DeGood Catherine

☐ Self Reported ☐ Verified FCVS

DO 00652
License Number

11/12/2009
Issue Date

Catherine De Good
Name

Application Received 9/22/09
Date

Fee Received 9/22/09
Date

National Practitioner Data Bank Self Query ☑

State Licensure Verified ny
Waiting: NY

Family Practice
Specialty Code

Reference Forms
☑ Cho
☑ Tio
☑ See Wald
☑ Elam

F.C.V.S. Application ☑

Comments

Staff Comments

****

Licensing Committee

Signature

Signature
Margaret Caughlin

Signature

☐ APPROVED
DATE OF APPROVAL

☐ DENIED
DATE OF DENIAL

☐ PHYSICIAN TO APPEAR BEFORE THE LICENSING COMMITTEE

FOR OFFICE USE ONLY

Receipt #	619801
ID #	367009,13
Issue Date	
License #	

Rhode Island
Board of Medical Licensure and Discipline

Room 205
3 Capitol Hill
Providence, RI 02908-5097

RECEIVED
SEP 22 '09
BOARD OF MEDICAL LICENSURE & DISCIPLINE

Instructions and License Application for:

- ☐ Allopathic Medicine
- ☒ Osteopathic Medicine
- ☐ Academic Faculty (Limited Medical Registration)

Catherine A. DeGood DO

Applicant – Print/Type Name (First/MI/Last)

Endorsement

☒ I am also applying for a RI Uniform Controlled Substance Registration (CSR) and I have attached the CSR application to this license application.

FP 9/18
NY
13626663
3L

Phone: (401) 222-3855 TTY/TDD: (800) 745-5555 Fax: (401) 222-2158

Addendum 1

1. **Specialty of Practice**: Refer to the ABMS Certification Codes List (ABMS Codes Pages 1 and 2) when completing this section. You must provide a copy of your ABMS certificate(s). You may report "None", "Other", or "Unknown" if necessary.

FP
Primary Specialty Code — Board Certified? ☒ Yes ☐ No
If Yes, Year Certified/Recertified: 2007

Secondary Specialty Code — Board Certified? ☐ Yes ☐ No
If Yes, Year Certified/Recertified: _____

Secondary Specialty Code — Board Certified? ☐ Yes ☐ No
If Yes, Year Certified/Recertified: _____

Secondary Specialty Code — Board Certified? ☐ Yes ☐ No
If Yes, Year Certified/Recertified: _____

2. **Practice Information**: Specify where in this State do you intend to practice, and list type of practice using the codes below. (If additional space is needed, attach a separate sheet)

ACD = Academia
ADM = Administration
FTY = Faculty
FEL = Fellowship
GRP = Group
HSP = Hospital
HMO = HMO
OFC = Office
RES = Research
OTH = Other

Location #1: Memorial Hospital of Rhode Island
City: Pawtucket — Practice Type(See Code): FTY
Location #2: _____
City: _____ — Practice Type(See Code): _____
Location #3: _____
City: _____ — Practice Type(See Code): _____

Identify any translational services that may be available at your primary practice location:

3. **Medical School Faculty Appointments**: Identify any appointments to medical school faculties and indicate as to whether you have had responsibility for graduate medical education within the most recent ten (10) years.

4. **Medical Licensure**: List all states or countries in which you are now, or ever have been licensed to practice medicine, or any other profession.

New York State, USA — ☒ Active ☐ Inactive
Country
☐ Active ☐ Inactive
Country
☐ Active ☐ Inactive
Country

5. **Board Discipline**: List any disciplinary actions by licensing boards in other states. Please describe any prior or pending Board action or investigation. Please attach any relevant supplemental materials. If necessary, you may continue on a separate sheet. ☒ Check here if not applicable

Licensing Board (abbreviate) and Nature of Action (e.g. TX – Professional Misconduct):	Month/Year	Type of Discipline:
	___/___	
	___/___	
	___/___	
	___/___	
	___/___	

American Board of Family Medicine, Inc.

Quality Healthcare, Public Trust . . . Setting the Standards in Family Medicine

September 18, 2009

To Whom It May Concern:

This letter verifies Catherine Ann DeGood, D.O. is currently certified with the American Board of Family Medicine (ABFM).

Family Medicine Certification History:

Dec 07, 2007 - Dec 31, 2014

Maintenance of Certification for Family Physicians (MC-FP):

Current Status: Participating and Current

Certification in Family Medicine is for a period of seven years. A Certificate of Added Qualifications (Geriatrics, Sports Medicine, etc.) has a length of 10 years. From 1970 through 2002, certification was renewed by completion of requirements for Recertification. Each physician (Diplomate) fulfilled the obligation of maintaining a full and unrestricted medical license, earning 300 hours of continuing medical education (CME), and successfully completing the recertification examination.

Beginning in 2004 with the family physicians who passed Certification and Recertification examinations in 2003, the ABFM began a gradual transition from Recertification to Maintenance of Certification for Family Physicians (MC-FP). MC-FP is designed to transition all Diplomates into the program by 2010, enrolling all physicians who certify or recertify as they successfully pass the examination.

The MC-FP program is divided into separate three-year stages. By completing Stage 1 and Stage 2 by specified deadlines, the life of a certificate will be extended from seven to ten years. Diplomates who are unable to complete these requirements will retain their original seven-year certificate. Regardless of whether a Diplomate is on a 10-year or 7-year cycle, MC-FP requirements must be completed prior to applying for the next cognitive examination. The prior requirements for licensure and CME are incorporated into the requirements of the MC-FP. Details of the MC-FP process are available online at www.theabfm.org.

Sincerely,

Kathy Baker

Kathy Baker
Verification Coordinator

Addendum 2

Hospital Privileges: List the name and address of all hospitals where you have ever held any type of privileges (e.g. courtesy, admitting, etc.). If necessary, you may duplicate this form.

