiction?
	X	5. Since May 19, 2002, have you been arrested for criminal homicide, aggravated assault, sexual offenses, or drug offenses in any state, territory, or country?
	X	6. Since your initial application or your last renewal, have you had practice privileges denied, revoked or restricted in a hospital or other health care facility?
	X	7. Since your initial application or your last renewal, have you had your DEA registration denied, revoked or restricted or have you had your provider privileges terminated by any medical assistance agency for cause?
	X	8. Since May 19, 2002, have any malpractice complaints been filed against you? If yes, the Board requires that you submit a copy of the <u>entire Civil Complaint</u> which must include the <u>filing date</u> and the <u>date you were served</u> .

Please review and update, as necessary, the following information regarding your license:

	Beginning Date	Ending Date	Level	Specialty	Hospital #	Hospital Name
Current	6/20/2003	6/19/2004	3	Obstetrics and Gynecology	HS000240L	THOMAS JEFFERSON UNIVERSITY
Renewal	7/1/04	6/30/05	4	" "	" "	" "

Signature of Licensee (Mandatory)

Date: 4/27/04

SSN: [REDACTED]

**ATTACHMENTS FOR RENEWING:**

- FEE - \$15.00 check payable to "COMMONWEALTH OF PENNSYLVANIA". Write your license number on your payment. A \$20.00 fee will be assessed for a returned payment.
- LATE FEE - \$5.00 per month, or part of a month. Late renewal fee will be assessed if postmarked after the expiration date.
- PGY 2 LEVEL - Copy of your USMLE Step 1 and 2 scores OR FLEX I scores OR National Board Part 1 and 2 scores OR an acceptable combination as indicated in the regulations.
- PGY 3 LEVEL or above - Copy of your USMLE Step 3 scores OR FLEX I and II scores OR National Board Parts 1-3 scores OR an acceptable combination as indicated in the regulations OR a copy of your unrestricted license WHICH SHOWS THE CURRENT EXPIRATION DATE.



# UNITED STATES MEDICAL LICENSING EXAMINATION™

Federation of State Medical Boards of the U.S., Inc.  
P.O. Box 619850, Dallas, Texas 75261-9850  
Telephone: (817) 571-2849

## STEP 3 SCORE REPORT

RECEIVED

MAY 10 2004

Gariepy, Aileen M

Test Date: May 23, 2004

USMLE ID: 5-051-625-1

The USMLE is a single examination program for all applicants for medical licensure in the United States; it replaced the Federation Licensing Examination (FLEX) and the certifying examinations of the National Board of Medical Examiners (NBME Parts I, II and III). The program consists of three Steps designed to assess an examinee's understanding of and ability to apply concepts and principles that are important in health and disease and that constitute the basis of safe and effective patient care. Step 3 is designed to assess whether an examinee possesses the medical knowledge and understanding of clinical science considered essential for the unsupervised practice of medicine, with an emphasis on patient management in ambulatory-care settings. Results of the examination are reported to medical licensing authorities in the United States and its territories for use in granting an initial license to practice medicine. The two numeric scores shown below are equivalent; each state or territory may use either score in making licensing decisions. These scores represent your results for the administration of Step 3 on the test date shown above.

**PASS**

This result is based on the minimum passing score recommended by USMLE for Step 3. Individual licensing authorities may accept the USMLE-recommended pass/fail result or may establish a different passing score for their own jurisdictions.

**214**

This score is determined by your overall performance on Step 3. For recent administrations, the mean and standard deviation for first-time examinees from U.S. and Canadian medical schools were approximately 210 and 19, respectively, with most scores falling between 140 and 260. A score of 182 is recommended by USMLE to pass Step 3. The standard error of measurement (SEM)<sup>1</sup> for this scale is approximately seven points.

**87**

This score is also determined by your overall performance on the examination. A score of 75 on this scale, which is equivalent to a score of 182 on the scale described above, is recommended by USMLE to pass Step 3. The SEM<sup>1</sup> for this scale is approximately two points.

