Linda Prine, MD

Licensed Physician #MD2014-0953

Issue Date	Expiration Date
12/01/2014	07/01/2015

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

Linda Prine, MD

License Number: MD2014-0953

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: 12/01/2014 Date Expires: 07/01/2015*

**A New Mexico medical license that has not been renewed by July 1 of the renewal year will remain temporarily active with respect to medical practice until September 30 of the renewal year at which time, the status will be changed to lapsed. A lapsed license is not valid for practice in New Mexico.*

This License Must Be Conspicuously Posted In Each Practice Location

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The New Mexico Physician and Practitioner Credentials Application ©

Physician (MD) Application

Rec'd 12/4/14

THE NEW MEXICO MEDICAL SOCIETY

Date of Application: October 10, 2014

Lic #164590

Application Fee: $400.00
TOTAL: $400.00

Name: Linda Prine
Maiden or Other Names Used

Will you be applying by endorsement? ☑ Yes ☐ No Applying using: ☑ NMMB ☐ HSC ☐ FCVS

What are your NM practice plans? Plan to work there in the winter Endorse

Gender: Female Citizenship: United States Place of Birth: Pittsburgh, PA
Social Security Number: [redacted] Date of Birth: [redacted]
State Tax ID#: 133273402 ☐ Pending Fed. Tax ID#: ☐ Pending
Medicare #: 65J771 ☐ Pending Medicaid #: 03116913 ☐ Pending
Unique Physician Identification Number (UPIN): E74360 ☐ Pending
National Provider Identifier Number (NPI): 1881688133 ☐ Applied
CLIA Number (if applicable): Approval Level: Expiration Date:

Home address

Street Address: [redacted]
City, State/Province and Zipcode: New York NY 10025
Country: United States
Telephone Number: [redacted] Pager Number:
Cell Phone Number: [redacted] Spouse's Name (Optional):

Credentials Correspondence Address

Department:
Street Address: [redacted]
City, State/Province and Zipcode: New York NY [redacted] 10025
Country: United States Email: [redacted]@mac.com
Telephone Number: [redacted] Facsimile Number:

Military Service

Branch: Type of Discharge:
Dates: From: To: ☐ Current Rank:

Immigration

Status: Certification Number:

ECFMG (Educational Commission for Foreign Medical Graduates)

Number (if applicable): Date Issued: (Please attach a copy of your ECFMG certificate)

Languages

Foreign Languages (spoken fluently by practitioner):

Certifications

ACLS CERTIFICATION	ATLS CERTIFICATION	PALS CERTIFICATION
Certified? ☑ Yes ☐ No	Certified? ☐ Yes ☑ No	Certified? ☐ Yes ☑ No
Expires: 05/25/2015	Expires:	Expires:

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Physician (MD) Application

THE NEW MEXICO MEDICAL SOCIETY

HOSPITAL AND HEALTHCARE AFFILIATIONS

☑ Are you a PCP? ☐ Do you deliver babies? ☑ Are you an MD, DO, or DPM

If you answered yes to any question above, you must:

(a) Have admitting privileges at a hospital (list below) OR
(b) Provide a written explanation as to the arrangements you have made with a physician to admit your patients, along with a signed letter from that physician confirming the arrangements, and the name of the facility where your patients will be admitted.

☑ Do you have courtesy or consulting privileges at this facility.

☑ If yes, do these courtesy or consulting privileges allow you to admit patients.

If no, provide a written explanation as to the arrangements you have made with a physician to admit your patients, along with a signed letter from that physician confirming the arrangements, and the name of the facility where your patients will be admitted.

Please list all hospital staff membership and/or healthcare organization affiliations in the past fifteen (15) years, and your status (active, courtesy, consulting, etc.) If an institution is no longer in existence, please provide an alternative cource of verification. Attach a separate page if necessary.

