

BUREAU OF PROFESSIONAL AND OCCUPATIONAL AFFAIRS

P. O. Box 2649

Harrisburg, PA 17105-2649

APPLICANT INFORMATION

| | | | | PERSONAL INF | ORMATIO | N | | | |
|-------------------------|-------------------------------------------------------------------------------|----------------------------------------------------------------------------------|------------------------------------------------------------------------------------------------------------|------------------------------------------------------------|-----------|---------------|----------------------|------|-----------------|
| Last Na | me | FRAREY | | | First Nar | me ALHA | AMBRA | | |
| Middle | Name | | | | Suffix | | | | |
| Full Na | me | ALHAMBRA | FRAREY | | | | | | |
| SSN | | | Date Of Birth | | Age | | er Ger | nder | FEMALE |
| | | | | ADDRESS D | DETAILS | | | | |
| Street A | Address | 3 | | | | | | | |
| City/Sta | ate/Zip | | | | | | | | |
| County | | | | | | | Country | | |
| | | | | CONTACT | DETAILS | | | 6 8 | |
| Phone r | number | • | | | Mobile Ph | one number | | | |
| Primary | / Email | Address | | | Secondary | y Email Addre | ss | | |
| | | | | CHECKLIST | T ITEMS | | | | |
| Checkli | st name | 9 | Status | | | | Submitted Date | e F | Expiration Date |
| Applica | ation | | Pending Re | view | | 10/03/2018 | | 018 | |
| Applica | ation F | ee | Completed | | | | 10/03/2 | 018 | |
| Child A | Abuse | CE | Not Receive | ed | | | 10/02/2 | 018 | |
| nig. | | | | LEGAL QUE | STIONS | A THE | | | |
| Questio | ns | | | | | Answer | Document Uploaded | File | e Name |
| 1 A | re you | u submitting a r | name change with | this renewal? | | N | No | | |
| 2 F | irst Na | ame | | | | | No | | |
| 3 N | /liddle | Name | | | | | No | | |
| 4 L | ast Na | ame | | | | | No | | |
| d (C n (C n | s). The locume 1) Mar 2) Divo lame: 3) Othe lame: 4) For | e following are a ents: riage Certificatorce decree wh er "legal" docur | py of a legal docu acceptable name e: ich indicates the ment indicating th change, a copy o | change verificat retaking of your re retaking of a n | maiden | | No | | |
| h | old, or egistra | r have you ever | the one you are or held, a license, outhorization to pra e or jurisdiction? | certificate, permi | t, | Y | No | | |

| 7 | Please provide the profession and state or jurisdiction. | MD-Kansas; MD-New Jersey | No | |
|----|------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|--------------------------------|-----|-----------------------------------------|
| 8 | Since your initial application or last renewal, whichever is later, have you had disciplinary action taken against a professional or occupational license, certificate, permit, registration or other authorization to practice a profession or occupation issued to you in any state or jurisdiction or have you agreed to voluntary surrender in lieu of discipline? | N | No | |
| 9 | Do you currently have any disciplinary charges pending against your professional or occupational license, certificate, permit or registration in any state or jurisdiction? | N | No | |
| 10 | Since your initial application or last renewal, whichever is later, have you withdrawn an application for a professional or occupational license, certificate, permit or registration, had an application denied or refused, or for disciplinary reasons agreed not to apply or reapply for a professional or occupational license, certificate, permit or registration in any state or jurisdiction? | N | No | |
| 11 | Since your initial application or last renewal, whichever is later, have you been convicted (found guilty, pled guilty or pled nolo contendere), received probation without verdict or accelerated rehabilitative disposition (ARD), as to any criminal charges, felony or misdemeanor, including any drug law violations? Note: You are not required to disclose any ARD or other criminal matter that has been expunged by order of a court. | | | |
| 12 | Do you currently have any criminal charges pending and unresolved in any state or jurisdiction? | N | No | |
| 13 | Since your initial application or your last renewal, whichever is later, have you had your DEA registration denied, revoked or restricted? | N | No | |
| 14 | Since your initial application or your last renewal, whichever is later, have you had provider privileges denied, revoked, suspended or restricted by a Medical Assistance agency, Medicare, third party payor or another authority? | N | No | |
| 15 | Since your initial application or your last renewal, whichever is later, have you had practice privileges denied, revoked, suspended, or restricted by a hospital or any health care facility? | N | No | |
| 16 | Since your initial application or your last renewal, whichever is later, have you been charged by a hospital, university, or research facility with violating research protocols, falsifying research, or engaging in other research misconduct? | N | No | |
| 17 | Since your initial application or last renewal, whichever is later, have you engaged in the intemperate or habitual use or abuse of alcohol or narcotics, hallucinogenics or other drugs or substances that may impair judgment or coordination? | | | |
| 18 | Since your initial application or your last renewal, whichever is later, have you been the subject of a civil malpractice lawsuit? | Y | No | |
| 19 | Have you previously reported the complaint to the Board? | N | No | |
| 20 | Provide the docket number: | | No | |
| 21 | Upload a copy of the entire Civil Complaint, which must include the filing date and the date you were served. | | Yes | Summons - November 2017 (002).pdf |
| 22 | Have you completed at least 2 hours of Board approved continuing education in pain management, identification of addiction or the practices of prescribing or dispensing of opioids? | Y | No | |
| 23 | Do you hold a DEA number or use the registration number of another person or entity to prescribe controlled substances? | | No | |
| 24 | Have you registered with the Pennsylvania Prescription Drug Monitoring Program? | | | |

| 25 | I will be retiring from practice but desire to place my li | | N | No | |
|---------------------------------------------------------------------------------------------------------------------------|--------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|----------------------------------------------------------------|------------------|----------------|-------|
| | active-retired status which will allow me to treat imme members. I am exempt from the CME requirements, | | | | |
| completion of the 2 hours of Board-approved continuing | | | | | |
| education in child abuse recognition and reporting and 2 hours of Board approved continuing education in pain management, | | | | | |
| | identification of addiction or the practices of prescribir | ng or | | | |
| | dispensing of opioids. Renewal must be completed a required. | nd fee | | | |
| 26 | Do you maintain current medical professional liability the Commonwealth of Pennsylvania? | insurance in | Y | No | |
| 27 | Upload an explanation or reason for an exemption rea | quest. | | No | |
| 28 | Have you met your continuing education requirement review the continuing education requirements posted Board's website at www.dos.pa.gov/med . Click on Ge Information. If you qualify for an exemption of the coneducation requirements, answer yes to the question. required to retain your official continuing education completion earned for this license renewal period until 31, 2020. | on the eneral Board tinuing You are ertificates of | Y | No | |
| | Licenses/Certificates/Permits/Regi | strations in | Any State/Jui | risdiction | |
| Profe | ssion | State/Jurisdic | tion | | |
| MD | | Kansas | | | |
| MD | | New Jersey | | | |
| | CONFIR | MATION | I Freguer | | |
| | All forman and a debt. Discourable to continue | | | 20/2040 40-22 | .07.\ |
| 凶 | All fees are non-refundable. Please check to continue | with your trai | nsaction. (10/0 | 03/2018 10:22: | 37) |

| Person Info Name:ALHAMBRA FRAREY Address Info Street Address: Phone City State Zipcode Country County | |
|--------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|-----|
| Survey Response Summary | |
| Question Response Summary | h + |
| Are you submitting a name change with this renewal? | N |
| Do you hold a license/certificate (active, inactive or expired) to practice in any other state or jurisdiction? | N |
| Since your initial application or last renewal, whichever is later, have you had disciplinary action taken against your license, certificate or registration issued to you in any profession in any other state or jurisdiction? | N |
| Since your initial application or last renewal, whichever is later, have you been convicted, found guilty or pleaded nolo contendere, or received probation without verdict, or accelerated rehabilitative disposition(ARD) as to any felony or misdemeanor, including any drug law violations, or do you have any criminal charges pending and unresolved in any state or jurisdiction? You are not required to disclose any ARD or other criminal matter that has been expunged by order of a court. | |
| Since your initial application or last renewal, whichever is later, have you withdrawn an application for a license, certificate or registration, had an application denied or refused, or for disciplinary reasons agreed not to reapply for a license, certificate or registration in any profession in any other state or jurisdiction? | N |
| Since your initial application or last renewal, whichever is later, have you been arrested for criminal homicide, aggravated assault, sexual offenses or drug offenses in any state, territory or country? | |
| Since your last renewal, have you been the subject of a civil malpractice law suit? If yes, please submit a copy of the entire Civil Complaint which must include the filing date and the date you were served. If you previously reported the complaint, email or fax the docket number to the Board. (email at st-medicine@state.pa.us or fax at 717-787-7769) | N |
| | N |

| Since your initial application or last renewal, whichever is | | | | |
|----------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|-------------------------|--|--|--|
| later, have you had your DEA registration denied, | | | | |
| revoked or restricted? | | | | |
| Since your initial application or last renewal, whichever is | | | | |
| later, have you had practice privileges denied, revoked or N restricted in a hospital or health care facility? | | | | |
| Since your initial application or last renewal, whichever is later, have your provider privileges been denied, revoked or restricted by any medical assistance agency for cause? | N | | | |
| Do you maintain current medical professional liability insurance in the Commonwealth of Pennsylvania? | Y | | | |
| Have you met your current CE requirements? | N | | | |
| Education Information | | | | |
| Edit | | | | |
| Profession: Medicine School: UNIV OF KS Credit Ho | urs: Education Type: | | | |
| From: To: 5/18/2008 | | | | |
| Employment Information | | | | |
| No employment records | | | | |
| remarks | | | | |
| Remarks: | | | | |
| Continuing Education Information | | | | |
| No CE Course records | | | | |

| Name:ALHAMBRA FRAREY Address Info Street Address Phone Fax | |
|-------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|---------------------------|
| State Zipcode Country County | |
| Survey Response Summary | |
| Question Response Summary | N |
| Are you submitting a name change with this renewal? | Y |
| Have you met your current CE requirements? | 1 |
| Have you completed 2 hours of Board-approved continuing education in child abuse recognition and reporting? | N |
| Do you hold, or have you ever held, a license, certificate, permit, registration or other authorization to practice a profession or occupation in any state or jurisdiction? | Y |
| If you answered yes to the above questions, please provide the profession and state or jurisdiction. | Medical license in Kansas |
| Since your initial application or last renewal, whichever is later, have you had disciplinary action taken against a professional or occupational license, certificate, permit, registration or other authorization to practice a profession or occupation issued to you in any state or jurisdiction or have you agreed to voluntary surrender in lieu of discipline? | |
| Do you currently have any disciplinary charges pending against your professional or occupational license, certificate, permit or registration in any state or jurisdiction? | N |
| Since your initial application or last renewal, whichever is later, have you withdrawn an application for a professional or occupational license, certificate, permit or registration, had an application denied or refused, or for disciplinary reasons agreed not to apply or reapply for a professional or occupational license, certificate, permit or registration in any state or jurisdiction? | N |
| Since your initial application or last renewal, whichever is later, have you been convicted (found guilty, pled guilty or pled nolo contendere), received probation without verdict or accelerated rehabilitative disposition (ARD), as to any criminal charges, felony or misdemeanor, including any drug law violations? Note: You are not | |