<sup>1</sup>Your score is influenced both by your general understanding of clinical medicine and by the specific set of items selected for this Step 3 examination. The Standard Error of Measurement (SEM) provides an index of the variation in scores that would be expected to occur if an examinee were tested repeatedly using different sets of items covering similar content.

COMMONWEALTH OF PENNSYLVANIA  
DEPARTMENT OF STATE  
BUREAU OF PROFESSIONAL AND OCCUPATIONAL AFFAIRS  
STATE BOARD OF MEDICINE

2383

MTOMD705T  
GARIEPY

RENEWAL APPLICATION

AILEEN GARIEPY  
THOMAS JEFFERSON UNIVERSITY  
HOUSE STAFF OFFICE  
111 SOUTH 11TH STREET  
SUITE 2170  
PHILADELPHIA PA 19107-5096

State Board of Medicine  
PO Box 2649  
Harrisburg, PA 17105-2649

RECEIVED  
MAY 19 2004

I will not be participating in graduate training in Pennsylvania after the expiration date indicated below and request license status. No fee is required. QUESTIONS MUST STILL BE ANSWERED

THE FOLLOWING QUESTIONS MUST BE ANSWERED

YES	NO	IF YES to 2-8 - provide details AND attach certified copies of legal document(s)
	X	1. Do you hold a license to practice this profession in any other state or jurisdiction? List:
	X	2. Since your initial application or your last renewal, have you had disciplinary orders taken or imposed on your license in any state or jurisdiction?
	X	3. Since your initial application or your last renewal, have you withdrawn an application for a license, had an application for a license denied or refused, or agreed not to apply for a license in any state or jurisdiction?
	X	4. Since your initial application or your last renewal, have you been convicted, found guilty or pleaded guilty, contended to, or received prohibition without verdict in any felony or misdemeanor involving any of the following violations or any criminal charges pending and unresolved in any state or jurisdiction?
	X	5. Since May 19, 2002, have you been arrested for criminal homicide, aggravated assault, sexual offenses, or drug offenses in any state, territory, or country?
	X	6. Since your initial application or your last renewal, have you had practice privileges denied, restricted or restricted in a hospital or other health care facility?
	X	7. Since your initial application or your last renewal, have you had your DE registration denied, restricted or restricted or have you had your provider privileges withdrawn by any medical association, agency, or court?
	X	8. Since May 19, 2002, have any malpractice complaints been filed against you? If yes, the Board requires that you submit a copy of the entire Civil Complaint which must include the filing date and the date you were served.

Please review and update, as necessary, the following information regarding your license:

	Beginning Date	Ending Date	Level	Specialty	Hospital #	Hospital Name
Current	07/01/2004	08/30/2005	1	Obstetrics and Gynecology	1150012401	THOMAS JEFFERSON UNIVERSITY
Renewal						

Signature of Licensee (Mandatory)

SSN:

Date 5/3/04

ATTACHMENTS FOR RENEWING:

- FEE - \$15.00 check payable to "COMMONWEALTH OF PENNSYLVANIA" with year received number on back and amount of \$15.00 for which assessed for a returned payment.
- LATE FEE - \$5.00 per month, or part of a month. Late renewal fee will be assessed if not received after the expiration date.
- PGY 2 LEVEL - Copy of your USMLE Step 1 and 2 scores OR PLE x 1 scores OR National Board Part 1 and 2 scores OR any combination as indicated in the regulations.
- PGY 3 LEVEL or above - Copy of your USMLE Step 1, 2, and 3 scores OR PLE x 1 and 2 scores OR National Board Part 1, 2, and 3 scores OR any combination as indicated in the regulations OR a copy of your institutional license. NO LATE FEE FOR LATE RECEIPT OF DOCUMENTS.



