Medical Quality Assurance Commission
Physician Application Worksheet

Name: GEETHA FINK | Date of Birth: 11/9/1983

Date Received: 5/11/17 | Temp Issued: | Number: | Closed:

X	WSP Check	X	Fee	X	Photo	X	Data1 15	X	AIDS	X	Attes	X	SSN		EBHAR

Chronology Complete:

MISSING
_____ to _____
_____ to _____
_____ to _____

FSMB	AMA	ECFMG	FBI REPORT
5/12/17 ✓	5/12/17 ✓		C 1/7

Personal Data "Yes"s	Documentation Received

Malpractice Cases	Synopsis	Disposition
1		
2		
3		
4		
5		
6		
7		

Medical School

Name: CHICAGO MEDICAL | Year of Degree: Jun-10 | 4/27/17 Transcripts ✓ | Translations:

Examination Type: National | FLEX | USMLE | State Exam | LMCC | 4/20/17 Scores Received ✓

Post Graduate Training Programs

Received	Training Programs
5/1/17	UCLA 7/10-6/11 ✓
5/16/17	PHOENIX INTEG 7/11-6/15 ✓
5/23	ICAHN FE 7/15-6/17 ✓

Post Graduate Training Programs

Received	Training Programs

Received	State	Received	Hospital verification	Received	Hospital verification
5/19/17	NY ✓				

Dillon Dumas 6/16/17

Washington State Department of Health

491-

PHYSICIAN & SURGEON

Revenue Section

Print Name Fink, Geetha

Return this portion with check & application

1F 0252090000 00236

"0768"

$491.00

0768-5 11/2017 7:37:28 AM-601

Washington State Department of Health

Background Check Processed
Background Check Stamp
MAY 2017
NPDB/HIPDB
DEPARTMENT OF HEALTH
MEDICAL COMMISSION

RECEIVED
Date Stamp Here
MAY 11 2017
MEDICAL COMMISSION

Revenue 0252090000

Medical Practice License Application for MDs only

☐ National Boards ☐ Other State Exam ☐ LMCC (Must have been obtained after 1969)
☐ Flex Examination ☑ USMLE Examination

Select if the following applies: ☐ Spouse or Registered Domestic Partner of Military Personnel

1. Demographic Information

Social Security Number (SSN) (If you do not have a SSN, see instructions)	National Provider Identifier Number (NPI) (Enter 10 digit number)	☐ Male ☑ Female
2 - DOH Licensee Social Security Numbe...	1982919437	

Name First	Middle	Last
Geetha	Narayani	Fink

Birth date (mm/dd/yyyy)	Place of birth		
	City	State	Country
11/09/1983	Beverly Hills	CA	USA.

Address 2703 ~~2703~~ 42nd Rd #10B.

City	State	Zip Code	County
Long Island City.	NY	11101	Queens.

Country: USA

Phone (enter 10 digit #)	Fax (enter 10 digit #)	Cell (enter 10 digit #)
1 - DOH Licensee Health Professional ...		1 - DOH Licensee Health Professio...

Email address: geetha.fink@gmail.com.

Mailing address if different from above address of record

City	State	Zip Code	County

Country:

Note: The mailing and email addresses you provide will be your addresses of record. It is your responsibility to maintain current contact information on file with the department.

Have you ever been known under any other name(s)? ☑ Yes ☐ No
If yes, list name(s): Geetha Narayani Vivekaandamorthy.

Will documents be received in another name? ☐ Yes ☑ No
If yes, list name(s):

Medical Speciality

Medical school	Year of Graduation
Chicago Medical School at Rosalind Franklin University	2010

Medical Specialty: Obstetrics and Gynecology

2. Personal Data Questions

	Yes	No
1. Do you have a medical condition which in any way impairs or limits your ability to practice your profession with reasonable skill and safety? If yes, please attach explanation.	☐	☑

"Medical Condition" includes physiological, mental or psychological conditions or disorders, such as, but not limited to orthopedic, visual, speech, and hearing impairments, cerebral palsy, epilepsy, muscular dystrophy, multiple sclerosis, cancer, heart disease, diabetes, intellectual disabilities, emotional or mental illness, specific learning disabilities, HIV disease, tuberculosis, drug addiction, and alcoholism.

If you answered yes to question 1, explain:

1a. How your treatment has reduced or eliminated the limitations caused by your medical condition.

1b. How your field of practice, the setting or manner of practice has reduced or eliminated the limitations caused by your medical condition.

Note: If you answered "yes" to question 1, the licensing authority will assess the nature, severity, and the duration of the risks associated with the ongoing medical condition and the ongoing treatment to determine whether your license should be restricted, conditions imposed, or no license issued.

The licensing authority may require you to undergo one or more mental, physical or psychological examination(s). This would be at your own expense. By submitting this application, you give consent to such an examination(s). You also agree the examination report(s) may be provided to the licensing authority. You waive all claims based on confidentiality or privileged communication. If you do not submit to a required examination(s) or provide the report(s) to the licensing authority, your application may be denied.

2. Do you currently use chemical substance(s) in any way which impair or limit your ability to practice your profession with reasonable skill and safety? If yes, please explain	☐	☑

"Currently" means within the past two years.

"Chemical substances" include alcohol, drugs, or medications, whether taken legally or illegally.

3. Have you ever been diagnosed with, or treated for, pedophilia, exhibitionism, voyeurism or frotteurism?	☐	☑
4. Are you currently engaged in the illegal use of controlled substances?	☐	☑

"Currently" means within the past two years.

