THE NEW MEXICO MEDICAL SOCIETY

NMHHSA
New Mexico Hospitals & Health Systems Association

5924 $ 284.00

926578
SEP 06 2007
926579

The New Mexico Statewide Application for Physician/Practitioner Appointment©

Physician (MD) Application
(Applying thru FCVS)

Date of Application: 8/22/07

Fees: $250.00 - Application Fee
34.00 - BackGround Check
Total: $284.00 to NM Medical Board

Demographics

Name	TAYLOR (Last)	BETSY (First)	JEAN (Middle)
Other Names Used	N/A		

Will you be applying by endorsement Yes ____ No X EXAMINATION
(See page 2 for requirements)

Are you requesting to be credentialed as a PCP if Family Practice, Internal Medicine, or Pediatrics?		Yes ____ No X	
Gender M (F) **Citizenship**	USA	**Place of Birth**	Stillwater, OK
Immigration Status	N/A	**Certification #**	—
***Social Security Number**	[redacted]	**Date of Birth**	[redacted] 1973
***NM Tax ID#**	N/A	Pending	[X]
***Fed. Tax ID#**	N/A	Pending	[ ]
Practice Name	University of New Mexico Department of Obstetrics and Gynecology		
Practice Limited to: (Clinical Specialty)	Obstetrics & Gynecology		
Street	MSC 10 5580 1 University of New Mexico		
City	Albuquerque State NM	Zip Code	87131-0001
Telephone Number	505-272-4155	Facsimile	505-272-3918
Answering Service		Effective Date	~~2/1/08~~ January 2008
Foreign Languages (spoken fluently by practitioner)	N/A		
Foreign Languages (spoken fluently at Practice)			
*** E-Mail Address** (confidential)	[redacted]@nc.rr.com		
***Current Mailing Address** (if different from above -confidential unless no practice address indicated)			
*Street	[redacted] CT.		
*City	[redacted] State NC	*Zip Code	27617
Telephone Number	[redacted]	Facsimile	N/A
Answering Service	N/A	Effective Date	
*CLIA Number (if applicable) N/A	Approval Level	Expiration Date	
*Office Manager or Contact Person	Theresa Everling (UNM)		

* Information Confidential

Billing Address (if different from above)					
Street					
City		State		Zip Code	
Telephone Number		Facsimile			
Answering Service		Effective Date			
Billing Manager or Contact Person	SEP 0 6 2007				
***Home Address**	[redacted]				
*Street	8[redacted]				
*City	R[redacted]				

Practice Associates	**Call Coverage** (if different)
Department of Obstetrics + Gynecology	
Division of Gynecology	
(UNM)	

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

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

Undergraduate Education						
College or University	Oklahoma Baptist University					
City	Shawnee		State/Country	OK	Zip Code:	74804
Dates Attended	**From:** 8/1993	**To:** 6/1997	Degree	BS	Graduation Date	6/1997
Graduate Education						
College or University						
City			State/Country		Zip Code:	
Dates Attended	**From:**	**To:**	Degree		Graduation Date	
Post-Graduate Education						
College or University						
City			State/Country		Zip Code:	
Dates Attended	**From:**	**To:**	Degree		Graduation Date	
Professional / Medical Education						
College or University	University of Oklahoma College of Medicine					
City	Oklahoma City		State/Country	OK	Zip Code:	73104
Dates Attended	**From:** 8/1997	**To:** 6/2001	Degree	MD	Graduation Date	6/2001
Other Professional Education						
College or University						
City			State/Country		Zip Code:	
Dates Attended	**From:**	**To:**	Degree		Graduation Date	

Internship	[X] Not Applicable				
Institution Name					SEP 0 6 2007
City		State/Country		Zip Code:	
Dates Attended	From:	To:	Field		
Residency/Fellowship	[ ] Not Applicable				
(1) Institution Name	University of Oklahoma ~~HSC~~ Health Science Center				
City	Oklahoma City	State/County	OK	Zip Code	73104
Dates Attended	From: 7/2001	To: 6/2005	Field	Obstetrics / Gynecology	
(2) Institution Name					
City		State/Country		Zip Code:	
Dates Attended	From:	To:	Field		
(3) Institution Name					
City		State/Country		Zip Code:	
Dates Attended	From:	To:	Field		

Work History

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

Location	Women's Healthcare of Raleigh	From	7/2005	To	7/2007
Street	2709 Blue Ridge Rd, Ste 290	Phone Number	(919) 782-5678		
City	Raleigh	State	NC	Zip Code	27607
Type of Practice	OBStetrics / Gynecology	Contact Person	N/A		
Type of Discharge	N/A	Rank Achieved	N/A		
Location		From		To	
Street		Phone Number			
City		State		Zip Code	
Type of Practice		Contact Person			
Type of Discharge		Rank Achieved			
Location		From		To	
Street		Phone Number			
City		State		Zip Code	
Type of Practice		Contact Person			
Type of Discharge		Rank Achieved			
Location		From		To	
Street		Phone Number			
City		State		Zip Code	
Type of Practice		Contact Person			
Type of Discharge		Rank Achieved			

Hospital and Healthcare Affiliations (other than postgraduate training) [ ] N/A

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

(1) Current Primary Admitting Facility (Hospital Name)	Rex ~~Hospital~~ Healthcare				
Street	4420 Lake Boone Trail				
City	Raleigh	State	NC	Zip Code	27607
Telephone Number	(919) 784-3100	Facsimile	N/A		
Appointment Dates	From: 7/2005	To: 7/2007			
Type of Appointment	Attending Physician				
Privileges Assigned	FULL PRIVILEGES - Admission, OR, Labor + Delivery				

(2) Facility Name					
Street					
City		State		Zip Code	
Telephone Number		Facsimile			
Appointment Dates	From:	To:			
Type of Appointment					
Privileges Assigned					

SEP 0 6 2007

(3) Facility Name					
Street					
City		State		Zip Code	
Telephone Number		Facsimile			
Appointment Dates	From:	To:			
Type of Appointment					
Privileges Assigned					

(4) Facility Name					
Street					
City		State		Zip Code	
Telephone Number		Facsimile			
Appointment Dates	From:	To:			
Type of Appointment					
Privileges Assigned					

(5) Facility Name					
Street					
City		State		ZIP Code	
Telephone Number		Facsimile			
Appointment Dates	From:	To:			
Type of Appointment					
Privileges Assigned					

(6) Facility Name					
Street					
City		State		Zip Code	
Telephone Number		Facsimile			
Appointment Dates	From:	To:			
Type of Appointment					
Privileges Assigned					

Professional References Please list three professional peers familiar with your professional performance in the past 5 years, (not including current or impending partners or associates in practice).

(1) Name and Title	Robert Mannel, M.D. - Department Chairman				
Address	Dept of OB/GYN - OUHSC P.O. Box 26901				
City	Oklahoma City	State	OK	Zip Code	73190
Telephone Number	(405) 271-8787	Facsimile	(405) 271-3490		
(2) Name and Title	Elisa Crouse, M.D. - Residency Director				
Address	Dept of OB/GYN - OUHSC P.O. Box 26901				
City	Oklahoma City	State	OK	Zip Code	73190
Telephone Number	(405) 271-8787	Facsimile	(405) 271-3490		
(3) Name and Title	Ruth Wind, M.D.				
Address	4414 Lake Boone Trail, Ste 300				
City	Raleigh	State	NC	Zip Code	27607
Telephone Number	(~~919~~) 804-986-1009 (cell)	Facsimile	(919) 781-5053		

Licensure-Registration-Certification Information

SEP 06 2007

ECFMG Number (if applicable)							
State Professional License/Certification Number				2005 - 00994			
State	NC	Issue Date	6/15/2005	Expiration Date	11/14/2007	Pending	☐

All Other State License Numbers (regardless of status - attach separate list if necessary.)

State	Number	Issue Year	Expiration Date
OK	22478	2002	7/1/2008

*Federal Drug Enforcement Admin. (DEA) Registration				N/A ☐
Number	[redacted]	Exp. Date	11/30/2008	Pending ☐
*State Controlled Substance Registration (CSR)				N/A ☒
Number	State		Exp. Date	Pending ☐
*Medicare Unique Physician Identification Number (UPIN)				I44497
Pending ☐				
*State Medicaid Provider Number				
Pending ☒				

Specialty Board Certifications ☐N/A

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

Certified/Recertified by the:					
1.					
Date Certified		Date Last Recertified		Expiration Date	
2.					
Date Certified		Date Last Recertified		Expiration Date	
3.					
Date Certified		Date Last Recertified		Expiration Date	
Accepted for Examination by the:	American Board of Obstetrics + Gynecology				
Until (expiration date)	1/2008	If not accepted, have you made application?		Yes No	

Certified/Recertified by the Subspecialty Board of					
1.					
Date Certified		Date Last Recertified		Expiration Date	
2.					
Date Certified		Date Last Recertified		Expiration Date	
Accepted for Examination by the Subspecialty Board of					

Professional Liability Insurance (confidential information)

Do you have current liability insurance? ☒ Yes ☐ No

(Please list liability insurance carriers for the past 5 years.) See attachment for additional info.

