Regular Mailing Address

State Board of Osteopathic Med.
P.O. Box 2649
Harrisburg, PA 17105-2649
717-783-4858

Courier Delivery Address

State Board of Osteopathic Medicine
124 Pine Street, 1st Floor
Harrisburg, PA 17101

For office use only

OT 006951 T

LEFK0 APPL

APPLICATION FOR A TEMPORARY LICENSE OR GRADUATE CERTIFICATE

THIS APPLICATION IS TO BE USED FOR INITIAL TEMPORARY LICENSE/GRADUATE CERTIFICATE.

DO NOT USE TO RENEW

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

FEE: $30.00

MAKE FEE PAYABLE TO COMMONWEALTH OF PENNSYLVANIA.

FEE IS NOT REFUNDABLE.

THIS APPLICATION MUST BE SUBMITTED AT LEAST 60 DAYS PRIOR TO START OF TRAINING.

Official Use:

Amount

Date

TO BE COMPLETED BY APPLICANT:

Please Print or Type

NAME: LEFKOWITZ (LAST) JANET (FIRST) BETH (MIDDLE) (MAIDEN)

ADDRESS: [redacted]

JENKINTOWN (CITY) PA (STATE) 19046 (ZIP CODE)

SOCIAL SECURITY [redacted] DATE OF BIRTH: [redacted] (MONTH/DAY/YEAR)

TELEPHONE NUMBERS [redacted] (WORK), (HOME)

NAME & ADDRESS OF MEDICAL SCHOOL	DATES OF ATTENDANCE	DATE OF GRADUATION
UNIVERSITY OF NEW ENGLAND COLLEGE OF OSTEOPATHIC MEDICINE, BIDDEFORD, ME	9/97 - 6/01	ANTICIPATED 06/02/01

NAME & ADDRESS OF HOSPITAL(S)	DATES OF PREVIOUS TRAINING	SPECIALTY
NO PREVIOUS TRAINING	N/A	N/A

TO BE COMPLETED BY HOSPITAL LOCATED IN PENNSYLVANIA:

NAME OF HOSPITAL: DELAWARE COUNTY MEMORIAL HOSPITAL HS: 000061 PL

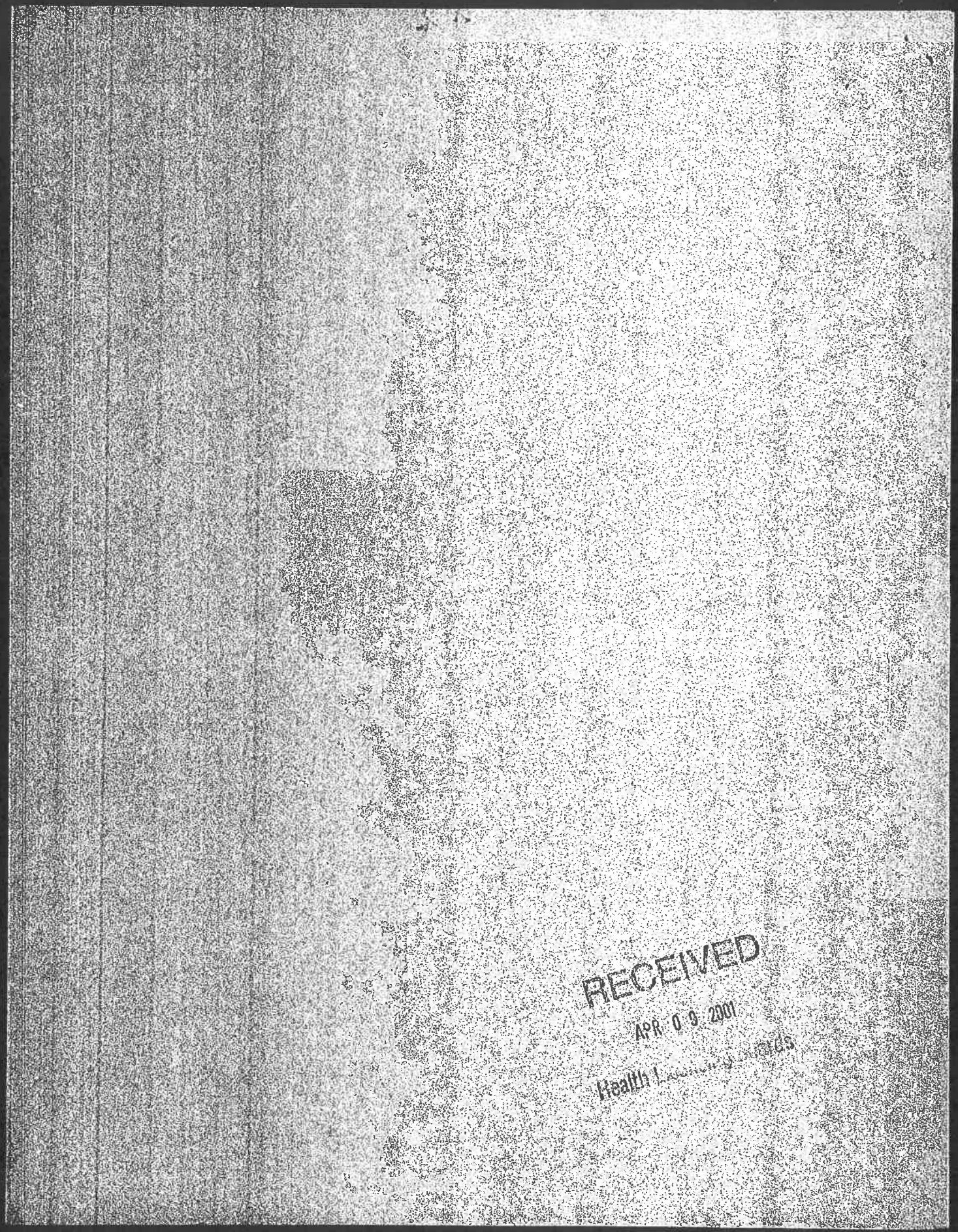
ADDRESS OF HOSPITAL: 501 N. Lansdowne Ave., Drexel Hill, PA 19026

