



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
ROOM 612 TRANSPORTATION & SAFETY BLDG.
COMMONWEALTH AVE. & FORSTER STREET
HARRISBURG, PA 17120

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LICENSE NUMBER

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

Amount 20.00
Date 11/18/92
da

Application Fee: \$20.00 *not refundable*
Make check payable to the "Commonwealth of Pennsylvania."

Please Print or Type

NAME: Christopher Kurt Walker
Last First Middle

Permanent Address: [REDACTED]

Philadelphia Pa 19108
City State Zip Code

Date of Birth: 8-19-64 Social Security Number: 175-60-1624

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

LIST MEDICAL SCHOOL(S) ATTENDED:	DATES OF ATTENDANCE	
<u>Tulane University, School of Medicine</u>	From: <u>8/86</u> <small>Mo & Yr</small>	to: <u>5/90</u> <small>Mo & Yr</small>
	From: _____ <small>Mo & Yr</small>	to: _____ <small>Mo & Yr</small>

Date of Graduation: 5/90

Check licensing examination passed:

- National Board
- FLEX - indicate state where taken: _____ Date Taken: _____
No. & Yr
- LMCC - Canadian
- State Board - indicate state: _____

List all states, territories and countries in which you have ever possessed a license to practice medicine and surgery (active or inactive, current or expired)

Post Graduate Education:

PGY1 Hospital: Temple University Hospital

From: 7/1/90 to: 6/30/91

PGY2 Hospital: Temple University Hospital

From: 7/1/91 to: present

ANSWER THE QUESTIONS BELOW:

- | | YES | NO |
|---|-------|-------------------------------------|
| 1. Have you ever had an application for a license denied in another state, territory or jurisdiction of the United States or any other country? | _____ | <input checked="" type="checkbox"/> |
| 2. Have you ever possessed a license to practice medicine and surgery, or professional license, or other authorization to practice a profession, that was suspended, revoked or subjected to other disciplinary conditions? | _____ | <input checked="" type="checkbox"/> |
| 3. Have you ever been convicted of a crime (exclusive of parking and traffic violations) or received probation without verdict, disposition in lieu of trial, or an accelerated rehabilitative disposition in the United States or other country? | _____ | <input checked="" type="checkbox"/> |
| 4. Have you or had practice privileges denied, revoked or restricted in a hospital or other health care facility? | _____ | <input checked="" type="checkbox"/> |
| 5. Have you ever had provider privileges denied or restricted by a drug enforcement administration, medical assistance agency or other authority? | _____ | <input checked="" type="checkbox"/> |
| 6. Have you within the last five years received treatment for drug or alcohol dependency or abuse or been arrested for drug or alcohol related offenses (e.g., DUI, DWI, etc.)? | _____ | <input checked="" type="checkbox"/> |

(You may answer "NO" if you are currently enrolled in, or have formally completed the Board's Impaired Professional Program without subsequent relapse or you have previously informed the Board of your problem and can document Board acceptance of the resolution.)

If you have answered "yes" to any of the above questions, give details on a separate 8 1/2 x 11 sheet.

AFFIDAVIT

I, KURT CHRISTOPHER being duly sworn according to law, depose and say I am
(PRINT NAME OF APPLICANT)

the person completing this application, that I am of good moral character, and that all statements therein are true and complete to the best of my knowledge and belief. I hereby authorize all hospitals, institutions or organizations, my references, personal physicians, employers (past and present), and all governmental agencies and instrumentalities (local, state, federal or foreign) to release to the Pennsylvania State Board of Medicine any information, files or records requested by the Board.

Signature of Applicant: _____

SUBSCRIBED AND SWORN TO BEFORE ME THIS

10 Day of June, 19 92

My Commission expires:

NOTARIAL SEAL
DONALD N. THEOMONU, Notary Public
City of Philadelphia, Philadelphia County
My Commission Expires Oct 29, 1994

Signature of Notary: _____

[Notary Seal]

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

7 2 3 3 0 8 0 9 5 9


Certification of Moral Character

To be completed by two physicians with an unrestricted license in good standing in the United States.

Name of Applicant: Kurt Walker Christopher

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

I have been personally acquainted with the applicant for 1 year(s) 10 month(s).

SIGNATURE:  Date: 5/22/92


Print or type name as signed above: ASHWIN CHATURVEDI

State in which licensed: PA License Number: 010 0213326

Name of Applicant: Kurt Walker Christopher

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

I have been personally acquainted with the applicant for 1 year(s) 10 month(s).

SIGNATURE:  Date: 5/22/92

Print or type name as signed above: Ed S. Zinner MD

State in which licensed: PA License Number: M00425931

Return Completed form to Applicant

Regular Mailing Address
State Board of Medicine
P.O. Box 2549
Harrisburg, PA 17105-2549

Courier Delivery Address
State Board of Medicine
Room 812, Transportation & Safety Bldg.
Commonwealth Bldg. & Porter St.
Harrisburg, PA 17120

MD-047568 L

VERIFICATION OF ACGME APPROVED GRADUATE MEDICAL TRAINING
Accredited Medical School Graduates

TO BE COMPLETED BY APPLICANT

Name: CHRISTOPHER KURT WALKER
Last First Surname

Address: [REDACTED]
Street

PHILADELPHIA PA 19106
City State Zip Code

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

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

Name of Hospital: TEMPLE UNIVERSITY HOSPITAL

Located in: PHILADELPHIA PA
City State

1st Year from 7/1/90 To 6/30/91 Specialty OB GYN Level PGY 1

2nd Year from 7/1/91 To 6/30/92 Specialty OB GYN Level PGY 2

"I certify that KURT WALKER CHRISTOPHER 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."

(Seal of Hospital) Signature of Program Director: [Signature]
Date: 8/1/92

If the hospital has no seal complete the following section and have the seal affixed.
I hereby certify that this hospital has no seal of stamp and that this form was completed by this hospital.

