

**MEDICAL DOCTOR
APPLICATION FOR LICENSURE**

Apply for your license online at www.flboardofmedicine.gov

1501
F122259

11/20/2014 705.00
ID: 122259 Type: F
BT: 3010172
VL: 914024101

Choose your application type:

- Endorsement (1021) Examination (1024)
 Military Veterans Fee Waiver

If you were honorably discharged from the U.S. armed services within 24 months of your application you will qualify for a waiver of the application fee and the initial licensure fee. In order to qualify, please check the box above indicating that you are seeking a waiver and submit a **DD-214** or **NGB-22 form** as proof of honorable discharge.

I plan to dispense medicinal drugs in the State of Florida for a fee or other remuneration and hereby register as required by Section 465.0276, F. S. I understand that the fee for the Dispensing Practitioner is \$100.00 in addition to the required initial license fee and will submit it along with the license fee.

1. PERSONAL INFORMATION

Name: Stumbar Sarah Eisenstein Date of Birth: 04/05/1985
Last/Surname First Middle MM/DD/YYYY

Mailing Address: (The address where mail and your license should be sent)

181 East 206th St Apt 1C Bronx
Street/ PO Box Suite/Apt. No City
NY 10458 USA 607-592-9587
State Zip Country Phone Number

Physical Location: A Post Office Box is not acceptable. This address will be posted on the Department Health's website. If you do not have a current practice address, your mailing address will be used. When you obtain a practice address, you will be required to update your online practitioner profile.

181 East 206th St Apt 1C Bronx
Street/ P.O. Box Suite/Apt. No City
NY 10458 USA
State Zip Country Alternate Phone Number

Email Address: sarah.stumbar@gmail.com

Under Florida law, email addresses are public records. If you do not want your e-mail address released in response to a public records request, do not provide an email address or send electronic mail to our office. Instead contact the office by phone or in writing.

Equal Opportunity Data: We are required to ask that you furnish the following information as part of your voluntary compliance with Section 2, Uniform Guidelines on Employee Selection Procedure (1978) 43 CFR 38296 (August 25, 1978). This information is gathered for statistical and reporting purposes only and does not in any way affect your candidacy for licensure.

SEX: Male Female RACE: White Black Asian/Pacific Islander Hispanic Other _____

Yes No

Availability for Disaster: Will you be available to provide health care services in special needs shelters or to help staff disaster medical assistance teams during times of emergency or major disaster?

✓

2. MEDICAL EDUCATION HISTORY

Federal Credentials Verification Services (FCVS) is not a requirement for licensure. FCVS will primary source verify and provide a copy of the medical school transcript(s), medical school diploma, medical school verification, name change document(s), national examination score report, ECFMG certificate, and ECFMG verification. For more information about FCVS, visit their web-site at www.fcvs.org/.

Yes No Are you using the FCVS to verify your core credentials?

Yes No Have you completed the equivalent of 2 academic years of preprofessional, postsecondary education including, courses in anatomy, biology, and chemistry prior to entering medical school?

Medical Education:

List in chronological order all medical schools attended, whether completed or not. Submit on a separate sheet if needed.

Medical School Name and Address:	From: (mm/yy)	To: (mm/yy)	Date Degree Received:
Stony Brook University School of Medicine, Stony Brook University Hospital, 101 Nicholls Rd, Stony Brook, NY 11794	08/08	05/12	May 17, 2012

Postgraduate Training:

Provide the following documentation to support your postgraduate training:

- Post-Graduate Training Form

In the table below list, in chronological order, all postgraduate training from date you graduated from medical school to present. Start with your first program and end with your last or current program. List all programs you began, whether you completed or received credit for the training.