YEAR IN TRAINING: First SPECIALTY: Rotating Internship LEVEL IN TRAINING: One

DATES OF TRAINING REQUESTED: 6/25/01 (BEGINNING DATE-MONTH/DAY/YEAR) TO 6/23/02 (ENDING DATE-MONTH/DAY/YEAR)

NAME OF PROGRAM DIRECTOR: James E. McHugh, DO, FACOI, MBA

SIGNATURE OF PROGRAM DIRECTOR: James E McHugh DO FACOI MBA


RECEIVED
APR 0 9 2001
Health Law Judges

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

		YES	NO
1.	Do you hold a license to practice medicine and surgery, active or inactive, current or expired) in any state, territory or country? If " yes" , list all states below.		✓
2.	Have you withdrawn an application for a license, had an application for a license denied or refused, or agreed not to reapply for a license in another state, territory or country?		✓
3.	Has any disciplinary action been taken against your license in another state, territory or country?		✓
4.	Have you been convicted, found guilty, or pleaded guilty or nolo contendere, or received probation without verdict as to any felony or misdemeanor, including any drug law violation, in any state or federal court?		✓
5.	Have you had practice privileges denied, revoked or restricted in a hospital or other health care facility?		✓
6.	Have you had your DEA registration denied, revoked or restricted or have you had your provider privileges terminated by any medical assistance agency for cause?		✓
7.	Are you, or have you ever been, addicted to the intemperate use of alcohol or to the habitual use of narcotics or other habit-forming drugs? **(NOTE: You may answer "NO" if you are currently a participant in or have successfully completed the requirements of the Board's Professional Health Monitoring Program.)**		[redacted]

****

SIGNED STATEMENT

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

[redacted] 17 March 2001

SIGNATURE OF APPLICANT DATE

State Board of Osteopathic Medicine
717-783-4858

MAR 2 6 2001
010413 0189
RECEIVED DIRECT

VERIFICATION OF MEDICAL EDUCATION

SECTION 1: To be completed by applicant:

Name: LEFKOWITZ (Last) JANET (First) BETH (Middle)

Name of medical school: UNECOM

Location: BIDDEFORD, MAINE

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

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

Name of medical student: Janet Beth Lefkowitz

Date student began to attend this medical school: 09 (Month) — 05 (Day) — 1997 (Year)

Expected date of graduation/date of graduation: 06 (Month) — 01 (Day) — 2001 (Year)

This form may be completed three months prior to graduation. If graduation does not take place, notify the Board immediately.