Program Director's Signature: _____
Date: _____

RETURN COMPLETED FORM DIRECTLY TO THE BOARD IN ORIGINAL HOSPITAL ENVELOPE [seal]

Entry Level Spec

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

The following specialties
prior to entry and wou

Aerospace Medicine
 Allergy and Immunole
 Blood Banking
 Cardiovascular Disease
 Chemical Pathology
 Child Neurology
 Child Psychiatry
 Colon and Rectal Surj
 Critical Care
 Dermatopathology
 Diagnostic Radiology
 Endocrinology and Me
 Forensic Pathology
 Gastroenterology
 Geriatrics
 Hand Surgery
 Hematology
 Immunopathology
 Infectious Diseases
 Medical Microbiology
 Medical Oncology
 Musculoskeletal Oncol
 Neonatal-Perinatal Me

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Board adopted April 2



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



Regular Mailing Address
State Board of Medicine
P.O. Box 2640
Harrisburg, PA 17103-2649

County Delivery Address
State Board of Medicine
Room 612, Transportation & Safety Bldg.
Commonwealth Ave. & Forster St.
Harrisburg, PA 17130



VERIFICATION OF ACGME APPROVED GRADUATE MEDICAL TRAINING 4/5/91
Accredited Medical School Graduates

TO BE COMPLETED BY APPLICANT

Name: Christopher Kurt Walker
Last First Middle

Address: [REDACTED]
Street

Philadelphia Pa 19106
City State Zip

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

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

Name of Hospital: TEMPLE UNIVERSITY HOSPITAL

Located in: PHILADELPHIA PA
City State

1st Year from 7/1/90 To 6/30/91 Specialty OB/GYN Level PGY 1

2nd Year from 7/1/91 To [REDACTED] Specialty OB/GYN Level PGY 2

"I certify that KURT WALKER 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."

Signature of Program Director: [Signature]
Date: 7/22/92

[Seal of Hospital] If the hospital has no seal complete the following section. If the hospital has a seal, seal with force or stamp. I hereby certify that this hospital has no seal or stamp and that this form was completed by this hospital.

Program Director's Signature: _____
Date: _____

RETURN COMPLETED FORM DIRECTLY TO THE BOARD OF MEDICINE, HARRISBURG, PA

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Endo
Foren
Gastr
Geria
Hand
Hema
Immu
Infect
Medic
Medic
Muscu
Neona

Board



148-0520-33
Temple University Hospital
Broad & Ontario Sts.
Philadelphia, Pennsylvania 19140

014005
TEMPLE UNIVERSITY
A Commonwealth University


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

Pennsylvania
Occupational Affairs
MEDICINE
05-2649

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

Residency Training Programs and *require training*
alternatives:

Nephrology
Neurosurgery
Neuropathology
Nuclear Medicine
Occupational Medicine
Ophthalmology
Orthopaedic Surgery
Otolaryngology
Pediatric Cardiology
Pediatric Endocrinology
Pediatric Hematology/Oncology
Pediatric Nephrology
Pediatric Orthopaedics
Pediatric Surgery
Plastic Surgery
Preventive Medicine/Public Health
Public Health
Pulmonary Diseases
Rheumatology
Sports Medicine
Thoracic Surgery
Urology
Vascular Surgery

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

GRADUATION YEAR

M	D	-							
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DEGREE NUMBER

						E	D	U	C	
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VERIFICATION OF MEDICAL EDUCATION
(By Graduates of Accredited Medical Schools)

SECTION 1: To be completed by applicant:

Name: Christopher Kurt Walker
Last First Middle

Name of medical school: Tufts University School of Medicine

Location: Boston, Massachusetts

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

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

Name of medical student: Kurt Walker Christopher

Date student began to attend this medical school: May 20, 1990
Month Day Year

Date of graduation: May 20, 1990
Month Day Year

(Seal of School)

I certify that all of the above information is correct.

Signature of

Dean or Registrar: [Signature]

Date:

June 4, 1992

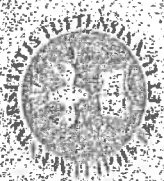
Upon completion, school must return this completed form directly to the Pennsylvania State Board of Medicine in official school envelope. DO NOT RETURN TO APPLICANT.

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

Order Delivery Address
State Board of Medicine
P.O. Box 2649
Harrisburg, PA 17105-2649
USA



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



TUFTS UNIVERSITY
School of Medicine
135 Harrison Avenue
Boston, Massachusetts 02111

NOV 15 1951

RECEIVED DIRECTOR

NATIONAL BOARD OF MEDICAL EXAMINERS

OF THE

STATE OF MISSISSIPPI

having authority in the State of Mississippi and subject to the laws of the State of Mississippi and the Department of Health of the State of Mississippi

ARTHUR SANDERS, JR., Director, M.D.

Chief Executive Officer

HEAL ROBERT L. TOLSON, M.D.

President

07/31/71

198-155

It is certified that the above is a true and correct copy of the results of the examination administered by the National Board of Medical Examiners, Inc. at the University of Mississippi School of Medicine on MAY 1970. The examination was held at the University of Mississippi School of Medicine, and the results of the examination are as follows:

Subject	Number of Candidates	Number of Passes
PART I passed 86/88		
Anatomy	88	86
Physiology	88	86
Biochemistry	88	86
Pathology	88	86
Microbiology	88	86
Immunology	88	86
Biophysics	88	86
TOTAL MEDICAL TECH PASSING SCORE 747/751		
PART II passed 89/88		
Medicine	88	87
Surgery	88	78
Obstetrics and Gynecology	88	78
Public Health and Preventive Medicine	88	71
Podiatry	88	76
Psychiatry	88	77
TOTAL MEDICAL TECH PASSING SCORE 747/751		
PART III passed 83/71		
A General Test of Clinical Competence	71	71
TOTAL MEDICAL TECH PASSING SCORE 747/751		
GENERAL AVERAGE (Parts I, II, and III) 77		

The above information is based on the examination administered on May 1970 at the University of Mississippi School of Medicine. The results of the examination are as follows:

MISSISSIPPI BOARD OF MEDICAL EXAMINERS

Robert L. Tolson
President

INTERPRETATION OF SCORES

STANDARD SCORES

Part I and Part II Examinations Passed Prior to June 1981

Total test score and subject scores are reported. The total test score is based on the number of questions answered correctly on the entire examination and is not the average of the subject scores. There are no minimum pass requirements for individual subjects within a Part. Scores are reported on a scale with a mean of 500 and a standard deviation of 100, in increments of 5.

Part I Examination - June & September 1981 Part II Examination - September 1981 & April 1982

Only total test score is reported. The total test score is based on the total number of questions answered correctly on the entire examination. Scores are reported on a scale with a mean of 500 and a standard deviation of 20, in increments of 1.

All Part III Examinations

Only total test score is reported. The total test score is based on the total number of questions answered correctly on the entire examination. Scores are reported on a scale with a mean of 500 and a standard deviation of 100, in increments of 5.

SCALE SCORES

For all examinations, the scale score mean is 62 and the minimum pass total scale score is 75. Scale scores are reported in increments of 1.



NATIONAL BOARD OF MEDICAL EXAMINERS®

3030 CHESTNUT STREET, PHILADELPHIA, PA 19104

RECORD OF SCORES

TO: DEPT OB/GYN RES PROGRAM
ATTENTION NARDA
TEMPLE H HOSP
BROAD & ONTARIO STREETS
PHILADELPHIA PA 19140

EXAMINEE : CHRISTOPHER KURT W
NBME ID NO: 306895

The official record of scores obtained by the above-named examinee on National Board of Medical Examiners examination(s) and the date(s) on which these scores were obtained are shown below:

Criteria for NBME certification include achievement of a passing total score on each of the three Part examinations. Total score is based on the total number of questions answered correctly and is not the average of the subject scores. There are no minimum pass requirements for individual subjects within a Part. The minimum passing total score for Part I is 380; for Part II, 290; and for Part III, 290.

