STATE OF TENNESSEE
DEPARTMENT OF HEALTH
DIVISION OF HEALTH LICENSURE AND REGULATION
OFFICE OF HEALTH RELATED BOARDS
665 Mainstream Drive, Second Floor
Nashville, TN 37243
http://tn.gov/health

Tennessee Board of Medical Examiners
Medical Doctors
1-800-778-4123 or 615-532-4384

October 26, 2018

Chava Kahn MD
7733 16th Street, NW
Washington, DC 20012 US

Dear Applicant:

It is my pleasure to inform you that your application for a license to practice as a Medical Doctor in Tennessee has been initially approved by the Board. Your number shall be 58359. This initial approval must be ratified by the Board of Medical Examiners at its next meeting, scheduled for 11/13/2018, before a license can be issued to you. **If ratified by the Board of Medical Examiners this number will become your permanent license number and a wall certificate will follow.**

However, this letter serves as your authorization to commence your practice, pending the final action by the Board of Medical Examiners. If the Board of Medical Examiners should not ratify the initial approval of your application, you will be notified in writing at which time this authorization shall cease to be effective.

Within 10 working days after the Board of Medical Examiners meeting, you will be sent either your certificate (indicating final approval by the Board of Medical Examiners) or a letter providing (1) an explanation as to why the Board of Medical Examiners failed to ratify issuance of your certificate and (2) specific instructions as to any action you may take to have the decision reviewed. No further action on your part is necessary at this time.

Our best wishes go with you into a new phase of your career.

Sincerely,

Board Administrator
Tennessee Board of Medical Examiners
INITAPRPTX

Important Information Regarding Professional Privilege Tax

T.C.A. §67-4-1701, et seq., requires the payment of an annual professional privilege (occupation) tax. For more information regarding the professional privilege (occupation) tax please go to:. http://www.tn.gov/revenue/topic/professional-privilege-tax.shtml.

Notice to All Prescribers: All prescribers with DEA numbers who prescribe controlled substances in Tennessee for more that fifteen (15) days per year, **shall** be registered in the controlled substance database. New licensees shall have up to thirty (30) calendar days after notification of licensure to register in the database. For more information, please go to: http://tn.gov/health/article/CSMD-about.shtml.

File Number 58359

CHECK SHEET

11-27-18
0- Day Deadline Date

Xact Number 944664

Chava Kahn MD
7733 16th Street, NW
Washington, DC. 20012

✓ 8-20 **Online Application** - 4 (years of med. ed.) ✓ list all prof. app. ✓ *health profession ✓

✓ 8-20 Profile Questionnaire (294668) Short-completed PH. ✓

✓ 8-20 Photograph

✓ 8-20 Fee ($410.00)

✓ 8-20 Declaration of Citizenship (as of 10/1/12)
______ Declaration Supporting Documents

✓ 8-20 Proof of Citizenship/Legal Entitlement

✓ 8-20 Letter of Recommendation (letterhead/date)
Seay MD

✓ 8-20 Letter of Recommendation (letterhead/date)
Bossano MD

______ Question(s) ____/____/____/____

Explanation ______ Final Documents ______

E-mail Address: chavykahn@gmail.com

✓ 8-29 Medical School Transcript: ✓ U.S. ______ Canada ______ Mexico ______ Foreign

______ E.C.F.M.G. (Foreign Medical School Graduates Only) (Notarized copy of ECFMG certificate only)

✓ ______ Postgraduate Training: (4) 8-29 08-12 / 9-20 12-14 / ____/____/____/____

✓ 8-29 Exam Scores: ✓ USMLE ____ FLEX ____ NBME ____ LMCC ____ STATE EXAM

✓ 9-25 Other Licenses: DC / MD / MI / ____/____/____/____

____/____/____/____/____/____/____/____/____

____/____/____/____/____/____/____/____/____

✓ 8-14 Criminal Background Check (as of 6/1/06)

______ SAVE/USCIS Verification (administrator)

✓ 8-24 TSOR Clearance (administrator)

✓ 8-24 FSMB Clearance (administrator)

______ Approved to send INS Letter* ______ More Information Needed

CONSULTANT REVIEW ✓ Approved for Licensure ______ Interview ______ Deny

Pierre Clausi-Devoe MD
Consultant Signature

10/9/18 Date

COMMENTS: ______

*INS ("but for") letters will only be sent for those who are <u>not</u> entitled to live or work in the U.S.

Deficiency Letter(s): 1st 8-27 /2nd ______ /3rd ______ /4th ______ /5th ______ /6th ______

Email(s): 1st 9-13 /2nd 10-9 /3rd 10-18 /4th 10-24 /5th ______ /6th ______

Phone Call(s): 1st 8-30 /2nd ______ /3rd ______ /4th ______ /5th ______ /6th ______

Are you the spouse of a member of the armed forces who has been transferred by the military to Tennessee or who has, within the preceding 180 days, retired from the armed forces, received a discharge other than a dishonorable discharge from the armed forces or been released from active duty to a reserve component? (If yes, please provide proof of same.)	
Type of intended primary specialty practice in Tennessee:	**Obstetrics and Gynecology**
Have you previously applied for a medical license in Tennessee?	**No**

Educational Information 1

Name of educational institution attended:	**Yeshiva University**
City:	**New York**
State:	**New York**
Degree/certificate earned:	**BA**
Program Major:	**English Literature**
Graduation date of education program:	**05/15/2002 (mm/dd/yyyy)**

Educational Information 2

Name of educational institution attended:	**Albert Einstein College of Med**
City:	**Bronx**
State:	**New York**
Degree/certificate earned:	**MD**
Program Major:	**Medicine**
Start Date Graduation date of education program:	05/15/2003 **06/05/2008 (mm/dd/yyyy)**

Educational Information 3

Name of educational institution attended:	**The University of Michigan**
City:	**Ann Arbor**
State:	**Michigan**
Degree/certificate earned:	**MPH**
Program Major:	**Epidemiology**
Start Date Graduation date of education program:	[illegible] **05/31/2014 (mm/dd/yyyy)**

EDUCATIONAL AND EXAMINATION INFORMATION

PRE-MEDICAL EDUCATION

From MM/YY To MM/YY Educational Institution Location

From MM/YY To MM/YY Educational Institution Location

From MM/YY To MM/YY Educational Institution Location

MEDICAL EDUCATION

I have spent _____ years in the study of medicine in the medical educational institutions below

From MM/YY To MM/YY Educational Institution Location

From MM/YY To MM/YY Educational Institution Location

POSTGRADUATE TRAINING

I have spent [illegible] years in medical training in the medical educational institutions below

From [illegible] MM/YY To [illegible] MM/YY [illegible] Educational Institution [illegible] Location

From [illegible] MM/YY To [illegible] MM/YY [illegible] Educational Institution [illegible] Location

From MM/YY To MM/YY Educational Institution Location

I have taken the following medical licensure examinations (Check all applicable)

1 ____ National Boards (NBME) Certificate Number
2 ____ FLEX examination administered by the State of ______ on Date
3 ____ Licensure by the Medical Council of Canada (LMCC)
4 ✓ USMLE
5 ____ State Board administered by ______ (State) prior to 1972

Are you ABMS Board certified? Y ◉ N ○

If yes, identify board of specialty/subspecialty Obstetrics & Gynecology

I intend to perform Level II Office Based Surgery which is integral to a planned treatment regimen and not performed on an urgent or emergent basis Y ◉ N ○

If you intend to perform Level III Office Based Surgery, you must apply for and obtain a permit prior to engaging in such practice. You may access the application by visiting [illegible]

Health

DECLARATION OF CITIZENSHIP

MUST ACCOMPANY ALL INITIAL LICENSURE OR RECIPROCITY LICENSURE APPLICATIONS

Pursuant to T.C.A. § 4-58-101 et seq. the Eligibility Verification for Entitlements Act (also known as the "SAVE Act") requires the Tennessee Department of Health (including all Boards, Commissions and contractors), along with every local health department in the State, to verify that every adult applicant applying for a professional license is either a U.S. citizen, a "qualified alien" or a nonimmigrant who meets the requirements set out at 8 U.S.C. 1621.

I am applying for a(n) Medical doctor ______________________
Healthcare Profession (Please Print) — License number (if applicable)

Please Print Legibly

1. Name: [illegible] — Last — First — Middle — Maiden
2. Mailing Address: [illegible] — Street/P.O. Box — City — State — Zip
3. Phone Number: [illegible] — Personal/Home — Office — Fax
4. I am a foreign national not physically present in the United States ☐ Yes ☒ No If you answered yes to this question, please sign this form in the presence of a notary and return it with your application. No further documentation is required.
5. I am a United States Citizen: ☒ Yes ☐ No
6. Applicants claiming United States Citizenship **MUST** provide a copy of one of the following:
   - a) Tennessee Driver's License, or photo ID issued by the Tennessee Department of Safety.
   - b) A valid driver license or ID issued by another state, provided its issuance requirements meet Tennessee Department of Safety criteria.
   - c) An official birth certificate issued by a U.S. state, territory, or other jurisdiction. Puerto Rican birth certificates issued before July 1, 2010 do not qualify.
   - d) A federally issued birth certificate.
   - e) A valid, unexpired U.S. passport.
   - f) A report of birth abroad of a U.S. citizen.
   - g) A certificate of citizenship.
   - h) A certificate of naturalization.
   - i) A U.S. citizen ID card.
   - j) Any successor document to #'s e-i above.
   - k) A Social Security Card that is verifiable with the Social Security Administration in accordance with federal law.

If you answered No to question 5, indicate from the list below which category applies to you. Check one.
- Permanent Resident
- A nonimmigrant applicant for a professional or commercial license whose visa for entry into the United States is related to such employment, or a nonimmigrant under the Immigration and Nationality Act (8 U.S.C. 1101 et seq.).

Division of Health Licensure and Regulation • Office of Emergency Medical Services
665 Mainstream Drive • Nashville, TN 37243
Tel 615 741 2[illegible] • Fax 615 741-4217 • Website tn.gov[illegible]

Not Legible

FCVS

FEDERATION CREDENTIALS VERIFICATION SERVICE

Medical Professional Information Profile

This report provides credentialing information for:

Name:	**Kahn, Chava**
Social Security Number:	[redacted]
Date of Birth:	**July 10, 1980**
FID#:	**215134560**
Recipient:	**TN - Tennessee Board of Medical Examiners**
Delivery Date:	**08/09/2018**

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.

400 FULLER WISER ROAD | EULESS, TX 76039 | TEL (817) 868 - 5000 | FAX (817) 868 - 5099

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.

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

Kahn
Applicant's Printed Last Name

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

7/25/2018
Date of Signature (must correspond to date of notarization)

TONI JOSETTE WRIGHT
ELECTRONIC NOTARY PUBLIC
REG # 7535120
EXPIRES 6/30/2020
COMMONWEALTH OF VIRGINIA

State of Virginia County of James City

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 25 day of July, 20 18

Notary Public Signature: Toni Josette Wright

My Notary Commission Expires: 06/30/2020

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

[illegible] FULLER WISER ROAD | SUITE [illegible] | EULESS, TX [illegible] | TEL [illegible]

DocID:5b5883736606830b9243cde8

FCVS | FEDERATION CREDENTIALS VERIFICATION SERVICE

Identity

Federation of STATE MEDICAL BOARDS

Biographic Information

Medical professional Name(s): **Kahn, Chava**

Date of Birth: July 10, 1980

Place of Birth: New York, NY, UNITED STATES

Contact Information

Home Address: 7733 16th Street, NW
Washington, DC 20012
UNITED STATES

Mobile Phone: (201) 394-9637

Email: chavkahn@gmail.com

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: Kahn (Last) Chava (First) _____ (Middle)

FCVS ID Number: 215134560

Notary – Please complete the section below:

State of Virginia County of James City

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 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) 25, of (Month) July, (Year) 2018.

