FORM 1
MEDICINE

THE UNIVERSITY OF THE STATE OF NEW YORK
THE STATE EDUCATION DEPARTMENT
DIVISION OF PROFESSIONAL [illegible]

Department Use Only
[illegible] 60
[illegible] 85058 [illegible]

APPLICATION FOR LICENSE AND FIRST REGISTRATION

Application must be postmarked NO LESS THAN 60 DAYS prior to the [illegible] examination—see circular for further information.

1. PRINT FULL NAME
Last: GLOWA
First: PATRICIA
Middle: T [illegible]

2. ADDRESS
Street: [redacted]
City: ROCHESTER
County: MONROE
State: NEW YORK
ZIP Code: [redacted]

3. BIRTH DATE: [redacted] (mo. day yr.)

4. TELEPHONE
At home: [redacted] (area code / number)
At [illegible]: [redacted]

5. CITIZEN OF: USA

If you were not born in the United States, your own original certificate of citizenship or of declaration of intention or of derivative citizenship must be submitted by registered or certified mail. Document will be returned by (illegible)

6/7/78
JUL 1 1978
134698

6. Professional school(s):

NATIONAL BOARD

INSTITUTION	LOCATION	COMPLETION DATE	DEGREE(S)
HARVARD MEDICAL SCHOOL	BOSTON MASS	JUNE 1977	M.D.

7. Present employer HIGHLAND HOSPITAL, SOUTH AVE AT BELLEVUE DR ROCHESTER, N.Y. 14620
Name / Address

8. Have you ever been convicted of a crime (felony or misdemeanor)? [redacted]
9. Are charges now pending against you for a crime (felony or misdemeanor)? [redacted]
10. Have you ever been found guilty of unprofessional conduct, professional misconduct or negligence? [redacted]
11. Are charges now pending against you for unprofessional conduct, professional misconduct or negligence? [redacted]

- If the answer to any of the above questions is "Yes," submit a letter giving complete explanation and include copies of any court records.

12. APPLICATION FOR LICENSURE BY: (Please check the appropriate item.)

- ☑ Acceptance of Examination of National Board of Medical Examiners.
- ☐ Acceptance of Examination of National Board of Examiners for Osteopathic Physicians and Surgeons.
- ☐ Acceptance of Federation Licensing Examination (FLEX) taken outside of New York State.
- ☐ Endorsement of out-of-state medical license. ☐ Admission to New York State [illegible]

If applying for admission to New York State examination please indicate:

Time of examination requested: ☐ June ☐ December
Place of examination requested: ☐ New York ☐ Albany
☐ Buffalo

NOTE: ALL APPLICANTS SHOULD READ CAREFULLY THE ATTACHED CIRCULAR OF INSTRUCTIONS BEFORE CONTINUING TO COMPLETE APPLICATION.

POSTGRADUATE HOSPITAL TRAINING AND PRACTICE (LIST CHRONOLOGICALLY)

DESCRIPTION	NAME OF INSTITUTION	DATES		LOCATION
		From	To	
Family Medicine Residency	The University of Rochester and Highland Hospital Family Medicine Program	[illegible]	6/78	885 Culver Avenue Rochester, NY 14620

Under penalties of perjury, I declare and affirm that the statements made in the foregoing application, including accompanying statements and transcripts are true, complete and correct. I understand that any false or misleading information in, or in connection with my application may be cause for denial or loss of licensure.

[redacted] 5/4/78

Signature of applicant Date

PERSONAL SIGNATURES OF THREE LICENSED PHYSICIANS RECOMMENDING APPLICANT

This certifies that I have been PERSONALLY acquainted with the applicant since the year indicated opposite my name that I BELIEVE OF MY OWN KNOWLEDGE THAT HE/SHE IS OF GOOD MORAL CHARACTER AND I KNOW OF NOTHING WHICH WOULD MILITATE AGAINST HIS/HER LICENSURE IN NEW YORK STATE; that the use of my signature signifies my willingness to submit a letter of recommendation [illegible] ANY RESERVATIONS I might have about the applicant I agree to send by registered mail [illegible]

Personal Signature	Post Office Address [illegible] (including [illegible])	[illegible]	[illegible]
Daniel P. [illegible] MD	885 South Avenue Rochester, NY [illegible]	NEW YORK	1977
Samuel H. Hench, M.D.	885 South Avenue Rochester, NY [illegible]	NEW YORK	1977
Jack [illegible] M.D.	885 South Avenue Rochester, NY [illegible]	NEW YORK	1977

CERTIFICATION BY MEDICAL SCHOOL

(Items (1) and (2) must be completed [illegible])

It is hereby certified that the applicant named herein: [illegible]

(1) Satisfactorily completed, prior to matriculation in professional school, the required preprofessional education [illegible]

....

