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SPON 141 (REV. 9/00)

Regular Mailing Address
STATE BOARD OF MEDICINE
P.O. BOX 2649
HARRISBURG, PA 17105-2649
717-783-1300
717-787-2381
Courier Delivery Address
STATE BOARD OF MEDICINE
124 PINE STREET, 1st FLOOR
HARRISBURG, PA 17101

MD 418235
M D K T H A P P L

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

Official Use Only
Amount 20.00
Date 1/5/02

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

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

Please print or type:

NAME: WILLIAM DAVID WILLIAMSON
Last First Middle

Permanent Address: [REDACTED]
Street
1234 PA 17101
City State Zip Code

Email address: [REDACTED] williamson@pa.com

Date of Birth: [REDACTED] Social Security Number: [REDACTED]

If your state requires registration and board approval, indicate the name of the board below.

LIST MEDICAL SCHOOL(S) ATTENDED:
UNIVERSITY OF PENNSYLVANIA

DATES OF ATTENDANCE
From: 8/44 to 1/98
Mo. & Yr. Mo. & Yr.
From: to
Mo. & Yr. Mo. & Yr.

Date of Graduation: 1998

Check licensing examination(s) passed:

- () FLEX - indicate state where taken: _____ Date taken: _____
- () FLEX COMPONENT 1 - indicate state where taken: _____ Date taken: _____
- () FLEX COMPONENT 2 - indicate state where taken: _____ Date taken: _____
- () NATIONAL BOARD - PART I _____ PART II _____ PART III _____
- (x) USMLE - STEP 1 STEP 2 STEP 3
- () LMCC - Canadian
- () STATE BOARD - indicate state where taken: _____

Post Graduate Education:

PGY1 Hospital: Boston Medical Center From: 7/1/98 to: 6/30/99

PGY2 Hospital: Boston Medical Center From: 7/1/99 to: 6/30/02

Answer the following questions, if "YES" is answered to any of them, provide complete details on a separate sheet as well as certified copies of relevant documents. Sign and date below.

- | | YES | NO |
|---|-------------------------------------|-------------------------------------|
| 1. Do you hold a license to practice medicine and surgery (active or inactive, current or expired) in any state, territory or country? If "yes", list all states below. | <input checked="" type="checkbox"/> | <input type="checkbox"/> |
| <u>Massachusetts</u> | | |
| 2. Have you withdrawn an application for a license, had an application for a license denied or refused, or agreed not to reapply for a license in another state, territory or country? | <input type="checkbox"/> | <input checked="" type="checkbox"/> |
| 3. Has any disciplinary action been taken against your license in another state, territory or country? | <input type="checkbox"/> | <input checked="" type="checkbox"/> |
| 4. 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"/> |
| 5. Have you had practice privileges denied, revoked or restricted in a hospital or other health care facility? | <input type="checkbox"/> | <input checked="" type="checkbox"/> |
| 6. 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"/> |
| 7. Are you, or have you ever been, addicted to the intemperate use of alcohol or to the habitual use of narcotics or other habit-forming drugs? (Note: You may answer "NO" if you are currently a participant in or have successfully completed the requirements of the Board's Health Monitoring Program.) | <input type="checkbox"/> | <input checked="" type="checkbox"/> |

SIGNED STATEMENT

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



SIGNATURE OF APPLICANT

RECEIVED

10/1/01

DATE

Health Services Board

Name of Applicant: Ann Marie Murphy

Thereby 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 2 year(s) 0 month(s).

SIGNATURE: 

Date: 12/14/01

Print or type name as signed above: W R CURRAN X

State in which licensed: MA

License Number: 5478

Return Completed Form to Applicant

SPCA 14117REV4/01
State Board of Medicine
P.O. Box 2649
Harrisburg, PA 17105-2649

Certification of Moral Character

To be completed by two physicians with a license without restriction in good standing in the United States or Canada.

Name of Applicant: ANTHONY S. MURPHY

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 3 year(s) 6 month(s).

SIGNATURE:  Date: 12/14/01

Print or type name as signed above: ANTHONY S. MURPHY License Number: 21110

State in which licensed: MA

02009-0059

SPOA 1411 (REV. 1/01)

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


Certification of Moral Character

To be completed by two physicians with a license without restriction in good standing in the United States or Canada.

