State of Utah

Date: 02/22/2012
Receipt Number: 3860687
Amount Paid:

DIVISION OF OCCUPATIONAL & PROFESSIONAL LICENSING

160 East 300 South, P.O. Box 146741
Salt Lake City, Utah 84114-6741
Telephone (801) 530-6628
www.dopl.utah.gov

License(s) Applying For:

- ☒ **PHYSICIAN AND SURGEON** *($200.00 Non Refundable Application Fee)*
- ☐ **OSTEOPATHIC PHYSICIAN AND SURGEON** *($200.00 Non Refundable Application Fee)*
- ☐ **TEMPORARY LICENSE** *($50.00 Non Refundable Application Fee)*
- ☒ **CONTROLLED SUBSTANCE** *($100.00 Non Refundable Application Fee)*
- ☐ **CONTROLLED *SUBSTANCE TEMPORARY*** *($50.00 Non Refundable Application Fee)*

NOTE: *You cannot apply for a temporary license separately.*

(Note: Microsoft Word users can fill in the blanks, print the form and save it for their records)

Please list your full legal name as it appears on your driver's license, Social Security Card, etc.		
Last Name: Torres	First Name: Leah	Middle Name: Nicole ✓
Social Security Number: [redacted] ✓	Maiden Name:	

I certify under penalty of perjury that:

☒ I am a citizen of the United States and I have a valid US Driver License or US State ID.
License/State ID Number: 29922348 State: PA ✓

☐ I am a citizen of the United States currently living outside the United States and do not have a valid US Drivers License or US State ID. Please attach a legible copy of your valid passport or other documentation to verify you are a legal citizen of the United States.

☐ I am a non-citizen of the United States, who is lawfully present in the United States and I have a valid US Drivers License or US State ID.
License/State ID Number: _____ State: __

☐ I am a non-citizen of the United States, who is lawfully present in the United States and I do not have a valid US Drivers License or US State ID.
Please attach a legible copy of your current and valid government issued document showing evidence of authorization to work in the United States.

☐ I am a foreign national not physically present in the United States.

Mailing Address: University of Utah, 30 North 1900 East, Suite 2B200 ✓			
City: Salt Lake City		State: UT	ZIP: 84132
☐ Male ✓ ☒ Female	Date of Birth: [redacted] ✓	Phone #: [redacted] ✓	E-Mail: [redacted] ✓

List all other licenses, registrations, or certifications issued by any state which you now hold or have ever held in any profession. *(Use additional sheets if necessary.)*

Profession: Physician	Issuing State: PA	
License Number: MT193829	License Status: Active	Issue Date: 7-1-2011
Profession:	Issuing State:	
License Number:	License Status:	Issue Date:
Profession:	Issuing State:	
License Number:	License Status:	Issue Date:
Profession:	Issuing State:	
License Number:	License Status:	Issue Date:
Profession:	Issuing State:	
License Number:	License Status:	Issue Date:

DO NOT WRITE IN THIS SECTION - FOR DIVISION USE ONLY

8243165-1205
BOM 8243165-1205 8905

License/Certificate Number: _____

Date License/Certificate Approved/Denied: 4/11/12 by Jami Stott

Reason for Denial/Other Comments: _____

RECEIVED APR 2012 FEE

Bureau Manager Review: QQ Yes answers or Education or Exam ☐ Approve ☐ Deny

☐ Yes ☒ No	28. Has any owner, officer, manager, pharmacist, pharmacy technician or medical practitioner associated with or employed by the applicant ever had a license, certificate, permit, registration to practice a regulated profession denied, conditioned, curtailed, limited, restricted, suspended, revoked, reprimanded, or disciplined in any way?
STOP	**If you answered "Yes" to question 15 you must submit a complete narrative of the circumstances and you must submit a National Practitioner Data Bank report outlining all professional liability claims made against your license and any settlements paid by or on your behalf.** **If you answered "yes" to any of the above questions, enclose with this application complete information with respect to all circumstances and the final result, if such has been reached. If you answered "Yes" to Questions 22, 23, 24, 25, 26, 27 or 28 you must submit a complete narrative of the circumstances that occurred for EACH and EVERY conviction, plea in abeyance, and/or deferred sentence. You must also attach copies of all applicable police report(s), court record(s), and probation/parole officer report(s).** **If you are unable to obtain any of the records required above, you must submit documentation on official letterhead from the police department and/or court indicating that the information is no longer available.** **If you have formally expunged a criminal record as evidenced by a court order signed by a judge, you do not need to disclose that criminal history. Expungement orders must be sent to the Bureau of Criminal Identification and the FBI to enable the expungement to be completed and the criminal history eliminated from the records.** **A "Yes" answer does not necessarily mean you will not be granted a license; however, DOPL may request additional documentation if the information submitted is insufficient.**