Current Carrier	MAG MUTUAL		Current ☒	Pending ☐
Address	P.O. Box 52979 Atlanta, GA 30355-0979			
Dates Insured	From 6/1/07	To PRESENT	Policy # / Coverage Limits	[redacted]
Carrier	MAG MUTUAL			
Address	P.O. Box 52979 Atlanta, GA 30355-0979			
Dates Insured	From 7/11/2005	To 6/1/2007	Policy # / Coverage Limits	[redacted]

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

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Question	Yes	No
1. Has your professional liability coverage ever been terminated by action of the insurance company?	Yes ☐	No ☒
2. Have you ever been denied professional liability insurance coverage?	Yes ☐	No ☒
3. Has your professional liability carrier ever excluded any specific procedures from your coverage?	Yes ☐	No ☒
4. Have you ever been denied membership or renewal thereof, or been subject to disciplinary action in any professional organization?	Yes ☐	No ☒
5. Have you ever been excluded from or sanctioned by Medicare and/or Medicaid?	Yes ☐	No ☒
6. Have you ever been charged with, arrested for, convicted of, or pled no contest to a misdemeanor or felony, or have you ever been named as a defendant in any criminal proceedings or subject to investigation by a governmental entity that could result in sanctions or licensure adverse actions?	Yes ☐	No ☒
7. Have you ever been named in any formal requests for corrective actions filed by any healthcare entity where you have had an appointment (a request which could result in either formal or informal proceedings).	Yes ☐	No ☒
8. Have your privileges at any healthcare entity ever been voluntarily or involuntarily suspended, restricted, diminished, revoked or not renewed, except for medical records?	Yes ☐	No ☒
9. Have you ever resigned from a healthcare entity to avoid modification, suspension, or termination of privileges?	Yes ☐	No ☒
10. Has your application for licensure or license to practice in any jurisdiction ever been investigated, voluntarily or involuntarily limited, suspended, revoked, denied or are any currently held licenses pending investigation or being challenged?	Yes ☐	No ☒
11. Have you ever been notified to appear before any licensing agency for a hearing or complaint of any nature?	Yes ☐	No ☒
12. Has your federal or state narcotics registration certificate in any jurisdiction ever been voluntarily or involuntarily limited (stipulations), suspended, revoked, restricted, or are there currently challenges to any of these items?	Yes ☐	No ☒
13. Have you ever been involved in a settlement, medical malpractice claim or suit, or have you ever received written notice of intent to file such a suit? If yes, please provide the following information for each claim or suit. Please type on a separate sheet of paper for each case. • Name, age, sex of patient/claimant. • Date(s) and type of treatment and/or surgery, which led to the allegations against you. • Nature of allegations in claims/suits. Specify whether a suit was ever filed. • Names of other practitioners and hospital, if any, involved in claims or suit. • Disposition or current status of claim or suit (be specific) • Name of insurance carrier defending you. • Name of defense attorney.	Yes ☐	No ☒
14. Do you know of any reason why you cannot perform the essential duties of the clinical privileges/functions for which you are requesting with or without a reasonable accommodation according to acceptable standards of professional performance and without posing a direct threat to patients?	Yes ☐	No ☒
15. Do you use illegal drugs or have you illegally used drugs in the past five years?	Yes ☐	No ☒

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

New Mexico Medical Board
2055 S. Pacheco St. Bldg. 400
Santa Fe, NM 87505 (505) 476-7220
Revised 6/07

SEP 0 6 2007

Licensing Exam: Please check all that apply:

☐ **State Board Exam** Which state? __________ Date(s) passed?__________

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

Part/Step 1 Date Passed 6/1999 (Month/Year) Part/Step 2 Date Passed 12/2000 (Month/Year) Part/Step 3 Date Passed 6/2002 (Month/Year)

PLEASE PROVIDE A WRITTEN EXPLANATION OF ANY "YES" ANSWERS

1. Have you been treated for mental or significant physical illness during the past five (5) years? **If yes, please have your treating physician send the NM Medical Board with a letter regarding your diagnosis and treatment.** [redacted]
2. Have you had personal or legal problems with narcotics, alcohol or other dangerous drugs during the past five (5) years? **You may answer "no" if you are a voluntary participant in a board approved monitoring program.** [redacted]
3. Have you ever:
   a) Resigned from a medical school or postgraduate training (PGT) program? ☐ Yes ☒ No
   b) Withdrawn from a medical school or postgraduate training program? ☐ Yes ☒ No
   c) Been suspended, dismissed, or expelled from a medical school or PGT program? ☐ Yes ☒ No
   d) Been placed on probation or remediation, including academic probation or remediation, by a medical school or PGT program? ☐ Yes ☒ No
   e) Taken a leave of absence or break from, or had any interruptions or extensions in, a medical school or PGT program for any reason, personal or professional (include illness, pregnancy, academic, etc)? ☐ Yes ☒ No

APPLICANT'S OATH

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

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

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

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

[signature] 8/22/07
Applicant Signature Date

RE: Specialty Board Certifications

I successfully completed my written boards administered by the American Board of Obstetrics and Gynecology in June 2005. I have been accepted to take my oral boards in November 2007. I should be notified of successful completion 1-2 months after the orals.

BA

SEP 06 2007

RE: Professional Liability Insurance

My insurance carrier during residency is as follows:
Medical Protective Co.
14241 Dallas Parkway
Suite 300
Dallas, TX 75254
Policy #[redacted]
Effective dates: 7/1/01 to 7/1/05
Coverage limits: [redacted]

SEP 06 2007

AMA Physician Profile

Name and Mailing Address:

BETSY JEAN TAYLOR MD

Primary Office Address:

SAME AS MAILING ADDRESS

Phone: UNKNOWN

Birthdate: /1973
Birthplace: STILLWATER, OK UNITED STATES OF AMERICA

Physician's Major Professional Activity: OFFICE BASED PRACTICE

Practice Specialties Self Designated by the Physician*:

Primary Specialty: OBSTETRICS & GYNECOLOGY

Secondary Specialty: UNSPECIFIED

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

AMA membership: NON MEMBER

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

Current and/or Historical Medical School:

UNIV OF OK COLL OF MED, OKLAHOMA CITY OK 73190

Degree Awarded: Yes

Degree Year: 2001

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AMA Physician Profile

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

Future training dates, as reported by the program, should be interpreted as "in progress" or "current" with projected date of completion. If the training program indicates that training for a physician in a particular specialty was not completed at their institution the training segment will be identified as "INCOMPLETE TRAINING".

Institution: UNIV OF OK COLL OF MED
Specialty : OBSTETRICS & GYNECOLOGY

State: OKLAHOMA
07/2001 - 06/2005
(VERIFIED)

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

Current and/or Historical Medical Licensure:

Jurisdiction	MD/ DO	Date Granted	Expiration Date	Status	License Type	Last Reported
NORTH CAROLINA	MD	06/15/2005	NOT RPTD	ACTIVE	UNLIMITED	08/08/2007
OKLAHOMA	MD	07/16/2002	07/01/2008	ACTIVE	UNLIMITED	08/03/2007

Note: When the specific month and day are unknown, the date will display the default value of "01." Not all licensing boards maintain or provide full date values. Please contact the appropriate licensing board directly for this information.

ECFMG Certfication:

Applicant Number:

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

Federal Drug Enforcement Administration:

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

DEA Number *	Schedule	Expiration Date	Last Reported
XXXXXX366	22N 33N 4 5	11/30/2008	08/13/2007

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

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AMA Physician Profile

Specialty Board Certification(s)*:

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

The AMA Physician Profile has been designated by the ABMS as an Official ABMS Display Agent of Member Board Certification data. Therefore, the ABMS Board Certification information on the AMA Physician Profile is considered a designated equivalent source in regard to credentialing standards set forth by accrediting bodies such as the Joint Commission and National Committee for Quality Assurance (NCQA).

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

Certificate:

Certificate Type:

Duration	Effective	Expiration	Occurrence	Last Reported

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

***This information is proprietary data maintained in a copyrighted database compilation owned by the American Board of Medical Specialties. Copyright 2007 American Board of Medical Specialties. All right reserved.**

Medicare/Medicaid Sanction(s):

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

Other Federal Sanction(s):

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

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AMA Physician Profile

Additional Information:

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

The content of the AMA Physician Profile is intended to assist with credentialing. Appropriate use of the AMA Physician Masterfile data contained on this Profile by an organization would meet the primary source verification requirements of the Joint Commission and the American Accreditation HealthCare Commission/URAC. The Physician Masterfile meets the National Committee for Quality Assurance (NCQA) standards for verification of medical education, post graduate medical training, board certification, DEA status, and Medicare/Medicaid sanctions.

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

Division of Database Products and Licensing
Attn: Credentialing Products
515 N. State Street
Chicago, IL 60610
800- 665-2882
312 464-5900 (fax)

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

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Betsy Jean Taylor, MD

Licensed Physician #MD2007-0721

Issue Date	Expiration Date
11/07/2007	07/01/2008
Signature of Holder	

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

New Mexico Medical Board

Triennial Renewal Certificate

This is to certify that

Betsy Jean Taylor, MD

License Number: MD2007-0721

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

Issue Date: 11/07/2007 Date Expires: 07/01/2008

This License Must Be Conspicuously Posted In Each Practice Location

NORTH CAROLINA MEDICAL BOARD

H. Arthur McCulloch. MD
President

Janelle A. Rhyne. MD
President-Elect

George L Saunders III. MD
Secretary

Ralph C Loomis MD
Treasurer

2007

New Mexico Medical Board
2055 S. Pacheco Street
Building 400
Santa Fe, NM 87505

LICENSE VERIFICATION FORM

DATE: **September 05, 2007**

TO WHOM IT MAY CONCERN:

This is to verify that the practitioner noted below was issued a North Carolina Carolina License A review of the files indicate the following information:

Name: Betsy Jean Taylor
Address: Women's Healthcare of Raleigh
2709 Blue Ridge Rd Ste 290
Raleigh, NC 27607

Annual Renewal Date: November 14 2007
Public File: No

License Number	License Type	Issue Date	Current Status	Expire Date
2005-00994	MD	06/15/2005	Active	
0090-00288	MD,Temporary	06/08/2005	Inactive	06/15/2005

Sincerely,

R. David Henderson

R David Henderson
Executive Director

R David Henderson
Executive Director

1203 Front Street
Raleigh. North Carolina 27609-7533

Mailing:
P.O. Box 20007
Raleigh North Carolina 27619-0007

Telephone: (919) 326-1100
Fax: (919) 326-1131
Email: info@ncmedboard.org
Web: www.ncmedboard.org