| that has been expunged by order of a court. | |
|--------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|---|
| Do you currently have any criminal charges pending and unresolved in any state or jurisdiction? | N |
| Since your initial application or last renewal, whichever is later, have you had your DEA registration denied, revoked or restricted? | N |
| Since your initial application or your last renewal, whichever is later, have you had provider privileges denied, revoked, suspended or restricted by a Medical Assistance agency, Medicare, third party payor or another authority? | N |
| Since your initial application or your last renewal, whichever is later, have you ever had practice privileges denied, revoked, suspended, or restricted by a hospital or any health care facility? | N |
| Since your initial application or your last renewal, whichever is later, have you been charged by a hospital, university, or research facility with violating research protocols, falsifying research, or engaging in other research misconduct? | N |
| Since your initial application or last renewal, whichever is later, have you engaged in the intemperate or habitual use or abuse of alcohol or narcotics, hallucinogenics or other drugs or substances that may impair judgment or coordination? | |
| If yes, are you currently participating in the Pennsylvania Professional Health Monitoring Program? | N |
| Since your initial application or your last renewal, whichever is later, have you been the subject of a civil malpractice lawsuit? | N |
| If yes, please submit a copy of the entire Civil Complaint, which must include the filing date and the date you were served. Submit a statement which includes complete details of the complaints that have been filed against you. PLEASE NOTE: If you previously reported the complaint to the Board you will only need to provide the docket number here: | |
| Do you maintain current medical professional liability insurance in the Commonwealth of Pennsylvania? | Y |
| If you answer "No", please provide an explanation or reason for an exemption request. | |
| Friday, Date Submitted:October 17, 2014 | |

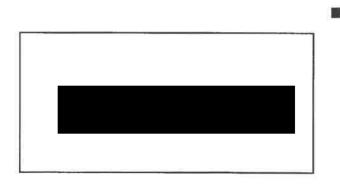
| Education Inf | o | | |
|---------------|------------------|-----------------------|--------------------|
| <u>Edit</u> | | | |
| Profession: | Medicine School: | UNIV OF Credit Hours: | Education Type: |
| From: | To: | 5/18/2008 | |
| Employment : | Information | | |
| | No empl | oyment records | |



Board: Medicine

<u>Licensee Full Náme:</u> ALHAMBRA FRAREY

License No:



| Reply 🏂 Reply to all 🗻 Forward 🔛 🍰 🗙 🔺 🗸 | Close | Q: Help |
|------------------------------------------|-------|---------|
|------------------------------------------|-------|---------|

This message was sent with high importance.

From:

ST, MEDICINE [ra-medicine@pa.gov]

Sent: Thu 11/1/2012 2:51 PM

To:

Undisclosed recipients

Cc:

CONTINUING EDUCATION ****IMPORTANT**** LICENSE RENEWAL

Subject: DISCREPANCY NOTICE

Attachments:

View As Web Page

Dear Licensee:

Thank you for processing your license renewal via our online renewal system.

Based on the answer(s) you provided to one or more of the questions on the renewal application, you are required to submit documentation before the license record can be renewed. You are required to send the Board the appropriate documentation regarding that answer as indicated below.

If you have more than one discrepancy, you will receive more than one automated email message.

Each discrepancy will be addressed in a separate email message.

Please be advised that your license WILL NOT be renewed until such time as the information and/or documents outlined below are received.

You answered "No" to the question of meeting the continuing education requirement. Your license cannot be renewed until you have met the requirement.

English

The second of the sec

| F YOU ANSWERED THIS QUESTION IN ERROR, PLEASE PROVIDE A WRITTEN STATEMENT TO THE BOARD INDICATING THAT THIS QUESTION WAS ANSWERED IN ERROR. |
|---------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|
| F YOU HAVE NOT MET THE CME REQUIREMENTS FOR THIS RENEWAL PERIOD, YOU CANNOT RENEW YOUR LICENSE. WHEN YOU HAVE MET THE CME REQUIREMENTS, PLEASE CONTACT THE BOARD FOR A REACTIVATION APPLICATION. |
| f you are exempt for one of the following reasons, please check the appropriate exemption below and return to the Board Office: |
| Obtained initial license within this renewal period. |
| Participated in an accredited training program during this renewal period. |
| Hold an Active-Retired License. |
| |
| To assist with expediting the processing your renewal, <u>please include a copy of this email with all</u> locuments that you return to the Board. Be sure to PRINT your name and license number below: |
| Frarey Alhambra First |
| Frarey Alhambra Last, First |
| License No |
| State Board of Medicine |
| PO Box 2649 |
| Harrisburg, PA 17105 |

Telephone: 717-783-1400 or 717-787-2381

Email: st-medicine@pa.gov

Web Site: www.dos.state.pa.us/med

This email contains confidential, privileged, nonpublic information intended to be conveyed only to the designated recipient(s). Any unauthorized use, dissemination, distribution or reproduction of this information, including attachments, is prohibited. If you are not an intended recipient, please destroy the attachments, and reply to sender.

| lame:ALHAMBRA FRAREY Address Info | |
|--------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|---------------------------|
| Street Address: Email: | |
| Phone Fax | |
| City | |
| State | |
| Zipcode Country | |
| County | |
| Survey Response Summary | 146 12 - Bur |
| Question Response Summary | |
| Are you submitting a name change with this renewal? | N |
| Have you completed your current CE requirements? Do you hold, or have you ever held, a license, certificate, permit, registration or other | Y |
| uthorization to practice any health-related profession in any state or jurisdiction? | Y |
| f you answered yes to the above question, please provide the profession and state or arisdiction. | medical license in Kansas |
| ince your initial application or last renewal, whichever is later, have you had disciplinary action | 1, |
| aken against a professional or occupational license, certificate, permit, registration or other uthorization to practice a profession or occupation issued to you in any state or jurisdiction or lave you agreed to voluntary surrender in lieu of discipline? | N |
| Do you currently have any disciplinary charges pending against your professional or ccupational license, certificate, permit or registration in any state or jurisdiction? | N |
| lince your initial application or last renewal, whichever is later, have you withdrawn an | |
| pplication for a professional or occupational license, certificate, permit or registration, had an pplication denied or refused, or for disciplinary reasons agreed not to apply or reapply for a | N |
| rofessional or occupational license, certificate, permit or registration in any state or unisdiction? | |
| lince your initial application or last renewal, whichever is later, have you been convicted | |
| found guilty, pled guilty or pled nolo contendere), received probation without verdict or ccelerated rehabilitative disposition (ARD), as to any criminal charges, felony or | |
| nisdemeanor, including any drug law violations? Note: You are not required to disclose any | |
| ARD or other criminal matter that has been expunged by order of a court. | |
| o you currently have any criminal charges pending and unresolved in any state or jurisdiction? | N |
| ince your initial application or last renewal, whichever is later, have you had your DEA egistration denied, revoked or restricted? | N |
| lince your initial application or your last renewal, whichever is later, have you had provider | |
| rivileges denied, revoked, suspended or restricted by a Medical Assistance agency, dedicare, third party payor or another authority? | N |
| lince your initial application or your last renewal, whichever is later, have you ever had | |
| ractice privileges denied, revoked, suspended, or restricted by a hospital or any health care acility? | N |
| ince your initial application or your last renewal, whichever is later, have you been charged by | 1- |
| hospital, university, or research facility with violating research protocols, falsifying research, rengaging in other research misconduct? | N |
| lince your initial application or last renewal, whichever is later, have you engaged in the | |
| ntemperate or habitual use or abuse of alcohol or narcotics, hallucinogenics or other drugs or ubstances that may impair judgment or coordination? | |
| ince your initial application or your last renewal, whichever is later, have you been the subject fa civil malpractice lawsuit? | N |
| f yes, please submit a copy of the entire Civil Complaint, which must include the filing date and | |
| ne date you were served. PLEASE NOTE: If you previously reported the complaint to the | |
| Board you will only need to provide the docket number here: | |
| Iave you completed 2 hours of Board-approved continuing education in child abuse ecognition and reporting? | Y |
| Oo you maintain current medical professional liability insurance in the Commonwealth of dennsylvania? | Υ |
| f you answer "No", please provide an explanation or reason for an exemption request. | , |
| lease provide the zip code of your primary employer/practice location. This data is being ollected for the purpose of identifying healthcare professionals during state emergencies and hay be provided to the Pennsylvania Emergency Management Agency for official use only. | 19104 |
| Monday, November 14, 2016 | |
| ducation Info | |
| No education records | |
| mployment Information | |

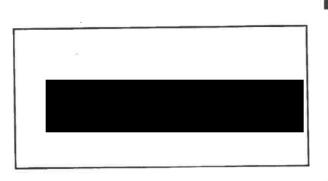
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TARGET SHEET

Board: Medicine

Licensee Full Name: ALHAMBRA FRAREY

License No:



49-101 (REV. 1-10)

Regular Mailing Address
STATE BOARD OF MEDICINE
P.O. BOX 2649
HARRISBURG, PA 17105-2649
717-783-1400/717-787-2381
Email: st-medicine@state.pa.us

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

APPLICATION FOR A LICENSE TO PRACTICE MEDICINE WITHOUT RESTRICTION For Graduates of ACCREDITED Medical Schools (SCHOOLS IN THE U.S. AND CANADA)

| Application Fee: Note: | A processing f | | harged for any che | ommonwealth of Pennsylvania." ock or money order returned unpaid by | your |
|----------------------------------------------------------------------|------------------------------------|--------------------------|----------------------|----------------------------------------------------------------------|------|
| | | Please Pr | int or Type | | |
| NAME:Fr | arey | Alh | ambra | | |
| 10 11161 | Last | Fin | | Middle | |
| Permanent Address: | 3 | | | | |
| All correspondence | Street | | | | |
| and the license will be mailed to this | 19- | | | | |
| address unless the Board is notified of a | City | ~ | State | Zip Code | |
| change. Email address | | | | | |
| Date of Birth: MM | DD YYYY | Social Security Nun | nber: | | |
| If your medical/licensu | re records are lis | ted under another nar | me or names list be | elow: | |
| Are you applying using | g credentials verif | fication from FCVS? | X YES | _NO | |
| Have you previously h | eld a Pennsylvan | nia graduate training li | cense? | | |
| YES; My licens | e number is | | | X_NO | |
| LIST MEDICAL SCHO | OOL(S) ATTEND | ED: | DATE | S OF ATTENDANCE: | |
| University of | f Kansa | School of | From: | MM/YYY MM/YYY | |
| | | | From: | MM/YYYY to MM/YYYY | |
| Date of Graduation: _ | 05/17/ MM/DD/YY | <u>m</u> | | MM/YYYY MM/YYYY | |
| Check licensing exar | nination(s) pass | sed: | | • | |
|) FLEX - indicate state) NATIONAL BOARD) USMLE -) LMCC - Canadian | where taken: -PART I STEP 1X | Date tak PART II STEP 2 | xen: Component 1PART | Component 2 | - |
| STATE BOARD - inc | dicate state where | e taken; | | land the fi | 1 |