07/2007 - 09/2009 (Month Year - Month Year)
Type of Privileges: Admitting, Attending
Name of Hospital: Beth Israel Medical Center
City: New York State: NY Zip/Postal Code: 10003

___/___ - ___/___ (Month Year - Month Year)
Type of Privileges: ___
Name of Hospital: ___
City: ___ State: ___ Zip/Postal Code: ___

___/___ - ___/___ (Month Year - Month Year)
Type of Privileges: ___
Name of Hospital: ___
City: ___ State: ___ Zip/Postal Code: ___

___/___ - ___/___ (Month Year - Month Year)
Type of Privileges: ___
Name of Hospital: ___
City: ___ State: ___ Zip/Postal Code: ___

___/___ - ___/___ (Month Year - Month Year)
Type of Privileges: ___
Name of Hospital: ___
City: ___ State: ___ Zip/Postal Code: ___

___/___ - ___/___ (Month Year - Month Year)
Type of Privileges: ___
Name of Hospital: ___
City: ___ State: ___ Zip/Postal Code: ___

___/___ - ___/___ (Month Year - Month Year)
Type of Privileges: ___
Name of Hospital: ___
City: ___ State: ___ Zip/Postal Code: ___

6. **Hospital Discipline**: Please explain any disciplinary actions and attach any relevant supplements materials. List any revocation of hospital privileges for reasons related to competence or quality of patient care that have been taken by the hospital's governing body or any other official of the hospital after procedural due process has been afforded. Also, report resignation from or the non-renewal of medical staff privileges or the restriction of privileges at a hospital during the course or threat of investigation. If necessary, you may continue on a separate sheet. ☒ Check here if not applicable

Name of Hospital

____/____/_____ _____
Month Day Year Type of Action

Name of Hospital

____/____/_____ _____
Month Day Year Type of Action

Name of Hospital

____/____/_____ _____
Month Day Year Type of Action

7. **Criminal Convictions**: Respond to the questions below, then list any criminal conviction(s) in the space provided. If necessary, you may continue on a separate sheet.

Have you ever been convicted of a violation, plead Nolo Contedere, or entered a plea bargain to any federal, state or local statute, or ordinance, or are any formal charges pending; including use of illicit substances or operating a motor vehicle while intoxicated (Please include any offenses which have been expunged from your record)?
☐ Yes ☒ No

Abbreviation of State and Conviction* (e.g. CA – Illegal possession of a controlled substance)	Month/Year
	____/____
	____/____
	____/____

*For purposes of this section, a person shall be deemed to be convicted of a crime if he/she please guilty or if he/she was found or adjudged guilty by a court of competent jurisdiction or has been convicted of a felony by the entry of Nolo Contendere in any state.

8. **Physician Honors and Peer-Reviewed Publications (Optional)**: List any information regarding professional or community service awards and/or information regarding publication in peer-reviewed medical literature within the last ten (10) years. Do **not** submit your curriculum vitae to satisfy the requirements of this sections. If necessary, you may continue on a separate sheet.

Awards, Honors:

Publications:

9. **Professional and Community Memberships (Optional)**: List any professional and community memberships. Do **not** submit your curriculum vitae to satisfy the requirements of this section. If necessary, you may continue on a separate sheet.

10. **Questions**: Check either "Yes" or "No" for each question below. Note: if you answer "Yes" to any question, you are required to furnish complete details, including date, place, reason and disposition of the matter on a separate sheet.

1. During any Professional/Medical Education, were you ever dismissed, suspended, restricted, put on probation, or otherwise acted against or did you take a leave of absence for medical reasons? ☐ Yes ☒ No
2. During any Professional/Medical Education, were you ever requested to leave or did you leave, temporarily or permanently, prior to completion of training? ☐ Yes ☒ No
3. During any Post Graduate Training, were you ever dismissed, suspended, restricted put on probation, or otherwise acted against or did you take a leave of absence for medical reasons? ☐ Yes ☒ No
4. During any post graduate training, were you ever requested to leave or did you leave temporarily or permanently, prior to completion of training? (excluding maternity leave) ☐ Yes ☒ No
5. Are there any charges or investigations pending, in any state, against you? ☐ Yes ☒ No
6. Have your staff privileges at any hospital, nursing home, or other health care facility or health care provider or HMO ever been reduced, revoked, or suspended or have you voluntarily surrendered your clinical privileges from any such unit or facility while under investigation in any state? ☐ Yes ☒ No
7. Have you ever had any disciplinary action(s) taken, or is any pending, against your License to practice medicine, DEA permit, State Controlled Substances Registration, Medicare Privileges, Medicaid Privileges, or are any complaints pending in any state? ☐ Yes ☒ No
8. Have you ever had a membership in a professional society revoked, suspended, or limited in any manner or have you voluntarily withdrawn while under investigation? ☐ Yes ☒ No
9. Have you ever failed to pass an examination for medical licensure (including National Boards, FLEX, USMLE)? If you have failed to pass any segment of the USMLE within three (3) attempts you do not meet the requirements for licensure. Please contact Laura Dixon at (401) 222-7887 to discuss. ☐ Yes ☒ No

Addendum 3

State of Rhode Island and Providence Plantations
Department of Health

This information is completely voluntary and will NOT affect your Application in any way.

VOLUNTARY RACE/ETHNICITY QUESTIONS*

Applicant Name: DeGood, Catherine Ann
Last First Middle

Note: This information is voluntary and refusal to provide it will not impact on the renewal of your license. It will be confidential and used only in accordance with Title VI of the Civil Rights Act of 1964.

1. **Ethnicity**: Are you Hispanic or Latino? **(Mark "No" if not Hispanic or Latino)**
   ☒ No, not Hispanic or Latino ☐ Yes, Hispanic or Latino
2. **Race**: What is your race? (Mark one or more)
   ☐ American Indian or Alaska Native ☐ Black or African American ☒ White
   ☐ Asian ☐ Native Hawaiian or other Pacific Islander

For purposes of the above questions kindly use the "Federal Minimum Data Collection" explanations listed below:

1. **Ethnic Categories**:

   Hispanic or Latino – A person of Cuban, Mexican, Puerto Rican, South or Central American, or other Spanish culture or origin, regardless of race. The term, "Spanish Origin" can be used in addition to "Hispanic or Latino."

   Not Hispanic or Latino – A person who is not Hispanic or Latino.

2. **Racial Categories**:

   American Indian or Alaska Native – A person having origins in any of the original peoples of North and South America (including Central America), and who maintains tribal affiliation or community attachment.

   Asian – A person having origins in any of the original peoples of the Far East, Southeast Asia, or the Indian subcontinent including, for example, Cambodia, China, India, Japan, Korea, Malaysia, Pakistan, the Philippine Islands, Thailand, and Vietnam.

   Black or African American – A person having origins in any of the Black racial groups of Africa. Terms such as "Haitian" or "Negro" can be used in addition to "Black or African American."

   Native Hawaiian or other Pacific Islanders – A person having origins in any of the original peoples of Hawaii, Guam, Samoa or other Pacific Islands.