Board of Medical Licensure & Supervision
State of Oklahoma

5104 N Francis Ave Suite C
Oklahoma City Oklahoma 73118-6087

P O Box 18256
Oklahoma City Oklahoma 73154-0256

Letter of Verification
September 01, 2007

This is to certify that the records of this Board indicate on the date of this letter the following information regarding:

Name:	BETSY J TAYLOR
Address Date:	June 12, 2007
Address 1:	WOMENS HEALTHCARE OF RALEIGH PA
Address 2:	2709 BLUE RIDGE ROAD
Address 3:	SUITE 290
City, State, ZIP:	RALEIGH, NC 27607

Profession:	MEDICAL DOCTOR
Profession Type:	MD
License Number:	22478
License Date:	07/16/2002
Status:	Active
Status Class:	
Expiration Date:	07/01/2008
Endorsed By:	USMLE
Restricted To:	

Previous Licenses:

Type	Issued	Expired
Training	07/01/2001	09/29/2002

Disciplinary Actions:

Date	Description
	No Disciplinary Actions Taken

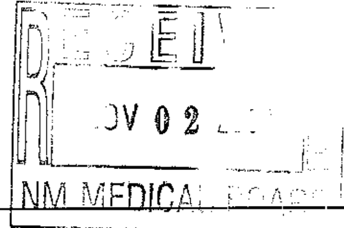
Details of Disciplinary Action if applicable, will be made available by photocopy from the public file upon written request only

To expedite the verification of licensure/certification process the above is the standard format for all professions regulated by this board

The Oklahoma State Board of Medical Licensure and Supervision certifies that the verification data displayed here is accurate according to the information stored in our database as of 09/01/2007.

Robyn Hall
Director of Licensing
(405) 848-6841 ext 113

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



WORK EXPERIENCE VERIFICATION

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

Betsy Taylor
Applicant Name

Applicant Signature

July 2005 – June 2007
*Dat[redacted]/yy (must be provided)

Tele

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

Jack R Inge MD
Type or Print Name of person completing this form

Senior partner
Title

Women Health care of Raleigh
Name of Institution

2700 Blue Ridge Rd Suite 290
Address

Raleigh NC 27607
City / State / Zip

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

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

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

Jack R Inge MD — [signature] — 10/30/07
Printed name of person completing this form — Signature — Date

No Notary Seal available
Signature of Notary (if applicable) — Date

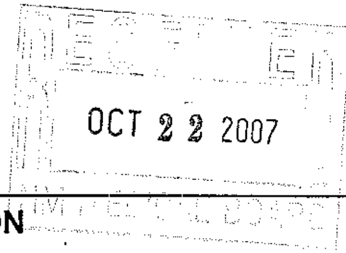
My commission expires: ____________

Please affix hospital or notary seal here

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

Revised 10/04

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



WORK EXPERIENCE VERIFICATION

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

Betsy Taylor
Applicant Name

[redacted]
City/State/Zip

Betsy Taylor
Applicant Signature

8/2005 – 7/2007
*Dates of Privilege/Employment mm/yy to mm/yy (must be provided)

Telep[redacted]

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

Wells Edmundson, MD
Type or Print Name of person completing this form

President, Medical Staff
Title

Rex Hospital
Name of Institution

4420 Lake Boone Trail
Address

Raleigh, NC 27607
City / State / Zip

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

***If not, please provide correct dates**: Beginning 7/2005 (Month/Year) Ending 6/2007 (Month/Year)

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

(President, Medical Staff)

Wells Edmundson, MD — Wells Edmundson — 10.17.07
Printed name of person completing this form — Signature — Date

Cynthia B Fadoul — 10/17/07
Signature of Notary (if applicable) — Date

Please affix hospital or notary seal here

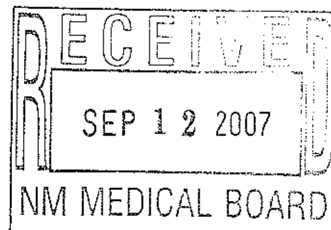
My commission expires: April 2, 2011

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

Revised 10/04

The Federation of State Medical Boards of the United States, Inc
Federation Credentials Verification Service
P O. Box 619850
Dallas, Texas 75261-9850
Telephone: (817) 868-4000
Fax: (817) 868-4099

Physician Information Profile



This report is compiled exclusively for:

Name: **Betsy Jean Taylor**
SSN: [redacted]
DOB: [redacted]
Packet ID: 77815
Recipient: **New Mexico Medical Board**

NOTICE:

The Federation Credentials Verification Service (FCVS) was retained by the above referenced physician to verify his/her medical credentials for submission to your agency/organization. Unless noted otherwise, all documents contained in this report were received directly from the issuing institution per written request made by FCVS. All documents bearing the official FCVS seal are ceritified to be an exact reproduction of the original. Where required, original documents are provided according to the agreements with the institution issuing such document. FCVS maintains all original documents (excluding third-party examination transcripts) in the physician's source file.

Physician Information Profile is compiled and published by the Federation of State Medical Boards of the United States, Inc as a reference source for its member boards and other authorized entities. Physician Information Profile may not be republished, sold, resold or duplicated, in whole or in part, for commercial or any other purposes, or for purposes of compiling lists or files without the express written consent of the Federation's Executive Vice President as authorized by its Board Of Directors. The use of this Physician Information Profile to establish independent data files or compendiums or information is strictly prohibited.

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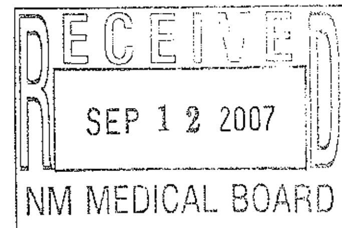
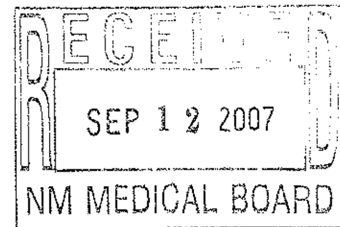




Section I

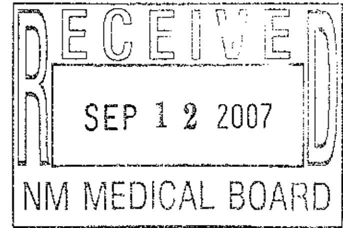
FCVS Reports

FEDERATION CREDENTIALS VERIFICATION SERVICE

Physician Information Report

Identity:

Name:	**Betsy Jean Taylor**
Other Name Used:	**N/A**
Gender:	**Female**
Date of Birth:	**973**
Place of Birth:	**Stillwater, OK USA**
SSN:	
Current Address:	
Permanent Address:	**Same**



Telephone Numbers:	Bus:	
	Fax:	**N/A**
	Home:	
	Other:	**N/A**
Physical Description:	Height:	**5' 08"**
	Weight:	**150 lbs**
	Eye Color:	**Blue**
	Hair Color:	**Brown**
Physical Marks:	Description:	**N/A**
	Location:	**N/A**

Premedical Education (Reported by physician Not verified by FCVS)**:**

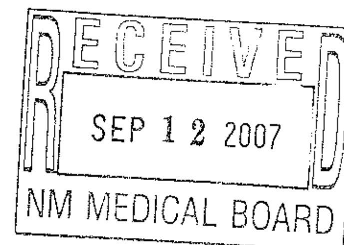
Institution:	**Oklahoma Baptist University, Shawnee, OK**
Dates of Attendance:	**08/1993 - 06/1997**
Degree Conferred/Issued:	**Bachelor of Science**

Medical Education:

Medical School:	**University of Oklahoma Health Science Center** **PO Box 26901 SU306A** **Oklahoma City, OK 73190-3040**
Dates of Attendance:	**08/25/1997 - 05/25/2001**
Date Degree Conferred/Issued:	**06/03/2001**
Degree Conferred/Issued:	**Doctor of Medicine**
Unusual Circumstance:	**None**

Post Graduate Medical Education:

Institution:	**University of Oklahoma Health Sciences Center** **Department of Obstetrics & Gynecology** **PO Box 26901** **Oklahoma City, OK 73190**
Post Graduate Year:	**1**
Program Type:	**Internship**
Department:	**Obstetrics and Gynecology**
Dates of Attendance:	**07/01/2001 - 06/30/2002**
Completion:	**Yes**
Accreditation:	**ACGME**
Post Graduate Year:	**2-3**
Program Type:	**Residency**
Department:	**Obstetrics and Gynecology**
Dates of Attendance:	**07/01/2002 - 06/30/2004**
Completion:	**Yes**
Accreditation:	**ACGME**
Post Graduate Year:	**4**
Program Type:	**Chief Resident**
Department:	**Obstetrics and Gynecology**
Dates of Attendance:	**07/01/2004 - 06/30/2005**
Completion:	**Yes**
Accreditation:	**ACGME**
Unusual Circumstance:	**None**



Fifth Pathway:

N/A

Examination History:

Transcripts Enclosed For:	**USMLE Step 1** **USMLE Step 2** **USMLE Step 3**

Board Action:

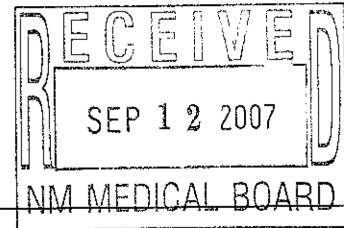
A Report of the results from a search of the Board Action Data Bank is enclosed.

Credentials Analysis Report

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

Physician Identification:

Name: Betsy Jean Taylor
DOB: [redacted]
SSN: [redacted]
Packet ID: 77815
Request ID: 17990887



OMISSIONS

Omission 1:

Section of Profile: **Medical Education**

Omission: Univ Oklahoma Col Med did not report the date of signature on the Medical Education form

Follow-Up: FCVS received the completed verification form on 08/24/2007.