Facility Name: Mount Sinai Medical Center ☐ Is this your primary admitting facility
Department: Family Medicine and Community Health
Street Address: Icahn School of Medicine at Mt. Sinai
1425 Madison Avenue
City: New York State/Province: NY Zip Code: 10029
Country: United States
Phone Number: 2126591411 Facsimile: 2126599071
Appointment Dates From: 04/2012 To: ☑ Present
Type of Appointment: Associate Professor Privileges Assigned:

Facility Name: Beth Israel Medical Center ☑ Is this your primary admitting facility
Department: Family Medicine
Street Address: 10 Nathan D Perlman Place
City: New York State/Province: NY Zip Code: 10003
Country: United States
Phone Number: 2122065252 Facsimile: 2126912786
Appointment Dates From: 09/1994 To: ☑ Present
Type of Appointment: Active Privileges Assigned:

WORK HISTORY

Please list all previous experience for the past fifteen (15) years, including months and years, listing the most recent first. Attach a separate page if necessary. Please attach a current CV or resume.

Organization: Planned Parenthood of NYC From: To:
Department: Family Planning ☑ Present

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Physician (MD) Application

THE NEW MEXICO MEDICAL SOCIETY

Street Address: 26 Bleecker Street
City: New York State/Province: NY Zip Code: 10012
Country: United States
Phone Number: Contact:
Type of Practice: Per-Diem
Please provide written explanation for any gaps in work history of six (6) months or more.

Organization: Sidney Hillman/Phillips Family Practice From: To:
Department: Family Medicine ☑ Present
Street Address: 16 East 16th STreet
City: New York State/Province: NY Zip Code: 10003
Country: United States
Phone Number: Contact:
Type of Practice: Ambulatory Medicine
Please provide written explanation for any gaps in work history of six (6) months or more.

Organization: East Somerville Health Centr From: To:
Department: Family Medicine ☐ Present
Street Address: 42 Cross Street
City: Somerville State/Province: MA Zip Code: 02145
Country: United States
Phone Number: Contact:
Type of Practice: Ambulatory Medicine
Please provide written explanation for any gaps in work history of six (6) months or more.

Organization: Dorchester House Multi-Service Center From: To:
Department: Medicine ☐ Present
Street Address: 1353 Dorchester Ave
City: Boston State/Province: MA Zip Code: 02122
Country: United States
Phone Number: Contact:
Type of Practice: Ambulatory Medicine
Please provide written explanation for any gaps in work history of six (6) months or more.

PRACTICE LOCATIONS

Group Name: Family Practice Center of Harlem Effective Date: 09/15/2012
Department: Family Medicine
Street Address: 1824 Madison Ave
City: New York State/Province: NY Zip Code: 10035

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Physician (MD) Application

THE NEW MEXICO MEDICAL SOCIETY

Country: United States

Phone Number: 2124234500 Facsimile Number: 2124231417

Email Address: ajones@institute2000.org Answering Service Number: 2124234500

Foreign Languages (spoken fluently at practice): English, Spanish

Office Manager or Contact Person: Adrienne Jones Phone: 2124234500

Billing Address

Contact Person: Adrienne Jones Tax ID #:

Department: Family Medicine

Street Address: 1824 Madison Ave,

City: New York State/Province: NY Zip Code: 10035

Country: United States

Phone Number: 2124234500 Facsimile Number: 2124231417

Practice Associates (if applicable): **Call Coverage (if applicable)**

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What are the office hours for your Practice or Group Practice? (Provide days/hours):

M-F 8A-10P, S&S 8A-8P

What provisions have been made for after hours?:

answering service

Group Name: Sidney Hillman/Phillips Family Practice Effective Date: 09/10/1994

Department: Family Medicine

Street Address: 16 East 16th Street

City: New York State/Province: NY Zip Code: 10003

Country: United States

Phone Number: 2122065200 Facsimile Number: 2122065279

Email Address: cestevez@institute2000.org Answering Service Number: 2122065200

Foreign Languages (spoken fluently at practice): english, spanish, russian

Office Manager or Contact Person: Cynthia Estevez Phone: 2122065213

Billing Address

Contact Person: Cynthia Estevez Tax ID #: 133273402

Department: Family Medicine

Street Address: 16 East 16th Street,

City: New York State/Province: NY Zip Code: 10003

Country: United States

Phone Number: 2122065200 Facsimile Number: 2122065279

Practice Associates (if applicable): **Call Coverage (if applicable)**

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Physician (MD) Application

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THE NEW MEXICO MEDICAL SOCIETY

What are the office hours for your Practice or Group Practice? (Provide days/hours):

M-F 8A-10P, S&S 8A-8P

What provisions have been made for after hours?:

answering service

CONTINUING EDUCATION

1. If you are applying for privileges at a hospital or clinic, please send documentation of all continuing education hours you have obtained in the last two (2) years or complete and send the statement of continuing medical education.