[Seal of School]

I certify that all of the above information is correct.

Signature of Dean or Registrar: Steve Kelly University Registrar

Date: 3/28/01

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

****

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

Courier Delivery Address:
State Board of Osteopathic Medicine
124 Pine Street, 1st Floor
Harrisburg, PA 17101

[redacted]

TARGET SHEET

Board: Osteopathic Medicine

Date Created:
10/12/2005

Licensee Full Name:
JANET BETH LEFKOWITZ

License No:
OS013238

APPL 1978167

COMMONWEALTH OF PENNSYLVANIA
DEPARTMENT OF STATE
BUREAU OF PROFESSIONAL AND OCCUPATIONAL AFFAIRS
P.O. BOX 2649
HARRISBURG, PA 17105

STATE BOARD OF OSTEOPATHIC MEDICINE

Telephone: (717) 783 4858
Fax: (717) 787 7769
www.dos.state.pa.us

September 19, 2002

DISCREPANCY LETTER

JANET LEFKOWITZ
[redacted]
WEST HARTFORD CT 06117

THE PENNSYLVANIA STATE BOARD OF OSTEOPATHIC MEDICINE IS IN RECEIPT OF YOUR APPLICATION FOR AN UNRESTRICTED LICENSE. THE FOLLOWING ITEMS ARE NEEDED TO COMPLETE YOUR APPLICATION:

- Moral Character
- Graduate Training Form (Must be received **direct** from the hospital) **Form may not be submitted before completion of internship** FORM MUST HAVE OFFICIAL HOSPITAL SEAL AND BE MAILED DIRECTLY TO US AT THE ABOVE ADDRESS. THE FORM WE RECEIVED DID NOT HAVE THE OFFICIAL HOSPITAL SEAL.
- Exam Scores (National Boards) Must be received **direct**.

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

COMMONWEALTH OF PENNSYLVANIA
DEPARTMENT OF STATE
BUREAU OF PROFESSIONAL AND OCCUPATIONAL AFFAIRS
STATE BOARD OF OSTEOPATHIC MEDICINE
P.O. BOX 2649
HARRISBURG, PENNSYLVANIA 17105
717-783-4858
OSTEOPAT PAGOR.DOS.STATE.PA.US

FAX: (717) 787-7769
WWW.DOS.STATE.PA.US

April 3, 2002

JANET B LEFKOWITZ DO
[redacted]
JENKINTOWN PA 19046

Dear Doctor:

Congratulations on your successful completion of the State Board of Osteopathic Medicine's OMT Examination. The following items are needed to complete your application for an unrestricted license:

VERIFICATION OF GRADUATION - MEDICAL SCHOOL TO SEAL FORM AND RETURN DIRECT TO THE STATE BOARD OFFICE

NATIONAL BOARD SCORES - TO BE RECEIVED IN THIS OFFICE DIRECT FROM NBOME

CERTIFICATE OF MORAL CHARACTER - TO BE COMPLETED BY TWO OSTEOPATHIC PHYSICIANS WITH UNRESTRICTED LICENSES

VERIFICATION OF AOA APPROVED INTERNSHIP (PRE-DATED FORM NOT ACCEPTABLE)

Sincerely
State Board of Osteopathic Medicine

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

SPOA-201

OFFICIAL USE ONLY

Target Sheet

APPLICATION FOR LICENSE

APPLICANT MUST SUBMIT THIS FORM TO:
PENNSYLVANIA STATE BOARD OF OSTEOPATHIC MEDICINE
P.O. BOX 2649, HARRISBURG, PA 17105-2649

	YES	NO
1. Have you ever had an application for a license to practice osteopathic medicine and surgery denied in another state, territory or jurisdiction of the United States or in any other country?	☐	☒
2. Have you ever possessed a license to practice osteopathic medicine and surgery or other professional license, or other authorization to practice a profession that was suspended, revoked or subjected to other disciplinary action taken by the proper licensing authority of another state, territory or country?	☐	☒
3. Have you ever been convicted of, pled guilty to, or entered a plea of nolo contendere to any crime in the courts of the Commonwealth of Pennsylvania, any other state, federal or territory court or the courts of another country?	☐	☒
4. Have you ever had practice privileges denied, revoked or restricted in a hospital or other health care facility?	☐	☒
5. Have you ever had provider privileges denied, revoked or restricted by a Drug Enforcement Administration, medical assistance agency or other authority?	☐	☒
6. 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 Impaired Professionals Program.)	☐	☒

If you have answered YES to any of the above questions, please give dates on a separate 8 1/2 X 11 sheet of paper.