DISCREPANCIES

Discrepancy 1:

Section of Profile: **Examination History**

Discrepancy: The applicant reports sitting for USMLE Step 2 as "Date Unknown". The USMLE transcript reports the examination dates was 12/21/2000

Follow-Up:

MISCELLANEOUS INFORMATION

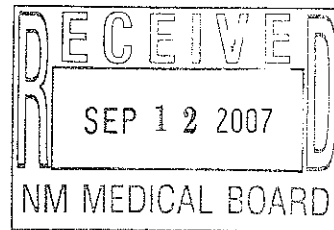
There are none identified.

End of report for Betsy Jean Taylor

Packet Id: 77815 Request Id: 17990887 Report Created By: MHD

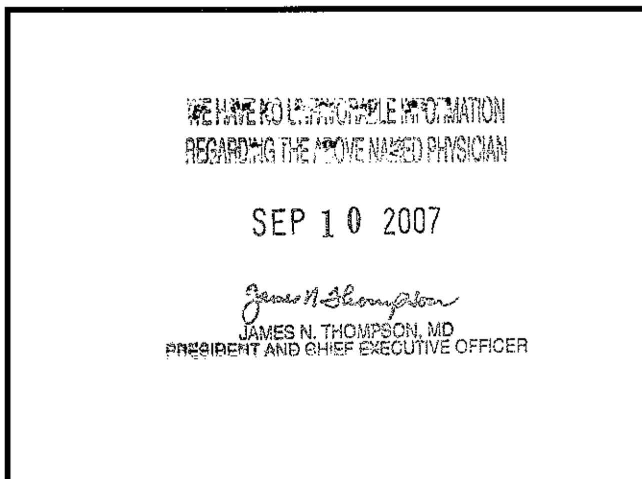
Board Action Databank Search

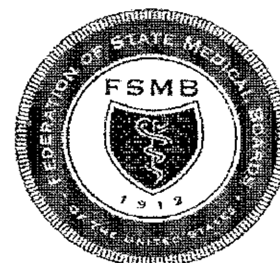
As of: 9/6/2007



State Queried For:	**New Mexico Medical Board**
Physician's Name	**Taylor, Betsy Jean**
Date of Birth:	**1973**
Medical School:	**037020 - University of Oklahoma Health Science Center**
Year of Graduation:	**2001**
Social Security Number:	**447-94-9499**
ECFMG Number:	**N/A**

Results:



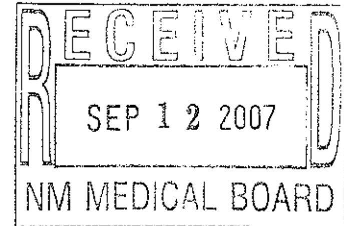


AMERICAN BOARD OF MEDICAL SPECIALTIES
VERIFICATION OF CERTIFICATION

As of: 9/6/2007

State Queried For: New Mexico Medical Board

Physician Name: Betsy Jean Taylor



Date of Birth:

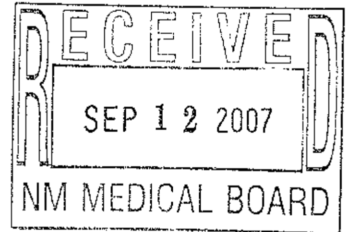
Year of Graduation:

Social Security Number:

ABMSU ID:

The data provided to FCVS by the ABMS does not include Specialty Certification information on file for this physician. This does not mean that the physician is not certified by one or more of the Member Boards of the American Board of Medical Specialties, as the data provided by ABMS does not include some physicians for which they have incomplete data.

REV 12/14/2006 Request ID: 17990887 Packet ID: 77815

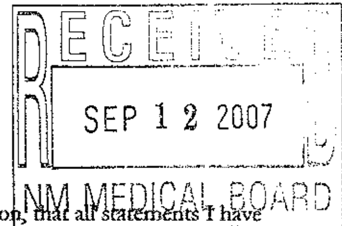


Section II

Identity

Federation of STATE MEDICAL BOARDS

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



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

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

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

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

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

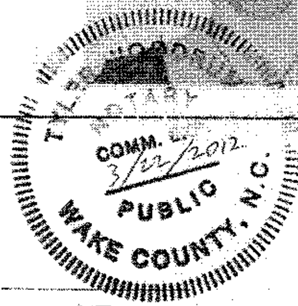
Applicant's Signature (must be signed in the presence of a notary)

TAYLOR
Applicant's Printed Last Name

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

7/16/07 ████ 1973
Date of Signature | Date of Birth

██████



NOTARY

Your seal or stamp must be partly upon the photograph.

State of North Carolina County of Wake

SUBSCRIBED AND SWORN TO before me this 16 day of July, 20 07

My commission expires: 3/22/2012

(NOTARY PUBLIC SIGNATURE & SEAL)

Notary Public signature: ______

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

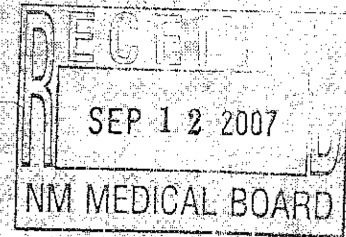
This is a true and correct copy of the official record on file in the Office of, Vital Statistics, Oklahoma City, Oklahoma, certified on the date stamped

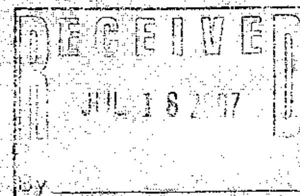
James M. Crutcher
Commissioner of Health
Office of Vital Statistics
Department of Health

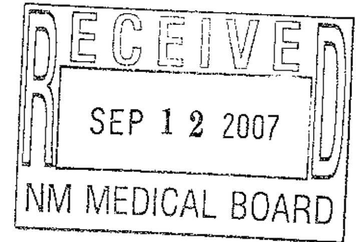
A01631811

It is in violation of Oklahoma Statutes, Title 63, Section 1-324 1, to "prepare or issue any certificate which purports to be an original, certified copy or copy of a certificate of birth, death or stillbirth, except as authorized in this act or rules and regulations adopted under this act."

CERTIFIED COPIES WILL BE PRODUCED ON MULTI-COLOR SECURITY PAPER.







Section III

Medical Education

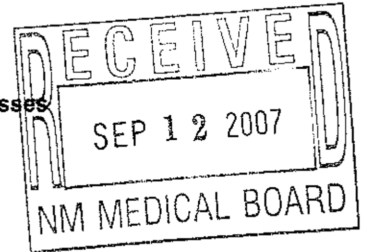
FEDERATION CREDENTIALS VERIFICATION SERVICE (FCVS)

VERIFICATION OF MEDICAL EDUCATION

(This form must be completed by the medical school)

INSTRUCTIONS TO THE DEAN

The individual identified on the attached Authorization For Release of Information, Documents and Records form has authorized your medical school to provide to the Federation Credentials Verification Service (FCVS) any and all information pertaining to their education at your institution. **Please complete this form and forward it to FCVS in the enclosed postage-paid, self-addressed envelope.**



Please note: If your institution processes transcript requests through another office, FCVS has likely made such a request under separate cover. **If your office also processes transcript requests, please attach the individual's official transcript (which indicates courses taken, dates and hours of attendance, and scores, grades, or evaluation)**.

VERIFICATION OF MEDICAL EDUCATION

Name of Institution: THE UNIVERSITY OF OKLAHOMA HEALTH SCIENCES CENTER

Complete Address: P.O. BOX 26901 SU306A

Street Address: OKLAHOMA CITY, OK 73190

City: ______ **ZIP Code (Postal Code):** ______

If name of institution was different when this individual attended, please note this name below:

______

Premedical Education:

Years of education required for admission to your medical school: 90 credit hours

Credential/degree presented by the applicant for admission to your medical school: Official Transcript

Enrollment and Participation: Our records indicate that Taylor, B.
(type/print individual's name: Last First Middle, Suffix)

attended our medical school for total of 154 weeks of medical education on the following dates (mm/dd/yy):

From 8 / 25 / 97 (Month Date Year) **To** 5 / 25 / 01 (Month Date Year)

This individual (check one):

Was awarded the degree of MD on 6 / 3 / 01 (Month Date Year)

Was NOT awarded a degree because: ______
(please explain - attach additional pages if necessary)

Certification: By my signature, I, [signature] (type/print name), certify that the above information is an accurate account of the above named individual's official records maintained in this and is true and correct to my knowledge.

2001 MAY 21 P 2:41 OUHSC ADMISSIONS & RECORDS STUDENT UNION

Signature: [signature]

Title: ______

Date of Sign ______

Phone: ______

Email: ______

SHIRLEY A. MENEFEE
ADMISSIONS & RECORDS OFFICER
THE UNIVERSITY OF OKLAHOMA
HEALTH SCIENCES CENTER
PHONE 405/271-2683 FAX 405/271-2682
DATE:

SEAL VERIFIED

77815

GDM

FEDERATION CREDENTIALS VERIFICATION SERVICE (FCVS)
(continued)

VERIFICATION OF MEDICAL EDUCATION

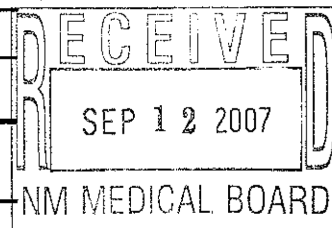
Unusual Circumstances: The following questions apply to unusual circumstances that occurred during **any part** of the individual's medical education. Please check the appropriate response and provide dates and requested information. "Yes" responses to any of these questions require a copy of explanatory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

1 Do this individual's official records reflect (an) interruption(s) or extension(s) in his/her medical education?
Response **YES** ☐ **NO** ☑

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

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

Please Specify: ____________________



2 Do this individual's official records reflect that he/she was ever placed on academic or disciplinary probation during his/her medical education?
Response **YES** ☐ **NO** ☑

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

	From Mo/Yr	To Mo/Yr
Academic Probation		
Probation for unprofessional conduct/behavioral		
Probation for other reason		

Please specify reason: ____________________

3 Do this individual's official records reflect that he/she was ever disciplined for unprofessional conduct/behavioral reasons by the medical school or parent university?
Response **YES** ☐ **NO** ☑

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

4 Do this individual's official records reflect that he/she was ever the subject of negative reports or an investigation by the medical school or parent university?
Response **YES** ☐ **NO** ☑

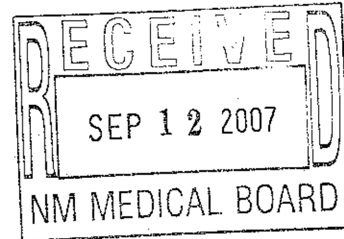
If YES, please provide detailed documentation/information about the circumstances and outcome(s):

5 Do this individual's official records reflect that there were any limitations or special requirements imposed on the individual because of questions of academic incompetence disciplinary problems, or any other reason?
Response **YES** ☐ **NO** ☑

If YES, please provide detailed documentation/information about the nature of the limitations or special requirements.