2. If you are applying for privileges at a hospital or clinic, please complete and send the privilege request form and ensure that you include any additional privileges that you are requesting. This will ensure your application is considered based upon the most accurate information available.

PROFESSIONAL REFERENCES

Please list five (5) professional peers with the same type of license, or a higher level of licensure, who are familiar with your professional performance in the past three (3) years.

Name and Title: Robert Schiller MD MD — Specialty: Family Medicine
Department: Chair of Family Medicine — Email: rschiller@institute2000.org
Street Address: 16 E. 16th St
City: NY — State/Province: UN — Zip Code: 10003
Country: United States
Phone Number: 2122065252 — Facsimile Number: 2122065279

Name and Title: Sarah Miller MD MD — Specialty: Family Medicine
Department: Walton Family Practice — Email: bozogan@gmail.com
Street Address: 1894 Walton Avenue
City: Bronx — State/Province: NY — Zip Code: 10453
Country: United States
Phone Number: 7185833060 — Facsimile Number: 7185833360

Name and Title: Sarah Nosal MD MD — Specialty: Family Medicine
Department: — Email: snosal@institute2000.org
Street Address: 50-98 East 168th Street
City: Bronx — State/Province: NY — Zip Code: 10452
Country: United States
Phone Number: 7182933900 — Facsimile Number: 7182933982

Name and Title: Ginger Gillespie MD MD — Specialty: Family Medicine
Department: — Email: ggillespie@institute2000.org
Street Address: 113 East 13th Street
City: New York — State/Province: NY — Zip Code: 10003
Country: United States
Phone Number: 2122531830 — Facsimile Number: 2122531914

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THE NEW MEXICO MEDICAL SOCIETY

Physician (MD) Application

Name and Title: Ruth Lesnewski MD MD
Specialty: Family Medicine
Department:
Email: rlesnewski@institute2000.org
Street Address: 113 East 13th Street
City: New York
State/Province: NY
Zip Code: 10003
Country: United States
Phone Number: 2122531830
Facsimile Number: 2122531914

LICENSURE REGISTRATION INFORMATION

List all licenses held in all jurisdictions. Attach a separate page if necessary.

State Professional License/Certification Number: 175059 ☐ Pending
State: NY
Issue Date: 06/30/1990
Expiration Date: 08/31/2015

LICENSING EXAM

Please check all that apply:

☐ State Board Exam (Prior to 1973) Which State? NY Date(s) passed? MM/YY

☐ FLEX
Part/Step 1 Date Passed MM/YY

☐ LMCC
Part/Step 1 Date Passed MM/YY

☐ National Board (NBME)
Part/Step 1 Date Passed MM/YY
Part/Step 2 Date Passed MM/YY
Part/Step 3 Date Passed MM/YY

☑ USMLE
Part/Step 1 Date Passed MM/YY
Part/Step 2 Date Passed MM/YY
Part/Step 3 Date Passed 04/01/1987 MM/YY

DRUG CERTIFICATION INFORMATION

Federal Drug Enforcement Administration (DEA) Registration: ☐ N/A
DEA Number: [redacted]
Expiration Date: 03/31/2017 ☐ Pending

State Controlled Substance Registration (CSR): ☐ N/A
CSR Number:
Expiration Date:
State: ☐ Pending

EDUCATION

List all medical, osteopathic, dental or podiatric schools attended for graduate education and list all hospitals where you received training for post-graduate training. Attach a copy of your certificate. Disclose every residency program initiated, whether completed or not, and all completed programs. Attach a separate page if necessary. Check the type of education listed.

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Physician (MD) Application

THE NEW MEXICO MEDICAL SOCIETY

Degree Level: Residency/Fellowship
Institution: Residency Program in Social Medicine
Department: Family Medicine
Street Address: 3544 Jerome Avenue,
City: Bronx State/Province: NY Zip Code:
Country: United States
Degree Earned: Residency/Fellowship or Specialty: Family Medicine
If teaching appointment: Department/Position:
Dates Attended: From: 07/1990 To: 06/1994
Graduation Date: 1994

Degree Level: Doctor of Medicine
Institution: Cornell University Medical College
Department: Office of Student Affairs
Street Address: 525 East 68th Street,
City: New York State/Province: NY Zip Code:
Country: United States
Degree Earned: Doctor of Medicine or Specialty: General Medicine
If teaching appointment: Department/Position:
Dates Attended: From: 09/1983 To: 05/1987
Graduation Date: 1987

SPECIALTY BOARD CERTIFICATIONS

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 by examination in your specialty, please give a brief explanation on an attached sheet. Explain any gaps or delays in achieving Board certification by the recognized Board in your specialty area.