7. Have you ever failed an examination for licensure in Pennsylvania? If yes, give date(s)	☐	☒
8. Have you possessed or do you possess a license to practice osteopathic medicine and surgery (active or inactive) in any state, territory or country? If yes, list all states, territories and countries: PA (Currently Inactive)	☒	☐

and request letters of good standing from each licensing board/agency listed be sent to:

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

In order to practice in Pennsylvania, you must comply with malpractice insurance requirements.

VERIFICATION STATEMENT

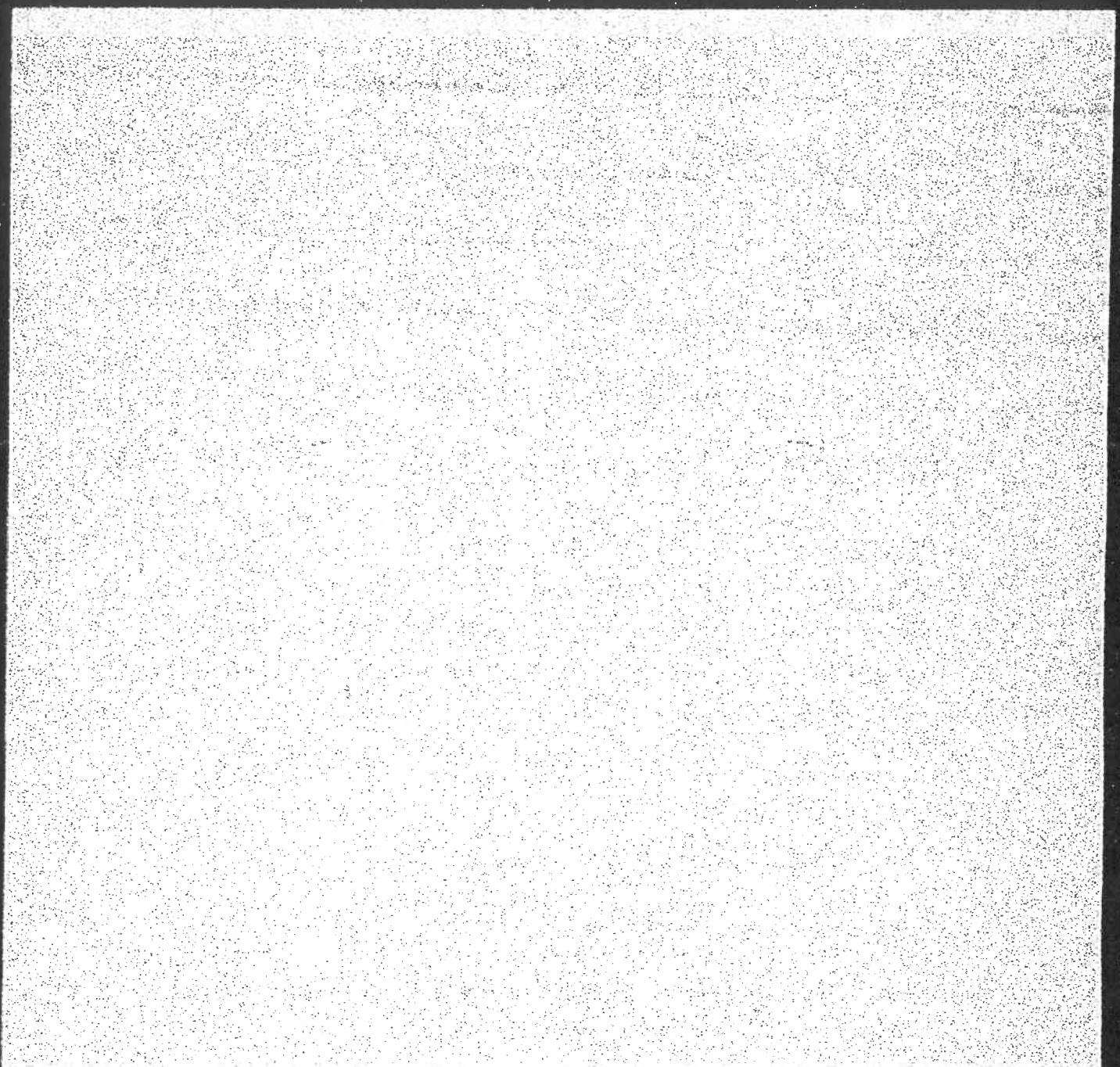
I verify that the statements on this application are true and correct to the best of my knowledge, information and belief. I understand that false statements are made subject to the penalties of 18 Pa. C.S. Section 4904 relating to unsworn falsification to authorities and may result in the suspension or revocation of my license or certificate.