Program Name and Full Mailing Address:	Specialty Area:	From: (mm/yy)	To: (mm/yy)	Did you receive credit? (Y/N)
Department of Family and Social Medicine, Montefiore Medical Center, 3544 Jerome Ave, Bronx NY 10467	Family Medicine	07/12	present	Y

Prevention of Medical Errors:

The education must meet requirements defined in § 456.013(7), Florida Statutes and be completed prior to the issuance of your license number. Please contact the Florida Medical Association (FMA) at (850) 224-6496 or www.flmedical.org for a list of providers of CME. Other resources for CME are the American Medical Association (AMA) at (312) 464-5000 or Medical Education Group Learning Systems (MEGLAS) at 800-547-0308 or www.informed.cme.edu.

I have completed a minimum of two (2) hours of Prevention of Medical Errors continuing medical education as defined by s. 456.013(7), Florida Statutes.

Loan History:

Yes No Are you currently in default on any health education loan or scholarship obligation? (If "yes", explain on a separate sheet providing accurate details.)

3. EXAMINATION HISTORY

State Board (prior to 1974), State Board (after 1974) & SPEX, LMCC & SPEX, NBME, FLEX, USMLE III, or Combination (prior to 2000)

Request that the score report be sent directly to the Board of Medicine. NOTE: If you took a state Board examination and are not currently licensed in three other states, you must also request your SPEX score be sent.

Exam taken: USMLE Step 3 Date passed: _____ mm/dd/yy

4. LICENSURE HISTORY

Request verification of licensure status directly from the licensing entity or www.veridoc.org. Request international license verification(s) if you have practiced outside of the U.S. for at least two of the previous four years.

Yes No Do you now hold or have you ever held a license to practice medicine or any other profession in any US State or territory, or foreign country? Please list in table below.

Jurisdiction	Profession	License number

If you answer "yes" to any of the questions in this section, you are required to send an explanation and supporting documentation.

Yes No Have you had any application for a medical license or professional license denied by any state board or other governmental agency of any state, territory, or country?

Yes No Are you currently under investigation in any jurisdiction for an act or offense that would constitute a violation of Section 458.331, Florida Statutes?

Yes No Have you ever had any professional license or license to practice medicine revoked, suspended, placed on probation, or other disciplinary action taken in any state, territory or country?

5. PRACTICE/EMPLOYMENT HISTORY

List the year you legally first began to practice medicine, 2012 (yyyy). This would be the year you began practicing medicine and could be the date you began your postgraduate training.

Yes No Have you practiced medicine in another jurisdiction for two of the last four years or completed a board approved post-graduate training program within the last two years?

Yes No If your answer to the question above was "No," have you passed a board approved clinical competency exam within the last year? If yes, then submit supporting documentation.

List in chronological order all employment for the last four (4) years.

Name and address of practice or employment	Type of employment	From: mm/yy	To: mm/yy
Department of Social and Family Medicine, Montefiore Medical Center, 3544 Jerome Ave, Bronx NY 10467	Resident Physician	07/12	present

Yes No Do you currently hold staff privileges in any hospital, health institution, clinic or medical facility? List each facility below.

Name of facility
Montefiore Medical Center (house staff)

If you answer "yes" to the following question, you are required to send an explanation and supporting documentation.

Yes No Have you ever had any staff privileges denied, suspended, revoked, modified, restricted, not renewed, or placed on probation, or have you been asked to resign or take a temporary leave of absence or were otherwise acted against by any facility?

Yes No Do you currently or have you had responsibility for graduate medical education within the last 10 years?

In the table below, list all institutions where you have had responsibility for graduate medical education or faculty appointment(s) at any medical school.

Name of institution

Yes No Are you certified by any specialty board recognized by the American Board of Medical Specialties or specialty board approved by the Florida Board of Medicine?

Board Name	Certification/ Specialty/Sub-Specialty	Date of Certification (mm/yy)

If you answer "yes" to any of the following questions, please explain on a separate sheet providing accurate details.

Yes No Have you ever had any final disciplinary action taken against you by a specialty board or other similar national organization?