DESIGNATION OF CONTACT PERSON FOR ACCESS TO MEDICAL RECORDS

In accordance with Subsection 58-67-302(1)(j) of the Utah Code and the Federal HIPAA Regulations every physician licensed in Utah must designate a contact person and an alternate contact person for access to his/her patients' medical records and provide such information to the DOPL. Each applicant is also required to establish a method of notifying patients of the identity and location of the contact persons (*i.e. a phone number or address where patients can obtain their medical records*).

If a hospital clinic or other medical facility is the owner of your patients' medical records the facility's records department could be listed as the primary contact. You may list yourself as the primary contact but you must also provide an alternate contact.

Please note that this statute became law in 2005 due to complaints from patients who could not gain access to their medical records. DOPL's responsibility is to collect each physician's contact information and to provide it to patients upon request. If you have not provided accurate information to DOPL you could be investigated for unprofessional conduct.

Contact Person: David Turok, MD U of U	Telephone: 801-581-7647 ✓	
Address of Contact Person: 30 North 1900 East, Rm 2A200		
City: Salt Lake City	State: ~~PA~~ UT	Zip: 84132
Alternate Contact Person:	Telephone:	
Address of Contact Person:		
City:	State:	Zip:

Method of Notifying Patients of Location of Records: (*check all that apply*)
☒ Phone ☒ Mail ☒ In Person

ELECTIVE ABORTIONS

☒ Yes ☐ No	Do you perform elective abortions in Utah in a location other than a hospital? *(For purposes of the immediately preceding question, elective abortion means an abortion other than one of the following: removal of a dead fetus, removal of an ectopic pregnancy, an abortion that is necessary to avert the death of a woman, an abortion that is necessary to avert a serious risk of substantial and irreversible impairment of a major bodily function of a woman, an abortion of a fetus that has a defect that is uniformly diagnosable and uniformly lethal, or an abortion where the woman is pregnant as a result of rape or incest. 58-68-304.3.b.)*

Business Information where the elective abortions are performed:

Business Name: University of Utah Dept of OB/Gyn	Telephone: 801-581-6170 ✓	
Mailing Address: 30 North 1900 East Room 2B200		
City: Salt Lake City	State: UT	ZIP: 84132
Business Name:	Telephone:	
Mailing Address:		
City:	State:	ZIP:

AFFIDAVIT IF APPLYING FOR LICENSURE FOR RESIDENCY TRAINING IN UTAH

I have successfully completed 12 months of resident training in an ACGME approved program after receiving a degree of doctor of medicine. I am successfully participating in an ACGME progressive residency program within Utah with no disciplinary action. I agree to surrender my license to DOPL without any proceedings under the Administrative Procedures Act and DOPL will automatically revoke my license as a physician and surgeon if I fail to continue in good standing in the ACGME approved residency program within Utah.

Signature of Applicant:	Date:

MEDICAL SCHOOL *(Use additional sheets if necessary.)*			
School Name: University of Illinois at Chicago			Dates Attended: 8/2004 to 5/2008
	Location: Chicago, IL		
	Degree Received: MD	Date of Graduation: 5/9/2008	
School Name:			Dates Attended: to
	Location:		
	Degree Received:	Date of Graduation:	

GRADUATE MEDICAL EDUCATION OR TRAINING – Complete the information below and account for **all** periods of training or postgraduate work from the time you graduated from medical school. *(Use additional sheets if necessary.)*			
Name of Hospital: Albert Einstein Medical Center		Position (*intern, resident, fellow*): Resident	
	Address of Hospital: 5501 Old York Rd		
	City: Philadelphia	State: PA	Zip: 19141
	Department: OB/Gyn	Date Began: 07/01/2008	Date Ended: 06/30/2012
Name of Hospital:		Position (*intern, resident, fellow*):	
	Address of Hospital:		
	City:	State:	Zip:
	Department:	Date Began:	Date Ended:

PROFESSIONAL EXAMINATION REQUIREMENT		
# Attempts	Examination	Date(s) Taken
1	USMLE Step 1	5-23-06
1	USMLE Step 2	11-7-07
1	USMLE Step 3	2-23-10
	NBOME Part I	
	NBOME Part II	
	NBOME Part III	
	FLEX Component 1	
	FLEX Component 2	
	LMCC Part 1	
	LMCC Part 2	
	SPEX Examination	
List Tests Taken if Not Listed Above:		
# Attempts	Examination	Date(s) Taken
2	USMLE Step 2 CS	4/2008 3-19-09