Name of Applicant: Amiragouri S. Murthy

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 3 year(s) 6 month(s)

SIGNATURE:  Date: 12/14/01


Print or type name as signed above: Ralph Varaklis MD

State in which licensed: MA License Number: 31110

Name of Applicant: Amiragouri S. Murthy

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 _____ year(s) _____ month(s)

SIGNATURE:  Date: 12/14/01

Print or type name as signed above: J.R. Curran MD

State in which licensed: MA License Number: 55735

Return Completed Form to Applicant

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

Carrier Delivery Address
State Board of Medicine
121 Pine Street, 1st floor
Harrisburg, PA 17101

VERIFICATION OF ACGME APPROVED GRADUATE MEDICAL TRAINING
Accredited Medical School Graduates
TO BE COMPLETED BY APPLICANT

NAME: MULLER ANDREW FORNELLER
Last First Middle

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 the second year of training, this form may be completed and signed by the program director fifteen (15) days prior to the completion of the approved training. Forms postmarked or signed prior to the fifteen days will not be accepted.

NAME OF HOSPITAL WHERE TRAINING WAS COMPLETED: Boston Medical Center

NAME OF SPONSORING INSTITUTION: Boston University Medical Center

LOCATED IN: Boston Massachusetts
City State

1st Year from 7/1/88 To 6/30/89 Specialty Int'l Surg Level (PGY) 1

2nd Year from 7/1/89 To 6/30/90 Specialty Int'l Surg Level (PGY) 2

→ I certify that ANDREW FORNELLER successfully completed will successfully complete this graduate medical training and that there is no disciplinary action outstanding against this applicant. If this applicant does not complete this training, the Board will be notified.

"I further certify that the above program was ACGME accredited at the time ANDREW FORNELLER completed the training."
Name of Applicant

[Seal of Hospital] Signature of Program Director [Redacted]
Date 12/7/89

If the hospital has no seal complete the following section and have this form notarized:

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 _____ [notary seal]

RETURN COMPLETED FORM DIRECTLY TO THE BOARD IN OFFICIAL HOSPITAL ENVELOPE.

Entry Level Specialties

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

The following specialties are *to entry* and would not be o

- Adult Reconstructive Surge
- Aerospace Medicine
- Allergy and Immunology
- Blood Banking
- Cardiovascular Disease
- Chemical Pathology
- Child Neurology
- Child and Adolescent Psycol
- Colon and Rectal Surgery
- Critical Care
- Dermatopathology
- Diagnostic Laboratory Imm
- Endocrinology and Metabo
- Forensic Pathology
- Gastroenterology
- Geriatrics
- Hand Surgery
- Hematology
- Immunopathology
- Infectious Diseases
- Medical Microbiology
- Medical Oncology
- Musculoskeletal Oncology
- Neonatal-Perinatal Medicin
- Nephrology
- Neurosurgery
- Neuropathology

Board adopted April 22, 1

RECEIVED

(MAY 19 2002)

Health Licensing Boards

Open Boston Health & Career Center
Boston, MA 02115-2107

BOSTON
MEDICAL

ogy

rehab

require training prior

17105-2649-33

Dr. [illegible]

To: State Board of Medicine
P.O. Box 2649
Hallowell, ME 04115-2649

c

BY
Oncology

Public Health



MD Pomer

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

VERIFICATION OF MEDICAL EDUCATION
For Graduates of Accredited Medical Schools.

SECTION 1: To be completed by applicant:

Name: MARTIN AMANDA GRACE
Last First Middle

Name of medical school: West Virginia School of Health Science Center @

Location: MARTINSBURG, WV MORGANTOWN

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

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

Name of medical student: Amanda Grace Greenhouse Martin

Date student began to attend this medical school: August 22, 2004
Month/Day/Year

Date of graduation: April 21, 2006
Month/Day/Year

[Seal of School]

I certify that all of the above information is correct.

Signature of [Signature]
Dean or Registrar:

Date: August 21, 2006

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.**

Regular Mailing Address
State Board of Medicine
P.O. Box 2649
Harrisburg, PA 17105-2649
U.S.A.
Courier Delivery Address
State Board of Medicine
124 Pine Street, 1st Floor
Harrisburg, PA 17101
U.S.A.