☑ Board or ☐ Specialty Board Name: American Board of Family Practice
Date Certified: 07/13/1990 Date Last Recertified: 04/19/2014 Expiration Date: 04/19/2024 ☐ Lifetime
Certification Number: 1011125154 Accepted for Examination? ☑ Yes ☐ No
If not accepted, have you made application? ☐ Yes ☐ No ☐ N/A If no, provide an explanation:

MEDICAL MALPRACTICE INSURANCE

Do you have current medical malpractice insurance? ☑ Yes ☐ No

Please list medical malpractice insurance carriers for the past five (5) years. Attach a separate page if necessary.

Carrier: One Beacon Limits: [redacted]
Department:
Address: 199 Scott Swamp Road ☐ Pending
City: Farmington State/Province: Zip Code:
Country: United States
Dates Insured: From: 08/01/2007 To: 12/31/2014 Policy Number: [redacted]

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The New Mexico Physician and Practitioner Credentials Application ©

Physician (MD) Application

THE NEW MEXICO MEDICAL SOCIETY

Carrier: Federal Tort Claims Act Limits: 0.00 0.00

Department: Malpractice

Address: 16 East 16th Street ☐ Pending

City: New York State/Province: Zip Code:

Country: United States

Dates Insured: From: 01/15/2004 To: 12/31/2014 Policy Number: No Policy Number

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Physician (MD) Application

THE NEW MEXICO MEDICAL SOCIETY

PROFESSIONAL PRACTICE QUESTIONS 1161

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

1	Has your professional liability coverage ever been terminated by action of the insurance company (except as a result of the company ceasing to offer insurance coverage to physicians or other practitioners)?	☐ 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 arrested? If so explain the circumstance, regardless of the outcome (i.e. expunged, dismissed, sealed, vacated).	☐ Yes ☑ No
7	Have you ever been named as a defendant in any criminal proceedings?	☐ Yes ☑ No
8	Have you ever been subject to investigation by a governmental entity or Board that either could have resulted, or did result, in licensure sanctions or other adverse actions, irrespective of the outcome?	☐ Yes ☑ No
9	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
10a	Have your privileges at any healthcare entity ever been voluntarily or involuntarily suspended, restricted, diminished, revoked, surrendered, or not renewed, except for medical records delinquency?	☐ Yes ☑ No
10b	Have you ever agreed not to exercise your clinical privileges while under investigation?	☐ Yes ☑ No
11	Have you ever resigned from a healthcare entity to avoid modification, suspension, or termination of privileges, or while under investigation?	☐ Yes ☑ No
12a	Has you application for licensure or license to practice in any jurisdiction ever been investigated, voluntarily or involuntarily limited, suspended, revoked, surrendered or denied?	☐ Yes ☑ No
12b	Are any currently held licenses pending investigation or being challenged?	☐ Yes ☑ No
13	Have you ever been notified to appear before any licensing agency for a hearing or complaint of any nature?	☐ Yes ☑ No
14	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
15	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 list on a separate sheet of paper for each case: Name, age, sex of patient/claimant, Date(s) and type of treatment and/or surgery that 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.	☐ Yes ☑ No
16	Have you ever been reported to the National Practitioner Data Bank?	☐ Yes ☑ No
17a	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?	[redacted]