FRAREY, ALHAMONA

49-101 (REV. 01-10)
ACGME Post Graduate Training:

| d copies of relevant documents. Sign and date below. | Yes | No |
|--------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|----------------------------|--------------------|
| Do you hold or have you ever held an unrestricted license, certification, or registration (active or inactive current or expired) to practice medicine and/or surgery in another jurisdiction? If yes, list the jurisdiction(s) here: | ž. | / |
| Have you withdrawn an application for a license, certificate or registration, had an application for a license denied or refused, or for any disciplinary reason agreed not to reapply for a license, certificate or registration in any profession in any state or jurisdiction? | a T | / |
| Have you had disciplinary action taken against your license, certificate or registration issued to you in an profession in any other state or jurisdiction? | у | / |
| Have you been convicted, found guilty or pleaded noto contenders; or received probation without verdict of accelerated rehabilitative disposition (ARD) as to any felony or misdemeanor, including any drug law violations, or do you have any criminal charges pending and unresolved in any state or jurisdiction? You are not required to disclose any ARD or other criminal matter that has been expunged by order of a court. | u | |
| Since May 19, 2002, have you been arrested for criminal homicide, aggravated assault, sexual offenses drug offenses in any state, territory or country? | or | |
| Have you had practice privileges denied, revoked or restricted in a hospital or other health care facility, have you been charged by a hospital, university, or research facility with violating research protocol falsifying research, or engaging in other research misconduct? | ЭГ 5, | / |
|) Have you had your DEA registration denied, revoked or restricted or have you had your provider privilege terminated by any medical assistance agency for cause? | s | / |
| Are you, or have you ever been, addicted to the intemperate use of alcohol or to the habitual use narcotics or other habit-forming drugs? Note: You may answer "NO" if you are currently participant in or have successfully completed the requirements of the Board's Professional Heat Monitoring Program.) | of a h | |
|) Since May 19, 2002, have any malpractice complaints been filed against you? If yes, the Board require that you submit a copy of the entire Civil Complaint which must include the docket number, filing date and the date you were served. | s B | / |
| SIGNED STATEMENT te that disclosing your social security number on this application is <u>mandator</u> in order for the State Board of Medicine to comply with the federal Social Security Act pertaining to child support enforcement, as implemented in the Commonwealth of Pennsylvania 04.1(a). In order to enforce domestic child support orders, the Commonwealth's licensing boards must provide to the Department omnation prescribed by DPW about the licensee, including the social security number. Additionally, disclosing the number is <u>mand</u> is board to comply with the reporting requirements of the federal National Practitioner Data Bank and the Healthcare integrity and ink, Reports to the NPDB/HIPDB must include the licensee's social security number. | of Public V Blory in or | Velfare der for |
| enify that the statements in this application are true and correct to the best of my knowledge, information and belief. I understand that is made subject to the penalties of 18 Pa. C.S. Section 4904 relating to unsworm falsification to authorities and may result in the occation of my license. I hereby authorize all hospitials, institutions or organizations, my references, personal physicians, empleantly and all governmental agencies and instrumentalities (local, state, federal or foreign) to release to the Pennsylvania State Best of the Pennsylvania St | e suspeni loyers (pa | son o |
| 4/10/12 | | - |

SERVICE STATE MEDICAL BOARDS

MD BL



Medical Professional Information Profile

This report provides credentialing information for

Name: Alhambra Frarey

Social Security: Number:

Date of Birth:

FID#:

Recipient: PA - Pennsylvania State Board of Medicine

ABOUT THIS PROFILE

The Federation Credentials Verification Service (FCVS) was retained by the above referenced medica professional to verify his/her medical oradentials for submission to your agency/organization. Unless noted otherwise, all documents contained in this report were received directly from the issuing institution per written request mode by FCVS.

NOTICE: All documents bearing an original Official FCVS seal are certified to be an exact reproduction of the original. Where required, original documents are provided according to the agreements with the institution issuing such document. FCVS meintains all original documents (excluding third-party examination transcripts) in the physician is acure file.

This FCVS medical professional Information Profile ("Profile") is compiled and provided by the Federation of State Medical Bounds of the United States, Inc. (Federation) as a reference accurate, and only for, is member boards and other entities authorized by the Federation. The Profile embodies and contains confidential business information because the information, and the format and presentation of that information, comprise trade secrets of the Federation and because the Profile's disclosure would harm the Federation by providing others with an unfair business adventage in compating with the Federation Ps FCVS services. Further, the form of the Profile and the contents of this Profile, including the compiletion of information in this Profile, are the Federation's copyrighted works and propietary, confidential information in this Profile, are the Federation's copyright and expense powering copyright, trademant and trade excents, as well as various state laws protecting the Federation's total excents and other intellectual preparty right. This Profile are the contents are too be (1) copied, reformation, modified, published or displayed publicly or (2) used, displaced, distributed, stereor or soft, in which or part, for any purpose, including us to establish any distance or otherwise, all of which is whichly probability distributed without the express wellian consent of the Federation's GEO.



Credentials Analysis Summary Report



Note: Your board may wish to review the unresolved items below marked by an "X" Please review the Credentials Analysis report for further details on the unresolved items Medical Professional Name: Alhambra Frarey Date of Birth: Social Security Number: FID: I. FCVS Reports II. FSMB and Other Reports III. Identity A. Valid Original Passport IV. Medical Education A. Pre-medical Schools B. Medical Schools University of Kansas School of Medicine 1. Medical Education Form 2. Medical Education L2 3. Medical Education Dean's Letter 4. Medical Education Transcript 5. Medical Education Diploma

- C. Fifth Pathway Program
- D. ECFMG Certification
- V. Graduate Medical Education

University of Kansas Hospital

- GME Form
- 2. GME Completion Certificate
- VI. Licensure Examination History
 - A. FSMB Exams

End of report for: Alhambra Frarey



Medical Professional Profile



Table of Contents

I. FCVS Reports

- A. Physician Information Report
- B. Credentials Analysis Report
- C. Chronology of Activities

II. FSMB and Other Reports

- A. Board Action Data Bank Report
- B. American Board of Medical Specialty Verification

III. Identity

- A. Affidavit
- B. Certified Birth Certificate or Original Passport
- C. Documentation to Support Name Variation

V. Medical Education

- A. Verification of Medical Education
- B. Clinical Clerkships (if applicable)
- C. Verification of Fifth Pathway (if applicable
- D. ECFMG Certification (if applicable)

V. Graduate Medical Education

A. Verification of Graduate Medical Education

VI. Licensure Examination History (State Licensing Authorities Only)

- A. LMCC Transcript
- B. State Medical Board Transcript
- C. NCCPA Transcript
- D. NBME Transcript
- E. NBOME Transcript
- F. LMCC Transcript
- G. FSMB Transcript

480 PULLER WIRER ROAD | SUITE 200 | SULESS, TR. 76839 | TEL(817)848-3888 | PAR(817)848-3999

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Medical Professional Information Profile



Section I

FCVS Reports



Medical Professional Information Report



identity

Medical Professional Name: Alhambra Frarey

Documentation: Valid Original Passport

Gender: Female

Date of Birth:

Place of Birth:

Social Security Number:

Physical Description: Height:

Weight:

Eye Color:

Hair Color:

Contact Information

Mailing Address:

Permanent Address:

Telephone Numbers: Primary:

Secondary: N/A

Fax:

N/A

Other:

N/A



Medical Professional Information Report



Premedical Education

(Provided by Applicant. Not verified with the primary source.)

Institution: Johnson County Community College

Address: Overland Park, KS 66210

UNITED STATES

Dates of Attendance: 08/-/1998 To 08/-/2000

Degree Conferred/Issued: Applicant did not graduate

(Provided by Applicant. Not verified with the primary source.)

Institution: The University of Kansas

Address: Lawrence, KS 66045-7535

UNITED STATES

Dates of Attendance: 08/-/1999 To 12/-/2003

Degree Conferred/Issued: Bachelor of Arts

ECFMG

There are none identified or not applicable.

Medical Education

Medical School: University of Kansas School of Medicine

Address: 3901 Rainbow Boulevard

Kansas City, KS 66160-7300

UNITED STATES

Dates of Attendance: 08/09/2004 to 02/23/2008

Date Certificate Issued: 05/18/2008

Degree Conferred/Issued: Doctor of Medicine

Unusual Circumstances

Leave of Absence/Extension: No

Probation: No Information Available

Disciplined: No Information Available

Negative Reports: No Information Available

Limitations: No Information Available

Fifth Pathway

There are none identified or not applicable.



Medical Professional Information Report



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Graduate Medical Education

Institution: University of Kansas Hospital

Address: 3901 Rainbow Boulevard Wescoe 3rd

Kansas City, KS 66160 UNITED STATES

Training Level: 1 - 3

Program Type: Residency

Specialty: Obstetrics and Gynecology

Dates of Attendance: 07/01/2008 To 06/30/2011

Completed Successfully: Yes

Accreditation: ACGME

Training Level: 4

Program Type: Residency

Specialty: Obstetrics and Gynecology

Dates of Attendance: 07/01/2011 To 06/30/2012

Completed Successfully: in Progress

Accreditation: ACGME

Unusual Circumstances

Leave of Absence/Extension: No

Probation: No

Disciplined: No

Negative Reports: No

Limitations: No



Medical Professional Information Report



Licensure Examinations

FSMB Transcript USMLE Step 1 Date: 06/2006 Passed the Exam FSMB Transcript USMLE Step 2 CK Date: 09/2007 Passed the Exam FSMB Transcript USMLE Step 2 CS Date: 08/2007 Passed the Exam FSMB Transcript USMLE Step 3 Date: 05/2009 Passed the Exam

ABMS Verification

A report of the result from a search of the data provided by the American Board of Medical Specialties is enclosed.

Board Action

A report of the results from a search of the Board Action Data Bank is enclosed.