NAME/BOX # **BOX 98**
 STATE UNIVERSITY OF NEW YORK
 HEALTH SCIENCE CENTER AT BROOKLYN
 450 CLARKSON AVENUE
 BROOKLYN, NY 11203-2068

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

UNIVERSITY OF ALABAMA
 ADMINISTRATION 109
 BALLEE AT SUNV NY
 PRESERVED PER 2000 127 CL 2 4 5 NY



AUG 17 1988



REC
 JAN 4
 Health Lic

State University of New York
Health Science Center at Brooklyn
also known as SUNY Downstate Medical Center
Academic Transcript

Printing Date: 01/24/02

Page 1 of 1

Student Name: **Murthy, Amitasrigowri Sreeniyasa** College: **College of Medicine**

IDN: [REDACTED] Program/Class of:

Matriculation Date: **Fall 1994** Degree Awarded: **Doctor of Medicine** Date Awarded: **05/21/98**

SUBJ NO	Course Title	Credits	Grade	SUBJ NO	Course Title	Credits	Grade
Fall 1994							
ANOR 1000	Gen. Anatomy	5.0	P	BIOL 4340	Science 1997	5.0	AT
BIOH 1000	General Histology	5.0	P	ASMC 4000	Health Care in Development Countries	5.0	AT
PSYH 1000	Behavioral Science	3.0	HP		Advanced Care	6.0	AT
PSYH 1001	Intro to Child & Adolescent	3.0	F		Family Credits	14.0	
ANCB 700	Embryology	0.5	HP		Total Earned Credits	15.0	
	Family Credits	1.5			No credits below 2.0/AT		
Spring 1995							
MIIM 1000	Microbiology	5.0	P				
NRSC 2000	PRC Statistics	1.0	HP				
PHYS 1000	Physiology	4.0	HP				
NSCB 1003	Histology Cell Histology	3.0	HP				
PHYS 1011	Pathophysiology	3.0	P				
PREV 1012	Prevention	1.0	F				
EMME 3001	Emergency Medicine Med. Off.	3.0	F				
	Family Credits	1.0					
Fall 1995							
PSYH 2006	Psychopathology	2.0	F				
PREV 2005	Prevention Medicine	2.0	F				
PHAR 2303	Pharmacology - PH	3.0	F				
PATD 2501	Pathophysiology - PH	4.0	F				
MBIO 2502	Microbiology - PH	3.0	F				
MBIO 2504	Microbiology	3.0	F				
PHO 2503	Pathology - PH	2.0	F				
	Family Credits	2.0					
Spring 1996							
PSYH 2006	Psychopathology	3.0	P				
PREV 2005	Prevention Medicine	3.0	HP				
MBIO 2502	Microbiology - PH	3.0	HP				
MBIO 2504	Microbiology	3.0	P				
PHAR 2501	Pharmacology - PH	3.0	HP				
PHAR 2503	Pathology - PH	3.0	HP				
MBIO 2503	Microbiology - PH	3.0	F				
	Family Credits	2.0					
Fall 1996							
PSYH 2500	Psychiatric Clinician	6.0	F				
PHYS 3200	ADVANCED CELLULAR	6.0	HP				
MBIO 3400	Microbiology Clinician	6.0	AT				
	Family Credits	2.0					
Spring 1997							
PHYS 3400	Pathology Clinician	6.0	F				
MBIO 3200	Microbiology PH	6.0	P				
MBIO 3600	Microbiology PH	6.0	HP				
	Family Credits	2.0					
Fall 1997							
PHYS 4400	Pathology Clinician	6.0	F				
MBIO 3200	Microbiology PH	6.0	P				
MBIO 3600	Microbiology PH	6.0	HP				
	Family Credits	2.0					
Spring 1998							
PHYS 4400	Pathology Clinician	6.0	HP				
MBIO 3200	Microbiology PH	6.0	P				
MBIO 3600	Microbiology PH	6.0	HP				
	Family Credits	2.0					
Total Credits							
		150					
No credits below 2.0/AT							

Completed requirements: 06/01/98

This Academic Transcript is considered Official **ONLY** with the impression of the Institution Seal and the signature/stamp of the Assistant Dean for Student Affairs

Sophie Christoforou
 Assistant Dean for Student Affairs and Registrar

in accordance with the Family Education Rights and Privacy Act of 1974 (as amended), information contained herein shall not be disclosed to a third party without the written authorization of the student.
 Confidential record for your exclusive use only.
NOT TO BE GIVEN TO STUDENT UNDER ANY CIRCUMSTANCES.