17b	Are you being treated with opiates for chronic pain? If yes, please provide to the Board upon application a current evaluation from your treating pain provider (MD or DO)	[redacted]
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 competently? If yes, please have your treating physician send the NM Medical Board a letter regarding your diagnosis and treatment.	[redacted]
19a	Have you ever, for any reason, resigned from a medical school or postgraduate training (PGT) program?	☐ Yes ☑ No
19b	Have you ever, for any reason, withdrawn from a medical school or postgraduate training (PGT) program?	☐ Yes ☑ No
19c	Have you ever, for any reason, been suspended, dismissed, or expelled from a medical school or postgraduate training (PGT) program?	☐ Yes ☑ No
19d	Have you ever, for any reason, been placed on probation or remediation, including academic probation or remediation, by a medical school or postgraduate training (PGT) program?	☐ Yes ☑ No
19e	Have you ever, for any reason, taken a leave of absence or break from, or had any interruptions or extensions in, a medical school or postgraduate training (PGT) program for any personal or professional reason (including illness or disability, pregnancy or maternity, any academic issues, etc)?	☐ Yes ☑ No

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

APPLICANT'S OATH

I, Linda W. Prine MD, **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.

Linda W. Prine MD
Applicant Signature

10/10/14
Date

*Passport-quality color photograph taken within six months prior to filing the application size 2 x 2 inches, head and shoulders only, full face, front view, plain white or off-white background, standard photo stock paper, scanned or computer-generated photographs should have no visible pixels or dots.

Applicant Name (printed) Linda W. Prine MD Date 10/10/14

American Board of Family Medicine, Inc.

Quality Healthcare, Public Trust . . . Setting the Standards in Family Medicine

October 10, 2014

To Whom It May Concern:

This letter verifies Linda Whisler Prine, M.D. (NPI: 1881688133) is currently certified with the American Board of Family Medicine (ABFM).

Family Medicine Certification History:

Jul 13, 1990 - Jul 10, 1997
Jul 11, 1997 - Jul 16, 2004
Jul 17, 2004 - Apr 18, 2014
Apr 19, 2014 - * Certification Number: 1011125154

* Certification is continuous as long as MC-FP Requirements are maintained.

Maintenance of Certification for Family Physicians (MC-FP):

Current Status: Meeting Requirements

Beginning in 2011 certification by the American Board of Family Medicine is maintained through successful completion of the Maintenance of Certification for Family Physicians (MC-FP) process. The MC-FP process is a continuous process that requires maintaining a currently valid, full, and unrestricted license to practice medicine in the United States or Canada, completing MC-FP activities in a timely fashion, and performing successfully on the examination every ten years. Failure to maintain any of these requirements will result in the loss of certification status with the ABFM. Physicians whose certificate has expired may renew their certification at such time as they fulfill all of the MC-FP requirements in effect at that time. Based upon the continuous nature of MC-FP, no end date for certification is presented above.

Certification in Family Medicine was for a period of seven years. From 1970 through 2002, certification was renewed by completion of requirements for Recertification. Each physician (Diplomate) fulfilled these requirements by maintaining a medical license to practice medicine in the United States or Canada, earning 300 hours of continuing medical education (CME), completing a computerized office record review, and performing successfully on the recertification examination.

In 2003 family physicians who performed successfully on the Certification and Recertification examinations began a gradual transition from Recertification to MC-FP. MC-FP was designed to transition all Diplomates into the program by 2010, enrolling all physicians who certified or recertified as they successfully passed the examination.

American Board of Family Medicine, Inc.

Quality Healthcare, Public Trust . . . Setting the Standards in Family Medicine

The ABFM website serves as primary source verification. Details of the MC-FP process are available online at www.theabfm.org.

Sincerely,

Mary McIntosh

Mary McIntosh
Verification Coordinator and Candidate Assistant

1648 McGrathiana Pkwy, Ste. 550 | Lexington, KY 40511-1247 | Ph: 859-269-5626 or 888-995-5700 | Fax: 859-335-7501 | www.theabfm.org

A Member Board of the American Board of Medical Specialties

AMA Physician Profile

Name and Mailing Address
LINDA WHISLER PRINE MD
16 E 16TH ST
NEW YORK NY 10003-3105

Primary Office Address

SIDNEY HILLMAN HEALTH CENTER
16 E 16TH ST
NEW YORK NY 10003-3169

Phone 1-212-924-7744

Birth date [redacted]1951

Physician's major professional activity OFFICE BASED PRACTICE

Self-designated practice specialty FAMILY MEDICINE (primary)

UNSPECIFIED (secondary)

Self-designated practice specialties (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 verification by a member board of the American Board of Medical Specialties (ABMS) or that the physician has been trained or has special competence to practice the SDPS.