Illegal use of controlled substances is the use of controlled substances (e.g., heroin, cocaine) not obtained legally or taken according to the directions of a licensed health care practitioner.

Note: If you answer "yes" to any of the remaining questions, provide an explanation and certified copies of all judgments, decisions, orders, agreements and surrenders. The department does criminal background checks on all applicants.

5. Have you ever been convicted, entered a plea of guilty, no contest, or a similar plea, or had prosecution or a sentence deferred or suspended as an adult or juvenile in any state or jurisdiction?	☐	☑

Note: If you answered "yes" to question 5, you must send certified copies of all court documents related to your criminal history with your application. If you do not provide the documents, your application is incomplete and will not be considered.

To protect the public, the department considers criminal history. A criminal history may not automatically bar you from obtaining a credential. However, failure to report criminal history may result in extra cost to you and the application may be delayed or denied.

2. Personal Data Questions (Cont.)

	Yes	No
6. Have you ever been found in any civil, administrative or criminal proceeding to have:		
a. Possessed, used, prescribed for use, or distributed controlled substances or legend drugs in any way other than for legitimate or therapeutic purposes?	☐	☑
b. Diverted controlled substances or legend drugs?	☐	☑
c. Violated any drug law?	☐	☑
d. Prescribed controlled substances for yourself?	☐	☑
7. Have you ever been found in any proceeding to have violated any state or federal law or rule regulating the practice of a health care profession? If "yes", please attach an explanation and provide copies of all judgments, decisions, and agreements?	☐	☑
8. Have you ever had any license, certificate, registration or other privilege to practice a health care profession denied, revoked, suspended, or restricted by a state, federal, or foreign authority?	☐	☑
9. Have you ever surrendered a credential like those listed in number 8, in connection with or to avoid action by a state, federal, or foreign authority?	☐	☑
10. Have you ever been named in any civil suit or suffered any civil judgment for incompetence, negligence, or malpractice in connection with the practice of a health care profession?	☐	☑
11. Have you ever had hospital privileges, medical society, other professional society or organization membership revoked, suspended, restricted or denied?	☐	☑
12. Have you ever been the subject of any informal or formal disciplinary action related to the practice of medicine?	☐	☑
13. To the best of your knowledge, are you the subject of an investigation by any licensing board as to the date of this application?	☐	☑
14. Have you ever agreed to restrict, surrender, or resign your practice in lieu of or to avoid adverse action?	☐	☑
15. Have you ever been disqualified from working with vulnerable persons by the Department of Social and Health Services (DSHS)?	☐	☑

3. Medical Education and Postgraduate Training

Provide a date listing of your educational preparation and postgraduate training. If you need more space, attach a piece of paper.

Schools attended (Location if other than U.S., quote names of schools in original language and translate to English.)	Diploma or degree obtained (Quote titles in original language and translate to English.)	Number of years attended	Dates granted	
			Start mm/yyyy	End mm/yyyy
Medical education (list all medical schools attended)				
Chicago Medical School at Rosalind Franklin	MD	5	08/2005	06/2010
Keck School of Medicine at Univ. of Southern California	MPH	2	05/2008	05/2012
Postgraduate training (list all programs attended)				
Preliminary General Surgery at Harbor UCLA		1	07/2010	06/2011
Phoenix Integrated Residency in Obstetrics & Gynecology		4	07/2011	06/2015
Family Planning Fellowship at Icahn School of Medicine Mount Sinai		1	07/2015	06/2017

4. Professional Experience

In date order list all professional experience received since graduation from medical school to the present. Exclude activities listed under other sections, identify any periods of time break of 30 days or more. If you need more space, attach a piece of paper.

Name and location of institution	From (mm/dd/yyyy	To (mm/dd/yyyy	Nature of experience or specialty
N/A - only postgraduate training			
no breaks.			

5. Hospital Privileges (Excluding postgraduate training hospital privileges.)

Excluding postgraduate training, list hospitals where all privileges that have been granted within the past five years. If you need more space, attach a piece of paper.

Name of hospital	Dates attended	
	Start date mm/dd/yyyy	End date mm/dd/yyyy
N/A.		

6. Licenses in Other States

List all licenses to practice medicine in any state, territory, Canadian province or other country. Include active, inactive, temporary and training licenses. Please provide verification directly from the state(s) that you have listed in this section.

State	Date license issued	License Number	Status of license	Any limitations on license
NY.	05/15/15	279805-1	Active.	☑ No ☐ Yes
				☐ No ☐ Yes
				☐ No ☐ Yes
				☐ No ☐ Yes
				☐ No ☐ Yes
				☐ No ☐ Yes

7. AIDS Education and Training Attestation

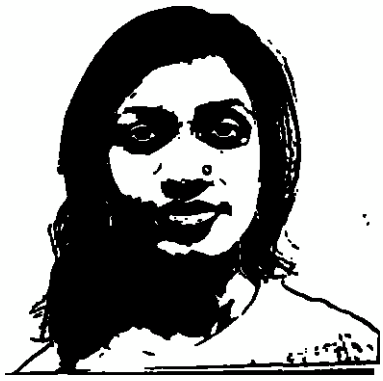
I certify that I have completed a minimum of four hours of education in the prevention, transmission, and treatment of AIDS. This education included topics of etiology and epidemiology, testing and counseling, infection control guidelines, clinical manifestations and treatment, legal and ethical issues to include confidentiality, and psychosocial issues to include special population considerations.