   White – A person having origins in any of the original peoples of Europe, the Middle East, or North Africa.

* This information is being collected in accordance with the Department of Health's policy for Maintaining, Collecting and Presenting Data on Race and Ethnicity. The mission of the Department is to protect and promote the health of the population and to prevent disease through life-style change, environmental change, and health services delivery. A copy of this policy is available upon request.

Addendum 7

Rhode Island Board of Medical Licensure & Discipline

Room 205, 3 Capitol Hill
Providence, RI 02908-5097
(401) 222-3855

IF Applying for CSR, this Application **MUST BE SUBMITTED ALONG WITH YOUR LICENSE APPLICATION.**
Substitute forms are not acceptable.

Rhode Island Uniform Controlled Substances Act Registration (CSR)

I am applying for a Rhode Island Uniform Controlled Substance Act Registration (CSR). **I understand that this application MUST be submitted along with my Board Application. I also understand that there is an additional $140.00 fee for this Registration and that the check or money order for $710.00 (Non-Refundable Board Application fee ($570.00) PLUS CSR Application fee ($140.00) must be made out to the "RI General Treasurer." Note: To be issued a RI Controlled Substance Registration you must have a Rhode Island Business Address.**

DeGood, Catherine Ann
Print/Type Full Name

Signature

9/18/09
Date

Memorial Hospital of Rhode Island
Business Name

111 Brewster St, Pawtucket, RI 02860
Business Address

(401) 729-2235
Business Telephone

Business Fax

Complete this application for registration to prescribe controlled substances in the State of Rhode Island	The Rhode Island Uniform Controlled Substances Act can be accessed at the following web site: http://www.rilin.state.ri.us/Statutes/Title21/21-28/index.htm **Drug Schedule (Check all that apply)** ☒ Schedule II ☒ Schedule III ☒ Schedule IV ☒ Schedule V
A CSR is not required if there will be no controlled substances prescriptions prescribed in this state. The CSR is renewed at the same time that the professional license is renewed. Note: Read important information on the bottom of this application.	**A Copy of the DEA Registration must be provided to the Medical Board within 60 Days of its issuance by the DEA.** The DEA Registration must be issued to your Rhode Island Practice Address in order for it to be valid. If you are relocating form another state, you need to apply for a DEA Registration that is specific to Rhode Island. See the bottom of this form for information on how to contact the DEA. * All Applicants MUST answer the following: A. Has the applicant been convicted of, or entered a plea of nolo contedere to a violation of any state or federal law relating to manufacturing, distributing, possessing, prescribing, administering or dispensing of drugs presently defined as controlled substances under Chapter 21-28, General Laws of Rhode Island? ☐ Yes ☒ No B. Has the registration application or registration of the applicant, corporation, firm, partner, or officer of the applicant been surrendered, revoked, suspended or denied under any law of the United State or of any state relating to drugs presently defined as controlled substances under Chapter 21-28, General Laws of Rhode Island, or is such action pending? ☐ Yes ☒ No **If you answered "Yes" to question "A" or "B" attach an explanation to this form.**

Important Information

Issuance of a Rhode Island Controlled Substances Registration is contingent upon registration by the U.S. Drug Enforcement Administration. If denied a "DEA Registration", the Rhode Island Controlled Substances Registration becomes "VOID." Licensed drug facilities and licensed practitioners with prescriptive privileges cannot dispense, possess, store or ship controlled substances in or into the State of Rhode Island without a valid drug facility or professional license. Rhode Island Controlled Substances Registration (CSR), and a federal Drug Enforcement Administration (DEA) Registration. Practitioners may only prescribe, dispense, possess, and store controlled substances within their particular "scope of practice." "Controlled Substances" for purposes of this application, means a prescription drug in Schedules II through V, pursuant to the Rhode Island Uniform Controlled Substances Act, and 21 CFR 1300 of the Federal Code of Regulations. Schedule I drugs are used by researchers, and require the submission of a protocol.

Without a Rhode Island CSR and federal DEA Registration, licensed drug facilities, and practitioners with prescriptive privileges, may dispense or possess non-controlled prescription medications under its facility or professional license. A CSR will not be granted to an applicant whose BOARD licensure application is "pending" in this state.

A Rhode Island CSR must be obtained prior to applying for DEA Registration. Federal regulations require that applicants comply with individual state requirements prior to issuance of a DEA Registration. Once the CSR is issued, applicants must apply to the U.S. Drug Enforcement Administration for a federal registration using that agency's DEA Form 224 (New Application for Retail Pharmacy, Hospitals/Clinics, Practitioner, Teaching Institution, or Mid-Level Practitioner). Applicants may apply on-line for the DEA Registration at the following website: www.deadiversion.usdoj.gov/drugreg/reg_apps/index.html

*You can also receive an application, or check the status of a pending DEA Registration by contacting the Drug Enforcement Administration at the following location: Registration Unit, US Drug Enforcement Administration, JFK Federal Bldg., 15 new Sudbury Street, Boston, MA 02203-0131, Telephone (888) 272-5174.

NOTE:

- Schedules II, III, and IV of section 21-28-2.08 will become void unless dispensed within thirty (30) days of the original date of the prescription.
- Prescriptions in schedules III, IV, and V cannot be written for more than one hundred (100) dosage units and not more than one hundred(100) dosage units may be dispensed at one time. For purposes of this section, a dosage unit shall be defined as a single capsule, tablet, or suppository, or not more that one (1) teaspoon of an oral liquid.
- Prescriptions in schedule II may be written for up to a 30-day supply, with a maximum of two hundred and fifty (250) dosage units, as determined by the prescriber's directions for use of the medication.

Addendum 6

MANDATORY ADDENDUM TO LICENSURE APPLICATION
VERIFICATION OF SOCIAL SECURITY NUMBER
Tax Payer Status Affidavit / Identity Verification

Rhode Island Department of Health
3 Capitol Hill
Providence RI, 02908-5097

All persons applying or renewing any license, registration, permit or other authority (herein after called "licensee") to conduct a business or occupation in the state of Rhode Island are required to file all applicable tax returns and pay all taxes owed to the state prior to receiving a license as mandated by state law(RIGL 5-76) except as noted below.

In order to verify that the state is not owed taxes, licensees are required to provide their Social Security Number, or Federal Tax Identification Number (for businesses) as appropriate. These numbers will be transmitted to the Division of Taxation to verify tax status prior to the issuance of a license.

Licensee Declaration

☒ I hereby declare, under penalty of perjury, that I have filed all required state tax returns and have paid all taxes owed.