Medical Education

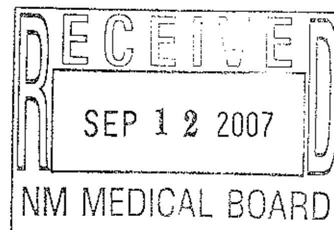
School	037020 - University of Oklahoma Health Science Center
Dates	08/1997 to 06/2001
Grad Date	06/03/2001
Degree	MD
Unusual Circumstances:	
	Interruptions: N
	Probation: N
	Disciplined: N
	Negative Reports: N
	Limitations: N



PROVIDED BY
APPLICANT

The University of Oklahoma
Health Sciences Center

OFFICE OF ADMISSIONS AND RECORDS ENROLLMENT VERIFICATION



Enrollment Verification as of 08-20-2007

Name: Taylor,B.
ID Nbr: 1500340

Degrees Earned

Degree Date	Degree	Program
2001-06-03	MD	Medicine - MD

Current Program of Study

Student does not have a current program of study.

Enrollment History

Term	Career	Begin-Date	End-Date	Units	GPA	Status
Fall 1997	MED	1997-08-25	1997-12-19	298.00	2.70	Full-Time
	Actual Enrollment:	1997-08-18	1997-12-19			
Spring 1998	MED	1998-01-12	1998-05-08	550.00	3.07	Full-Time
	Actual Enrollment:	1998-01-05	1998-05-22			
Fall 1998	MED	1998-08-17	1998-12-11	222.00	4.00	Full-Time
	Actual Enrollment:	1997-08-17	1998-12-11			
Spring 1999	MED	1999-01-11	1999-05-07	704.00	3.30	Full-Time
	Actual Enrollment:	1999-01-04	1999-06-09			
Fall 1999	MED	1999-08-23	1999-12-17	960.00	3.67	Full-Time
	Actual Enrollment:	1999-07-06	1999-12-17			
Spring 2000	MED	2000-01-03	2000-05-19	800.00	3.50	Full-Time
Fall 2000	MED	2000-08-31	2000-12-15	840.00	4.00	Full-Time
	Actual Enrollment:	2000-07-24	2000-12-15			
Spring 2001	MED	2001-01-16	2001-05-11	800.00	4.00	Full-Time
	Actual Enrollment:	2001-01-08	2001-05-25			

Due to the number of requests received, this form is used to complete all verifications.

Shirley A. Menefee
Admissions & Records Officer

Basic Sciences Education Building, Room 200, Post Office Box 26901, Oklahoma City, Oklahoma 73190-0001
Admissions and Records: (405) 271-2359, FAX: (405) 271-2480
Web: http://www.admissions.ouhsc.edu E-Mail: admissions@ouhsc.edu

SEAL VERIFIED

Official Transcript

University of Oklahoma Health Sciences Center
P. O. Box 26901
Oklahoma City, OK 731906001
United States

Name : Taylor,B.
Student ID: 1500340
Birthdate : [redacted]

Print Date : 2007-08-20

--- Degrees Awarded ---

Degree : Doctor of Medicine
Confer Date : 2001-06-03
Plan : Medicine

--- External Degrees ---

Oklahoma Baptist University
1997-05-01 Bachelor of Science

--- Academic Program History ---

Program : Medicine MD
1997-08-15 : Active in Program
1997-08-15 : Medicine - MD Major
2001-06-03 : Completed Program

--- Beginning of Medicine Record ---

Fall 1997

Course		Description	Attempted	Earned	Grade	Points
ANAT	8100	Gross Anatomy	130.00	130.00	C	260.000
ANAT	8110	Human Embryology	32.00	32.00	B	96.000
ANAT	8120	Microanatomy	95.00	95.00	B	285.000
BIOC	8201	Molec Med Genetics	41.00	41.00	A	164.000
FM	8900	Principles of Clinical Med I		0.00	Y	
PSBS	8800	Human Behavior I		0.00	Y	

TERM GPA : 2.701 GPH: 298.00 TOTALS : 298.00 298.00 805.000

OUHSC GPA : 2.701 GPH: 298.00 TOTALS : 298.00 298.00 805.000

Spring 1998

Course		Description	Attempted	Earned	Grade	Points
BIOC	8202	Bioch&Molec Biol	87.00	87.00	B	261.000
FM	8900	Principles of Clinical Med I	90.00	90.00	A	360.000
FM	8930	Epidemiology and Medical Stats	16.00	16.00	B	48.000
OCNS	8080	Medical Neurosciences	145.00	145.00	C	290.000
PHYO	8600	Medical Physiology	120.00	120.00	B	360.000
PSBS	8800	Human Behavior I	92.00	92.00	A	368.000

TERM GPA : 3.067 GPH: 550.00 TOTALS : 550.00 550.00 1687.000

OUHSC GPA : 2.939 GPH: 848.00 TOTALS : 848.00 848.00 2492.000

Fall 1998

Course		Description	Attempted	Earned	Grade	Points
CELL	8500	Med Pharmacology & Therapeutic		0.00	Y	
INDT	8090	Introduction To Human Illness		0.00	Y	
MED	8250	Principles of Clin Medicine II		0.00	Y	
MI	8300	Microbiology and Immunology	222.00	222.00	A	888.000

TERM GPA : 4.000 GPH: 222.00 TOTALS : 222.00 222.00 888.000

OUHSC GPA : 3.159 GPH: 1070.00 TOTALS : 1070.00 1070.00 3380.000

Spring 1999

Course		Description	Attempted	Earned	Grade	Points
CELL	8500	Med Pharmacology & Therapeutic	140.00	140.00	B	420.000
INDT	8090	Introduction To Human Illness	344.00	344.00	B	1032.000
INDT	9668	Professional Ethics	16.00	16.00	S	
MED	8250	Principles of Clin Medicine II	160.00	160.00	A	640.000
PSBS	8810	Human Behavior II	44.00	44.00	A	176.000

TERM GPA : 3.297 GPH: 688.00 TOTALS : 704.00 704.00 2268.000

OUHSC GPA : 3.213 GPH: 1758.00 TOTALS : 1774.00 1774.00 5648.000

NM MEDICAL BOARD
SEP 1 2 2007

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This information is released in accordance with the Family Education Privacy Act of 1974 and is also released under the condition that other parties will not have access to this information without the students written consent.

REGISTRAR, OUHSC

Official Transcript

University of Oklahoma Health Sciences Center
P. O. Box 26901
Oklahoma City, OK 731900001
United States

Name : Taylor B.
Student ID: 1500340

Print Date : 2007-08-20

Fall 1999

Course		Description	Attempted	Earned	Grade	Points
FM	9540	Family Medicine Clerkship	160.00	160.00	A	640.000
PEDI	9650	Pediatric Clerkship	240.00	240.00	A	960.000
PSBH	9520	Psychiatry Clerkshp	240.00	240.00	A	960.000
SURG	9760	Surgery Clerkship	320.00	320.00	B	960.000

TERM GPA : 3.667 GPH: 960.00 TOTALS : 960.00 960.00 3520.000

OUHSC GPA : 3.373 GPH: 2718.00 TOTALS : 2734.00 2734.00 9168.000

Spring 2000

Course		Description	Attempted	Earned	Grade	Points
MED	9250	Medicine Clerkship	320.00	320.00	B	960.000
NEUR	9370	Clinical Neurosciences Clrkshp	80.00	80.00	B	240.000
OBGY	9210	OB/Gyn & Gynecology Clerkship	240.00	240.00	A	960.000
RADI	9700	Radiology Elective	160.00	160.00	A	640.000

TERM GPA : 3.500 GPH: 800.00 TOTALS : 800.00 800.00 2800.000

OUHSC GPA : 3.402 GPH: 3518.00 TOTALS 3534.00 3534.00 11968.000

Fall 2000

Course		Description	Attempted	Earned	Grade	Points
ANES	9100	Anesthesiology/Selective	160.00	160.00	A	640.000
FM	9098	Preceptorship-Madill, OK	160.00	160.00	A	640.000
MED	9230	Ambulatory Care/Medicine	160.00	160.00	A	640.000
MED	9276	Clinical Cardiology VA/OU Med	160.00	160.00	A	640.000
OBGY	9208	Extern In Ob: Maternal Fetal	160.00	160.00	A	640.000
OPHT	9417	Introduction to Ophthalmology	40.00	40.00	A	160.000

TERM GPA : 4.000 GPH: 840.00 TOTALS : 840.00 840.00 3360.000

OUHSC GPA : 3.517 GPH: 4358.00 TOTALS : 4374.00 4374.00 15328.000

Spring 2001

Course		Description	Attempted	Earned	Grade	Points
CELL	8507	Directed Read in Pharmacology	80.00	80.00	S	
DERM	9160	Introduction to Dermatology	80.00	80.00	A	320.000
EM	9761	Externship-Emer Med & Trauma	80.00	80.00	A	320.000
MI	8306	Research Problems Microbiology	160.00	160.00	S	
ORL	9630	Intro to Otorhinolaryngology	80.00	80.00	S	
PEDI	9641	Adolescent Medicine	160.00	160.00	A	640.000
RADI	9707	Mammography	160.00	160.00	A	640.000

