Emily Cohen, MD

Licensed Physician #MD2017-0104

Issue Date	Expiration Date
03/03/2017	07/01/2019

Signature of Holder

The bearer is prohibited by law from using this identification card to give the impression that they are in any way connected with a governmental agency

New Mexico Medical Board

Triennial Renewal Certificate

This is to certify that

Emily Cohen, MD

License Number: MD2017-0104

Having complied with the provisions of the Medical Practice Act is hereby granted a license to practice in the State of New Mexico as a Physician.

Issue Date: 03/03/2017 Date Expires: 07/01/2019*

**A New Mexico medical license that has not been renewed by July 1 of the renewal year will remain temporarily active with respect to medical practice until September 30 of the renewal year at which time, the status will be changed to lapsed. A lapsed license is not valid for practice in New Mexico.*

This License Must Be Conspicuously Posted In Each Practice Location

MEMO

ELISHIA LUCERO
NM MEDICAL BOARD
ELISHIAF.LUCERO@STATE.NM.US
(505) 476-7227
FAX (505) 476-7233

To: Finance Department
Date: January 19, 2017
RE: Licensure Application Fee Refund for Emily Cohen, MD

In collaboration with Governor Richardson's goal to attract more physicians to New Mexico, beginning July 1, 2008 the New Mexico Medical Board began waiving the $400.00 licensure application fee for applicants who choose NM as their first state of licensure. The authority to waive the fee passed the 2008 Legislature, and was signed by Governor Richardson pursuant to Senate Bill 127.

On January 17, 2017 we received and deposited Dr. Cohen's licensure application fee of $400.00 via credit card(paypal). This is Dr. Cohen's first state of licensure and therefore qualifies for the waiver. We are requesting a $400.00 refund to Dr. Cohen.

Thank you for your help with this request.

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RECEIVED
JAN 17 2017
NM MEDICAL BOARD

The New Mexico Physician and Practitioner Credentials Application ©

Physician (MD) Application

THE NEW MEXICO MEDICAL SOCIETY

Date of Application: January 14, 2017 R#1915048

Application Fee: $400.00
TOTAL: $400.00

Name: Emily Cohen Elam FCVS 1st Quem
Maiden or Other Names Used

Will you be applying by endorsement? ☐ Yes ☑ No Applying using: ☐ NMMB ☐ HSC ☑ FCVS

What are your NM practice plans? Primary Care provider

Gender: Female Citizenship: United States Place of Birth:
Social Security Number: [redacted] Date of Birth: [redacted]1984
State Tax ID#: ☐ Pending Fed. Tax ID#: ☐ Pending
Medicare #: ☐ Pending Medicaid #: ☐ Pending
Unique Physician Identification Number (UPIN): ☐ Pending
National Provider Identifier Number (NPI): [redacted] ☐ Applied
CLIA Number (if applicable): Approval Level: Expiration Date:

Home address

Street Address: [redacted]
City, State/Province and Zipcode: Albuquerque NM 87104
Country: United States
Telephone Number: [redacted] Pager Number:
Cell Phone Number: Spouse's Name (Optional):

Credentials Correspondence Address

Department:
Street Address: [redacted]
City, State/Province and Zipcode: Albuquerque NM 87104
Country: United States Email: [redacted].unm.edu
Telephone Number: [redacted] Facsimile Number:

Military Service

Branch: Type of Discharge:
Dates: From: To: ☐ Current Rank:

Immigration

Status: Certification Number:

ECFMG (Educational Commission for Foreign Medical Graduates)

Number (if applicable): Date Issued: (Please attach a copy of your ECFMG certificate)

Languages

Foreign Languages (spoken fluently by practitioner):

Certifications

ACLS CERTIFICATION
Certified? ☐ Yes ☑ No
Expires:

ATLS CERTIFICATION
Certified? ☐ Yes ☑ No
Expires:

PALS CERTIFICATION
Certified? ☐ Yes ☑ No
Expires:

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The New Mexico Physician and Practitioner Credentials Application ©

Physician (MD) Application

THE NEW MEXICO MEDICAL SOCIETY

HOSPITAL AND HEALTHCARE AFFILIATIONS

☐ Are you a PCP? ☐ Do you deliver babies? ☐ Are you an MD, DO, or DPM

If you answered yes to any question above, you must:

(a) Have admitting privileges at a hospital (list below) OR
(b) Provide a written explanation as to the arrangements you have made with a physician to admit your patients, along with a signed letter from that physician confirming the arrangements, and the name of the facility where your patients will be admitted.

☐ Do you have courtesy or consulting privileges at this facility.

☐ If yes, do these courtesy or consulting privileges allow you to admit patients.

If no, provide a written explanation as to the arrangements you have made with a physician to admit your patients, along with a signed letter from that physician confirming the arrangements, and the name of the facility where your patients will be admitted.

Please list all hospital staff membership and/or healthcare organization affiliations in the past fifteen (15) years, and your status (active, courtesy, consulting, etc.) If an institution is no longer in existence, please provide an alternative cource of verification. Attach a separate page if necessary.

Facility Name: _____ ☐ Is this your primary admitting facility

Department: _____

Street Address: _____

City: _____ State/Province: _____ Zip Code: _____

Country: _____

Phone Number: _____ Facsimile: _____

Appointment Dates From: _____ To: _____ ☐ Present

Type of Appointment: _____ Privileges Assigned: _____

WORK HISTORY

Please list all previous experience for the past fifteen (15) years, including months and years, listing the most recent first. Attach a separate page if necessary. Please attach a current CV or resume.

Organization: _____ From: _____ To: _____

Department: _____ ☐ Present

Street Address: _____

City: _____ State/Province: _____ Zip Code: _____

Country: _____ Phone Number: _____

Contact: _____ Fax Number: _____

Type of Practice: _____

Please provide written explanation for any gaps in work history of six (6) months or more.

PRACTICE LOCATIONS

Group Name: _____ Effective Date: _____

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Physician (MD) Application

THE NEW MEXICO MEDICAL SOCIETY

Department:

Street Address:

City: State/Province: Zip Code:

Country:

Phone Number: Facsimile Number:

Email Address: Answering Service Number:

Foreign Languages (spoken fluently at practice):

Office Manager or Contact Person: Phone:

Billing Address

Contact Person: Tax ID #:

Department:

Street Address:

City: State/Province: Zip Code:

Country:

Phone Number: Facsimile Number:

Practice Associates (if applicable): **Call Coverage (if applicable)**

/

/

/

What are the office hours for your Practice or Group Practice? (Provide days/hours):

What provisions have been made for after hours?:

CONTINUING EDUCATION

1. If you are applying for privileges at a hospital or clinic, please send documentation of all continuing education hours you have obtained in the last two (2) years or complete and send the statement of continuing medical education.

2. If you are applying for privileges at a hospital or clinic, please complete and send the privilege request form and ensure that you include any additional privileges that you are requesting. This will ensure your application is considered based upon the most accurate information available.

PROFESSIONAL REFERENCES

Please list five (5) professional peers with the same type of license, or a higher level of licensure, who are familiar with your professional performance in the past three (3) years.

Name and Title: Specialty:

Department: Email:

Street Address:

City: State/Province: Zip Code:

Country:

Phone Number: Facsimile Number:

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Physician (MD) Application

THE NEW MEXICO MEDICAL SOCIETY

LICENSURE REGISTRATION INFORMATION

List all licenses held in all jurisdictions. Attach a separate page if necessary.