☐ I have entered a written installment agreement to pay delinquent taxes that is satisfactory to the tax administrator.

☐ I am currently pursuing administrative review of taxes owed to the state.

☐ I am in federal bankruptcy. (Case # _____)

☐ I am in state receivership. (Case # _____)

☐ I have been discharged from bankruptcy. (Case # _____)

Physician
Type of Professional License for which you are applying.

DeGood, Catherine Ann
Full Name (Please Print or Type)

[redacted]
Social Security Number

9/16/09
Signature

[redacted]
Phone Number

9/18/09
Date

This form must be completed, signed and attached to your license application for processing.

Affidavit and Authorization for Release of Information: You must attach a recent (less than 6 months old) passport quality, color photograph of yourself to this form. Take the form to a notary public and sign the form in the presence of the notary public. The notarized form then must be sent directly to this Board.

Affidavit
And
Authorization For Release of Information

I, the undersigned, being duly sworn, 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 read and understand the Application for Physician Licensure and 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 my 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 Board any such information, including documents, records regarding charges or complaints filed against me, formal or informal, pending or closed, or any other pertinent data and to permit the Board or any of its agents or representatives to inspect and make copies of such documents, records, and other information in connection with this application.

I hereby release, discharge and exonerate the Board, its agents or representatives and any 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 of any and all liability of every nature and kind arising out of investigation made by the Board.

I will immediately notify the board in writing of any changes to the answers to any of the questions contained in this application if such a change occurs at any time prior to a license to practice medicine being granted to me by the board

I understand my failure to answer questions contained in this application truthfully and completely may lead to denial, revocation, or other disciplinary sanction of my licensure or permit to practice medicine.

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

DeGood
Applicant's Printed Last Name

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

9/19/09
Date of Signature

NOTARY

Dated 9-19-09 Signed _____

State of RI County of PROVIDENCE

SUBSCRIBED AND SWORN TO before me this 19 day of, SEPT 20 09.

My commission expires: _____ DAVID GIACOMINI NOTARY PUBLIC STATE OF RHODE ISLAND MY COMMISSION EXPIRES DEC 1 2010 (NOTARY PUBLIC SIGNATURE & SEAL)

Common Licensure Application - Self-Reported

CSLA Username:cdegood1 Submitted on: 9/18/2009 8:53 AM

1. Name

Name	Catherine Ann DeGood DO
Maiden Name	
Alternate Name(s)	

2. Address/Phone

(Practice)	Memorial Hospital of Rhode Island 111 Brewster Street
	Pawtucket, RI 02860
	USA
	Public Access: Public Mailing: N
(Home)	[redacted]
	Public Access: None Mailing: Y
Phone	
Business	
Business Fax	
Home	[redacted]
Home Fax	
Email	
Primary	
Secondary	[redacted]

3. Identification

Birth Date	[redacted]
Location:	
	USA
SSN	[redacted]
National Provider ID	1386861623
U.S. Citizen	Y
Gender	F

4. Medical Education

School	University of New England College of Osteopathic Medicine
Address	11 Hills Beach Road Biddeford, ME 04005 USA
Attendance Dates	07/2000 to 06/2004
Grad Date	6/5/2004
Degree	DO

5. Fifth Pathway

No information reported.

6. Postgraduate Medical Education

Montefiore Medical Center

Hospital	Montefiore Medical Center
	3544 Jerome Avenue
	Bronx, NY 10467
	USA
PGY	

Year(s):1	Internship/Residency: **Complete?**: Completed
	Family Medicine
	Dates: 07/2004 to 06/2005
Year(s):2	Residency: **Complete?**: Completed
	Family Medicine
	Dates: 07/2005 to 06/2006
Year(s):3	Residency: **Complete?**: Completed
	Family Medicine
	Dates: 07/2006 to 06/2007

7. Examination History

Exam	NBOMEC1
Date	06/2002
Attempts	[redacted]
Pass/Fail	

Exam	COMLEX
Date	01/2004
Attempts	[redacted]
Pass/Fail	

Exam	NBOMEC3
Date	06/2005
Attempts	[redacted]
Pass/Fail	

8. ECFMG

ECFMG ID:	
Cert Date:	

9. State or Professional Licensure

State	NY
License Number	239753
Type	MD : Doctor of Medicine - MD
Status	ACT

Issue Date	4/12/2006

10. Chronology of Activities

Dates	07/2007 to 09/2009
Practice/Employment Name	Beth Israel Medical Center
Address	160 Water Street 24th Floor
	New York, NY 10038
Position	Attending Physician
Department	Medicine
% Clinical / % Adm	100% / 0%
Employment	N
Staff Priviledges	N
Affiliation	N
Other	N

Dates	09/2008 to 07/2009
Practice/Employment Name	Hello Health
Address	105 Berry Street
	Brooklyn, NY 11211
Position	Family Physician
Department	
% Clinical / % Adm	100% / 0%
Employment	N
Staff Priviledges	N
Affiliation	N
Other	N

11. Malpractice Liability Claims Information

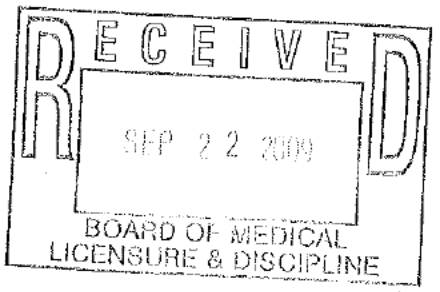
No information reported.

ver 200611113

National Practitioner Data Bank
Healthcare Integrity and Protection Data Bank
P.O. Box 10832
Chantilly, VA 20153-0832

http://www.npdb-hipdb.hrsa.gov

DCN: 5500000056784585
Process Date: 06/08/2009
Page: 1 of 1



To: DEGOOD, CATHERINE ANN
[redacted]

From: National Practitioner Data Bank / Healthcare Integrity and Protection Data Bank
Re: Response to Your Self-Query

The enclosed information is released by the National Practitioner Data Bank (NPDB) for restricted use under the provisions of Title IV of Public Law 99-660, the Health Care Quality Improvement Act of 1986, as amended, and the Healthcare Integrity and Protection Data Bank (HIPDB) for restricted use under the provisions of Section 1128E of the Social Security Act.

