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GOVERNMENT OF THE DISTRICT OF COLUMBIA
MURIEL BOWSER, MAYOR

$ 805

MEDICINE AND OSTEOPATHY (MD/DO)
NEW LICENSE APPLICATION

e every section of this application and submit the original application and all required supporting documents. If y answer questions, attach additional sheets with typed responses. False or misleading statements will be cause uld be cause for criminal prosecution pursuant to ***DC Code 22-2405***. YOU MUST INITIAL EACH PAGE OF THE

If you have any questions, call HRLA Customer Service at **(877) 672-2174, Monday through Friday, 8:30AM to 4:00PM EST.**

SECTION 1: LICENSURE TYPE & FEES

Professional Designation:	**Graduate Type:**	**Application Type:**
☑ Medicine & Surgery (MD)	☑ U.S./Canada	☑ License by Examination ($805.00)
☐ Osteopathy & Surgery (DO)	☐ International	

SECTION 2: APPLICANT INFORMATION

First Name: RYAN	**MI:** J	**Last Name:** MONTOYA
Date of Birth: [redacted]		**SSN:** [redacted]

Gender: ☑ Male ☐ Female

Degree(s) Held: ☑ MD ☐ DO ☐ MBBS ☐ MBA ☐ MPH ☐ PHD ☐ Other:

Race & Ethnicity (Optional):

- ☐ American Indian/Alaskan Native
- ☑ Asian/South Asian
- ☐ Black/African American
- ☐ Caucasian/White
- ☐ Native Hawaiian or Other Pacific Islander
- ☐ Hispanic or Latino
- ☐ Choose Not to Disclose
- ☐ Other: _____

Language(s) Spoken (Other than English):

- ☑ Spanish
- ☐ Vietnamese
- ☐ French
- ☑ Tagalog
- ☐ Amharic
- ☐ Mandarin
- ☐ Cantonese
- ☐ Russian
- ☐ German
- ☐ Korean
- ☐ Other: _____

SECTION 3: OTHER NAME(S) USED

If your name has changed at any point since you have taken any exams or attended college or university, you must provide a copy of a legal name change document for each time that it has changed. Acceptable documents for individuals are marriage certificates, divorce decrees, court orders, copies of social security cards or a passport.

First Name: N/A	**MI:**	**Last Name:**
First Name:	**MI:**	**Last Name:**
First Name:	**MI:**	**Last Name:**

SECTION 4: MAILING ADDRESS

Indicate your preferred mailing address by placing an "X" in the appropriate box. This will be the address to which all future licensing documents will be mailed.

☒ **HOME ADDRESS** ☐ **BUSINESS ADDRESS**

SECTION 5: HOME ADDRESS

A P.O. Box may NOT be used for an address. Home address information will NOT be made available to the public.

Current Home Address: [redacted]		
City: ARLINGTON	**State:** VA	**Zip Code:** 22204
Phone Number: [redacted]	**Email Address:** [redacted]	

SECTION 6: BUSINESS ADDRESS(ES)

A P.O. Box may NOT be used for an address. Business address information WILL be made available to the public.

Current Business Address #1: 26 HIGH ROCK WAY		
City: ALLSTON	**State:** MA	**Zip Code:** 02134
Phone Number: 617-787-4706	**Email Address:** RJMONTOYA CONSULTANTS @ GMAIL.COM	
Current Business Address #2: N/A		
City:	**State:**	**Zip Code:**
Phone Number:	**Email Address:**	

IMPORTANT MESSAGE RE: UPDATING CONTACT INFORMATION

Physicians are required to update changes to their name, home address or business address within thirty (30) days of the change. Failure to do so may result in disciplinary action. It is imperative that you update your information in writing, either via mail or email, to the point of contact listed below:

Attn.: District of Columbia Board of Medicine
899 N. Capitol St. NE, 2nd Floor
Washington, DC 20002
E: dcbomed@dc.gov

SECTION 7: MEDICAL SCHOOL(S) ATTENDED

List all medical schools attended, in reverse chronological order, beginning with the most recent at the top. Transcripts should be provided in a sealed envelope from the issuing institution for each school that you attended and listed below. Use additional sheets if necessary.

School #1 Name: UNIVERSITY OF MASSACHUSETTS MEDICAL SCHOOL	**Graduation Date:** 6/30/11	**Degree/Certificate Awarded:** MEDICAL DOCTOR (MD)
City: WORCESTER	**State:** MA	**Country (If not the United States):**
School #2 Name: N/A	**Graduation Date:**	**Degree/Certificate Awarded:**
City:	**State:**	**Country (If not the United States):**

Applicant's Initials: RJM

SECTION 8: POST-GRADUATE MEDICAL TRAINING

List all post-graduate medical training you attended, regardless of whether you completed the program. Include both accredited and non-accredited internships, residencies and fellowships. Also include verification letters from your training programs. For "Type of Position", use the letter key code below. List experience in reverse chronological order, beginning with the most recent. Explain all gaps greater than three (3) months. Use additional sheets if necessary.