AMA membership status NON MEMBER

All information from this point forward is provided by the primary source

Current and/or historical NPI information

National Provider Identifier (NPI)	Enumeration date	Deactivation date	Reactivation date	Replacement number	Last reported date
1881688133	09/01/2005	NOT RPTD	NOT RPTD	NOT RPTD	10/04/2014

Current and/or historical medical school

WEILL CORNELL MEDICAL COLLEGE OF CORNELL UNIVERSITY, NEW YORK, NY 10021
Degree Awarded: Yes
Degree Year: 1987

AMA AMERICAN MEDICAL ASSOCIATION

Current and/or historical post graduate medical training programs accredited by the Accreditation Council for Graduate Medical Education (ACGME)

Beginning with the 2010 cycle of the National GME Census, post-graduate training segments will include the name of the program attended in addition to the sponsoring institution. Program-level information prior to 2010 will not be available for reporting. Future training dates, as reported by the program, should be interpreted as "in progress" or "current" with the projected date of completion.

Post-graduate training performed at accredited osteopathic institutions or in Canada are updated on the AMA Physician Masterfile only upon verification by the program. US licensing authorities accept graduate medical education from both entities as equivalent to training performed in a US program accredited by ACGME.

Sponsoring Institution: MONTEFIORE M C-H&L MOSES DIV
Sponsoring State: NEW YORK
Specialty: FAMILY MEDICINE
Dates: 07/1987 - 06/1990 (Verified)

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.

NATIONAL BOARD OF MEDICAL EXAMINERS (NBME) CERTIFICATION YEAR: MD: 1988

Current and/or historical medical licensure

Jurisdiction	MD/ DO	Date granted	Expiration date	Status	License type	Last reported
MASSACHUSETTS	MD	08/15/1990	NOT RPTD	INACTIVE	UNLIMITED	08/25/2003
NEW YORK	MD	07/01/1988	08/31/2015	ACTIVE	UNLIMITED	09/30/2014

ECFMG Certfication

Applicant Number:

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 online at ***https://cvsonline2.ecfmg.org/***

AMA AMERICAN MEDICAL ASSOCIATION

U.S. Drug Enforcement Administration (DEA)

DEA number	Schedule	Expiration date	Last Reported date	Address:
XXXXXX218	22N 33N 4	03/31/2017	09/02/2014	Sidney Hillman Health Center, 16 E 16th St, New York, NY 10003-3169

Only the last three characters of active DEA numbers are displayed

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.

Specialty Board Certification

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 Joint Commission. The AMA is also an NCQA-approved source for verification of medical school, postgraduate medical training, ABMS Board certification, and Federal DEA registration.

Certifying board: AMERICAN BOARD OF FAMILY MEDICINE
Certificate: FAMILY MEDICINE
Certificate type: GENERAL

Duration	Effective Date	Expiration Date	Reverification Date	Occurrence	Last Reported Date
MOC+	04/19/2014		02/15/2015	RE-CERT	10/03/2014
TIME LIMITED	07/17/2004	12/31/2014		RE-CERT	10/03/2014
TIME LIMITED	07/11/1997	12/31/2004		RE-CERT(**)	10/03/2014

AMA AMERICAN MEDICAL ASSOCIATION

Certifying board: AMERICAN BOARD OF FAMILY MEDICINE
Certificate: FAMILY MEDICINE
Certificate type: GENERAL

Duration	Effective Date	Expiration Date	Reverification Date	Occurrence	Last Reported Date
TIME LIMITED	07/13/1990	12/31/1997		INITIAL(**)	10/03/2014

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.

+The above certifying board has implemented standards which specify that the board certification is contingent upon meeting ongoing requirements of Maintenance of Certification (MOC). Only certificates issued by a MOC participating board will reflect a reverification date.

Action notifications

To date, there have been no actions reported to the AMA by any US state licensing agency.

To date, there have been no Medicare/Medicaid sanctions reported to the AMA by the Department of Health and Human Services.

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.

AMA
AMERICAN
MEDICAL
ASSOCIATION

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. An organization's appropriate use of the data contained in the AMA Physician Masterfile meets selected primary source verification requirements of the Joint Commission, the Accreditation Association for Ambulatory Health Care (AAAHC) and the American Accreditation Health Care Commission (AAHCC)/Utilization Review Accreditation Commission (URAC). The AMA Physician Masterfile is also an NCQA-approved source for verification of medical school, post-graduate medical training, ABMS Board Certification and federal DEA registration.

