[redacted]

TARGET SHEET

Board: Medicine

Date Created:
05/03/2010

Licensee Full Name:
MATTHEW IAN FELLOWS

License No:
MT197271

APPL 2788263

271

SPOA 1415 (1/10)

Regular Mailing Address
State Board of Medicine
P.O. Box 2649
Harrisburg, PA 17105-2649
Phone: 717-783-1400 or 717-787-2381
Email: st-medicine@state.pa.us

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

HOSPITAL USE ONLY
TO BE COMPLETED FOR BULK CHECK USAGE
Hospital Name: TJUH
HS # 000240L
Receipt # 506.3315

APPLICATION FOR A GRADUATE LICENSE FOR GRADUATES OF ACCREDITED MEDICAL SCHOOLS (SCHOOLS IN THE U.S. AND CANADA)

Application Fee: $30.00 not refundable. Make check payable to the "Commonwealth of Pennsylvania." Note: A processing fee of $20.00 will be charged for any check or money order returned unpaid by your bank, regardless of the reason for non-payment.

220428

TO BE COMPLETED BY APPLICANT: (Please Print or Type)

NAME: Fellows (Last) Matthew (First) Ian (Middle)

ADDRESS: [redacted] (Street)

Philadelphia (City) PA (State) 19107 (Zip Code)

SOCIAL SECURITY # [redacted] DATE OF BIRTH: [redacted] MM/DD/YYYY

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

Are you applying using credentials verification from FCVS? ☐ YES ☐ NO

NAME & ADDRESS OF MEDICAL SCHOOL	DATES OF ATTENDANCE	DATE OF GRADUATION
Drexel University 2900 Queen Lane, Philadelphia, PA 19129	Aug '06 → May '10	May 21, 2010

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

TO BE COMPLETED BY HOSPITAL LOCATED IN PENNSYLVANIA:

NAME OF HOSPITAL: Thomas Jefferson University Hospital HS- 000240 -L

ADDRESS OF HOSPITAL: 111 S. 11th Street, Suite 2170, Philadelphia, PA 19107

YEAR IN TRAINING: 1 ACGME SPECIALTY: Family Medicine OK LEVEL IN TRAINING (PGY) 1

DATES OF TRAINING REQUESTED: June 20, 2010 (BEGINNING DATE-(MM/DD/YYYY)) TO June 19, 2011 (ENDING DATE-(MM/DD/YYYY))

I VERIFY THAT I AM THE PROGRAM DIRECTOR FOR THE HOSPITAL PROGRAM LISTED ABOVE AND THAT THIS IS AN ACGME ACCREDITED PROGRAM AT THIS HOSPITAL.

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

SIGNATURE OF PROGRAM DIRECTOR: Debra A Cifelli

RECEIVED
APR 22 2010

SPOA 1415 (1/10)

Answer the following questions. If "YES" is answered to Questions #2 through #9, provide complete details on a separate sheet as well as certified copies of relevant documents. Sign and date below.

	Yes	No
1) Do you hold or have you ever held an unrestricted license, certification, or registration (active or inactive, current or expired) to practice medicine and/or surgery in another jurisdiction? If yes, list the jurisdiction(s) here: _____		X
2) Have you withdrawn an application for a license, certificate or registration, had an application for a license denied or refused, or for any disciplinary reason agreed not to reapply for a license, certificate or registration in any profession in any state or jurisdiction?		X
3) Have you had disciplinary action taken against your license, certificate or registration issued to you in any profession in any other state or jurisdiction?		X
4) Have you been convicted, found guilty or pleaded nolo contendere, or received probation without verdict or accelerated rehabilitative disposition (ARD) as to any felony or misdemeanor, including any drug law violations, or do you have any criminal charges pending and unresolved in any state or jurisdiction? You are not required to disclose any ARD or other criminal matter that has been expunged by order of a court.		X
5) Since May 19, 2002, have you been arrested for criminal homicide, aggravated assault, sexual offenses or drug offenses in any state, territory or country?		X
6) Have you had practice privileges denied, revoked or restricted in a hospital or other health care facility, or have you been charged by a hospital, university, or research facility with violating research protocols, falsifying research, or engaging in other research misconduct?		X
7) Have you had your DEA registration denied, revoked or restricted or have you had your provider privileges terminated by any medical assistance agency for cause?		X
8) Are you, or have you ever been, addicted to the intemperate use of alcohol or to the habitual use of narcotics or other habit-forming drugs? Note: You may answer "NO" if you are currently a participant in or have successfully completed the requirements of the Board's Professional Health Monitoring Program.)	[redacted]	
9) Since May 19, 2002, have any malpractice complaints been filed against you? If yes, the Board requires that you submit a copy of the entire Civil Complaint which must include the docket number, filing date, and the date you were served.		X

SIGNED STATEMENT

Note that disclosing your social security number on this application is mandatory in order for the State Board of Medicine to comply with the requirements of the Federal Social Security Act pertaining to child support enforcement, as implemented in the Commonwealth of Pennsylvania at 23 Pa. C.S. 4304.1(a). In order to enforce domestic child support orders, the Commonwealth's licensing boards must provide to the Department of Public Welfare information prescribed by DPW about the licensee, including the social security number. Additionally, disclosing the number is mandatory in order for this board to comply with the reporting requirements of the Federal National Practitioner Data Bank and the Healthcare Integrity and Protection Data Bank. Reports to the NPDB/HIPDB must include the licensee's social security number.

I verify that the statements in this application are true and correct to the best of my knowledge, information and belief. I understand that false statements are made subject to the penalties of 18 Pa. C.S. Section 4904 relating to unsworn falsification to authorities and may result in the suspension or revocation of my license. I hereby authorize all hospitals, institutions or organizations, my references, personal physicians, employers (past and present), and all governmental agencies and instrumentalities (local, state, federal or foreign) to release to the Pennsylvania State Board of Medicine any information, files or records requested by the Board.

[redacted]
SIGNATURE OF APPLICANT

4-2-2010
DATE

SPOA 1415 (1/10)

Regular Mailing Address
State Board of Medicine
P.O. Box 2649
Harrisburg, PA 17105-2649
Phone: 717-783-1400 or 717-787-2381
Email: st-medicine@state.pa.us

Courier Delivery Address
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HOSPITAL USE ONLY
TO BE COMPLETED FOR BULK CHECK USAGE
Hospital Name: TJUH
HS # 000240L
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APPLICATION FOR A GRADUATE LICENSE FOR GRADUATES OF ACCREDITED MEDICAL SCHOOLS (SCHOOLS IN THE U.S. AND CANADA)

Application Fee: $30.00 not refundable. Make check payable to the "Commonwealth of Pennsylvania." Note: A processing fee of $20.00 will be charged for any check or money order returned unpaid by your bank, regardless of the reason for non-payment.

TO BE COMPLETED BY APPLICANT: (Please Print or Type) 220428

NAME: Fellows (Last) Matthew (First) Ian (Middle)

ADDRESS [redacted] (Street)

Philadelphia (City) PA (State) 19107 (Zip Code)

SOCIAL SECURITY [redacted] DATE OF BIRTH: [redacted] (MM/DD/YYYY)

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

Are you applying using credentials verification from FCVS? ☐ YES ☐ NO

NAME & ADDRESS OF MEDICAL SCHOOL	DATES OF ATTENDANCE	DATE OF GRADUATION
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NAME OF PROGRAM DIRECTOR: Debra A. Cifelli, Director, Medical Staff and House Staff Affairs

SIGNATURE OF PROGRAM DIRECTOR: Debra A Cifelli

RECEIVED
APR 22 2010

22C126

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

RECEIVED DIRECT

APR 26 2010

VERIFICATION OF MEDICAL EDUCATION
For Graduates of Accredited Medical Schools

SECTION 1: To be completed by applicant:

Name: Fellows (Last) Matthew (First) Ian (Middle)

Name of medical school: Drexel University College of Medicine

Location: Philadelphia, PA

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

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

Name of medical student: Matthew Ian Fellows

Date student began to attend this medical school: 8-28-2006 (MM/DD/YYYY)

Date of graduation: 5-21-2010 (MM/DD/YYYY)

I certify that all of the above information is correct.