State Professional License/Certification Number: _____ ☐ Pending

State: _____ Issue Date: _____ Expiration Date: _____

LICENSING EXAM

Please check all that apply:

☐ State Board Exam (Prior to 1973) Which State? UN Date(s) passed? _____ MM/YY

☐ FLEX
Part/Step 1 Date Passed _____ MM/YY

☐ LMCC
Part/Step 1 Date Passed _____ MM/YY

EXAM

☐ National Board (NBME)
Part/Step 1 Date Passed _____ MM/YY Part/Step 2 Date Passed _____ MM/YY Part/Step 3 Date Passed _____ MM/YY

☐ USMLE
Part/Step 1 Date Passed _____ MM/YY Part/Step 2 Date Passed _____ MM/YY Part/Step 3 Date Passed _____ MM/YY

DRUG CERTIFICATION INFORMATION

Federal Drug Enforcement Administration (DEA) Registration: ☑ N/A

DEA Number: _____ Expiration Date: _____ ☐ Pending

State Controlled Substance Registration (CSR): ☑ N/A

CSR Number: _____ Expiration Date: _____ State: _____ ☐ Pending

EDUCATION

List all medical, osteopathic, dental or podiatric schools attended for graduate education and list all hospitals where you received training for post-graduate training. Attach a copy of your certificate. Disclose every residency program initiated, whether completed or not, and all completed programs. Attach a separate page if necessary. Check the type of education listed.

Degree Level: _____

Institution: _____ Dates Attended:

Department: _____ From: _____

Street Address: _____ To: _____

City: _____ State/Province: _____ Zip Code: _____

Country: _____ Graduation Date: _____

Degree Earned: _____ or Specialty: _____

If teaching appointment: Department/Position: _____

SPECIALTY BOARD CERTIFICATIONS

If you are not Board certified by a Board recognized by the American Board of Medical Specialties, the American Osteopathic Association, the National Commission on Certification of Physician Assistants, the American Nurses' Credentialing Center, or the National Certification Commission, or accepted by examination in your specialty, please give a brief explanation on an attached sheet. Explain any gaps or delays in achieving Board certification by the recognized Board in your specialty area.

☐ Board or ☐ Specialty Board Name: _____

Date Certified: _____ Date Last Recertified: _____ Expiration Date: _____ ☐ Lifetime

Certification Number: _____ Accepted for Examination? ☐ Yes ☐ No

If not accepted, have you made application? ☐ Yes ☐ No ☐ N/A If no, provide an explanation: _____

MEDICAL MALPRACTICE INSURANCE

Do you have current medical malpractice insurance? ☐ Yes ☐ No

Please list medical malpractice insurance carriers for the past five (5) years. Attach a separate page if necessary.

Carrier: _____ Limits: _____ _____

Department: _____

Address: _____ ☐ Pending

City: _____ State/Province: _____ Zip Code: _____

Country: _____

Dates Insured: From: _____ To: _____ Policy Number: _____

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Physician (MD) Application

THE NEW MEXICO MEDICAL SOCIETY

PROFESSIONAL PRACTICE QUESTIONS

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Please answer all of the following Yes or No questions. If you answer YES to any question, you must give details including name, address, and telephone number of significant parties on a separate sheet of paper. You must respond to each question.

1	Has your professional liability coverage ever been terminated by action of the insurance company (except as a result of the company ceasing to offer insurance coverage to physicians or other practitioners)?	☐ Yes ☑ No
2	Have you ever been denied professional liability insurance coverage?	☐ Yes ☑ No
3	Has your professional liability carrier ever excluded any specific procedures from your coverage?	☐ Yes ☑ No
4	Have you ever been denied membership or renewal thereof, or been subject to disciplinary action in any professional organization?	☐ Yes ☑ No
5	Have you ever been excluded from or sanctioned by Medicare and/or Medicaid?	☐ Yes ☑ No
6	Have you ever been arrested? If so explain the circumstance, regardless of the outcome (i.e. expunged, dismissed, sealed, vacated).	☐ Yes ☑ No
7	Have you ever been named as a defendant in any criminal proceedings?	☐ Yes ☑ No
8	Have you ever been subject to investigation by a governmental entity or Board that either could have resulted, or did result, in licensure sanctions or other adverse actions, irrespective of the outcome?	☐ Yes ☑ No
9	Have you ever been named in any formal requests for corrective actions filed by any healthcare entity where you have had an appointment (a request which could result in either formal or informal proceedings)?	☐ Yes ☑ No
10a	Have your privileges at any healthcare entity ever been voluntarily or involuntarily suspended, restricted, diminished, revoked, surrendered, or not renewed, for any reason, except for medical records delinquency unrelated to your professional competence or conduct?	☐ Yes ☑ No
10b	Have you ever agreed not to exercise your clinical privileges while under investigation?	☐ Yes ☑ No
10c	Have you ever been investigated and/or terminated by a healthcare entity for cause, or without cause, related to your clinical competence or conduct, which could impact patient safety/care, or allowed to resign in lieu of termination for such reason?	☐ Yes ☑ No
11	Have you ever resigned from a healthcare entity to avoid modification, suspension, or termination of privileges, or while under investigation?	☐ Yes ☑ No
12a	Has your application for licensure or license to practice in any jurisdiction ever been investigated, voluntarily or involuntarily limited, suspended, revoked, surrendered or denied?	☐ Yes ☑ No
12b	Are any currently held licenses pending investigation or being challenged?	☐ Yes ☑ No
13	Have you ever been notified to appear before any licensing agency for a hearing or complaint of any nature?	☐ Yes ☑ No
14	Has your federal or state narcotics registration certificate in any jurisdiction ever been investigated, or voluntarily or involuntarily limited, suspended, revoked, or restricted?	☐ Yes ☑ No
15	Have you ever been involved in a settlement, medical malpractice claim or suit, or have you ever received written notice of intent to file such a suit? If yes, please provide the following information for each claim or suit. Please list on a separate sheet of paper for each case: Name, age, sex of patient/claimant, Date(s) and type of treatment and/or surgery that led to the allegations against you, Nature of allegations in claims/suits. Specify whether a suit was ever filed, Names of other practitioners and hospital, if any, involved in claims or suit, Disposition or current status of claim or suit (be specific), Name of insurance carrier defending you.	☐ Yes ☑ No
16	Have you ever been reported to the National Practitioner Data Bank?	☐ Yes ☑ No

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THE NEW MEXICO MEDICAL SOCIETY

Physician (MD) Application

17a	Are you now, or were you in the past, addicted to, abusive of, or in treatment for abuse of any controlled substances, habit-forming drugs, illegal drugs, prescription medication or alcohol?	[redacted] No
17b	Are you being treated with opiates for chronic pain? If yes, please provide to the Board upon application a current evaluation from your treating pain provider (MD or DO)	[redacted] No
18	In the five (5) years prior to this application, have you had any physical injury or disease, or mental illness or impairment, which you are currently under treatment for or could reasonably be expected to affect your on-going ability to practice medicine safely and competently? If yes, please have your treating physician send the NM Medical Board a letter regarding your diagnosis and treatment.	[redacted] No
19a	Have you ever, for any reason, resigned from a medical school or postgraduate training (PGT) program?	☐ Yes ☑ No
19b	Have you ever, for any reason, withdrawn from a medical school or postgraduate training (PGT) program?	☐ Yes ☑ No
19c	Have you ever, for any reason, been suspended, dismissed, or expelled from a medical school or postgraduate training (PGT) program?	☐ Yes ☑ No
19d	Have you ever, for any reason, been placed on probation or remediation, including academic probation or remediation, by a medical school or postgraduate training (PGT) program?	☐ Yes ☑ No
19e	Have you ever, for any reason, taken a leave of absence or break from, or had any interruptions or extensions in, a medical school or postgraduate training (PGT) program for any personal or professional reason (including illness or disability, pregnancy or maternity, any academic issues, etc)?	☑ Yes ☐ No
	1. Voluntary medical school-approved leave of absence for 1 year to pursue professional interests relevant to medical practice2. 2 weeks maternity leave during residency	
20	I attest that I will limit my practice to areas in which I am competent to practice.	☑ Yes ☐ No
21	Are you currently in arrears for payments of amounts required to be paid pursuant to an outstanding judgment and order for child support in New Mexico or in any other state?	☐ Yes ☑ No

Uniform Application for Physician Licensure

Application ID: 220332
FID: [redacted]