Notary Public Signature: Toni Josette Wright

Commission Expiration Date* (Month) 06 /(Day) 30 /(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.**

Notary Stamp Here

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., Suite 300
Euless, TX 76039-3856

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
08/15/2003	06/05/2008	Medical Education	Albert Einstein College of Medicine of Yeshiva University Bronx New York UNITED STATES
07/01/2008	06/30/2012	Postgraduate Training	Montefiore Medical Center/Albert Einstein College of Medicine Program Bronx New York UNITED STATES
07/01/2012	06/30/2014	Postgraduate Training	University of Michigan Ann Arbor Michigan UNITED STATES

End of Chronology of Activities report for: Kahn, Chava

FCVS FEDERATION CREDENTIALS VERIFICATION SERVICE

Medical Education

Federation of STATE MEDICAL BOARDS

Medical Education

Medical School: **Albert Einstein College of Medicine of Yeshiva University**

Location: Bronx, NY

UNITED STATES

Credentials Analysis Information for Medical Education

Issue:
FCVS has identified a medical education Discrepancy at Albert Einstein College of Medicine of Yeshiva University.

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 Medical Education

Federation of STATE MEDICAL BOARDS

Instruction to the Dean

Please complete both pages of this form, sign date and seal on the front page then return to:

Federation Credentials Verification Service
400 Fuller Wiser Road
Suite 300
Euless, TX 76039

The individual identified on the attached Authorization for Release of Information, Documents and Records form has authorized your medical school to provide to the Federation Credentials Verification Service (FCVS) any and all information pertaining to their education at your institution.

Please note: If your institution processes transcript requests through another office, FCVS has likely made such a request under separate cover.

If your office also processes transcript requests, please attach the individual's official transcript (which indicates courses taken, dates and hours of attendance, and scores, grades, or evaluation).

Institution Name: Albert Einstein College of Medicine of Yeshiva University

Address Line 1: Belfer Educational Center, Room 210

Address Line 2:

City: Bronx **State/Province:** NY **Zip Code (Postal Code):** 10461

Country: US

If name of institution was different when this individual attended, please note this name below:
N/A

Premedical Education:
Years of education required for admission to your medical school: 4
Credential/degree presented by the applicant for admission to your medical school: B.A.

Enrollment and Participation: Our records indicate that Kahn, Chava
(type/print individual's name: Last, First, Middle, Suffix)
attended our medical school for total of 5 years of medical education on the following dates: **From:** 08/20/2003 (Month Day Year) **To:** 05/30/2008 (Month Day Year)

This individual
Was awarded the degree of Doctor of Medicine on 06/05/2008 (Month Day Year)
Was NOT awarded a degree because: (please explain - additional page if necessary)

Attestation

Affix Institutional Seal Here

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

Watermark
For FCVS internal use only

ELECTRONIC SEAL VERIFIED

Name: Hayley Erickson

Signature: *Hayley Erickson*

Title: Registrar
Date of Signature: 07/26/2018 **Phone:** (718) 430-2102
Fax: (718) 430-4123 **Email:** hayley.erickson@einstein.yu.edu

215134560 57 215134560

Unusual Circumstances

1. Do this individual's official records reflect (an) interruption(s) or extension(s) in his/her medical education? Yes

If Yes, please specify the reason(s) for, indicate the date of the interruptions(s) or extension(s) and check whether the interruption/extension was approved or unapproved:

	From Date:	To Date:	
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)			
Participation in non-degree research			
Other: Transferred Class	06/19/2006	05/31/2007	Approved
Other:			

Please Specify:

Transferred to the Class of 2008 on June 19, 2006

2. Do this individual's official records reflect that he/she was ever placed on academic or disciplinary probation during his/her medical education? No

If YES, please select the reason(s) for the probation, indicate the dates of placement on and removal from probation and attach additional documentation to this report:

	From Date:	To Date:
Academic Probation		
Probation for unprofessional conduct/behavioral		
Other:		

Please specify a reason:

3. Do this individual's official records reflect that he/she was ever disciplined for unprofessional conduct/behavioral reasons by the medical school or parent university? No

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

4. Do this individual's official records reflect that he/she was ever the subject of negative reports for behavioral reasons or an investigation by the medical school or parent university? No

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

5. Do this individual's official records 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? No

If YES, please provide detailed documentation/information about the nature of the limitations or special requirement:

400 FULLER WISER ROAD | SUITE 300 | EULESS, TX 76039 TEL(817)868-5000 FAX(817)868-5099

FCVS | FEDERATION CREDENTIALS VERIFICATION SERVICE

Applicant Reported Unusual Circumstances

Federation of STATE MEDICAL BOARDS

Medical School

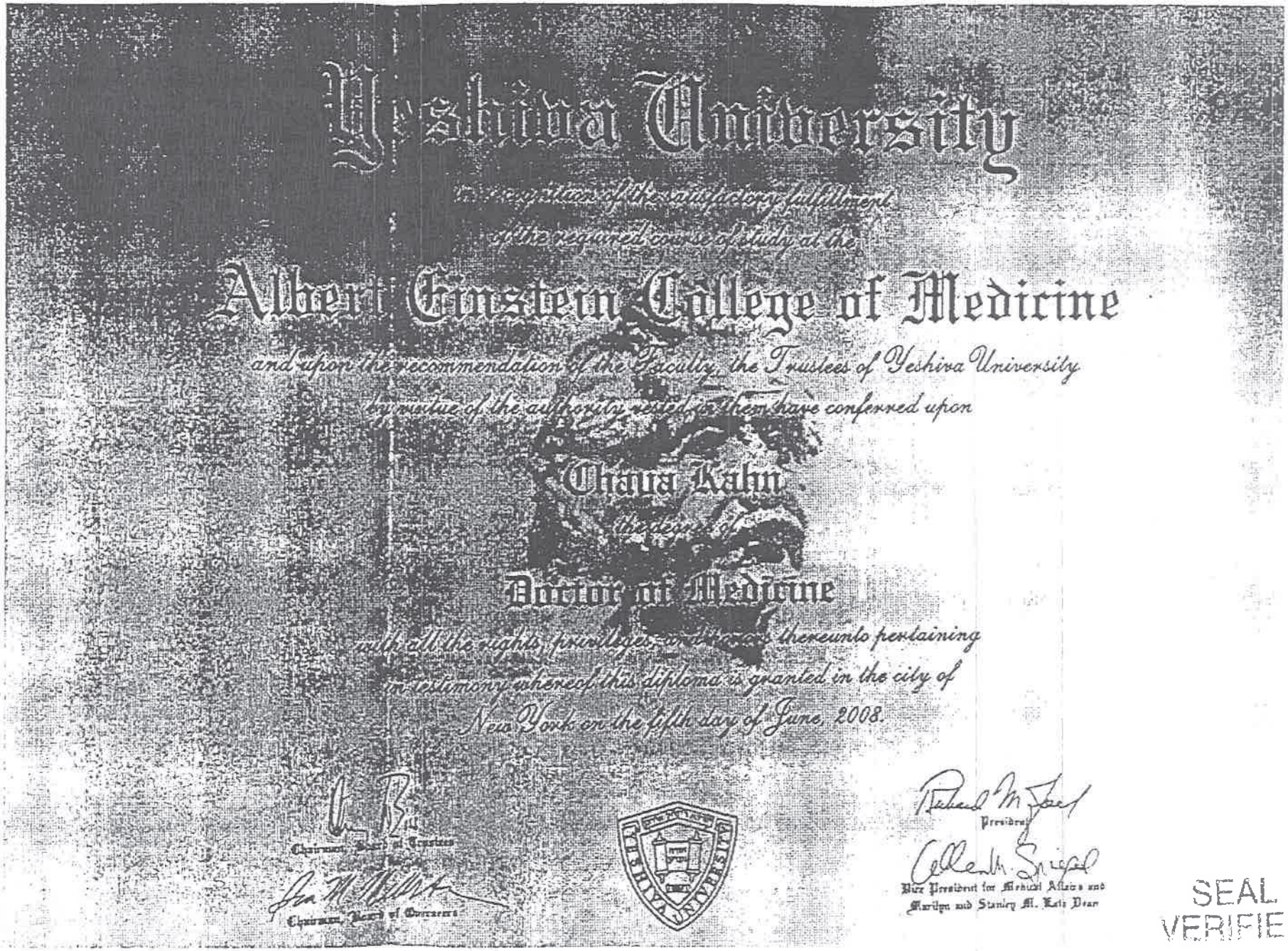
Medical Professional Name: Kahn, Chava

Albert Einstein College of Medicine of Yeshiva University

Unusual Circumstances

Did you have any interruption(s) or extension(s) in your medical education?	**No**
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: Kahn, Chava



Yeshiva University

In recognition of the satisfactory fulfillment
of the required course of study at the

Albert Einstein College of Medicine

and upon the recommendation of the Faculty, the Trustees of Yeshiva University
by virtue of the authority vested in them have conferred upon

Chana Kahn

the degree of

Doctor of Medicine

with all the rights, privileges and distinctions thereunto pertaining
In testimony whereof this diploma is granted in the city of
New York on the fifth day of June, 2008.

Chairman, Board of Trustees

Chairman, Board of Overseers

President

Vice President for Medical Affairs and
Marilyn and Stanley M. Katz Dean

SEAL
VERIFIED

This is to certify that this is a copy of the original diploma of Dr. Chava Kahn who received her MD degree on June 5, 2008.

Hayley Erickson, Registrar

SEAL:

SEAL
VERIFIED

FCVS | FEDERATION CREDENTIALS VERIFICATION SERVICE

Postgraduate Training

Federation of STATE MEDICAL BOARDS

Postgraduate Training

Accreditation ID: 2203521178

Institution: Montefiore Medical Center/Albert Einstein College of Medicine Program

Location: Bronx, NY
UNITED STATES

Accreditation ID: None

Institution: University of Michigan

Location: Ann Arbor, MI
UNITED STATES

Credentials Analysis Information for Postgraduate Training

Issue:
The Verification of Post Graduate Training Form from University of Michigan dated 07/01/2012 to 06/30/2014 reported in the Chronology of Activities is not included in the Profile.

Solution(s):
FCVS does not obtain verification of non-accredited training programs.

FCVS | FEDERATION CREDENTIALS VERIFICATION SERVICE

Verification of Graduate Medical Education

Federation of STATE MEDICAL BOARDS

Institution: Montefiore Medical Center/Albert Einstein College of Medicine Program **Affiliated University:** Montefiore Medical Center/Albert Einstein College of Medicine

Address Line 1:

Address Line 2:

Country: US **City:** Bronx **State/Prov.:** NY **Zip Code:**

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

Verification For: Kahn, Chava **Date of Birth:** July 10, 1980

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	Training Level	From	To	Successfully Completed?	Accredited by	Specialty/Subspecialty
IR	1-1	07/01/2008	06/30/2009	Yes	ACGME	Obstetrics and Gynecology
R	2-2	07/01/2009	06/30/2010	Yes	ACGME	Obstetrics and Gynecology
R	3-3	07/01/2010	06/30/2011	Yes	ACGME	Obstetrics and Gynecology

Rotation Information Not Available

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: ErikaBanks **MD/DO:** Yes

Signature: *Erika Banks*

Title: Program Director **Date:** 08/08/2018

Tel: (718) 430-4031 **Fax:** (718) 430-2576 **Email:** ebanks@montefiore.org

215134560 100198 215134560

FCVS FEDERATION CREDENTIALS VERIFICATION SERVICE

Verification of Graduate Medical Education

Federation of STATE MEDICAL BOARDS

Program Participation (Continued):

Program Type			
RR	Training Level: 4-4	Specialty/Subspecialty: Obstetrics and Gynecology	
	From: 07/01/2011	To: 06/30/2012	
	Successfully Completed? Yes		
	Accredited by: ACGME		

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			
	Training Level:	Specialty/Subspecialty:	
	From:	To:	
	Successfully Completed?		If no, was credit awarded?
	Accredited by:		

Program Type			
	Training Level:	Specialty/Subspecialty:	
	From:	To:	
	Successfully Completed?		If no, was credit awarded?
	Accredited by:		

Program Type			
	Training Level:	Specialty/Subspecialty:	
	From:	To:	
	Successfully Completed?		If no, was credit awarded?
	Accredited by:		