PART II		DATE SEPTEMBER 1989				TOTAL
MED	SURG	OB/GYN	P H	PEO	PSYCH	SCORE
399	350	380	310	370	405/400	335

BTAL

Melanie Valente
Secretary for Certification

06/18/91

Date

720709
Curriculum Vitae

Personal

Name: Kurt Walker Christopher
Born: [REDACTED]
Home Address: [REDACTED]
Boston, Massachusetts 02116
Home Phone: [REDACTED]

Education

High School: Lower Merion High School, Ardmore, Pa., 1978-81
The Collegiate Schools, Richmond, Va., 1982

Undergraduate: Colgate University
Bachelor of Arts Degree, Chemistry, 1986

Honors: Magna Cum Laude

Phi Beta Kappa

Most Promising Chemist Award - 1984

Most Outstanding Physical Chemist Award - 1985

Activities: Varsity Ice Hockey - 1982, 1983

Tennis - 1982, 1983

Math Team - 1984

Physical Chemistry Research - 1984, 1985

Calculus Tutor - 1985

Medical School: Tufts University School of Medicine
Candidate for Doctor of Medicine Degree - May, 1990

Courses with High Pass/Honors:

Preclinical: Biochemistry, Molecular Biology, Cell Biology,
Immunology, Gross Anatomy, Neuroscience,
Introduction to Clinical Medicine

Clinical: Pediatrics, Gynecological Surgery

Activities: Tufts Med Ice Hockey Team Coordinator - 1987, 1988, 1989

Society Memberships: American Medical Student Association
Massachusetts Medical Society

Employment Experience

Bartender, Cafe Mariavio, Boston - 1986-87

Tennis Instructor, Wakonda Country Club, San Moine, Ia. - 1986

Calculus Tutor - 1985

Research: Chemistry Research at North Dakota State U. - Summer, 1985

Endocrinology Research at Old College Virginia - Summer, 1985

Interests/Activities

All Sports, Home Remodeling, Current Events

Since Medical School:

7/1986 - 6/1988 Resident Scientist Temple University Hospital
Philadelphia, Pa.

PRINT NO. 3082184000

GENERAL INFORMATION DIS. CODE REQUEST

REGIONS CASE NO. 000000

THE FOLLOWING INFORMATION IS REQUESTED FROM THE DIVISIONS OF TITLE VIII OF PUB. L. 91-502, 15 APR 1970, FOR OTHER INFORMATION. READ THE ACTION PLAN TO BE COMPLETED BY THE ENTRY WHICH REPORTED THE INFORMATION. THE INFORMATION REQUESTED IS AS FOLLOWS:

NAME: ERIC MARIE SMITH

CHILDSPOON, SHOT WALKER

OPERATION NAME: ROK CASTLES

HOME ADDRESS: 115 MADON ST

CITY: PHILADELPHIA PA 19108

STATE: PA ZIP CODE: 19108

CITY: PHILADELPHIA

DATE OF BIRTH: [REDACTED]

FEDERAL ID NO. [REDACTED]

PROFESSION: TEACH, UNIVERSITY SCHOOL OF MEDICINE

YEAR OF BIRTH: 1932

STATE OF BIRTH: PA

STATE OF RESIDENCE: PA

SOCIAL SECURITY NO.: 175 80 723

FEDERAL RES. NO.:

YEAR OF PRODUCTION: 1982

STATE OF RESIDENCE: PA

SOCIAL SECURITY NO.: 175 80 723

FEDERAL RES. NO.:

YEAR OF PRODUCTION: 1982

STATE OF BIRTH: PA

STATE OF RESIDENCE: PA

INFORMATION ON FILE FOR LISTED STATIONS

Kurt Christopher
713 Walnut St., 2nd Floor
Philadelphia, PA 19106

STATE BOARD OF MEDICINE
P.O. BOX 2649 0 4 3
HARRISBURG, PA 17105-2649

July 22, 1992

Dear Doctor:

The items checked below are required to complete your application. Additional information is listed below the item, if necessary.

1. Application - page 1
2. Application - page 2 - Affidavit
3. Application - page 3 - Certification of Moral Character
4. Application - page 4 - Verification of ACGME Approved Graduate Medical Training - must be received DIRECTLY from the Hospital(s) in official hospital envelope(s).
The form received was signed 5/22/92. Your second year of training was not completed until 6/30/92. The form should not have been signed until 15 days before the end date of the second year.
5. Application - page 6 - Verification of Medical Education - must be received DIRECTLY from the Medical School in an official Medical School envelope.
6. National Board scores - Endorsement of Certification must be received DIRECTLY from the National Board in an official agency envelope.
7. LMCC score certification must be received DIRECTLY from the Medical Council of Canada in an official agency envelope.
8. FLEX scores must be received DIRECTLY from the Federation of State Medical Boards, Inc. in an official agency envelope.
9. State Board score certification must be received DIRECTLY from the State Medical Board in an official State Board envelope.
10. Curriculum vitae
11. Fee in the amount of \$20.00 made payable to the "Commonwealth of Pennsylvania". Check or money order must be drawn on a US bank.
12. Letter(s) of good standing must be received DIRECTLY from the State Board in an official State Board envelope from the following states:
13. National Practitioner Data Bank Disclosure Information - must be received DIRECTLY from the National Practitioner Data Bank in an official National Practitioner Data bank envelope.
14. Other:

YOU MAY NOT PRACTICE IN THE COMMONWEALTH OF PENNSYLVANIA UNTIL A LICENSE HAS BEEN ISSUED BY THE PENNSYLVANIA STATE BOARD OF MEDICINE.

COMMONWEALTH OF PENNSYLVANIA
STATE BOARD OF MEDICINE
POST OFFICE BOX 2649
HARRISBURG, PA 17105-2649
(717)787-2381



Application For A Graduate License For
Graduates From Accredited
Medical Schools

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3763
5-29-90
\$15

07 OFFICIAL USE ONLY
DO NOT WRITE IN THIS SPACE

MT	025416	T
LICENSE NUMBER		
CHRIS	APPL	
NAME	CODE	INITIALS
CARTIDGE NUMBER		
APPROVED DATES:		
Beginning Date	TO	Ending Date

THIS APPLICATION MUST BE SUBMITTED AT LEAST 60 DAYS PRIOR TO START OF TRAINING. THIS APPLICATION IS TO BE USED FOR INITIAL GRADUATE LICENSE. DO NOT USE TO RENEW.

