# ALABAMA BOARD OF MEDICAL EXAMINERS

P.O. Box 946 / Montgomery, AL 36101-0946 / (334) 242-4116

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ABME

## APPLICATION FOR CERTIFICATE OF QUALIFICATION TO PRACTICE MEDICINE IN ALABAMA

Under Alabama law, this document is a public record and will be provided upon request.

To the Alabama Board of Medical Examiners:
I hereby make application for a certificate to practice medicine in the state of Alabama, and submit the following statement concerning my age, moral character, preliminary and medical education and practice:

**Type in the following:**

Name in Full (First, Middle, Last,) Leah Nicole Torres (M.D./D.O.) MD

Alternate Name(s) Used: _____

Address REDACTED City Carlsbad State NM Zip 88220

Place of Birth U.S.A. Date of Birth REDACTED 1979 Sex F

Social Security #* REDACTED 4354 Email REDACTEDgmail.com

Telephone (H/C) REDACTED Telephone (W) _____

* Social Security Number (Pursuant to Ala. Code § 30-3-194, it is mandatory that we request and that you provide your social security number (SSN) on this application. The uses of your SSN are limited to the purpose of administering the state child support program and intra-agency for identification purposes. If your SSN is not provided, your application is not complete and no license will be issued)

**Answer yes or no (if any answers below are in the affirmative, please explain in detail and provide the complete name and address of any state board, hospital, psychiatrist/psychologist, etc.):** **YES** **NO**

1. Have you ever been convicted of a crime or offense (felony or misdemeanor) related to the practice of medicine? (If yes, please provide the name of the court of record or a copy of the record of conviction) ☐ ☒

2. Have you ever been convicted of any violation of a state or federal law relating to controlled substances? (If yes, please provide the name of the court of record or a copy of the record of conviction) ☐ ☒

3. Have you ever been cited for, charged with, or convicted of any violation of any law, felony or misdemeanor (excluding minor traffic violations such as speeding and parking tickets), or are you required to register as a sex offender for any reason? (If yes, please provide the name of the agency, jurisdiction, and/or court along with the case number and incident date). NOTE: Include felony and misdemeanor criminal matters that have been dismissed, expunged, sealed, subject to a diversion or deferred prosecution program, or otherwise set aside. ☐ ☒

4. Has your DEA registration or any state controlled substance certificate been denied or subject to any discipline, including but not limited to the following: revocation; suspension; probation; restriction(s); condition(s); reprimand or fine; or has your DEA registration or any state controlled substance certificate been voluntarily surrendered while under investigation? ☐ ☒

5. Has your certificate of qualification or license to practice medicine in any state been denied or subject to any discipline, including but not limited to the following: revocation; suspension; probation; restriction(s); condition(s); reprimand or fine; or has your certificate of qualification or license to practice medicine in any state been voluntarily surrendered while under investigation or under threat of discipline? ☐ ☒

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6. Have your staff privileges at any hospital or health care facility been revoked, suspended, curtailed, limited, or placed under conditions restricting your practice? ☐ ☒

7. Have you ever been denied a certificate of qualification or a license to practice medicine in any state or has your application for a certificate of qualification or license to practice medicine been withdrawn under threat of denial? ☐ ☒

8. Have you ever had a judgment rendered against you, or action settled relating to performance of your professional service? ☐ ☒

9. To your knowledge, are you the subject of an investigation or proposed action by any licensing board/agency as of the date of this application? ☐ ☒

10. Within the past five years, have you ever raised the issue of consumption of drugs or alcohol or the issue of a mental, emotional, nervous, or behavioral disorder or condition as a defense, mitigation, or explanation for your actions in the course of any administrative or judicial proceeding or investigation; any inquiry or other proceeding; or any proposed termination by an educational institution; employer; government agency; professional organization; or licensing authority? ☐ ☒

11. Have you ever been diagnosed as having or have you ever been treated for pedophilia, exhibitionism, or voyeurism? ☐ ☒

12. Are you currently* engaged in the excessive use of alcohol, controlled substances, or the use of illegal drugs, or received any therapy or treatment for alcohol or drug use, sexual boundary issues or mental health issues? (If you are an anonymous participant in the Alabama Professionals Health Program and are in compliance with your contract, you may answer "No" to this question. Such answer for this purpose will not be deemed upon certification as providing false information to the Alabama Board of Medical Examiners or the Medical Licensure Commission of Alabama) If you answer "Yes", then a description is required. ☐ ☒

**IMPORTANT:** The Board recognizes that licensees encounter health conditions, including those involving mental health and substance use disorders, just as their patients and other health care providers do. The Board expects its licensees to address their health concerns and ensure patient safety. Options include anonymously self-referring to the Alabama Professionals Health Program (334-954-2596), a physician advocacy organization dedicated to improving the health and wellness of medical professionals in a confidential manner. The failure to adequately address a health condition, where the licensee is unable to practice medicine with reasonable skill and safety to patients, can result in the Board taking action against the license to practice medicine.