Program Type			
	Training Level:	Specialty/Subspecialty:	
	From:	To:	
	Successfully Completed?		If no, was credit awarded?
	Accredited by:		

Rotation Schedule

400 FULLER WISER ROAD | SUITE 300 | EULESS, TX 76039 TEL(817)868-5000 FAX(817)868-5099

FCVS FEDERATION CREDENTIALS VERIFICATION SERVICE

Applicant Reported Unusual Circumstances

Federation of STATE MEDICAL BOARDS

Graduate Medical Education

Medical Professional Name:	Kahn, Chava
Accreditation ID:	2203521178
Institution:	Montefiore Medical Center/Albert Einstein College of Medicine Program
Specialty:	Obstetrics & Gynecology

Unusual Circumstances

Training Period: 7/1/2008 - 6/30/2012 **Internship/Residency**

Did you have any interruption(s) or extension(s) in your medical education?	**No**
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: Kahn, Chava

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EINSTEIN
Albert Einstein College of Medicine
OF YESHIVA UNIVERSITY

Montefiore
THE UNIVERSITY HOSPITAL

AND THEIR AFFILIATED HOSPITALS OF THE
NEW YORK CITY HEALTH AND HOSPITALS CORPORATION
JACOBI MEDICAL CENTER

This is to certify that

Chava Kahn, M.D.

has satisfactorily fulfilled the training program requirements of

Obstetrics & Gynecology and Women's Health

in the capacity of: Resident

for the period of: July 1, 2008 to June 30, 2012

In Witness whereof, the undersigned have affixed their signatures this 30th day of June, 2012

Dean, Albert Einstein College of Medicine

President and CEO, Montefiore Medical Center

Department Chairman

Program Director

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
Federation of State Medical Boards of the United States, Inc. (FSMB)
400 Fuller Wiser Road, Euless, TX 76039-3856 - Telephone (817) 868-4000

Date: 08/09/2018

Federation Credentials Verification Service
ATTN: FCVS

FCVSID: 406924

Examinee: Kahn, Chava
Alt Name(s):

Examinee ID: 5-163-836-9
Date of Birth: 07/10/1980

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. 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	Score	Minimum Pass	Comments
06/10/2005	Pass	188	(182)	

USMLE STEP 2

Clinical Knowledge (CK)

Test Date	Pass/Fail	Score	Minimum Pass	Comments
08/17/2006	Pass	213	(182)	

Clinical Skills (CS)

Test Date	Pass/Fail	Comments
01/02/2008	Pass	

USMLE STEP 3

Test Date	Pass/Fail	Score	Minimum Pass	Comments
04/22/2009	Pass	202	(187)	

End of Exam History

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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This document was prepared by
Federation of State Medical Boards of the United States, Inc. (FSMB)
400 Fuller Wiser Road, Euless, TX 76039-3856 - Telephone (817) 868-4000

Examinee: Kahn, Chava

Examinee ID: 5-163-836-9
Date of Birth: 07/10/1980

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 <u>not</u> 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

fsmb

PRACTITIONER PROFILE

Prepared for: FCVS As of Date:8/9/2018

PRACTITIONER INFORMATION

Name:	Kahn, Chava
DOB:	7/10/1980
Medical School:	Albert Einstein College of Medicine of Yeshiva University Bronx, New York, UNITED STATES
Year of Grad:	2008
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
DC	MD043836	04/14/2016	12/31/2018	08/01/2018
MARYLAND	D81052	02/23/2016	09/30/2018	08/03/2018
MICHIGAN	4301099940	01/31/2012	01/31/2019	07/30/2018

PRACTITIONER PROFILE

Prepared for: FCVS As of Date:8/9/2018

Practitioner Name: Kahn, Chava

ABMS® CERTIFICATION HISTORY

Certifying Board: American Board of Obstetrics and Gynecology
Certificate: Obstetrics and Gynecology
Certification Type: General
Certification Status: Certified
Participating in MOC: Yes

Status	Duration	Effective Date	Expiration Date	Reverification Date	Occurrence	Last Reported
Active	Time Limited	12/11/2017	12/31/2018		Initial	07/26/2018

The presence and display of ABMS certification data in no way constitutes any affiliation, association with or endorsement of any advertising, promotion or sponsorship by ABMS, its Member Boards and the Board Certified Physicians listed in this directory. ABMS disclaims any responsibility or affiliation for other data that is provided in the directory that is not ABMS sourced information.

AOA® CERTIFICATION HISTORY

No AOA Certifications found.

ATTACHMENT 2

TENNESSEE BOARD OF MEDICAL EXAMINERS
(800) 778-4123, ext. 532-4384 or (615) 532-3202, ext. 532-4384

VERIFICATION OF POSTGRADUATE MEDICAL TRAINING

APPLICANT: Provide the information requested in the top box and then mail this form to each institution in which you received any postgraduate medical training. If additional forms are required, copy this one.

Institution Administration: I am applying for a Tennessee medical license and hereby authorize you to release any and all information in your files concerning my medical training. I was in training at your institution as follows:

Applicant's name: KAHN (Last) CHAVA (First) _____ (Middle/Maiden)

Name of Institution: University of Michigan Program Title: Fellowship in Family Planning

Applicant's Signature

07/01/12 - 06/30/14
Dates

THIS PORTION IS TO BE COMPLETED BY THE TRAINING PROGRAM'S ADMINISTRATIVE OFFICE

Please complete (including questions) and return to:

State of Tennessee
Board of Medical Examiners
665 Mainstream Drive
Nashville, TN 37243

CIRCLE ONE

Is your training program currently ACGME approved? Yes (No)

Was the above program LCME/ACGME approved at the time the applicant completed training? Yes (No)

Were there any adverse charges or actions taken during the residency? Yes (No)
If yes, please attach supporting information and/or documentation

Would you recommend the applicant for licensure? (Yes) No

Did the applicant successfully complete the program (Yes) No

The applicant attended the program from 07/12 (Mo/Yr) to 6/14 Mo/Yr

I certify that the information on this form is true and correct.

Lisa M. Harris
Program Director's/Dean's Signature

9/18/18
Date

Subscribed and sworn before me this the 18 day of September 2018

Jane E Juckno
Notary Public

(Affix Seal Here)

My Commission Expires 09/11/2019

JANE E JUCKNO
Notary Public - Michigan
Livingston County
My Commission Expires Sep 11, 2019
Acting in the County of Washtenaw

Courtney Lewis

From: Chava Kahn <chavkahn@gmail.com>
Sent: Thursday, September 20, 2018 8:49 AM
To: Courtney Lewis
Subject: Re: Chava Kahn MD
Attachments: image001.png; Fellowship verification.pdf

I also have attached a copy of my postgraduate verification form here.

Best,
Chava Kahn

On Thu, Sep 13, 2018 at 2:11 PM Courtney Lewis <Courtney.Lewis@tn.gov> wrote:

Good morning.

I am responding to an email that you sent Orlanda Folston. Page 2 of the paper application needs to also list all post graduate training (2008-2012 and 2012-2014) that you have or are currently attending. Page 7 of the practitioner profile will need to list the post graduate training for 2012-2014. All post graduate training will need to be verified. Therefore, the post graduate training for 2012-2014 will need to be verified on the attached form by your program director.

Thank you.

Courtney Lewis, Administrative Services Assistant 3

Board of Medical Examiners

665 Mainstream Drive

Nashville, TN 37243

DC HEALTH GOVERNMENT OF THE DISTRICT OF COLUMBIA
DEPARTMENT OF HEALTH
Health Regulation and Licensing Administration

GOVERNMENT OF THE DISTRICT OF COLUMBIA
MURIEL BOWSER, MAYOR

Dear Sir or Madam:

This is to certify the following information, maintained in the records of the Department of Health Board of MEDICINE for the below referenced Health Care Practitioner:

Name:	CHAVA KAHN
License Type:	MEDICINE AND SURGERY
License Number:	MD043836
Original Licensure Date:	04/14/2016
Expiration Date:	12/31/2018
Obtained By:	Waiver of Examination
License Status:	Active

Received By:
SEP 27 2018
BME Unit

Unless stated below, there is **no** disciplinary action pending nor has any been taken.

NOTE: _____ If this blank has been checked, disciplinary action has been taken.
(See attached copies.)

Thank you.

Sincerely,

Frank B. Meyers, JD
Executive Director
DC Board of Medicine

SEAL

899 North Capitol St. NE, 2nd Flr.| Washington, DC, 20002 |T: 202 724-8800|F: 202 442-8117
www.doh.dc.gov/bomed| www.facebookcom/dc.bomed

MARYLAND Department of Health Board of Physicians

Larry Hogan, Governor · Boyd K. Rutherford, Lt. Governor · Robert R. Neall, Secretary

September 5, 2018

Tennessee State Board of Medical Examiners
665 Mainstream Drive

Nashville TN 37243-0001

This is to verify the records of the Maryland Board of Physicians. The following information is available under the Maryland Public Information Act. State Government Article, Section 4-333. regarding the following practitioner:

Chava Kahn

For the Practice of:	Physician-M.D.
License Number:	D81052
Date Issued:	**02/23/2016**
Current Status:	**Active**
Expiration Date	**09/30/2020**
*Disciplinary Actions	**No disciplinary actions.**

*Disciplinary information can be found on our website. Go to https://www.mbp.state.md.us and select Lookup a License.

For malpractice claim information, please contact the Maryland Health Care Alternative Dispute Resolution Office 410.767.8200.

Respectfully,

Maryland Board of Physicians
Verification Unit

4201 Patterson Avenue – Baltimore, Maryland 21215
Toll Free 1-800-492-6836 – TTY/Maryland Relay Service 1-800-735-2258
Web Site: www.mbp.state.md.us

Practitioner's Name _____ TN License # 55359 (if applicable)

Profession Medical Physician

II. MEDICAL, PROFESSIONAL OR TRAINING SCHOOLS AND GRADUATE MEDICAL EDUCATION OR OTHER GRADUATE-LEVEL TRAINING

A. What school(s)/educational programs have you attended? And, what type(s) of degree(s) do you hold? Do not include coursework taken to meet the continuing education requirement for licensure renewal

	PROGRAM/INSTITUTION	CITY/STATE/COUNTRY (IF NOT COMPLETED IN THE U.S.)	DATE OF GRADUATION MM/DD/YYYY	TYPE OF DEGREE
1				
2				
3				

B. List in chronological order from date of graduation to the present, all completed medical/professional graduate and/or post-graduate training (internship, residency, fellowship or other program). Do not include coursework taken to meet continuing education requirements for licensure renewal

	PROGRAM AND SPECIALTY AREA (INTERNSHIP, RESIDENCY, FELLOWSHIP, ETC.)	LOCATION OF TRAINING (CITY, STATE OR COUNTRY IF NOT COMPLETED IN THE U.S.)	FROM MM/DD/YYYY	TO MM/DD/YYYY
1.	Albert Einstein College of Medicine Internship & Residency in Pediatrics & Gynecology	Bronx NY, USA	07/01/2008	06/30/2012
2.	University of Michigan, Fellowship in Family Planning	Ann Arbor MI, USA	07/01/2012	06/30/2014

III. SPECIALTY BOARD CERTIFICATIONS (if applicable):

Do you hold a certification, specialty or subspecialty from any specialty board recognized by the board regulating the profession for which you are licensed? (see instructions) YES ___ NO ___

If "Yes", complete section below

	CERTIFYING BODY/BOARD INSTITUTION	CERTIFICATION/SPECIALTY/SUBSPECIALTY
1.		
2.		
3.		
4.		
5.		

Courtney Lewis

From: mdh.mbpverifications@maryland.gov
Sent: Tuesday, September 4, 2018 3:03 PM
To: Courtney Lewis
Subject: Maryland Online License State Board Verification

Date: 9/4/2018
This is confirmation that a request for verification was emailed to: Tennessee State Board of Medical Examiners.
Please click on the link below to download the verification request submitted 9/4/2018.
Invoice#: 24650
Practitioner Name: Chava Kahn
License#: D81052

Requester Individual: Chava Kahn
Requester Email: chavkahn@gmail.com

For problems or concerns, please contact the requesting party.