End of report for Alhambra Frarey FID:



Credentials Analysis Report



The Credentials Analysis Report is a comparative report of a medical professional's credentials as reported to FCVS by the applicant and the primary source (Medical School, PGT program, etc.). It will also list particular missing documentation, if any, as outlined in the FCVS Policies and Procedures.

| Medical Professional Identific | | | |
|--------------------------------|------------------------|--------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|---------|
| Medic | al Professional Name: | Alhambra Frarey | |
| | Date of Birth: | | |
| S | ocial Security Number: | | |
| | FID: | | |
| Omissions | | The Thirty of th | H = 2 3 |

There are no omissions identified.



Credentials Analysis Report



Discrepancies

Discrepancy 1:

Section of Profile: MedEd

Discrepancy: The applicant reports attendance at University of Kansas School of Medicine from 08/-

-/2004 to 05/-/2008. The institution reports attendance from 08/09/2004 to 02/23/2008.

Action Taken:

FCVS has contacted the Institution in an attempt to resolve the attendance date discrepancy. The Institution has verified the date information reported is accurate according to their records.

Discrepancy 2:

Section of Profile: MedEd

> The applicant reports the degree/diploma was issued/conferred/awarded by University of Kansas School of Medicine on 05/17/2008. The institution reports 05/18/2008. Discrepancy:

FCVS has defined "graduation date" as the date the diploma was issued to the applicant Action Taken:

by the medical school.

Miscellaneous Information

There is no miscellaneous information identified.

End of report for: Alhambra Frarey

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Chronology of Activities



The Chronology of Activities is a comprehensive report of a medical professional's activities as reported to FCVS by the medical-professional applicant.

Medical Professional Name: Date of Birth:

Social Security Number:

FID#:



| Start Date | End Date | Activity | Location | Overlap Explanation | Program Length Explanation |
|---------------|-------------|-----------------------------|----------------------------------------------------------------------------------------------------------------------|---------------------|----------------------------|
| 8/2004 | 05/2008 | Medical Education Record | University of Kansas School of Medicine,3901 Rainbow Boulevard Kansas City, KS 66160- 7300 UNITED STATES | | |
| 7/2008 | 06/2012 | GME Record | University of Kansas Hospital,3901 Rainbow Boulevard Wescoe 3rd Kansas City, KS 66160 UNITED STATES | | |

End of report for Alhambra Frarey



Medical Professional Information Profile



Section II

FSMB and Other Reports

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FEDERATION PHYSICIAN DATA CENTER

Board Action Clearance Report



March 23, 2012

Attn: Tracy Bevers

FCVS

Re: Board Action Query Dated: FSMB Batch Number:

March 23, 2012

The following is a report of the search results from the Board Action Data Bank as of

March 23, 2012

for practitioners submitted as part of the above-referenced batch for which NO board actions were identified.

Provider cleared with No Actions as of

March 23, 2012

| Name | DOB | School | Yr/Grad | Provider ID |
|-----------------|-------------|-------------------|---------|-------------|
| Alhambra Frarey | | | | |
| | License H | listory | | |
| | Licensing I | Entity | | |
| | No Licensu | re Information Fo | ound | |

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

400 FULLER WISER ROAD | SUITE 300 | EULESS. TX 76039 TEL(817)868-5000 FAX(817)868-5099



Medical Professional Information Profile



Section III

Identity



Affidavit and Release and Authorization for Release of Information, Documents and Records

I, the undersigned, being duly sworn, hereby certify under oath that I am the person named in this application, that all statements I have or shall make with respect thereto are true, that I am the original and lawful possessor and person named in the various forms and credentials famished or to be furnished with respect to my application and that all documents, forms or copies thereof furnished or to be furnished with respect to my application are strictly true in every aspect.

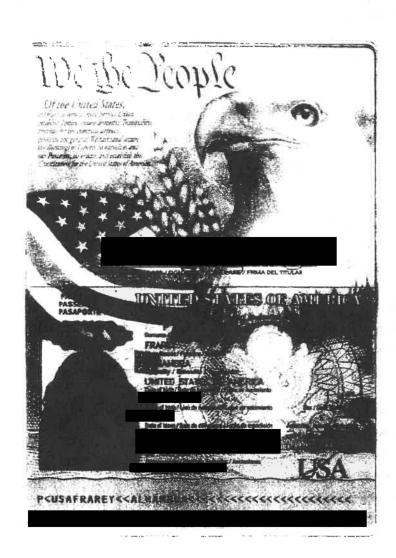
I acknowledge that I have read and understand the "Instructions for Completing the FCVS Application" and have answered all questions contained in the application truthfully and completely. I further acknowledge that failure on my part to answer questions truthfully and completely may lead to my being prosecuted under appropriate federal and state laws.

I waive confidentiality, authorize and request every person, hospital, clinic, government agency (local, state, federal or foreign), court, association, institution or law enforcement agency having custody or control of any documents, records and other information pertaining to me to furnish to the Federation Credentials Verification Service (FCVS) any such information, including documents, records regarding charges or complaints filed against me, formal or informal, pending or closed, my examination grades, or any other pertinent data and to permit FCVS or any of its agents or representatives to inspect and make copies of such documents, records, and other information in connection with this application that can subsequently be provided to professional licensing boards, hospitals and other entities when I apply for licensure, staff membership, employment or other privileges.

I hereby release, discharge and exonerate FCVS, its agents or representatives and any person, hospital, clinic, government agency (local, state, federal or foreign), court, association, institution or law enforcement agency having custody or control of any documents, records and other information pertaining to me of any and all liability of every nature and kind arising out of investigation made by FCVS.

I will immediately notify FCVS in writing of any changes to the answers to any questions contained in this application if such a change accept at any time prior to my FCVS Physician Information Profile being mailed.

| Appacant Sagnature (must be | signed in the presence of a notary) | ATTANTON |
|--------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|--------------------------------------------------------------|--------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|
| Frarey | | |
| Applicant's Printed Last Name | | |
| Alhambra | | |
| Applicant's Printed First Name | , Middle Initial, and Suffix (e.g., Jr.) | |
| 12/9/11 | 11/08/1981 | |
| Date of Signature | Date of Birth | |
| Applicant SSN | | The second second |
| | NOTARY | Experien.10-115 |
| Your seal or stamp must be pa | rtly upon the photograph. | |
| State of NALSAS | County of LUVALISOTIE TO before me this 9TH day of Sections | 360 001 |
| SUBSCRIBED AND SWORM My commission expires: 12 | TO before me this day of | ock , 20 11 |
| twy examination expires. 12 | 9,601 | |
| (NOTARY PUBLIC SIGN | | |
| Notary Public eignature:_ | | |
| I certify that on the date set for | th above the individual named above did appear person | sally before me and that I did identify this applicant by: |
| (a) comparing his/her physical | | cument presented by the applicant and with the photo- |
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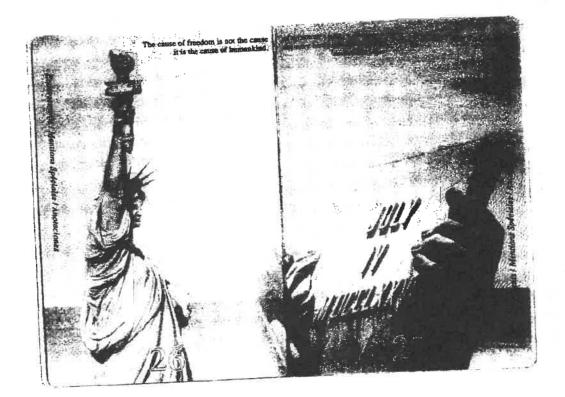


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Kevin Caldwell
Federation Credentials Verification Service

January 10, 2012

Date





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Kevin Caldwell Federation Credentials Verification Service January 10, 2012

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Medical Professional Information Profile



Section IV

Medical Education

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Verification of **Medical Education**



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Verification of **Medical Education**



Unusual Circumstances __ YES <u>X</u> NO 1. Do this imitvidual's official records reflect (an) interruption(s) or extension(s) in higher medical education? if Yae, please specify the reason(s) for, indicate the date of the interruptions(s) or extension(s) and check whether the interruption/extension was approved or unapproved: _From (Mo/Yr)___/___ To (Mo/Yr)_ From (Mo/Yr) To (Mo/VI) To (Mo/Yr)__ From (Mo/Yr) Health From (Mo/Yr)__/ Financial Perticipation in joint degree Program (e.g., MD/PhD) From (Me/Yr) Participation in non-separate special study (e.g., fellowship, international experience) From (Mo/Yr)__ To (Mo/Vi)_ Approved _ From (Mo/Yr)___/_ To (Mo/W)_ Perticipation in non-degree research, To (Mo/W)__/_ From (Mo/Yr)___/_ Please Specify: 2. Do this individually efficial records reflect that hashe was over placed on academic or disciplinary probables do medical aducation? If YES, please educt the reason(a) for the probation, indicate the dates of placement on and removal from probation and affects additional documentation to this report: The Office of the Registrar does not maintain this information. From (Mo/Yr) To MayYel Probation for unprofessional conduct/behavioral To (Mo/Yr)___/_ _From (Mo/Yr)___/__ Probation for other excess. Please specify & reserve 3. Do this instriction's efficial records reflect that twiste was ever disciplined for improfessional conducty the medical actual or parent university? The Office of the Registrar does not If YES, please provide detailed documentation/information about the circumstances and outcome(s): maintain this information. 4. Do Dila individuate efficial records reflect that he/size was ever the ambject of negative reports for behavioral reast levestigation by the medical actual or parent university? If YES, places provide detailed documentation/information about the circumstances and outcome(s): The Office of the Registrar does not maintain this information. 5. De this instriguer's efficial records reflect that there were any limitations or special requires because of questions of academic incompolance, illectylinary problems, or any other resoun? ments Imposed on the individual If YES, please provide detailed documentation/information about the nature of the limitations or special requirements:

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Applicant Reported Unusual Circumstances



Page 1 of 1

| Medical School | | |
|-----------------------------------------------------------------------------------------------------------------------------------------------------------------|-----|-------------|
| Medical Professional Name: Alhambra Frarey University of Kansas School of Medicine | | 5 - 15-50-5 |
| Unusual Circumstances | | |
| Did you have any interruption(s) or extension(s) in your medical education? | Yes | No |
| Were you ever placed on probation? | Yes | No |
| Were you ever disciplined or placed under investigation? | Yes | No |
| Were any negative reports for behavioral reasons ever filed by instructors? | Yes | No |
| Were any limitations or special requirements imposed on you because of academic performance, incompetence, disciplinary problems or for any other reason? | Yes | No |