If AIDS education was included in your professional education or training, an additional course is not required.

Applicant's initials	Date
GM	4/24/17

8. Applicant's Photograph

Photo Here



Height 5'5"

Weight 115 lbs

Hair color Black

Color of eyes Black

Signature GM

Date of Photo 5/2/17

9. Applicant's Attestation

I, Geetha Narayani Fink , declare under penalty of perjury under the
(Print applicant name clearly)

laws of the state of Washington that the following is true and correct:

- I am the person described and identified in this application.
- I have read RCW 18.130.170 and RCW 18.130.180 of the Uniform Disciplinary Act.
- I have answered all questions truthfully and completely.
- The documentation provided in support of my application is accurate to the best of my knowledge.
- I have read all laws and rules related to my profession.

I understand the Department of Health may require more information before deciding on my application. The department may independently check conviction records with state or federal databases.

I authorize the release of any files or records the department requires to process this application. This includes information from all hospitals, educational or other organizations, my references, and past and present employers and business and professional associates. It also includes information from federal, state, local or foreign government agencies.

I understand that I must inform the department of any past, current or future criminal charges or convictions. I will also inform the department of any physical or mental conditions that jeopardize my ability to provide quality health care. If requested, I will authorize my health providers to release to the department information on my health, including mental health and any substance abuse treatment.

Dated 04/24/2017. at New York, NY.
(mm/dd/yyyy) (City, state)

By: _____
(Signature of applicant)

ROSALIND FRANKLIN UNIVERSITY of MEDICINE AND SCIENCE

DATE ISSUED : 21 Apr 2017
RFU-ID : 0131309
RECORD OF : FINK, GEETHA NARAYANI
ACAD. PROGRAM : MEDICINE

Previous Institutions Attended: University of California-Los Angeles - BS - 06/2005

FALL QUARTER 2005

COURSE	COURSE TITLE	CRD	GRD
HMTD500	INTERPROFESSIONAL HEALTHCARE T	1.00	P
MBCH502	MOLECULAR CELL BIOLOGY	5.00	B
MCBA500A	CLINICAL ANATOMY	5.00	#
MCBA502A	HISTOLOGY	3.00	#
MMED502A	INTRO. TO CLINICAL MEDICINE	2.00	#
MPHY500A	MEDICAL PHYSIOLOGY	7.00	#

WINTER QUARTER 2005

COURSE	COURSE TITLE	CRD	GRD
MBCH505A	MEDICAL BIOCHEMISTRY	2.00	#
MCBA500B	CLINICAL ANATOMY	11.00	C
MCBA502B	HISTOLOGY	5.00	C
MCBA504	EMBRYOLOGY	3.00	C
MPHY500B	MEDICAL PHYSIOLOGY	14.00	C

SPRING QUARTER 2006

COURSE	COURSE TITLE	CRD	GRD
MBCH505B	MEDICAL BIOCHEMISTRY	6.00	B
MBCH508	HUMAN GENETICS	3.00	A
MMED502B	INTRO. TO CLINICAL MEDICINE	2.00	#
MMTD509	EPIDEMIOLOGY	2.00	P
MMTD510	INTRODUCTION TO MEDICAL ETHICS	2.00	P
MNSC501	MEDICAL NEUROSCIENCE	7.00	C

FALL QUARTER 2006

COURSE	COURSE TITLE	CRD	GRD
MCMP600A	FOUNDATIONS OF MED. PHARMACOLO	3.00	#
MMED602C	INTRO. TO CLINICAL MEDICINE	3.00	#
MMIC600A	MED. MICROBIOLOGY & IMMUNOLOGY	6.00	#
MPAT600A	GENERAL AND SYSTEMIC PATHOLOGY	6.00	#
MPSY601A	CLINICAL NEUROSCIENCE	4.00	#

WINTER QUARTER 2006

COURSE	COURSE TITLE	CRD	GRD
MCMP600B	FOUNDATIONS OF MED. PHARMACOLO	4.00	#
MCUR602	BIOETHICS AND THE LAW	3.00	P
MMED602D	INTRO. TO CLINICAL MEDICINE	3.00	#
MMIC600B	MED. MICROBIOLOGY & IMMUNOLOGY	6.00	#
MPAT600B	SYSTEMIC PATHOLOGY	6.00	#
MPSY601B	CLINICAL NEUROSCIENCE	7.00	C

SPRING QUARTER 2007

COURSE	COURSE TITLE	CRD	GRD
MCMP600C	FOUNDATIONS OF MED. PHARMACOLO	11.00	C
MCUR601	MEDICAL SPANISH	1.00	P
MMED602E	INTRO. TO CLINICAL MEDICINE	15.00	C
MMIC600C	MED. MICROBIOLOGY & IMMUNOLOGY	15.00	C
MMTD601	PREVENTIVE MEDICINE	2.00	P
MPAT600C	SYSTEMIC PATHOLOGY	19.00	C

SUMMER QUARTER 2007

COURSE	COURSE TITLE	CRD	GRD
MCUR606	CLINICAL SKILLS COURSE	3.00	P
MINT800	INTRAMURAL ELECTIVE	4.50	P
	Colon Cancer Research		
	● NORTHWESTERN		
MNEU700	NEUROLOGY CLERKSHIP	4.50	B