A GRADUATE LICENSE EMPOWERS THE LICENSEE TO PARTICIPATE IN GRADUATE MEDICAL TRAINING WITHIN THE COMPLEX OF THE HOSPITAL TO WHICH THE LICENSEE IS ASSIGNED AND ANY SATELLITE FACILITY OR OTHER TRAINING LOCATION UTILIZED IN THE GRADUATE TRAINING PROGRAM. IT IS VALID FOR TWELVE MONTHS AND IF TRAINING IS TO CONTINUE AFTER 12 MONTHS, THE GRADUATE LICENSE MUST BE RENEWED. ALL PERSONS ENROLLED IN GRADUATE MEDICAL TRAINING IN PENNSYLVANIA MUST HOLD A GRADUATE LICENSE EVEN IF AN UNRESTRICTED LICENSE TO PRACTICE MEDICINE IS ALSO HELD.

WRITE THE NAME AND ADDRESS ON THE DISCREPANCY NOTICE. PLEASE NOTE THAT THIS NOTICE LISTING THE DISCREPANCIES WILL BE SENT DIRECTLY TO THE NAME AND ADDRESS INDICATED. THE APPLICANT OR HOSPITAL'S NAME AND ADDRESS MAY BE USED. RETURN WITH PAGE 1 AND 2 OF THE APPLICATION.

FEE: \$15.00 MAKE FEE PAYABLE TO "COMMONWEALTH OF PENNSYLVANIA." FEE IS NOT REFUNDABLE.

NAME: Kurt Walker
Last First Maiden
SOCIAL SECURITY # [REDACTED] DATE OF BIRTH: [REDACTED]

NAME & ADDRESS OF MEDICAL SCHOOL(S)	DATES OF ATTENDANCE	DATE OF GRADUATION
<u>Temple University School of Medicine</u>	<u>7/76 - 5/90</u>	<u>5/21/90</u>

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

TRAINING APPROVAL REQUESTED: TO BE COMPLETED BY THE HOSPITAL LOCATED IN PENNSYLVANIA

NAME OF HOSPITAL: Temple University Hospital HS- 1239

ADDRESS OF HOSPITAL: 34th & Ontario Streets, Philadelphia, PA 19104

YEAR IN TRAINING 1 SPECIALTY Obstetrics & Gynecology LEVEL IN SPECIALTY 1

DATES OF TRAINING REQUESTED 7/1/90 TO 6/30/91
Beginning Date (Month/Day/Year) Ending Date (Month/Day/Year)

SIGNATURE OF PROGRAM DIRECTOR: [REDACTED]

NAME OF PROGRAM DIRECTOR: (type) William C. Williams MD

- | | YES | NO |
|---|--------------------------|-------------------------------------|
| 1. ARE YOU, OR HAVE YOU EVER BEEN ADDICTED TO THE INTEMPERATE USE OF ALCOHOL OR THE HABITUAL USE OF NARCOTICS OR OTHER HABIT-FORMING DRUGS? | | <input checked="" type="checkbox"/> |
| 2. HAVE YOU EVER BEEN CONVICTED OF A CRIME (EXCLUSIVE OF PARKING AND TRAFFIC VIOLATIONS) OR RECEIVED PROBATION WITHOUT VERDICT, DISPOSITION IN LIEU OF TRIAL, OR AN ACCELERATED REHABILITATIVE DISPOSITION IN THE UNITED STATES OR OTHER COUNTRY? | <input type="checkbox"/> | <input checked="" type="checkbox"/> |
| 3. HAVE YOU EVER HAD AN APPLICATION FOR A LICENSE DENIED IN ANOTHER STATE, TERRITORY OR JURISDICTION OF THE UNITED STATES OR ANY OTHER COUNTRY? | <input type="checkbox"/> | <input checked="" type="checkbox"/> |
| 4. HAVE YOU EVER POSSESSED A LICENSE TO PRACTICE MEDICINE AND SURGERY OR OTHER PROFESSIONAL LICENSE, OR OTHER AUTHORIZATION TO PRACTICE A PROFESSION THAT WAS SUSPENDED, REVOKED OR SUBJECT TO OTHER DISCIPLINARY CONDITIONS? | <input type="checkbox"/> | <input type="checkbox"/> |
| 5. HAVE YOU EVER HAD PROVIDER PRIVILEGES DENIED OR RESTRICTED BY A DRUG ENFORCEMENT AGENCY, MEDICAL ASSISTANCE AGENCY OR OTHER AUTHORITY? | <input type="checkbox"/> | <input type="checkbox"/> |
| 6. HAVE YOU EVER HAD PROVIDER PRIVILEGES DENIED, REVOKED OR RESTRICTED IN A HOSPITAL OR OTHER HEALTH CARE FACILITY? | <input type="checkbox"/> | <input checked="" type="checkbox"/> |

IF YOU HAVE ANSWERED "YES" TO ANY OF THESE QUESTIONS, GIVE DETAILS ON A SEPARATE 8 1/2" x 11" SHEET. THE FAILURE TO PROVIDE SUFFICIENT INFORMATION FOR THESE ITEMS MAY RESULT IN A DELAY IN PROCESSING THE APPLICATION OR REQUIRE THE RETURN OF THE APPLICATION.

LIST ALL STATES, TERRITORIES AND COUNTRIES IN WHICH YOU HAVE EVER POSSESSED A LICENSE TO PRACTICE MEDICINE AND SURGERY (ACTIVE OR INACTIVE):

NOTE: A LICENSE CANNOT BE ISSUED UNTIL ALL THE ITEMS ARE RECEIVED AND THE APPLICATION IS COMPLETED. YOU MAY NOT BEGIN PARTICIPATION IN A GRADUATE MEDICAL EDUCATION PROGRAM IN PENNSYLVANIA UNTIL YOU HAVE RECEIVED A GRADUATE LICENSE.

AFFIDAVIT

STATE OF:
COUNTY OF:

I, Kurt Christopher, being duly sworn according to law, depose and say that I am the person completing this application, that I am of good moral character, and that all statements therein are true and correct to the best of my knowledge and belief.