COMMONWEALTH OF PENNSYLVANIA  
DEPARTMENT OF STATE  
BUREAU OF PROFESSIONAL AND OCCUPATIONAL AFFAIRS  
STATE BOARD OF MEDICINE

MT049735T  
GARIEPY

### RENEWAL APPLICATION

AILEEN GARIEPY  
THOMAS JEFFERSON UNIVERSITY  
HOUSE STAFF OFFICE  
111 SOUTH 11TH STREET  
SUITE 2170  
PHILADELPHIA PA 19107-5086

State Board of Medicine  
PO Box 2649  
Harrisburg, PA 17105-2649

I will not be participating in graduate training in Pennsylvania after the expiration date indicated below and request inactive status. No fee is required. QUESTIONS MUST STILL BE ANSWERED.

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	X	4. Since your initial application or your last renewal, have you been convicted, found guilty or pleaded nolo contendere, or received probation without verdict as to any felony or misdemeanor, including any drug law violations, or any criminal charges pending and unresolved in any state or jurisdiction?
	X	5. Since May 19, 2002, have you been arrested for criminal homicide, aggravated assault, sexual offenses, or drug offenses in any state, territory, or country?
	X	6. Since your initial application or your last renewal, have you had practice privileges denied, revoked or restricted in a hospital or other health care facility?
	X	7. Since your initial application or your last renewal, have you had your DEA registration denied, revoked or restricted or have you had your provider privileges terminated by any medical assistance agency for cause?
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Please review and update, as necessary, the following information regarding your license:

	Beginning Date	Ending Date	Level	Specialty	Hospital #	Hospital Name
Current	06/20/2002	06/19/2003	2	Obstetrics and Gynecology	HS000240L	THOMAS JEFFERSON UNIVERSITY
Renewal	6/20/03	6/19/04	3	" "	HS000240L	TJU

Signature of Licensee (Mandatory):

Date: 5/5/05

SSN:

#### ATTACHMENTS FOR RENEWING:

- **FEE** - \$15.00 check payable to "COMMONWEALTH OF PENNSYLVANIA". Write your license number on your payment. A \$20.00 fee will be assessed for a returned payment.
- **LATE FEE** - \$5.00 per month, or part of a month. Late renewal fee will be assessed if postmarked after the expiration date.
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# UNITED STATES MEDICAL LICENSING EXAMINATION™

Federation of State Medical Boards of the U.S., Inc.  
P.O. Box 619850, Dallas, Texas 75261-9850  
Telephone: (817) 571-2949

## STEP 3 SCORE REPORT

**Garlepy, Aileen M**

**Test Date: May 23, 2002**

**USMLE ID: 5-051-625-1**

The USMLE is a single examination program for all applicants for medical licensure in the United States. It replaced the Federation Licensing Examination (FLEX) and the certifying examinations of the National Board of Medical Examiners (NBME Parts I, II and III). The program consists of three Steps designed to assess an examinee's understanding of and ability to apply concepts and principles that are important in health and disease and that constitute the basis of safe and effective patient care. Step 3 is designed to assess whether an examinee possesses the medical knowledge and understanding of clinical science considered essential for the unsupervised practice of medicine, with an emphasis on patient management in ambulatory-care settings. Results of the examination are reported to medical licensing authorities in the United States and its territories for use in granting an initial license to practice medicine. The two numeric scores shown below are equivalent; each state or territory may use either score in making licensing decisions. These scores represent your results for the administration of Step 3 on the test date shown above.

**PASS**

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This score is determined by your overall performance on Step 3. For recent administrations, the mean and standard deviation for first-time examinees from U.S. and Canadian medical schools were approximately 210 and 19, respectively, with most scores falling between 140 and 260. A score of 182 is recommended by USMLE to pass Step 3. The standard error of measurement (SEM)<sup>1</sup> for this scale is approximately seven points.

**87**

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<sup>1</sup>Your score is influenced both by your general understanding of clinical medicine and by the specific set of items selected for this Step 3 examination. The Standard Error of Measurement (SEM) provides an index of the variation in scores that would be expected to occur if an examinee were tested repeatedly using different sets of items covering a similar content.