[redacted] 1/6/12

Signature of Applicant

ANGELA LEFKOVITZ

Print/Type Name of Applicant



RECEIVED DIRECT

COMMONWEALTH OF PENNSYLVANIA
STATE BOARD OF OSTEOPATHIC MEDICINE
VERIFICATION OF AOA APPROVED INTERNSHIP

SUBMIT TO:
STATE BOARD OF OSTEOPATHIC MEDICINE
P.O. BOX 2649
HARRISBURG, PA 17105-2649
1-717-783-4858

OFFICE USE ONLY - DO NOT WRITE IN THIS SPACE

O S [redacted] L
LICENSE NUMBER

[redacted] E D U C
NAME CODE INITIAL

Completion of one year of an AOA-approved internship is required.

SECTION 1 - TO BE COMPLETED BY APPLICANT.
PLEASE PRINT OR TYPE.

NAME: LIFKOWITZ (LAST) [redacted] JANET (FIRST) BETH (MIDDLE)

ADDRESS: [redacted] (STREET) West Hartford (CITY) CT (STATE) 06117 (ZIP CODE)

NAME OF HOSPITAL: DELAWARE COUNTY MEMORIAL HOSPITAL

LOCATION: LANSDOWNE AVE

DREXEL HILL PA

SECTION 2 - TO BE COMPLETED BY DIRECTOR OF MEDICAL EDUCATION. UPON COMPLETION, HOSPITAL MUST RETURN THIS FORM IN OFFICIAL ENVELOPE DIRECTLY TO THE STATE BOARD OF OSTEOPATHIC MEDICINE AT THE ABOVE ADDRESS. DO NOT RETURN TO THE

This is to certify that Janet B Lifkowitz D.O. has completed an AOA approved internship at:

Delaware County Memorial Hosp.
501 North Lansdowne Avenue
Drexel Hill, PA 19026-1186
NAME OF HOSPITAL

STREET ADDRESS CITY STATE ZIP CODE

From June 25 2001 To June 23 2002
MONTH DAY YEAR MONTH DAY YEAR

[redacted]
SIGNATURE OF DIRECTOR OF MEDICAL EDUCATION

Sept 4, 2002
DATE

James E. McHugh, DO, FACOI, MBA
Director, Osteopathic Medical Education
Crozer-Keystone Health System
Delaware County Memorial Hospital
501 N. Lansdowne Avenue
Drexel Hill, PA 19026-1186

PROFESSIONAL
CREDENTIAL
SERVICES INC

150 Fourth Avenue North, Suite 700
Nashville, Tennessee 37219 • (877) UTRYPCS

Osteopath Score Notice
March 2002 Examination

JANET BETH LEFKOWITZ

March 22, 2002

File #: 01-043-56-6957
Jurisdiction: Pennsylvania
03/02 Examination ID#: 107-01-0506

Results for the 03/02 Examination:
Examination Taken: OSTEOPATH
Examination Status: Passed

Examination Scores:
Scaled Score: 90
Required Scaled Score to Pass: 75

The State Board of Osteopathic Medicine is pleased to congratulate you on successful completion of the Osteopathic Medical Licensing Examination.
The results of your State Osteopathic Manipulative Therapy (OMT) Examination taken under the jurisdiction of the Pennsylvania State Board of Osteopathic Medicine are shown above.