Signature of Applicant

SUBSCRIBED AND SWORN TO BEFORE ME THIS
15th DAY May 1990

Janet S. Kerle
Notary Public
JANET S. KERLE, Notary Public
Commonwealth of Massachusetts
My Commission Expires October 11, 1996

- ATTACHMENTS:**
- ENTERING SECOND YEAR/LEVEL IN AN ENTRY LEVEL SPECIALTY: A copy of your unrestricted license/registration card displaying the expiration date OR copy of your scores from one of the following examinations:
- FLEX I - 75.0 passing score
 - FLEX - 75.0 weighted average in an individual attempt (Must have been taken between June 1985 and December 1984)
 - National Boards - Passing score on Parts I and II
 - WCC - Must have been taken in or after May 1970
 - State Board - Must have been taken prior to December 1973
- ENTERING THIRD YEAR/LEVEL OR ABOVE IN AN ENTRY LEVEL SPECIALTY OR ANY ADVANCED LEVEL SUBSPECIALTY: A copy of your unrestricted license/registration card displaying the expiration date OR copy of your scores from one of the following examinations:
- FLEX I and II - 75.0 passing score in both components
 - FLEX - 75.0 weighted average in an individual attempt (Must have been taken between June 1985 and December 1984)
 - National Boards - Passing score on Parts I, II and III
 - WCC - Must have been taken in or after May 1970
 - State Board - Must have been taken prior to December 1973



COMMONWEALTH OF PENNSYLVANIA
DEPARTMENT OF STATE
STATE BOARD OF MEDICINE

P.O. BOX 2649
HARRISBURG, PENNSYLVANIA 17105-2649
717-783-1400

KURT WALKER CHRISTOPHER
TEMPLE UNIVERSITY HOSPITAL
HOSPITAL ADMINISTRATION
ELAINE DORSEY
BROAD & ONTARIO STREETS
PHILADELPHIA PA 19140

910108 1128

OFFICE USE ONLY - DO NOT WRITE IN THIS SPACE

M	T	025916	T
LICENSE NUMBER			
CHRIS	RNEW		
NAME	CODE	INITIALS	

WRITE THIS NUMBER
ON YOUR PAYMENT

MT-025416-T/CHRIS/10/2

THIS IS YOUR RENEWAL NOTICE

Your Graduate License to participate in graduate medical training will expire on the ending date listed below. The information for your 1990-1991 year is indicated below. You must renew your license if you are to continue training past the ending date. In order to renew, attach a \$10.00 fee made payable to the "Commonwealth of PA". An individual fee for each renewal is required. Attach a copy of the required examination scores or unrestricted license to practice medicine and indicate the correct information for the 1991-1992 training year below, making all necessary changes. If you are not going to train past the ending date, check the "NOT TRAINING IN 1991-1992" space below. If you are changing hospitals, use this form to renew your license and write the new hospital under the old hospital's name.

In an effort to ensure timely receipt of a renewed license, the Board Office would appreciate receiving this renewal form with the attachment no later than MAY 1, 1991. A late penalty fee of \$5.00 per month or part of a month will be charged for renewals postmarked after the ending date listed below.

1990-	BEGIN	END			
1991	DATE	DATE	LEVEL	SPECIALTY	HOSPITAL
	07/01/90	06/30/91	1	OBG	TEMPLE UNIVERSITY HOSPITAL

1991-	BEGIN	END			
1992	DATE	DATE	LEVEL	SPECIALTY	HOSPITAL
	7/1/91	6/30/92	2	OB/GYN	Temple University Hospital

NOT TRAINING IN PA IN 1991-1992

REQUIRED ATTACHMENT - COPY OF YOUR UNRESTRICTED LICENSE/REGISTRATION CARD DISPLAYING EXPIRATION DATE OR COPY OF FLEX 1 (75 PASSING SCORE) OR COPY OF PASSING SCORES ON NATIONAL BOARDS PART 1 AND 2. (BOTH PARTS ARE REQUIRED)

COMPLETE REVERSE SIDE

THE FOLLOWING QUESTIONS MUST BE ANSWERED

YES NO

1. Do you hold a license to practice Medicine and Surgery in Pennsylvania or any other state, territory, or country? _____

If you answered yes, please list each state, territory or country:

2. 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? (You may answer "no" if you are currently a participant in or have successfully completed the requirements of the Board's Impaired Professional Program.)



3. Have you ever been convicted of a crime (exclusion of parking and traffic violations) or received probation without verdict, disposition in lieu of trial, or an accelerated rehabilitative disposition in the United States or in any other country? _____

4. Have you ever had an application for a license denied in another state, territory or jurisdiction of the United States or in any other country? _____

5. Have you ever possessed a license to practice medicine and surgery, or other professional license, or other authorization to practice a profession, that was suspended, revoked or subjected to other disciplinary conditions? _____

6. Have you ever had provider privileges denied or restricted by the Drug Enforcement Administration, a medical assistance agency, or other authority? _____

7. Have you ever had practice privileges denied, revoked or restricted in a hospital or other health care facility? _____

NOTE: ALL OF THE ABOVE QUESTIONS MUST BE ANSWERED AND YOU MUST SIGN AND DATE THIS FORM BEFORE RETURNING IT TO BE PROCESSED.

Signature

4/30/91
Date

If you answered "yes" to questions 2 thru 7, please provide complete details on 8 1/2 x 11 sheets of paper, and include copies of legal documents, unless you have previously notified the Board and no further details are available.

1. after the board has issued a registration, any of the events in questions 2 thru 7 occur, you must report that matter to the Board in writing within 30 days after its occurrence.

910160 1120

NATIONAL BOARD OF MEDICAL EXAMINERS
280 CHESTNUT STREET
PHILADELPHIA, PA. 19106

REPORT OF SCORES PART I

NAME NUMBER	STANDARD SCORE	PERCENTILE	PERCENTILE
5-86895	490	45	40
TEST DATE	PERCENTILE	PERCENTILE	PERCENTILE
06-88	495	47	42
SCORE	PERCENTILE	PERCENTILE	PERCENTILE
175	50	48	43

PHYS	PHYS	PHYS	PHYS	PHYS	PHYS	PHYS	PHYS	PHYS	PHYS	PHYS	PHYS	PHYS
520	620	400	495	690	370	400	400	400	400	400	400	400
88	85	22	48	53	28	41	41	41	41	41	41	41
88	85	22	48	53	28	41	41	41	41	41	41	41

SCORE INTERPRETATION IS PROVIDED ON THE ENCLOSED SHEET

CHRISTOPHER KURT B

PH103695 6

BLSTON PA

02116



NATIONAL BOARD OF MEDICAL EXAMINERS
3930 CHESTNUT STREET, PHILADELPHIA, PA 19104

RECORD OF SCORES

TO: DEPT OB/GYN RES PROGRAM
ATTENTION NARDA
TEMPLE U HOSP
BROAD & ONTARIO STREETS
PHILADELPHIA PA 19140

EXAMINEE : CHRISTOPHER KURT W
NBME ID NO: 386895

The official record of scores obtained by the above-named examinee on National Board of Medical Examiners examination(s) and the date(s) on which these scores were obtained are shown below.