Yes No Have you ever been denied or surrendered a DEA registration?

6. CRIMINAL HISTORY

If you answer "Yes" to the following question you are required to send the following items:

- o Self-explanation describing in detail the circumstances surrounding each offense; including dates, city and state, charges and final results.
- o Final Dispositions and Arrest Records for all offenses. The Clerk of the Court in the arresting jurisdiction will provide you with these documents. Unavailability of these documents must come in the form of a letter from the Clerk of the Court.
- o Completion of Sentence Documents. You may obtain document from the Department of Corrections. The report must include the start date, end date and that the conditions were met.

Yes No Have you ever been convicted of, or entered a plea of guilty, nolo contendere, or no contest to, a crime in any jurisdiction other than a minor traffic offense? You must include all misdemeanors and felonies, even if adjudication was withheld. Driving under the influence (DUI) or driving while impaired (DWI) are not minor traffic offenses for purposes of this question.

7. MILITARY HISTORY

A. Yes No Have you ever been in the United States Military and/or Public Health Service?

B. Yes No Have you ever been disciplined by any branch of the United States Armed Services or Public Health Service? If you answered "yes" please provide a detailed explanation and supporting documentation.

8. CRIMINAL AND MEDICAID/MEDICARE FRAUD QUESTIONS

Applicants for licensure, certification or registration and candidates for examination may be excluded from licensure, certification or registration if their felony conviction falls into certain timeframes as established in Section 456.0635(2), Florida Statutes. If you answer "Yes" to any of the following questions, please provide a written explanation for each question. Supporting documentation includes court dispositions or agency orders where applicable.

1. Yes No Have you been convicted of, or entered a plea of guilty or nolo contendere to, regardless of adjudication, a felony under Chapter 409, F.S. (relating to social and economic assistance), Chapter 817, F.S. (relating to fraudulent practices), Chapter 893, F.S. (relating to drug abuse prevention and control) or a similar felony offense(s) in another state or jurisdiction?

If you responded "No" to the question above, skip to question 2.

- a. Yes No If "yes" to 1, for the felonies of the first or second degree, has it been more than 15 years from the date of the plea, sentence and completion of any subsequent probation?
- b. Yes No If "Yes" to 1, for felonies of the third degree, has it been more than 10 years from the date of the plea, sentence and completion of any subsequent probation? (This question does not apply to felonies of the third degree under Section 893.13(6)(a), Florida Statutes)
- c. Yes No If "Yes" to 1, for the felonies of the third degree under Section 893.13(6)(a), Florida Statutes, has it been more than 5 years from the date of the plea, sentence and completion of any subsequent probation?
- d. Yes No If "Yes" to 1, have you successfully completed a drug court program that resulted in the plea for the felony offense being withdrawn or charges dismissed?

2. Yes No Have you been convicted of, or entered a plea of guilty or nolo contendere to, regardless of adjudication, a felony under 21 U.S.C. ss. 801-970 (relating to controlled substances) or 42 U.S.C. ss. 1395-1396 (relating to public health, welfare, Medicare and Medicaid issues)?

If you responded "No" to the question above, skip to question 3.

- a. Yes No If "Yes" to 2, has it been more than 15 years before the date of application since the sentence and any subsequent period of probation for such conviction or plea ended?

3. Yes No Have you ever been terminated for cause from the Florida Medicaid Program pursuant to Section 409.913, Florida Statutes?

If you responded "No" to the question above, skip to question 4.

- a. Yes No If you have been terminated but reinstated, have you been in good standing with the Florida Medicaid Program for the most recent five years?

4. Yes No Have you ever been terminated for cause, pursuant to the appeals procedures established by the state, from any other state Medicaid Program?

If you responded "No" to the question above, skip to question 5.

- a. Yes No Have you been in good standing with a state Medicaid program for the most recent five years?
- b. Yes No Did the termination occur at least 20 years before the date of this application?