State University of New York Health Science Center at Brooklyn

COLLEGE OF MEDICINE

TRANSCRIPT KEY

Grading System as of July 1, 1995

H - Honors	I - Incomplete	EF - Elective course fail
HP - High Pass	CR - Credit	EH - Elective course honors
P - Pass	W - Withdrawal	EP - Elective course pass
C - Conditional	WP - Withdrawal/Passing	IP - In Progress
F - Fail	WF - Withdrawal/Failing	Y - Year-Long Course

Explanation of Grades

Honors - Outstanding work in the subject area, far exceeding requirements of the course.

High Pass - Above average work in the subject area which exceeds the requirements of the course.

Pass - Successful completion of all requirements of the course.

Conditional - Borderline failure, requiring remedial work for part of the course (i.e. written exam)

Fail - Failure to successfully complete the requirements for a major part of the course.

Incomplete - a portion of the requirements of the course have not been attempted usually for reasons beyond the control of the student (i.e. illness)

Credit - the transcript notation when a student has advanced standing for a course previously completed.

Withdrawal - Student withdraws from a course prior to 25% of the completion of the course.

Withdrawal Passing - Student withdraws from a course at a passing level after 25% completion but prior to 75% of the completion of the course.

Withdrawal Failing - Student withdraws from a course at a failing level after 25% completion but prior to 75% of the completion of the course. WF is considered an academic deficiency.

EF, EP, EH - Electives during the preclinical years are taken for no credit. In the grades Elective Fail, Elective Pass and Elective Honor, the "E" signifies a no-credit elective. The definitions of the second letter of the grade are reflected above.

In Progress - Course is still in progress.

Year-long Course - Will be listed as the grade for the first semester for a year long course.

Grading System prior to July 1, 1995

H - Honors	U - Unsatisfactory	EF - Elective course fail
HP - High Pass (Effective Fall 1989)	I - Incomplete	EH - Elective Course Honors
P - Pass	E - Exemption	EP - Elective course pass
S - Satisfactory (phased out in 1989)		

A recorded grade which has a slash (/) with a new grade after it indicates a change of grade. The last grade is considered the FINAL grade.

The College of Medicine does not assign quality points to its grades and therefore does not calculate a GPA.

In accordance with the Family Educational Rights and Privacy Act of 1974, this information is released with the condition that it not be made available to any other party without written consent of student.

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JAN 30 2002

Health Licensing Boards



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

[Handwritten Signature]

This Transcript was prepared by the Federation of State Medical Boards

Date of Certification: 01/16/2002

Pennsylvania State Board of Medicine
ATTN: Cindy J. Warner, Administrator
PO Box 2649
Harrisburg, PA 17405-2649

RECEIVED

Examinee: Murthy, Anurasigowri Sreemivasa
USMLE ID#: 5-002-027-0
DOB: [REDACTED]
All Name(s):

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

STEP	Test Date	Pass/Fail	Three-Digit Score (Passing)	Two-Digit Score (Passing)	Comments
STEP 1	6/14/1996	PASS	215 (176)	86 (75)	
STEP 2	8/26/1997	PASS	213 (170)	85 (75)	
STEP 3	State Board				
MASSACHUSETTS	5/14/1999	PASS	198 (177)	81 (75)	

A search of the Board Action Data Bank of the Federation of State Medical Boards (FSMB) reveals no reported information on the above-named examinee.

Authenticity of USMLE Transcripts

An original, certified transcript of United States Medical Licensing Examination scores is printed using black ink on blue safety paper and is produced only by the Educational Commission for Foreign Medical Graduates, Federation of State Medical Boards, or National Board of Medical Examiners. The TamperSafe® Hologram in the lower left corner certifies the authenticity of this document. Alteration or forgery of a USMLE transcript may result in appropriate legal action and/or a determination of irregular behavior, as described below.

To Test for Authenticity: Touch, rub or breathe on TouchSafe® Fingerprint and the word **VALID** will appear. When liquid bleach is applied to the face of the document, the paper will turn brown. Also, when photocopied, a security statement containing the words **UNOFFICIAL COPY, NOT AN ORIGINAL DOCUMENT**, will appear prominently across the face of the entire document.