FALL QUARTER 2007

COURSE	COURSE TITLE	CRD	GRD
MPED700	PEDIATRICS CLERKSHIP	9.00	B
MOBG700	OBSTETRICS/GYNECOLOGY CLERK	9.00	B

WINTER QUARTER 2007

COURSE	COURSE TITLE	CRD	GRD
MPSY700	PSYCHIATRY CLERKSHIP	9.00	B
MFPM700	FAMILY MEDICINE CLERKSHIP	6.00	B
MEMG702	EMERGENCY MEDICINE	6.00	B

Rosalind Franklin University
of Medicine and Science
3333 Green Bay Road
North Chicago, IL 60064
(847) 578-3228

Timothy G. Carroll, Registrar

ROSALIND FRANKLIN
UNIVERSITY
of MEDICINE AND SCIENCE

Office of the Registrar
3333 Green Bay Road
North Chicago, IL 60064
(847) 578-3228

Former University Names:
The Chicago Medical School
University of Health Sciences/The Chicago Medical School
Finch University of Health Sciences/The Chicago Medical School

Former Names of Dr. William M. Scholl College of Podiatric Medicine:
Illinois College of Podiatric Medicine
Illinois College of Podiatry
Illinois College of Chiropody & Foot Surgery
Illinois College of Chiropody
Dr. William M. Scholl College of Podiatric Medicine
Dr. William M. Scholl College of Podiatric Medicine
at Finch University of Health Sciences/The Chicago Medical School

Accreditation
Rosalind Franklin University of Medicine and Science receives its degree-granting authority from the Illinois Board of Higher Education and is accredited by the Higher Learning Commission.
Higher Learning Commission
230 South LaSalle Street, Suite 7-500
Chicago, IL 60604
800.621.7440

The University consists of the following five schools:
Chicago Medical School
Dr. William M. Scholl College of Podiatric Medicine
College of Health Professions
School of Graduate and Postdoctoral Studies
College of Pharmacy

Family Educational Rights and Privacy Act
In Accordance with the Family Educational Rights and Privacy Act of 1974, the information on the enclosed transcript is provided with the understanding that the recipient will not allow any other person to have access to this information without the written consent of the student.

Academic Calendar
All schools within Rosalind Franklin University operate under a quarter calendar, and credit is expressed in quarter hours. Prior to 2003, Dr. William M. Scholl College of Podiatric Medicine operated under the semester calendar and credit was expressed in semester hours.

Grading System - Includes grades awarded by all schools of the University. A specific grade may not be valid in a particular school.

A	–	High Achievement
B	–	Above Average Achievement
C	–	Average Achievement
D	–	Below Average, but passing
H	–	Honors
P	–	Pass
HP	–	High Pass (used by Chicago Medical School for third year clinical courses only)
F	–	Fail
W	–	Withdrawal
PP	–	Pass Proficiency Exam
I	–	Incomplete
#	–	Graded at Sequence End
IP	–	In Progress
NR	–	Needs Remediation
NC	–	No Credit given
AU	–	Audit

In addition to the current grading system, prior to Fall 2002, the following notations were used:

AH	= 'A' with Honors
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#C	= Failed/Passed Retake Exam and received a 'C'
#P	= Failed/Passed Retake Exam
#F	= Failed/Failed Retake Exam
+C	= Failed/Passed Retake Course and received a 'C'
+P	= Failed/Passed Retake Course
+F	= Failed/Failed Retake Course
*	Graded at Sequence End
WP	= Withdrawal/Passing
WF	= Withdrawal/Failing
R	= Registered for Research
Q	= Qualified
S	= Satisfactory
CT	= Credit
+	= Same course as taken by Medical Students

Prior to 1975, Dr. William M. Scholl College issued numerical grades for the didactic courses.
Prior to 1982, Dr. William M. Scholl College used compound grades (e.g. FA, FB, DC); Students took a retake exam in the course; both grades were calculated in grade point average.

Starting 2013, Chicago Medical School initiated Pass Fail grading in the pre-clerkship courses.

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Starting in 2017, Chicago Medical School requires students to pass USMLE Step 1, USMLE Step 2 Clinical Knowledge (CK), and USMLE Step 2 Clinical Skills (CS) for graduation.

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DATE ISSUED : 21 Apr 2017
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RECORD OF : FINK, GEETHA NARAYANI
ACAD. PROGRAM : MEDICINE

Previous Institutions Attended: University of California-Los Angeles - BS - 06/2005

SPRING QUARTER 2008

COURSE	COURSE TITLE	CRD	GRD
MSUR700	SURGERY CLERKSHIP	12.00	B
MMED700	MEDICINE CLERKSHIP	15.00	B

SUMMER QUARTER 2008

COURSE	COURSE TITLE	CRD	GRD
MPAT835	FORENSIC PATHOLOGY	6.00	P
MSUR851	BREAST HEALTH	3.00	P

SUMMER QUARTER 2009

COURSE	COURSE TITLE	CRD	GRD
MELE847	GYNECOLOGIC ONCOLOGY KAISER PERM	6.00	P
MELE811	OBSTETRICS/GYNECOLOGY HIGH RISK OB HARBOR	4.50	P
MELE847	GYNECOLOGIC ONCOLOGY GYN/ONCOLOGY USC	6.00	P