[Seal of School]

Signature of Dean or Registrar:

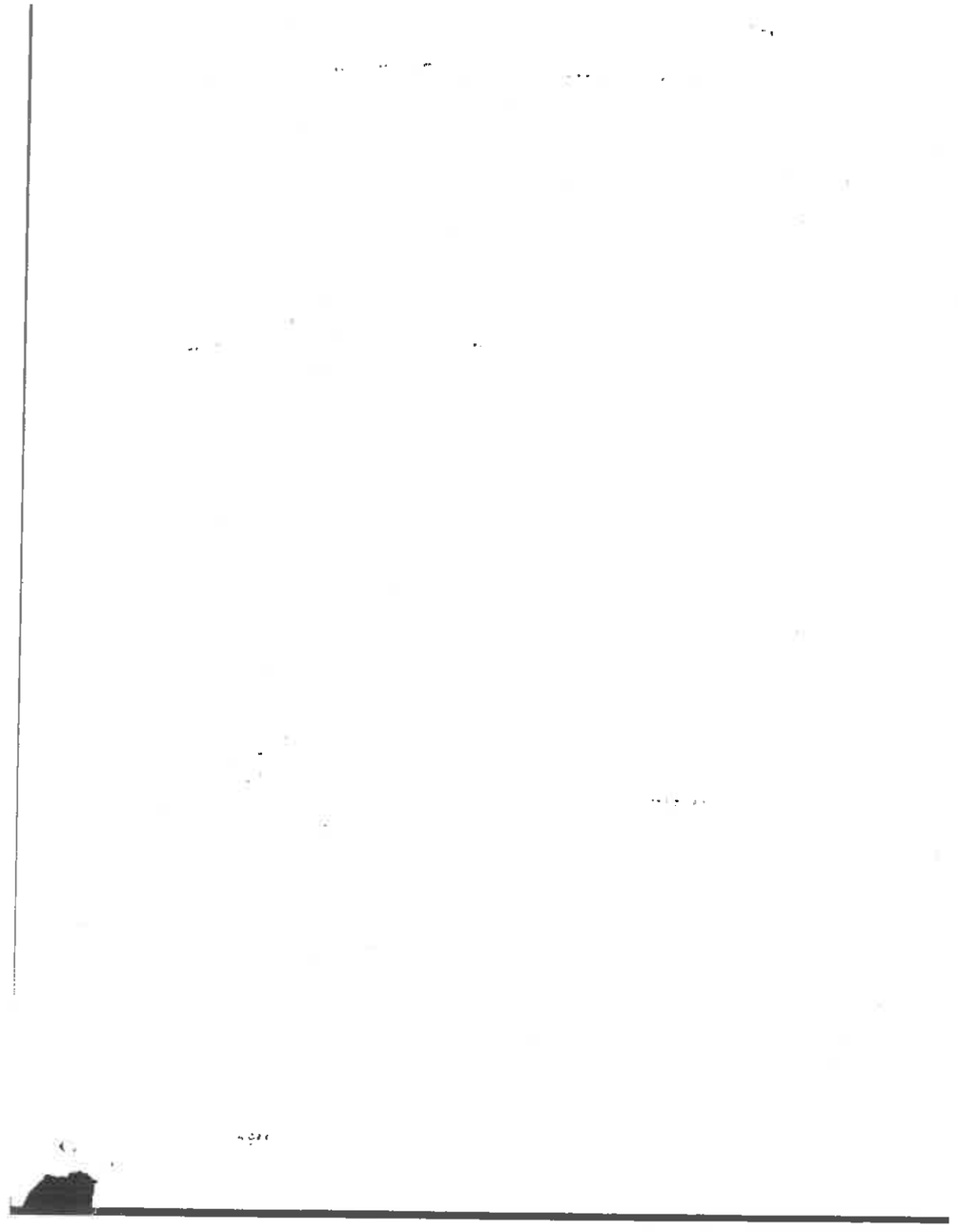
Date: 4-20-2010

This form may be completed ONLY three months prior to graduation. Upon completion, school must return this completed form directly to the Pennsylvania State Board of Medicine in an official school envelope. ***If graduation DOES NOT take place, notify the Board immediately***

DO NOT RETURN TO APPLICANT

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

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



The Federation of State Medical Boards
of the United States, Inc
PO Box 619850
Dallas, Texas 75261-9850
Telephone: (817)868-4000
FAX (817)868-4099

BOARD ACTION CLEARANCE REPORT

April 29, 2010

Attn: Tammy Radel, Administrator
Pennsylvania State Board of Medicine
PO Box 2649
Harrisburg, PA 17105

Re: Board Action Query Dated: April 29, 2010
Your Reference Number: VKUNKEL
FSMB Batch Number: BQ1753627

The following is a report of the search results from the Board Action Data Bank as of April 29, 2010 for practitioners submitted as part of the above-referenced batch for which NO board actions were identified.

Practitioners Cleared with No Actions as of April 29, 2010

Item	Name	DOB	School	Yr/Grad	Request ID
3	DEVITT, SEAN	[redacted]		2010	22185674
		LICENSE HISTORY State Board No License Information Available			
2	ENNIS, CHRISTINE	[redacted]		2010	22185659
		LICENSE HISTORY State Board No License Information Available			
1	FELLOWS, MATTHEW	[redacted]		2010	22185657
		LICENSE HISTORY State Board No License Information Available			
4	LOPEZ-GARIB, ANGEL	[redacted]		2009	22185680
		LICENSE HISTORY State Board No License Information Available			

PLEASE NOTE: The licensure history information contained in these reports is not considered licensure verification but rather an indicator of known states of historical licensure for these individuals. Use of this information should be limited to cross-reference purposes.

[redacted]

TARGET SHEET

Board: Medicine

Licensee Full Name:
MATTHEW IAN FELLOWS

License No:
MT197271

2788263_LIC_2_04/10/2014

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

MT197271
FELLOWS

RENEWAL APPLICATION

MATTHEW IAN FELLOWS [redacted]
THOMAS JEFFERSON UNIVERSITY
HOUSE STAFF OFFICE
111 SOUTH 11TH STREET
SUITE 2170
PHILADELPHIA PA 19107-5096

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

2013 APR 17 PM 2 10

[X] I will not be participating in graduate training in Pennsylvania after the expiration date indicated below and request inactive status. **No fee is required. YOU MUST SIGN, DATE AND RETURN THIS FORM.**