TERM GPA : 4.000 GPH: 480.00 TOTALS 800.00 800.00 1920.000

OUHSC GPA : 3.565 GPH: 4838.00 TOTALS : 5174.00 5174.00 17248.000

Medicine Career Totals

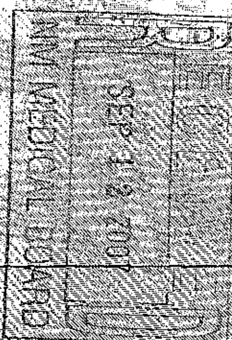
OUHSC GPA : 3.565 GPH: 4838.00 TOTALS : 5174.00 5174.00 17248.000

Post-Baccalaureate Career Totals

OUHSC GPA : 3.565 GPH: 302.37 TOTALS 323.37 323.37 1078.000

- - - - - End Of Career (1 of 1) - - - - -

- - - - - End Of Transcript - - - - -



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This information is released in accordance with the Family Education Privacy Act of 1974 and is also released

Registrar's Office
941 Stanton L. Young Blvd.
BSE 200
Oklahoma City, OK 73190

EXPLANATION OF RECORD
THE UNIVERSITY OF OKLAHOMA HEALTH SCIENCES CENTER
OUHSC FICE CODE 5889

PHONE (405) 271-2359
FAX (405) 271-2480
www.ouhsc.edu

UNIT OF CREDIT: The unit of credit for undergraduate and graduate courses is the semester hour. Prior to Summer 2002, the unit of credit for professional courses is the clock hour. The unit of credit for the College of Medicine (MD) is the clock hour. Each course taken at OUHSC is recorded on the student's transcript including courses passed, failed, repeated, exempted, audited, etc. All course work is residence credit unless otherwise indicated.

GRADES USED AT OUHSC:

Grades Used in the Calculation of Grade Point Average (GPA)

A = Excellent (4 grade points)
B = Good (3 grade points)
C = Average (2 grade points)
D = Poor (1 grade point) not considered passing in some programs
F = Failing (0 grade points)

her Symbols

= Incomplete (student lacks a test, project, paper, etc.)
AU = Audit (no credit)
W = Withdrawal
AW = Administrative Withdrawal
S = Satisfactory (GPA neutral, counted in the total number of attempted hours)
U = Unsatisfactory (GPA neutral, counted in the total number of attempted hours)
P = Passing (GPA neutral, counted in the total number of attempted hours)
NP = No Pass (GPA neutral, counted in the total number of attempted hours)
X = Graduate thesis or dissertation in progress (GPA neutral)

Program Specific Symbols

CE = Continuing Education
EX = Exempt from a required course, student has earned equivalent credit
R = Requirements successfully completed
Y = Year-Long Course

FULL-TIME COURSE LOAD:

Summer (Undergraduate)	= 6 semester hours
Summer (Graduate)	= 4 semester hours
l (Undergraduate)	= 12 semester hours
l (Graduate)	= 9 semester hours
Spring (Undergraduate)	= 12 semester hours
Spring (Graduate)	= 9 semester hours

Professional students are considered full-time unless otherwise indicated.

TERM DEFINITIONS:

Summer	= 8 weeks in length
Summer I	= 8 weeks in length
Summer II	= 6 weeks in length
Fall	= 16 weeks in length
Spring	= 16 weeks in length

TRANSCRIPT SUMMARY:

Career totals
Transfer statistics (if posted)
OUHSC statistics
Combined statistics

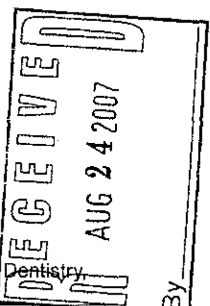
COURSE NUMBER:

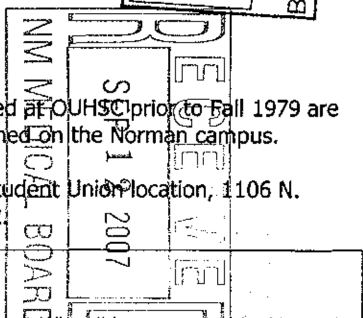
1000 – 1999	= Freshman level courses
2000 – 2999	= Sophmore level courses
3000 – 3999	= Junior level courses
4000 – 4999	= Senior level courses
5000 – 6999	= Graduate level courses
5000 – 5999	= Bachelor degree program in College of Pharmacy Undergraduate level courses
7000 – 9999	= Professional degree courses

DEGREE HONORS:

Distinction
Special Distinction
Outstanding Distinction

OUHSC recognizes honors for degrees conferred by the Colleges of Allied Health, Dentistry, Medicine, Nursing, and Pharmacy.





NORMAN/OKLAHOMA CITY/TULSA SCHUSTERMAN CAMPUSES: Transcripts for all undergraduate and graduate students who were enrolled at OUHSC prior to Fall 1979 are located in the Office of Admissions and Records on the Norman campus. Work completed on the Norman campus prior to enrollment at OUHSC is maintained on the Norman campus.

Regardless of campus copies of OUHSC records may be obtained through the transcript request process at the OUHSC Office of Admissions and Records Student Union location, 1106 N. Stonewall, Oklahoma City, OK 73117-1200. Questions regarding the transcript request process may be directed to (405) 271-2683 or FAX (405) 271-2682.

TO TEST FOR AUTHENTICITY: The face of this transcript is printed on burgundy security paper.

ADDITIONAL TESTS: When photocopied, a patent security statement containing the institutional name and the words COPY COPY COPY appear over the face of the entire document. When this paper is touched by fresh liquid bleach, an authentic document will stain. A black and white or color copy of this document is not an original and should not be accepted as an official institutional document. This document cannot be released to a third party without the written consent of the student. This is in accordance with the Family Educational Rights and Privacy Act of 1974. If you have any questions about this document, please contact our office at (405) 271-2359. ALTERATION OF THIS DOCUMENT MAY BE A CRIMINAL OFFENSE!

The Oklahoma State Regents for Higher Education
acting through

The University of Oklahoma

have admitted

Betsy J. Taylor

to the degree of

Doctor of Medicine

and all the honors, privileges and obligations belonging thereto,
and in witness thereof have authorized the issuance of
this Diploma duly signed and sealed
Issued at the University of Oklahoma at Oklahoma City, Oklahoma on the
third day of June, two thousand and one.

I certify this to be a true copy of the diploma originally issued by the University of Oklahoma Health Sciences Center.

Officer's Name

8/20/07

Date

For the State Regents

Chairman

Secretary

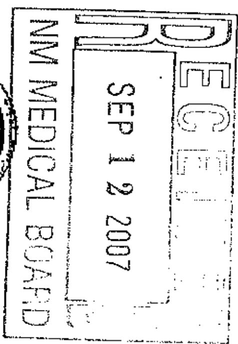
Chancellor

For the University

Chairman, Board of Regents

President of the University

Executive Dean



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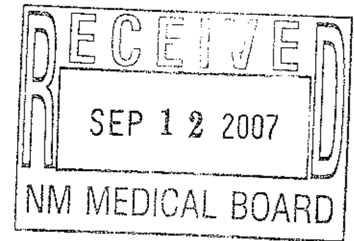


Section IV

Postgraduate Training

Federation of STATE MEDICAL BOARDS

[ ]eration Credentials Verification Service (F[ ])

Federation Place, P.O. Box 619850, Dallas, TX 75261-9850
Tel: (817) 868-5000 Fax: (817) 868-5099

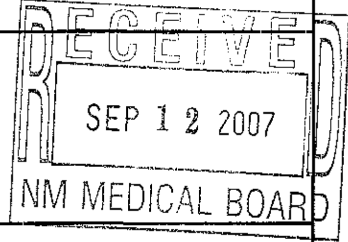
Verification of Postgraduate Medical Education

Institution: University of Oklahoma

Address: Department of OB/GYN
Oklahoma City OK 73104

Attention: **Program Director**

Affiliated University: University of Oklahoma Health Sciences Center



Verification For:

Name: **Taylor, Betsy Jean**

DOB [redacted]1973

Individual's Name on Record (If different from above): ______

Program Participation:

Important:
Report Incomplete postgraduate years (PGY) separate from those that were successfully completed

If the postgraduate year is currently in progress report the expected completion date in the "To" field

Report Internships, Residencies and Fellowships separately

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

PGY: 1
- ☒ Internship
- ☐ Residency
- ☐ Chief Residency
- ☐ Fellowship
- ☐ Research

Specialty/Subspecialty: OB/GYN
From: 07/01/2001 **To:** 06/30/2002
Successfully Completed?: ☒Yes ☐No ☐In Progress
Accredited by: ☒ACGME ☐AOA ☐LCGME ☐RSC ☐CFPC ☐RCPSC ☐APPAP ☐None of these

PGY: 2-3
- ☐ Internship
- ☒ Residency
- ☐ Chief Residency
- ☐ Fellowship
- ☐ Research

Specialty/Subspecialty: OB/GYN
From: 07/01/2002 **To:** 06/30/2004
Successfully Completed?: ☒Yes ☐No ☐In Progress
Accredited by: ☒ACGME ☐AOA ☐LCGME ☐RSC ☐CFPC ☐RCPSC ☐APPAP ☐None of these

PGY: 4
- ☐ Internship
- ☐ Residency
- ☒ Chief Residency
- ☐ Fellowship
- ☐ Research

Specialty/Subspecialty: OB/GYN
From: 07/01/2004 **To:** 06/30/2005
Successfully Completed?: ☒Yes ☐No ☐In Progress
Accredited by: ☒ACGME ☐AOA ☐LCGME ☐RSC ☐CFPC ☐RCPSC ☐APPAP ☐None of these