_____ Please initial certifying that you understand and acknowledge your duty as a licensee to address any such condition as stated above.

* The term "currently" does not mean on the day of, or even in the weeks or months preceding the completion of this application. Rather, it means recently enough so that the condition referred to may have an ongoing impact on one's functioning as a physician within the past two years.

13. Within the past five years, have you been convicted of driving under the influence (DUI) or have you been charged with DUI and been convicted of a lesser offense such as reckless driving? ☐ ☒

14. Has your medical education, training or practice been interrupted or suspended, or have you ceased to engage in direct patient care, for a period longer than 60 days for any reason other than a vacation or for the birth or adoption of a child? ☒ ☐
Between June 2018 to Feb 2019 I worked as a Locum Tenens physician with Weatherby and had not procured a position. I promptly took a permenent position in NM.

15. Have you ever been placed on academic or disciplinary probation by a medical school or postgraduate program? ☐ ☒

16. Have you ever been disciplined for unprofessional conduct/behavior reasons by a medical school or postgraduate program? ☐ ☒

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17. Were you notified in writing that there were limitations or special requirements imposed on you because of questions of academic, clinical, or disciplinary problems, or any other reason during your medical education or postgraduate training, such as repeating a class or classes, taking time off from school to study for an examination? ☐ ☒

**Please provide the following information:**

Place provide a brief description and the location of your intended medical practice in the state of Alabama:
West Alabama Women's Center

**Pre-Medical Education: List all schools attended, undergraduate and post-graduate work other than medical school, dates attended, and degree conferred.**

| | Date | Name of School | Degree |
|---|---|---|---|
| 1. | From 9/97 To 08/01 | University of Michigan | BA |
| 2. | From_____ To_____ | | |
| 3. | From_____ To_____ | | |
| 4. | From_____ To_____ | | |

**Medical Education: List all medical schools attended, dates, and complete addresses of institutions. Do not list post-graduate medical education training.**

| | Date | Name of School | Degree |
|---|---|---|---|
| 1. | From 08/04 To 06/08 | University of Illinois at Chicago | MD |
| 2. | From_____ To_____ | | |
| 3. | From_____ To_____ | | |
| 4. | From_____ To_____ | | |

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**Post-graduate Medical Education Training: List all post-graduate medical education training since graduation from medical school, dates, and complete addresses of institutions. Do not list practice experience.**

| | Date | Name of School | Address |
|---|---|---|---|
| 1. | From 7/08 To 6/12 | Albert Einstein Medical Center | 5501 old York Rd, Philadelphia, PA |
| 2. | From 7/12 To 6/14 | University of Utah | 30 N 1900 E Salt Lake City, UT |
| 3. | From ____ To ____ | | |
| 4. | From ____ To ____ | | |
| 5. | From ____ To ____ | | |

**Specialty(s):**

Obstetrics and Gynecology

**Specialty Board Certification:**

Are you CURRENTLY certified by one of the specialty boards approved by the American Board of Medical Specialties or the American Osteopathic Association? If Yes, have your specialty board send verification to the Board. ☐ Yes ☒ No

I am currently "board eligible" and taking my oral examination at the end of 2020 to complete my certification in OB/Gyn through the American Board of Obstetrics and Gynecology

**Original Full License (if applicable):**

Provide name of state/territory, date issued, license number, and examination taken.

| State/Territory | Date Issued | License Number | Examination Taken |
|---|---|---|---|
| UT | 4-12-12 | 8243165 | |

Has this license been the subject of any disciplinary action? ☐ YES ☑ NO If yes, please provide summary and supporting documentation.