FALL QUARTER 2009

COURSE	COURSE TITLE	CRD	GRD
MELE847	OB/GYN GEN. OB/GYN CEDAR SINAI	3.00	P
MELE817	MEDICINE ELECTIVE/EXTRAMURAL QUALITY MGMT IN HEALT ● HARBOR	4.50	P
MMED800	MEDICINE SUB INTERNSHIP	6.00	A

WINTER QUARTER 2009

COURSE	COURSE TITLE	CRD	GRD
MFPM835	HEADACHE DIAGNOSIS & MGMT.	3.00	P
HNUT802	FUNDAMENTAL OF HUMAN NUTR	3.00	P
MCUR800	ONLINE CLINICAL ETHICS	3.00	P
MMED701	AMBULATORY CARE	4.50	P
MCUR851	PRO FOR AN IND SENIOR ELEC PR NON-CLINICAL	3.00	P

Degree Received: Doctor of Medicine
Date Conferred.: 06/04/2010
Majors.....: Medicine

Academic Standing(s):
Leave of Absence - 08/18/08
Return from LOA - 06/01/09

End of official record.

Rosalind Franklin University
of Medicine and Science
3333 Green Bay Road
North Chicago, IL 60064
(847) 578-3228

AN OFFICIAL SIGNATURE IS WHITE WITH A GRAY BACKGROUND

Timothy G. Carroll, Registrar

FINK, GEETHA MD60760037 PAGE 1

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ROSALIND FRANKLIN UNIVERSITY
of MEDICINE AND SCIENCE

3333 Green Bay Road
North Chicago, IL 60064-3095

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State of Washington
Medical Quality Assurance Commission
PO Box 47866
Olympia, WA 98504-7866

OFFICE OF THE REGISTRAR

Timothy G. Carroll
REGISTRAR

Timothy G. Carroll
REGISTRAR

ROSALIND FRANKLIN UNIVERSITY

OF MEDICINE AND SCIENCE

on the recommendation of the Faculty of

The Chicago Medical School

the Board of Trustees has conferred the degree of

DOCTOR OF MEDICINE

upon

Geetha Narayani Fink

who has honorably fulfilled all the requirements for that degree.

Given in the city of North Chicago, Illinois,
this 4th day of June, 2010.

Ruth M. Rothstein
Chair, Board of Trustees

President

Dean

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, 400 Fuller Wiser Road, Suite 300, Euless, TX 76039-3856 --Telephone (817)868-4000

Recipient: **Date:** 04/20/2017

WASHINGTON MEDICAL QUALITY ASSURANCE COMMISSION

Examinee: cFink, Geetha Narayani **Examinee ID:** 51902278

Alt Name(s): Vivekaandamorthy, Geetha Narayani **Date of Birth:** 11/09/1983

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, the recommended minimum passing score ("MP") is shown in parentheses. Pass/fail outcomes are based upon the minimum passing level in place at the time of test administration and are not altered by subsequent revisions to the minimum passing level. Effective April 1, 2013, test results are reported on a three-digit scale only; two-digit scores reported for prior administrations will no longer be reported. Test results reported as passing represent an exam score of 75 or higher on a two-digit scoring scale.

USMLE STEP 1

Test Date	Pass/Fail	Total	MP	Comments
6/11/2007	Pass	203	(185)	

USMLE STEP 2

Clinical Knowledge (CK)

Test Date	Pass/Fail	Total	MP	Comments
8/27/2008	Pass	221	(184)	

Clinical Skills (CS)*

Test Date	Pass/Fail	Total	MP	Comments
1/20/2010	Pass			

USMLE STEP 3

Test Date	Pass/Fail	Total	MP	Comments
6/11/2012	Pass	215	(190)	

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

RE[illegible]D

APR 21 2017

MEDICAL COMMISSION

RECEIVED

MAY 01 2017

DEPARTMENT OF HEALTH
MEDICAL COMMISSION

MD

Health
Medical Quality Assurance Commission
P.O. Box 47866
Olympia, WA 98504-7866
360-236-2750

Postgraduate Training Program Director Verification and Evaluation of Training

To be completed by the applicant:

Facility name Harbor - UCLA Medical Center.

Address 1000 W. Carson St. Torrance CA 90509

I am applying for a license to practice medicine in the state of Washington and before my application can be reviewed, a verification and evaluation of the postgraduate training performed in your institution is required. I am authorizing the release of and would appreciate you providing the information and returning it, at your earliest convenience, **directly** to the address shown below. **All questions must be answered.**

Applicant Name (Print or type)	Birth date (mm/dd/yyyy)
Geetha Narayani Fink.	11/09/1953
Signature of applicant	

To be completed by the facility/agency/program:

1. GEETHA N. FINK (Applicant Name (Print or type)) is or was engaged in postgraduate training in our program LOS ANGELES COUNTY - HARBOR-UCLA MEDICAL CENTER GENERAL SURGERY
   from Beginning date (month/year) 06/2010 to Ending date (month/year) 06/2011
   in the field of GENERAL SURGERY
2. At the time this individual was in training, was this program accredited through the accreditation council for graduate medical education, the Royal College of Physicians and Surgeons, or the college of family Physicians of Canada? ☑ Yes ☐ No
   If no, does this program qualify the applicant to become board certified? ☐ Yes ☐ No
3. Was the participant ever placed on probation, restricted, suspended, terminated or requested to voluntarily resign his/her participation in the program? ☐ Yes ☑ No
   If yes, please explain _____
4. Did this applicant successfully complete this training program? ☑ Yes ☐ No
   ☐ In process OR ☐ expected date of completion _____