Submitted to: New Mexico Medical Board
Submission Date: 12/04/2016

Practitioner Name

Cohen, Emily

Contact Information

Address

Public Access	Board Contact	Type	Address
No	Yes	Home	[redacted]
Yes	No	Business	MSC 09 5040 University of New Mexico Albuquerque, NM 87131 UNITED STATES

Phone

Public Access	Board Contact	Type	Phone Number	Phone Extension
Yes	No	Business	(505) 272-6607	
No	Yes	Mobile	[redacted]	

Email

Public Access	Board Contact	Email
No	Yes	[redacted]@gmail.com
Yes	No	eacohen@salud.unm.edu

Identification

USMLE Number	SSN	Birth Date	Birth Place	Gender	NPI	Practitioner Type	US Citizen
08168700	[redacted]	[redacted]1984	Wilmington, DE UNITED STATES	F	[redacted]	MD	Yes

Medical School

Medical School Name	Address	Start Date	End Date	Graduation Date	Degree Code
Ben-Gurion University of The Negev	PO Box 653 Beer Sheva, D 84105 ISRAEL	07/21/2009	05/21/2014	05/21/2014	MD

Fifth Pathway

None Reported

ECFMG

Certificate Number	Issue Date
08168700	05/21/2014

Postgraduate Training

Hospital Name:	**University of New Mexico** Albuquerque, NM UNITED STATES	**Program Code:**	ACGME 1203421197
		Attendance Dates:	
Institution:	University of New Mexico	**Start Date:**	06/21/2014
Training Speciality Area:	Family Medicine	**End Date:**	07/08/2017
Training Specialty:	Family Medicine	**Program Type:**	Residency
Training Status:	Active		

Examination History

Exam	State	Last Attempt	Pass/Fail	Number Of Attempts
USMLE Step 1 Examination		08/01/2011	Pass	1
USMLE Step 2 CK Examination		08/29/2012	Pass	1
USMLE Step 2 CS Examination		11/02/2013	Pass	1
USMLE Step 3 Examination		11/09/2015	Pass	1

State Licensure History

MD, DO, PA License History

License Entity	Licensing State	License Number	Issue Date	Expiration Date	License Type	License Status
New Mexico Medical Board	NM	RS2014-0348	06/19/2014	07/01/2017	Training	Active (Current, Valid)

Physician Reported License History

Practitioner License Type	Licensing State	License Number	Issue Date	Expiration Date	Type	License Status
None Reported						

Chronology of Activity Type

Practice/Emp/ Desc:	**University of New Mexico**	**Chronology Type:**	Accredited Training
	Address: Albuquerque, NM US	**Attendance Dates:**	
	Position/Dept:	**Start Date:**	06/21/2014
		End Date:	07/08/2017
	Clinical %:		
	Admin %:		
	Employment: **Staff Privileges:**	**Affiliation:**	

Practice/Emp/ Desc:	**Ben-Gurion University of The Negev**	**Chronology Type:**	Medical Education
	Address: Beer Sheva, D IL	**Attendance Dates:**	
	Position/Dept:	**Start Date:**	07/21/2009
		End Date:	05/21/2014
	Clinical %:		
	Admin %:		
	Employment: **Staff Privileges:**	**Affiliation:**	

Malpractice

None Reported

PDC PHYSICIAN DATA CENTER

Federation of STATE MEDICAL BOARDS

PRACTITIONER PROFILE

Prepared for:	Uniform Application for Physician State Licensure	As of Date:10/26/2016

PRACTITIONER INFORMATION

Name:	Emily Anne Cohen
DOB:	[redacted]1984
Medical School:	Ben-Gurion University of The Negev Beer Sheva, HaDarom, ISRAEL
Year of Grad:	
Degree Type:	MD
NPI:	[redacted]

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 MEXICO	RS2014-0348	6/19/2014	7/1/2017	9/28/2016

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

PDC PHYSICIAN DATA CENTER

Federation of STATE MEDICAL BOARDS

PRACTITIONER PROFILE

Prepared for:	Uniform Application for Physician State Licensure	As of Date:10/26/2016
Practitioner Name:	Emily Anne Cohen	

ABMS® CERTIFICATION HISTORY

No ABMS Certifications found.

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

AMA Physician Profile

PREPARED FOR

New Mexico Medical Board, Santa Fe, NM

Name and Mailing Address

EMILY ANNE COHEN

[redacted]

Birth date [redacted]1984

Primary Office Address

Phone UNKNOWN

Physician's major professional activity HOSPITAL BASED RESIDENTS - ALL YEARS

AMA membership status NON MEMBER

Specialty

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
None Reported					

Current and/or historical medical school

BEN-GURION UNIVERSITY OF THE NEGEV FACULTY OF HEALTH SCIENCES

Degree Awarded: YES
Degree Year: 2014

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.

AMA
AMERICAN MEDICAL ASSOCIATION

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:	UNIVERSITY OF NEW MEXICO SCHOOL OF MEDICINE
Sponsoring State:	NEW MEXICO
Program name:	UNIVERSITY OF NEW MEXICO PROGRAM
Specialty:	FAMILY MEDICINE
Training Type:	SPECIALTY
Dates:	6/2014 - 6/2017 (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	Effective Date	Expiration Date	Reverification Date	Occurrence	Last Reported Date

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. (**) Indicates an expired certificate.

Current and/or historical medical licensure

Jurisdiction	MD / DO	Date Granted	Expiration Date	Status	License Type	Last Reported
New Mexico	MD	06/19/2014	07/01/2017	ACTIVE	RESIDENT	01/10/2017

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
None Reported				

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 Certfication

Applicant Number: 08168700

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

AMA
AMERICAN MEDICAL ASSOCIATION

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:	New Mexico Medical Board	As of Date:1/18/2017

PRACTITIONER INFORMATION

Name:	Emily Anne Cohen
DOB:	[redacted]1984
Medical School:	Ben-Gurion University of The Negev Beer Sheva, HaDarom, ISRAEL
Year of Grad:	2014
Degree Type:	MD
NPI:	1023437449

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 MEXICO	RS2014-0348	6/19/2014	7/1/2017	1/9/2017

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PDC PHYSICIAN DATA CENTER

Federation of STATE MEDICAL BOARDS

PRACTITIONER PROFILE

Prepared for:	New Mexico Medical Board	As of Date:1/18/2017
Practitioner Name:	Emily Anne Cohen	

ABMS® CERTIFICATION HISTORY

No ABMS Certifications found.

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

New Mexico Medical Board
2055 S. Pacheco St. Bldg. 400
Santa Fe, NM 87505 (505) 476-7220

APPLICANT'S OATH

I, Emily Cohen, **hereby certify that I am the person pictured below and named in this application for a license to practice as a Physician in the State of New Mexico; that all statements I have made herein are true; that I am the original and lawful possessor and person named in the various forms and credentials furnished to the New Mexico Medical Board (Board) with my application.**

I acknowledge and state that I have read the Information and Instructions that accompanied this application and I have answered all questions truthfully. I understand that the fee I submitted is not refundable.

I authorize and request every person, hospital, clinic, community, governmental agency, court, association, institution or other organization having control of any documents, records, and other information pertaining to me, to furnish to the Board any such information, including documents, records regarding charges or complaints filed against me, formal or informal, pending or closed, or any other pertinent data and to permit the Board or their agents or representatives to inspect and make copies of such documents, records and other information, in connection with this application.

I hereby release, discharge, and exonerate the Board, and their agents or representatives, and any person furnishing information, from any and all liability of every nature and kind arising out of the furnishing or inspection of such documents, records, other information, or the investigation made by the Board. I authorize the Board to release information, material, documents, orders, or the like relating to me or to this application to any other agency of the State of New Mexico or the appropriate licensing agency of any other state or Territory of the United States or any agency of the United States government.

Applicant Signature — Date: 1/14/17

*Passport-quality color photograph taken within six months prior to filing the application, approximate size 2 x 2 inches, head and shoulders only, full face, front view, plain white or off-white background, standard photo stock paper, scanned or computer-generated photographs should have no visible pixels or dots.