Title IV established the NPDB as an information clearinghouse to collect and release certain information related to malpractice payment history and professional competence or conduct of physicians, dentists, and other licensed health care practitioners. Regulations governing the NPDB are codified at 45 CFR part 60. Responsibility for operating the NPDB resides with the Secretary of the U.S. Department of Health and Human Services (HHS), HRSA, Division of Practitioner Data Banks.

Section 1128E was established by Section 221(a) of Public Law 104-191, the Health Insurance Portability and Accountability Act of 1996, as amended. The statute established the HIPDB to combat fraud and abuse in health insurance and health care delivery and to improve the quality of patient care. The HIPDB serves as a source of final adverse action information on health care practitioners, providers, and suppliers. The HIPDB collects and releases information related to adverse licensure actions; health care-related convictions and judgments; exclusions from Federal and State health care programs; and other adjudicated actions or decisions. Regulations governing the HIPDB are codified at 45 CFR Part 61. Responsibility for operating the HIPDB resides with the Secretary of the U.S. Department of Health and Human Services (HHS), Office of Inspector General, and HRSA, Division of Practitioner Data Banks.

Reports from the NPDB and HIPDB contain limited summary information and should be used in conjunction with information from other sources in granting clinical privileges or making employment affiliation, contracting, or licensure decisions. The NPDB and HIPDB response may contain more than one report on a particular incident, if two or more actions were taken as a result of a single incident (e.g., an adverse licensure action and an exclusion from the Medicare and Medicaid programs). The NPDB and HIPDB is a flagging system and a report may be included for a variety of reasons that do not necessarily reflect adversely on the professional competence or conduct of the subject named in the report.

All information received from the NPDB and HIPDB is considered confidential and must be used solely for the purpose for which it was disclosed. ANY PERSON WHO VIOLATES THE CONFIDENTIALITY PROVISIONS AS SPECIFIED IN TITLE IV OF PUBLIC LAW 99-660, AS AMENDED, IS SUBJECT TO A CIVIL MONEY PENALTY OF UP TO $11,000 FOR EACH VIOLATION. Subjects of reports who obtain information about themselves from the NPDB and/or HIPDB are permitted to share that information with anyone they choose.

If you require additional assistance, visit the NPDB-HIPDB web site (http://www.npdb-hipdb.hrsa.gov) or contact the NPDB-HIPDB Customer Service Center at 1-800-767-6732 (TDD: 1-703-802-9395). Information Specialists are available to speak with you weekdays from 8:30 a.m. to 6:00 p.m. (5:30 p.m. on Fridays) Eastern Time. The NPDB-HIPDB Customer Service Center is closed on all Federal holidays.

National Practitioner Data Bank
Healthcare Integrity and Protection Data Bank
P.O. Box 10832
Chantilly, VA 20153-0832

http://www.npdb-hipdb.hrsa.gov

DCN: 5500000056784585
Process Date: 06/08/2009
Page: 1 of 1

SELF-QUERY RESPONSE

This self-query was processed under the provisions of:

[X] Title IV (NPDB) [X] Section 1128E (HIPDB)

[redacted]

Copies of these reports are enclosed for restricted/limited use as prescribed by Title IV of Public Law 99-660, as amended, and by Section 1128E of the Social Security Act. Information from the NPDB and HIPDB is confidential and must be used solely for the purpose for which it was disclosed. ANY PERSON WHO VIOLATES THE CONFIDENTIALITY PROVISIONS AS SPECIFIED IN TITLE IV IS SUBJECT TO A CIVIL MONEY PENALTY OF UP TO $11,000 FOR EACH VIOLATION. Subjects of reports who obtain information about themselves from the NPDB and/or HIPDB are permitted to share that information with anyone they choose.

END OF DOCUMENT

THE UNIVERSITY OF THE STATE OF NEW YORK
THE STATE EDUCATION DEPARTMENT
DIVISION OF PROFESSIONAL LICENSING SERVICES
89 WASHINGTON AVENUE
ALBANY, NEW YORK 12234

RT

This is to certify that according to the records of the Division of Professional Licensing Services, New York State Education Department Albany, New York, DEGOOD CATHERINE ANN
was issued license/certificate number 239753 for the practice of MEDICINE on 04/12/06.

Our records also indicate the following information:
Date of birth: [redacted]
School attended: UNIVERSITY OF NEW ENGLAND
Date of graduation: 06/05/04
Degree earned: DO

Program was acceptable in accordance with the NYS Regulations of the Commissioner of Education. Requirements met at the time of licensure.

Basis of licensure:

DATE	FLEX1	NBME1	USML1	NBME2	FLEX2	USML2	NBME3	USML3	OTHER
06/05							0000P		OSTEO
01/04				0000P					
06/02		0000P							

EXMS TAKEN=03
A license is valid during the life of the holder unless revoked, annulled or suspended by the Board of Regents. A licensee must register periodically with this Department to practice in this state.

Currently Registered: YES Reg period ends: 05/31/11
Address: [redacted]

Disciplinary information: No charges have been preferred against this licensee
Comments:

I, Martin Carmody, Principal Clerk, Division of Professional Licensing Services of the New York State Education Department, do hereby state that as Principal Clerk of said Division, I have legal custody of the official records of the Division of Professional Licensing Services and to the best of my knowledge, the aforesaid information is true and correct.

SEAL

Martin Carmody 09/25/09
Principal Clerk

Addendum 5

Rhode Island Board of Medical Licensure and Discipline

Room 205, 3 Capitol Hill
Providence, RI 02908-5097
(401) 222-3855

Substitute forms are not acceptable. This form may be duplicated as needed.

Reference Form

I am applying for a license to practice medicine in the State of Rhode Island. The Rhode Island Board of Medical Licensure and Discipline requires this reference form be completed as part of my application process. This constitutes you authority to provide information about my character and professional abilities, favorable or otherwise, directly to the Rhode Island Board of Medical Licensure and Discipline at the above address.

DeGood, Catherine Ann — Print/Type Full Name

[redacted] — Signature

9/19/09 — Date

Previous Names Used

[redacted] — Social Security Number

[redacted] — Date of Birth

THIS SECTION TO BE COMPLETED BY THE INDIVIDUAL PROVIDING THE REFERENCE

Please Note: References must be typed or printed clearly. Illegible references may delay a candidate's application

EVALUATION
Based upon demonstrated performance and composite of evaluations by supervisors on file.