(SEAL)

Signature _____

Title PROGRAM DIRECTOR

Email rmmorrison@labiomed.org

Address 1000 WEST CARSON STREET, BOX 461

TORRANCE, CA 90509

Return to address listed above

Date 24 APRIL 2017 Phone (310) 222-2700

DOH 657-121 July 2016

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MAY 16 2017

MD

DEPARTMENT OF HEALTH
MEDICAL COMMISSION

Health
Medical Quality Assurance Commission
P.O. Box 47866
Olympia, WA 98504-7866
360-236-2750

Postgraduate Training Program Director Verification and Evaluation of Training

To be completed by the applicant:

Facility name Phoenix Integrated Residency in Obstetrics & Gynecology

Address 2601 E. Roosevelt St Phoenix, AZ 85008

I am applying for a license to practice medicine in the state of Washington and before my application can be reviewed, *a verification and evaluation of the postgraduate training performed in your institution is required. I am authorizing the* release of and would appreciate you providing the information and returning it, at your earliest convenience, **directly** to the address shown below. **All questions must be answered.**

Applicant Name (Print or type)	Birth date (mm/dd/yyyy)
Geetha Narayani Fink	11/09/1968
Signature of applicant	

To be completed by the facility/agency/program:

1. Geetha N. Fink, MD (Applicant Name (Print or type)) is or was engaged in postgraduate training in our program The Phoenix Integrated Residency in Ob/Gyn at Maricopa Medical Center & St. Joseph's Hospital and Medical Center

   from Beginning date (month/year) 6/16/2011 to Ending date (month/year) 6/30/2015

   in the field of Obstetrics and Gynecology

2. At the time this individual was in training, was this program accredited through the accreditation council for graduate medical education, the Royal College of Physicians and Surgeons, or the college of family Physicians of Canada? ☒ Yes ☐ No
   If no, does this program qualify the applicant to become board certified? ☐ Yes ☐ No

3. Was the participant ever placed on probation, restricted, suspended, terminated or requested to voluntarily resign his/her participation in the program? ☐ Yes ☒ No

   If yes, please explain ✓

4. Did this applicant successfully complete this training program? ☒ Yes ☐ No
   ☐ in program OR ☐ expected date of completion ✓

[redacted]

Signature Sabrina Duarte Sabrina Duarte

Title Program Coordinator

Email Sabrina_Duarte@dmgaz.org

Address Maricopa Medical Center - Dept Ob/Gyn , 2601 E. Roosevelt St., Phoenix, Az 85008

Return to address listed above

Date 4/24/2017 Phone 602-344-5084

DOH 657-121 July 2016

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MAY 31 2017

MD

DEPARTMENT OF HEALTH
MEDICAL COMMISSION

Health
Medical Quality Assurance Commission
P.O. Box 47866
Olympia, WA 98504-7866
360-236-2750

Postgraduate Training Program Director Verification and Evaluation of Training

To be completed by the applicant:

Facility name Icahn School of Medicine at Mount Sinai

Address 1176 5th Avenue, New York, NY 10029

I am applying for a license to practice medicine in the state of Washington and before my application can be reviewed, a verification and evaluation of the postgraduate training performed in your institution is required. I am authorizing the release of and would appreciate you providing the information and returning it, at your earliest convenience, directly to the address shown below. **All questions must be answered.**

Applicant Name (Print or type)	Birth date (mm/dd/yyyy)
Geetha Narayani Fink.	11/09/1983
Signature of applicant	

To be completed by the facility/agency/program:

1. Geetha Fink is or was engaged in postgraduate training in our
   Applicant Name (Print or type)
   program Fellowship in Family Planning at Icahn School of Medicine at Mount Sinai
   from Beginning date (month/year) 07/15 to Ending date (month/year) 06/17
   in the field of Family Planning
2. At the time this individual was in training, was this program accredited through the accreditation council for graduate medical education, the Royal College of Physicians and Surgeons, or the college of family Physicians of Canada? ☐ Yes ☒ No
   If no, does this program qualify the applicant to become board certified? ☐ Yes ☒ No
3. Was the participant ever placed on probation, restricted, suspended, terminated or requested to voluntarily resign his/her participation in the program? ☐ Yes ☒ No
   If yes, please explain _____
4. Did this applicant successfully complete this training program? ☒ Yes ☐ No
   ☐ in process OR ☒ expected date of completion 6/14/17

(SEAL)

Signature _____

Title Director, Fellowship in Family Planning

Email gillian.dean@mssm.edu

Address 1176 Fifth Ave, 9th Floor
NY NY 10029

Return to address listed above

Date 5/17/17 Phone 212-241-6703

DOH 657-121 July 2016

THE UNIVERSITY OF THE STATE OF NEW YORK
THE STATE EDUCATION DEPARTMENT
DIVISION OF PROFESSIONAL LICENSING SERVICES
89 WASHINGTON AVENUE
ALBANY, NEW YORK 12234

RECEIVED
MAY 19 2017
DEPARTMENT OF HEALTH
MEDICAL COMMISSION

WA

This is to certify that according to the records of the Division of Professional Licensing Services, New York State Education Department Albany, New York, FINK GEETHA NARAYANI was issued license/certificate number 279805 for the practice of MEDICINE on 05/15/2015

Our records also indicate the following information:
Date of birth: 11/09/1983
School attended: ROSALIND FRANKLIN UNIV
Date of graduation: 06/04/10
Degree earned: MD

Program was acceptable in accordance with the NYS Regulations of the Commissioner of Education. Requirements met at the time of licensure.