THE FOLLOWING QUESTIONS MUST BE ANSWERED

YES	NO	If YES to 2-8 - provide details AND attach certified copies of legal document(s).
	X	1. Do you hold or have you ever held a license, certification, or registration (active or inactive, current or expired) to practice this profession in any other state or jurisdiction? List:
	X	2. **Since your initial application or your last renewal, whichever is later,** have you ever had disciplinary action taken against your license, certification, or registration issued to you in any profession in any other state or jurisdiction?
	X	3. **Since your initial application or your last renewal, whichever is later,** have you withdrawn an application for a license, certification, or registration, had an application denied or refused, or for disciplinary reasons agreed not to reapply for a license, certificate or registration in any profession in any state or jurisdiction?
	X	4. **Since your initial application or your last renewal, whichever is later,** have you been convicted, found guilty or pleaded nolo contendere, or received probation without verdict or accelerated rehabilitative disposition (ARD) as to any felony or misdemeanor, including any drug law violations, or do you have any criminal charges pending and unresolved in any state or jurisdiction? You are not required to disclose any ARD or other criminal matter that has been expunged by order of a court.
	X	5. **Since May 19, 2002, have you been arrested for criminal homicide, aggravated assault, sexual offenses, or drug offenses in any state, territory, or country?**
	X	6. **Since your initial application or your last renewal, whichever is later,** have you had practice privileges denied, revoked or restricted in a hospital or other health care facility?
	X	7. **Since your initial application or your last renewal, whichever is later,** have you had your DEA registration denied, revoked or restricted or have you had your provider privileges terminated by any medical assistance agency for cause?
	X	8. **Since May 19, 2002, have any malpractice complaints been filed against you? If yes, the Board requires that you submit a copy of the entire Civil Complaint, which must include the filing date and the date you were served. If the Civil Complaint was previously submitted, provide a statement, which lists the docket number.**

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

	Beginning Date	Ending Date	Level	Specialty	Hospital #	Hospital Name
Current	7/1/2012	6/30/2013	Level 3	Family Medicine	HS000240L	THOMAS JEFFERSON UNIVERSITY
Renewal						

Signature of Licensee (Mandator[redacted] Matthew Fellows, M.D. Date: 4/9/13

Medical School Graduation Date: May, 2010 SSN [redacted]

ATTACHMENTS FOR RENEWING:

- **FEE** – $15.00 check payable to "COMMONWEALTH OF PENNSYLVANIA". Write your license number on your payment. A $20.00 fee will be assessed for a returned payment.
- **LATE FEE** - $5.00 per month, or part of a month. Late renewal fee will be assessed if postmarked after the expiration date.
- **NAME CHANGE DOCUMENT – Submit a photocopy of a legal document verifying name change (i.e., marriage certificate, divorce decree, etc.)**
- **PGY 2 LEVEL** – Copy of your USMLE Step 1 and 2 scores OR FLEX I scores OR National Board Part 1 and 2 scores OR an acceptable combination as indicated in the regulations.
- **PGY 3 LEVEL or above** – Copy of your USMLE Step 3 scores OR FLEX I and II scores OR National Board Parts 1-3 scores OR an acceptable combination as indicated in the regulations OR a copy of your unrestricted license WHICH SHOWS THE CURRENT EXPIRATION DATE.

[redacted]

TARGET SHEET
BOARD
Medicine

Licensee Full Name
MATTHEW IAN FELLOWS
License No
MT197271

2788263_LIC_2_6/2/2011

5722187

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

MT197271
FELLOWS

RENEWAL APPLICATION

MATTHEW IAN FELLOWS [redacted]
THOMAS JEFFERSON UNIVERSITY
HOUSE STAFF OFFICE
111 SOUTH 11TH STREET
SUITE 2170
PHILADELPHIA PA 19107-5096

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

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THE FOLLOWING QUESTIONS MUST BE ANSWERED

YES	NO	If YES to 2-8 - provide details AND attach certified copies of legal document(s).
	✓	1. Do you hold or have you ever held a license, certification, or registration (active or inactive, current or expired) to practice this profession in any other state or jurisdiction? List:
	✓	2. Since your initial application or your last renewal, whichever is later, have you ever had disciplinary action taken against your license, certification, or registration issued to you in any profession in any other state or jurisdiction?
	✓	3. Since your initial application or your last renewal, whichever is later, have you withdrawn an application for a license, certification, or registration, had an application denied or refused, or for disciplinary reasons agreed not to reapply for a license, certificate or registration in any profession in any state or jurisdiction?
	✓	4. Since your initial application or your last renewal, whichever is later, have you been convicted, found guilty or pleaded nolo contendere, or received probation without verdict or accelerated rehabilitative disposition (ARD) as to any felony or misdemeanor, including any drug law violations, or do you have any criminal charges pending and unresolved in any state or jurisdiction? You are not required to disclose any ARD or other criminal matter that has been expunged by order of a court.
	✓	5. Since May 19, 2002, have you been arrested for criminal homicide, aggravated assault, sexual offenses, or drug offenses in any state, territory, or country?
	✓	6. Since your initial application or your last renewal, whichever is later, have you had practice privileges denied, revoked or restricted in a hospital or other health care facility?
	✓	7. Since your initial application or your last renewal, whichever is later, have you had your DEA registration denied, revoked or restricted or have you had your provider privileges terminated by any medical assistance agency for cause?
	✓	8. Since May 19, 2002, have any malpractice complaints been filed against you? If yes, the Board requires that you submit a copy of the entire Civil Complaint, which must include the filing date and the date you were served. If the Civil Complaint was previously submitted, provide a statement, which lists the docket number.

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

	Beginning Date	Ending Date	Level	Specialty	Hospital #	Hospital Name
Current	06/20/2010	06/19/2011	Level 1	Family Medicine	HS000240L	THOMAS JEFFERSON UNIVERSITY
Renewal	7/1/2011	6/30/2012	2	Family Medicine	HS000240L	Thomas Jefferson Univ

Signature of Licensee **(Mandatory)**: [redacted] Date: 4/14/11

Medical School Graduation Date: May 2010 MAY 05 2011 SSN: [redacted]

ATTACHMENTS FOR RENEWING:

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US·MLE
United States Medical Licensing Examination™

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

This document was prepared by
National Board of Medical Examiners® (NBME®)
3750 Market Street Philadelphia, PA 19104-3190 - Telephone (215) 590-9700

Date: 01/25/2010

Examinee: Fellows, Matthew Ian

Examinee ID: 5-211-674-6
Date of Birth: [redacted]

Results for all 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
06/09/2008	Pass	239	(185)	99	(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
09/24/2009	Pass	231	(184)	95	(75)	

Clinical Skills (CS)*

Test Date	Pass/Fail	Comments
10/29/2009	Pass	

*Performance on the CS component of Step 2 is reported as pass or fail.

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

[redacted]

TARGET SHEET
BOARD
Medicine

Licensee Full Name
MATTHEW IAN FELLOWS
License No
MT197271

2788263_LIC_2_6/5/2012

6205513

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

MT197271
FELLOWS

RENEWAL APPLICATION

MATTHEW IAN FELLOWS 9849
THOMAS JEFFERSON UNIVERSITY
HOUSE STAFF OFFICE
111 SOUTH 11TH STREET
SUITE 2170
PHILADELPHIA PA 19107-5096

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

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THE FOLLOWING QUESTIONS MUST BE ANSWERED

YES	NO	If YES to 2-8 - provide details AND attach certified copies of legal document(s).
	X	1. Do you hold or have you ever held a license, certification, or registration (active or inactive, current or expired) to practice this profession in any other state or jurisdiction? List:
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Current	07/01/2011	06/30/2012	Level 2	Family ~~State Board of~~ Medicine	HS000240L	THOMAS JEFFERSON UNIVERSITY
Renewal	7/1/2012	6/30/2013	3	Family Medicine	"	"

Signature of Licensee (Mandatory): [redacted] Date: 4/12/12

Medical School Graduation Date: May, 2010 SSN: [redacted]

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RECEIVED
MAY 16 2012
BY

US·MLE
United States Medical Licensing Examination®

UNITED STATES MEDICAL LICENSING EXAMINATION®

STEP 3 SCORE REPORT

This score report is provided for the use of the examinee.
Third-party users of USMLE information are advised to rely solely on official USMLE transcripts.