5. Yes No Are you currently listed on the United States Department of Health and Human Services Office of Inspector General's List of Excluded Individuals and Entities?

6. Yes No If "Yes" to any of the questions 1 through 5 above, on or before July 1, 2009, were you enrolled in an educational or training program in the profession in which you are seeking licensure that was recognized by the Board of Medicine or the Department of Health?
(If "Yes", please provide official documentation verifying your enrollment status.)

If you answer "Yes" to the questions below, you are required to send the following items:

- A statement indicating date of each incident and the number for each case.
- An explanation of details for each case and your involvement for each case.
- Submit the enclosed Exhibit 1 form.
- A copy of complaint, judgments and/or settlements for each case.
- Submit a complete copy of the trial record(s) of each case, including the trial transcript, evidentiary exhibits and final judgment in electronic format.

Yes No

Have you ever had a judgment entered against you for medical malpractice where the incident(s) of malpractice occurred after November 2, 2004?

Yes No

Within the last 10 years have you had any liability claim(s) or action(s) for damages for personal injury settled or finally adjudicated in an amount that exceeds \$100,000.00?

10. FINANCIAL RESPONSIBILITY

The Financial Responsibility options are divided into two categories, coverage and exemptions. Check only one option of the ten provided as required by s. 458.320, Florida Statutes.

Category I: Financial Responsibility Coverage

- 1. I do not have hospital staff privileges and I have established an irrevocable letter of credit or an escrow account in an amount of \$100,000/\$300,000, in accord with Chapter 675, F. S., for a letter of credit and s. 625.52, F. S., for an escrow account.
- 2. I have hospital staff privileges and I have established an irrevocable letter of credit or escrow account in an amount of \$250,000/\$750,000, in accord with Chapter 675, F. S., for a letter of credit and s. 625.52, F. S., for an escrow account.
- 3. I do not have hospital staff privileges and I have obtained and maintain professional liability coverage in an amount not less than \$100,000 per claim, with a minimum annual aggregate of not less than \$300,000 from an authorized insurer as defined under s. 624.09, F. S., from a surplus lines insurer as defined under s. 626.914(2), F. S., from a risk retention group as defined under s. 627.942, F. S., from the Joint Underwriting Association established under s. 627.351(4), F. S., or through a plan of self-insurance as provided in s. 627.357, F. S.
- 4. I have hospital staff privileges and I have professional liability coverage in an amount not less than \$250,000 per claim, with a minimum annual aggregate of not less than \$750,000 from an authorized insurer as defined under s. 624.09, F. S., from a surplus lines insurer as defined under s. 626.914(2), F. S., from a risk retention group as defined under s. 627.942, F. S., from the Joint Underwriting Association established under s. 627.351(4), F. S., or through a plan of self-insurance as provided in s. 627.357, F. S.
- 5. I have elected not to carry medical malpractice insurance however, I agree to satisfy any adverse judgments up to the minimum amounts pursuant to s. 458.320(5)(g)1, F. S. I understand that I must either post notice in a sign prominently displayed in my reception area or provide a written statement to any person to whom medical services are being provided that I have decided not to carry medical malpractice insurance. I understand that such a sign or notice must contain the wording specified in s. 458.320(5)(g), F. S.