JANET BETH LEFKOWITZ
[redacted]
JENKINTOWN, PA 19046

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

PRACTICAL EXAMINATION
OSTEOPATHIC MANIPULATIVE THERAPEUTICS

Exam Date: 03/2002
Name: JAMEY BETH LEFEVRE
ID#: 107019[redacted]

Numerical Rating 90

Signature of Examiner [redacted]

TECHNIQUES APPLICABLE TO THE ENTIRE BODY (Remarks by Examiner)

Cervical Technique

Dorsal Technique

Lumbar Technique [redacted]

Sacroiliac Subluxation

Sacroiliac Lesion on the Right (posteriorly)

Lymphatic Pump Technique [redacted]

Occipital Atlanta Lesion

First Rib

Second and Dorsal Lesion

Anterior Dislocation of Right Shoulder

Ulnar Lesion of the Elbow

Dislocated Medial Meniscus

Colles Fracture

Cuboid Dislocation

Other

Other

Other

Remarks by Examiner [redacted]

PAOMTPract 083400

PENNSYLVANIA

STATE BOARD OF OSTEOPATHIC MEDICINE

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OST 016

1995 | SK

05012238

SCHEDULING FORM FOR THE PENNSYLVANIA OSTEOPATHIC MANIPULATIVE THERAPY (OMT) EXAMINATION

Please complete and submit to: Professional Credential Services, PA OMT Coordinator, P.O. Box 198689, Nashville, TN 37219-8689

Record the information requested using a ball point pen or typewriter. Place a check in the appropriate box below. Where spaces are provided, print one letter or digit per space leaving an empty space between words. Omit punctuation and abbreviate as necessary.

1. EXAM DATE:

☐ Jan 19, 2002 (Nov 16 deadline) ☒ Mar 16, 2002 (Jan 16 deadline) ☐ Jun 15, 2002 (Apr 12 deadline) ☐ Sep 21, 2002 (Jul 13 deadline) ☐ Nov 17, 2002 (Sep 16 deadline)

* For applications after the deadline, please refer to the late application section in the "Information to Applicants"

2. SOCIAL SECURITY NUMBER [redacted]

3. DATE OF BIRTH [redacted] BIRTH DAY YEAR

4. NAME:

DANIEL | BRIAN | HEIFERMAN

FIRST MIDDLE LAST

MAIDEN/PREVIOUS SUFFIX Title (check one) ☐ Mr ☐ Ms ☐ Mrs ☐ Miss

5. CORRESPONDENCE INFORMATION:

ADDRESS

[redacted]

MAILING ADDRESS - LINE 1

[redacted]

MAILING ADDRESS - LINE 2

HENRIETTA | PA | 19026

CITY STATE ZIP CODE + 4 FOREIGN POSTAL CODE

[redacted]

E-MAIL

[redacted]

Daytime Telephone Number Evening Telephone Number Fax Number

6. EXAMINATION FEE. Payment must be by certified check or money order made payable to Professional Credential Services/PA OMT and received by the application deadline. Cash will not be accepted. A processing fee of $25.00 will be charged for any certified check or money order returned unpaid for any reason. Please record your social security number on the check. NOTE: FEES WILL NOT BE TRANSFERRED TO FUTURE EXAMINATIONS (no postponements).

EXAMINATION	EXAM FEE		LICENSING FEE		TOTAL FEE *
☒ NEW Candidate for OMT	$150.00	+	$45.00	=	$195.00
☐ REPEAT Candidate for OMT	150.00	+	0.00	=	150.00

Date of examination last taken.

7. EXAMINATION LOCATION REQUEST. (check one)

☐ Erie Area (Lake Erie College of Osteopathic Medicine) - *offered in June and November only*

☒ Philadelphia Area (Philadelphia College of Osteopathic Medicine) - *offered on all examination dates*

PAPE SCHEDULING 9 10 01

CONTINUED ON PAGE 2

REC'D JAN 11 2002

THE COMMONWEALTH OF

PENNSYLVANIA

STATE BOARD OF OSTEOPATHIC MEDICINE

SCHEDULING FORM

SCHEDULING FORM FOR THE PENNSYLVANIA OSTEOPATHIC MANIPULATIVE THERAPY (OMT) EXAMINATION

8. A. **EDUCATION**

Name and Address of Osteopathic School(s)	Date of Attendance	Date of Graduation
UNIVERSITY OF NEW ENGLAND COLLEGE OF OSTEOPATHIC MEDICINE	9/97 6/01	6/01

B. **ROTATING INTERNSHIP**

Name and Address of hospital	Beginning Date	Ending Date
DELAWARE COUNTY MEMORIAL HOSPITAL LANSDOWNE AVE, DREXEL HILL, PA	6/01	6/02

9. **EXAM HISTORY.** Please indicate which examination you have taken. Be sure these results from the testing agency were forwarded directly to the State Board.