Basis of licensure:

DATE	FLEX1	NBME1	USML1	NBME2	FLEX2	USML2	NBME3	USML3	OTHER
06/12								0000P	OOSAZ
08/08						0000P			
06/07			0000P						

EXMS TAKEN=03

A license is valid during the life of the holder unless revoked, annulled or suspended by the Board of Regents. A licensee must register periodically with this Department to practice in this state.

Currently Registered: YES Reg period ends: 10/31/18
Address: 2703 42ND RD 10B
LONG ISLAND CITY NY 11101-0000
Disciplinary information: No charges have been preferred against this licensee
Comments:

I, Cathy Hanczaryk, Principal Clerk, Division of Professional Licensing Services of the New York State Education Department, do hereby state that as Principal Clerk of said Division, I have legal custody of the official records of the Division of Professional Licensing Services and to the best of my knowledge, the aforesaid information is true and correct.

Cathy Hanczaryk 05/10/17
Office Assistant Three

AMA Physician Profile

PREPARED FOR
Washington State Department of Health, Tumwater, WA

Name and Mailing Address

GEETHA NARAYANI FINK
APT 10B
2703 42ND RD
LONG IS CITY, NY 11101-4135

Birth date 11/09/1983

Primary Office Address

1176 5TH AVE
NEW YORK, NY 10029-6503

Phone UNKNOWN

Physician's major professional activity OFFICE BASED PRACTICE

Self-designated practice specialty OBSTETRICS & GYNECOLOGY (primary)
UNSPECIFIED (secondary)

Self-designated practice specialties (SDPS) listed on the AMA Physician Profile do not imply recognition or endorsement of any field of medical practice by the Association nor does it imply verification by a member board of the American Board of Medical Specialties (ABMS) or that the physician has been trained or has special competence to practice the SDPS.

AMA membership status NON MEMBER

All information from this point forward is provided by the primary source

Current and/or historical NPI information

National Provider Identifier (NPI)	Enumeration Date	Deactivation Date	Reactivation Date	Replacement Number	Last Reported Date
1982919437	08/09/2010	NOT RPTD	NOT RPTD	NOT RPTD	04/21/2017

Current and/or historical medical school

CHICAGO MEDICAL SCHOOL AT ROSALIND FRANKLIN UNIVERSITY-MEDICINE & SCIENCES

Degree Awarded: YES
Degree Year: 2010

AMA
AMERICAN MEDICAL ASSOCIATION

Current and/or historical post graduate medical training programs accredited by the Accreditation Council for Graduate Medical Education (ACGME)

Beginning with the 2010 cycle of the National GME Census, post-graduate training segments will include the name of the program attended in addition to the sponsoring institution. Program-level information prior to 2010 will not be available for reporting. Future training dates, as reported by the program, should be interpreted as "in progress" or "current" with the projected date of completion.

Beginning with the 2016/2017 cycle of the National GME Census post-graduate training segments will include a training type of specialty (residency) or subspecialty (fellowship). Training types for programs reported prior to 2016 will not include this designation.

Post-graduate training performed at accredited osteopathic institutions or in Canada are updated on the AMA Physician Masterfile only upon verification by the program. US licensing authorities accept graduate medical education from both entities as equivalent to training performed in a US program accredited by ACGME.

If a segment below is indicated as "being re-verified", it typically means that the physician is a current resident and the AMA is confirming with the residency program that the physician is still enrolled - this standard process occurs on an annual basis.

Sponsoring Institution:	MARICOPA MEDICAL CENTER
Sponsoring State:	ARIZONA
Program name:	PHOENIX INTEGRATED RESIDENCY PROGRAM ✓
Specialty:	OBSTETRICS & GYNECOLOGY
Training Type:	
Dates:	6/2011 - 6/2015 (Verified)

Specialty Board Certification

Specialty Board Certification(s) by one or more of the 24 boards recognized by the American Board of Medical Specialties (ABMS) and the American Medical Association (AMA) through the Liaison Committee on Specialty Boards, as reported by the ABMS:

The AMA Physician Profile has been designated by the ABMS as an Official ABMS Display Agent of Member Board Certification data. Therefore, the ABMS Board Certification information on the AMA Physician Profile is considered a designated equivalent source in regard to credentialing standards set forth by Joint Commission. The AMA is also an NCQA-approved source for verification of medical school, postgraduate medical training, ABMS Board certification, and Federal DEA registration.

Certifying board:	TO DATE, THERE HAVE BEEN NO BOARD CERTIFICATIONS REPORTED.
Certificate:	
Certificate type:	

Duration	Status	Effective Date	Expiration Date	Reverify Date	Occurrence	Last Reported	Participating in MOC

For certification dates, a default value of "01" appears in the day or month field if data were not provided to AMA. Please contact the appropriate specialty board directly for this information.

Current and/or historical medical licensure

Jurisdiction	MD / DO	Date Granted	Expiration Date	Status	License Type	Last Reported
New York	MD	06/18/2014	10/31/2018	ACTIVE	UNLIMITED	05/04/2017

Action Notifications

To date, there have been no actions reported to the AMA by any US state licensing agency.

To date, there have been no Medicare/Medicaid sanctions reported to the AMA by the Department of Health and Human Services.