Fellows, Matthew Ian
USMLE ID: 5-211-674-6 **Test Date: December 7, 2011**

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

PASS	This result is based on the minimum passing score recommended by USMLE for Step 3. Individual licensing authorities may accept the USMLE-recommended pass/fail result or may establish a different passing score for their own jurisdictions.
232	This score is determined by your overall performance on Step 3. For recent administrations, the mean and standard deviation for first-time examinees from U.S. and Canadian medical schools are approximately 217 and 17, respectively, with most scores falling between 140 and 260. A score of 190 is recommended by USMLE to pass Step 3. The standard error of measurement (SEM)‡ for this scale is approximately six points.
86	This score is also determined by your overall performance on the examination. A score of 75 on this scale, which is equivalent to a score of 190 on the scale described above, is recommended by USMLE to pass Step 3. The SEM‡ for this scale is approximately one point.

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

COMMONWEALTH OF PENNSYLVANIA
DEPARTMENT OF STATE

BUREAU OF PROFESSIONAL AND OCCUPATIONAL AFFAIRS
POST OFFICE BOX 2649
HARRISBURG, PA 17105-2649

www.dos.pa.gov

11/23/2016

VERIFICATION/CERTIFICATION OF LICENSE

This is to certify that the individual or business named below is licensed by the Department of State, Bureau of Professional and Occupational Affairs:

NAME:	FELLOWS, MATTHEW
LICENSE TYPE:	Medical Physician and Surgeon
LICENSE #:	MD448251
LICENSE STATUS:	Active
LICENSE ISSUE DATE:	04/02/2013
LICENSE EXPIRATION DATE:	12/31/2016
DISCIPLINARY HISTORY:	No Disciplinary Action Exists

Ian J. Harlow, Commissioner
Bureau of Professional and Occupational Affairs

Person Info
Name: MATTHEW IAN FELLOWS
Address Info

Street Address [redacted] **Ema** [redacted]@GMAIL.COM
Phone [redacted]
Fax
City Philadelphia
State PA
Zipcode 19107
Country 82
County Philadelphia

Are you submitting a name change with this renewal?	N
Have you met your current CE requirements?	Y
Have you completed 2 hours of Board-approved continuing education in child abuse recognition and reporting?	Y
Do you hold, or have you ever held, a license, certificate, permit, registration or other authorization to practice a profession or occupation in any state or jurisdiction?	N
If you answered yes to the above questions, please provide the profession and state or jurisdiction.	
Since your initial application or last renewal, whichever is later, have you had disciplinary action taken against a professional or occupational license, certificate, permit, registration or other authorization to practice a profession or occupation issued to you in any state or jurisdiction or have you agreed to voluntary surrender in lieu of discipline?	N
Do you currently have any disciplinary charges pending against your professional or occupational license, certificate, permit or registration in any state or jurisdiction?	N
Since your initial application or last renewal, whichever is later, have you withdrawn an application for a professional or occupational license, certificate, permit or registration, had an application denied or refused, or for disciplinary reasons agreed not to apply or reapply for a professional or occupational license, certificate, permit or registration in any state or jurisdiction?	N
Since your initial application or last renewal, whichever is later, have you been convicted (found guilty, pled guilty or pled nolo contendere), received probation without verdict or accelerated rehabilitative disposition (ARD), as to any criminal charges, felony or misdemeanor, including any drug law violations? Note: You are not required to disclose any ARD or other criminal matter that has been expunged by order of a court.	N
Do you currently have any criminal charges pending and unresolved in any state or jurisdiction?	N
Since your initial application or last renewal, whichever is later, have you had your DEA registration denied, revoked or restricted?	N
Since your initial application or your last renewal, whichever is later, have you had provider privileges denied, revoked, suspended or restricted by a Medical Assistance agency, Medicare, third party payor or another authority?	N
Since your initial application or your last renewal, whichever is later, have you ever had practice privileges denied, revoked, suspended, or restricted by a hospital or any health care facility?	N
Since your initial application or your last renewal, whichever is later, have you been charged by a hospital, university, or research facility with violating research protocols, falsifying research, or engaging in other research misconduct?	N
Since your initial application or last renewal, whichever is later, have you engaged in the intemperate or habitual use or abuse of alcohol or narcotics, hallucinogenics or other drugs or substances that may impair judgment or coordination?	[redacted]
If yes, are you currently participating in the Pennsylvania Professional Health Monitoring Program?	
Since your initial application or your last renewal, whichever is later, have you been the subject of a civil malpractice lawsuit?	N
If yes, please submit a copy of the entire Civil Complaint, which must include the filing date and the date you were served. Submit a statement which includes complete details of the complaints that have been filed against you. PLEASE NOTE: If you previously reported the complaint to the Board you will only need to provide the docket number here:	
Do you maintain current medical professional liability insurance in the Commonwealth of Pennsylvania?	Y
If you answer "No", please provide an explanation or reason for an exemption request.	

Date Submitted: Wednesday, November 05, 2014

Education Info

No education records

Employment Information

No employment records

[redacted]

TARGET SHEET

Board: Medicine

Licensee Full Name:
MATTHEW IAN FELLOWS

License No:
MD448251

3092535_LIC_1_04/02/2013

I

MD448251 (01/2013)

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

APPLICATION FOR A LICENSE TO PRACTICE MEDICINE WITHOUT RESTRICTION FOR GRADUATES OF ACCREDITED MEDICAL SCHOOLS (SCHOOLS IN THE U.S. AND CANADA)

MT197271 319758

Submit the $35 fee, check or money order, made payable to the "Commonwealth of Pennsylvania." **FEES ARE NOT REFUNDABLE.** **Check or money order must be in U.S. funds**. Note: A processing fee of $20 will be charged for any check or money order returned unpaid by your bank, regardless of the reason for non-payment. Your cancelled check is your receipt of payment.

TO BE COMPLETED BY APPLICANT
(Please print or type)

NAME:	Last: Fellows	First: Matthew	Middle: Ian
ADDRESS:	Street: [redacted]		
City: Philadelphia		State: PA	ZIP: 19107
DATE OF BIRTH: Month / Day / Year [redacted]		SOCIAL SECURITY NUMBER: [redacted]	
EMAIL ADDRESS: [redacted]@gmail.com			
PHONE NUMBER: [redacted]			
If your medical/licensure records are listed under another name or names, please list below:			
APPLYING USING FCVS (FEDERATION CREDENTIAL VERIFICATION SERVICE):		☐ YES	☐ NO
HAVE YOU PREVIOUSLY HELD A PA MEDICAL TRAINING LICENSE?	☒ YES - LICENSE NO. MT197271		☐ NO

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FEB 26 2013

(01/2013)

APPLICATION FOR UNRESTRICTED LICENSE - AMERICAN

NAME OF APPLICANT:	Last	First	Middle
	Fellows	Matthew	Ian

NAME & ADDRESS OF MEDICAL SCHOOL

1. NAME OF MEDICAL SCHOOL:	Drexel University College of Medicine											
ADDRESS OF SCHOOL:	2900 W. Queen Lane, Philadelphia, PA 19129											
DATE OF ATTENDANCE:	FROM	Month	Day	Year	TO	Month	Day	Year	DATE OF GRADUATION:	Month	Day	Year
		08		2006		05	21	10		5	21	10
2. NAME OF MEDICAL SCHOOL:												
ADDRESS OF SCHOOL:												
DATE OF ATTENDANCE:	FROM	Month	Day	Year	TO	Month	Day	Year	DATE OF GRADUATION:	Month	Day	Year