[illegible]

..............................A.B., (City College [illegible]) 1973 ....

(2) Was graduated from this professional school after the completion of not less than 32 months with the degree of ..M.D.................on .....16 June 1977

Name Audrey Noreen Koller
(Original signature)

Audrey Noreen Koller

Official position .....Registrar.........

Medical school .....Harvard Medical School.........

Date ....May 15, 1978

[illegible] Certification [illegible]

NOT TO BE FILLED IN BY APPLICANT

CERTIFICATION BY SECRETARY OF STATE BOARD OF MEDICAL EXAMINERS

(TO BE COMPLETED ONLY IF APPLICANT TOOK STATE LICENSING EXAMINATION PRIOR TO 1/1/72)

Last Name [redacted] Middle Name

Name of applicant in full

Place of examination ..... Date of examination .....

License number ..... Date issued .....

Name in which applicant's license is issued .....

SUBJECTS OF WRITTEN EXAMINATION	RATING	SUBJECTS OF WRITTEN EXAMINATION	RATING
.....	.....	.....	.....
.....	.....	.....	.....
.....	.....	.....	.....
.....	.....	.....	.....
.....	.....	.....	.....
.....	.....	.....	.....
.....	.....	.....	.....
.....	.....	.....	.....

Number of examinations retaken after failures ..... Final average .....

CERTIFICATE

I hereby certify that to the best of my knowledge and belief the foregoing is a true statement of the record of the applicant named on the first page of this form and further certify that this board has never taken any disciplinary action against the applicant and that insofar as this board has knowledge there have been no charges preferred against him/her nor has any information been presented to the board relating to any question of unprofessional or immoral conduct and I recommend endorsement of his/her license by the State of New York.

Signature .....

(SEAL) Secretary of the .....

Date .....

INSTRUCTION TO THE MEDICAL BOARD: Please complete above certification and return this form to the applicant.

SPACES FOR NEW YORK STATE EDUCATION DEPARTMENT USE ONLY

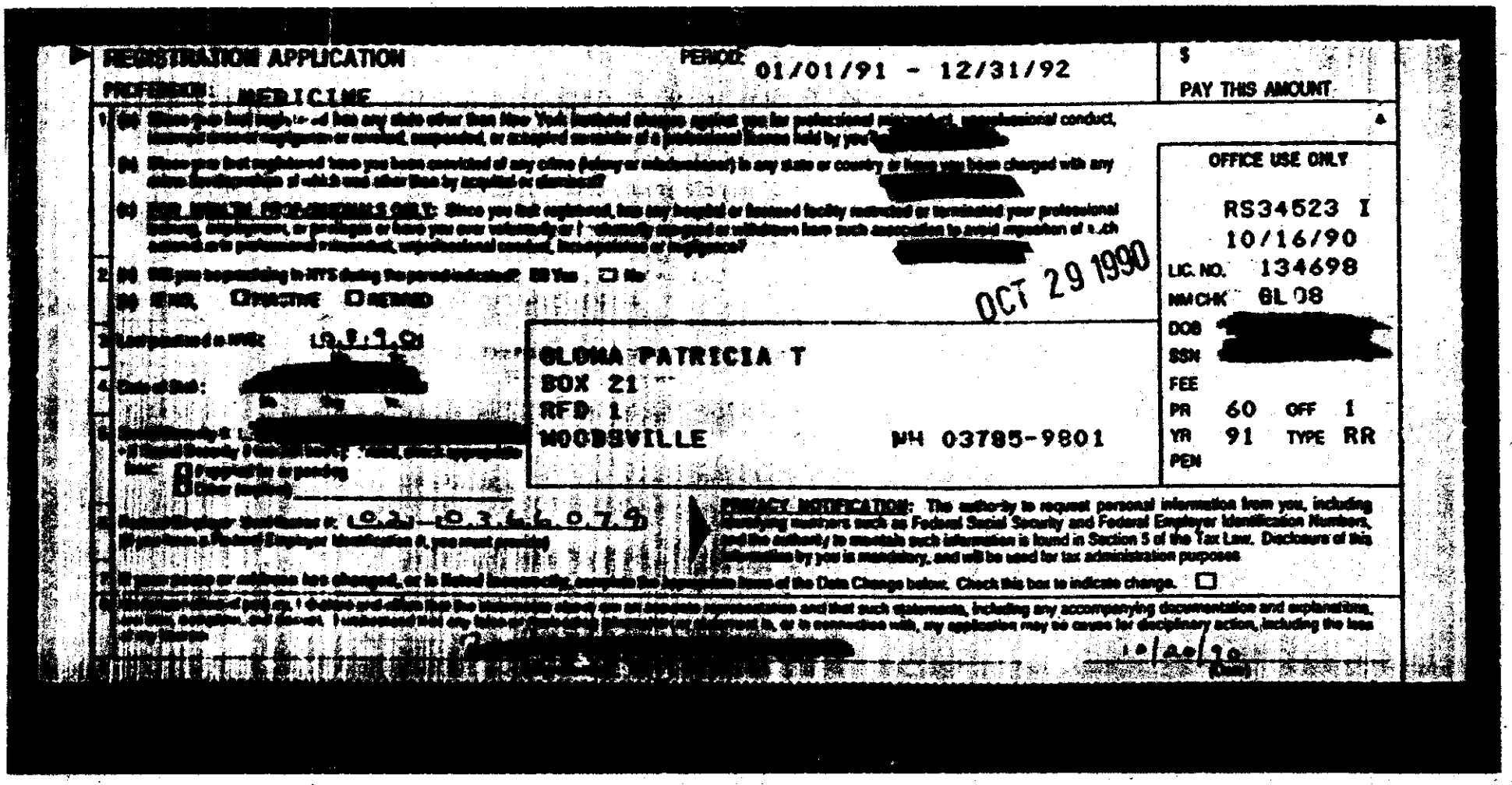
ITEM	COMMENT, IF ANY	APPROVED	DISAPPROVED	BY	DATE
Professional school	.....	✓	.....	.....	.....
Grades	.....	✓	.....	[illegible]	6/7/78