* Disciplinary Actions can be found on our website. Go to www.mbp.state.md.us and select Search Practitioner Profiles

---

Please click the link below to activate the encrypted verification pdf document.

Please click to download and view the verification (.pdf Format)

STATE OF MICHIGAN

RICK SNYDER
GOVERNOR

DEPARTMENT OF LICENSING AND REGULATORY AFFAIRS
LANSING

SHELLY EDGERTON
DIRECTOR

VERIFICATION OF LICENSURE

MICHIGAN BOARD OF MEDICINE

VERIFICATION OF LICENSURE AS OF 09/14/2018

Received By:
SEP 25 2018
BME Unit

State of Tennessee
Board of Medical Examiners
665 Mainstream Drive
Nashville, TN 37243

NAME: Chava Kahn **BIRTHDATE:** XX/XX/1980

ADDRESS: 20 Heatheridge St.
Ann Arbor MI 48104

TYPE: Medical Doctor **ORIGINAL DATE:** 01/31/2012

LICENSE NUMBER: 4301099940 **STATUS:** Active **EXPIRATION DATE:** 01/31/2019

OBTAINED BY: Examination

EXAM DATE	EXAM TYPE	EXAM RESULTS
04/22/2009	USMLE	PASS

DISCIPLINARY ACTION NONE

OPEN FORMAL COMPLAINTS NONE

D- Gage

Dawn Gage, Licensing Manager
Bureau of Professional Licensing
Licensing Division
(517) 335-0918

STATE OF MICHIGAN

Good morning.

The board consultant has reviewed your file. Please:

- List the start date of your premed, med school, and MPH on the attached application.

Email the corrected page back to me.

Thank you.

Courtney.Lewis@tn.gov

tn.gov/health

From: Chavi [mailto:chavkahn@gmail.com]
Sent: Wednesday, October 17, 2018 1:10 PM
To: Courtney Lewis
Subject: Fwd: Chava Kahn MD

***** This is an EXTERNAL email. Please exercise caution. DO NOT open attachments or click links from unknown senders or unexpected email - STS-Security. *****

Please see attached. Thank you.

Chava Kahn

Sent from my iPhone

Begin forwarded message:

> **From:** Rafi Pristoop <rafiki@gmail.com>
> **Date:** October 17, 2018 at 3:29:38 PM GMT+3
> **To:** Chavi Kahn <chavkahn@gmail.com>
> **Subject: Re: Chava Kahn MD**
>
> attached
>
> On Tue, Oct 16, 2018 at 5:59 AM Chava Kahn <chavkahn@gmail.com> wrote:
>
> ---------- Forwarded message ---------
> From: **Courtney Lewis** <Courtney.Lewis@tn.gov>
> Date: Wed, Oct 10, 2018 at 5:13 PM
> Subject: Chava Kahn MD
> To: chavkahn@gmail.com <chavkahn@gmail.com>

From: Chava Kahn [mailto:chavkahn@gmail.com]
Sent: Wednesday, October 24, 2018 9:00 AM
To: Courtney Lewis
Subject: Re: Chava Kahn MD

Hello,

I apologize for the delay, I was out of the country. Please see attached.

Thanks so much.

Chava Kahn

On Thu, Oct 18, 2018 at 11:09 AM Courtney Lewis <Courtney.Lewis@tn.gov> wrote:

Good morning,

Your md degree should be corrected to 08/15/2003-06/05/2008, post graduate training for Albert Einstein should be 07/01/2008-06/30/2012, and post graduate training for University of Michigan should be 07/01/2012-06/30/2014. Please correct page 4 of the application and email to me.

Thank you,

Courtney Lewis, Administrative Services Assistant 3

Board of Medical Examiners

665 Mainstream Drive

Nashville, TN 37243

Courtney Lewis

From: Chava Kahn <chavkahn@gmail.com>
Sent: Wednesday, October 24, 2018 2:07 PM
To: Courtney Lewis
Subject: Re: Chava Kahn MD
Attachments: image001.png; pg. 4_corrected 1.pdf

Hello,

Sorry, I am a little confused. Page 4 refers to my educational information, not my postgraduate training. I completed a MPH at University of Michigan (which is what page 4 refers to) simultaneously with my postgraduate medical training there. I have put a start date though for the MPH if that is what you are asking for and I have attached it to this email.

Best,
Chava Kahn

On Wed, Oct 24, 2018 at 1:04 PM Courtney Lewis <Courtney.Lewis@tn.gov> wrote:

Good afternoon,

The attached page 4 is missing the start date for the post graduate training for University of Michigan.

Thank you,

Courtney Lewis, Administrative Services Assistant 3

Board of Medical Examiners

665 Mainstream Drive

Nashville, TN 37243

Courtney.Lewis@tn.gov

tn.gov/health

The board consultant has reviewed your file. Please:

- List the start date of your premed, med school, and MPH on the attached application.

Email the corrected page back to me.

Thank you,

From: Chavi [mailto:chavkahn@gmail.com]
Sent: Wednesday, October 17, 2018 1:10 PM
To: Courtney Lewis
Subject: Fwd: Chava Kahn MD

Please see attached. Thank you.

Chava Kahn

Sent from my iPhone

Begin forwarded message:

> **From:** Rafi Pristoop <rafiki@gmail.com>
> **Date:** October 17, 2018 at 3:29:38 PM GMT+3
> **To:** Chavi Kahn <chavkahn@gmail.com>
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> ---------- Forwarded message ---------
> From: **Courtney Lewis** <Courtney.Lewis@tn.gov>
> Date: Wed, Oct 10, 2018 at 5:13 PM
> Subject: Chava Kahn MD
> To: chavkahn@gmail.com <chavkahn@gmail.com>
>
> Good morning,

Courtney Lewis

From: Chava Kahn <chavkahn@gmail.com>
Sent: Wednesday, October 24, 2018 9:00 AM
To: Courtney Lewis
Subject: Re: Chava Kahn MD
Attachments: image001.png; pg. 4_corrected.pdf

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Chava Kahn

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Thank you,

Courtney Lewis, Administrative Services Assistant 3

Board of Medical Examiners

665 Mainstream Drive

Nashville, TN 37243

Courtney.Lewis@tn.gov

tn.gov/health

On Tue, Oct 16, 2018 at 5:59 AM Chava Kahn <chavkahn@gmail.com> wrote:

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From: **Courtney Lewis** <Courtney.Lewis@tn.gov>
Date: Wed, Oct 10, 2018 at 5:13 PM
Subject: Chava Kahn MD
To: chavkahn@gmail.com <chavkahn@gmail.com>

Good morning,

The board consultant has reviewed your file. Please:

- List the start date of your premed, med school, and MPH on the attached application.

Email the corrected page back to me.

Thank you,

Courtney Lewis

From: Courtney Lewis
Sent: Thursday, October 18, 2018 10:10 AM
To: 'Chavi'
Subject: RE: Chava Kahn MD

Good morning,

Your md degree should be corrected to 08/15/2003-06/05/2008, post graduate training for Albert Einstein should be 07/01/2008-06/30/2012, and post graduate training for University of Michigan should be 07/01/2012-06/30/2014. Please correct page 4 of the application and email to me.

Thank you,

TN Health

Courtney Lewis, Administrative Services Assistant 3
Board of Medical Examiners
665 Mainstream Drive
Nashville, TN 37243
Courtney.Lewis@tn.gov
tn.gov/health

From: Chavi [mailto:chavkahn@gmail.com]
Sent: Wednesday, October 17, 2018 1:10 PM
To: Courtney Lewis
Subject: Fwd: Chava Kahn MD

Please see attached. Thank you.

Chava Kahn

Sent from my iPhone

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> **Date:** October 17, 2018 at 3:29:38 PM GMT+3
> **To:** Chavi Kahn <chavkahn@gmail.com>
> **Subject: Re: Chava Kahn MD**
>
> attached

Are you the spouse of a member of the armed forces who has been transferred by the military to Tennessee or who has, within the preceding 180 days, retired from the armed forces, received a discharge other than a dishonorable discharge from the armed forces or been released from active duty to a reserve component? (If yes, please provide proof of same.)	
Type of intended primary specialty practice in Tennessee:	**Obstetrics and Gynecology**
Have you previously applied for a medical license in Tennessee?	**No**

Educational Information 1

Name of educational institution attended:	**Yeshiva University**
City:	**New York**
State:	**New York**
Degree/certificate earned:	**BA**
Program Major:	**English Literature**
start date:	08/01/1998
Graduation date of education program:	**05/15/2002 (mm/dd/yyyy)**

Educational Information 2

Name of educational institution attended:	**Albert Einstein College of Med**
City:	**Bronx**
State:	**New York**
Degree/certificate earned:	**MD**
Program Major:	**Medicine**
start date:	07/01/2002
Graduation date of education program:	**06/05/2008 (mm/dd/yyyy)**

Educational Information 3

Name of educational institution attended:	**The University of Michigan**
City:	**Ann Arbor**
State:	**Michigan**
Degree/certificate earned:	**MPH**
Program Major:	**Epidemiology**
start date:	07/01/2012
Graduation date of education program:	**05/31/2014 (mm/dd/yyyy)**

Courtney Lewis

From: Chavi <chavkahn@gmail.com>
Sent: Wednesday, October 17, 2018 1:10 PM
To: Courtney Lewis
Subject: Fwd: Chava Kahn MD
Attachments: Page 4.pdf

Please see attached. Thank you.

Chava Kahn

Sent from my iPhone

Begin forwarded message:

> **From:** Rafi Pristoop <rafiki@gmail.com>
> **Date:** October 17, 2018 at 3:29:38 PM GMT+3
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> Subject: Chava Kahn MD
> To: chavkahn@gmail.com <chavkahn@gmail.com>
>
> Good morning,
>
> The board consultant has reviewed your file. Please:
>
> - List the start date of your premed, med school, and MPH on the attached application.
>
> Email the corrected page back to me.

Courtney Lewis

From: Courtney Lewis
Sent: Wednesday, October 10, 2018 9:13 AM
To: 'chavkahn@gmail.com'
Subject: Chava Kahn MD
Attachments: {3CAAD74C-D2D6-4CA7-847F-8D619D47F854}

Good morning,

The board consultant has reviewed your file. Please:

- List the start date of your premed, med school, and MPH on the attached application.

Email the corrected page back to me.

Thank you,

Courtney Lewis

From: Chava Kahn <chavkahn@gmail.com>
Sent: Thursday, September 20, 2018 8:47 AM
To: Courtney Lewis
Subject: Re: Chava Kahn MD
Attachments: image001.png; application_pg 2.pdf; pract profile_p.7.pdf

Hello,

Thank you so much. Attached are the requested changes. I have confirmed with University of Michigan, and verification of my postgraduate training is in the mail.

Thanks so much
Chava Kahn

On Thu, Sep 13, 2018 at 2:11 PM Courtney Lewis <Courtney.Lewis@tn.gov> wrote:

Good morning,

I am responding to an email that you sent Orlanda Folston. Page 2 of the paper application needs to also list all post graduate training (2008-2012 and 2012-2014) that you have or are currently attending. Page 7 of the practitioner profile will need to list the post graduate training for 2012-2014. All post graduate training will need to be verified. Therefore, the post graduate training for 2012-2014 will need to be verified on the attached form by your program director.

Thank you,

Courtney Lewis, Administrative Services Assistant 3

Board of Medical Examiners

665 Mainstream Drive

Courtney Lewis

From: Courtney Lewis
Sent: Thursday, September 13, 2018 1:11 PM
To: 'chavkahn@gmail.com'
Subject: Chava Kahn MD
Attachments: PGT Verification Form.pdf

Good morning,

I am responding to an email that you sent Orlanda Folston. Page 2 of the paper application needs to also list all post graduate training (2008-2012 and 2012-2014) that you have or are currently attending. Page 7 of the practitioner profile will need to list the post graduate training for 2012-2014. All post graduate training will need to be verified. Therefore, the post graduate training for 2012-2014 will need to be verified on the attached form by your program director.