Unusual Circumstances:

Check the correct response. Omitted responses require written explanation

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

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

Please explain any "Yes" response from above:

____

____

Affix your institutional se[al]...ce. If no seal is available, form notarized

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

N[am]e: Elisa A. Crouse, M.D Signature: *Elisa A Crouse, MD*

Ti[tle]: Residency Program Director Date of Signature: 08/28/2007

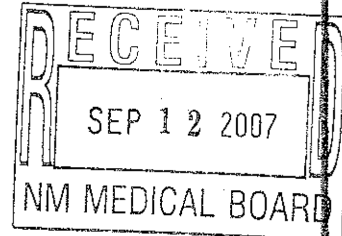
T[el]: 405-271-8470 Fax: 405-271-8547 E-Mail: elisa-crouse@ouhsc.edu

Rev. 09/07/05 Packet ID 77815 Request ID: 17990887 GDM IFM CODE[10132]

Postgraduate Medical Education
University of Oklahoma Health Science Center

Hospital University of Oklahoma Health Science Center

Affiliated School University of Oklahoma
920 Stanton L Young
Oklahoma City, OK 73104
099



Unusual Circumstances:

Interruptions: N
Probation: N
Disciplined: N
Negative Reports: N
Limitations: N

PGY

Year(s):PGY 1 Internship/Residency: Complete?: Yes
Obstetrics and Gynecology
Dates: 07/2001 to 06/2002

Year(s):PGY 2 Residency: Complete?: Yes
Obstetrics and Gynecology
Dates: 07/2002 to 06/2003

Year(s):PGY 3 Residency: Complete?: Yes
Obstetrics and Gynecology
Dates: 07/2003 to 06/2004

Year(s):PGY 4 Residency/Chief Residency: Complete?: Yes
Obstetrics and Gynecology
Dates: 07/2004 to 06/2005

PROVIDED BY APPLICANT

The Oklahoma State Regents for Higher Education

acting through

The University of Oklahoma Health Sciences Center

makes known by these presents that

Betsy J. Taylor, M.D.

has served as

Resident in Obstetrics and Gynecology

from July 1, 2001 through June 30, 2005

Given under the Seal of the University of Oklahoma
at the Health Sciences Center,
Oklahoma City, Oklahoma.

For the State Regents

Chairman

Secretary

Chancellor

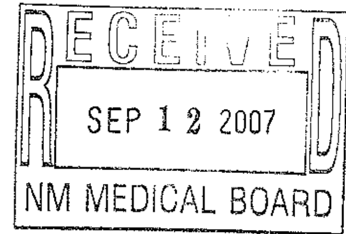
For the University

Chairman, Board of Regents

President of the University

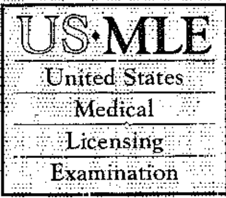
Professor and Chair

SEP 12 2007
NM MEDICAL BOARD



Section V

Examination History/Score Transcripts



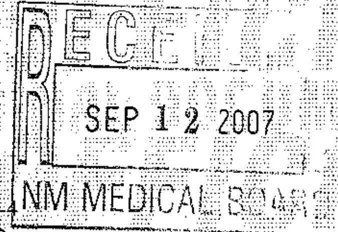
United States Medical Licensing Examination™ (USMLE™)
Certified Transcript of Scores

This document was prepared by the
Federation of State Medical Boards of the United States, Inc
Federation Place, PO Box 619850, Dallas, TX 75261-9850 – Telephone (817) 868-4041

Date : 08/14/2007

Recipient:

Federation Credentials Verification Service
ATTN: FCVS



Packet ID: 77815

Examinee ID#: 5-060-119-4
Examinee: Taylor, Betsy Jean
Date of Birth: ████1973
Alt Name(s):

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 Total	Three-Digit Score MP	Two-Digit Score Total	Two-Digit Score MP	Comments
	06/11/1999	Pass	213	179	86	75	

USMLE STEP 2

Clinical Knowledge (CK)

	Test Date	Pass/Fail	Three-Digit Score Total	Three-Digit Score MP	Two-Digit Score Total	Two-Digit Score MP	Comments
	12/21/2000	Pass	221	174	87	75	

USMLE STEP 3

	Test Date	Pass/Fail	Three-Digit Score Total	Three-Digit Score MP	Two-Digit Score Total	Two-Digit Score MP	Comments
OKLAHOMA	06/04/2002	Pass	227	182	92	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

Patent 5636874

GDM

TamperSafe Patent #5,772,248
TouchSafe®

	QUESTION_ID	QUESTION_TEXT	ANSWER	CREATE_DATE	UPDATE_DATE
Taylor, Betsy Jean	MD2007-0721				
Taylor, Betsy Jean		Since your last renewal, have any complaints been filed against you with any licensing agency?	N		4/21/2008
		Since your last renewal, has your license to practice in any jurisdiction been investigated, voluntarily or involuntarily limited, suspended, revoked, denied or are any currently held licenses pending investigation or being challenged?	N		4/21/2008
		Since your last renewal, has your professional liability coverage been terminated by action of the insurance company?	N		4/21/2008
		Since your last renewal, have you been denied professional liability insurance coverage?	N		4/21/2008
		Since your last renewal, has your professional liability carrier excluded any specific procedures from your coverage?	N		4/21/2008
		Since your last renewal, have you been denied membership or renewal thereof, or been subject to disciplinary action in any professional organization?	N		4/21/2008
		Since your last renewal, have you been excluded from or sanctioned by Medicare and/or Medicaid?	N		4/21/2008
		Since your last renewal, have you been named in any formal requests for corrective actions filed by any healthcare entity where you have had an appointment (a request which could result in either formal or informal proceedings)?	N		4/21/2008
		Since your last renewal, have your privileges at any healthcare entity been voluntarily or involuntarily suspended, restricted, diminished, revoked or not renewed, except for medical records?	N		4/21/2008
		Since your last renewal, have you resigned from a healthcare entity to avoid investigation, modification, suspension, or termination of privileges?	N		4/21/2008
		Since your last renewal, has your application for licensure in any jurisdiction been investigated or denied, or are any current applications pending investigation or being challenged?	N		4/21/2008
		Since your last renewal, have you been notified to appear before any licensing agency for a hearing or complaint of any nature?	N		4/21/2008
		Since your last renewal, has your DEA or Controlled Substance license in any jurisdiction been investigated, voluntarily or involuntarily limited (stipulations), suspended, revoked, restricted, or are there currently challenges to any of these items?	N		4/21/2008
		Since your last renewal, have you been charged with, arrested for, convicted of, or pled no contest to a misdemeanor or felony, or have your been named as a defendant in any criminal proceedings or subject to investigation by a governmental entity that could result in sanctions or licensure adverse actions?	N		4/21/2008
		Since your last renewal, have you been involved in a settlement, medical malpractice claim or suit, or have you received written notice of intent to file such a suit? If yes, please provide the following information for each claim or suit. Please type on a seperate sheet of paper each case. <p> . Name, age, sex of patient/claimant. . Date(s) and type of treatment and/or surgery, which led to the allegations against you. . Nature of allegations in claims/suits. Specify whether a suit was ever filed. . Names of other practitioners and hospitals, if any, involved in claims or suit. . Disposition or current status of claim or suit (be specific). . Name of Insurance carrier defending you. . Name of defense attorney.	N		4/21/2008
		Have you had personal or legal problems with narcotics, alcohol or other dangerous drugs during the past 5 years? (If you are currently a voluntary participant in a Board approved monitoring program you may answer "No")	N		4/21/2008
		Since your last renewal, have you had any physical injury or disease, or mental illness or impairment which either has affected or could reasonably be expected to affect your on-going ability to practice medicine safely and competently? If yes, please have your treating physician send the NM Medical Board a letter regarding your diagnosis and treatment .	N		4/21/2008
		Are you currently more than a month in arrears in court-ordered child support payments in New Mexico or in any other state?	N		4/21/2008
		Since your last renewal, have you been reported to the National Practitioner Data Bank?	N		4/21/2008
		I certify that I have completed a minimum of 75 AMA Category I hours of Continuing Medical Education as required by 16.10.4 NMAC.	Y		4/21/2008
		Please select a statement that BEST describes your practice: * 	Engaged in		4/21/2008
		Do you practice full-time in New Mexico? * If yes, estimate the % of time you spend in the following areas (total = 100):	Y		4/21/2008
		Direct patient care:	71-80%		4/21/2008
		Teaching:	51-60%		4/21/2008
		Do you practice part-time in New Mexico? * If yes, estimate the % of time you spend in the following areas (total = <100):	N		4/21/2008
		Are you retired but maintain an active license? <font color = red> * <font>	N		4/21/2008
		If you practice in New Mexico please indicate number of work location(s): Office(s):	1		4/21/2008
		Hospital(s):	2		4/21/2008