End of report for Alhambra Frarey

PROVIDED BY APPLICANT

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Chris Meiers
Associate Vice Chancellor for Student Services/Registrar
December 28, 2011



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upon the recommendation of the Naculty of the

confers upon

Alhambra Frarey

the degree of

Doctor of Aedicine

this eighteenth day of May, two thousand and eight. with all its rights, privileges, and responsibilities. Given under the seal of the Antversity of Kansas







State Spard of Secrets



Medical Professional Information Profile



Section V

Graduate Medical Education

STATE MEDICAL BOARDS

Federation Credentials Verification Service (FCVS)

Federation Place / 400 Fuller Weer Road Suite 300 / Euless, TX 78059 Tel: (317) 888-5900 Fex: (317) 888-5099

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| Institution: University of | Kansas Hospital | Attention: Program Director |
| Address: Department | of OB/GYN | Affiliated University: |
| Kansas City | KS 66160 | |
| Verification For: | Name: Frarey, Alhambra | |
| | | |
| | DOB Individual's Name on Record (If different from | abrush: C. Å. |
| | | above): |
| Program | Training Level: 4 Specialty/Subs | secialty: OB/GYN |
| Participation: | (e.g., 1, 2, 3, etc.) Specially/Subs [Internation From: 07/01/2 | |
| Important: Report Incomplete | ⊠Residency | mpleted?: Yes No Min Progress |
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| were successfully completed. | Research | □RCPSC □APPAP □None of these |
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| Inusual | 1. Did this individual ever take a leave of abs | ence or break from his/her training? |
| Circumstances: | 2. Was this individual ever placed on probable | n7 |
| Check the correct response. Omitted responses require | 3. Was this individual ever disciplined or place | nd under investigation? |
| written explanation. | 4. Were any negative reports for behavioral r | essons ever filed by instructors? 🔲 Yes 🛮 🖾 No |
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Applicant Reported Unusual Circumstances



Page 1 of 1

| Graduate Medical Education | | |
|-----------------------------------------------------------------------------------------------------------------------------------------------------------|-----|----|
| Medical Professional Name: Alhambra Frarey University of Kansas Hospital Obstetrics and Gynecology | | |
| Unusual Circumstances | | |
| Did you have any interruption(s) or extension(s) in your medical education? | Yes | No |
| Were you ever placed on probation? | Yes | No |
| Were you ever disciplined or placed under investigation? | Yes | No |
| Were any negative reports for behavioral reasons ever filed by instructors? | Yes | No |
| Were any limitations or special requirements imposed on you because of academic performance, incompetence, disciplinary problems or for any other reason? | Yes | No |

End of report for Alhambra Frarey

PROVIDED BY APPLICANT

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Medical Professional Information Profile



Section VI

Licensure Examination History

(State Licensing Authorities Only)



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

This document was prepared by the
Federation of State Medical Boards of the United States, Inc.
Federation Place, 480 Fuller Wiser Road, Suite 300, Euless, TX 76039-3856 — Telephone (817) 868-4041

Date: 02/15/2012

Federation Credentials Verification Service ATTN: FCVS

Packet ID:

Examinee: Alt Name(s): Frarey, Alhambra

William Barrier

2141

Examinee ID#; Date of Birth:

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

| USMLE STEP 1 | | | | | | | | |
|-----------------------|------------|-----------|-----------|----------|-----------|-------|----------|--|
| | | | Three-Dig | it Score | Two-Digit | Score | | |
| | Test Date | Pass/Fail | Total | MP | Total | MP | Comments | |
| | 06/09/2006 | Pass | 231 | 182 | 94 | 75 | | |
| USMLE STEP 2 | | - | | | | | | |
| Clinical Knowledge (C | K) | | | | | | | |
| | | | Three-Dig | it Score | Two-Digit | Score | | |
| | Test Date | Pass/Fail | Total | MP | Total | MP | Comments | |
| | 09/21/2007 | Pass | 252 | 184 | 99 | 75 | | |
| Clinical Skills (CS)* | | | | | | | | |
| , , | | | Three-Dig | it Score | Two-Digit | Score | | |
| | Test Date | Pass/Fail | Total | MP | Total | MP | Comments | |
| | 08/31/2007 | Pass | | | | | | |
| USMLE STEP 3 | | | | | | | | |
| | | | Three-Dig | it Score | Two-Digit | Score | | |
| | Test Date | Pass/Fail | Total | MP | Total | MP | Comments | |
| KANSAS | 05/19/2009 | Pass | 205 | 187 | 85 | 75 | | |

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

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Interpretation of results

USMLE transcripts include a complete results history and notations of any examinations for which the examinee sat and no results were reported, e.g., "incomplete." On those Step examinations for which numeric scores are reported, two different scales are used. The first is a three-digit score scale on which most scores fall between 140 and 280. The recommended minimum passing score is store for each administration. The second is a two-digit scale on which a score of 75 is the recommended minimum passing score. The level of proficiency required to meet the recommended minimum passing level for each USMLE Step is reviewed periodically and is subject to change.

For examinations with reported scores, the Standard Error of Measurement (SEM) provides an index of the variation that would be expected to occur if an examinee were tested repeatedly using different sets of items covering similar content. The SEM is usually in the range of 4 to 8 points on the three-digit scale and 1 to 2 points on the two-digit scale.

STEP 2 CLINICAL SKILLS (CS)

The Clinical Skills (CS) component of Step 2 was introduced in 2004 and the USMLE transcript has been modified to reflect this change. The Step 2 examination that existed prior to the introduction of Step 2 CS continues to be administered as the Clinical Knowledge (CK) component of Step 2. The label "Step 2 CK" is used for this examination whether taken before or after the introduction of the Step 2 CS component.

Step 2 CS results are reported as pass or fail. Had the two-digit reporting scale been used, examinees would have had to achieve a score of 75 or higher in order to pass.

Some individuals may be required to take and pass Step 2 CS prior to registering for Step 3. Transcript users can find information on eligibility requirements for all USMLE examinations in the USMLE Bulletin of Information and from periodic Step 2 CS updates, available at the USMLE website (www.usmle.org.).

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 rature of the indeterminate score and the determination of the Committee on Score Validity is available. If such information is not enclosed within 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 Data 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 to the individual physician, and the existence of such an action may be indicated on the USMLE transcript by a "Note".

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Page 2 de 4

49-101 (REV. 01-10) State Board of Medicine 717-783-1400 717-787-2381 RECEIVED DIRECT

VERIFICATION OF MEDICAL EDUCATION For Graduates of Accredited Medical Schools

| SECTION 1: To be complete | ed by applicant: | |
|--------------------------------------------------------------------------------------------------|-----------------------------------------------------------------|-----------------------------------------------------------------------------------------------|
| Name: Frarey | Alhambra First | |
| Last / | First | Middle |
| Name of medical school: | iversity of Kansas Sch | col of Medicine |
| Location: Ransas City | iversity of Kensus Scho | |
| SUBMIT THE VERIFICATION OF YOUR SCHOOL TO RETURN THE ENVELOPE. | MEDICAL EDUCATION FORM TO YOU E COMPLETED FORM DIRECTLY TO T | R MEDICAL SCHOOL AND REQUEST HE BOARD IN AN OFFICIAL SCHOOL |
| SECTION 2: To be complete | d by Dean or Registrar of medical | school: |
| Name of medical student: | Alhambra Frarey | |
| Date student began to attend the | his medical school:06/09 / | / 2004 /DD/YYYY |
| Date of graduation: 05/19 | MM/DD/YYYY | |
| | I certify that all of the above infe | ormation is correct. |
| [Seal of School] | Signature of Deep ex Resistrar: Date: /24/(2 | |
| Upon completion, school mu Board of Medicine in an offic | st return this completed form di | |
| | DO NOT RETURN TO APPLICAN | IT |
| Regular Mailing Address State Board of Medicine P.O. Box 2649 Harrisburg, PA 17105-2649 | | Courier Delivery Address State Board of Medicine 2601 North Third Street Harrisburg, PA 17110 |

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the DataBank

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

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

5500000072810086

Process Date: 01/26/2012

Page: 1 of 1

SELF-QUERY RESPONSE

This self-query was processed under the provisions of:

X Title IV (NPDB)

X Section 1921 (NPDB)

X Section 1128E (HIPDB)

| A. SEARCH RESULT (Based on the sul | ject identification Inform | ation provided, the reports found are listed below.) | £ 100 |
|----------------------------------------|----------------------------|------------------------------------------------------|------------|
| Medical Malpractice Payment Report(s): | No Reports | Health Plan Action(s): | No Reports |
| State Licensure Action(s): | No Reports | Professional Society Action(s): | No Reports |
| Exclusion or Debarment Action(s): | No Reports | DEA/Federal Licensure Action(s): | No Reports |
| Government Administrative Action(s): | No Reports | Judgment or Conviction Report(s): | No Reports |
| Clinical Privileges Action(s): | No Reports | Peer Review Organization Action(s): | No Reports |

FRAREY, ALHAMBRA

HOME

B. SUBJECT IDENTIFICATION INFORMATION

Subject Name:

Gender:

Date of Birth:

Other Name(s) Used:

Organization Name:

Organization Type:

Home or Work Address: City, State, ZiP:

Telephone:

Social Security Numbers (SSN):

Individual Taxpayer Identification Numbers (ITIN):

Professional School(s) & Year of Graduation:

Occupation/Field of Licensure (Code):

State License Number, State of Licensure:

Specialty:

Drug Enforcement Administration (DEA) Numbers:

National Provider Identifiers (NPI):

Federal Employer Identification Numbers (FEIN): Unique Physician Identification Numbers (UPIN): PHYSICIAN (MD)

OBSTETRICS & GYNECOLOGY

C. PAYMENT INFORMATION Credit Card Number: a

Additional Paper Copies Requested:

NPDB Charge:

HIPDB Charge:

* Each charge will appear separately on your credit card statement.

\$8.00*

\$8.00*

Expiration Date:

11/2014

NPDB Bill Reference Number:

N27511553

HIPDB Bill Reference Number: Transaction Date:

UNIVERSITY OF KANSAS SCHOOL OF MEDICINE (2008)

H27511553 01/26/2012

Copies of these reports are enclosed for restricted/limited use as prescribed by Title IV of Public Law 99-660, as amended, and Section 1921 of the Social Security Act, as amended by Section 5(b) of the Medicare and Medicaid Patient and Program Protection Act of 1987, and as of the Social Security Act, as amended by Section 5(0) of the Medical Fall of Medical Fall of Together No.

amended by the Omnibus Budget Reconciliation Act of 1990 and by Section 1128E of the Social Security Act. Information from the NPDB and HIPDB is confidential and must be used solely for the purpose for which it was disclosed. ANY PERSON WHO VIOLATES THE CONFIDENTIALITY PROVISIONS AS SPECIFIED IN TITLE IV IS SUBJECT TO A CIVIL MONEY PENALTY OF UP TO \$11,000 FOR EACH VIOLATION, Subjects of reports who obtain information about themselves from the NPDB and/or HIPDB are permitted to share that

information with anyone they choose.