Thank you,

TN Health

Courtney Lewis, Administrative Services Assistant 3
Board of Medical Examiners
665 Mainstream Drive
Nashville, TN 37243
Courtney.Lewis@tn.gov
tn.gov/health

Orlanda Folston

From: Chava Kahn <chavkahn@gmail.com>
Sent: Wednesday, September 05, 2018 10:03 AM
To: Orlanda Folston
Subject: Re: Medical License Corrections
Attachments: image001.png; medical training.pdf; dec of citizen.pdf; profile.pdf

Hello,

I hope you had a nice Labor Day weekend. Attached are the edits that you had requested. Please let me know if there are still any outstanding issues with them.

Additionally, we had discussed that you needed verification of my fellowship training at University of Michigan, but I just wanted to confirm which document I should have University of Michigan complete. Attachment 2 entitled Verification of Postgraduate Medical Education does not apply to them because the Fellowship in Family Planning which I completed is not an ACGME approved fellowship. Rather, the fellowship is a 2 year program after residency that although recognized in the field of Obstetrics and Gynecology, it is not a formal ACGME fellowship. I hope this is clear!

Best,
Chava Kahn
(c) 201-394-9637

On Fri, Aug 31, 2018 at 10:36 AM Orlanda Folston <Orlanda.Folston@tn.gov> wrote:

Good Morning Dr. Kahn,

The following corrections are needed:

Please add the start date of your Medical Education and List all post graduate training on page 2 of the Application.

List your Health Profession (Medical Doctor) on the Declaration of Citizenship.

List the start and end dates of your Post Graduate Medical Training on the Mandatory Practitioner Profile Questionnaire.

Thanks and have a wonderful weekend!

Two (2) individual letters of professional recommendation from licensed physicians on professional letterhead. Please make sure the letters have been **dated** and written within the last six (6) months. One (1) letter has been received from

Applicants for initial licensure in Tennessee must obtain a criminal background check. Please follow the directions that are enclosed. (However if you have already submitted your Criminal Background Check to the appropriate reporting agency please feel free to contact the office at (615) 532-4381)

Your first set of fingerprints was rejected by TBI/FBI. Please submit new prints.

Your second set of fingerprints was rejected by TBI/FBI. You will be required to travel to Tennessee to have your prints taken electronically.

The criminal background check that we received was dated by TBI/FBI. This office can only accept criminal background checks that completed within the last six (6) months. Please resubmit an updated criminal background check.

Notarized copy of legal entitlement to live or work in the United States (for U.S. Citizens, birth certificate or current passport only). For non-U.S. citizens, if your current visa is expired please notify us in writing and submit proof of waiver, H1B visa, or other pending visa application request.

✓ Declaration of Citizenship must accompany all applications for initial licensure or reinstatement of licensure. The "SAVE ACT" requires the Tennessee Department of health (including all Boards, Commissions, and contractors), along with every local health department in the State, to verify that every adult applicant for a professional license is either a U.S. citizen, a "qualified alien," or a nonimmigrant who meets the requirements set out of 8 U.S.C. 1621.

☐ Answer question # 5 on page 1 ☐ Remove license number

☐ Complete mailing address on line 2 to list health profession

✓ Completed Mandatory Practitioner Profile Questionnaire (this is a separate document from the application). You may download it from the website and fax the completed form (6 pages) to 615-253-4184, or mail it to this office.

☐ We received your profile; however, the following pages are incomplete or incorrect: list street address of post graduate training

Notarized copy of your specialty certificate.

Application indicates pending legal action, malpractice judgment, or settlement. **Please have a copy of the complaint, answer, and/or final action sent to this office concerning your response to question #** _____.

Please submit a written explanation for an affirmative answer to Question(s) # on the application.

Affirmative responses require final documents or orders from the issuing states, courts and/or agencies. Please submit these for affirmative response to question(s) #

Please submit documentation showing proof of hours of continuing education.

Please submit court documents in regards to the arrest date(s)

Other:

It can take up to fourteen (14) days for documents sent by U.S. Mail to reach this office. U.S. mail is delivered to our State Post Office, then distributed. *Overnight and special courier mail* may reduce your mailing time; however, you must use the Zip Code 37228 for all *overnight or special courier mail*.

Board Administrator

TENNESSEE BOARD OF MEDICAL EXAMINERS
665 MAINSTREAM DRIVE
NASHVILLE, TENNESSEE 37243
www.tennessee.gov/health

Today's Date: 8-27-18

Chava Kahn MD
7733 16th Street, NW
Washington, DC. 20012

DEFICIENCY LETTER

This letter is prepared to notify you of deficiencies remaining in order to complete your application for licensure as a medical doctor in the state of Tennessee. Pursuant to Board rule, applications not complete within ninety days of the initial deficiency letter will be closed. An applicant seeking licensure after the closure of his or her application file will be required to submit a new application and fee. ***Please let our office know if additional documents are uploaded to the online system.***

Date of your initial deficiency letter: 8-27-18 Date your application will be closed: 11-27-18

Review of your application on the above date revealed the items checked below are required to complete your file:

✓ We are in receipt of your application; however, page(s) 2 is incomplete and/or incorrect.
* list start date of med. education and all post graduate training.

___ $ _____ is required to complete payment of licensure fees. **Please remit this amount now.**

_____ A recent passport-type photograph, passport-type.

_____ Official graduate transcript, indicating courses taken, grades, and M.D. (or equivalent) degree. **Transcripts must be submitted directly from the University to our office.** International graduates must also submit an official English translation of the transcript and curriculum if original is not in English.

_____ If you are an international medical school graduate, please provide proof that your medical school's admission standards meet or exceed those of the Liaison Committee on Medical Education (LCME). Please consult the Board's rules and policy for further clarification on this matter: Tenn. Comp. R. & Regs. 0880-02-.04(3)
https://www.tn.gov/content/dam/tn/health/documents/Foreign_Medical_School_Policy.pdf

_____ A notarized copy of your E.C.F.M.G. certificate.

✓ Verification of successful completion of qualifying postgraduate medical education (Attachment 2) must be completed by program director, notarized, and sent directly from the training program to this office. ALL TRAINING completed in the US (including Internships, Residencies, and Fellowships) **must be verified** for every applicant. Forms submitted prior to completion of required training will not be accepted. Any training listed below has not been received:

2012-2014 ___/___ ___/___

_____ NBME, FLEX, LMCC, USMLE or State Board exam scores. This information must come to this office **directly from the testing agency.**

✓ Verification of licensure directly from each state, country or province in which you hold or have ever held a license. Clearance form has not been received from:

DC / MD / MS ___/___ ___/___ ___/___

Health

DECLARATION OF CITIZENSHIP
MUST ACCOMPANY ALL INITIAL LICENSURE OR RECIPROCITY LICENSURE APPLICATIONS

Pursuant to T.C.A. § 4-58-101 et seq, the Eligibility Verification for Entitlements Act (also known as the "SAVE Act") requires the Tennessee Department of Health (including all Boards, Commissions and contractors), along with every local health department in the State, to verify that *every adult* applicant applying for a professional license is either a U.S. citizen, a "qualified alien" or a nonimmigrant who meets the requirements set out at 8 U.S.C. 1621.

I am applying for a(n) _____ _____
Healthcare Profession (Please Print) License number (if applicable)

Please Print Legibly

1. Name: _____
Last First Middle Maiden

2. Mailing Address: _____
Street/P.O. Box City State Zip

3. Phone Number: ( ) - ( ) - ( ) -
Personal/Home Office Fax

4. I am a foreign national not physically present in the United States ☐ Yes ☒ No If you answered yes to this question please sign this form in the presence of a notary and return it with your application. No further documentation is required.

5. I am a United States Citizen: ☒ Yes ☐ No

6. Applicants claiming United States Citizenship **MUST** provide **a copy** of *one* of the following:
   a) Tennessee Driver's License, or photo ID issued by the Tennessee Department of Safety.
   b) A valid driver license or ID issued by another state, provided its issuance requirements meet Tennessee Department of Safety criteria.
   c) An official birth certificate issued by a U.S. state, territory, or other jurisdiction. Puerto Rican birth certificates issued before July 1, 2010 do not qualify.
   d) A federally issued birth certificate.
   e) A valid, unexpired U.S. passport.
   f) A report of birth abroad of a U.S. citizen.
   g) A certificate of citizenship.
   h) A certificate of naturalization.
   i) A U.S. citizen ID card.
   j) Any successor document to #'s e-i above.
   k) A Social Security Card that is verifiable with the Social Security Administration in accordance with federal law.

7. If you answered "No" to question 5, indicate from the list below which category applies to you. (check one)
   ☐ Permanent Resident
   ☐ A nonimmigrant applicant for a professional or commercial license whose visa for entry into the United States is related to such employment, or a nonimmigrant under the Immigration and Nationality Act (8 U.S.C. 1101 *et seq.*).

Division of Health Licensure and Regulation • Office of Emergency Medical Services
665 Mainstream Drive • Nashville, TN 37243
Telephone (615) 741-2364 • Fax (615) 741-4217 • Website tn.gov/health/topic/ems-about

PDC PHYSICIAN DATA CENTER

fsmb

PRACTITIONER PROFILE

Prepared for:	Tennessee State Board of Medical Examiners	As of Date:8/24/2018
Practitioner Name:	Kahn, Chava	

ABMS® CERTIFICATION HISTORY

Certifying Board:	American Board of Obstetrics and Gynecology
Certificate:	Obstetrics and Gynecology
Certification Type:	General
Certification Status:	Certified
Participating in MOC:	Yes

Status	Duration	Effective Date	Expiration Date	Reverification Date	Occurrence	Last Reported
Active	Time Limited	12/11/2017	12/31/2018		Initial	07/26/2018

The presence and display of ABMS certification data in no way constitutes any affiliation, association with or endorsement of any advertising, promotion or sponsorship by ABMS, its Member Boards and the Board Certified Physicians listed in this directory. ABMS disclaims any responsibility or affiliation for other data that is provided in the directory that is not ABMS sourced information.

AOA® CERTIFICATION HISTORY

No AOA Certifications found.

400 FULLER WISER ROAD EULESS, TX 76039 TEL(317)868 4000 ; FAX (817)868 4099

PDC PHYSICIAN DATA CENTER

fsmb

PRACTITIONER PROFILE

Prepared for:	Tennessee State Board of Medical Examiners	As of Date:8/24/2018

PRACTITIONER INFORMATION

Name:	Kahn, Chava
DOB:	7/10/1980
Medical School:	Albert Einstein College of Medicine of Yeshiva University Bronx, New York, UNITED STATES
Year of Grad:	2008
Degree Type:	MD
NPI:	1801179577

BOARD ACTIONS

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

LICENSE HISTORY

Jurisdiction	License Number	Issue Date	Expiration Date	Last Updated
DC	MD043836	04/14/2016	12/31/2018	08/01/2018
MARYLAND	D81052	02/23/2016	09/30/2020	08/24/2018
MICHIGAN	4301099940	01/31/2012	01/31/2019	07/30/2018

TN Health

DECLARATION OF CITIZENSHIP
MUST ACCOMPANY ALL INITIAL LICENSURE OR RECIPROCITY LICENSURE APPLICATIONS

Pursuant to T.C.A. § 4-58-101 et seq, the Eligibility Verification for Entitlements Act (also known as the "SAVE Act") requires the Tennessee Department of Health (including all Boards, Commissions and contractors), along with every local health department in the State, to verify that *every adult* applicant applying for a professional license is either a U.S. citizen, a "qualified alien" or a nonimmigrant who meets the requirements set out at 8 U.S.C. 1621.