Taylor, Betsy Jean **Medical Doctor** **MD2007-0721**

Question	Answer	Date
11. Since your last renewal have you resigned from a healthcare entity to avoid modification, suspension, or termination of privileges, or while under investigation?	N	05/26/2011
10. b. Since your last renewal have you agreed not to exercise your clinical privileges while under investigation?	N	05/26/2011
12. b. Are any currently held licenses pending investigation or being challenged?	N	05/26/2011
6. Since your last renewal, have you been arrested? If so explain the circumstance, regardless of the outcome (i.e. expunged, dismissed, sealed, vacated).	N	05/26/2011
13. Since your last renewal have you been notified to appear before any licensing agency for a hearing or complaint of any nature?	N	05/26/2011
15. Since your last renewal have you been involved in a settlement, medical malpractice claim or suit, or have you ever received written notice of intent to file such a suit? If yes, please provide the following information for each claim or suit. Please type on a separate sheet	N	05/26/2011
16. Since your last renewal have you been reported to the National Practitioner Data Bank?	N	05/26/2011
2. Since your last renewal have you been denied professional liability insurance coverage?	N	05/26/2011
14. Since your last renewal has your federal or state narcotics registration certificate in any jurisdiction been voluntarily or involuntarily limited (stipulations), suspended, revoked, restricted, or are there currently challenges to any of these items?	N	05/26/2011
17. Are you now, or were you in the past, addicted to, abusive of, or in treatment for abuse of any controlled substances, habit-forming drugs, illegal drugs, prescription medication or alcohol?	[illegible]	05/26/2011
18. In the five (5) years prior to this application, have you had any physical injury or disease, or mental illness or impairment, which you are currently under treatment for or could reasonably be expected to affect your on -going ability to practice medicine safely and	[illegible]	05/26/2011
1. Since your last renewal has your professional liability coverage been terminated by action of the insurance company except as a result of the company ceasing to offer insurance to physicians ?	N	05/26/2011
3. Since your last renewal has your professional liability carrier excluded any specific procedures from your coverage?	N	05/26/2011
4. Since your last renewal have you been denied membership or renewal thereof, or been subject to disciplinary action in any professional organization?	N	05/26/2011
5. Since your last renewal have you been excluded from or sanctioned by Medicare and/or Medicaid?	N	05/26/2011
7. Since your last renewal, have you been named as a defendant in any criminal proceedings?	N	05/26/2011
8. Since your last renewal, have you been subject to investigation by a governmental entity or Board that either could have resulted or did result in licensure sanction or other adverse actions, irrespective of the outcome?	N	05/26/2011
9. Since your last renewal have you been named in any formal requests for corrective actions filed by any healthcare entity where you have had an appointment (a request which could result in either formal or informal proceedings).	N	05/26/2011
10. a. Since your last renewal have your privileges at any healthcare entity been voluntarily or involuntarily suspended, restricted, diminished, revoked, surrendered, or not renewed, except for medical records delinquency?	N	05/26/2011
12. a. Since your last renewal has your application for licensure or license to practice in any jurisdiction been investigated, voluntarily or involuntarily limited, suspended, revoked, surrendered or denied?	N	05/26/2011
19. I certify that I have completed a minimum of 75 AMA Category I hours of Continuing Medical Education as required by 16.10.4 NMAC?	Y	05/26/2011
20. Are you ABMS (American Board of Medical Specialties) Board Certified?	Y	05/26/2011
21. If yes do you hold Lifetime Certification?	N	05/26/2011
22 . If yes do you hold Time Limited Certification?	Y	05/26/2011

10/20/2014

Taylor, Betsy Jean **Medical Doctor** **MD2007-0721**

Question	Answer	Date
1. Since your last renewal has your professional liability coverage been terminated by action of the insurance company except as a result of the company ceasing to offer insurance to physicians?	N	06/12/2014
2. Since your last renewal have you been denied professional liability insurance coverage?	N	06/12/2014
3. Since your last renewal has your professional liability carrier excluded any specific procedures from your coverage?	N	06/12/2014
4. Since your last renewal have you been denied membership or renewal thereof, or been subject to disciplinary action in any professional organization?	N	06/12/2014
5. Since your last renewal have you been excluded from or sanctioned by Medicare and/or Medicaid?	N	06/12/2014
6. Since your last renewal, have you been arrested? If so explain the circumstance, regardless of the outcome (i.e. expunged, dismissed, sealed, vacated).	N	06/12/2014
7. Since your last renewal, have you been named as a defendant in any criminal proceedings?	N	06/12/2014
8. Since your last renewal, have you been subject to investigation by a governmental entity or Board that either could have resulted or did result in licensure sanction or other adverse actions, irrespective of the outcome?	N	06/12/2014
9. Since your last renewal have you been named in any formal requests for corrective actions filed by any healthcare entity where you have had an appointment (a request which could result in either formal or informal proceedings).	N	06/12/2014
10. a. Since your last renewal have your privileges at any healthcare entity been voluntarily or involuntarily suspended, restricted, diminished, revoked, surrendered, or not renewed, except for medical records delinquency?	N	06/12/2014
10. b. Since your last renewal have you agreed not to exercise your clinical privileges while under investigation?	N	06/12/2014
11. Since your last renewal have you resigned from a healthcare entity to avoid modification, suspension, or termination of privileges, or while under investigation?	N	06/12/2014
12. a. Since your last renewal has your application for licensure or license to practice in any jurisdiction been investigated, voluntarily or involuntarily limited, suspended, revoked, surrendered or denied?	N	06/12/2014
12. b. Are any currently held licenses pending investigation or being challenged?	N	06/12/2014
13. Since your last renewal have you been notified to appear before any licensing agency for a hearing or complaint of any nature?	N	06/12/2014
14. Since your last renewal has your federal or state narcotics registration certificate in any jurisdiction been voluntarily or involuntarily limited (stipulations), suspended, revoked, restricted, or are there currently challenges to any of these items?	N	06/12/2014
15. Since your last renewal have you been involved in a settlement, medical malpractice claim or suit, or have you ever received written notice of intent to file such a suit? If yes, please provide the following information for each claim or suit. Please type on a separate sheet	Y	06/12/2014
16. Since your last renewal have you been reported to the National Practitioner Data Bank?	N	06/12/2014
17. Are you now, or were you in the past, addicted to, abusive of, or in treatment for abuse of any controlled substances, habit-forming drugs, illegal drugs, prescription medication or alcohol?	█	06/12/2014
18. In the five (5) years prior to this application, have you had any physical injury or disease, or mental illness or impairment, which you are currently under treatment for or could reasonably be expected to affect your on -going ability to practice medicine safely and	█	06/12/2014
19. I certify that I have completed a minimum of 75 AMA Category I hours of Continuing Medical Education as required by 16.10.4 NMAC?	Y	06/12/2014
20. Are you ABMS (American Board of Medical Specialties) Board Certified?	Y	06/12/2014
21. If yes do you hold Lifetime Certification?	N	06/12/2014
22 . If yes do you hold Time Limited Certification?	Y	06/12/2014

Taylor, Betsy Jean **Medical Doctor** **MD2007-0721**

Question	Answer	Date
1. Since your last renewal has your professional liability coverage been terminated by action of the insurance company except as a result of the company ceasing to offer insurance to physicians?	N	05/03/2017
2. Since your last renewal have you been denied professional liability insurance coverage?	N	05/03/2017
3. Since your last renewal has your professional liability carrier excluded any specific procedures from your coverage?	N	05/03/2017
4. Since your last renewal have you been denied membership or renewal thereof, or been subject to disciplinary action in any professional organization?	N	05/03/2017
5. Since your last renewal have you been excluded from or sanctioned by Medicare and/or Medicaid?	N	05/03/2017
6. Since your last renewal, have you been arrested? If so explain the circumstance, regardless of the outcome (i.e. expunged, dismissed, sealed, vacated).	N	05/03/2017
7. Since your last renewal, have you been named as a defendant in any criminal proceedings?	N	05/03/2017
8. Since your last renewal, have you been subject to investigation by a governmental entity or Board that either could have resulted or did result in licensure sanction or other adverse actions, irrespective of the outcome?	N	05/03/2017
9. Since your last renewal have you been named in any formal requests for corrective actions filed by any healthcare entity where you have had an appointment (a request which could result in either formal or informal proceedings).	N	05/03/2017
10. a. Since your last renewal have your privileges at any healthcare entity been voluntarily or involuntarily suspended, restricted, diminished, revoked, surrendered, or not renewed, for any reason, except for medical records delinquency unrelated to your professional	N	05/03/2017
10. b. Since your last renewal have you agreed not to exercise your clinical privileges while under investigation?	N	05/03/2017
10. c. Since you last renewal, have you been investigated and/or terminated by a healthcare entity for cause, or without cause, related to your clinical competence or conduct, which could impact patient safety/care, or allowed to resign in lieu of termination for such reason?	N	05/03/2017
11. Since your last renewal have you resigned from a healthcare entity to avoid modification, suspension, or termination of privileges, or while under investigation?	N	05/03/2017
12. a. Since your last renewal has your application for licensure or license to practice in any jurisdiction been investigated, voluntarily or involuntarily limited, suspended, revoked, surrendered or denied?	N	05/03/2017
12. b. Are any currently held licenses pending investigation or being challenged?	N	05/03/2017
13. Since your last renewal have you been notified to appear before any licensing agency for a hearing or complaint of any nature?	N	05/03/2017
14. Since your last renewal has your federal or state narcotics registration certificate in any jurisdiction ever been investigated, voluntarily or involuntarily limited, suspended, revoked, or restricted?	N	05/03/2017
15. Since your last renewal have you been involved in a settlement, medical malpractice claim or suit, or have you ever received written notice of intent to file such a suit? If yes, please provide the following information for each claim or suit. Please type on a separate sheet	N	05/03/2017
16. Since your last renewal have you been reported to the National Practitioner Data Bank?	N	05/03/2017
17. Are you now, or were you in the past, addicted to, abusive of, or in treatment for abuse of any controlled substances, habit-forming drugs, illegal drugs, prescription medication or alcohol?	█	05/03/2017
18. In the five (5) years prior to this application, have you had any physical injury or disease, or mental illness or impairment, which you are currently under treatment for or could reasonably be expected to affect your on -going ability to practice medicine safely and	█	05/03/2017
19. I certify that I have completed a minimum of 75 AMA Category I hours of Continuing Medical Education as required by 16.10.4 NMAC	Y	05/03/2017
19a. I certify that 5 hours of the required 75 hours of CME are in Pain Management, as required by 16.10.14. 11 NMAC OR I certify that I do NOT hold a NM Controlled Substance Registration.	Y	05/03/2017
20. I attest that I will limit my practice to areas in which I am competent to practice.	Y	05/03/2017
21. Are you currently in arrears in payments of amounts required to be paid pursuant to an outstanding judgement and order for child support in New Mexico or in any other state?	N	05/03/2017