Position Key Code:

A. Fellowship | **B.** Internship | **C.** Residency | **D.** Other

Program #1 Name: UNIVERSITY OF MASSACHUSETTS MEDICAL SCHOOL - FITCHBURG	**Start Date:** 7/1/11	**End Date:** 6/30/14	**Type of Position:** FAMILY MEDICINE RESIDENT **C.**
City: FITCHBURG	**State:** MA		**Country (if not the United States):**
Program #2 Name:	**Start Date:**	**End Date:**	**Type of Position:**
City:	**State:**		**Country (if not the United States):**
Program #3 Name:	**Start Date:**	**End Date:**	**Type of Position:**
City:	**State:**		**Country (if not the United States):**
Program #4 Name:	**Start Date:**	**End Date:**	**Type of Position:**
City:	**State:**		**Country (if not the United States):**
Program #5 Name:	**Start Date:**	**End Date:**	**Type of Position:**
City:	**State:**		**Country (if not the United States):**
Program #6 Name:	**Start Date:**	**End Date:**	**Type of Position:**
City:	**State:**		**Country (if not the United States):**

SECTION 9: WORK EXPERIENCE

List **ALL** work experience covering the five (5) year period prior to the submission of the application. Explain all gaps greater than three (3) months. Use additional sheets if necessary.

Employer #1 Name: RJM CONSULTANTS, INC.	**Start Date:** 7/1/14	**End Date:** (Present) 8/29/18	**Reason for Leaving:** MOVING WITH FAMILY
City: ALLSTON	**State:** MA		**Country (if not the United States):**
Employer #2 Name:	**Start Date:**	**End Date:**	**Reason for Leaving:**
City:	**State:**		**Country (if not the United States):**
Employer #3 Name:	**Start Date:**	**End Date:**	**Reason for Leaving:**
City:	**State:**		**Country (if not the United States):**
Employer #4 Name:	**Start Date:**	**End Date:**	**Reason for Leaving:**
City:	**State:**		**Country (if not the United States):**

SECTION 10: OTHER MEDICAL LICENSES

List all states and jurisdictions in which you have **EVER** held a medical license, regardless of status. Verifications should be provided from the issuing jurisdiction(s) for each license. For license type, indicate whether it was a full license, a temporary license, a training license, or any other type of license issued to you. Use additional sheets if necessary.

Jurisdiction #1: MASSACHUSETTS	**License Type:** FULL	**Issue Date:** 8/26/18	**Exp. Date:** 8/26/20	**License Number:** 266460
Jurisdiction #2:	**License Type:**	**Issue Date:**	**Exp. Date:**	**License Number:**
Jurisdiction #3:	**License Type:**	**Issue Date:**	**Exp. Date:**	**License Number:**
Jurisdiction #4:	**License Type:**	**Issue Date:**	**Exp. Date:**	**License Number:**

SECTION 11: PRACTICE SPECIALTIES & BOARD CERTIFICATIONS

If you practice in a specialty area, indicate your specialty in the boxes below. Use the specialty codes listed if applicable. If a specialty code is not listed, please write the full specialty in the boxes provided.

- AC Academic Medicine
- ADM Administrative Medicine
- AI Allergy & Immunology
- AN Anesthesiology
- DE Dermatology
- EM Emergency Medicine
- FM Family Medicine
- GE Geriatrics
- HOS Hospitalist
- IN Internal Medicine (General)
- IN Internal Medicine
  - IN/CA Cardiology
  - IN/EN Endocrinology
  - IN/GI Gastroenterology
  - IN/HEM Hematology
  - IN/ID Infectious Disease
  - IN/NEP Nephrology
  - IN/NEU Neurology
  - IN/ONC Oncology
  - IN/PCC Pulmon. Critical Care
  - IN/PUD Pulmon. Disease
  - IN/RH Rheumatology
- MG Medicine Genetics
- NU Nuclear Medicine
- OB Obstetrics & Gynecology
- OC Occupational Health
- OP Ophthalmology
- OMT Osteopathic Manipulative Treatment
- ENT Otolaryngology
- PA Pathology
- PED Pediatrics (General)
- PED Pediatrics
  - PED/AD Adolescent Medicine
  - PED/CA Cardiology
  - PED/EN Endocrinology
  - PED/GI Gastroenterology
  - PED/HEM Hematology
  - PED/NEO Neonatology
  - PED/NEP Nephrology
  - PED/NEU Neurology
  - PED/ONC Oncology
  - PED/PCC Pulmon. Critical Care
  - PED/PUD Pulmon. Disease
  - PED/RH Rheumatology
- PMR Physical Medicine & Rehabilitation
- PR Preventive Medicine/Public Health
- PSY Psychiatry
- RA Radiology
- REM Research Medicine
- SU Surgery (General)
- SU Surgery
  - SU/BT Burn/Trauma
  - SU/CS Cardiac Surgery
  - SU/CO Colon & Rectal Surgery
  - SU/GE General Surgery
  - SU/NE Neurological Surgery
  - SU/OR Orthopedic Surgery
  - SU/PL Plastic Surgery
  - SU/TH Thoracic Surgery
  - SU/TP Transplant
  - SU/UR Urology
  - SU/VA Vascular