I am applying for a(n) _____ _____.
Healthcare Profession (Please Print) **License number (if applicable)**

Please Print Legibly

1. Name: Kaha Chava
   Last **First** **Middle** **Maiden**
2. Mailing Address: 7733 16th St., NW Washington DC 20012
   Street/P.O. Box **City** **State** **Zip**
3. Phone Number: (301) 344-9637 ( ) - ( ) -
   Personal/Home **Office** **Fax**
4. I am a foreign national not physically present in the United States ☐ Yes ☒ No If you answered yes to this question, please sign this form in the presence of a notary and return it with your application. No further documentation is required.
5. I am a United States Citizen: ☒ Yes ☐ No
6. Applicants claiming United States Citizenship **MUST** provide a copy of *one* of the following:
   a) Tennessee Driver's License, or photo ID issued by the Tennessee Department of Safety.
   b) A valid driver license or ID issued by another state, provided its issuance requirements meet Tennessee Department of Safety criteria.
   c) An official birth certificate issued by a U.S. state, territory, or other jurisdiction. Puerto Rican birth certificates issued before July 1, 2010 do not qualify.
   d) A federally issued birth certificate.
   e) A valid, unexpired U.S. passport.
   f) A report of birth abroad of a U.S. citizen.
   g) A certificate of citizenship.
   h) A certificate of naturalization.
   i) A U.S. citizen ID card.
   j) Any successor document to #'s e-i above.
   k) A Social Security Card that is verifiable with the Social Security Administration in accordance with federal law.
7. If you answered "No" to question 5, indicate from the list below which category applies to you: (check one)
   ☐ Permanent Resident
   ☐ A nonimmigrant applicant for a professional or commercial license whose visa for entry into the United States is related to such employment, or a nonimmigrant under the Immigration and Nationality Act (8 U.S.C. 1101 *et seq.*).

Division of Health Licensure and Regulation • Office of Emergency Medical Services
665 Mainstream Drive • Nashville, TN 37243
Tel: 615-741-2584 • Fax: 615-741-4217 • Website: tn.gov/health/article/ems-about

- ☐ Asylees who meet the qualifications set out in 8 U.S.C. 1158.
- ☐ Refugees who meet the qualifications set out in 8 U.S.C. 1157.
- ☐ Persons who have been "paroled into the United States," under 8 U.S.C. 1182(d)(5) or whose deportation has been withheld under 8 U.S.C. 1253.
- ☐ Cuban or Haitian entrants as defined by section 501(e) of the Refugee Education Assistance Act of 1980.
- ☐ Persons granted conditional entry into the U.S. under 8 U.S.C. 1153(a)(7) before April 1, 1980, because of persecution or fear of persecution on account of race, religion, or political opinion or because of being uprooted by catastrophic national calamity.
- ☐ An alien who has been "battered" or subjected to "extreme cruelty" by a parent or spouse as defined by 8 U.S.C. 1641(c), and also meets the qualifications set out 8 U.S.C. 1641(c)(1)(B). Under the circumstances set out in 8 U.S.C. 1641(c)(2) and (3), victims' children, or the parents of children who are victims, may also apply for benefits as qualified aliens.

Applicants claiming qualified alien status (question 7 above), please submit two of the following forms of "documentation of identity and immigration status" as determined by U.S. Homeland Security to be acceptable for verification through the SAVE program. Common types of documents used to verify immigration status are listed below. **(Note: If you can provide only one document, your status will be verified through the U.S. Department of Homeland Security's SAVE program):**

I-327 (Reentry Permit)

I-551 (Permanent Resident Card or "Green Card")

I-571 (Refugee Travel Document)

I-766 (Employment Authorization Card)

Machine Readable Immigrant Visa (with Temporary I-551 language)

Temporary I-551 stamp (on passport or I-94)

I-94 (Arrival/Departure record)

Unexpired foreign passport

WT/WB Admission Stamp in unexpired foreign passport

I-20 (Certificate of Eligibility for Nonimmigrant F (1) student status– "student visa")

DS2019 (Certificate of Eligibility for Exchange Visitor (J-1) Status)

ALL APPLICANTS MUST SIGN AND HAVE NOTARIZED

I affirm under the penalty of perjury that the above is true and correct.

Signed this 07 day of August, 2018

Signature

Sworn to before me this 7th day of August, 2018.

NOTARY PUBLIC

My Commission Expires: Dec 26th, 2021

AFFIX SEAL HERE
Notary Public-Maryland
Montgomery County
My Commission Expires
December 26, 2021

If an applicant is discovered to be an unqualified alien, or otherwise ineligible for benefits under the Act, all recurring benefits provided to that applicant must be immediately terminated. Anyone who purposefully makes a false, fictitious, or fraudulent claim of U.S. citizenship or qualified alien status will be liable under the Tennessee Medicaid False Claims Act, or Tennessee's False Claims Act. Any person who conspires to defraud the state or any local health department by securing a false claim allowed or paid to another person in violation of the Act may be liable under Tennessee's False Claims Act. Upon discovery of an applicant's false, fictitious, or fraudulent claim of U.S. citizenship or qualified alien status, state governmental entities and local health departments must also file a criminal complaint with the Office of the Attorney General and/or the United State Attorney.

Department of Gynecology and Obstetrics
A Building, 1st Floor, Room 121
4940 Eastern Avenue
Baltimore, Maryland, 21224-2780
410-550-0336 (Phone)
410-550-0196 (Fax)

JOHNS HOPKINS
MEDICINE
JOHNS HOPKINS
BAYVIEW MEDICAL CENTER

August 16, 2018

State of Tennessee
Department of Health
Health Related Boards
665 Mainstream Drive
Nashville, Tennessee 37243

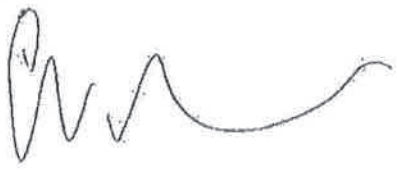
To Whom It May Concern:

It is with pleasure that I write this letter of recommendation for Dr. Chava Kahn. I have personally known Dr. Kahn for the past two years, while working together in the Department of Gynecology and Obstetrics at Johns Hopkins Bayview Medical Center.

Dr. Kahn is hard working and provides exceptional care to her patients. She is always kind, calm and polite, and maintains sound clinical judgment and a positive atmosphere, even during emergencies. She gets along with both hospital and clinic staff very well and holds herself to the highest standards of ethics and integrity.

I unreservedly attest to Dr. Kahn's honorable moral character. Please do not hesitate to contact me if you have any further questions.

Best,



Carla Bossano, MD

Department of Gynecology and Obstetrics
A Building, 1st Floor, Room 121
4940 Eastern Avenue
Baltimore, Maryland, 21224-2780
410-550-0336 (Phone)
410-550-0196 (Fax)

JOHNS HOPKINS
MEDICINE
JOHNS HOPKINS
BAYVIEW MEDICAL CENTER

August 16, 2018

State of Tennessee
Department of Health
Health Related Boards
665 Mainstream Drive
Nashville, Tennessee 37243

To Whom It May Concern:

My name is Dr. Rachel Chan Seay, and I am proud to write this letter of recommendation for Dr. Chava Kahn, whom I have personally known for the past two years at Johns Hopkins Bayview Medical Center.

During my working relationship with Dr. Kahn, I have experienced a hard-working physician who performs her duties exceptionally well. She is always respectful, empathic and has excellent clinical judgment. She is skilled at making her patients feel comfortable and cared for, and is well-liked by all the staff who work with her. It is without reservation that I attest to her upstanding moral character.

If you have any questions, please do not hesitate to contact me.

Best,

Rachel Chan Seay, MD

SACHIN GUPTA
Notary Public-Maryland
Montgomery County
My Commission Expires
December 26, 2021

Application Summary

Application Detail

License Type:	**Medical Doctor**
Application:	**Medical Doctor: Initial Standard License Application**
Application Date:	**08/20/2018 (mm/dd/yyyy)**

Application Questions

Do you currently have any physical or psychological limitations or impairments caused by an existing medical condition which are reduced or ameliorated by ongoing treatment or monitoring, or the field of practice, the setting or the manner in which you have chosen to practice?	**No**
At any time within the past two years, have you engaged in the illegal use of illicit or controlled substances?	**No**
Are you currently participating in a supervised rehabilitation program or professional assistance program that monitors you to assure that you do not consume alcohol and/or do not engage in the illegal use of illicit or controlled substances?	**No**
Have you ever been diagnosed as having or have you ever been treated for pedophilia, exhibitionism, voyeurism or other diagnosis of a predatory nature?	**No**
Have you ever held or applied for a license, privilege, registration or certificate to practice medicine in any state, country, or province, that has been or was ever denied, reprimanded, suspended, restricted, revoked, otherwise disciplined, curtailed, or voluntarily surrendered under threat of investigation or disciplinary action?	**No**
Have you ever had staff privileges at any hospital or health care facility that were ever revoked, suspended, curtailed, restricted, limited, otherwise disciplined, or voluntarily surrendered under threat of restriction or disciplinary action?	**No**

Have you ever applied for or held a state or federal controlled substance certificate that was ever denied, revoked, suspended, restricted, voluntarily surrendered or otherwise disciplined or surrendered under threat of restriction or disciplinary action?	**No**
Have you ever been convicted (including a nolo contendere plea or guilty plea) of a felony or misdemeanor (other than a minor traffic offense) whether or not sentence was imposed or suspended?	**No**
Have you ever been rejected or censured by a professional association or society?	**No**
In relation to the performance of your professional services in any profession: Have you ever had a final judgment rendered against you?	**No**
In relation to the performance of your professional services in any profession: Have you ever entered into any settlement of any legal action?	**No**
In relation to the performance of your professional services in any profession: Are there any legal actions pending against you or to which you are a party?	**No**
Have you ever held a license, registration, privilege or certificate in any profession that has ever been reprimanded, suspended, restricted, revoked, otherwise disciplined, curtailed, or voluntarily surrendered under threat of investigation or disciplinary action in any jurisdiction?	**No**
My name has been placed on the registry of persons who have abused, neglected or misappropriated the property of vulnerable individuals (Tennessee abuse registry or an abuse registry in another state)?	**No**

Personal Detail

First Name:	**Chava**
Last Name:	**Kahn**
Professional Qualifier:	**MD**
Birthdate:	**07/10/1980 (mm/dd/yyyy)**

Gender:	**Female**
Race:	**White**
Social Security Number:	*********

Addresses

Mailing Address

Address:	**7733 16th Street, NW** **DISTRICT OF COLUMBIA** **Washington, DC** **20012** **US**
Phone Number:	**201-394-9637**
Extension:	
E-mail Address:	**chavkahn@gmail.com**

License Attributes Selected

Specialty	**Obstetrics & Gynecology**

General Information

Have you been known by any other names?	**No**
Are you a U. S. Citizen?	**Yes**
Are you a member of the U.S. armed forces who has, within the preceding 180 days, retired from the armed forces, received any discharge other than a dishonorable discharge from the armed forces, or been released from active duty to a reserve component of the armed forces? (If yes, please provide proof of status.)	**No**
Are you the spouse of a member of the armed forces who has been transferred by the military to Tennessee or who has, within the preceding 180 days, retired from the armed forces, received a discharge other than a dishonorable discharge from the armed forces or been released from active duty to a reserve component? (If yes, please provide proof of same.)	**No**

Are you the spouse of a member of the armed forces who has been transferred by the military to Tennessee or who has, within the preceding 180 days, retired from the armed forces, received a discharge other than a dishonorable discharge from the armed forces or been released from active duty to a reserve component? (If yes, please provide proof of same.)	
Type of intended primary specialty practice in Tennessee:	**Obstetrics and Gynecology**
Have you previously applied for a medical license in Tennessee?	**No**

Educational Information 1

Name of educational institution attended:	**Yeshiva University**
City:	**New York**
State:	**New York**
Degree/certificate earned:	**BA**
Program Major:	**English Literature**
Graduation date of education program:	**05/15/2002 (mm/dd/yyyy)**

Educational Information 2

Name of educational institution attended:	**Albert Einstein College of Med**
City:	**Bronx**
State:	**New York**
Degree/certificate earned:	**MD**
Program Major:	**Medicine**
Graduation date of education program:	**06/05/2008 (mm/dd/yyyy)**