Category II: Financial Responsibility Exemptions

- 6. I practice medicine exclusively as an officer, employee, or agent of the federal government, the state, or its agencies or subdivisions.
- 7. I hold a limited license issued pursuant to s. 458.317, F. S., and practice only under the scope of the limited license.
- 8. I do not practice medicine in the State of Florida.
- 9. I meet all of the following criteria:
 - (a) I have held an active license to practice in this state or another state or some combination thereof for more than 15 years;
 - (b) I am retired or maintain part time practice of no more than 1000 patient contact hours per year;
 - (c) I have had no more than two claims resulting in an indemnity exceeding \$25,000 within the previous five-year period;
 - (d) I have not been convicted of or pled guilty or nolo contendere to any criminal violation specified in Chapter 458, F. S. or the medical practice act in any other state; and
 - (e) I have not been subject, within the past ten years of practice, to license revocation, suspension, or probation for a period of three years or longer, or a fine of \$500 or more for a violation of Chapter 458, F. S., or the medical practice act of another jurisdiction. A regulatory agency's acceptance of a relinquishment of license, stipulation, consent order, or other settlement offered in response to or in anticipation of filing of administrative charges against a license is construed as action against a license. I understand if I am claiming an exception under this section that I must either post notice in a sign prominently displayed in my reception area or provide a written statement to any person to whom medical services are being provided that I have decided not to carry medical malpractice insurance. See Section 458.320(5)(f), Florida Statutes, for specific notice requirements.
- 10. I practice only in conjunction with my teaching duties at an accredited medical school or its teaching hospitals. (Interns and residents do not qualify for this exemption).

If you select an exemption based on number 9, you must also complete the affidavit on the following page.

BOARD OF MEDICINE
Financial Responsibility Affidavit of Exemption

This affidavit is only required if you are claiming an Exemption based on number 9 on the preceding page.

I, _____, do hereby certify and attest that I meet all of the following criteria:

- (a) I have held an active license to practice in this state or another state or some combination thereof for more than 15 years;
- (b) I am retired or maintain part time practice of no more than 1000 patient contact hours per year;
- (c) I have had no more than two claims resulting in an indemnity exceeding \$25,000 within the previous five-year period;
- (d) I have not been convicted of or pled guilty or nolo contendere to any criminal violation specified in Chapter 458, F. S. or the medical practice act in any other state; and
- (e) I have not been subject, within the past ten years of practice, to license revocation, suspension, or probation for a period of three years or longer, or a fine of \$500 or more for a violation of Chapter 458, F. S., or the medical practice act of another jurisdiction. A regulatory agency's acceptance of a relinquishment of license, stipulation, consent order, or other settlement offered in response to or in anticipation of filing of administrative charges against a license is construed as action against a license. I understand if I am claiming an exception under this section that I must either post notice in a sign prominently displayed in my reception area or provide a written statement to any person to whom medical services are being provided that I have decided not to carry medical malpractice insurance. See Section 458.320(5) (f), F.S., for specific notice requirements.

Dated: _____

Signature: _____

STATE OF _____
COUNTY OF _____

Sworn to (or affirmed) and subscribed before me this _____ day of _____, by

(Signature of Notary Public - State of Florida)

(Print, Type, or Stamp Commissioned Name of Notary Public)

Personally Known _____ OR Produced Identification _____

Type of Identification Produced _____

11. FLORIDA BIRTH RELATED NEUROLOGICAL COMPENSATION ASSOCIATION

You must choose one of the three options described below. Please be sure to view the information about each exemption at www.nica.com. Check only one.

\$5,000
Participating

\$250
Non-participating

\$0
Exempt

Amount enclosed

If you choose "\$0 Exempt" provide appropriate documentation to the Board of Medicine and to NICA.

I have read the explanatory information provided by NICA, and I choose the option above.



Signature

11/4/2014

Date

Sarah Stumbar

Name
181 E 206th St, Apt 1C

Street Address
BRONX, NY 10458

City, State, Zip

If you are a participating or non-participating physician, or a physician claiming exemption, you must complete, sign and date this form and return it with your payment to this address.

Board of Medicine
4052 Bald Cypress Way, #C-03
Tallahassee, FL 32399-3253

If you are a physician claiming exemption, you must also send a copy of your completed, signed, and dated form with proof of your exemption to:

NICA
2360 Christopher Place
Tallahassee, FL 32308

If you have any questions about NICA or this form, please contact NICA at www.nica.com or (850) 488-8191.