EXAMINATION INFORMATION

CHECK LICENSING EXAMINATION(S) PASSED:		STATE WHERE TAKEN	DATE TAKEN	
	☐ FLEX		COMPONENT 1:	
			COMPONENT 2:	
	☐ NATIONAL BOARD	PART I:	PART II:	PART III:
	☒ USMLE	STEP 1: 6/9/08 - 239	STEP 2: CS: 10/24/09 9/24/09 - 231	STEP 3: 12/7/11 - 232
	☐ LMCC – CANADIAN			
	☐ STATE BOARD	INDICATE STATE WHERE TAKEN:		

ACGME POST GRADUATE TRAINING

PGY 1 HOSPITAL:	Thomas Jefferson University Hosp.	FROM: (MM/DD/YYYY) 06/20/2010	TO: (MM/DD/YYYY) 06/30/2011
PGY 2 HOSPITAL:	Thomas Jefferson University Hosp.	FROM: (MM/DD/YYYY) 7/1/2011	TO: (MM/DD/YYYY) 6/30/2012
Other HOSPITAL:		FROM: (MM/DD/YYYY)	TO: (MM/DD/YYYY)
Other HOSPITAL:		FROM: (MM/DD/YYYY)	TO: (MM/DD/YYYY)

IF YOU NEED TO LIST ADDITIONAL POST GRADUATE TRAINING, PLEASE MAKE COPIES OF THIS FORM.

PGY 3 7/1/12 to present

FEB 26 2013

(01/2013)

LEGAL QUESTIONS

You must answer the following questions.

If you answer "YES" to #2 through #9, provide complete details on a separate sheet as well as certified copies of relevant documents. **Sign and date below.**

		Yes	No
1.	Do you hold or have you ever held an unrestricted license, certification, or registration (active or inactive, current or expired) to practice medicine and/or surgery in any jurisdiction? **If yes, list the jurisdiction(s) here:**		X
2.	Have you withdrawn an application for a license, certificate or registration, had an application for a license denied or refused, or for any disciplinary reason agreed not to reapply for a license, certificate or registration in any profession in any state or jurisdiction?		X
3.	Have you had disciplinary action taken against your license, certificate or registration issued to you in any profession in any other state or jurisdiction?		X
4.	Have you been convicted, found guilty or pleaded nolo contendere, or received probation without verdict or accelerated rehabilitative disposition (ARD) as to any felony or misdemeanor, including any drug law violations, or do you have any criminal charges pending and unresolved in any state or jurisdiction? You are not required to disclose any ARD or other criminal matter that has been expunged by order of a court.		X
5.	Since May 19, 2002, have you been arrested for criminal homicide, aggravated assault, sexual offenses or drug offenses in any state, territory or country?		X
6.	Have you had practice privileges denied, revoked or restricted in a hospital or other health care facility, or have you been charged by a hospital, university, or research facility with violating research protocols, falsifying research, or engaging in other research misconduct?		X
7.	Have you had your DEA registration denied, revoked or restricted or have you had your provider privileges terminated by any medical assistance agency for cause?		X
8.	Are you, or have you ever been, addicted to the intemperate use of alcohol or to the habitual use of narcotics or other habit-forming drugs? **Note: You may answer "NO" if you are currently a participant in or have successfully completed the requirements of the Pennsylvania Department of State Professional Health Monitoring Program.**	[redacted]	
9.	Since May 19, 2002, have any malpractice complaints been filed against you? If yes, the Board requires that you submit a copy of the **entire Civil Complaint** which must include the **docket number**, **filing date**, and the **date you were served**.		X

SIGNED STATEMENT

Note that disclosing your social security number on this application is mandatory in order for the State Board of Medicine to comply with the requirements of the federal Social Security Act pertaining to child support enforcement, as implemented in the Commonwealth of Pennsylvania at 23 Pa. C.S. 4304.1(a). In order to enforce domestic child support orders, the Commonwealth's licensing boards must provide to the Department of Public Welfare information prescribed by DPW about the licensee, including the social security number. Additionally, disclosing the number is mandatory in order for this board to comply with the reporting requirements of the federal National Practitioner Data Bank and the Healthcare Integrity and Protection Data Bank. Reports to the NPDB/HIPDB must include the licensee's social security number.

I verify that the statements in this application are true and correct to the best of my knowledge, information and belief. I understand that false statements are made subject to the penalties of 18 Pa. C.S. Section 4904 relating to unsworn falsification to authorities and may result in the suspension or revocation of my license or certificate. I hereby authorize all hospitals, institutions or organizations, my references, personal physicians, employers (past and present), and all governmental agencies and instrumentalities (local, state, federal or foreign) to release to the [redacted] files or records requested by the Board.

[redacted]
Signature of Applicant

2/20/2013
Date

Matthew Fellows M.D.
Printed Name of Applicant

FEB 26 2013

MD

BL

(01/2013)

RECEIVED [illegible]

VERIFICATION OF ACGME APPROVED GRADUATE MEDICAL TRAINING
(Graduates of American/Canadian Medical Schools)

SECTION 1 – TO BE COMPLETED BY APPLICANT

NAME:	Last	First	Middle
	Fellows	Matthew	Ian

1. If training began before July 1, 1987, one year of approved training at a first (PGY 1) or second (PGY 2) year level must be verified. If the training began on or after July 1, 1987, two (2) years of approved training are required, one at first (PGY 1) year level and one at second (PGY 2) year level.

2. Training at a first (PGY 1) year must be ACGME approved entry level (training which requires no previous training). Training at a second (PGY 2) year must be ACGME approved and can be any specialty.

3. **Effective immediately, ALL applicants will be required to submit verification of any and all U.S. or Canadian postgraduate training completed (including ACGME or non-ACGME accredited). This is in addition to verifying the required PGY1 and PGY2 listed above. Until all postgraduate training has been verified, the application will be considered incomplete and a license will NOT be issued.**

4. If training was completed at more than one hospital, duplicate this form and submit to each hospital.

SECTION 2 – TO BE COMPLETED BY PROGRAM DIRECTOR WHERE THE GRADUATE TRAINING OCCURRED

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

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

LOCATED IN: CITY	STATE	
Philadelphia	PA	

	FROM (MM/DD/YYYY)	TO (MM/DD/YYYY)	SPECIALTY	ACGME ACCREDITED Yes	No
PGY LEVEL 1	06/20/2010	06/19/2011	Family Medicine	✓	
PGY LEVEL 2	07/01/2011	06/30/2012	Family Medicine	✓	

"I certify that the above named applicant successfully completed/will successfully complete this graduate medical training and that there was/is no disciplinary action outstanding against this applicant. If this applicant does not complete this training, the Board will be notified." If there has been disciplinary or administrative action regarding this applicant, please provide a separate statement outlining the details.

If the hospital has no seal or stamp to affix to this document, I will have the form notarized to verify that it was completed by this hospital.

[signature] — **Signature of Program Director**

3/6/13 — **Date**

(Seal)

Notary Signature

Notary Commission Expiration Date: _____

Regular Mailing Address
STATE BOARD OF MEDICINE
P.O. BOX 2649
HARRISBURG, PA 17105-2649
717-783-1400/717-787-2381

Courier Delivery Address
STATE BOARD OF MEDICINE
2601 NORTH THIRD STREET
HARRISBURG, PA 17110

RECEIVED
MAR 14 2013
By _____

RETURN COMPLETED FORM DIRECTLY TO THE BOARD IN OFFICIAL HOSPITAL ENVELOPE

MD

BL

(01/2013)

RECEIVED DIRECT

PENNSYLVANIA STATE BOARD OF MEDICINE

VERIFICATION OF MEDICAL EDUCATION
(For Graduates of American/Canadian Medical Schools)

SECTION 1 – TO BE COMPLETED BY APPLICANT

NAME:	Last Fellows	First Matthew	Middle Ian
NAME OF MEDICAL SCHOOL:	Drexel University College of Medicine		
LOCATION:	2900 W. Queen Lane, Philadelphia, PA 19129		

Submit the verification of medical education form to your medical school and request the school return the completed form directly to the Board in an official school envelope.