	Superior	Satisfactory	Unsatisfactory	No Information
Basic Clinical Knowledge	✓			
Professional Judgement	✓			
Clinical Competence	✓			
Reliability/Sense of Responsibility	✓			
Patient Management	✓			
Ethical Conduct	✓			
Physician-Patient Relationship	✓			
Ability to Work with Other Hospital Staff	✓			
Appearance	✓			
Medical Recordkeeping	✓			
Ability to Communicate Verbally	✓			
Recommendation: **OVERALL RATING:**	✓			

✓ Recommended Highly without Reservation __ Recommended as Qualified and Competent __ Recommended with Reservation
__ No Comment __ Not Recommended

Additional Comments (Use reverse side if necessary):

Dr. Degood is an extremely capable & conscientious medical provider. She will be an asset to any institution.

You must affix your institution's office seal or have your signature notarized

CAROLYN CHU — Printed Name of Reference

[signature] — Signature

MD — Title

9/25/09 — Date

PAST CO-WORKER AT MONTEFIORE MEDICAL CENTER (BRONX, NY) — Relationship to Applicant

Please return directly to the Board at the above address. Thank you for your prompt cooperation.

Please affix Department Hospital or Notarial Seal

Amita N. Parikh
Notary Public, State of New York
Qualified in New York County
01PA5081002
Commission Expires June 30, 2011

Sworn to me on 09/25/09 Amita N. Parikh

Addendum 5

Rhode Island Board of Medical Licensure and Discipline

Room 205, 3 Capitol Hill
Providence, RI 02908-5097
(401) 222-3855

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DeGood, Catherine Ann — Print/Type Full Name
[redacted] — Signature
9/19/09 — Date

Previous Names Used
[redacted] — Social Security Number
[redacted] — Date of Birth

THIS SECTION TO BE COMPLETED BY THE INDIVIDUAL PROVIDING THE REFERENCE

Please Note: References must be typed or printed clearly. Illegible references may delay a candidate's application

EVALUATION
Based upon demonstrated performance and composite of evaluations by supervisors on file.

	Superior	Satisfactory	Unsatisfactory	No Information
Basic Clinical Knowledge	✓			
Professional Judgement	✓			
Clinical Competence	✓			
Reliability/Sense of Responsibility	✓			
Patient Management	✓			
Ethical Conduct	✓			
Physician-Patient Relationship	✓			
Ability to Work with Other Hospital Staff	✓			
Appearance		✓		
Medical Recordkeeping	✓			
Ability to Communicate Verbally	✓			
Recommendation: **OVERALL RATING:**	✓			

✓ Recommended Highly without Reservation __ Recommended as Qualified and Competent __ Recommended with Reservation
__ No Comment __ Not Recommended

Additional Comments (Use reverse side if necessary):

You must affix your institution's office seal or have your signature notarized

Roy C. Tio — Printed Name of Reference
[signature] — Signature
D.O. ASSISTANT MEDICAL DIRECTOR BIMC MMTP — Title
9/29/09 — Date
former Supervising physician — Relationship to Applicant

Please affix Department, Hospital or Notarial Seal Here

BRUCE A. LONGMORE
NOTARY PUBLIC, State of New Y
No. 01LO4983584
Qualified in Bronx County
Commission Expires December 10, 20
2010

Please return directly to the Board at the above address. Thank you for your prompt cooperation.

Addendum 5

Rhode Island Board of Medical Licensure and Discipline

Room 205, 3 Capitol Hill
Providence, RI 02908-5097
(401) 222-3855

RECEIVED
NOV - 3 2009
BOARD OF MEDICAL LICENSURE & DISCIPLINE

Substitute forms are not acceptable. This form may be duplicated as needed.

Reference Form

I am applying for a license to practice medicine in the State of Rhode Island. The Rhode Island Board of Medical Licensure and Discipline requires this reference form be completed as part of my application process. This constitutes you authority to provide information about my character and professional abilities, favorable or otherwise, directly to the Rhode Island Board of Medical Licensure and Discipline at the above address.

DeGood, Catherine Ann — Print/Type Full Name
Signature
9/19/09 — Date

Previous Names Used
[redacted] — Social Security Number
[redacted] — Date of Birth

THIS SECTION TO BE COMPLETED BY THE INDIVIDUAL PROVIDING THE REFERENCE

Please Note: References must be typed or printed clearly. Illegible references may delay a candidate's application

EVALUATION
Based upon demonstrated performance and composite of evaluations by supervisors on file.

	Superior	Satisfactory	Unsatisfactory	No Information
Basic Clinical Knowledge	✓			
Professional Judgement	✓			
Clinical Competence	✓			
Reliability/Sense of Responsibility	✓			
Patient Management	✓			
Ethical Conduct	✓			
Physician-Patient Relationship	✓			
Ability to Work with Other Hospital Staff	✓			
Appearance	✓			
Medical Recordkeeping	✓			
Ability to Communicate Verbally	✓			
Recommendation: **OVERALL RATING:**	✓			

✓ Recommended Highly without Reservation ___ Recommended as Qualified and Competent ___ Recommended with Reservation
___ No Comment ___ Not Recommended

Additional Comments (Use reverse side if necessary):

You must affix your institution's office seal or have your signature notarized

KATHRYN SEEWALD — Printed Name of Reference
Signature
MEDICAL DIRECTOR — Title
10/30/09 — Date
SUPERVISOR — Relationship to Applicant

Please affix Department Hospital or Notarial Seal Here

VIVIAN GUARDINO
Notary Public - State of New York
No. 01GU6207149
Qualified in New York County
My Commission Expires June 8, 2013

Vivian Guardino
10/30/09

Please return directly to the Board at the above address. Thank you for your prompt cooperation.

Addendum 5

Rhode Island Board of Medical Licensure and Discipline
Room 205, 3 Capitol Hill
Providence, RI 02908-5097
(401) 222-3855

Substitute forms are not acceptable. This form may be duplicated as needed.

Reference Form

I am applying for a license to practice medicine in the State of Rhode Island. The Rhode Island Board of Medical Licensure and Discipline requires this reference form be completed as part of my application process. This constitutes you authority to provide information about my character and professional abilities, favorable or otherwise, directly to the Rhode Island Board of Medical Licensure and Discipline at the above address.

DeGood, Catherine Ann — Print/Type Full Name
Signature — 9/19/09 Date
Previous Names Used — [redacted] Social Security Number — [redacted] Date of Birth

THIS SECTION TO BE COMPLETED BY THE INDIVIDUAL PROVIDING THE REFERENCE

Please Note: References must be typed or printed clearly. Illegible references may delay a candidate's application

EVALUATION
Based upon demonstrated performance and composite of evaluations by supervisors on file.