Applicant Name Emily Cohen **Date** 1/14/17

New Mexico Medical Board
2055 S. Pacheco, Building 400
Santa Fe, NM 87505
505-476-7220 fax 505-476-7237
(toll free within New Mexico 800-945-5845)

General Information

Licensee	Emily Cohen	License Type	Resident
Business address	MSC11 6093	License Number	RS2014-0348
Business address	1 UNM	License Status	Active
Business city state zip	Albuquerque NM 87131	License Date	06/19/2014
Business phone	None	**License Expires	07/01/2017

* The Board does not verify current specialties. For more information please see the American Board of Medical Specialties website at: www.abms.org to determine if the physician has earned a specialty certification from this private agency.

** A New Mexico medical license that has not been renewed by July 1 of the renewal year will remain temporarily active with respect to medical practice until September 30 of the renewal year at which time, the status will be changed to lapsed.A lapsed license is not valid for practice in New Mexico.

PUBLIC ACTIONS:None
(while licensed in New Mexico)
New Search

This Board's data has been searched 2413623 times since 05/08/2001
Date information last updated 01/18/17

Please read the AIM **Disclaimer**

FCVS FEDERATION CREDENTIALS VERIFICATION SERVICE

Rcvd 01/9/2017

Medical Professional Information Profile

This report provides credentialing information for:

Name:	**Cohen, Emily Anne**
Social Security Number:	**XXX-XX-4424**
Date of Birth:	[redacted] **1984**
FID#:	**217440767**
Recipient:	**NM - New Mexico Medical Board**
Delivery Date:	**12/28/2016**

ABOUT THIS PROFILE

The Federation Credentials Verification Service (FCVS) was retained by the above referenced medical professional to verify his/her medical credentials 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 made 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 maintains all original documents (excluding third-party examination transcripts) in the physician's source file.

FCVS FEDERATION CREDENTIALS VERIFICATION SERVICE

Affidavit and Release

Federation of STATE MEDICAL BOARDS

I, the undersigned, 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 furnished 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 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 me being prosecuted under appropriate federal and state laws.

I 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 any such information, including documents, records regarding charges or complaints filed against me, formal or informal, pending or closed, or any other pertinent data and to permit the Federation Credentials Verification Service or any of its agents or representatives to inspect and make copies of such documents, records, and other information in connection with this application.

Notary:
Your seal (or stamp) must be partly upon the photo and partly upon the signature of the applicant.

I hereby release, discharge and exonerate the Federation Credentials Verification Service, its agents or representatives and any person furnishing information, of any and all liability of every nature and kind arising out of investigation made by the Federation Credentials Verification Service. I authorize the Federation Credentials Verification Service to release information, material, documents, orders or the like relating to me or this application to any entity at my request.

Applicant's Signature (must be signed in the presence of a notary)

Cohen
Applicant's Printed Last Name

Emily A.
Applicant's Printed First Name, Middle Initial, and Suffix (e.g., Jr.)

11/7/16
Date of Signature (must correspond to date of notarization)

State of New Mexico, County of Bernalillo

I certify that on the date set forth below the individual named above did appear personally before me and that I did identify this applicant by: (a) comparing his/her physical appearance with the photograph on the identifying document presented by the applicant and with the photograph affixed hereto, and (b) comparing the applicant's signature made in my presence on this form with the signature on his/her identifying document. The statements on this document are subscribed and sworn to before me by the applicant on this 7th day of November, 2016.

Notary Public Signature: Gabriela Melendez

My Notary Commission Expires: September 21st 2020

OFFICIAL SEAL
GABRIELA MELENDEZ
NOTARY PUBLIC - STATE OF NEW MEXICO
My commission expires 9/21/20

Please complete and mail this original document to the Federation of State Medical Boards at:

400 FULLER WISER ROAD | EULESS, TX 76039 | TEL(817)868-3000

FCVS ID Number
FCVS

FID Number
217440767

217 440 767

FCVS FEDERATION CREDENTIALS VERIFICATION SERVICE

Identity

Federation of STATE MEDICAL BOARDS

Biographic Information

Medical professional Name(s): **Cohen, Emily Anne**

Date of Birth: [redacted]1984

Place of Birth: Wilmington, DE, UNITED STATES

Contact Information

Business Address: MSC 09 5040
University of New Mexico
Albuquerque, NM 87131
UNITED STATES

Home Address: [redacted]

Mobile Phone: [redacted]

Business Phone: (505) 272-6607

Email: [redacted]@gmail.com

Email: eacohen@salud.unm.edu

Credentials Analysis Information for Identity

There is no Omission/Discrepancy/Miscellaneous information identified.

CERTIFICATION OF IDENTIFICATION

Certification by Notary Public Is Required

Applicant Full Legal Name: Cohen (Last) Emily (First) Anne (Middle)

FCVS ID Number: FCVS

Notary – Please complete the section below:

State of New Mexico County of Bernalillo

I certify that on the date set forth below, the individual named above, did appear personally before me and presented one of the following forms of identification as proof of his/her identity (Birth Certificate or Valid Passport). I further certify that I did identify this applicant by comparing his/her physical appearance with the photograph on a Government issued photo identification presented by the applicant.

The statements on this document are subscribed and sworn to before me by the applicant on this (Day) 7th, of (Month) November, (Year) 2016.

Notary Public Signature: [signature]

Commission Expiration Date* (Month) September (Day) 21st (Year) 2020

*** The notary's commission expiration date must be current and legible. If no expiration date, such as 'lifetime', an explanation must be provided. If you are in California, the notary may attach a California All-Purpose Acknowledgement form to this document.**

Notary Stamp Here

OFFICIAL SEAL
GABRIELA MELENDEZ
NOTARY PUBLIC - STATE OF NEW MEXICO
My commission expires 9/21/20

Please complete and mail this original document and a photocopy of the birth certificate or passport presented to the Notary to:

Federation of State Medical Boards
ATTN: FCVS
400 Fuller Wiser Rd
Euless, TX 76039-3856

FCVS ID Number
FCVS

HID Number
217440767

217 440 767

ND

FCVS FEDERATION CREDENTIALS VERIFICATION SERVICE

Chronology of Activities

Federation of STATE MEDICAL BOARDS

The Chronology of Activities is a comprehensive report of a medical professional's activities as reported to FCVS in the medical professional application.

Start Date	End Date	Activity Type	Location
07/21/2009	05/21/2014	Medical Education	Ben-Gurion University of The Negev Beer Sheva HaDarom ISRAEL
06/21/2014	07/08/2017	Postgraduate Training	University of New Mexico Albuquerque New Mexico UNITED STATES

End of Chronology of Activities report for: Cohen, Emily Anne

FCVS FEDERATION CREDENTIALS VERIFICATION SERVICE

Medical Education

Federation of STATE MEDICAL BOARDS

Medical Education

Medical School: **Ben-Gurion University of The Negev**

Location: Beer Sheva, D

ISRAEL

Credentials Analysis Information for Medical Education

There is no Omission/Discrepancy/Miscellaneous information identified.

ECFMG ® EDUCATIONAL COMMISSION FOR FOREIGN MEDICAL GRADUATES

3624 Market Street
Philadelphia PA 19104-2685
215-386-5900 | 215-386-6327
www.ecfmg.org

VERIFICATION OF MEDICAL EDUCATION

INSTRUCTIONS TO THE DEAN

The individual identified on the attached *Medical School Release Request*, *Certification of Identification Form*, or *Certification Statement* has authorized your medical school to provide to the Educational Commission for Foreign Medical Graduates (ECFMG) any and all information pertaining to his/her education at your institution. Please complete this VERIFICATION OF MEDICAL EDUCATION form and return it to ECFMG with the attached medical diploma and a final medical school transcript in the enclosed, addressed envelope.