If any of the data in this Profile is believed to be incorrect, please log onto our website **(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 questions. Or you can mark the issues on a copy of the profile and mail or fax to:

American Medical Association
Division of Database Products
Attn: Physician Products Portfolio
AMA Plaza
330 N. Wabash Ave., Suite 39300
Chicago, IL 60611-5885

Fax: (312) 464-5900

If you have any questions or need additional information about the AMA Physician Profile Service, please call (800) 665-2882.

PDC PHYSICIAN DATA CENTER

Federation of STATE MEDICAL BOARDS

PRACTITIONER PROFILE

Prepared for:	New Mexico Medical Board	As of Date:10/15/2014

PRACTITIONER INFORMATION

Name:	Linda Whisler Prine
DOB:	[redacted]1951
Medical School:	Cornell University Medical College New York, New York, UNITED STATES
Year of Grad:	1987
Degree Type:	MD

BOARD ACTIONS

To date, there have been no actions reported to the FSMB

LICENSE HISTORY

Jurisdiction	License Number	Issue Date	Expiration Date	Last Reported
NEW YORK	175059	7/1/1988	8/31/2015	10/6/2014

400 FULLER WISER ROAD EULESS, TX 76039 | TEL(817)868 4000 | FAX (817)868 4099

NYSED.gov

Office of the Professions

Verification Searches

The information furnished at this web site is from the Office of Professions' official database and is updated daily, Monday through Friday. The Office of Professions considers this information to be a secure, primary source for license verification.

License Information *

10/14/2014

Name : PRINE LINDA WHISLER
Address : NEW YORK NY
Profession : MEDICINE
License No: 175059
Date of Licensure : 07/01/88
Additional Qualification :
Status : REGISTERED
Registered through last day of : 08/15
Medical School: CORNELL UNIV MEDICAL COLL **Degree Date :** 05/28/1987

(Use your browser's back key to return to licensee list.)

* Use of this online verification service signifies that you have read and agree to the terms and conditions of use. See HELP glossary for further explanations of terms used on this page.

Note: The Board of Regents does not discipline *physicians(medicine), physician assistants,* or *specialist assistants.* The status of individuals in these professions may be impacted by information provided by the NYS Department of Health. To search for the latest discipline actions against individuals in these professions, please check the New York State Department of Health's Office of Professional Medical Conduct homepage.

Further information on physicians may be found on the following external sites (The State Education Department is not responsible for the accuracy or completeness of information located on external Internet addresses.):

American Board of Medical Specialties

American Medical Association:
- For the general public: AMA Physician Select, On-line Doctor Finder
- For organizations that verify physician credentials: AMA Physician Profiles

American Osteopathic Association, AOA-Net

Association of State Medical Board Executive Directors-(A.I.M."DOCFINDER")

New York State Department of Health Physician Profiles

The following sites provide additional information concerning the medical profession:

CLEAR (Council on Licensure, Enforcement and Regulation)

Federation of State Medical Boards

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.**

Linda W. Prine MD
[redacted]
City/State/Zip

Linda W. Prine MD
Applicant Signature

2/2/13 - 2/1/15
*Dates of Privilege/Employment mm/yy to mm/yy (must be provided)

Telephone Number

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.

Nikki Langford
Type or Print Name of person completing this form

Professional Appointments Manager
Title

The Institute for Family Health
Name of Institution

22 West 19th Street, 8th Floor
Address

New York, NY 10011
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 2/13 (Month/Year) Ending 2/15 (Month/Year) (current)

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.

Please affix hospital or notary seal here

Nikki Langford — Nikki Langford — 10/17/14
Printed name of person completing this form — Signature — Date

Nikki Langford — 10/17/14
Signature of Notary (if applicable) — Date

My commission expires: October 3, 2015

NIKKI LANGFORD
Notary Public, State of New York
No. 01LA6249066
Qualified in New York County
Commission Expires October 3, 2015

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 8/2008

NATIONAL BOARD OF MEDICAL EXAMINERS® (NBME®)
Endorsement of Certification

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

Recipient: New Mexico Medical Board
2055 S. Pacheco St. Bldg. 400
Santa Fe, NM 87505

Date: 10/13/2014

Examinee: Linda Whisler Prine

Examinee ID: 3-346-737-4
Date of Birth: [redacted]951

NBME Certification Date: 07/01/1988

Certificate#: 346737

It is certified that the physician named above successfully completed the examination, education and training requirements for certification by the NBME as of the certification date shown above. This record shows only passing scores for each NBME Part examination reported on this document. If applicable, results for all USMLE Steps taken by this examinee (and for which scores have been reported to date) are also shown.