INTERPRETATION OF SCORES

USMLE transcripts include a complete score history and notations of any examinations for which the examinee sat and no scores were reported, such as "Incomplete" or "Indeterminate." Scores are reported on two different scales. For each Step, the mean and standard deviation of scores on the three-digit scale for the original anchor group of first-time examinees from medical schools in the United States was 200 and 20, respectively. Most scores fall between 145 and 260. An equivalent value score on a two-digit scale is also provided. A score of 75 on the two-digit scale is the recommended minimum passing score. The recommended minimum passing score on each scale is shown on the front of the transcript next to the examinee's score for each examination administration. The level of proficiency required to meet the recommended minimum passing level for each USMLE Step is reviewed periodically and is subject to change.

Factors which influence an examinee's score include the examinee's general understanding of the subject matter being tested and the specific set of test items used for an administration. The Standard Error of Measurement (SEM) provides an index of the variation in scores that would be expected to occur if an examinee were tested repeatedly using different sets of items covering similar content. The SEM for a USMLE score is usually in the range of 4 to 8 score points on the three-digit scale and 1 to 2 score points on the two-digit scale.

ANNOTATIONS APPEARING UNDER "COMMENTS"

Circumstances in connection with an administration shown on this transcript may result in one or more annotations listed next to the score. A description of each "Comment" is provided below.

Indeterminate - Results that cannot be certified as representing a valid measure of the examinee's knowledge or competence as sampled by the examination. Decisions to classify results as indeterminate may be made on the basis of factors that include, but are not limited to, unexplained inconsistency of performance within the examination or between administrations of the same Step. **No score is reported.** Information regarding the nature of the indeterminate score and the determination of the Committee on Score Validity is available. If such information is not enclosed with this transcript, it may be obtained by contacting the organization from which you received the transcript or the USMLE Secretariat, 3750 Market Street, Philadelphia, PA 19104, telephone (215) 590-9700.

Incomplete - The examinee sat for some, but not all, of the scheduled examination. **No score is reported.**

Irregular Behavior - The Committee on Irregular Behavior determined that the examinee engaged in irregular behavior. Examples of irregular behavior are described in the current edition of the *USMLE Bulletin of Information*. Information regarding the nature of the irregular behavior and the determination of the Committee is available. If such information is not enclosed with this transcript, it may be obtained by contacting the organization from which you received the transcript or the USMLE Secretariat, 3750 Market Street, Philadelphia, PA 19104, telephone (215) 590-9700.

Score Not Available - The score is not available. Further review and/or analysis may be pending, or it may have been determined that the score cannot be reported.

Test Accommodations - Following review and approval of a request from the examinee, test accommodations were provided in the administration of the examination.

ANNOTATIONS APPEARING AS "NOTE"

Circumstances not in connection with an administration shown on this transcript may result in one or more annotations and an explanation or instructions to contact the appropriate individual or organization. The "Note" will appear at the end of the document.

BOARD ACTION DATA BANK INFORMATION APPEARING AS "NOTE"

The Board Action Data Bank of the Federation of State Medical Boards (FSMB) contains actions reported to the FSMB by U.S. licensing and disciplinary boards, Canadian licensing authorities, the U.S. Armed Forces, the U.S. Department of Health and Human Services, and other credentialing entities. To be included in the Bank, an action must be a matter of public record or be legally releasable to state medical boards or other entities with recognized authority to review physician credentials. Certain actions reported to and released by the Board Action Data Bank are not disciplinary or otherwise prejudicial in nature. Such actions are reported to ensure that records are complete and to assist in preventing misrepresentation or the use of lost or stolen credentials by unauthorized persons. Once reported to the FSMB, an action becomes part of the permanent record of the individual physician, and the existence of such an action may be indicated on the USMLE transcript by a "Note."