RE: Emily Anne Cohen
0-816-870-0
Ben-Gurion University of the Negev Faculty of Health Sciences
POB 653
Beer Sheva 84105
ISRAEL

Please notify ECFMG if the name of your institution has changed or is different from the name displayed.

SECTION 1: MEDICAL SCHOOL TRANSCRIPT

Attach an official medical school transcript in the original language that displays course grades or marks, not just hours, to this Verification of Medical Education form and return to ECFMG -- Affix your official stamp to the transcript -- Non-English language transcripts must include a word-for-word English language translation prepared by a recognized translator -- An official English language version medical school transcript is also acceptable -- Transcripts returned to ECFMG under separate cover must include the individual's ECFMG Identification Number to prevent processing delays.

SECTION 2A: CERTIFICATION

By my signature below, I certify: (1) the information provided on this form is an accurate account of the above named individual's official records maintained in this medical school and is true and correct to my knowledge, and, (2) that I am authorized to certify this on behalf of this institution as reported to ECFMG on an Authorized Signature List for Medical School Officials or other official notification from this institution.

Signature, Printed Name, Title and Official Seal must match samples provided to ECFMG by the medical school

Signature: Leaura Navi

Printed Name: Leaura Navi

Title: Administrative Director, MSIH

Date of Signature: 25 May 2014

Phone: +97286479909 **Fax:** +97286479856

Email: lnavi@exchange.bgu.ac.il

SECTION 2B: DEGREE CERTIFICATION

This individual:
Was conferred/issued the degree of **MD** on **21/05/2014** (dd/mm/yyyy) and the attached medical diploma is authentic and correct.
-- Or --
Was not conferred/issued a degree or the attached diploma is not authentic and correct because:

SEAL
VERIFIED

SECTION 3A: PRE-MEDICAL EDUCATION

Years of education required for admission to your medical school : 15 years

Credential/degree presented by the applicant for admission to your medical school : BS Biology

Did this individual transfer credits to your medical school from another institution? YES ( ) NO (X)

If you checked 'YES' please print the name of the institution(s) from where the credits were transferred:

_____

_____

SECTION 3B: MEDICAL EDUCATION

Enrollment and Participation: Our records indicate that Emily Anne Cohen attended our medical school for total of 180 weeks of medical education on the following dates:

From 26/07/2009 (dd/mm/yyyy) To 15/05/2014 (dd/mm/yyyy)

_____

SECTION 4: UNUSUAL CIRCUMSTANCES

The following questions apply to unusual circumstances that occurred during any part of the individual's medical education. Please provide dates and requested information if you check "YES" to questions 1-5.

1. Does this individual's official record reflect (an) interruption(s) or extension(s) in his/her medical education? YES (X) NO ( )

If you checked "YES" please select the reason(s) for, indicate the dates of the interruption(s) or extension(s) and check whether the interruption/extension was approved or unapproved.

	From Month/Year	To Month/Year	Approved	Unapproved
Personal/Family	__/____	__/____	( )	( )
Academic remediation	__/____	__/____	( )	( )
Health	__/____	__/____	( )	( )
Financial	__/____	__/____	( )	( )
Participation in joint degree Program (e.g., MD/PhD)	__/____	__/____	( )	( )
Participation in non-research special study (e.g., fellowship, international experience)	01 / 2013	12 / 2013	(X)	( )
Participation in non-degree research	__/____	__/____	( )	( )
Other	__/____	__/____	( )	( )

Please Specify: _____

2. Does this individual's official record reflect that he/she was ever placed on academic or disciplinary probation during his/her medical education? YES ( ) NO (X)

If you checked "YES" please select the reason(s) for the probation, indicate the date(s) of placement on and removal from probation and attach additional documentation to this report.

_____

	From Month / Year	To Month / Year
Academic Probation_____	__/____	__/____
Probation for unprofessional conduct/behavioral_____	__/____	__/____
Probation for other reason_____	__/____	__/____

Please specify reason: _____

3. Does this individual's official record reflect that he/she was ever disciplined for unprofessional conduct/behavioral reasons by the medical school or parent university? YES ( ) NO (X)

If you checked "YES" please provide detailed documentation/information about the circumstances and outcome(s):

_____
_____

4. Does this individual's official record reflect that he/she was ever the subject of negative reports or an investigation by the medical school or parent university? YES ( ) NO (X)

If you checked "YES" please provide detailed documentation/information about the circumstances and outcome(s):

_____
_____

5. Does this individual's official record reflect that there were any limitations or special requirements imposed on the individual because of questions of academic incompetence, disciplinary problems, or any other reason? YES ( ) NO (X)

If you checked "YES" please provide detailed documentation/information about the nature of the limitations or special requirements:

_____
_____

FCVS FEDERATION CREDENTIALS VERIFICATION SERVICE

Applicant Reported Unusual Circumstances

Federation of STATE MEDICAL BOARDS

Medical School

Medical Professional Name: Cohen, Emily

Ben-Gurion University of The Negev

Unusual Circumstances

Did you have any interruption(s) or extension(s) in your medical education?	**Yes**

Dates: 01/2013 To 01/2014

Medical School-approved 1 year leave of absence to pursue further training and work at National Abortion Federation

Were you ever placed on probation?	**No**
Were you ever disciplined or placed under investigation?	**No**
Were any negative reports for behavioral reasons ever filed by instructors?	**No**
Were any limitations or special requirements imposed on you because of academic performance, incompetence, disciplinary problems or for any other reason?	**No**

End of Applicant Reported Unusual Circumstances report for: Cohen, Emily

אוניברסיטת בן-גוריון בנגב
Ben-Gurion University of the Negev

ACADEMIC TRANSCRIPT

Faculty of Health Sciences

Medical School for International Health

In Collaboration with Columbia University Medical Center

May 21, 2014

Student Name: Emily Anne Cohen

Registration Number: [redacted]6199

Academic Year 2009-10, First Semester, July 2009– December 2009

Course Number	Course Name	Total Course Hours	Final Grade
1010	Emergency Medicine	55	Pass
1012	Microbiology A	60	Pass
1016	Clinical and Global Medicine	50	Pass
1018	Histology	52	Pass
1019	Immunology	56	Pass
1020	Biostatistics	22	Pass
1040	Biochemistry	62	Pass
1060	Hebrew§	54	Pass
1070	Introduction to IHM A	50	Honors
1090	Epidemiology	44	Honors

Academic Year 2009-10, Second Semester, January 2010 – June 2010

Course Number	Course Name	Total Course Hours	Final Grade
1005	Endocrinology System	98	Pass
1006	Physiology	75	Honors
1011	Microbiology B	93	Pass
1017	Clinical and Global Medicine	40	Honors
1022	Pharmacology	68	Pass
1023	Hematology System	81	Pass
1024	Pathology	54	Pass
1025	Preventive Cardiology*	52	Pass
1038	Genetics	25	Pass
1042	Molecular and Cell Biology	76	Pass
1050	Hebrew§	54	Pass
1071	Introduction to IHM B	32	Pass

§ This course is graded by attendance only.
* Part of the International Medicine requirements

[In accordance with the Family Educational Rights and Pri
information from this transcript may not be released to a th
written consent of the student.]