To date, there have been no federal sanctions reported to the AMA by any branch of the US military, the Veteran's Administration or the US Department of Justice.

U.S. Drug Enforcement Administration (DEA)

DEA number	Schedule	Expiration Date	Last Reported Date	Address
XXXXXX267	22N 33N 4 5	09/30/2017	05/01/2017	1176 5th Ave New York, NY 10029-6503

Only the last three characters of active DEA numbers are displayed

Many states require their own controlled substances registration/license. Please check with your state licensing authority for requirement information as the AMA does not maintain this information.

ECFMG Certification

AMA
AMERICAN MEDICAL ASSOCIATION

Applicant Number:

The Educational Commission for Foreign Medical Graduates (ECFMG) applicant identification number does not imply current ECFMG certification status. To verify ECFMG status, contact the ECFMG Certification Verification Service online at https://cvsonline2.ecfmg.org/

Profile Information

The content of the AMA Physician Profile is intended to assist with credentialing. An organization's appropriate use of the data contained in the AMA Physician Masterfile meets selected primary source verification requirements of the Joint Commission, the Accreditation Association for Ambulatory Health Care (AAAHC) and the American Accreditation Health Care Commission(AAHCC)/Utilization Review Accreditation Commission (URAC). The AMA Physician Masterfile is also an NCQA-approved source for verification of medical school, post-graduate medical training, ABMS Board Certification and federal DEA registration.

If any of the data in this Profile is believed to be incorrect, please log in to your account on our profiles website, go to the profile manager tab, find the provider for whom you think we have inaccurate information and click on the "Report" button in the "Report a Discrepancy" column. Enter any of the information that you feel needs to be researched. The AMA will contact the primary source of the data to determine which data is correct. We will notify you of the outcome of our research. If any changes are made to the profile we will update the link in profile manager for this provider so that you can access the new, updated information.

If you have any questions or need additional information about the AMA Physician Profile Service, please call (800) 665-2882.

PDC PHYSICIAN DATA CENTER

Federation of STATE MEDICAL BOARDS

PRACTITIONER PROFILE

Prepared for:	Washington Medical Quality Assurance *Commission*	As of Date:5/12/2017

PRACTITIONER INFORMATION

Name:	Geetha Narayani Fink
Alternate Name(s):	Geetha Narayani Vivekaandamorthy
DOB:	11/9/1983
Medical School:	Rosalind Franklin University of Medicine and Science North Chicago, Illinois, UNITED STATES
Year of Grad:	2010
Degree Type:	MD

BOARD ACTIONS

To date, there have been no actions reported to the FSMB

LICENSE HISTORY

Jurisdiction	License Number	Issue Date	Expiration Date	Last Updated
NEW YORK	279805	5/15/2015	10/31/2018	5/10/2017

400 FULLER WISER ROAD EULESS, TX 76039 | TEL(817)868 4000 | FAX (817)868 4099

PRACTITIONER PROFILE

Prepared for: Washington Medical Quality Assurance Commission

As of Date:5/12/2017

Practitioner Name: Geetha Narayani Fink

ABMS® CERTIFICATION HISTORY

No ABMS Certifications found.

400 FULLER WISER ROAD EULESS, TX 76039 | TEL(817)868 4000 | FAX (817)868 4099

Nimon, Lori (DOH)

From: Nimon, Lori (DOH)
Sent: Tuesday, May 23, 2017 8:54 AM
To: 'geetha.fink@gmail.com'
Subject: Pending MD License 60760977

May 23, 2017

Dear Dr. Fink,

This is to acknowledge receipt of your fees and application for your physician and Surgeon licensure in the state of Washington. At this time these are the items we still need before we can fully review your application file.

MISSING ITEMS

Need Post Grad training verification from Icahn 7/15-6/17
Need fingerprints packet we mailed on 5/5/2017

You can email me at anytime for a current status update on your application file.

*If you are using the FCVS packet with the Federation of State Medical Boards (FSMB) you will need to contact FSMB to determine when this packet will be released to us. The FCVS packet will verify medical school transcripts, exam scores, and postgraduate training.

Please note: while this information was contained in the application packet you had been sent and is stipulated in Washington Administrative Code (WAC) 246-12-020(3), let me reiterate that upon approval, your initial license will be issued *only* to your next birthday after the approval date – unless your birthday falls within 90 days of approval, in which case it will expire on your second birthday following approval.

If you have any further questions or need additional information, email me at lori.nimon@doh.wa.gov, or write to me at the address listed below.

Lori Nimon
Health Services Consultant 1
Medical Quality Assurance Commission
PO Box 47866
Olympia, WA. 98504
lori.nimon@doh.wa.gov
(360) 236-2765 ☎
(360) 236-2795 🖷

"Promoting Patient Safety and Enhancing the Integrity of the Profession through licensing, discipline, rule-making, and education."

Case File_1306374_pdf-r.pdf redacted on: 1/9/2020 14:16

Redaction Summary (3 redactions)

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2 Privilege / Exemption reasons used:

1 -- "DOH Licensee Health Professional Home Address and/or Home Phone Number - RCW 42.56.350(2)" (2 instances)
2 -- "DOH Licensee Social Security Number - RCW 42.56.350(1)" (1 instance)

Redacted pages:

Page 4, DOH Licensee Health Professional Home Address and/or Home Phone Number - RCW 42.56.350(2), 2 instances
Page 4, DOH Licensee Social Security Number - RCW 42.56.350(1), 1 instance