Specialty #1: FM	
Specialty #2:	
Specialty #3:	
Specialty #4:	

If you are Board Certified in a specialty, please list the specialty and the related certifying agency below.

Certifying Board #1: N/A	**Certifying Agency:**
Certifying Board #2:	**Certifying Agency:**
Certifying Board #3:	**Certifying Agency:**
Certifying Board #4:	**Certifying Agency:**

Applicant's Initials: RJM

SECTION 12: REQUIRED SCREENING QUESTIONS

Please answer questions 1 through 15 by placing an "X" in the appropriate boxes. If you answer "Yes" to any question, you must provide full information and complete details on a separate sheet of paper, as well as attach copies of all relevant documents such as final court orders. Failure to provide relevant information will delay the application processing time.

1.	Have you ever been arrested, charged, convicted, pled guilty to, or pled no contest to the violation of any federal, state or other statute or ordinance constituting a felony or misdemeanor, including driving under the influence or *while impaired, but excluding minor traffic violations?*	☐ Yes ☒ No
2.	Have you been a defendant or respondent to a claim for damages or a malpractice action? If you answer "Yes", please complete the Malpractice Claims Form and submit it along with all relevant court documents (e.g., Complaint, Answer, and Final Order/Decision). A separate Malpractice Claims Form MUST be completed for each malpractice case.	☐ Yes ☒ No
3.	Have you ever voluntarily surrendered a license or registration certificate, or allowed it to lapse, after formal charges had been brought against you or while you were under investigation?	☐ Yes ☒ No
4.	Have you ever surrendered your clinical privileges, voluntarily or involuntarily, or had your clinical privileges denied, revoked, or suspended at any hospital or health care facility?	☐ Yes ☒ No
5.	Have you ever been terminated or resigned, voluntarily or involuntarily, from a clinical or professional training program for any reason?	☐ Yes ☒ No
6.	Has any licensing authority, in any healthcare field, taken adverse action against your license or privileges or informed you of any pending charges?	☐ Yes ☒ No
7.	Has any licensing authority, health facility, or peer review board, in any healthcare field, informed you of any pending charge(s) or investigation(s) against you?	☐ Yes ☒ No
8.	Are you presently now, or have you ever been, under a corrective action plan imposed by an employer, medical facility or educational program?	☐ Yes ☒ No
9.	Do you have a medical condition or have you become aware of any medical condition that impairs or limits your ability to practice your profession?	☐ Yes ☒ No
10.	Have you ever engaged in any conduct that either indicated an impairment, or actually impaired, your ability to *practice your profession?*	☐ Yes ☒ No
11.	Have you ever entered into a monitoring program for purposes of monitoring your abuse of alcohol, drugs, or other controlled substances?	☐ Yes ☒ No
12.	Have you ever entered into a monitoring program for purposes of monitoring your professional behavior including recordkeeping, billing, boundaries, quality of care or any other matter related to the practice of your profession?	☐ Yes ☒ No
13.	Within the last ten (10) years have you voluntarily resigned, been asked to resign, terminated, or disciplined by any employer?	☐ Yes ☒ No
14.	Have you ever withdrawn a license application or have you been denied a license or denied the privilege of taking a license examination by any professional licensing board or agency?	☐ Yes ☒ No
15.	Have you ever been excluded from any federal or state run insurance program, including Medicare and/or Medicaid?	☐ Yes ☒ No

SECTION 13: CLEAN HANDS

Clean Hands Before Receiving a License or Permit Act of 1996 Certification Requirement

Please read the information below carefully before responding to this yes or no question, as any false information provided requires that the Department of Health proceed to revoke your license or permit for which you are now applying, and fine you one thousand dollars ($1,000.00), pursuant to D.C. Official Code § 47-2864 (2001).

IF YOU ANSWER "YES" TO THIS QUESTION, PLEASE SUBMIT PROOF OF THE ARRANGEMENTS YOU HAVE MADE TO PAY THE OUTSTANDING DEBT. IF YOU DO NOT HAVE AN APPROVED PAYMENT SCHEDULE TO PAY THE AMOUNT YOU OWE OR IF NO APPEAL IS PENDING, THE LAW REQUIRES THAT YOUR NEW LICENSE APPLICATION BE DENIED.