SPECIALTY BOARD CERTIFICATION - List your ABMS or AOA specialty board certification(s) and date(s) of specialty certification(s): *(Use additional sheets if needed.)*	
Board: Obstetrics and Gynecology	Date: 6/2012
Board:	Date:
Board:	Date:
Board:	Date:

State of Utah
Department of Commerce
Division of Occupational and Professional Licensing

GARY R. HERBERT
Governor

FRANCINE A. GIANI
Executive Director

MARK B. STEINAGEL
Division Director

February 23, 2012

LEAH NICOLE TORRES
C/O UNIVERSITY OF UTAH
30 N 1900 E STE 2B200
SALT LAKE CITY UT 84132

RESPONSE DEADLINE: 90 DAYS FROM THE DATE OF THIS LETTER

Dear Dr. Torres:

Notice of Incomplete Application and Conditional Denial:
Your application for licensure as a Physician and Surgeon with a Controlled Substance is conditionally denied because it is incomplete and cannot be processed. The following items are needed to process your application:

- Submit a Federation Credentials Verification Service (FCVS) report that includes primary source verification of your medical education, post-graduate training, examination scores, disciplinary actions (if any), and ECFMG Certification that is valid indefinitely (if applicable).

  Request an application packet from the Federation Credentials Verification Service, P.O. Box 970900, Dallas, TX 75397-0900, Telephone (817) 868-5000, Fax (817) 868-5009, www.fsmb.org . Complete and return the FCVS application to the FCVS who will submit the report directly to DOPL.

Response Procedure:
In order to have your application for licensure approved, you must correct the deficiencies in your application. Please submit the item listed above with a copy of this letter to:

Joyce McStotts
Division of Occupational and Professional Licensing
PO Box 146741
Salt Lake City, Utah 84114-6741

Failure to submit listed items by the deadline will result in a final denial of your application:
Your application is only conditionally denied because it is incomplete. If the listed items are not received by the Division by the deadline, your application will be denied and you will be required to submit a new application and comply with the licensing requirements that are in effect at the time of submittal.

Presumption a Response is Complete:
Unless you specify otherwise, the Division will treat any response received from you prior to the deadline as your final response, and may take final action immediately.

If you have any questions, or wish to request an extension of the deadline date call the individual below. If you are requesting an extension, either verbally or in writing, it must be received prior to deadline.

Sincerely,

Joyce

Joyce McStotts
Utah Licensing Specialist
801-530-6347
jmcstotts@utah.gov

PHYSICIAN & SURGEON
October 2011

jam

NAME Torres, Leah Nicole LICENSE NO: 8243165-1205 / 8905
APPLICATION CHECKLIST (complete each blank with "yes", "no" or "x"):

PHYSICIAN & SURGEON:

✓ $200 Application Fee	✓ Fee Posted	___ Temp$50 Application Fee	___ Fee Posted
✓ $100 Application Fee	✓ Fee Posted	___ Temp $50 CS Application Fee	___ Fee Posted
___ CE Requirement			

✓ Social Security Number
✓ Driver License
✓ Affidavit and Release Authorization signed and dated
✓ Utah Controlled Substances Law and Rule Examination 100%
✓ Qualifying Questionnaire
___ yes answers ___ **To Noël for review**
___ Police report, court docket, any probation/parole officer report and narrative of circumstances and resolution for EACH and EVERY arrest and/or conviction.
___ Yes answer on **#15,** NPDB **AND** HIPDB for Defendant listed in malpractice suit
✓ Designation of Contact Person for Access to Medical Records
✓ Elective Abortions section completed
___ Signed agreement in application, to surrender license if 24 months of residency is not completed

ENDORSEMENT:
___ Documented practice as a physician for no less than 6000 hours in the five years immediately preceding application.
___ Signed endorsement qualification.

TEMPORAY LICENSE:
___ Complete Application (everything except FCVS) ___ **To Noël for review**
___ Temporary section complete with signature
___ Meets all endorsement criteria
___ Original Letter(s) of Invite ___ **Approved/Denied by** _____ **Date** _____

Temporary Expiration Date: _____

AMERICAN MEDICAL ASSOCIATION (AMA):
✓ Print AMA report
✓ Specialty Listed ✓ Verified with AMA & FCVS packets ___ Entered Specialty Tab
✓ Verification of all State licenses listed
☑ ~~Pennsylvania Resident~~ Resident ☐ _____ ☐ _____
✓ No derogatory of conflicting information

FOR REVIEW:
___ Foreign Medical Graduate
___ Interrupted Education/Training/Work History
___ Inconsistent/Derogatory Information
___ Non-Accredited Post Graduate Training
___ Failed Exams More Than Three Times.