☐ National Board Examination ☐ FLEX/USMLE Examination ☐ State Examination

10. **CANDIDATES WITH DISABILITIES.** Candidates requiring modifications in the examination administration because of a disability must obtain an official modification form from Professional Credential Services. Candidates must complete and submit this form every time that they apply for the examination and need special modifications. The completed forms must be returned to Professional Credential Services with all required documentation by the entry deadline.

☐ **Check this box only if requesting special modifications.**

11. **AFFIDAVIT:** Applicant must read the following paragraph and sign the application form attesting to the following. *I certify that the statements in this application are true and correct to the best of my knowledge, information and belief, and that I am of good moral character. I verify that this form is in the original format as supplied Professional Credential Services and has not been altered or otherwise modified in any way. I understand that any false statement made is 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 or certificate. I understand that it is my responsibility to provide all of the required information and documentation by the deadline. Failure to do so will make me ineligible for this examination. I understand that every attempt will be made to seat me at the test site I have selected. I also understand that site selection cannot be guaranteed and that I will be admitted only to the test site for which I have been scheduled by Professional Credential Services. I understand that fees are subject to change. I understand that the money that I have paid for the exam date I have selected on this form will not be transferred to future exam dates. I agree that in the event my examination papers are lost, or if the examination is not held for any reason, my claim I may have will be limited to the examination fee paid by me. I further understand that submission of this form acknowledges that I understand and agree to all provisions contained in this form.*

[redacted]

Applicant Signature

1/6/02

Date

Mail scheduling materials postmarked no later than the deadline to:

PROFESSIONAL CREDENTIAL SERVICES/PA OMT

P.O. Box 198689
Nashville, TN 37219-8689

-OR-

150 Fourth Avenue North, Suite 700
Nashville, TN 37219

toll free (877) U-TRY-PCS (615) 880-4275
http://www.pcshq.com

Examination applicants must ALSO submit the application for license to the Board office in Harrisburg by the applicable deadline.

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

OT006951T
LEFKOWITZ

RENEWAL APPLICATION

JANET BETH LEFKOWITZ
DELAWARE CO MEMORIAL HOSPITAL
DEPT OF OSTEO MED ED
501 N LANSDOWNE AVENUE
DREXEL HILL PA 19026-0000

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

☑ I will not be participating in graduate training in Pennsylvania after the expiration date indicated below and request inactive status. **No fee is required. QUESTIONS MUST STILL BE ANSWERED.**

THE FOLLOWING QUESTIONS MUST BE ANSWERED

YES	NO	If YES – provide details AND attach certified copies of legal document(s).
	✓	1. Do you hold a license to practice this profession in any other state or jurisdiction? List.
	✓	2. **Since your initial application or your last renewal,** have you had disciplinary action taken against your license in any state or jurisdiction?
	✓	3. **Since your initial application or your last renewal,** have you withdrawn an application for a license, had an application for a license denied or refused, or agreed not to reapply for a license in any state or jurisdiction?
	✓	4. **Since your initial application or your last renewal,** have you been convicted, found guilty or pleaded nolo contendere, or received probation without verdict as to any felony or misdemeanor, including any drug law violations, or any criminal charges pending and unresolved in any state or jurisdiction?
	✓	5. **Since your initial application or your last renewal,** have you had practice privileges denied, revoked or restricted in a hospital or other health care facility?
	✓	6. **Since your initial application or your last renewal,** have you had your DEA registration denied, revoked or restricted or have you had your provider privileges terminated by any medical assistance agency for cause?

Please review and update, as necessary, the following information regarding your license:

	Beginning Date	Ending Date	Level	Specialty	Hospital #	Hospital Name
Current	06/25/2001	06/23/2002	1	Internship/Rotating	HS000081L	DELAWARE CO MEMORIAL HOSPITAL
Renewal						

Signature of Licensee **(Mandatory)** [redacted] Date 4/30/02

SSN [redacted]

ATTACHMENTS FOR RENEWING:

☑ **FEE** – $26.00 check payable to "COMMONWEALTH OF PENNSYLVANIA". Write your license number, **OT006951T**, on your payment. A $20.00 fee will be assessed for a returned payment.

☐ **LATE FEE** - $5.00 per month, or part of a month. Late renewal fee will be assessed if postmarked after **06/23/2002**