CONFIDENTIAL DOCUMENT - FOR AUTHORIZED USE ONLY

Alhambra Frarey

EDUCATION

University of Kansas Obstetrics and Gynecology Resident, July 2008-present University of Kansas School of Medicine, M.D., May 2008
University of Kansas, Bachelor of Arts, Biology, December 2003

EMPLOYMENT EXPERIENCE

Resident physician, University of Kansas Department of Obstetrics and Gynecology, July 2008-present, Kansas City, KS

RESIDENCY HONORS AND AWARDS

Administrative Chief Resident, 2011-2012
Outstanding Research Project Co-Recipient, 2011
Highest CREOG Score PGY3, 2011
Outstanding Teaching Resident PGY3, 2011
Student Voice Award, 2011
Outstanding Teaching Resident of the Year, 2009-2010
Outstanding Junior Resident of the Year, 2009-2010

ACTIVITIES

CREOG Leadership Workshop, May 2011
Visiting Resident, Externship in Family Planning, University of Colorado, March 2011
Facilitator, Medical Student Practice Base Learning, 2009-present
Committee Member, Resident Counsel, 2009-present
Committee Member, O2 Electronic Medical Record Super Users, 2009-present
Medical Student Preceptor, 2009-present
Volunteer, JayDoc Free Health Clinic, 2004-present

RESEARCH EXPERIENCE

Researcher, Department of Obstetrics and Gynecology, 2011

"Postpartum Contraception Compliance"

Researcher, Department of Anatomy and Ceil Biology, 2008-2010

"Placenta mediated escape of the allogeneic fetus from rejection by the maternal immune system"

University of Kansas Health of the Public, October 2007

University of Kansas Medical Center Department of Family Medicine, July 2005

Researcher, University of Kansas Herpetology Department, 2002

PROFESSIONAL PRESENTATIONS

Central Association of Obstetricians and Gynecologists Annual Meeting

"Postpartum Intrauterine Device Compliance" October 2011

Sterling Williams Resident Research Forum

"Postpartum Intrauterine Device Compliance" June 2011

University of Kansas Resident, Fellow and Post-doc Research Day

"Postpartum Contraception Compliance" May 2011

University of Kansas Department of Obstetrics and Gynecology Educational Didactics

"Controversies in Preterm Premature Rupture of Membranes" August 2010

"Active Phase of Labor Arrest: Revisiting the 2-Hour Minimum" August 2010

"Maternal death in the 21st century" April 2010

"Eclampsia" April 2010

"Uterine Anomalies" January 2010

"Congenital Adrenal Hyperplasia" January 2010

"Embryology and Developmental Biology" February 2009

"Preterm Premature Rupture of Membranes" July 2007

University of Kansas Department of Obstetrics and Gynecology Journal Club

"New Diagnostic Criteria for Gestational Diabetes" May 2010

Region VII Infertility Prevention meeting, Kansas City, MO, November 2007

"Chlamydia: Screening Practices and Partner Notification"

Student Research Forum, University of Kansas School of Medicine, April 2006

"Comparing Infectious Disease and Ethnic Correlates in County Public Health Data"

ESRI GIS Research Conference, Chicago, IL, October 2005

"Comparing Infectious Disease and Ethnic Correlates in County Public Health Data"

PROFESSIONAL SOCIETY MEMBERSHIP

American Association of Gynecologic Laparoscopists, 2011

American College of Obstetrics and Gynecology, April 2007-present

American Medical Association, 2004-present

American Medical Woman's Association, 2004-present

References available upon request

Kansas State Board of Healing Arts 800 SW Jackson, Lower Level-Suite A Topeka, KS 66612



phone: 785-296-7413 1-888-886-7205 fax: 785-296-0852 www.ksbha.org

Sam Brownback, Governor

Kathleen Selzler Lippert Executive Director

RECEIVED DIRECT

January 27, 2012

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

This is to certify that: Alhambra Frarey has been licensed to practice in Kansas in the following profession: Medical Doctor (MD)

License Number:

Date of Birth:

Profession:

Medical Doctor (MD)

License Designation:

Postgraduate Permit License

License Status:

Original License Date:

Expiration Date:

Current

Disciplinary Action:

Unless otherwise indicated, this licensee has not been subject to disciplinary proceeding by the Kansas Board of Healing Arts.

Verified by:

Sandra Fienhage Sandra Fienhage

Senior Administrative Assistant

JAN 31 2012

49-101 (REV. 01-10) State Board of Medicine P. O. BOX 2649 HARRISBURG, PA 17105-2649

Certification of Moral Character

To be completed by **two** physicians who hold an unrestricted license in good standing in the United States or Canada and have known you for at **least six months**. ORIGINAL SIGNATURES ARE REQUIRED.

| Name of Applicant: _ | Alhambra Fre | arey |
|---------------------------------------------------------------------------------------------------------------------------------------------|-------------------------------------------------------------------------------------------------------------------------------------------|------------------------------------------------------------------------------------------------------------------------------------------------------------|
| knowledge, he/she is a narcotic or other ha | not addicted to the intemper | ood moral character and to the best of my ate use of alcohol or to the habitual use of nd the applicant for a license to practice |
| have been personal | No | year(s) 6 month(s). |
| SIGNATURE: | | Date: |
| Print or type name as | s signed above: John I | J. Calkins MD |
| | ed: Kansas | License Number: |
| State in which license | eu. 1/cm/3 x/3 | _LICENSE NUMBER. |
| | Alhambra F | |
| Name of Applicant: hereby certify that I knowledge, he/she is a narcotic or other ha | Alhambra F | |
| Name of Applicant: hereby certify that I knowledge, he/she is a narcotic or other ha | Ahambra F know the applicant to be of g not addicted to the intemper abit forming drug. I recommen monwealth of Pennsylvania. | ood moral character and to the best of my ate use of alcohol or to the habitual use of |
| Name of Applicant: hereby certify that I knowledge, he/she is a narcotic or other ha medicine in the Comr | Ahambra F know the applicant to be of g not addicted to the intemper abit forming drug. I recommen monwealth of Pennsylvania. | ood moral character and to the best of my ate use of alcohol or to the habitual use of all the applicant for a license to practice |
| Name of Applicant: hereby certify that I knowledge, he/she is a narcotic or other ha medicine in the Comr have been personal | Ahambra F know the applicant to be of g not addicted to the intemper abit forming drug. I recommen monwealth of Pennsylvania. | ood moral character and to the best of my ate use of alcohol or to the habitual use of all the applicant for a license to practice year(s) month(s) Date: |

Return Completed Form to Applicant

Long, Brenda (ST)

From:

Alhambra Frarey

Sent:

Thursday, April 19, 2012 5:33 PM

Subject:

Long, Brenda (ST) Re: PENNSYLVANIA APPLICATION

Thank you for your email. I apologize for the confusion. I initially thought that I had an unrestricted license but when I inquired with the state of Kansas it seems that I have a license restricted to training only since I am a resident. I sent the third page after I realized that I do not acutally hold an unrestricted. Again, I apologize for the confusion. Thank you for contacting me.

-Alhambra Frarey

>>> "Long, Brenda (ST)" 04/19/12 3:50 PM >>>

I now have rec?d 3 different page 2?s. The first one, dated 1/10/12, you marked ?yes? to an unrestricted license, but did not list states. The second one rec?d 4/9/12, you marked ?yes? and listed Kansas. The third one rec?d 4/10/12, you marked ?no?. You need to email me and tell me, do you have an unrestricted license and why you listed what you did on various page 2?s. This is the only thing holding up your license.

If you do have an unrestricted license from KS, you need to have it verified to the PA Board.

State Board of Medicine PO Box 2649 Harrisburg PA 17105

st-medicine@pa.gov

Web Site: www.dos.state.pa.us/med

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This email contains confidential, privilaged, nonpublic information intended to be conveyed only to the designated recipient(s). Any unauthorized use, dissemination, distribution or reproductions of this information, including attachments, is prohibited. If you are not an intended recipient, please destroy the attachments, and reply to sender.

Hoppital Mainereite of Kantas Hospital

FRAREY, ALHAMBAA

From: 711 108 to: 6 1801 09

49-101 (REV. 01-10) **ACGME Post Graduate Training:**

| ilea | copies of relevant documents. Sign and date below. | Yes | No |
|----------|------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|------|-----|
| | | 1 68 | 140 |
| | Do you hold or have you ever held an unrestricted license, certification, or registration (active or inactive, current or expired) to practice medicine and/or surgery in another jurisdiction? If yes, list the jurisdiction(s) here: | X | |
| | Have you withdrawn an application for a license, certificate or registration, had an application for a license denied or refused, or for any disciplinary reason agreed not to reapply for a license, certificate or registration in any profession in any state or jurisdiction? | | × |
| 3) | Have you had disciplinary action taken against your license, certificate or registration issued to you in any profession in any other state or jurisdiction? | | X |
| | Have you been convicted, found guilty or pleaded nolo contendere, or received probation without verdict or accelerated rehabilitative disposition (ARD) as to any felony or misdemeanor, including any drug law violations, or do you have any criminal charges pending and unresolved in any state or jurisdiction? You are not required to disclose any ARD or other criminal matter that has been expunged by order of a court. | | |
| 5) | Since May 19, 2002, have you been arrested for criminal homicide, aggravated assault, sexual offenses or drug offenses in any state, territory or country? | | |
| | Have you had practice privileges denied, revoked or restricted in a hospital or other health care facility, or have you been charged by a hospital, university, or research facility with violating research protocols, falsifying research, or engaging in other research misconduct? | | × |
| 7) | Have you had your DEA registration denied, revoked or restricted or have you had your provider privileges terminated by any medical assistance agency for cause? | | × |
| 8) | Are you, or have you ever been, addicted to the intemperate use of alcohol or to the habitual use of narcotics or other habit-forming drugs? Note: You may answer "NO" If you are currently a participant in or have successfully completed the requirements of the Board's Professional Health Monitoring Program.) | | |
| \vdash | Since May 19, 2002, have any malpractice complaints been filed against you? If yes, the Board requires | | |