Associate Registrar

Affixed by medical school on:
25 May 2014

EXPLANATORY NOTES ARE PRIN[illegible]SE SIDE

Medical School for International Health
Tel: (972) 8-6479908/9 - Fax: (972) 8-6479856 - E-mail: lnavie@bgu.ac.il

SEAL VERIFIED

אוניברסיטת בן-גוריון בנגב
Ben-Gurion University of the Negev

ACADEMIC TRANSCRIPT

Faculty of Health Sciences

Medical School for International Health

In Collaboration with Columbia University Medical Center

May 21, 2014

Student Name: Emily Anne Cohen

Registration Number: [redacted]6199

Academic Year 2010-11, First Semester, August 2010 - December 2010

Course Number	Course Name	Total Course Hours	Final Grade
2020	Embryology	14	Pass
2021	Cardiovascular System	140	Pass
2022	Respiratory System	105	Pass
2027	Nephrology System	63	Pass
2060	Clinical Communication Skills	40	Pass
2062	Gross Anatomy – Abdomen and Pelvis	56	Pass
2063	Gross Anatomy – Chest & Thorax	65	Honors

Academic Year 2010-11, Second Semester, January 2011 – June 2011

Course Number	Course Name	Total Course Hours	Final Grade
2026	Gastrointestinal System	98	Pass
2028	Neuroanatomy System	63	Pass
2030	Rheumatology System	84	Pass
2032	Embryology	4	Pass
2061	Clinical Communication Skills	68	Pass
2064	Gross Anatomy – Head and Neck	77	Pass
2067	Gross Anatomy of Limbs	77	Pass
2079	Reproductive System	84	Pass
2095	Psychiatry System	160	Pass
2098	Neurology System	120	Pass

IHM Modules*

Course Number	Course Name	Total Course Hours	Final Grade
2004	Disaster Relief§	8	Pass
2014	Health Systems Around the World§	8	Pass
2016	Medical Humanities Through the Arts§	8	Pass
2040	Midwifery Around the World§	8	Pass

Elective course

Course Number	Course Name	Total Course Hours	Final Grade
2019	Healer's Art§	21	Pass

§ This course is graded by attendance only.
* Part of the International Medicine requirements

[In accordance with the Family Educational Rights and Privacy Act of 1974, information from this transcript may not be released to a third party without written consent of the student.]

EXPLANATORY NOTES ARE PRINTED ON REVERSE

Associate Registrar

Medical School for International Health
Tel: (972) 8-6479908/9 - Fax: (972) 8-6479856 - E-mail: lnavi@bgu.ac.il

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אוניברסיטת בן-גוריון בנגב
Ben-Gurion University of the Negev

ACADEMIC TRANSCRIPT

Faculty of Health Sciences

Medical School for International Health

In Collaboration with Columbia University Medical Center

May 21, 2014

Student Name:	Registration Number:
Emily Anne Cohen	[redacted]6199

Academic Year 2011-12, First Semester, Clinical Courses, July 2011 – December 2011

Course Number	Course Name	Number of weeks	Final Grade
3010	Emergency Medicine	1	Pass
3070	Introduction to Clinical Medicine	2	Pass
3071	Pediatrics Clerkship	7	Pass
3072	Family Medicine Clerkship	4	Honors
3073	Internal Medicine Clerkship	10	Pass

Academic Year 2011-12, Second Semester, Clinical Courses, January 2012- June 2012

Course name and number		Number of weeks	Final Grade
3030	Cross Culture Medicine*§	1	Pass
3074	Surgery Clerkship	6	Pass
3078	Psychiatry Clerkship	5	Pass
3079	Obstetrics and Gynecology Clerkship	5	Pass
3098	Neurology Clerkship	2	Pass

§ This course is graded by attendance only.
* Part of the International Medicine requirements

[In accordance with the Family Educational Rights and Privacy Act of 1974, information from this transcript may not be released to a third party without written consent of the student.]

Associate Registrar

EXPLANATORY NOTES ARE PRINTED ON REVERSE SIDE

Medical School for International Health
Tel: (972) 8-6479908/9 - Fax: (972) 8-6479856 - E-mail: lnavi@bgu.ac.il

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אוניברסיטת בן-גוריון בנגב
Ben-Gurion University of the Negev

ACADEMIC TRANSCRIPT

Faculty of Health Sciences
Medical School For International Health
In Collaboration with Columbia University Medical Center

May 21, 2014

Student Name: Emily Anne Cohen

Registration Number: [redacted]6199

Academic Year 2012-13, , First Semester, Clinical Courses, July 2012 – December 2012

Course Number	Course Name		Number of weeks	Final Grade
4001	Elective at Institute for Family Health, Phillips Family Practice, New York, NY	Family & Community Medicine	4	Honors
4002	Elective at Columbia University, Ob/Gyn-Family Planning & Preventive Services New York, NY[2]	Family Planning & Reproductive Health	4	Honors
4003	Subinternship at Columbia University Medical Center/St. Luke's-Roosevelt Hospital Center, New York, NY[2]	Internal Medicine	4	Honors
4004	Subinternship at Columbia Univ. Med. Ctr. Of the New York-Presbyterian Hospital, New York, NY[2]	Gynecologic Oncology	4	Honors

* Part of the International Medicine requirement.
1 Rotation done at Soroka University Medical Center
2 Rotation done at Columbia University Medical Cent

[In accordance with the Family Educational Rights and Privacy Act of 1974, information from this transcript may not be released to a third party without written consent of the student.]

Associate Registrar

EXPLANATORY NOTES ARE PRINTED ON REVERSE SIDE

Medical School for International Health
Tel: (972) 8-6479908/9 - Fax: (972) 8-6479856 - E-mail: lnavi@bgu.ac.il

SEAL VERIFIED

אוניברסיטת בן-גוריון בנגב
Ben-Gurion University of the Negev

ACADEMIC TRANSCRIPT

Faculty of Health Sciences

Medical School For International Health

In Collaboration with Columbia University Medical Center

May 21, 2014

Student Name: Emily Anne Cohen

Registration Number: [redacted]6199

Academic Year 2013-14, , Second Semester, Clinical Courses, January 2014- May 2014

Course Number	Course Name		Number of weeks	Final Grade
4005	International Medicine Clerkship *	University of Kentucky, USA	8	Pass
4090	Selective [1]	ENT	2	Pass
4096	Selective [1]	Anesthesiology/ICU	2	Pass
4044	Selective [1]	Pediatrics Surgery	2	Pass
4045	Selective [1]	Vascular Surgery	2	Pass

* Part of the International Medicine requirement.
1 Rotation done at Soroka University Medical Center
2 Rotation done at Columbia University Medical Cent

This student has fulfilled all the requirements towards the degree
Doctor of Medicine

She received her Diploma May 21, 2014

Associate Registrar

[In accordance with the Family Educational Rights and Privacy Act of 1974, information from this transcript may not be released to a third party without written consent of the student.]

EXPLANATORY NOTES ARE PRINTED ON REVERSE SIDE

SEAL VERIFIED

Medical School for International Health
Tel: (972) 8-6479908/9 - Fax: (972) 8-6479856 - E-mail: lnavi@bgu.ac.il

CERTIFIED COPY

העתק מאושר

Ben-Gurion University of the Negev
The Faculty of Health Sciences

אוניברסיטת בן-גוריון בנגב
הפקולטה למדעי הבריאות

Medical School for International Health In Collaboration with Columbia University Medical Center
בית הספר לרפואה בינלאומית בשיתוף המרכז הרפואי האוניברסיטאי קולומביה

The Rector of the University and the Dean of the Faculty of Health Sciences, upon the recommendation of the Faculty Council and with the Approval of the Senate, have conferred the degree of

רקטור האוניברסיטה ודיקן הפקולטה למדעי הבריאות, על פי המלצת מועצת הפקולטה ואישור הסינאט מעניקים את התואר

DOCTOR of MEDICINE
דוקטור לרפואה
M.D.

upon

Emily Anne Cohen
אמילי אן כהן

Having completed the required course of study as laid down in the Constitution of the University and its Regulations.
לאחר שסיימה את מסכת לימודיה בהתאם לחוקת האוניברסיטה ותקנותיה.

In witness whereof the seal of the University and its authorized signatories are appended below.
ולראיה הוטבע בתעודה זו החותם ובאנו על החתום.