Amiasrigowri S. Murlhy

[Redacted]

Boston, MA 02118

[Redacted]

E-mail: [Redacted]

Education:

- 1998-Present Resident Obstetrics and Gynecology
Boston Medical Center
Boston University School of Medicine
Boston, MA 02118
Chair: Philip G. Stubblefield, M.D.
- 1994-1997 Doctor of Medicine
State University of New York Health Science Center at Brooklyn -
College of Medicine
- 1994-1997 Bachelor of Arts Comparative Literature - cum laude
City University of New York - Brooklyn College
Seven year B.A./M.D. Honors Program

Honors and Awards

- 1994 **Avery Award in Comparative Literature** - Recognizes outstanding effort by a student in Comparative Literature.
- 1994 **Golden Key National Honor Society** - Honor society recognizing excellence of academics and leadership in school activities.
- 1994 **Brooklyn College Foundation Scholarship** - Half-Euition Merit scholarship awarded before entry into college.

Memberships:

- 1998-Present American Medical Association - member
- 1998-Present Massachusetts Medical Society - member
- 1998-Present American College Of Obstetricians and Gynecologists - Junior Fellow
- 1994-Present American Association of Physicians of Indian Origin - Medical Student Resident section - member
- 1994-1997 **Kanada Ikoota of New York Executive Committee** - Youth Committee Chair (1989-1993), Joint Secretary (1994-1996)

- 1994-1998 **Hindu Temple Society of North America** - volunteer
- 1994-1999 **Committee on Educational Policy and Curriculum** - elected for four year term as member on standing school committee
- 1994-2000 **University Council** - elected to plan and schedule campus wide events and represent school at statewide SUNY meetings
- 1994-2001 **South Asian Association at Brooklyn** - elected to organize meetings to promote awareness of health issues in South Asian community
- 1994-1997 **Dormitory Council** - elected to serve as Secretary and floor representative during meetings

Research:

- 2000 Chair of Plenary Session on Cesarean Section - Federation Internationale de Gynecologie et Obstetries (FIGO) World Conference, Washington, D.C.
- 2000 Presentation Plenary Session on Cesarean Section - FIGO World Conference, Washington, D.C. Titled "Do Fibroids Affect Labor?" Murthy, AS; Fernandez, A; Chaudhury, AK; Hutchins, R. (to be submitted)
- 2006 Presentation Association of Reproductive Health, Annual Meeting, Chicago, Ill. "Pregnancies During Depo-Provera Use" Bongatta, L, Kupterman, SP; Murthy, AS; Burnhill, M, Beardsley, L, Chuang, C. (to be submitted)
- 1999 Presentation National Abortion Federation Risk Management Seminar, Denver, CO. "Interventional Radiology for Post-Abortal Hemorrhage" Bongatta, L; Chen, AY; Stubblefield, PG; Murthy, AS.

Personal Interests

Indian Classical Dance and vocal music;
 Languages: French, Spanish, and Kannada
 Reading, theater, travel

References



32 Worcester Square
Boston, MA 02118
April 1, 2002

One Boston Medical Center Place
Boston, MA 02118-2291
Tel: 617-778-8000
Fax: 617-778-8700

To:
The State Medical Board of Pennsylvania
P.O. Box 2649
Commissioner's Office
Harrisburg, PA 07105

RE: application for licensure in state of Pennsylvania
Applicant Amitasrigowri S. Murthy

To Whom It May Concern,

This letter is written after a conversation that I had with Ms. Sharon Morgan today regarding my application for licensure. It appears that there is an error on the paperwork that I have filled out. I erroneously wrote that I held an unrestricted license to practice medicine in the state of Massachusetts. In actuality, I have only a limited license, due to the fact that I am currently a resident in the field of Obstetrics and Gynecology. This license only allows me to only practice medicine at the teaching hospital that I am employed by. Please find enclosed with this letter a copy of my limited license.

If there are any further questions about this, please feel free to contact me via my home telephone [redacted] or my pager [redacted] number [redacted] or my e-mail, which is [redacted]@hotmail.com. Thank you for your attention to this matter.

Sincerely,

[Redacted signature area]

Amitasrigowri S. Murthy

For the Medical Center
Boston Medical Center School of Public Health
Boston Medical Center School of Public Health
Boston Medical Center School of Public Health



Commonwealth of Massachusetts Board of Registration in Medicine

10 West Street
Boston, Massachusetts 02111

(617) 727-3086
Fax: (617) 451-9588

An Agency within the Office of Consumer Affairs and Business Regulation

ARGEO PAUL CELLUCCI
GOVERNOR

JANE SWIFT
LIEUTENANT GOVERNOR

HANGY ACHIN SULLIVAN
EXECUTIVE DIRECTOR

CERTIFICATE OF LIMITED REGISTRATION (under G.L. c. 112, sec. 9)

License Number: 7729

This is to certify that Amitasrigowri S Murthy, M.D. has been granted Limited Registration to serve as Resident with authority to practice medicine only in Boston Medical Center and affiliates. Service at the hospital begins on 07/01/1998. Expected date of completion of program will be 06/30/2002. This license automatically terminates at the end of each academic year, unless the conditions for annual issuance are met pursuant to 243 CMR 2.02 (2).