As of this date, do any of the below statements apply to you:

- I owe more than $100 in fines, penalties, or interest assessed pursuant to D.C. Official Code Title 2, Chapter 18 (Civil Infractions Act of 1985);
- I owe more than $100 in fines, penalties, or interest assessed pursuant to D.C. Official Code Title 8, Chapter 8 (Litter Control Administrative Act of 1985);
- I owe more than $100 in fines, penalties, or interest assessed pursuant to D.C. Official Code Title 8, Chapter 9 (Illegal Dumping Enforcement Act of 1994);
- I owe more than $100 in fines, penalties, or interest assessed pursuant to D.C. Official Code Title 31, Chapter 24 (The Compulsory/No-Fault Motor Vehicle Insurance Act of 1982);
- I owe more than $100 in fines, penalties, or interest assessed pursuant to D.C. Official Code Title 50, Chapter 3 (Department of For-Hire Vehicles Establishment Act of 1985);
- I owe more than $100 in fines, penalties, or interest assessed pursuant to D.C. Official Code Title 50, Chapter 15 (Registration of Motor Vehicles);
- I owe more than $100 in fines, penalties, or interest assessed pursuant to D.C. Official Code Title 50, Chapter 23 (Traffic Adjudication Act of 1978);
- I owe more than $100 in fines, penalties, or interest assessed by another jurisdiction; provided, that a reciprocity agreement is in effect between the jurisdiction and the District;
- I owe more than $100 in past due taxes;
- I owe more than $100 in any outstanding fines, penalties, or interest due to the District of Columbia;
- I owe any amount of past due District of Columbia Water and Sewer Authority service fees;
- I owe any amount of a vehicle conveyance fee pursuant to D.C. Official Code Title 50, Chapter 23;
- I owe any amount of past due fines, penalties, or past due restitution on behalf of an employee due to a violation of D.C. Official Code Title 32, Chapters 1A, 10, 13 or Title 2, Subchapter X-A; or
- I have failed to file required District tax returns.

☐ Yes ☒ No

The information presented above is in compliance with the requirement to submit with your application for licensure or permit under the *Clean Hands Before Receiving a License Permit Act of 1996*, effective May 11, 1996 (D.C. Law 11-118, D.C. Code §47-2861, et seq.).

SECTION 14: DOCUMENT CHECKLIST

Please indicate the supporting documents you have included with this package or requested to be sent to the DC Board of Medicine. Please keep a photocopy of any submitted documents for your records, as they will not be returned.

☐ **Authorization to Release Information Form** I DO NOT REQUIRE THIS FORM.

The Board cannot discuss the status or details of your application with a third party, without a signed release from you authorizing the Board and its staff to communicate said matters.

☑ **Two (2) recent and identical passport type photos of the applicant's face (approx. 2" x 2") with the applicant's name printed on the back**

The photo must be original photos and cannot be computer-generated copies, or paper copies.

☑ **One (1) photocopy of a current government issued photo ID**

☑ **Criminal Background Check (CBC)** COMPLETED ON 8/24/18

To access the CBC form and instructions, go to https://dchealth.dc.gov/node/120532 or contact the CBC unit at (877) 783-4187.

☑ **Three (3) Character Reference Forms** TO BE MAILED BY THOSE FILLING OUT THE FORMS

Must be completed by an MD or DO in good standing in a jurisdiction of the United States who has knowledge of the applicants abilities and qualifications to practice medicine. If you have completed your postgraduate training within three years of the date of this application, at least one (1) reference letter needs to come from the director of your post-graduate clinical training program and one(1) from a supervising physician of your post-graduate clinical training program.

☑ **AMA/AOA Profile** SENT BY AMA

The profile should be submitted from the issuing institution.

☑ **Verification(s) of Licensure** REQUESTED TO BE MAILED TO DC ON 8/25/18

Verifications should be provided from the issuing jurisdiction(s) for each license identified in Section 10 of the application.

☑ **Medical School Transcripts**

Transcripts should be provided in a sealed envelope from the issuing institution for each school listed in Section 7.

☑ **Verification of Post-Graduate Training**

Verifications should be provided in a sealed envelope from the post-graduate institution for each program identified in Section 8 of the application. Each verification should be signed by the training program director or someone with authority to verify the applicant's participation in the identified post-graduate training program.

☑ **Examination Scores** SENT ELECTRONICALLY BY FSMB ON 8/26/18

Examination scores must be received from the examining body.