	Superior	Satisfactory	Unsatisfactory	No Information
Basic Clinical Knowledge	✓			
Professional Judgement	✓			
Clinical Competence	✓			
Reliability/Sense of Responsibility	✓			
Patient Management	✓			
Ethical Conduct	✓			
Physician-Patient Relationship	✓			
Ability to Work with Other Hospital Staff	✓			
Appearance	✓			
Medical Recordkeeping	✓			
Ability to Communicate Verbally	✓			
Recommendation: OVERALL RATING:	✓			

✓ Recommended Highly without Reservation __ Recommended as Qualified and Competent __ Recommended with Reservation
__ No Comment __ Not Recommended

STATE OF NEW YORK } SS
COUNTY OF NEW YORK

Additional Comments (Use reverse side if necessary):

Subscribed and sworn to before me this 2nd day of November, 2009

You must affix your institution's office seal or have your signature notarized

Rashiah Elam MD — Printed Name of Reference
Signature
Medical Director - Primary Care — Title
11/2/09 — Date
Colleague — Relationship to Applicant

Please affix Seal Here.
PATRICIA M. ODOM
NOTARY PUBLIC, State of New York
No. 01OD6132016
Qualified in New York County
Commission Expires August 22, 2013

Please return directly to the Board at the above address. Thank you for your prompt cooperation.

The Federation of State Medical Boards of the United States, Inc.
Federation Credentials Verification Service
P.O. Box 619850
Dallas, Texas 75261-9850
Telephone: (817) 868-4000
Fax: (817) 868-4099

Physician Information Profile

This report is compiled exclusively for:

Name:	**Catherine Ann DeGood**
SSN:	[redacted]
DOB:	
Packet ID:	**108999**
Recipient:	**Rhode Island Board of Medical Licensure and Discipline**

NOTICE:

The Federation Credentials Verification Service (FCVS) was retained by the above referenced physician 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. All documents bearing the official FCVS seal are ceritified 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.

Table of Contents

Section I

FCVS Reports

FEDERATION CREDENTIALS VERIFICATION SERVICE

Physician Information Report

Identity:

Name:	**Catherine Ann DeGood**
Other Name Used:	**N/A**
Gender:	**Female**
Date of Birth:	[redacted]
Place of Birth:	
SSN:	
Current Address:	[redacted]
Permanent Address:	**Same**
Telephone Numbers:	Bus: [redacted]
	Fax: N/A
	Home: [redacted]
	Other: N/A
Physical Description:	Height: [redacted]
	Weight:
	Eye Color:
	Hair Color:
Physical Marks:	Description: **N/A**
	Location: **N/A**

Premedical Education (Reported by physician. Not verified by FCVS):

Institution:	**Reed College, Portland, OR 97202-8199**
Dates of Attendance:	**09/1993 - 05/1995**
Degree Conferred/Issued:	**None**
Institution:	**University of Virginia, Charlottesville, VA 22903**
Dates of Attendance:	**09/1995 - 05/1997**
Degree Conferred/Issued:	**Bachelor of Arts**

Medical Education:

Medical School:	**University of New England College of Osteopathic Medicine** **11 Hills Beach Road** **Biddeford, ME 04005**
Dates of Attendance:	**08/02/2000 - 06/05/2004**
Date Degree Conferred/Issued:	**06/05/2004**
Degree Conferred/Issued:	**Doctor of Osteopathy**
Unusual Circumstance:	**None**

Post Graduate Medical Education:

Institution:	**Montefiore Medical Center** **Department of Family Practice** **3544 Jerome Avenue** **Bronx, NY 10467**
Post Graduate Year:	**1-3**
Program Type:	**Internship /Residency**
Department:	**Family Medicine**
Dates of Attendance:	**07/01/2004 - 06/30/2007**
Completion:	**Yes**
Accreditation:	**ACGME**
Unusual Circumstance:	**None**

Fifth Pathway:

N/A

Examination History:

Licensure Examinations:	**NBOME - Comlex Level 1** **NBOME - Comlex Level 2 CE** **NBOME - Comlex Level 3**

Board Action:

A Report of the results from a search of the Board Action Data Bank is enclosed.

Credentials Analysis Report

The Credentials Analysis Report is a comparative report of a physician's credentials as reported to FCVS by the physician applicant and the primary source (Medical School, PGT program, etc.). It will also list particular missing documentation, if any, as outlined in the FCVS Policies and Procedures.

Physician Identification:

Name:	Catherine Ann DeGood
DOB:	
SSN:	[redacted]
Packet ID:	108999
Request ID:	21329115

OMISSIONS

There are none identified.

DISCREPANCIES

There are none identified.

MISCELLANEOUS INFORMATION

Miscellaneous 1:

Section of Profile:	**Continuity of Education**
Issue:	There is an interruption of education between completion of premedical education at University of Virginia (ends 05/1997) and entrance into medical school at University of New England College of Osteopathic Medicine (begins 08/02/2000).
Follow-Up:	Provided as information only. No follow up performed.

End of report for Catherine Ann DeGood

Board Action Databank Search

State Queried For:	**Rhode Island Board of Medical Licensure and Discipline**
Physician's Name	**DeGood, Catherine Ann**
Date of Birth:	[redacted]
Medical School:	**020010 - University of New England College of Osteopathic Medicine**
Year of Graduation:	**2004**
Social Security Number:	[redacted]
ECFMG Number:	N/A

Results:

WE HAVE NO UNFAVORABLE INFORMATION
REGARDING THE ABOVE NAMED PHYSICIAN

OCT 2 2 2009

Barbara S. Schneidman, MD, MPH
Interim President
And Chief Executive Officer

AMERICAN BOARD OF MEDICAL SPECIALTIES
VERIFICATION OF CERTIFICATION

As of: 10/23/2009

State Queried For:	Rhode Island Board of Medical Licensure and Discipline
Physician Name:	Catherine Ann DeGood
Date of Birth:	[redacted]
Year of Graduation:	2004
Social Security Number:	
ABMSU ID:	[redacted]

Certification:

Board:	Family Practice
Specialty:	Family Practice
Status:	ACTIVE
Initial Certification:	12/07/2007

Section II

Identity

Federation of STATE MEDICAL BOARDS

Affidavit and Release and Authorization for Release of Information, Documents and Records

I, the undersigned, being duly sworn, 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 read and understand the "Instructions for Completing the FCVS Application" and 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 my being prosecuted under appropriate federal and state laws.