Criteria for NBME certification include achievement of a passing total score on each of the three Part examinations. Total score is based on the total number of questions answered correctly and is not the average of the subject scores. There are no minimum pass requirements for individual subjects within a Part. The minimum passing total score for Part I is 380; for Part II, 290; and for Part III, 290.

PART II		DATE SEPTEMBER 1989				TOTAL
MED	SURG	OB/GYN	P H	PED	PSYCH	SCORE
395	350	380	310	370	405	335

SEAL

William Valente

Secretary for Certification

05715791



COMMONWEALTH OF PENNSYLVANIA
 DEPARTMENT OF STATE
 BUREAU OF PROFESSIONAL AND
 OCCUPATIONAL AFFAIRS
 STATE BOARD OF MEDICINE
 P.O. BOX 2649
 HARRISBURG, PENNSYLVANIA 17105-2649
 717-783-1400

YURT WALPER CHRISTOPHER
 TEMPLE UNIVERSITY HOSPITAL
 HOSPITAL ADMINISTRATION
 ELAINE DORSEY
 BROAD & ONTARIO STREETS
 PHILADELPHIA PA 19140

020124 1414

OFFICIAL USE ONLY

M T 025416 T

CHRIS R NEW

MT 025416 T

THIS IS YOUR RENEWAL NOTICE

Your Graduate License to participate in graduate medical training will expire on the ending date listed below. The information for your 1991-1992 year is indicated below. You must renew your license if you are to continue training past the ending date. In order to renew, attach a \$10.00 fee made payable to the "Commonwealth of PA". Write your license number on your check. An individual fee for each renewal is required. Attach a copy of the required examination scores or unrestricted licenses to practice medicine and indicate the correct information for the 1992-1993 training year below, making all necessary changes. If you are not going to train past the ending date, check the "NOT TRAINING IN 1992-1993" space below. If you are changing hospitals, use this form to renew your license and write the new hospital under the old hospital's name.

In an effort to ensure timely receipt of a renewed license, the Board Office would appreciate receiving this renewal form with the attachment no later than MAY 1, 1992. A late penalty fee of \$5.00 per month or part of a month will be charged for renewals postmarked after the ending date listed below.

1991-1992 TRAINING:

BEGINNING DATE	ENDING DATE	LEVEL	SPECIALTY	HOSPITAL NAME	HOSPITAL LICENSE #
07/01/91	06/30/92	2	OBG	TEMPLE UNIVERSITY HOSPITAL	HS-000239-L

1992-1993 TRAINING:

BEGINNING DATE	ENDING DATE	LEVEL	SPECIALTY	HOSPITAL NAME	HOSPITAL LICENSE #
7/1/92	6/30/93	3	OBG	Temple University Hospital	

MAY 1992
 DIVISION

() NOT TRAINING IN PA IN 1992-1993

REQUIRED ATTACHMENT - COPY OF YOUR UNRESTRICTED LICENSE/REGISTRATION CARD DISPLAYING EXPIRATION DATE OR COPY OF SCORES OF FLEX 1 AND 2 (75 PASSING SCORE) OR COPY OF PASSING SCORES ON NATIONAL BOARDS PART 1, 2 AND 3. (ALL THREE PARTS ARE REQUIRED)

COMPLETE REVERSE SIDE

All of the questions must be answered and you must sign and date this form before returning it to be processed.

If you answer "YES" to questions 2 thru 5 on the questionnaire, you must provide complete details on an additional sheet.

If, after the board has issued a registration, any of the events in questions 2, 3, 4, or 5 occur, you must report that matter to the Board in writing within 30 days after its occurrence.

- | | YES | NO |
|--|-------|-------------------------------------|
| 1. Do you hold a license to practice medicine and surgery in any other jurisdiction?
If yes, list each one: _____ | _____ | <input checked="" type="checkbox"/> |
| 2. Since your last renewal, has any disciplinary action been taken against your license in another state, territory or country? | _____ | <input checked="" type="checkbox"/> |
| 3. Since your last renewal, have you been convicted, found guilty, or pleaded guilty or nolo contendere, or received probation without verdict as to any felony or misdemeanor, including any drug law violation, in any state or federal court? | _____ | <input checked="" type="checkbox"/> |
| 4. Since your last renewal, have you had practice privileges denied, revoked or restricted in a hospital or other health care facility? | _____ | <input checked="" type="checkbox"/> |
| 5. Since your last renewal, have you had your DEA registration denied, revoked or restricted or have you had your provider privileges terminated by any medical assistance agency for cause? | _____ | <input checked="" type="checkbox"/> |

[Redacted Signature]

SIGNATURE

4/23/92
DATE

NATIONAL BOARD OF MEDICAL EXAMINERS
3950 Chestnut St. Philadelphia, PA 19104
REPORT OF SCORE - PART III

Your standard score on the Part III Examination is shown below. Score interpretation information that shows you to compare your performance with that of other candidates is enclosed. To pass part III, your score must be at least 250.

NAME NUMBER 396895 EXAMINATION DATE 03/06/91 YOUR SCORE 330 PASS/FAIL PASS
L CHRISTOPHER KURT W M.D.
PHILADELPHIA PA 19106

MAY 1991
RECEIVED

020163 0027

STATE BOARD OF MEDICINE
P.O. BOX 2649
HARRISBURG, PA 17105-2649
717-783-1400

OFFICIAL USE ONLY

MT - 025416 - T

CHRIS R NEW

Dr. Christopher
Thomas Jefferson University Hosp.
Dept. of Medical Education
10th & Walnut Streets
Philadelphia, PA 19107

MT- 025416 - T

THIS IS YOUR RENEWAL NOTICE

Your Graduate License to participate in graduate medical training will expire on the ending date listed below. The information for your 1991-1992 year is indicated below. You must renew your license if you are to continue training past the ending date. In order to renew, attach a \$10.00 fee made payable to the "Commonwealth of PA". Write license number on your check. An individual fee for each renewal is required. Attach a copy of the required examination scores or unrestricted license to practice medicine and indicate the correct information for the 1992-1993 training year below, making all necessary changes. If you are not going to train past the ending date, check the "NOT TRAINING IN 1992-1993" space below. If you are changing hospitals, use this form to renew your license and write the new hospital under the old hospital's name.

In an effort to ensure timely receipt of a renewed license, the Board Office would appreciate receiving this renewal form with the attachment no later than MAY 1, 1992. A late penalty fee of \$5.00 per month or part of a month will be charged for renewals postmarked after the ending date listed below.