Educational Information 3

Name of educational institution attended:	**The University of Michigan**
City:	**Ann Arbor**
State:	**Michigan**
Degree/certificate earned:	**MPH**
Program Major:	**Epidemiology**
Graduation date of education program:	**05/31/2014 (mm/dd/yyyy)**

Postgraduate Training History

Educational Institution where you completed your postgraduate training:	**Albert Einstein College of Medicine of Yeshiva University**
City where the postgraduate training was completed:	**Bronx**
State or Country were the postgraduate training was completed:	**New York**
Date Started:	**07/01/2008 (mm/dd/yyyy)**
Date Ended:	**06/30/2012 (mm/dd/yyyy)**
Specify the total number of years you have spent in postgraduate medical training:	**4**

Employment Information 1

Have you ever been employed in healthcare in any position?	**Yes**
Company/Employer:	**Johns Hopkins University School of Medicine**
City and state/country/province where you last practiced:	**Baltimore, MD**
Position:	**Assistant Professor**
Duties:	**Outpatient and inpatient general obstetrics and gynecology; surgical gynecology; training of fellows, residents and medical students**
From Date:	**August 2016**
To Date:	**Present**

Employment Information 2

Have you ever been employed in healthcare in any position?	**Yes**
Company/Employer:	**University of Michigan Health System**
City and state/country/province where you last practiced:	**Ann Arbor, MI**
Position:	**Clinical Instructor**
Duties:	**Outpatient and inpatient general obstetrics and gynecology; surgical gynecology; training of fellows, residents and medical students**

From Date:	**July 2014**
To Date:	**February 2016**

Exam History

National Boards (NBME)?	**No**
FLEX examination?	**No**
Licensure by the Medical Council of Canada (LMCC)?	**No**
USMLE?	**Yes**
State board examination administered prior to 1972?	**No**
Are you ABMS Board certified?	**Yes**
If yes, identify board of specialty/subspecialty:	**Obstetrics and Gynecology**

Fitness and Competency Questions

Do you currently use any chemical substances which in any way impair or limit your ability to practice your profession with reasonable skill and safety?	**No**

Other Licensure 1

Are you or have you ever been licensed in this profession in another state/country/province?	**Yes**
License number:	**MD043836**
State/country/province where you held the license:	**District of Columbia**
Status of the license:	**Licensed**
Name used when licensed:	**Chava Kahn**
Are you or have you ever been licensed in any other profession in Tennessee or another state/country/province?	**No**

Other Licensure 2

Are you or have you ever been licensed in this profession in another state/country/province?	**Yes**
License number:	**D0081052**

State/country/province where you held the license:	**Maryland**
Status of the license:	**Licensed**
Name used when licensed:	**Chava Kahn**
Are you or have you ever been licensed in any other profession in Tennessee or another state/country/province?	**No**

Other Licensure 3

Are you or have you ever been licensed in this profession in another state/country/province?	**Yes**
License number:	**4301099940**
State/country/province where you held the license:	**Michigan**
Status of the license:	**Licensed**
Name used when licensed:	**Chava Kahn**
Are you or have you ever been licensed in any other profession in Tennessee or another state/country/province?	**No**

Additional Information

If you have an NPI number, please provide:	[redacted]
Do you intend to perform Level II Office Based Surgery which is integral to a planned treatment regiment and not performed on an urgent or emergent basis? If you intend to perform Level III Office Based Surgery, you must apply for and obtain a permit prior to engaging in such practice.	**Yes**
Do you have a DEA number?	**Yes**
If yes, what is the number?	[redacted]

Fees

State Regulatory Fee	**$10.00**
Medical Doctor - Initial Application Fee	**$400.00**
Total Amount Due:	**$410.00**

Attestation

I, being duly sworn and identified as the person referred to in this application, attest to the truth of each statement made in said application. I further swear that I have read and understand the law and the Rules and Regulations regarding the practice of my profession, which are posted on the Board's Internet site and/or were provided to me by the Board office, and agree to abide by them in the practice as a medical doctor in the State of Tennessee. I HEREBY: SIGNIFY my willingness to appear to answer such questions as the Board may find necessary, which may include a full Board interview. RELEASE to the Board, its staff, and their representatives, any and all documentation necessary now and in the future to establish my physical and mental capabilities to safely practice as a medical doctor. AUTHORIZE the Board, its staff, and their representatives to consult with my prior and current associates and others who may have information bearing on my professional competence, character, health status, ethical qualifications, ability to work cooperatively with others, and other qualifications. RELEASE from liability the Board, its staff, and all their representatives and any and all organizations which provide information for their acts performed and statements made in good faith and without malice concerning my competence, ethics, character, and/or other qualifications, for certification. ACKNOWLEDGE that I, as an applicant for licensure, have the burden of producing adequate information for a proper evaluation of my professional, ethical, and other qualifications, and for resolving any doubts about such qualifications. AUTHORIZE release, use and disclosure of otherwise HIPAA protected health information to the limited extent necessary for my application to receive full consideration up to and including discussion in a public forum should that become necessary. This certifies that the information submitted by me in this application is true and complete to the best of my knowledge and belief.

TN Department of Health

Online Payment Receipt

Receipt Issued By:
Board of Medical Examiners - Medical Doctors & Genetic Counselors

Receipt Issued To:
Chava Kahn
7733 16th Street, NW
Washington, DC 20012

Date: 08/20/2018
Transaction Identifier: [redacted]
Trace Number: [redacted]

License Type	Licensee	Transaction	Application #	Account #	Amount
Medical Doctor	Chava Kahn	Medical Doctor: Initial Standard License Application	1606-294666	[redacted]	$410.00

Application Summary

Application Detail

License Type:	**Medical Doctor**
Application:	**Initial Mandatory Practitioner Profile Questionnaire**
Application Date:	**08/30/2018 (mm/dd/yyyy)**

Application Questions

Do you hold a certification, specialty or subspecialty from any specialty board recognized by the board regulating the profession for which you are licensed?(This question refers to any certification, specialty or subspecialty from any specialty board recognized by the American Medical Association, American Osteopathic Association, American Podiatry Association, American Chiropractic Association, American Dental Association, APN certifications or any other specialty certifying body as determined by your Tennessee licensing board.)	**Yes**
Do you currently hold staff privileges at a hospital?	**No**
Do you participate in any managed care plans?	**No**
Do you participate in any TennCare plan(s)?	**No**
Within the previous ten (10) years, have you ever had any final disciplinary action taken against you by an agency regulating your license, in this state or any other jurisdiction?(The term final means the matter was fully adjudicated at a hearing and the appeal's period expired, or that the applicable board issued an agreed order or consent decree. The term disciplinary action includes, but is not limited to: • Probation • Limitation/Restriction • Suspension • Revocation • Voluntary relinquishment in lieu of disciplinary action • Compulsory surrender of license or privilege	**No**

• Civil or other monetary fine or penalty
• Restriction of privileges in lieu of, or in settlement of, a pending disciplinary case related to competence or character)

Within the previous ten (10) years, have you ever had your hospital privileges revoked or involuntarily restricted for reasons related to competence or character by the hospital's governing body?(The term final means the matter was fully adjudicated at a hearing and the appeal's period expired, or that the applicable governing body or the hospital issued an agreed order or consent decree. The term disciplinary action against your privileges includes, but is not limited to: • Curtailed • Limited • Suspended • Revoked • Any other adverse action taken against a privilege by a medical/health related institution • Compulsory surrender of license or privilege • Civil or other monetary fine or penalty.)	**No**
Within the previous ten (10) years, have you ever been asked to or allowed to resign from or had any medical staff privileges restricted or not renewed by any hospital in lieu of or in settlement of a pending disciplinary action related to competence or character?(The term final means the matter was fully adjudicated at a hearing and the appeal's period expired, or that the applicable governing body or the hospital issued an agreed order or consent decree. The term disciplinary action includes, but is not limited to: • Resignation from or non-renewal of medical staff membership at a hospital in lieu of, or in settlement of, a pending disciplinary case related to competence or character • Restriction of privileges in lieu of, or in settlement of, a pending disciplinary case related to competence or character)	**No**
Have you within the most recent ten (10) years, been found guilty, regardless of whether adjudication of guilt was withheld, or pled guilty or nolo contendere to a criminal misdemeanor or felony in any jurisdiction?(This part requires you to report any state or federal felony criminal offense	**No**

also requires the reporting of misdemeanor offenses, regardless of classification, in which any element of the offense involves sex; alcohol or drugs; physical injury or threat of injury to any person; abuse or neglect of any minor, spouse or the elderly; fraud or theft in Tennessee or another jurisdiction; or unlicensed practice within the most recent ten (10) years. If any misdemeanor conviction reported is expunged, a copy of the order of expungement signed by the judge must be submitted to the Department before the conviction will be removed from any profile.)	
Have you had a medical malpractice court judgment, arbitration award, or settlement against you since May 19, 1998?(You are required to indicate all medical malpractice court judgments, arbitration awards, or settlements in which a payment was awarded to a complaining party beginning with judgments or settlements entered or executed within the previous ten (10) years. That means if the act or event leading to the claim occurred greater than ten (10) years but was finally adjudicated against you within the last ten (10) years, you must indicate that claim in the space provided. JUDGMENTS OR SETTLEMENTS BELOW THE FOLLOWING AMOUNTS ARE NOT REQUIRED TO BE SUBMITTED. Pending malpractice claims are not required to be reported unless/until final adjudication against you. A) For Medical Doctors and Osteopathic Physicians, judgments or settlements below $75,000 are not required to be B) For Chiropractors, judgments or settlements below $50,000 are not required to be submitted. submitted. C) For Dentists, judgments or settlements below $25,000 are not required to be submitted. D) For all other professions, judgments or settlements below $10,000 are not required to be submitted.)	**No**

Practice Address Questions for Clarification

Is your practice address your home address?	**No**

Medical, Professional or Training Schools

What school(s)/educational programs have you attended?	**Albert Einstein College of Medicine**
City:	**Bronx**
State:	**New York**
Country:	**United States of America**
Date graduated from institution:	**06/05/2008 (mm/dd/yyyy)**
What type of degree do you hold from the institution?	**Doctor of Medicine**

Graduate Medical Education or other Graduate-Level Training

Institution you attended for medical/professional graduate and/or post-graduate training (internship, residency, fellowship or other program).	**Albert Einstein College of Medicine**
Specialty Area:	**Obstetrics and Gynecology**
State:	**New York**
Date attendance ended at institution:	**06/30/2012 (mm/dd/yyyy)**

Attestation

Date of Profile Submission:	**08/30/2018 (mm/dd/yyyy)**

Specialty Board Certifications

Name of certifying body or board institution which issued the recognized specialty:	**American Board of Obstetrics and Gynecology**
Name of the recognized certification, specialty or subspecialty:	**Obstetrics and Gynecology**

Attestation

PRACTITIONER PROFILE ATTESTATION: I affirm these statements are true and correct and recognize that providing false information may result in disciplinary action against my license pursuant to T.C.A. §§ 63-32-113 and/or 63-32-118. I understand that by submitting this profile questionnaire, I realize that I willnot receive a confirmation report before this information is published online.