SECTION 2 – TO BE COMPLETED BY DEAN OR REGISTRAR OF MEDICAL SCHOOL

NAME OF MEDICAL SCHOOL:	Drexel University College of Medicine		
NAME OF MEDICAL STUDENT:	Last Fellows	First Matthew	Middle I.

	Month	Day	Year
DATE STUDENT BEGAN TO ATTEND THIS MEDICAL SCHOOL:	08	10	2006
DATE OF GRADUATION:	05	21	2010

I CERTIFY THAT ALL OF THE INFORMATION LISTED ABOVE IS CORRECT

SIGNATURE OF DEAN/REGISTRAR:			
DATE:	Month 03	Day 05	Year 2013

(Seal of School)

Upon completion, school must return this completed form directly to the Pennsylvania State Board of Medicine in an official school envelope.

DO NOT RETURN THIS FORM TO THE APPLICANT

Regular Mailing Address
STATE BOARD OF MEDICINE
P.O. BOX 2649
HARRISBURG, PA 17105-2649
717-783-1400/717-787-2381

Courier Delivery Address
STATE BOARD OF MEDICINE
2601 NORTH THIRD STREET
HARRISBURG, PA 17110

MAR 11 2013

USMLE
United States Medical Licensing Examination

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

This document was prepared by the
Federation of State Medical Boards of the United States, Inc.
Federation Place, 400 Fuller Wiser Road, Suite 300, Euless, TX 76039-3856 -- Telephone (817) 868-4000

Date: 02/21/2013

Recipient:

Pennsylvania State Board of Medicine
ATTN: Tammy Dougherty
2601 N Third Street
Harrisburg, PA 17110

319758

Examinee: Fellows, Matthew
Alt Name(s): Fellows, Matthew Ian

Examinee ID#: 5-211-674-6
Date of Birth: [redacted]

Results for Steps taken by this examinee (and for which results have been reported to date) are shown below. For Steps that span more than one day, the test date reflects the day on which the examination began. Where numeric scores are reported, there are two scales used and the recommended minimum passing score ("MP") on each scale is shown in parentheses.

USMLE STEP 1

			Three-Digit Score		Two-Digit Score		
Test Date	Pass/Fail	Total	MP	Total	MP	Comments
06/09/2008	Pass	239	185	99	75	

USMLE STEP 2

Clinical Knowledge (CK)

			Three-Digit Score		Two-Digit Score		
Test Date	Pass/Fail	Total	MP	Total	MP	Comments
09/24/2009	Pass	231	184	95	75	

Clinical Skills (CS)*

			Three-Digit Score		Two-Digit Score		
Test Date	Pass/Fail	Total	MP	Total	MP	Comments
10/29/2009	Pass					

USMLE STEP 3

			Three-Digit Score		Two-Digit Score		
Test Date	Pass/Fail	Total	MP	Total	MP	Comments
PENNSYLVANIA 12/07/2011	Pass	232	190	86	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.

FEB 21 2013

Matthew Ian Fellows, MD

HOME ADDRESS
[redacted]
Philadelphia, PA 19107
[redacted]@gmail.com

HOSPITAL ADDRESS
833 Chestnut St, Suite 301
Philadelphia, PA 19107

EDUCATION

Thomas Jefferson University Hospital — July 2010 – June 2013 (anticipated)
Family Medicine Resident Program, Philadelphia, PA

Drexel University College of Medicine — August 2006 – June 2010
Doctor of Medicine. Philadelphia, PA

University of California at Berkeley — August 2001 – December 2005
Bachelor of Science, Microbial Biology. Berkeley, CA.
- Minor in Music
- Graduated with Honors

PROJECTS/ACCOMPLISHMENTS

- Rapid HIV Testing — 2011 – present
  - Overseeing an attempt to implement a rapid HIV test in the office
- Intern Education Liaison — 2012 – 2013
  - Responsible for organizing speakers and content for the intern lecture series
- Quality Improvement – Department of Family & Community Medicine — 2011 – present
  - Spent over 100 additional hours for the department to improve reporting of quality measures and addressing gaps in patient care
- Quality Improvement – Resident Team Projects — 2011 – present
  - Improving rates of colorectal cancer screening
  - Improving practice no-show rates
- HIV Medical Management — December 2012
  - Completed a three-day course by the MidAtlantic AIDS Education and Training Center
- Patient Experience Improvement Committee — 2012 – present
  - Charged with creating an atmosphere that promotes patient- and family-centered care throughout Jefferson Family Medicine
- Residency Selection Committee — 2011 – 2012
- JFMA Bookclub – organizer — 2012 – present
- Professionalism Citation of the Peer Evaluation Program — June 2008
  - For Exemplifying the Highest Standards of Professionalism in Pre-Clinical Studies during medical school
- Academic Assistant in Microanatomy — 2007 – 2008
  - Tutored 1st year students in microanatomy and cell biology

SKILLS AND COMPETENCIES

- HIV Care Management
- Cross-sex hormone therapy and treatment of transgender individuals
- Mirena IUD insertion

- Nexplanon implant insertion
- Colposcopy
- Endometrial biopsy
- Motivational interviewing of adolescent patients
- Refugee health

RESEARCH IN PROGRESS/SCHOLARY ACTIVITY

"*Effects on biomarkers after starting cross-sex hormone therapy*" — 2012 – present
- A retrospective chart review of FTM and MTF transsexual patients to evaluate the effects of starting cross-sex hormone therapy on routine biomarkers. Co-investigator. In progress. PI: Andrew Goodman, MD

"*Rapid HIV Testing in a large, urban, primary care setting*" — 2011 – present
- In conjunction with the department of infectious disease, I am implementing a rapid HIV test in the family medicine office in an effort to ultimately comply with the CDC guidelines of universal testing. Co-investigator. In progress. PI: Kathleen Squires, MD

"*Description of a Transgender population in an inner-city LGBT health center*" — 2012 – present
- A descriptive study of the transgender population at the Mazzoni Center in Philadelphia, PA. Co-investigator. In progress. PI: Andrew Goodman, MD

"*A Phase III Clinical Trial to Study the Tolerability and Immuno-genicity of V503, a Multivalent Human Papillomavirus (HPV) L1 Virus-Like Particle (VLP) Vaccine, in 16- to 26-Year-Old Men and 16- to 26-Year-Old Women*" — 2012 – present
- Trial for 9-valent HPV vaccine. Key personnel at the Jefferson clinical site. In progress. Responsible for recruitment within the MSM population

PROFESSIONAL PRESENTATIONS

- "*Acne: Beyond Benzoyl Peroxide*." Resident Lecture Series — August 2011
- "*Cirrhosis*." Resident Lecture Series — March 2012
- "*Journal Club*." Resident Lecture Series — October 2012
- "*Morbidity and Mortality*." Grand Rounds — November 2012, June 2012, January 2012

VOLUNTEER ACTIVITIES

Adolescent Walk-In Clinic – Mazzoni Center. Philadelphia, PA. — 2009 – present
- Weekly volunteer clinician at a free walk-in clinic on Wednesday nights geared toward LGBT adolescents