1992 - 1993

1991-1992 Training:

Beginning Date	Ending Date	LEVEL	SPECIALTY	HOSPITAL	Hospital License #
7/1/92	7/1/93	3	OBG	Thomas Jefferson University	HS-000240-1

1992-1993 Training:

Beginning Date	Ending Date	LEVEL	SPECIALTY	HOSPITAL	Hospital License #
Dr. Christopher registered with Temple; however, he resigned and accepted a position at Temple Hospital HS-100239					

NOT TRAINING IN PA IN 1992-1993

REQUIRED ATTACHMENT - Copy of your unrestricted license/registration card displaying expiration date OR copy of scores of FLEX 1 and 2 (75 passing score) OR copy of passing scores on National Boards Part 1, 2 and 3. (All three parts are required.)

COMPLETE REVERSE SIDE

All of the questions must be answered and you must sign and date this form before returning it to be processed.

If you answer "YES" to questions 2 thru 5 on the questionnaire, you must provide complete details on an additional sheet.

If, after the board has issued a registration, any of the events in questions 2, 3, 4 or 5 occur, you must report that matter to the Board in writing within 30 days after its occurrence.

- | | YES | NO |
|--|-----|-------|
| 1. Do you hold a license to practice medicine and surgery in any other jurisdiction?
If yes, list each one: _____ | ___ | ___ ✓ |
| 2. Since your last renewal, has any disciplinary action been taken against your license in another state, territory or country? | ___ | ___ ✓ |
| 3. Since your last renewal, have you been convicted, found guilty, or pleaded guilty or nolo contendere, or received probation without verdict as to any felony or misdemeanor, including any drug law violation, in any state or federal court? | ___ | ___ ✓ |
| 4. Since your last renewal, have you had practice privileges denied, revoked or restricted in a hospital or other health care facility? | ___ | ___ ✓ |
| 5. Since your last renewal, have you had your DEA registration denied, revoked or restricted or have you had your provider privileges terminated by any medical assistance agency for cause? | ___ | ___ ✓ |

[Redacted Signature]

Signature

7/1/91

Date

NATIONAL BOARD OF MEDICAL EXAMINERS
 3930 CHESTNUT STREET PHILADELPHIA, PA 19104

REPORT OF SCORES PART I

NBME NUMBER	STANDARD SCORE	AMAT	PWYS	ROSI	PHI	MCRO	FWYS	ROSI	PHI	PASS
386895	490	520	620	400	499	490	370	460		
TEST DATE	PERCENTILE CRITERION	45	47	68	25	47	80	9	41	SCORE INTERPRETATION IS PROVIDED ON THE ENCLOSED SHEET
06-88	PERCENTILE REFERENCE	45	88	85	22	48	55	100	49	
SCHOOL CODE										
175 90										

CHRISTOPHER KURT W

NOJ83899

8

BLSTON MA

02116

The official record of scores obtained by the above-named examinee on National Board of Medical Examiners examination(s) and the date(s) on which these scores were obtained are shown below.

Criteria for NBME certification include achievement of a passing total score on each of the three Part examinations. Total score is based on the total number of questions answered correctly and is not the average of the subject scores. There are no minimum pass requirements for individual subjects within a Part. The minimum passing total score for Part I is 380; for Part II, 290; and for Part III, 290.

PART II	DATE	SEPTEMBER 1989	TOTAL SCORE
MED SURG	OB/GYN	P H PED	335
395	350	380 310 370	605

NATIONAL BOARD OF MEDICAL EXAMINERS®
 3930 Chestnut St. Philadelphia, PA 19104
 REPORT OF SCORE - PART III

Your standard score on the Part III Examination is shown below. Score Interpretation information that allows you to compare your performance with that of other candidates is enclosed. To pass part III your score must be at least 290.

NBME NUMBER 386895 EXAMINATION DATE 03/06/91 YOUR SCORE 330 PASS/FAIL PASS

CHRISTOPHER KURT W

M.D.

PHILADELPHIA PA

19106



STATE BOARD OF MEDICINE
 P. O. BOX 2849
 HARRISBURG, PA 17105-2849
 717-787-2381

5/52/90

2 2 1

PHYSICIAN USE ONLY
 DO NOT WRITE IN THESE SPACES

M	D					
				E	D	U

VERIFICATION OF GRADUATION
 FROM MEDICAL SCHOOL

234/16-T
Completed 5/30/90

For graduates of United States or Canadian medical schools.

TO BE COMPLETED BY APPLICANT

Name: Christopher Kurt Walker
First Middle Surname

Address: [REDACTED]

Street Boston State Ma Zip Code 02116
City State Zip Code

Name of medical school: Tufts University School of Medicine
 Location: 145 Harrison Avenue, Boston, MA 02111

To be completed by Dean or Registrar

I certify that Kurt Walker Christopher, who began
(Name of Applicant)
 attendance at this school on 9/2/86, has successfully completed all the
(Date)
 required courses and examinations and has graduated from the above named school on
5/26/90.
(Date)

[Seal of School]

Signature of
 Dean or Registrar

Janet A. Kerle

Date: 5/25/90

UPON COMPLETION, SCHOOL MUST RETURN THIS FORM DIRECTLY TO THE PENNSYLVANIA STATE BOARD OF MEDICINE. DO NOT RETURN TO THE APPLICANT.

1 2 3 4 5 6 7 8 9 0

TARGET SHEET

MT - 025416 - T

LICENSE NUMBER

CHRIS EDUC

NAME

CODE



TUFTS UNIVERSITY
School of Medicine
145 Harrison Avenue
Boston, Massachusetts 02111

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





STATE BOARD OF MEDICINE
 P.O. BOX 2649
 HARRISBURG, PA 17105-2649
 717-787-2381

5-528-90
 OFFICIAL USE ONLY
 DO NOT WRITE IN THIS SPACE

M	D					
				E	D	U
				C		

**VERIFICATION OF GRADUATION
 FROM MEDICAL SCHOOL**

For graduates of United States or Canadian medical schools.

TO BE COMPLETED BY APPLICANT

Name: Christopher Kurt Walker
Last First Middle Surname

Address: [REDACTED]
Street
Boston Ma 02116
City State Zip Code

Name of medical school: Tufts University School of Medicine

Location: 145 Harrison Avenue, Boston, MA 02111

To be completed by Dean or Registrar

I certify that Christopher Kurt Walker, who began
(Name of Applicant)
 attendance at this school on 9/2/86, has successfully completed all the
(Date)
 required courses and examinations and has graduated from the above named school on
7/15/90
(Date)

(Seal of School)

Signature of

Dean or Registrar: Janet A. Kerle

Date: 5/15/90

UPON COMPLETION, SCHOOL MUST RETURN THIS FORM DIRECTLY TO THE PENNSYLVANIA STATE BOARD OF MEDICINE. DO NOT RETURN TO THE APPLICANT.