☐ **ECFMG Certificate (for foreign-trained applicants only)** NOT APPLICABLE

☐ **Malpractice Claims Form (if responded "Yes" to screening question #2)** NOT APPLICABLE

Must submit all relevant court documentation (e.g., Complaint, Answer, and Final Order/Decision).

☑ **National Practitioner Databank (NPDB) Self Query Report**

The Self-Query Report must be requested from the NBPD (https://www.npdb.hrsa.gov/ext/selfquery/SQHome.jsp) no more than thirty (30) days prior to submission of the application.

Applicant's Initials: RJM

SECTION 15: PAYMENT AND MAILING INFORMATION.	
Make your check or money order payable to **"DC Treasurer"**. A charge of sixty-five dollars ($65.00) will be imposed for dishonored checks (Public Law 89-208). **ALL FEES ARE NON-REIMBURSABLE.**	Mail your completed application and check to: **Board of Medicine – MD/DO New Application** **HRLA 1** **PO Box 37801** **Washington, DC 20013**

SECTION 16: APPLICANT'S AFFIDAVIT	
I hereby attest that the information given in this application, including all writings and exhibits attached hereto, is true and complete to the best of my knowledge. I understand that the making of a false statement on this application, including all writings and exhibits attached hereto, is punishable by criminal penalties.	
SIGNATURE OF APPLICANT:	**DATE:** 8/29/18

REPORT FRAUD, WASTE, AND ABUSE: To report fraud, waste, or abuse within the District government, contact the DC Office of the Inspector General's hotline by phone at 1-800-521-1639 (toll free) or 202-724-TIPS (8477), by email at hotline.oig@dc.gov, or by TTY at 711. For additional information, visit the Office of the Inspector General's website at https://oig.dc.gov.

DC | HEALTH
Health Regulation & Licensing Administration

GOVERNMENT OF THE DISTRICT OF COLUMBIA
MURIEL BOWSER, MAYOR

2018 SEP -6 PM 4:22

District of Columbia Board of Medicine
Character Reference Form

The District of Columbia Board of Medicine (Board), in its consideration of a candidate for licensure, depends on information by persons listed (i.e., references) regarding the candidate's character, employment and observed performance while providing care to patients and working with peers and staff. Please complete this form to the best of your ability and return it to the Board so the information you provide can be given consideration in the processing of this candidate's application.

APPLICANT INFORMATION		
First Name: Ryan	**MI:**	**Last Name:** Montoya

CHARACTER REFERENCE

1. **Date and type of service:**

   The above named individual served with us as Family Medicine Resident from 7/2011 to 6/2014.

   If you are responding for a training program, please provide the number of months of professional or postgraduate training awarded: 36 months.

2. **Please evaluate the following:**

	Poor	Fair	Good	Superior
Professionalism				✓
Clinical Judgment				✓
Relationship w/Patients				✓
Ethical/Professional Conduct				✓
Interest in Work				✓
Ability to Communicate				✓

3. **To your knowledge, has the applicant been the subject of any disciplinary or legal proceeding convened by a medical school, state regulatory agency or board, employer hospital, or health care facility? If yes, please explain on a separate sheet of paper.**

   No

4. **Recommendation (choose one):**

- ☑ Recommend high and without reservation.
- ☐ Recommend as qualified and competent
- ☐ Recommend with some reservation (please explain):
- ☐ Do not recommend (please explain):

_____

_____

5. **The above report is based on (choose all that apply):**

- ☑ Close Personal Observation;
- ☐ General impression;
- ☐ A composite of evaluations;
- ☐ Other:

_____

_____

6. **Relationship to applicant:**

- ☐ Medical school professor;
- ☐ Program Director;
- ☑ Attending Physician;
- ☐ Other:
- ☐ _____

_____

ATTESTATION OF REFERENCE

I hereby attest that I am the individual who completed this form and provided the below responses, and that the responses given are true and accurate.

First Name: Peter	**MI:** C	**Last Name:** McConarty	
SIGNATURE OF REFERENCE: Peter C McConarty MD			**DATE:** 3/29/18

DC | HEALTH
Health Regulation & Licensing Administration

GOVERNMENT OF THE DISTRICT OF COLUMBIA
MURIEL BOWSER, MAYOR

District of Columbia Board of Medicine
Character Reference Form

The District of Columbia Board of Medicine (Board), in its consideration of a candidate for licensure, depends on information by persons listed (i.e., references) regarding the candidate's character, employment and observed performance while providing care to patients and working with peers and staff. Please complete this form to the best of your ability and return it to the Board so the information you provide can be given consideration in the processing of this candidate's application.

APPLICANT INFORMATION

First Name: Ryan	MI:	Last Name: Montoya

CHARACTER REFERENCE

1. **Date and type of service:**

   The above named individual served with us as 3rd year Resident from 7/13 to 6/14.