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**Activities following Medical School and Training: List all practice experience since completion of your formal training, providing dates, institutions/hospitals, and complete addresses.**

| | Date | Name of Institution/Hospital | Address |
|---|---|---|---|
| 1. | From 8/14 To 10/15 | Cache Valley Community Health Center | 1515 N 400 E, Ste 104 Logan, UT |
| 2. | From 11/15 To 6/18 | Rocky Mountain Women's Health Center | 3336 S Pioneer Pkwy Ste 301 ~~Salt~~ West Valley City, UT |
| 3. | From 7/18 To 2/19 | Locum Tenens work | |
| 4. | From 2/19 To Present | Women's Health Services | 2420 W Pierce St Ste 200 Carlsbad, NM |
| 5. | From ____ To ____ | | |
| 6. | From ____ To ____ | | |
| 7. | From ____ To ____ | | |
| 8. | From ____ To ____ | | |

**Hospital Privileges: List all hospitals where you have held staff privileges of any type, providing dates, hospital names, and complete addresses**

| | Date | Name of Hospital | Address |
|---|---|---|---|
| 1. | From 8/14 To 10/15 | Logan Regional Hospital | 500 E 1400 N Logan, UT |
| 2. | From 11/15 To 6/18 | Jordan Valley Medical Center | 3460 Pioneer Pkwy, West Valley, UT |
| 3. | From 2/19 To Present | Carlsbad Medical Center | 2430 W Pierce St, Carlsbad, NM |
| 4. | From ____ To ____ | | |
| 5. | From ____ To ____ | | |
| 6. | From ____ To ____ | | |
| 7. | From ____ To ____ | | |

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## State Licensure:

List all states where you have been licensed to practice medicine. List all licenses including training or educational licenses.

| | | | |
|---|---|---|---|
| PA MT193829 | (Training) Full | UT 8243165 | Training (Full) |
| VT 042.0014096 | Training (Full) | IA MD-45764 | Training (Full) |
| NM MD2018-0911 | Training (Full) | | Training Full |
| | Training Full | | Training Full |
| | Training Full | | Training Full |
| | Training Full | | Training Full |
| | Training Full | | Training Full |
| | Training Full | | Training Full |
| | Training Full | | Training Full |
| | Training Full | | Training Full |

**SPEX:**

Have you successfully completed a written licensing examination within the last ten years? ☒ YES ☐ NO

Have you been certified or re-certified within the past ten years by one of the specialty boards approved by the American Board of Medical Specialties or the American Osteopathic Association? ☐ YES ☒ NO See above

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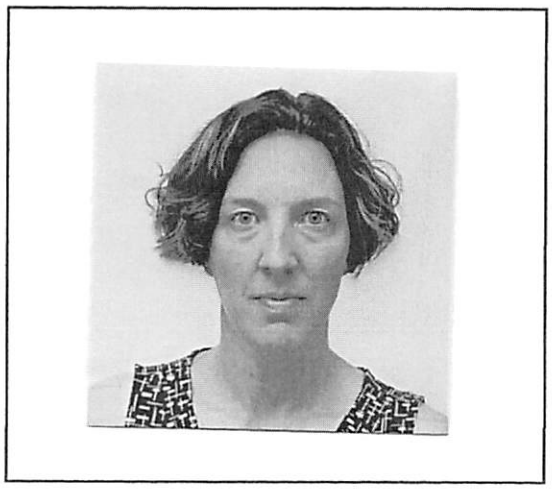
**Release:**

I, Leah Torres certify that all of the information supplied in the foregoing application is true and correct to the best of my knowledge, that the photograph submitted is a true likeness of myself and was taken within sixty days prior to the date of this application. I acknowledge that any false or untrue statement or representation made in this application may result in the revocation of my license to practice medicine and criminal prosecution to the fullest extent of the law.

I further consent to and authorize the release of this application and any information submitted with it or information collected by the Alabama Board of Medical Examiners in connection with this application, including derogatory information, to any person or organization having a legitimate need for the information, and I release the Alabama Board of Medical Examiners from all liability for the release of this information. I further consent to and authorize the release of information, including derogatory information, which may be in the possession of other individuals or organizations to the Alabama Board of Medical Examiners, and I release this individual or organization from any liability for the release of information.

Applicant's signature



Under Alabama law, this document is a public record and will be provided upon request.
**The Alabama Board of Medical Examiners will enforce the Board's rules and option for the issuance of a Non-Disciplinary Citation and Administrative Charge when an applicant falsifies an application.**

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