JeffHOPE – Jefferson Medical College, Philadelphia, PA. — 2010 – present
- Supervising physician for various student-run free clinics

Drexel LGBTPM – Lesbian, Gay, Bisexual, Transgender People in Medicine — 2007 – 2008
- Co-President, organized activities to educate classmates about how to care for LGBT patients and promote tolerance and understanding

The Attic Youth Center — 2006 – 2007
- The Attic is the largest lesbian, gay, bisexual, transgender youth center in the Philadelphia area
- Facilitated a weekly art group

PROFESSIONAL MEMBERSHIPS/EXAMS

American Academy of Family Physicians
Pennsylvania Academy of Family Physician
USMLE Steps I, II, and III – Passed

WORK EXPERIENCE

Go Vertical Rock Climbing Gym — June 2007 – June 2008

- Worked part-time belaying for participants at rock climbing facility

The Scholar's Workstation - UC Berkeley's campus computer store — January 2002 – June 2006

- Sales Assistant and Buyer
- Responsible for purchasing and maintaining inventory of computer accessories and IBM/Lenovo computers

PROFESSIONAL INTERESTS

LGBT healthcare, HIV primary care, Care of the urban underserved, Teaching of students and residents

mO

the DataBank

P.O. Box 10832
Chantilly, VA 20153-0832

http://www.npdb-hipdb.hrsa.gov

5500000080291507
Process Date: 02/27/2013
Page: 1 of 1

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FELLOWS, MATTHEW IAN - SELF-QUERY RESPONSE

YOUR IDENTIFYING INFORMATION (Entities should verify that it is correct)

Practitioner Name: FELLOWS, MATTHEW IAN
Date of Birth: [redacted] **Gender:** MALE
Organization Name: MATTHEW FELLOWS
Organization Type: MEDICAL GROUP/PRACTICE (365)
Work Address: 1035 SPRUCE ST #306, PHILADELPHIA, PA 19107
Social Security Number: [redacted] **NPI:** 1679894372
License: PHYSICIAN INTERN/RESIDENT (MD), MT197271, PA, GENERAL PRACTICE/FAMILY PRACTICE
Professional School(s): DREXEL UNIVERSITY COLLEGE OF MEDICINE (2010)

PAYMENT INFORMATION

Credit Card Information: [redacted]
NPDB Charge: $8.00* **NPDB Bill Reference Number:** N30555553
HIPDB Charge: $8.00* **HIPDB Bill Reference Number:** H30555553
* Each charge will appear separately on your credit card statement.
Transaction Date: 02/27/2013 **Additional Paper Copies Requested:** 0

SUMMARY OF REPORTS ON FILE WITH THE DATA BANK AS OF 02/27/2013

The following report types have been searched:

Medical Malpractice Payment Report(s):	No Reports	Health Plan Action(s):	No Reports
State Licensure Action(s):	No Reports	Professional Society Action(s):	No Reports
Exclusion or Debarment Action(s):	No Reports	DEA/Federal Licensure Action(s):	No Reports
Government Administrative Action(s):	No Reports	Judgment or Conviction Report(s):	No Reports
Clinical Privileges Action(s):	No Reports	Peer Review Organization Action(s):	No Reports

Copies of these reports are enclosed for restricted/limited use as prescribed by statutes listed on the preceeding cover page.

---------- **No Reports Found** ----------

Received
MAR 25 2013
By

CONFIDENTIAL DOCUMENT - FOR AUTHORIZED USE ONLY

the DataBank

P.O. Box 10832
Chantilly, VA 20153-0832

http://www.npdb-hipdb.hrsa.gov

5500000080291507
Process Date: 02/27/2013
Page: 1 of 1

To: FELLOWS, MATTHEW IAN
[redacted]
PHILADELPHIA, PA 19107

From: National Practitioner Data Bank / Healthcare Integrity and Protection Data Bank
Re: Response to Your Self-Query

The enclosed information is released by the National Practitioner Data Bank (NPDB) for restricted use under the provisions of Title IV of Public Law 99-660, the Health Care Quality Improvement Act of 1986, as amended and Section 1921 of the Social Security Act and the Healthcare Integrity and Protection Data Bank (HIPDB) for restricted use under the provisions of Section 1128E of the Social Security Act.

Title IV established the NPDB as an information clearinghouse to collect and release certain information related to malpractice payment history and professional competence or conduct of physicians, dentists, and other licensed health care practitioners.

Section 1921 of the Social Security Act, as amended by Section 5(b) of the Medicare and Medicaid Patient and Program Protection Act of 1987, and as amended by the Omnibus Reconciliation Act of 1990, expanded the scope of the NPDB. Section 1921 was enacted to protect program beneficiaries from unfit health care practitioners, and to improve the anti-fraud provisions of Federal and State health care programs. This legislation authorizes the NPDB to collect certain adverse State licensure actions, as well as any negative action or finding that a State licensing authority, peer review organization, or private accreditation organization has concluded against a health care practitioner or health care entity.

Section 1128E of the Social Security Act was established by Section 221 (a) of Public Law 104-191, The Health Insurance Portability and Accountability Act of 1996, as amended. This legislation established the HIPDB to combat fraud and abuse in health care delivery and to improve the quality of patient care . The HIPDB serves as a source of final adverse action information on health care practitioners, providers, and suppliers. The HIPDB collects and releases information related to adverse licensure actions, health care-related convictions and judgments; exclusions from Federal and State health care programs; and other adjudicated actions or decisions.

Regulations governing the NPDB are codified at 45 CFR part 60 and Section 1921 and the HIPDB are codified at 45 CFR part 61. Responsibility for operating the NPDB resides with the U.S. Department of Health and Human Services, Health Resources Services Administration, Division of Practitioner Data Banks. Responsibility for operating the HIPDB resides with the U.S. Department of Health and Human Services, Office of Inspector General, and the Health Resources Services Administration, Division of Practitioner Data Banks.

Reports from the NPDB and HIPDB contain limited summary information and should be used in conjunction with information from other sources in granting privileges, or in making employment affiliation, contracting or licensure decisions. NPDB/HIPDB responses may contain more than one report on a particular incident, if two or more actions were taken as a result of a single incident (e.g., an exclusion from a Federal or State health plan and an adverse licensure action). The NPDB-HIPDB is a flagging system, and a report may be included for a variety of reasons that do not necessarily reflect adversely on the professional competence or conduct of the subject named in the report.

All information received from the NPDB and HIPDB is considered confidential and must be used solely for the purpose for which it was disclosed. ANY PERSON WHO VIOLATES THE CONFIDENTIALITY PROVISIONS AS SPECIFIED IN TITLE IV OF PUBLIC LAW 99-660, AS AMENDED, IS SUBJECT TO A CIVIL MONEY PENALTY OF UP TO $11,000 FOR EACH VIOLATION. Subjects of reports who obtain information about themselves from the NPDB and/or HIPDB are permitted to share that information with anyone they choose.

If you require additional assistance, visit the NPDB-HIPDB web site (http://www.npdb-hipdb.hrsa.gov) or contact the NPDB-HIPDB Customer Service Center at 1-800-767-6732 (TDD: 1-703-802-9395). Information Specialists are available to speak with you weekdays from 8:30 a.m. to 6:00 p.m. (5:30 p.m. on Fridays) Eastern Time. The NPDB-HIPDB Customer Service Center is closed on all Federal holidays.