Recommendations: NATIONAL BOARD CERTIFICATE

Board or Exec. Secretary to State Board for Medicine ..... #180951 DATED 7/1/78

D.P.L.S.

67520



REGISTRATION APPLICATION

PERIOD: 01/01/91 - 12/31/92

$
PAY THIS AMOUNT

PROFESSION: MEDICINE

OFFICE USE ONLY

RS34523 I
10/16/90
LIC. NO. 134698
NM CHK GL 08
DOB [redacted]
SSN [redacted]
FEE
PR 60 OFF 1
YR 91 TYPE RR
PEN

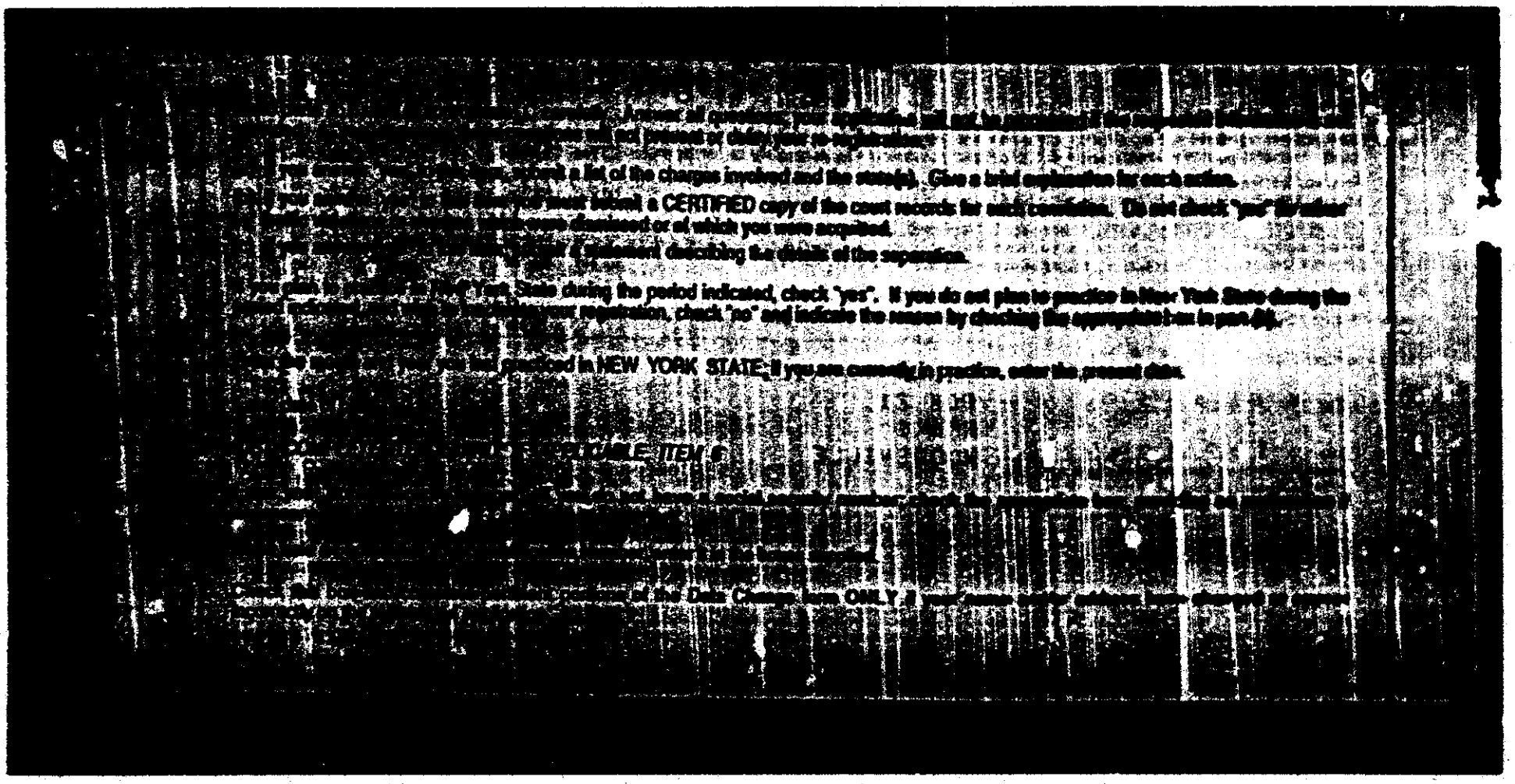
OCT 29 1990

GLORIA PATRICIA T
BOX 21
RFD 1
WOODSVILLE NH 03785-9801

PRIVACY NOTIFICATION: The authority to request personal information from you, including identifying numbers such as Federal Social Security and Federal Employer Identification Numbers, and the authority to maintain such information is found in Section 5 of the Tax Law. Disclosure of this information by you is mandatory, and will be used for tax administration purposes.

Check this box to indicate change. ☐

10/26/90



DELAYED **REGISTRATION APPLICATION**
PROFESSION: MEDICINE

6/02-SPOT

$ 600 .00
PAY THIS AMOUNT

READ INSTRUCTIONS ON THE BACK BEFORE COMPLETING FORM

FOR DEPOSIT ONLY NYSED
CASH NO.

F40437

OFFICE USE ONLY
DATE: 03/18/02
LIC. NO.: 134698
CHK: GLO8
DOB: [redacted]
SSN: [redacted]
FEE: 600
PR: 60 OFF: 1
YR: 02 TYPE: DR
PEN:
CA: NY

SENT DR AND LDCC

TO FEE UNIT 6/24 LDT

ALL PROFESSIONS ARE REQUIRED TO ANSWER THE QUESTIONS BELOW:

1. **Since you last registered,** has any state other than New York instituted charges against you for professional misconduct, unprofessional conduct, incompetence or negligence or revoked, suspended, or accepted surrender of a professional license held by you? [redacted]

2. **Since you last registered,** have you been convicted of any crime (felony or misdemeanor) in any state or country or have you been charged with any crime the disposition of which was other than by acquittal or dismissal? [redacted]

3. (a) Are you under an obligation to pay child support? ☐ YES ☒ NO
If no, proceed to question #4 below.
(b) If yes, do you meet one of the four requirements listed below? ☐ YES ☐ NO

1) I am current or not four or more months in arrears in the payment of child support;
2) I am making payments by income execution or by a court agreed payment or repayment plan or by a plan agreed to by the parties;
3) My child support obligation is the subject of a pending court proceeding;
4) I am receiving public assistance or supplemental security income.

4. I am a U.S. Citizen or I am an alien lawfully admitted for permanent residence in the U.S. or I am a non immigrant alien lawfully admitted to the U.S. as defined on the back of this form. ☒ YES ☐ NO

5.