   If you are responding for a training program, please provide the number of months of professional or postgraduate training awarded: _____.

2. **Please evaluate the following:**

	Poor	Fair	Good	Superior
Professionalism				X
Clinical Judgment				X
Relationship w/Patients				X
Ethical/Professional Conduct				X
Interest in Work				X
Ability to Communicate				X

3. **To your knowledge, has the applicant been the subject of any disciplinary or legal proceeding convened by a medical school, state regulatory agency or board, employer hospital, or health care facility? If yes, please explain on a separate sheet of paper.**

   NO

4. **Recommendation (choose one):**

- [x] Recommend high and without reservation.
- [ ] Recommend as qualified and competent
- [ ] Recommend with some reservation (please explain):
- [ ] Do not recommend (please explain):

5. **The above report is based on (choose all that apply):**

- [x] Close Personal Observation;
- [x] General impression;
- [ ] A composite of evaluations;
- [x] Other: working closely with Dr Montoya during my intern year he exemplified strong leadership and care

6. **Relationship to applicant:**

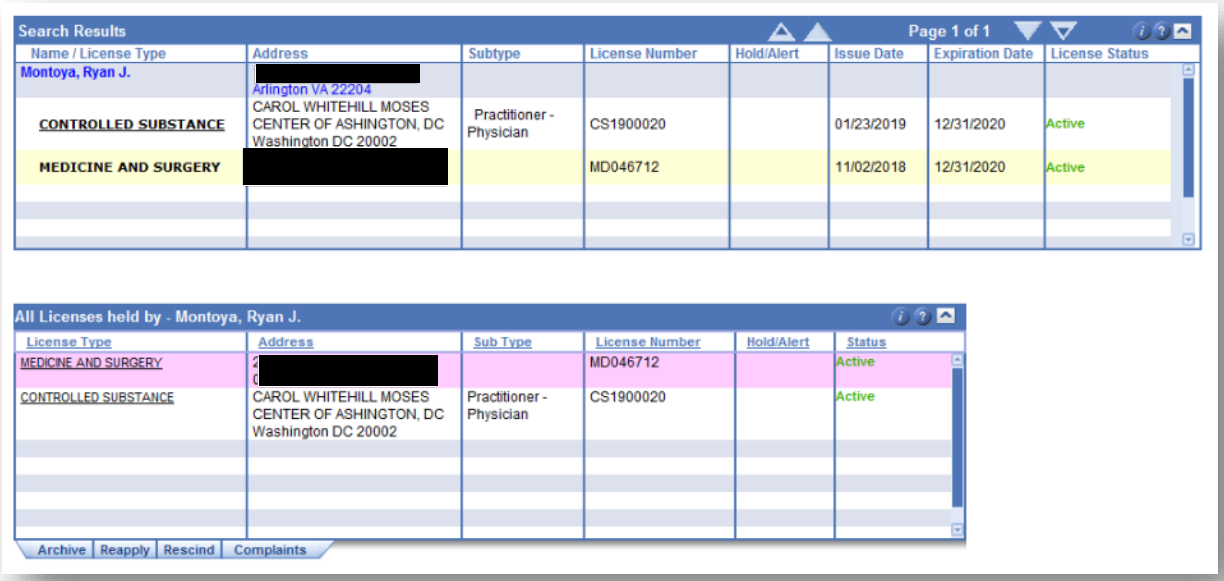
- [ ] Medical school professor;
- [ ] Program Director;
- [ ] Attending Physician;
- [x] Other: intern with Dr Montoya as my senior resident
- [ ]

ATTESTATION OF REFERENCE

I hereby attest that I am the individual who completed this form and provided the below responses, and that the responses given are true and accurate.

First Name: Jonathan	MI: B	Last Name: Yoder
SIGNATURE OF REFERENCE:	MD	DATE: 10/23/18

Ryan Montoya (MD046712)