CONFIDENTIAL DOCUMENT - FOR AUTHORIZED USE ONLY

The Federation of State Medical Boards
of the United States, Inc.
PO Box 619850
Dallas, Texas 75261-9850
Telephone: (817) 868-4000
FAX (817) 868-4099

BOARD ACTION CLEARANCE REPORT

February 27, 2013

Pennsylvania State Board of Medicine
Attn: Tammy Dougherty
PO Box 2649
Harrisburg, PA 17105

Re: Board Action Query Dated: February 27, 2013
Your Reference Number: BLONG
FSMB Batch Number: BQ2211538

The following is a report of the search results from the Board Action Data Bank as of February 27, 2013 for practitioners submitted as part of the above-referenced batch for which NO board actions were identified.

Practitioners Cleared with No Actions as of February 27, 2013

Item	Name	DOB	School	Yr/Grad	Request ID
2	FELLOWS, MATTHEW	[redacted]		2010	26348334
		LICENSE HISTORY State Board No License Information Available			
1	SHAH, PARINDA	[redacted]		2001	26348331
		LICENSE HISTORY State Board NEW YORK			
3	TASSO, DAVID	[redacted]		2005	26348335
		LICENSE HISTORY State Board MINNESOTA TEXAS			

PLEASE NOTE: The licensure history information contained in these reports is not considered licensure verification but rather an indicator of known states of historical licensure for these individuals. Use of this information should be limited to cross-reference purposes.

COMMONWEALTH OF PENNSYLVANIA
STATE BOARD OF MEDICINE
P. O. BOX 2649
HARRISBURG, PENNSYLVANIA 17105
st-medicine@pa.gov
www.dos.state.pa.us/med

March 20, 2013

MATTHEW IAN FELLOWS 9849
[redacted]
PHILADELPHIA PA 19107

Telephone: 717-783-1400/787-2381
Fax: 717-787-7769

EVALUATOR: BRENDA 1742

RE: DISCREPANCY NOTICE – Unrestricted (American)

Dear Doctor:

The Board has received your application for an unrestricted medical license. The items listed below are needed to complete your application. A license cannot be issued until all items are received, approved and the application is complete. **You may not practice in the Commonwealth of Pennsylvania as a Physician and Surgeon until a license has been issued by the Board.**

- **PAGE 2:** PAGE 2 OF APPLICATION DID NOT LIST CURRENT TRAINING FROM 7/1/12 TO PRESENT. NEED TO SUBMIT PAGE 2 LISTING ALL TRAINING.
- Verification of ACGME Approved Graduate Medical Training **must be received DIRECTLY from the Hospital(s) in official, sealed hospital envelope.**

  REC'D PGY1 AND PGY2. STILL NEED PGY3 VERIFIED.
- **BOTH** the National Practitioner Data Bank **AND** the Healthcare Integrity and Protection Data Bank self query disclosure information (**www.npdb-hipdb.com**) – **NPDB & HIPDB** reports are required. **Must provide original documents of both reports.**

APPLICATIONS NOT COMPLETED WITHIN SIX MONTHS WILL REQUIRE UPDATES OF CERTAIN DOCUMENTS.

You may check the status of your application online at www.mylicense.state.pa.us. Click on the link duplicate licenses/address changes/application status. First time users will be required to register and create a user ID and password. Your registration code to register is: ztZUTneS

Sincerely,

Pennsylvania State Board of Medicine

COMMONWEALTH OF PENNSYLVANIA
STATE BOARD OF MEDICINE
P. O. BOX 2649
HARRISBURG, PENNSYLVANIA 17105
st-medicine@pa.gov
www.dos.state.pa.us/med

February 28, 2013

MATTHEW IAN FELLOWS 9849
[redacted]
PHILADELPHIA PA 19107

Telephone: 717-783-1400/787-2381
Fax: 717-787-7769

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  NEED ALL TRAINING VERIFIED PAST/CURRENT. PGY1 AND PGY2 MUST BE LISTED SEPERATELY, CANNOT BE COMBINED ON VERIFICATION.
- Curriculum Vitae listing **ALL** periods of employment or unemployment (i.e., child rearing, research, etc.) from graduation from medical school to present. The list must be in chronological order, include the month and year, and indicate the state/territory in which the employment occurred.
- **BOTH** the National Practitioner Data Bank **AND** the Healthcare Integrity and Protection Data Bank self query disclosure information (**www.npdb-hipdb.com**) – **NPDB & HIPDB** reports are required. **Must provide original documents of both reports.**

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Sincerely,

Pennsylvania State Board of Medicine

Person Info
Name: MATTHEW IAN FELLOWS
Address Info

Street Address: [redacted]
Email: [redacted]@GMAIL.COM
Phone [redacted]
Fax
City Philadelphia
State PA
Zipcode 19107
Country 82
County Philadelphia

Are you submitting a name change with this renewal?	N
Have you completed your current CE requirements?	Y
Do you hold, or have you ever held, a license, certificate, permit, registration or other authorization to practice any health-related profession in any state or jurisdiction?	N
If you answered yes to the above question, please provide the profession and state or jurisdiction.	
Since your initial application or last renewal, whichever is later, have you had disciplinary action taken against a professional or occupational license, certificate, permit, registration or other authorization to practice a profession or occupation issued to you in any state or jurisdiction or have you agreed to voluntary surrender in lieu of discipline?	N
Do you currently have any disciplinary charges pending against your professional or occupational license, certificate, permit or registration in any state or jurisdiction?	N
Since your initial application or last renewal, whichever is later, have you withdrawn an application for a professional or occupational license, certificate, permit or registration, had an application denied or refused, or for disciplinary reasons agreed not to apply or reapply for a professional or occupational license, certificate, permit or registration in any state or jurisdiction?	N
Since your initial application or last renewal, whichever is later, have you been convicted (found guilty, pled guilty or pled nolo contendere), received probation without verdict or accelerated rehabilitative disposition (ARD), as to any criminal charges, felony or misdemeanor, including any drug law violations? Note: You are not required to disclose any ARD or other criminal matter that has been expunged by order of a court.	N
Do you currently have any criminal charges pending and unresolved in any state or jurisdiction?	N
Since your initial application or last renewal, whichever is later, have you had your DEA registration denied, revoked or restricted?	N
Since your initial application or your last renewal, whichever is later, have you had provider privileges denied, revoked, suspended or restricted by a Medical Assistance agency, Medicare, third party payor or another authority?	N
Since your initial application or your last renewal, whichever is later, have you ever had practice privileges denied, revoked, suspended, or restricted by a hospital or any health care facility?	N
Since your initial application or your last renewal, whichever is later, have you been charged by a hospital, university, or research facility with violating research protocols, falsifying research, or engaging in other research misconduct?	N
Since your initial application or last renewal, whichever is later, have you engaged in the intemperate or habitual use or abuse of alcohol or narcotics, hallucinogenics or other drugs or substances that may impair judgment or coordination?	[redacted]
Since your initial application or your last renewal, whichever is later, have you been the subject of a civil malpractice lawsuit?	N
If yes, please submit a copy of the entire Civil Complaint, which must include the filing date and the date you were served. PLEASE NOTE: If you previously reported the complaint to the Board you will only need to provide the docket number here:	
Have you completed 2 hours of Board-approved continuing education in child abuse recognition and reporting?	Y
Do you maintain current medical professional liability insurance in the Commonwealth of Pennsylvania?	Y
If you answer "No", please provide an explanation or reason for an exemption request.	
Please provide the zip code of your primary employer/practice location. This data is being collected for the purpose of identifying healthcare professionals during state emergencies and may be provided to the Pennsylvania Emergency Management Agency for official use only.	19107

Date Submitted: Friday, November 18, 2016

Education Info

No education records

Employment Information

No employment records