THIS CERTIFICATE DOES NOT ENTITLE Amitasrigowri S Murthy, M.D. TO PRACTICE IN THE ABOVE HOSPITAL AFTER 07/01/2002.



Rafik Attia, M.D., Secretary

Seal

- Board Approval Date(s)
- 06/24/1998
- 04/30/1999
- 05/25/2000
- 05/29/2001





Commonwealth of Massachusetts
Board of Registration in Medicine

10 West Street
Boston, Massachusetts 02111
Tel: 727-4386
Fax: 727-451-9508

020094 0058

Date: 01/03/2009

To Whom It May Concern:

This is to certify **AMITASRIGOWRI S. MURTHY, M.D.**, a graduate of
State University of New York Downstate Medical Ctr
in the year **0**, has been duly registered by this board as provided by the laws
of the Commonwealth.

Certificate Number **7729** was issued to Dr. **MURTHY** on
THIS LICENSE IS CURRENT. The expiration date is **Jul 3 2009**.

Our files contain no open complaint information on this physician.

Our files contain no closed complaint information on this physician.

Our files contain no disciplinary information on this physician.

SBAU



Peter Nadras, M.D., Chairman

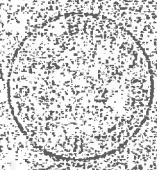
Please be advised that the above information is based on the information provided by the applicant and the Board's review of the applicant's records. Based on a review of the applicant's records, the Board is required to provide the following information:

Commonwealth of Massachusetts
BOARD OF REGISTRATION IN MEDICINE
10 West Street - Third Floor
Roxbury, Massachusetts 02111

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

17105+2649 99

17105+2649 99



REC-71
MAR 06 2002
Health Licensing Board

State Board of Medicine
P.O. Box 2649
Harrisburg, PA 17105-2649
717-783-1400 or 717-787-2381

January 22, 2002

AMFASHE WRT MURPHY

BOSTON, MA 02118

Dear Doctor:

The items checked below are required to complete your application. Additional information is listed below the item, if necessary. **You may not practice in the Commonwealth of Pennsylvania until the Pennsylvania State Board of Medicine has issued a license.**

- 1 Application - page 1
- 2 Application - page 2
- 3 Application page 3 - Certification of Moral Character
The attached must be completed where indicated.
- 4 Application - page 4 - Verification of ACGME Approved Graduate Medical Training - must be received DIRECTLY from the Hospital(s) in official hospital envelope(s).
- 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 USMLE scores must be received DIRECTLY from the Federation of State Medical Boards, Inc. in an official agency envelope.
- 9 FLEX scores must be received DIRECTLY from the Federation of State Medical Boards, Inc. in an official agency envelope

PAGE #2

- 10. State Board certification must be received DIRECTLY from the State Medical Board in an official State Board envelope
- 11. Curriculum vitae
- 12. 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. **NOTE: A processing fee of \$20.00 will be charged for any check or money order returned unpaid by your bank, regardless of the reason for non-payment.**
- 13. Letter(s) of good standing must be received DIRECTLY from the State Board in an official State Board envelope from the following states:
Massachusetts
- 14. National Practitioner Data Bank / Healthcare Integrity and Protection Data Bank Disclosure Information - NPDB & HIPDB
- 15. Other:

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



TARGET SHEET

Board: Medicine

Date Created:
11/04/2004

Licensee Full Name:
AMITASRIGOWRI SREENIVASA MURTHY

License No:
MD418685

MISC	1957766
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0101-140000123

020347 1578

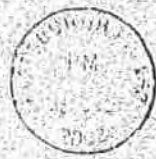
MD	4	1	8	6	8	5		
M	u	r	t	h	M	I	S	C

Amiascador S. Murthy



Harrisburg, PA 17108

MD-418685



Medical Professional Liability
 Catastrophe Loss Fund
 P.O. Box 12030
 Harrisburg, PA 17108

17108+2030 23




150 East 85th Street
Apt 10A
New York, NY 10028

To:
Pennsylvania State Board of Medicine
P.O. Box 2649
Harrisburg, PA 17105

To Whom It May Concern:

I am writing to you today to change the status of my medical license. I am no longer practicing in Pennsylvania, as I have accepted a position with another facility in New York City. I would like to change the status of my license from active to inactive. My PA license number is MD 418685. I am including a copy of my license as well. I appreciate your attention to this matter.