Affixed by medical school on 25 May 2014

Prof. Gabriel Schreiber, Dean of the Faculty
פרופ' גבריאל שרייבר, דיקן הפקולטה

Beer Sheva, Israel, May 21st, 2014

Prof. Zvi Hacohen, Rector
פרופ' צבי הכהן, רקטור

באר שבע, ביום כ"א באייר תשע"ד

Ben-Gurion University of the Negev
Faculty of Health Sciences
Medical School for International Health
CERTIFIED COPY
Signature M. Smyth Date MAY 21, 2014

SEAL VERIFIED

ECFMG®
EDUCATIONAL COMMISSION FOR
FOREIGN MEDICAL GRADUATES

3624 Market St
Philadelphia, PA 19104-2685 USA
215-386-5900 | 215-386-3185 FAX
www.ecfmg.org

NEW MEXICO MEDICAL BOARD
LICENSING MANAGER
c/o Federation Credentials Verification Service
2055 S. PACHECO ST., BLDG 400
SANTA FE, NM, 87505

State Board Code:
032
Please include this number on all requests

ECFMG® CERTIFICATION STATUS REPORT

USMLE™/ECFMG Identification Number: 0-816-870-0
Applicant's Name: Emily Anne Cohen
Applicant's Date of Birth: [redacted]1984
ECFMG Certified:Yes
Certificate Issue Date: 06/10/2014
English Test Valid Through: Valid Indefinitely
Clinical Skills Assessment Valid Through: Valid Indefinitely

Passing Performance on Medical Science Examinations:

Examination	Date	Two Digit Score	Three Digit Score
USMLE Step 1	01 Aug 2011	*	*
USMLE Step 2 CK	29 Aug 2012	*	*

Most Recent Passing Performance on Clinical Skills Examination:

Examination	Date
USMLE Step 2 CS	02 Nov 2013

Name of Medical School and Country:Ben-Gurion University of the Negev Faculty of Health Sciences, Beer-Sheva, ISRAEL

Degree Year: 2014

† Medical Education Credentials Status: Complete

This information is reported directly from ECFMG computer records and is current as of 12/28/16.

How to Verify the Authenticity of this Report:

This report was issued to the named recipient on the date shown below. To verify the authenticity of this report, visit https://cvsonline2.ecfmg.org/verify/verify.aspx and enter the unique verification code at the bottom of the report. The information contained in this report is current as of the issue date. Any changes to the physician's status after the issue date will not be reflected, and you are encouraged to request an updated report.

The purpose of this Status Report is to indicate whether this individual is certified by ECFMG. It reflects only examinations that were used to fulfill requirements for ECFMG Certification. The most recent passing performance on the clinical skills examination is reflected, regardless of whether this individual was required to take a clinical skills examination for ECFMG Certification. This Status Report is not a complete score history of all examinations for this individual. This Status Report does not include examinations that were taken but not passed. Furthermore, if this individual passed examinations that were not used to fulfill the requirements for ECFMG Certification, these examinations are not included.

* To obtain a complete history of and scores for USMLE Step examination(s) that may have been taken by this individual, contact the appropriate registration entity to request a USMLE transcript.

† Since July 1986, ECFMG has verified medical school credentials directly with the medical schools, or through a reasonable alternative that has been approved by the ECFMG Medical Education Credentials Committee.

Important Note:

Requesting organizations must normally secure and retain the physician's signed authorization to obtain certification information. Organizations may not resell the information or make it available to any party beyond the initial request as authorized by the physician. The information may only be used to confirm ECFMG certification for the purpose for which the physician provided authorization.

Report Verification Code: V0DWLCTLKH

Educational Commission for Foreign Medical Graduates

The ECFMG® certifies that

Emily Anne Cohen

has successfully passed the required examinations, satisfied all the requirements of the Commission, and has been awarded this Certificate.

Chair, Board of Trustees

President and Chief Executive Officer

Certificate Number	0-816-870-0
Medical Science	
USMLE Step 1	August 1, 2011
USMLE Step 2 CK	August 29, 2012
Clinical Skills	
USMLE Step 2 CS	November 2, 2013

Date Issued June 10, 2014

FCVS FEDERATION CREDENTIALS VERIFICATION SERVICE

Postgraduate Training

Federation of STATE MEDICAL BOARDS

Postgraduate Training

Accreditation ID: **1203421197**

Institution: **University of New Mexico**

Location: Albuquerque, NM
UNITED STATES

Credentials Analysis Information for Postgraduate Training

Issue:
FCVS has identified a postgraduate training Discrepancy at University of New Mexico.

Unusual Circumstances

Solution(s):
FCVS does not follow up with the Medical Professional or the institution with inconsistent information on Unusual Circumstances questions.

FCVS FEDERATION CREDENTIALS VERIFICATION SERVICE

Verification of Graduate Medical Education

Federation of STATE MEDICAL BOARDS

Institution: University of New Mexico **Affiliated University:** University of New Mexico
Address Line 1:
Address Line 2:

Country: US **City:** Albuquerque **State/Prov.:** NM **Zip Code:**

If name of institution was different when this individual attended, please note this name:

Verification For: Cohen, Emily **Date of Birth:** [redacted]1984
Individual's Name on Record (If different from above):

Program Participation:

Important:

Report Incomplete Training Levels (year) separate from those that were successfully completed.

If the training level (years) is currently in progress, report the expected completion date in the "To" field.

Report Internships, Residencies and Fellowships separately.

Use one section per Department/Specialty. If the Department or Specialty is rotating or transitional, please provide a schedule of rotations.

Program Type			
R	**Training Level:** 1-1	**Specialty/Subspecialty:** Family Medicine	
	From: 06/21/2014	**To:** 06/30/2015	
	Successfully Completed? Yes		
	Accredited by: ACGME		
	Rotation Information Not Available		
Program Type	**Training Level:** 2-2	**Specialty/Subspecialty:** Family Medicine	
R	**From:** 07/02/2015	**To:** 06/30/2016	
	Successfully Completed? Yes		
	Accredited by: ACGME		
Program Type	**Training Level:** 3-3	**Specialty/Subspecialty:** Family Medicine	
R	**From:** 07/01/2016	**To:** 06/30/2017	
	Successfully Completed?	In Progress	
	Accredited by: ACGME		

Unusual Circumstances

Check the correct response.

Omitted responses require written explanation.

If necessary, you may continue your explanation on a separate sheet of paper.

1. Did this individual ever take a leave of absence or extension from his/her training?	No
If "Yes" provide start and end dates: **From:** **To:**	
2. Was this individual ever placed on probation?	No
3. Was this individual ever disciplined or placed under investigation?	No
4. Were any negative reports for behavioral reason ever filed by instructors?	No
5. Were any limitations or special requirements placed upon this individual because of questions of academic incompetence, disciplinary problems or any other reason?	No

Please explain any "Yes" response from above:

Attestation

Affix Institutional Seal Here.

If no seal is available, this form must be notarized.

Watermark

For FCVS internal use only.

ELECTRONIC SEAL VERIFIED

Completion attests the information above is an accurate account of this individual's records and is true and correct. Signature line must contain original signature or electronic typed signature of program director

Print Name: DanielWaldman **MD/DO:** Yes

Signature: *Daniel Waldman*

Title: Program Director **Date:** 12/07/2016

Tel: (505) 272-8291 **Fax:** (505) 272-1348 **Email:** dpwaldman@salud.unm.edu

217440767 114617 217440767

FCVS FEDERATION CREDENTIALS VERIFICATION SERVICE

Applicant Reported Unusual Circumstances

Federation of STATE MEDICAL BOARDS

Graduate Medical Education

Medical Professional Name:	Cohen, Emily
Accreditation ID:	1203421197
Institution:	University of New Mexico
Specialty:	Family Medicine

Unusual Circumstances

Training Period: 6/21/2014 - 7/8/2017 **Residency**

Did you have any interruption(s) or extension(s) in your medical education? **Yes**

Dates: 02/2016 to 02/2016

2 weeks maternity leave

Were you ever placed on probation? **No**

Were you ever disciplined or placed under investigation? **No**

Were any negative reports for behavioral reasons ever filed by instructors? **No**

Were any limitations or special requirements imposed on you because of academic performance, incompetence, disciplinary problems or for any other reason? **No**

End of Applicant Reported Unusual Circumstances report for: Cohen, Emily

FCVS FEDERATION CREDENTIALS VERIFICATION SERVICE

Licensure / Examinations

Federation of STATE MEDICAL BOARDS

Licensure / Examinations

Exam: USMLE

Credential Analysis Information for Licensure / Examinations

There is no Omission/Discrepancy/Miscellaneous information identified.