12. STATEMENT OF APPLICANT

I state that these statements are true and correct. I recognize that providing false information may result in denial of licensure, disciplinary action against my license, or criminal penalties pursuant to Sections 456.067, 775.083, and 775.084, Florida Statutes. I state that I have read Chapters 456, 458 and 766.301-.316, Florida Statutes and Chapter 64B8, Florida Administrative Code.

I hereby authorize all hospitals, institutions or organizations, my references, personal physicians, employers (past and present), and all governmental agencies and instrumentalities (local, state, federal, or foreign) to release to the Florida Board of Medicine information which is material to my application for licensure.

I have carefully read the questions in the foregoing application and have answered them completely, without reservations of any kind. I state that my answers and all statements made by me herein are true and correct.

Should I furnish any false information in this application, I hereby agree that such act constitutes cause for denial, suspension, or revocation of my license to practice Medicine in the State of Florida. If there are any changes to my status or any change that would affect any of my answers to this application I must notify the board within 30 days.

I understand that my records are protected under federal and state regulations governing Confidentiality of Mental Health Patient Records and cannot be disclosed without my written consent unless otherwise provided in the regulations. I understand that my records are protected under federal and state regulations governing Confidentiality of Alcohol and Drug Abuse Patient Records, 42CFR Part 2, and cannot be disclosed without my written consent unless otherwise provided in the regulations. I also understand that I may revoke this consent at any time except to the extent that action has been taken in reliance upon it.

Sarah Stumbar

Print name

[Handwritten Signature]

Signature

11/4/14

Date

EXHIBIT 1 – REPORT ON PROFESSIONAL LIABILITY CLAIMS AND ACTIONS

Include information relating to liability actions occurring within the previous 10 years. The actions are required to be reported under section 456.039(1)(b) F. S. You must submit a completed form for each occurrence. If you are an allopathic, osteopathic, or podiatric physician, to satisfy this reporting requirement you may submit copies of reports previously submitted under the requirements of s. 456.049 F. S. instead of this exhibit.

Date of occurrence: / / ___ Date reported to licensee: / / ___ Date claim reported to insurer or self-insurer / / ___

Injured person's name: (last, first, middle initial) _____

Street Address: _____

City: _____ State: _____ Zip Code: _____

Age: _____ Sex: _____

Date of suit, if filed: / / ___

List all defendants with their health care provider license number involved in this claim:

1. _____ 2. _____
3. _____ 4. _____

Date of final claim disposition: ___/___/___

Date and amount of judgment or settlement, if any: _____

Was there an itemized verdict? [] Yes [] No (If "YES", attach copy of settlement verdict)

Indemnity paid on behalf of this defendant: \$ _____

Loss adjustment expense paid to defense counsel: \$ _____

All other loss adjustment expense paid: \$ _____

The date and reason for final disposition, if no judgment or settlement: _____

Name of institution at which the injury occurred: _____

Location of injury occurrence:

- Patient's Room Physical Therapy Dept. Radiology Labor & Delivery Room
- Operating Suite Nursery Emergency Room Special Procedure Room
- Recovery Room Critical Care Unit Other

Final diagnosis for which treatment was sought or rendered: _____

Describe misdiagnosis made, if any, of the patient's actual condition. _____

Describe the operation, diagnostic, or treatment procedure causing the injury. Use nomenclature and/or descriptions of the procedures used. Include method of anesthesia, or name of drug used for treatment, with detail of administration. _____

Describe the principal injury giving rise to the claim. Use nomenclature and/or descriptions of the injury. Include type of adverse effect from drugs where applicable. _____

Safety management steps taken by the licensee to make similar occurrences less likely: _____

I represent that these statements are true and correct pursuant to s. 837.06, Florida Statutes. I recognize that providing any false statements made in writing with the intent to mislead the Department staff in the performance of their official duties, shall be punishable as provided in s. 775.082 and 775.083, Florida Statutes.

Signature of physician: _____