Thank you


Amitasigowal S. Murthy, MD, MPH

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

31942

MD418685
Renewal ID : 533125
MURTHY

RENEWAL APPLICATION - MD

AMITASRIGOWRI SREENIVASA MURTHY

[REDACTED]
PITTSBURGH PA 15232

RETURN TO:

State Board of Medicine
PO Box 8414
Harrisburg, PA 17105-8414

Important Information

You can now renew your license online by pointing your browser to www.myLicense.state.pa.us and following the instructions as indicated. Your license renewal will be processed easier and quicker than by mail.

- I will not be practicing this profession in Pennsylvania after the expiration date indicated below and request inactive status. No fee is required. Renewal must still be completed - questions answered, signed and dated.
- I am retired from practice but desire to keep my license active to treat immediate family members. I am exempt from the medical professional liability insurance and CME requirements. Renewal must be completed and fee required.

Name Change	Address Change
Indicate new name below. Submit a photocopy of a legal document verifying name change (i.e., marriage certificate, divorce decree or legal document indicating retaking of a maiden name, etc.)	

THE FOLLOWING QUESTIONS MUST BE ANSWERED

YES	NO	If YES to question 2, 3, 4, 5, 6, 7 or 8 - provide details AND attach certified copies of legal document(s).
<input checked="" type="checkbox"/>	<input type="checkbox"/>	1. Do you hold a license (active, inactive or expired) to practice in any other state or jurisdiction? List <u>Massachusetts</u>
<input type="checkbox"/>	<input checked="" type="checkbox"/>	2. Since your initial application or your last renewal, have you had disciplinary action taken against your license in any other state or jurisdiction?
<input type="checkbox"/>	<input checked="" type="checkbox"/>	3. Since your initial application or your last renewal, have you withdrawn an application for a license, had an application for a license denied or refused, or agreed not to reapply for a license in any state or jurisdiction?
<input type="checkbox"/>	<input checked="" type="checkbox"/>	4. Since your initial application or your last renewal, have you been convicted, found guilty or pleaded nolo contendere or received probation without verdict as to any felony or misdemeanor, including any drug law violations, or any criminal charges pending and unresolved in any state or jurisdiction?
<input type="checkbox"/>	<input checked="" type="checkbox"/>	5. Since May 18, 2002, have you been arrested for criminal homicide, aggravated assault, sexual offenses or drug offenses in any state, territory or country?
<input type="checkbox"/>	<input checked="" type="checkbox"/>	6. Since your initial application or 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"/>	7. Since your initial application or 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"/>	8. Since May 19, 2002, have any malpractice complaints been filed against you?
<input type="checkbox"/>	<input checked="" type="checkbox"/>	9. I am in compliance with the professional liability insurance requirements under Section 711 of the Medical Care Availability and Reduction of Error (MCare) Act No. 13 of 2002.

I verify that this form is in the original format as supplied by the Department of State and has not been altered or otherwise modified in any way. I am aware of the criminal penalties for tampering with public records or information pursuant to 18 PA C.S. 4911 and that any false statement made is subject to the penalties of 18 PA C.S. 4912. My signature and the signature of the licensee may result in my license being disciplined.

Signature of Licensee (Mandatory) [REDACTED]

Date: 11/15/02

EXPIRATION DATE:	December 31, 2002
FEE - Payable to "COMMONWEALTH OF PENNSYLVANIA" Write your license number on your payment. A \$20.00 fee will be assessed for returned payment.	\$360.00 MD418685
LATE FEE - \$5.00 per month, or part of a month Late renewal fee will be assessed if postmarked after December 31, 2002	PRACTICING ON AN EXPIRED LICENSE MAY RESULT IN DISCIPLINARY ACTIONS AND ADDITIONAL MONETARY PENALTIES