COMMENTS: _____

Federation Credentials Verification Service (FCVS):
✓ FSMB/FPDC Board Action Clearance Report

Education:
✓ Has earned a degree of doctor of medicine from an LCME accredited medical school.
✓ Official transcripts documenting degree and graduation date in English OR FCVS form.

OR

_____ Has earned a degree of doctor of medicine from a foreign medical school which met criteria for LCME accreditation.
____ Official transcripts documenting degree and graduation date in English OR FCVS form.
_____ Current ECFMG certification that is valid indefinitely or FCVS form.

Residency:
36 Completed 24 months of progressive residency in an ACGME program after receiving MD (US)
_____ Completed 24 months of progressive residency in a RCPSC OR CFPE program after receiving MD (Canada)

Utah Progressive Residency:
_____ Proof of successfully completed 12 months of resident training in an ACGME approved program.
FCVS packet or Form from Director (Circle One)
_____ Has been accepted in and is successfully participating in progressive resident training in an ACGME approved program within Utah.
Hospitals approved in Utah are: U of U, LDS, McKay Dee, St Marks and Utah Valley Regional. (Circle One)
_____ Signed agreement in application, to surrender license if 24 months of residency is not completed.

Examinations:
✓ Professional Examinations Requirements section is complete and consistent with scores received.
Date of last qualifying exam: 2/23/10

Were any combination or single exams failed 3 or more times? ✓ No _____ Yes ____ **To Noël for review**

✓ The USMLE, Steps 1,2 and 3 **AND/OR**
Step I Score: 93 IL
Step II Score: 86 PA
Step: III Score: 87

_____ The NBME, Parts 1,2 and 3
Part 1 Score: _____
Part 2 Score: _____
Part 3 Score: _____

OR

_____ The FLEX components I and II.
PART I Score: _____
PART II Score: _____

OR

_____ The FLEX component I and USMLE Step 3
FLEX I Score: _____
USMLE Step 3 Score: _____

OR

___ The NBME part I and II OR USMLE Step 1 and 2 AND the FLEX component II
NBME Part I OR USMLE Step 1 Score: _____
NBME Part II OR USMLE Step 2 Score: _____
FLEX II Score: _____

OR

___ LCMM Part 1 and 2
LCMM Part 1 Score: _____
LCMM Part 1 Score: _____

Summary

Name	Address	License Type	License Number	License Status
Leah Nicole Torres	**2223 S HIGHLAND DR STE E6 285 SALT LAKE CITY UT 84106**	**Physician & Surgeon**	**8243165-1205**	**Active**

Fees

Details

Fee Type [Complaint#]	Date Posted	Date Due	Fee Amount	Status	Balance
Application Fee	02/23/2012		$100.00	Paid in Full	**$0.00**
Application Fee	02/23/2012		$200.00	Paid in Full	**$0.00**
Renewal Fee	09/12/2013	01/31/2014	$183.00	Paid in Full	**$0.00**
Renewal Fee	09/20/2017	01/31/2018	$78.00	Paid in Full	**$0.00**
Renewal Fee	09/13/2013	01/31/2014	$78.00	Paid in Full	**$0.00**
Renewal Fee	10/30/2015	01/31/2016	$78.00	Paid in Full	**$0.00**
Renewal Fee	10/30/2015	01/31/2016	$183.00	Paid in Full	**$0.00**
Renewal Fee	09/19/2017	01/31/2018	$183.00	Unpaid	**$183.00**
Renewal Fee	09/20/2017	01/31/2018	$78.00	Unpaid	**$78.00**
Renewal Fee	09/20/2017	01/31/2018	$183.00	Paid in Full	**$0.00**
Renewal Fee	09/20/2017	01/31/2018	$183.00	Unpaid	**$183.00**

Payments

Details

Receipt Number	Receipt Total	Date Received	Manual Receipt No	Balance	Refunded Amount
3860687	$300.00	02/22/2012		$0.00	$0.00
5445568	$261.00	12/12/2013	00082431651205	$0.00	$0.00
6300291	$261.00	01/19/2016	00082431651205	$0.00	$0.00
7194211	$261.00	01/08/2018	00082431651205	$0.00	$0.00

Back