NBME PART I

Test Date	Pass/Fail	Score Scale	Total Score	(Min.Pass)	Individual Subject Scores Anat	Phys	Bioc	Path	Micr	Phar	Beh Sci
06/11/1985	Pass	Three-Digit	545	(380)	555	585	560	505	370	580	580
		Two-Digit	83	(75)	84	86	84	81	72	86	86

NBME PART II

Test Date	Pass/Fail	Score Scale	Total Score	(Min.Pass)	Individual Subject Scores Med	Surg	ObGyn	Prev	Peds	Psych
09/23/1986	Pass	Three-Digit	555	(290)	520	500	565	620	545	520
		Two-Digit	84	(75)	83	82	85	88	84	83

NBME PART III

Test Date	Pass/Fail	Score Scale	Total Score	(Min.Pass)
03/02/1988	Pass	Three-Digit	535	(290)
		Two-Digit	83.4	(75)

/80532 NM

SEE REVERSE SIDE FOR EXPLANATION OF INFORMATION REPORTED ABOVE.

NATIONAL BOARD OF MEDICAL EXAMINERS® (NBME®)
Record of Scores

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

Recipient: New Mexico Medical Board
2055 S. Pacheco St. Bldg. 400
Santa Fe, NM 87505

Date: 10/13/2014

Examinee: Prine, Linda W

Examinee ID: 3-346-737-4
Date of Birth: [redacted]/1951

This record shows a complete Part history for this examinee.

NBME PART I

Test Date	Pass/Fail	Score Scale	Total Score	(Min.Pass)	Individual Subject Scores Anat	Phys	Bioc	Path	Micr	Phar	Beh Sci
06/11/1985	Pass	Three-Digit	545	(380)	555	585	560	505	370	580	580
		Two-Digit	83	(75)	84	86	84	81	72	86	86

NBME PART II

Test Date	Pass/Fail	Score Scale	Total Score	(Min.Pass)	Individual Subject Scores Med	Surg	ObGyn	Prev	Peds	Psych
09/23/1986	Pass	Three-Digit	555	(290)	520	500	565	620	545	520
		Two-Digit	84	(75)	83	82	85	88	84	83

NBME PART III

Test Date	Pass/Fail	Score Scale	Total Score	(Min.Pass)
03/02/1988	Pass	Three-Digit	535	(290)
		Two-Digit	83.4	(75)

/80532

Prine, Linda **Medical Doctor** **MD2014-0953**

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	06/22/2015
2. Since your last renewal have you been denied professional liability insurance coverage?	N	06/22/2015
3. Since your last renewal has your professional liability carrier excluded any specific procedures from your coverage?	N	06/22/2015
4. Since your last renewal have you been denied membership or renewal thereof, or been subject to disciplinary action in any professional organization?	N	06/22/2015
5. Since your last renewal have you been excluded from or sanctioned by Medicare and/or Medicaid?	N	06/22/2015
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	06/22/2015
7. Since your last renewal, have you been named as a defendant in any criminal proceedings?	N	06/22/2015
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	06/22/2015
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	06/22/2015
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	06/22/2015
10. b. Since your last renewal have you agreed not to exercise your clinical privileges while under investigation?	N	06/22/2015
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	06/22/2015
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	06/22/2015
12. b. Are any currently held licenses pending investigation or being challenged?	N	06/22/2015
13. Since your last renewal have you been notified to appear before any licensing agency for a hearing or complaint of any nature?	N	06/22/2015
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	06/22/2015
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	06/22/2015
16. Since your last renewal have you been reported to the National Practitioner Data Bank?	N	06/22/2015
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?	[redacted]	06/22/2015
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	[redacted]	06/22/2015
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	06/22/2015
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	06/22/2015
20. I attest that I will limit my practice to areas in which I am competent to practice.	Y	06/22/2015