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

Date: 12/28/2016

Federation Credentials Verification Service
ATTN: FCVS

FCVSID: 5383

Examinee: Cohen, Emily Anne **Examinee ID:** 08168700

Alt Name(s): **Date of Birth:** [redacted]1984

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
8/1/2011	Pass	192	(188)	

USMLE STEP 2

Clinical Knowledge (CK)

Test Date	Pass/Fail	Total	MP	Comments
8/29/2012	Pass	234	(196)	

Clinical Skills (CS)*

Test Date	Pass/Fail	Total	MP	Comments
11/2/2013	Pass			

USMLE STEP 3

Test Date	Pass/Fail	Total	MP	Comments
11/9/2015	Pass	221	(190)	

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

United States Medical Licensing Examination (USMLE)
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Examinee: Cohen, Emily Anne

Examinee ID: 08168700

Date of Birth: [redacted]/1984

INTERPRETATION OF RESULTS
USMLE transcripts include a complete examination history. On those Step examinations for which numeric scores are reported, a three-digit scale is used. Most scores fall between 140 and 260 on this scale. The recommended minimum passing score is shown on the front of the transcript next to the examinee's score for each administration along with a pass/fail outcome. Test results reported as passing represent an exam score of 75 or higher on a two-digit scoring scale. The level of proficiency required to meet the recommended minimum passing level for each USMLE Step is reviewed periodically and is subject to change. Such changes do not alter pass/fail outcomes from prior test administrations.

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.

STEP 2 CLINICAL SKILLS (CS)
Step 2 CS results are reported as pass or fail, with no numeric score. Had the two-digit reporting scale been used, examinees would have had to achieve a score of 75 or higher in order to pass.

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 are at or above the passing level but cannot be certified as representing a valid measure of the examinee's knowledge or competence as sampled by the examination. No score is reported. Information regarding the nature of the indeterminate score is available. If such information is not enclosed with this transcript, it may be obtained by contacting the organization from which you received the transcript or the USMLE Secretariat, 3750 Market Street, Philadelphia, PA 19104, telephone (215) 590-9700.

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

Irregular Behavior - The Committee for Individualized Review 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.

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.

PHYSICIAN DATA CENTER INFORMATION APPEARING AS "NOTE"
The Physician Data Center of the Federation of State Medical Boards (FSMB) contains actions reported to the FSMB by U.S. licensing and disciplinary boards, the U.S. Department of Health and Human Services, government regulatory entities and international licensing authorities. To be included in the Physician Data Center, 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 Physician Data Center are not disciplinary or otherwise prejudicial in nature. Such actions are reported to ensure that records are complete and to assist in preventing misrepresentation or the use of lost or stolen credentials by unauthorized persons. Once reported to the FSMB, an action becomes part of the permanent record of the individual physician, and the existence of such an action may be indicated on the USMLE transcript by a Note.

03/2015

This document was printed from a secure website and accurately reflects score information maintained by the FSMB.

PDC PHYSICIAN DATA CENTER

Federation of STATE MEDICAL BOARDS

PRACTITIONER PROFILE

Prepared for:	FCVS	As of Date:12/28/2016

PRACTITIONER INFORMATION

Name:	Emily Anne Cohen
DOB:	[redacted]1984
Medical School:	Ben-Gurion University of The Negev Beer Sheva, HaDarom, ISRAEL
Year of Grad:	2014
Degree Type:	MD
NPI:	[redacted]

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 MEXICO	RS2014-0348	6/19/2014	7/1/2017	11/22/2016

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

PDC PHYSICIAN DATA CENTER

Federation of STATE MEDICAL BOARDS

PRACTITIONER PROFILE

Prepared for:	FCVS	As of Date:12/28/2016
Practitioner Name:	Emily Anne Cohen	

ABMS® CERTIFICATION HISTORY

No ABMS Certifications found.

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

Cohen, Emily **Medical Doctor** **MD2017-0104**

1. Since your last renewal has your professional liability coverage been terminated by action of the insurance company except as a result of the company ceasing to offer insurance to physicians ?	N	06/07/2019
2. Since your last renewal have you been denied professional liability insurance coverage?	N	06/07/2019
3. Since your last renewal has your professional liability carrier excluded any specific procedures from your coverage?	N	06/07/2019
4. Since your last renewal have you been denied membership or renewal thereof, or been subject to disciplinary action in any professional organization?	N	06/07/2019
5. Since your last renewal have you been excluded from or sanctioned by Medicare and/or Medicaid?	N	06/07/2019
6. Since your last renewal, have you been arrested? If so explain the circumstance, regardless of the outcome (i.e. expunged, dismissed, sealed, vacated).	N	06/07/2019
7. Since your last renewal, have you been named as a defendant in any criminal proceedings?	N	06/07/2019
8. Since your last renewal, have you been subject to investigation by a governmental entity or Board that either could have resulted or did result in licensure sanction or other adverse actions, irrespective of the outcome?	N	06/07/2019
9. Since your last renewal have you been named in any formal requests for corrective actions filed by any healthcare entity where you have had an appointment (a request which could result in either formal or informal proceedings).	N	06/07/2019
10. a. Since your last renewal have your privileges at any healthcare entity been voluntarily or involuntarily suspended, restricted, diminished, revoked, surrendered, or not renewed, for any reason, except for medical records delinquency unrelated to your professional	N	06/07/2019
10. b. Since your last renewal have you agreed not to exercise your clinical privileges while under investigation?	N	06/07/2019
10. c. Since you last renewal, have you been investigated and/or terminated by a healthcare entity for cause, or without cause, related to your clinical competence or conduct, which could impact patient safety/care, or allowed to resign in lieu of termination for such reason?	N	06/07/2019
11. Since your last renewal have you resigned from a healthcare entity to avoid modification, suspension, or termination of privileges, or while under investigation?	N	06/07/2019
12. a. Since your last renewal has your application for licensure or license to practice in any jurisdiction been investigated, voluntarily or involuntarily limited, suspended, revoked, surrendered or denied?	N	06/07/2019
12. b. Are any currently held licenses pending investigation or being challenged?	N	06/07/2019
13. Since your last renewal have you been notified to appear before any licensing agency for a hearing or complaint of any nature?	N	06/07/2019
14. Since your last renewal has your federal or state narcotics registration certificate in any jurisdiction ever been investigated, voluntarily or involuntarily limited, suspended, revoked, or restricted?	N	06/07/2019
15. Since your last renewal have you been involved in a settlement, medical malpractice claim or suit, or have you ever received written notice of intent to file such a suit? If yes, please provide the following information for each claim or suit. Please type on a separate sheet	N	06/07/2019
16. Since your last renewal have you been reported to the National Practitioner Data Bank?	N	06/07/2019
17. Are you now, or were you in the past, addicted to, abusive of, or in treatment for abuse of any controlled substances, habit-forming drugs, illegal drugs, prescription medication or alcohol?	[redacted]	06/07/2019
18. Since your last renewal have you been diagnosed with an illness or condition which impairs your judgment or affects your ongoing ability to practice medicine in a competent, ethical and professional manner? <b>If yes, please have your treating physician send the NM	[redacted]	06/07/2019
19. I certify that I have completed a minimum of 75 AMA Category I hours of Continuing Medical Education as required by 16.10.4 NMAC	Y	06/07/2019
19a. I certify that 5 hours of the required 75 hours of CME are in Pain Management, as required by 16.10.14. 11 NMAC OR I certify that I do NOT hold a NM Controlled Substance Registration.	Y	06/07/2019
20. I attest that I will limit my practice to areas in which I am competent to practice.	Y	06/07/2019
21. Are you currently in arrears in payments of amounts required to be paid pursuant to an outstanding judgement and order for child support in New Mexico or in any other state?	N	06/07/2019