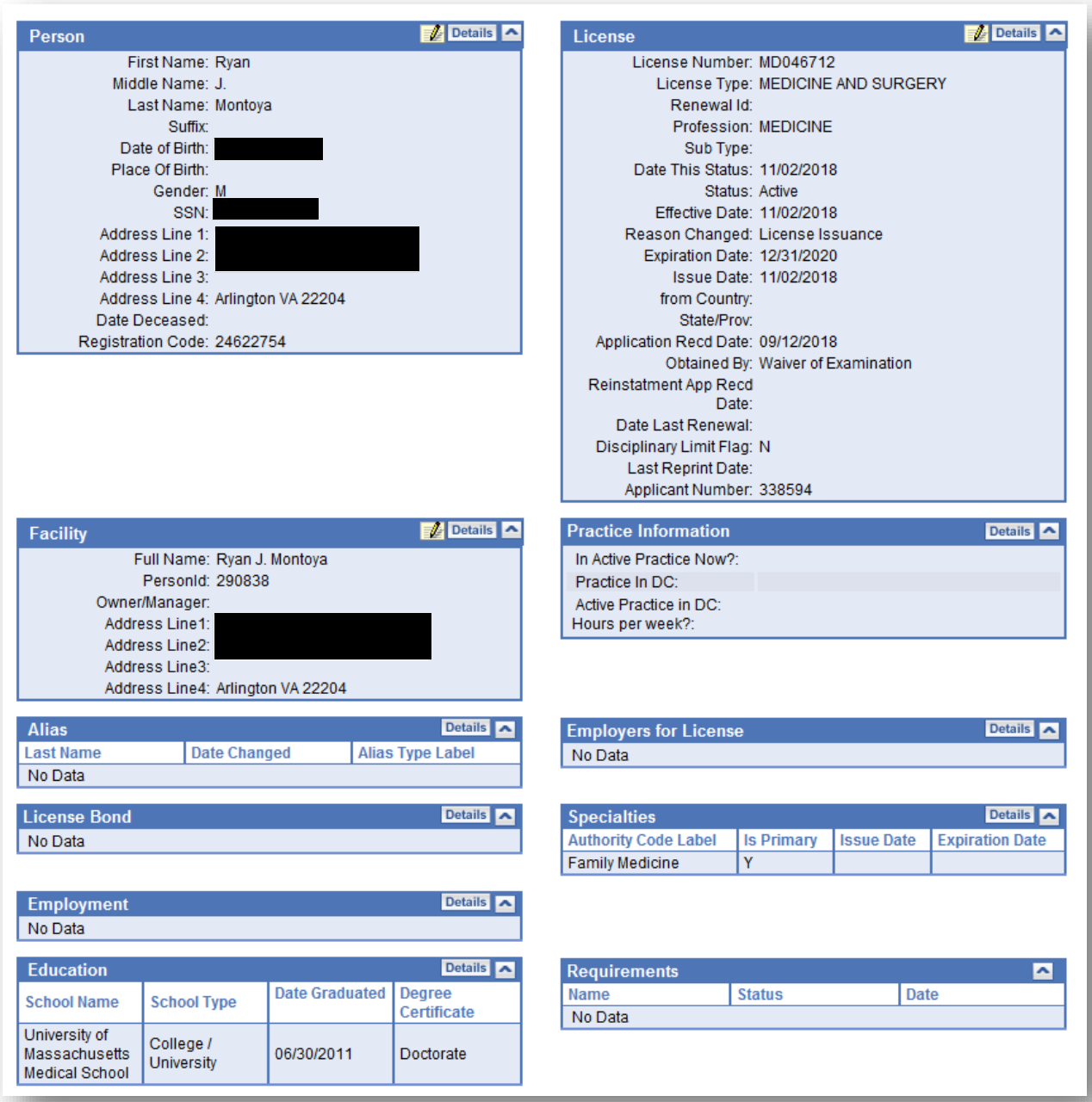
Search Results — Page 1 of 1

Name / License Type	Address	Subtype	License Number	Hold/Alert	Issue Date	Expiration Date	License Status
Montoya, Ryan J.	[redacted] Arlington VA 22204						
CONTROLLED SUBSTANCE	CAROL WHITEHILL MOSES CENTER OF ASHINGTON, DC Washington DC 20002	Practitioner - Physician	CS1900020		01/23/2019	12/31/2020	Active
MEDICINE AND SURGERY	[redacted]		MD046712		11/02/2018	12/31/2020	Active

All Licenses held by - Montoya, Ryan J.

License Type	Address	Sub Type	License Number	Hold/Alert	Status
MEDICINE AND SURGERY	[redacted]		MD046712		Active
CONTROLLED SUBSTANCE	CAROL WHITEHILL MOSES CENTER OF ASHINGTON, DC Washington DC 20002	Practitioner - Physician	CS1900020		Active

Archive | Reapply | Rescind | Complaints



Person Details

First Name: Ryan
Middle Name: J.
Last Name: Montoya
Suffix:
Date of Birth: [redacted]
Place Of Birth:
Gender: M
SSN: [redacted]
Address Line 1: [redacted]
Address Line 2:
Address Line 3:
Address Line 4: Arlington VA 22204
Date Deceased:
Registration Code: 24622754

License Details

License Number: MD046712
License Type: MEDICINE AND SURGERY
Renewal Id:
Profession: MEDICINE
Sub Type:
Date This Status: 11/02/2018
Status: Active
Effective Date: 11/02/2018
Reason Changed: License Issuance
Expiration Date: 12/31/2020
Issue Date: 11/02/2018
from Country:
State/Prov:
Application Recd Date: 09/12/2018
Obtained By: Waiver of Examination
Reinstatment App Recd Date:
Date Last Renewal:
Disciplinary Limit Flag: N
Last Reprint Date:
Applicant Number: 338594