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

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

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Signatu

| Hospital: Wilvestry of Ikansos Hospital From: 7 lol pag 1500 150 150 150 150 150 150 150 150 15 | 1 | Hospital University of Kansas HOSPItal | From: 07/0/12w8 to | 06,3 | رو ان |
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----|------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|---------------------------------------------------------------------------------------------------------------|----------------------------------------------|
| wer the following questions. If "YES" is answered to #2 through #9, provide complete details on a separate sheet as we iffed copies of relevant documents. Sign and date below. Yes Not provide the provided provided to practice medicine and/or surgery in another jurisdiction, or registration (active or inactive. If yes, list the lurisdictionis) here: 2) Have you withdrawn an application for a license, certificate or registration, had an application for a license deficine and/or surgery in another jurisdiction, and an application for a license, certificate or registration in any profession in any state or jurisdiction? 3) Have you withdrawn an application for a license, certificate or registration is any profession in any other state or jurisdiction? 4) Have you been convicted, found guilty or pleaded noto contendere, or received probation without verdict or accelerated rehabilitative disposition (ARD) as to any felony or misdemeanor, including any drug law violations, or do you have any ARD or other criminal matter that has been expunged by order of a court. 5) Since May 19, 2002, have you been arrested for criminal homicide, aggravated assault, sexual offenses or drug offenses in any state, territory or country? 6) Have you had practice privileges denied, revoked or restricted in a hospital or other health care facility, or have you been charged by a hospital, university, or research facility with violating research protocols, falsifying research, or engaging in other research misconduct? 7) Have you had your DEA registration denied, revoked or restricted or have you had your provider privileges terminated by any medical assistance agency for cause? 8) Are you, or have you ever been, addicted to the intemperate use of alcohol or to the habitual use of narcotics or other habit-forming drugs? Note: You may answer "No" if you are currently a participant in or have successfully completed the requirements of the Board's Professional Health Monitoring Program.) 9) Since May 19, 2002, have any malpractice comp | | , | | | |
| 1) Do you hold or have you ever held an unrestricted license, certification, or registration (active or inactive, if yes, list the lurisdiction(s) here: 2) Have you withdrawn an application for a license, certificate or registration, had an application for a license denied or refused, or for any disciplinary reason agreed not to reapply for a license, certificate or registration in any profession in any state or jurisdiction? 3) Have you had disciplinary action taken against your license, certificate or registration issued to you in any profession in any other state or jurisdiction? 4) Have you been convicted, found guilty or pleaded noto contendere, or received probation without verdict or accelerated rehabilitative disposition (ARD) as to any felony or misdemeanor, including any drug law violations, or do you have any criminal charges pending and unresolved in any state or jurisdiction? You are not required to disclose any ARD or other criminal matter that has been expunged by order of a court. 5) Since May 19, 2002, have you been arrested for criminal homicide, aggravated assault, sexual offenses or drug offenses in any state, territory or country? 6) Have you had practice privileges denied, revoked or restricted in a hospital or other health care facility, or have you been charged by a hospital, university, or research facility with violating research protocols, fallsifying research, or engaging in other research misconduct? 7) Have you had your DEA registration denied, revoked or restricted or have you had your provider privileges terminated by any medical assistance agency for cause? 8) Are you, or have you ever been, addicted to the intemperate use of alcohol or to the habitual use of narcotics or other habit-forming drugs? Note: You may answer "NO" if you are currently a participant in or have successfully completed the requirements of the Board's Professional Health Monitoring Program.) 9) Since May 19, 2002, have any malpractice complaints been filed against you? If yes, the Board requires tha | ver th | the following questions. If "YES" is answered to #2 through #9, pro | | | |
| 1) Do you hold or have you ever held an unrestricted license, certification, or registration (active or inactive, current or expired) to practice medicine and/or surgery in another jurisdiction? 11 Yes, But the jurisdiction(s) here: 2) Have you withdrawn an application for a license, certificate or registration, had an application for a license denied or refused, or for any disciplinary reason agreed not to reapply for a license, certificate or registration in any profession in any state or jurisdiction? 3) Have you had disciplinary action taken against your license, certificate or registration issued to you in any profession in any other state or jurisdiction? 4) Have you been convicted, found guilty or pleaded nolo contendere, or received probation without verdict or accelerated rehabilitative disposition (ARD) as to any felony or misdemeanor, including any drug law violations, or do you have any oriminal charges pending and unresolved in any state or jurisdiction? You are not required to disclose any ARD or other criminal matter that has been expunged by order of a court. 5) Since May 19, 2002, have you been arrested for criminal homicide, aggravated assault, sexual offenses or drug offenses in any state, territory or country? 6) Have you had practice privileges denied, revoked or restricted in a hospital or other health care facility, or have you been charged by a hospital, university, or research facility with violating research protocols, falsifying research, or engaging in other research misconduct? 7) Have you had your DEA registration denied, revoked or restricted or have you had your provider privileges terminated by any medical assistance agency for cause? 8) Are you, or have you ever been, addicted to the intemperate use of alcohol or to the habitual use of narcotics or other habit-forming drugs? Note: You may answer "NO" if you are currently a participant in or have successfully completed the requirements of the Board's Professional Health Monitoring Program.) 9) Since May 19, 2002, have a | 160 0 | copies of relevant documents. Sign and date below. | | Vec 1 | No. |
| 3) Have you had disciplinary action taken against your license, certificate or registration issued to you in any profession in any other state or jurisdiction? 4) Have you been convicted, found guilty or pleaded noto contendere, or received probation without verdict or accelerated rehabilitative disposition (ARD) as to any felony or misdemeanor, including any drug law violations, or do you have any criminal charges pending and unresolved in any state ny jurisdiction? You are not required to disclose any ARD or other criminal matter that has been expunged by order of a court. 5) Since May 19, 2002, have you been arrested for criminal homicide, aggravated assault, sexual offenses or drug offenses in any state, territory or country? 6) Have you had practice privileges denied, revoked or restricted in a hospital or other health care facility, or have you been charged by a hospital, university, or research facility with violating research protocols, falsifying research, or engaging in other research misconduct? 7) Have you had your DEA registration denied, revoked or restricted or have you had your provider privileges terminated by any medical assistance agency for cause? 8) Are you, or have you ever been, addicted to the intemperate use of alcohol or to the habitual use of narcotics or other habit-forming drugs? Note: You may answer "NO" If you are currently a participant in or have successfully completed the requirements of the Board's Professional Health Monitoring Program.) 9) Since May 19, 2002, have any melipractice complaints been filed against you? If yes, the Board requires that you submit a copy of the antire Clyli Complaint which must include the docket number, filling date, and the date you were served. SIGNED STATEMENT Note that disclosing your social security number on this application is mandatory in order for the State Board of Medicine to comply with the requirements of the federal Social Security Act pertaining to child support enforcement, as implemented in the Commonwealth of Pennsylvania | 1) Do | Do you hold or have you ever held an unrestricted license, certifical current or expired) to practice medicine and/or surgery in another juri If yes, list the jurisdiction(s) here: | tion, or registration (active or inactive, sdiction? | | |
| 4) Have you been convicted, found guilty or pleaded note contendere, or received probation without verdict or accelerated rehabilitative disposition (ARD) as to any felony or misdemeanor, including any drug law violations, or do you have any criminal charges pending and unresolved in any state or jurisdiction? You are not required to disclose any ARD or other criminal matter that has been expunged by order of a court. 5) Since May 19, 2002, have you been arrested for criminal homicide, aggravated assault, sexual offenses or drug offenses in any state, territory or country? 6) Have you had practice privileges denied, revoked or restricted in a hospital or other health care facility, or have you been charged by a hospital, university, or research facility with violating research protocols, falsifying research, or engaging in other research misconduct? 7) Have you had your DEA registration denied, revoked or restricted or have you had your provider privileges terminated by any medical assistance agency for cause? 8) Are you, or have you ever been, addicted to the intemperate use of alcohol or to the habitual use of narcotics or other habit-forming drugs? Note: You may answer "NO" if you are currently a participant in or have successfully completed the requirements of the Board's Professional Health Monitoring Program.) 9) Since May 19, 2002, have any malpractice complaints been filed against you? If yes, the Board requires that you submit a copy of the entire Civil Complaint which must include the docket number, filling date, and the date you were served. SIGNED STATEMENT Note that disclosing your social security number on this application is mandatory in order for the State Board of Medicine to comply with the reputing requirements of the federal National Practitioner Data Bank and the Healthcare Integrity and Protection Data. Reports to the NPDD/HIPDE must include the licensee's social security number. Additionally, disclosing the number is mandatory in order for plant by the submers of the NPDD/HIPDE mu | 2) Ha | Have you withdrawn an application for a license, certificate or registred denied or refused, or for any disciplinary reason agreed not to registration in any profession in any state or jurisdiction? | ration, had an application for a license reapply for a license, certificate or |) | X |
| accelerated rehabilitative disposition (ARD) as to any felony or misdemeanor, including any drug law violations, or do you have any criminal charges pending and unresolved in any state or jurisdiction? You are not required to disclose any ARD or other criminal matter that has been expunged by order of a court. 5) Since May 19, 2002, have you been arrested for criminal homicide, aggravated assault, sexual offenses or drug offenses in any state, territory or country? 6) Have you had practice privileges denied, revoked or restricted in a hospital or other health care facility, or have you been charged by a hospital, university, or research facility with violating research protocols, falsifying research, or engaging in other research misconduct? 7) Have you had your DEA registration denied, revoked or restricted or have you had your provider privileges terminated by any medical assistance agency for cause? 8) Are you, or have you ever been, addicted to the intemperate use of alcohol or to the habitual use of narcotics or other habit-forming drugs? Note: You may answer "NO" if you are currently a participant in or have successfully completed the requirements of the Board's Professional Health Monitoring Program.) 9) Since May 19, 2002, have any malpractice complaints been filed against you? If yes, the Board requires that you submit a copy of the antire Civil Complaint which must include the docket number, filling date, and the date you were served. SIGNED STATEMENT Note that disclosing your social security number on this application is mandatory in order for the State Board of Medicine to comply with the requirements of the federal Social Security Act pertaining to child support orders, the Commonwealth's licensing boards must provide to the Department of Public Welfare information prescribed by DPW about the licensee, including the social security number. Additionally, discing the number is mandatory in order for the State Board of Medicine to the Pennsylvania at 23 Pa. C.S. Section 4904 relating to unsworm | 3) Ha | Have you had disciplinary action taken against your license, certifica profession in any other state or jurisdiction? | te or registration issued to you in any |) | X |
| drug offenses in any state, territory or country? 6) Have you had practice privileges denied, revoked or restricted in a hospital or other health care facility, or have you been charged by a hospital, university, or research facility with violating research protocols, falsifying research, or engaging in other research misconduct? 7) Have you had your DEA registration denied, revoked or restricted or have you had your provider privileges terminated by any medical assistance agency for cause? 8) Are you, or have you ever been, addicted to the intemperate use of alcohol or to the habitual use of narcotics or other habit-forming drugs? Note: You may answer "NO" if you are currently a participant in or have successfully completed the requirements of the Board's Professional Health Monttoring Program.) 9) Since May 19, 2002, have any malpractice complaints been filed against you? If yes, the Board requires that you submit a copy of the entire Civil Complaint which must include the docket number, filling date, and the date you were served. SIGNED STATEMENT Note that disclosing your social security number on this application is mandatory in order for the State Board of Medicine to comply with the requirements of the federal Social Security Act pertaining to child support orders, the Commonwealth's licensing boards must provide to the Department of Public Wolfare information prescribed by DPW about the licensee, including the social security number. Additionally, disclosing the number is mandatory in order for this board to comply with the reporting requirements of the federal National Practitioner Data Bank and the Healthcare Integrity and Protection Date Bank. Reports to the NPDB/HIPDE must include the licensee's social security number. I verify that the statements in this application are true and correct to the best of my knowledge, information and bellef. 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 re | ac vi | accelerated rehabilitative disposition (ARD) as to any felony or ni violations, or do you have any criminal charges pending and unresc | nisdemeanor, including any drug law olved in any state or jurisdiction? You | | |
| have you been charged by a hospital, university, or research facility with violating research protocols, falsifying research, or engaging in other research misconduct? 7) Have you had your DEA registration denied, revoked or restricted or have you had your provider privileges terminated by any medical assistance agency for cause? 8) Are you, or have you ever been, addicted to the intemperate use of alcohol or to the habitual use of narcotics or other habit-forming drugs? Note: You may answer "NO" if you are currently a participant in or have successfully completed the requirements of the Board's Professional Health Monttoring Program.) 9) Since May 19, 2002, have any malpractice complaints been filed against you? If yes, the Board requires that you submit a copy of the entire Clyll Complaint which must include the docket number, filling date, and the date you were served. SIGNED STATEMENT Note that disclosing your social security number on this application is mandatory in order for the State Board of Medicine to comply with the requirements of the federal Social Security Act pertaining to child support enforcement, as implemented in the Commonwealth of Pennsylvania at 23 Pa. C.S 4304.1(a). In order to enforce domestic child support orders, the Commonwealth's licensing boards must provide to the Department of Public Welfare Information prescribed by DPW about the licensee, including the social security number. Additionally, disclosing the number is mandatory in order for his board to comply with the reporting requirements of the federal National Practitioner Data Bank and the Healthcare Integrity and Protection Data Bank. Reports to the NPDB/HIPDB must include the licensee's social security number. 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 evocation | | | aggravated assault, sexual offenses or | | |
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| B) Since May 19, 2002, have any malpractice complaints been filed against you? If yes, the Board requires that you submit a copy of the entire Civil Complaint which must include the docket number, filing date, and the date you were served. SIGNED STATEMENT Note that disclosing your social security number on this application is mandatory in order for the State Board of Medicine to comply with the requirements of the federal Social Security Act pertaining to child support enforcement, as implemented in the Commonwealth of Pennsylvania at 23 Pa. C.S. 4304.1(a). In order to enforce domestic child support orders, the Commonwealth's licensing boards must provide to the Department of Public Welfare Information prescribed by DPW about the licensee, including the social security number. Additionally, disclosing the number is mandatory in order for his board to comply with the reporting requirements of the federal National Practitioner Data Bank and the Healthcare Integrity and Protection Data Sank. Reports to the NPDB/HIPDB must include the licensee's social security number. 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 of evocation of my license. I hereby authorize all hospitals, institutions or organizations, my references, personal physicians, employers (past and provided in the penalties of 18 Pa. C.S. Section 4904 relating to unsworn falsification to authorities and may result in the suspension of evocation of my license. I hereby authorize all hospitals, institutions or organizations, my references, personal physicians, employers (past and provided in the penalties of 18 Pa. C.S. Section 4904 relating to unsworn falsification to authorities and may result in the suspension of evocation of my license. I hereby authorize all hospitals, institutions or organization | 7) Ha | Have you had your DEA registration denied, revoked or restricted or terminated by any medical assistance agency for cause? | have you had your provider privileges | , | X |
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| Note that disclosing your social security number on this application is <u>mandatory</u> in order for the State Board of Medicine to comply with the requirements of the federal Social Security Act pertaining to child support enforcement, as implemented in the Commonwealth of Pennsylvania at 23 Pa. C. S. 4304.1(a). In order to enforce domestic child support orders, the Commonwealth's licensing boards must provide to the Department of Public Welfare information prescribed by DPW about the licensee, including the social security number. Additionally, disclosing the number is <u>mandatory</u> in order for this board to comply with the reporting requirements of the federal National Practitioner Data Bank and the Healthcare Integrity and Protection Data Bank. Reports to the NPDB/HIPDB must include the licensee's social security number. I verify that the statements in this application are true and correct to the best of my knowledge, information and belief. I understand that false statements are made subject to the penalties of 18 Pa. C.S. Section 4904 relating to unsworn falsification to authorities and may result in the suspension or revocation of my license. I hereby authorize all hospitals, institutions or organizations, my references, personal physicians, employers (past and present), and all governmental agencies and instrumentalities (local, state, federal or foreign) to release to the Pennsylvania State Board of Medicine and provided the provided that the Board. | th | that you submit a copy of the entire Civil Complaint which must inc | ainst you? If yes, the Board requires lude the docket number, filing date, | | X |
| 2 | of the 1304.1(Information both the stank. If the stank. If the stank is the stank | that disclosing your social security number on this application is <u>mandatory</u> in order for electeral Social Security Act pertaining to child support enforcement, as impleme 1(a). In order to enforce domestic child support orders, the Commonwealth's licens nation prescribed by DPW about the licensee, including the social security number. loard to comply with the reporting requirements of the federal National Practitioner. Reports to the NPDB/HIPDB must include the licensee's social security number. by that the statements in this application are true and correct to the best of my knowled nade subject to the penalties of 18 Pa. C.S. Section 4904 relating to unsworn fall ation of my license. I hereby authorize all hospitals, institutions or organizations ent), and all governmental agencies and instrumentalities (local, state, federal or for ested by the Board. | nted in the Commonwealth of Pennsylvania at ing boards must provide to the Department of P Additionally, disclosing the number is mandator Data Bank and the Healthcare Integrity and Privage, information and belief. I understand that falsification to authorities and may result in the signification to release to the Pennsylvania State Board 1/0/12—Date | 23 Pa. C ublic Welfa y in order otection Da se statemen uspension rs (past a d of Medici | .S. are for ata nts or and |
| MAR 0 6 2012 | | 2 MΔR Λ | | | |