- Check ONE box only: (Please refer to Section 6502 of the Education Law and the notice regarding Definition of Practice, which has been enclosed.)

____ A. I HAVE practiced my profession in NEW YORK STATE since my registration expired. If you checked (A), please DO NOT SEND ANY MONEY. You will be notified in a separate letter the amount to be paid.

Dates of non-registered practice are from :
__ __ - __ __ - __ __ to __ __ - __ __ - __ __
(month) (day) (year) (month) (day) (year)

✓ B. I HAVE NOT practiced my profession in NEW YORK STATE since my registration expired. If you checked (B), please remit the appropriate fee which appears on the top line of this application.

- Since you last registered, has any hospital or licensed facility restricted or terminated your professional training, employment, or privileges or have you ever voluntarily or involuntarily resigned or withdrawn from such association to avoid imposition of such action due to professional misconduct, unprofessional conduct, incompetence or negligence ? ____ Yes ✓ No
If Yes, please provide documentation.

- If you have not met the child abuse requirement, you must attach proof of completion or exemption with this registration application. DO NOT RETURN THIS APPLICATION WITHOUT PROOF OF COMPLETION OR EXEMPTION OF THE CHILD ABUSE REQUIREMENT.

RECEIVED
JUN 20 2002
Registration Fee Problems

GLOWA PATRICIA T
[redacted] 091
HANOVER [redacted] NH [redacted]

6. DATE OF BIRTH: [redacted] Mo. Day Yr.

7. SOCIAL SECURITY NUMBER: [redacted]
☐ # applied for or pending ☐ Explanation attached

8. FEDERAL EMPLOYER IDENTIFICATION NUMBER: ☐☐-☐☐☐☐☐☐☐ (applicable only if you are an employer required to report employment taxes to the I.R.S.)

9. Under penalties of perjury, I declare and affirm that the statements above are an accurate representation and that such statements, including any accompanying documentation and explanations, are true, complete, and correct. I understand that any false or misleading information or statement in, or in connection with, my application may be cause for disciplinary action, including the loss of my license, and that willful failure to register while continuing to practice my profession constitutes professional misconduct.

Signature: [redacted] Date: 6/7/02

134698GL08006000060104

REGISTRATION RENEWAL DOCUMENT
THE STATE EDUCATION DEPARTMENT
Professional Licensing Services
89 Washington Avenue
Albany, NY 12234-1000

01/02/04
LIC: 134698
NME: GL08
YR: 04
OFF: 1
DOB: [redacted]
SSN:
EIN:

GLOWA PATRICIA T
[redacted]
HANOVER NH [redacted]

Name/address change
Complete only if change has occurred

Name
[redacted]
Street
City
State/Zip

PROFESSION: 80 MEDICINE
PERIOD: 06/01/04 - 05/31/06

$ 600
AMOUNT DUE

Complete and sign reverse side of this application

Cat 6 - 2001

1. Do you wish to register for the period indicated? ..... X Yes ___ No

2. Since your last registration application,
   a. Have you been found guilty after trial, or pleaded guilty, no contest, or nolo contendere to a crime (felony or misdemeanor) in any court? .....
   b. Has any licensing or disciplinary authority revoked, annulled, cancelled, accepted surrender of, suspended, placed on probation, or refused to issue or renew a professional license or certificate held by you now or previously, or fined, censured, reprimanded or otherwise disciplined you? .....
   c. Are criminal charges pending against you in any court? .....
   d. Are charges pending against you in any jurisdiction for any sort of professional misconduct? .....
   e. Has any hospital or licensed facility restricted or terminated your professional training, employment, or privileges, or have you voluntarily or involuntarily resigned or withdrawn from such association to avoid the imposition of such action due to professional misconduct, unprofessional conduct, incompetency, or negligence? .....

3. a. Are you under an obligation to pay child support? ..... ___ Yes X No
   b. If you are under such an obligation, do you meet one of the four requirements listed in the Child Support Law section below? ..... ___ Yes ___ No

4. Are you a U.S. citizen or a qualified alien as defined below? ..... X Yes ___ No

DO NOT WRITE IN THIS BOX
FOR OFFICIAL USE ONLY

I certify that the statements made in this application and any accompanying documentation are true, complete and correct. I understand that any misrepresentation or any false or misleading information made in connection with my application may result in criminal prosecution and may be cause for disciplinary action, including the loss of my license; and that the willful failure to register while continuing to practice my profession constitutes professional misconduct.