Application Summary

Application Detail

License Type:	**Medical Doctor**
Application:	**Initial Mandatory Practitioner Profile Questionnaire**
Application Date:	**08/20/2018 (mm/dd/yyyy)**

Application Questions

Do you hold a certification, specialty or subspecialty from any specialty board recognized by the board regulating the profession for which you are licensed?(This question refers to any certification, specialty or subspecialty from any specialty board recognized by the American Medical Association, American Osteopathic Association, American Podiatry Association, American Chiropractic Association, American Dental Association, APN certifications or any other specialty certifying body as determined by your Tennessee licensing board.)	**Yes**
Do you currently hold staff privileges at a hospital?	**No**
Do you participate in any managed care plans?	**No**
Do you participate in any TennCare plan(s)?	**No**
Within the previous ten (10) years, have you ever had any final disciplinary action taken against you by an agency regulating your license, in this state or any other jurisdiction?(The term final means the matter was fully adjudicated at a hearing and the appeal's period expired, or that the applicable board issued an agreed order or consent decree. The term disciplinary action includes, but is not limited to: • Probation • Limitation/Restriction • Suspension • Revocation • Voluntary relinquishment in lieu of disciplinary action • Compulsory surrender of license or privilege	**No**

• Civil or other monetary fine or penalty
• Restriction of privileges in lieu of, or in settlement of, a pending disciplinary case related to competence or character)

Within the previous ten (10) years, have you ever had your hospital privileges revoked or involuntarily restricted for reasons related to competence or character by the hospital's governing body?(The term final means the matter was fully adjudicated at a hearing and the appeal's period expired, or that the applicable governing body or the hospital issued an agreed order or consent decree. The term disciplinary action against your privileges includes, but is not limited to: • Curtailed • Limited • Suspended • Revoked • Any other adverse action taken against a privilege by a medical/health related institution • Compulsory surrender of license or privilege • Civil or other monetary fine or penalty.)	**No**
Within the previous ten (10) years, have you ever been asked to or allowed to resign from or had any medical staff privileges restricted or not renewed by any hospital in lieu of or in settlement of a pending disciplinary action related to competence or character?(The term final means the matter was fully adjudicated at a hearing and the appeal's period expired, or that the applicable governing body or the hospital issued an agreed order or consent decree. The term disciplinary action includes, but is not limited to: • Resignation from or non-renewal of medical staff membership at a hospital in lieu of, or in settlement of, a pending disciplinary case related to competence or character • Restriction of privileges in lieu of, or in settlement of, a pending disciplinary case related to competence or character)	**No**
Have you within the most recent ten (10) years, been found guilty, regardless of whether adjudication of guilt was withheld, or pled guilty or nolo contendere to a criminal misdemeanor or felony in any jurisdiction?(This part requires you to report any state or federal felony criminal offense	**No**

also requires the reporting of misdemeanor offenses, regardless of classification, in which any element of the offense involves sex; alcohol or drugs; physical injury or threat of injury to any person; abuse or neglect of any minor, spouse or the elderly; fraud or theft in Tennessee or another jurisdiction; or unlicensed practice within the most recent ten (10) years. If any misdemeanor conviction reported is expunged, a copy of the order of expungement signed by the judge must be submitted to the Department before the conviction will be removed from any profile.)	
Have you had a medical malpractice court judgment, arbitration award, or settlement against you since May 19, 1998?(You are required to indicate all medical malpractice court judgments, arbitration awards, or settlements in which a payment was awarded to a complaining party beginning with judgments or settlements entered or executed within the previous ten (10) years. That means if the act or event leading to the claim occurred greater than ten (10) years but was finally adjudicated against you within the last ten (10) years, you must indicate that claim in the space provided. JUDGMENTS OR SETTLEMENTS BELOW THE FOLLOWING AMOUNTS ARE NOT REQUIRED TO BE SUBMITTED. Pending malpractice claims are not required to be reported unless/until final adjudication against you. A) For Medical Doctors and Osteopathic Physicians, judgments or settlements below $75,000 are not required to be B) For Chiropractors, judgments or settlements below $50,000 are not required to be submitted. submitted. C) For Dentists, judgments or settlements below $25,000 are not required to be submitted. D) For all other professions, judgments or settlements below $10,000 are not required to be submitted.)	**No**

Practice Address Questions for Clarification

Is your practice address your home address?	**No**

Medical, Professional or Training Schools

What school(s)/educational programs have you attended?	**Albert Einstein College of Medicine**
City:	**Bronx**
State:	**New York**
Country:	**United States of America**
Date graduated from institution:	**06/05/2008 (mm/dd/yyyy)**
What type of degree do you hold from the institution?	**Doctor of Medicine**

Graduate Medical Education or other Graduate-Level Training

Institution you attended for medical/professional graduate and/or post-graduate training (internship, residency, fellowship or other program).	**Albert Einstein College of Medicine**
Specialty Area:	**Obstetrics and Gynecology**
State:	**New York**
Date attendance ended at institution:	**06/30/2012 (mm/dd/yyyy)**

Attestation

Date of Profile Submission:	**08/20/2018 (mm/dd/yyyy)**

Specialty Board Certifications

Name of certifying body or board institution which issued the recognized specialty:	**The American Board of Obstetrics and Gynecology, Inc.**
Name of the recognized certification, specialty or subspecialty:	**Obstetrics and Gynecology**

Attestation

PRACTITIONER PROFILE ATTESTATION: I affirm these statements are true and correct and recognize that providing false information may result in disciplinary action against my license pursuant to T.C.A. §§ 63-32-113 and/or 63-32-118. I understand that by submitting this profile questionnaire, I realize that I willnot receive a confirmation report before this information is published online.

Application Summary

Application Detail

License Type:	**Medical Doctor**
Application:	**Renewal Medical Doctor**
Application Date:	**05/01/2020 (mm/dd/yyyy)**

Application Questions

Have you been convicted (including a nolo contendere plea or guilty plea) of a felony or misdemeanor(other than a minor traffic offense) whether or not sentence was imposed or suspended, but have not provided written notice to the Board regarding such action?	**No**
Has your license been disciplined in another state, but you have not provided written notice to the Board regarding such action?	**No**
Has your physical and/or mental health declined to the point where you have developed an impairment that affects your ability to practice medicine with reasonable skill and safety in a competent, ethical and professional manner? (You may answer "No" if you are being appropriately treated.)	**No**
Has your name been placed on the registry of persons who have abused, neglected, or misappropriated the property of vulnerable individuals as defined in the Tennessee Abuse Registry?	**No**
I have been denied a license to practice my profession in another jurisdiction and have not previously notified the Board of the denial.	**No**
I currently perform Level II Office Based Surgery which is integral to a planned treatment regimen and not performed on an urgent or emergent basis.	**No**
Have you engaged in the excessive use of alcohol, controlled substances or prescription drugs, or in the use of illegal drugs, or received any therapy or treatment for alcohol or drug use? (If you are an anonymous participant in the Tennessee	**No**

Medical Foundation Physicians Health Program and are in compliance with your contract, you may answer "No" to this question)

Personal Detail

First Name:	**Chava**
Last Name:	**Kahn**
Professional Qualifier:	**MD**
Birthdate:	**07/10/1980 (mm/dd/yyyy)**
Gender:	**Female**
Race:	**White**
Social Security Number:	*********

Addresses

Mailing Address

Address:	**7733 16th Street, NW** **DISTRICT OF COLUMBIA** **Washington, DC** **20012** **US**
Phone Number:	**201-394-9637**
Extension:	
E-mail Address:	**chavkahn@gmail.com**

Educational Information 1

Name of educational institution attended:	**Yeshiva University**
City:	**New York**
State:	**New York**
Degree/certificate earned:	**BA**
Program Major:	**English Literature**
Start date of education program:	**09/01/1998 (mm/dd/yyyy)**

Graduation date of education program:	**05/15/2002 (mm/dd/yyyy)**

Educational Information 2

Name of educational institution attended:	**Albert Einstein College of Med**
City:	**Bronx**
State:	**New York**
Degree/certificate earned:	**MD**
Program Major:	**Medicine**
Start date of education program:	**08/01/2003 (mm/dd/yyyy)**
Graduation date of education program:	**06/05/2008 (mm/dd/yyyy)**

Educational Information 3

Name of educational institution attended:	**The University of Michigan**
City:	**Ann Arbor**
State:	**Michigan**
Degree/certificate earned:	**MPH**
Program Major:	**Epidemiology**
Start date of education program:	**08/01/2012 (mm/dd/yyyy)**
Graduation date of education program:	**05/31/2014 (mm/dd/yyyy)**

Other Licensure 1

Are you or have you ever been licensed in this profession in another state/country/province?	**Yes**
License number:	**MD043836**
State/country/province where you held the license:	**District of Columbia**
Status of the license:	**Licensed**
Name used when licensed:	**Chava Kahn**
Are you or have you ever been licensed in any other profession in Tennessee or another state/country/province?	**No**

Other Licensure 2

Are you or have you ever been licensed in this profession in another state/country/province?	**Yes**

Are you or have you ever been licensed in this profession in another state/country/province?	
License number:	**D0081052**
State/country/province where you held the license:	**Maryland**
Status of the license:	**Licensed**
Name used when licensed:	**Chava Kahn**
Are you or have you ever been licensed in any other profession in Tennessee or another state/country/province?	**No**

Other Licensure 3

Are you or have you ever been licensed in this profession in another state/country/province?	**Yes**
License number:	**4301099940**
State/country/province where you held the license:	**Michigan**
Status of the license:	**Licensed**
Name used when licensed:	**Chava Kahn**
Are you or have you ever been licensed in any other profession in Tennessee or another state/country/province?	**No**

Additional Information

If you have an NPI number, please provide:	[redacted]
Do you intend to perform Level II Office Based Surgery which is integral to a planned treatment regiment and not performed on an urgent or emergent basis? If you intend to perform Level III Office Based Surgery, you must apply for and obtain a permit prior to engaging in such practice.	**Yes**
Do you have a DEA number?	**Yes**
If yes, what is the number?	[redacted]

Practice Address Questions for Clarification

Is your practice address your home address?	**No**

Medical, Professional or Training Schools

What school(s)/educational programs have you attended?	**Albert Einstein College of Medicine**
City:	**Bronx**
State:	**New York**
Country:	**United States of America**
Date attendance started at institution:	**08/01/2003 (mm/dd/yyyy)**
Date attendance ended at institution:	**06/05/2008 (mm/dd/yyyy)**
Date graduated from institution:	**06/05/2008 (mm/dd/yyyy)**
What type of degree do you hold from the institution?	**Doctor of Medicine**

Graduate Medical Education or other Graduate-Level Training 1

Institution you attended for medical/professional graduate and/or post-graduate training (internship, residency, fellowship or other program).	**Albert Einstein College of Medicine**
Specialty Area:	**Obstetrics and Gynecology**
State:	**New York**
Date attendance started at institution:	**07/01/2008 (mm/dd/yyyy)**
Date attendance ended at institution:	**06/30/2012 (mm/dd/yyyy)**

Graduate Medical Education or other Graduate-Level Training 2

Institution you attended for medical/professional graduate and/or post-graduate training (internship, residency, fellowship or other program).	**UNIV OF MI**
Specialty Area:	**FAMILY PLANNING**
State:	**Michigan**
Date attendance started at institution:	**07/01/2012 (mm/dd/yyyy)**
Date attendance ended at institution:	**06/30/2014 (mm/dd/yyyy)**

Specialty Board Certifications 1

Name of certifying body or board institution which issued the recognized specialty:	**The American Board of Obstetrics and Gynecology, Inc.**
Name of the recognized certification, specialty or subspecialty:	**Obstetrics and Gynecology**

Specialty Board Certifications 2

Name of certifying body or board institution which issued the recognized specialty:	**American Board of Obstetrics and Gynecology**
Name of the recognized certification, specialty or subspecialty:	**Obstetrics and Gynecology**

Attestation

Date of Profile Submission:	**05/01/2020 (mm/dd/yyyy)**

Fees

Medical Doctor - State Regulatory Fee	**$10.00**
Medical Doctor - Renewal Fee	**$300.00**
Total Amount Due:	**$310.00**

Attestation

In making this application, I certify that the statements given in this application are true and correct and that I have complied with all renewal requirements and, if applicable, satisfied all continuing education requirements set forth in the Tennessee Code Annotated and the Official Compilation Rules and Regulations of the State of Tennessee regulating the practice of my profession in Tennessee.

TN Department of Health

Online Payment Receipt

Receipt Issued By:
Board of Medical Examiners - Medical Doctors & Genetic Counselors

Receipt Issued To:
Chava Kahn
7733 16th Street, NW
Washington, DC 20012

Date: 05/01/2020
Transaction Identifier: [redacted]
Trace Number: [redacted]

License Type	Licensee	Transaction	Application #	Account #	Amount
Medical Doctor	Chava Kahn	Renewal Medical Doctor	1606-330602	[redacted]	$310.00