AIM

Association of State Medical Board Executive Directors

Kansas Board of Healing Arts Search Results

| Licensee Name | Alhambra Frarey |
|-------------------------|-------------------------------|
| Profession Description | POSTGRADUATE MD/DO |
| License Type | Active |
| License Status | Current |
| Specialty | 39-Obstetrics/Gynecology |
| License Number | |
| Address | Kansas Univ Medical Center |
| Address | |
| City State Zip | |
| School | Univ of Kansas Medical Center |
| Degree Date | 05/18/2008 |
| Birthdate | 1 |
| Original License Date | (|
| License Expiration Date | e (|
| No Derogatory Informa | tion on File |

This data effective 04/02/2012

Direct questions and comments about these results to Kansas Board of Healing Arts 800 SW Jackson, Lower Level Suite A Topeka, KS 66612 Phone (785) 296-7413

Return to the Kansas State Board of Healing Arts Home Page
This Board's data has been searched 14434126 times since 12/11/1997

Please read the AIM Disclaimer

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The Federation of State Medical Boards of the United States, Inc PO Box 619850 Dallas, Texas 75261-9850 Telephone: (317)868-4000 FAX (817)868-4099

BOARD ACTION CLEARANCE REPORT

April 20, 2012

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

Re: Board Action Query Dated: April 20, 2012 Your Reference Number: BLONG FSMB Batch Number: BQ2063551

The following is a report of the search results from the Board Action Data Bank as of April 20, 2012 for practitioners submitted as part of the above-referenced batch for which NO board actions were identified.

Practitioners Cleared with No Actions as of April 20, 2012

| Item | Name | DOB | School | Yr/Grad | Request ID | 190 |
|------|------------------|---------------------------------------------------------|----------|---------|------------|-----|
| i | FRAREY, ALHAMBRA | | | | | |
| | | LICENSE HISTORY State Board No License Information Av | vailable | | | |

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



COMMONWEALTH OF PENNSYLVANIA STATE BOARD OF MEDICINE P. O. BOX 2849 HARRISBURG, PENNSYLVANIA 17105 st-medicinefips.gov www.dos.state.ps.us/med April 2, 2012

ALHAMBRA FRAREY

Telephone: 717-783-1400/787-2381

Fax: 717-787-7769

EVALUATOR: BRENDA

RE: DISCREPANCY NOTICE - Unrestricted (American)

Dear Doctor:

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

➤ Application – Page #2.

ANSWERED YES TO QUESTION 1 ON PAGE 2, BUT DID NOT LIST STATE. RESUBMIT CORRECTED PAGE 2 WITH LETTER OF EXPLANATION.

REC'D A VERIFICATION OF A TRAINING LICENSE FROM KS. IF YOU ONLY HAVE A TRAINING LICENSE IN KS, YOU DO NOT HAVE TO SEND VERIFICATION OR MARK YES TO QUESTION 1. IF IT IS AN UNRESTRICTED LICENSE, WHICH IS WHAT YOU CHECKED YES TO ON YOU APPLICATION, YOU WOULD NEED TO HAVE THAT VERIFIED.

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

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

Sincerely,

Pennsylvania State Board of Medicine



COMMONWEALTH OF PENNSYLVANIA STATE BOARD OF MEDICINE P. O. BOX 2849 HARRISBURG, PENNSYLVANIA 17105 91-medicine@ps.gov

st-medicine@pa.gov www.dos.state.pa.us/med March 19, 2012

ALHAMBRA FRAREY

Telephone: 717-783-1400/787-2381

Fax: 717-787-7769

EVALUATOR: BRENDA

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> Application - Page #2.

ANSWERED YES TO QUESTION 1 ON PAGE 2, BUT DID NOT LIST STATE(S). RESUBMIT CORRECTED PAGE 2 WITH LETTER OF EXPLANATION.

- Verification of ACGME Approved Graduate Medical Training must be received DIRECTLY from the Hospital(s) In official, sealed hospital envelope.
- > USMLE scores <u>must be received DIRECTLY from the Federation of State Medical Boards, Inc. in an official agency envelope.</u> (817-868-4000)

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

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

Sincerely,

Pennsylvania State Board of Medicine