Facility Details

Full Name: Ryan J. Montoya
PersonId: 290838
Owner/Manager:
Address Line1: [redacted]
Address Line2:
Address Line3:
Address Line4: Arlington VA 22204

Practice Information Details

In Active Practice Now?:
Practice In DC:
Active Practice in DC:
Hours per week?:

Alias Details

Last Name	Date Changed	Alias Type Label
No Data		

Employers for License Details

No Data

License Bond Details

No Data

Specialties Details

Authority Code Label	Is Primary	Issue Date	Expiration Date
Family Medicine	Y		

Employment Details

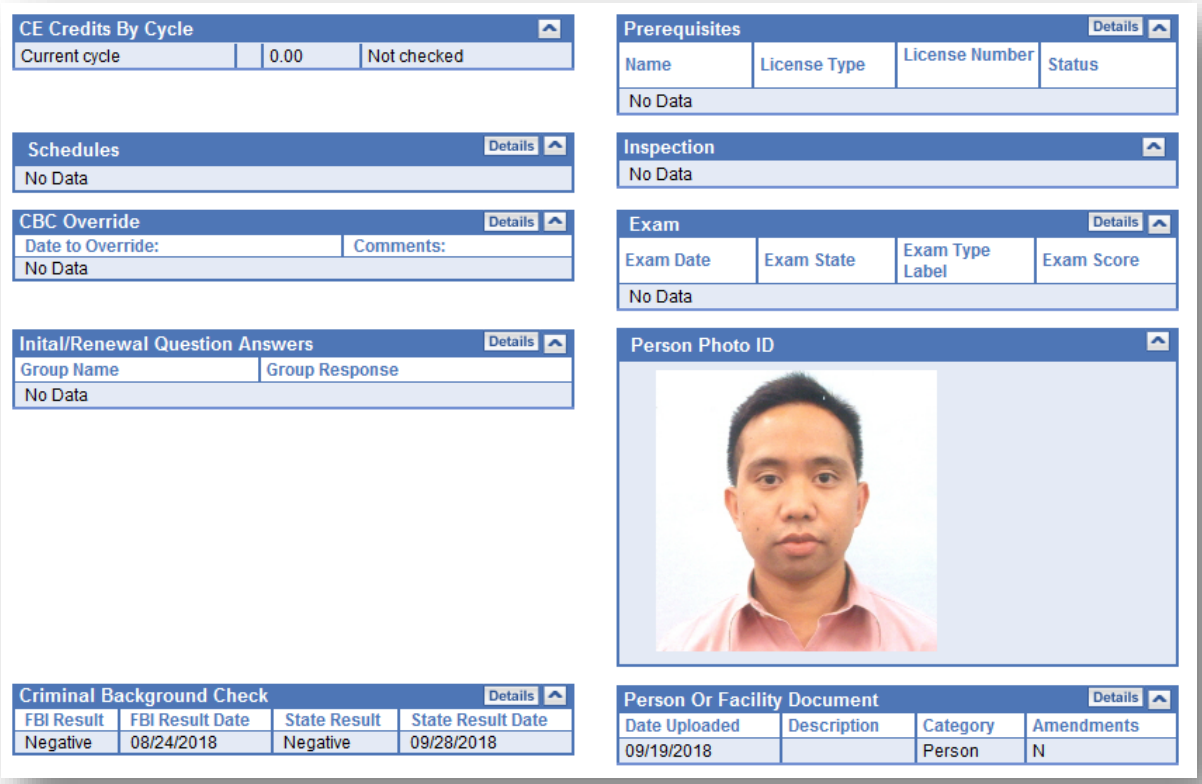
No Data

Education Details

School Name	School Type	Date Graduated	Degree Certificate
University of Massachusetts Medical School	College / University	06/30/2011	Doctorate

Requirements

Name	Status	Date
No Data		



CE Credits By Cycle

Current cycle	0.00	Not checked

Prerequisites Details

Name	License Type	License Number	Status
No Data			

Schedules Details

No Data

Inspection

No Data

CBC Override Details

Date to Override:	Comments:
No Data	

Exam Details

Exam Date	Exam State	Exam Type Label	Exam Score
No Data			

Inital/Renewal Question Answers Details

Group Name	Group Response
No Data	

Person Photo ID

Criminal Background Check Details

FBI Result	FBI Result Date	State Result	State Result Date
Negative	08/24/2018	Negative	09/28/2018

Person Or Facility Document Details

Date Uploaded	Description	Category	Amendments
09/19/2018		Person	N