TUFTS UNIVERSITY
School of Medicine
145 Harrison Avenue
Boston, Massachusetts 02111

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

1011001001001001001001001001001001

COSTON
MAY 19 1979
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930149 0349

COMMONWEALTH OF PENNSYLVANIA
DEPARTMENT OF STATE
BUREAU OF PROFESSIONAL AND
OCCUPATIONAL AFFAIRS
STATE BOARD OF MEDICINE
P.O. BOX 2649
HARRISBURG, PENNSYLVANIA 17105-2649
717-783-1400

Official Use Only
MT - 025416
CHRIS RNEW

KURT WALKER CHRISTOPHER
THOMAS JEFFERSON UNIVERSITY
HOUSE STAFF OFFICE
2019 GIBBON OFFICE
111 SOUTH 11TH STREET
PHILADELPHIA, PA 19107

Present Training Period:

Beginning Date	Ending Date	Level	Specialty	Hospital License #	Hospital Name
07/01/92	06/30/93	3	OBG	HS-000240-L	THOMAS JEFFERSON UNIVERSITY

THIS IS YOUR RENEWAL NOTICE

1. Renewal Training Period:

Beginning Date	Ending Date	Level	Specialty	Hospital License #	Hospital Name
7/1/93	6/30/94	TO	OBG OBG	HS-000240-L	Thomas Jefferson Hospital

- 2. If you are not training in PA past ending date, check here.
- 3. Required Attachment - See #3B on instruction page.

Physician must answer all questions, sign and date form.

- | | Yes | No |
|--|--------------------------|-------------------------------------|
| 4. Do you hold a license to practice medicine and surgery in any other jurisdiction? If yes, list each one: _____ | <input type="checkbox"/> | <input checked="" type="checkbox"/> |
| 5. Since your last renewal, has any disciplinary action been taken against your license in another state, territory or country? | <input type="checkbox"/> | <input checked="" type="checkbox"/> |
| 6. Since your last renewal, have you been convicted, found guilty, or pleaded guilty or nolo contendere, or received probation without verdict as to any felony or misdemeanor, including any drug law violation, in any state or federal court. | <input type="checkbox"/> | <input checked="" type="checkbox"/> |
| 7. Since your last renewal, have you had practice privileges denied, revoked or restricted in a hospital or other health care facility? | <input type="checkbox"/> | <input checked="" type="checkbox"/> |
| 8. Since your last renewal, have you had your DEA registration denied, revoked or restricted or have you had your provider privileges terminated by any medical assistance agency for cause? | <input type="checkbox"/> | <input checked="" type="checkbox"/> |

[Redacted Signature]

Signature

3/22/93
Date

**GRADUATE LICENSE
RENEWAL INFORMATION AND INSTRUCTIONS**

Your graduate license to participate in graduate medical training will expire on the ending date indicated on the renewal notice under "Present Training Period". You must renew your license if you are to continue training past that ending date. In order to renew, follow these instructions:

1. Indicate the correct information for the next training period in the space marked "Renewal Training Period" (1.)
2. If you are not going to train past the ending date, check the "Not training in PA past ending date" (2.)
3. **Required Attachment**
A - Attach a copy of your unrestricted license/registration card displaying expiration date **OR** copy of scores of FLEX 1; **OR** National Boards Part I and II; **OR** Part I of the National Boards or Step 1 of the USMLE plus Part II of the National Boards or Step 2 of the USMLE

B - Attach a copy of your unrestricted license/registration card displaying expiration date **OR** copy of scores of FLEX 1 and 2; **OR** National Boards Part I, II and III; **OR** Part I of the National Boards or Step 1 of the USMLE plus Part II of the National Boards or Step 2 of the USMLE plus Part III of the National Boards or Step 3 of the USMLE; **OR** Part I of the National Boards or Step 1 of the USMLE plus Part II of the National Boards or Step 2 of the USMLE plus FLEX 1; **OR** FLEX 1 plus Step 3 of the USMLE
4. Answer questions 4-8 on the renewal notice. If you answer "Yes" to questions 5-8, you must provide complete details on an additional sheet. If, after the board has issued a license any of the events in questions 5, 6, 7, or 8 occur, you must report that matter to the Board in writing within 30 days after its occurrence.
5. Sign and date the form.
6. Attach a \$10.00 fee made payable to the "Commonwealth of PA". Write your license number on your check. (The number is at the top of the notice). An individual fee is due for each renewal. Mail to the address on top of the renewal notice.

NOTE -

A late penalty fee of \$5.00 per month or part of a month will be charged for renewals postmarked after the ending date.

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

If, since your last renewal, you have experienced difficulties as a result of alcohol ~~and~~ other drugs such as diagnosis of/treatment for chemical dependency or abuse or arrests for chemical-use-related offenses, you may contact the Bureau's Impaired Professional Program for confidential information and assistance. Information concerning the Program is available at 1-800-554-3428.

130149 0849

COMMONWEALTH of PENNSYLVANIA
DEPARTMENT of STATE
 BUREAU OF PROFESSIONAL AND OCCUPATIONAL AFFAIRS
 P.O. BOX 1788 HARRISBURG, PA 17103-1788

MEDICAL PHYSICIAN AND SURGEON

CLASSIFICATION

CERTIFICATE NUMBER: **MB-047568-L**
 CERTIFICATION DATE: **AUG 28 1992**
 EXPIRES: **DEC 31 1996**

ISSUES: **FEB 25 1993**

ISSUED TO:

KURT WALKER CHRISTOPHER
 [REDACTED]
 PHILADELPHIA PA 19106

George L. Shewlin
 COMMISSIONER OF PROFESSIONAL AND OCCUPATIONAL AFFAIRS

CONTROLLED SUBSTANCE REGISTRATION CERTIFICATE
UNITED STATES DEPARTMENT OF JUSTICE
DRUG ENFORCEMENT ADMINISTRATION
 WASHINGTON, D.C. 20537

The Controlled Substances Act of 1970 reads in part as follows:
 Sec. 301 (a) A registration pursuant to section 303 to manufacture, distribute, or dispense a controlled substance may be suspended or revoked by the Attorney General upon a finding that the registrant
 (1) has repeatedly violated any application filed pursuant to or issued by this title or 32a of
 (2) has been convicted of a felony under this title or title 18 or any other law of the United States, or of any State, relating to any substance defined in this title as a controlled substance, or
 (3) has had his State license or registration suspended, revoked, or denied by another State authority and is no longer authorized by that State to engage in the manufacturing, distribution, or dispensing of controlled substances.

DEA REGISTRATION NUMBER	THIS REGISTRATION EXPIRES	FEE PAID
6C9623249	08-31-95	860.00
SCHEDULE		DATE ISSUED
2, 2H, 3, 3H, 4, 5 PRACTITIONER		11-20-92

THIS CERTIFICATE IS NOT TRANSFERABLE ON CHANGE OF OWNERSHIP.