Signature Pat[redacted] Business phone [redacted] Date 4/14/04

1346986L08006000060106

REGISTRATION RENEWAL DOCUMENT
THE STATE EDUCATION DEPARTMENT
Professional Licensing Services
89 Washington Avenue
Albany, NY 12234-1000

01/03/06
LIC: 134698
NME: GL06
YR: 06
OFF: 1
EIN:

GLOVA PATRICIA T
[redacted]
HANOVER NH [redacted]

PROFESSION: 80 MEDICINE
PERIOD: 06/01/06 - 05/31/06

Complete and sign reverse side of this application

Cat 21P [redacted]

Name/address change
Complete only if change has occurred

Name

Street

City

State/Zip

$ 600
AMOUNT DUE

1. Do you wish to register for the period indicated?	☑ Yes	☐ No
2. Since your last registration application,		
a. Have you been found guilty after trial, or pleaded guilty, no contest, or nolo contendere to a crime (felony or misdemeanor) in any court?	[redacted]	
b. Has any licensing or disciplinary authority revoked, annulled, cancelled, accepted surrender of, suspended, placed on probation, or refused to issue or renew a professional license or certificate held by you now or previously, or fined, censured, reprimanded or otherwise disciplined you?		
c. Are criminal charges pending against you in any court?		
d. Are charges pending against you in any jurisdiction for any sort of professional misconduct?		
e. Has any hospital or licensed facility restricted or terminated your professional training, employment, or privileges, or have you voluntarily or involuntarily resigned or withdrawn from such association to avoid the imposition of such action due to professional misconduct, unprofessional conduct, incompetency, or negligence?		
3. a. Are you under an obligation to pay child support?	☐ Yes	☑ No
b. If you are under such an obligation, do you meet one of the four requirements listed in the Child Support Law section below?	☐ Yes	☐ No
4. Are you a U.S. citizen or an alien admitted for permanent residence in the U.S.?	☑ Yes	☐ No

[redacted]

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Signature [redacted] Daytime phone ([redacted] Date 2/18/06

21

134698GL0800600006010B

REGISTRATION RENEWAL DOCUMENT
THE STATE EDUCATION DEPARTMENT
Professional Licensing Services
89 Washington Avenue
Albany, NY 12234-1000

04/15/08
LIC: 134698
NME: GL08
YR: 08
OFF: 1
EIN:

GLOMA PATRICIA T
[redacted]
HANOVER NH [redacted]

PIN: QV01842

PROFESSION: 80 MEDICINE
PERIOD: 06/01/08 - 05/31/10

****
*** 2ND REQUEST ***
****

Complete and sign reverse side of this application

Address change
Complete only if change has occurred

Street

City

State/Zip

$ 600
AMOUNT DUE

1. Do you wish to register for the period indicated? ..... ☐ Yes ☒ No

2. Since your last registration application,
   a. Have you been found guilty after trial, or pleaded guilty, no contest, or nolo contendere to a crime (felony or misdemeanor) in any court? .....
   b. Has any licensing or disciplinary authority revoked, annulled, cancelled, accepted surrender of, suspended, placed on probation, or refused to issue or renew a professional license or certificate held by you now or previously, or fined, censured, reprimanded or otherwise disciplined you?
   c. Are criminal charges pending against you in any court? .....
   d. Are charges pending against you in any jurisdiction for any sort of professional misconduct? .....
   e. Has any hospital or licensed facility restricted or terminated your professional training, employment, or privileges, or have you voluntarily or involuntarily resigned or withdrawn from such association to avoid the imposition of such action due to professional misconduct, unprofessional conduct, incompetency, or negligence? .....

[redacted]

3. a. Are you under an obligation to pay child support? ..... ☐ Yes ☒ No
   b. If you are under such an obligation, do you meet one of the four requirements listed in the Child Support Law section below? ..... ☐ Yes ☐ No

4. Are you a U.S. citizen or an alien admitted for permanent residence in the U.S.? ..... ☒ Yes ☐ No

[redacted]

DO NOT WRITE IN THIS BOX
FOR OFFICIAL USE ONLY

I certify that the statements made in this application and any accompanying documentation are true, complete and correct. I understand that any misrepresentation or any false or misleading information made in connection with my application may result in criminal prosecution and may be cause for disciplinary action, including the loss of my license; and that the willful failure to register while continuing to practice my profession constitutes professional misconduct.

Signature [redacted] Daytime phone [redacted] Date 4/21/08

CMPR 1100K