I waive confidentiality, 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 (FCVS) any such information, including documents, records regarding charges or complaints filed against me, formal or informal, pending or closed, my examination grades, or any other pertinent data and to permit FCVS or any of its agents or representatives to inspect and make copies of such documents, records, and other information in connection with this application that can subsequently be provided to professional licensing boards, hospitals and other entities when I apply for licensure, staff membership, employment or other privileges.

I hereby release, discharge and exonerate FCVS, its agents or representatives and any 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 of any and all liability of every nature and kind arising out of investigation made by FCVS.

I will immediately notify FCVS in writing of any changes to the answers to any questions contained in this application if such a change occurs at any time prior to my FCVS Physician Information Profile being mailed.

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

DeGroot
Applicant's Printed Last Name

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

9/2/09 [redacted]
Date of Signature Date of Birth

[redacted]
Applicant SSN

NOTARY

STATE OF RHODE ISLAND
MY COMMISSION EXPIRES 04/10/2013

Your seal or stamp must be partly upon the photograph.

State of RI County of Providence

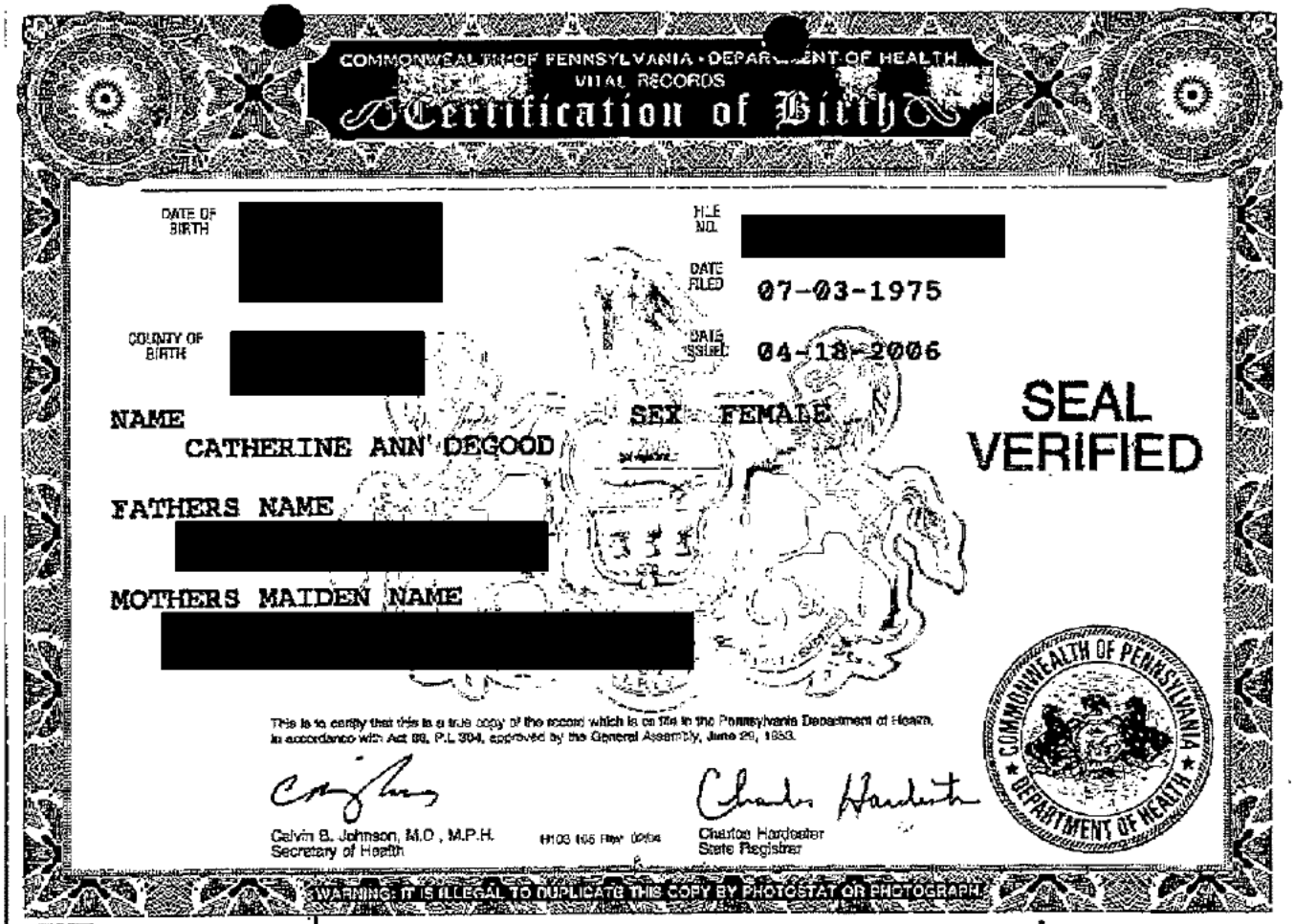
SUBSCRIBED AND SWORN TO before me this 2 day of September, 20 09

My commission expires: 4/10/13

(NOTARY PUBLIC SIGNATURE & SEAL)

Notary Public signature:

I certify that on the date set forth above 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.



COMMONWEALTH OF PENNSYLVANIA - DEPARTMENT OF HEALTH
VITAL RECORDS

Certification of Birth

DATE OF BIRTH [redacted]

FILE NO. [redacted]

DATE FILED 07-03-1975

COUNTY OF BIRTH [redacted]

DATE ISSUED 04-18-2006

NAME CATHERINE ANN DEGOOD

SEX FEMALE

SEAL VERIFIED

FATHERS NAME [redacted]

MOTHERS MAIDEN NAME [redacted]

This is to certify that this is a true copy of the record which is on file in the Pennsylvania Department of Health, in accordance with Act 66, P.L.304, approved by the General Assembly, June 29, 1953.

Calvin B. Johnson, M.D., M.P.H.
Secretary of Health

H103 165 Rev 0704

Charles Hardester
State Registrar

COMMONWEALTH OF PENNSYLVANIA ★ DEPARTMENT OF HEALTH ★

WARNING: IT IS ILLEGAL TO DUPLICATE THIS COPY BY PHOTOSTAT OR PHOTOGRAPH.

BME

13401671

Section III

Medical Education

Federation of STATE MEDICAL BOARDS

FEDERATION CREDENTIALS VERIFICATION SERVICE (FCVS)

VERIFICATION OF MEDICAL EDUCATION

(This form must be completed by the medical school)

INSTRUCTIONS TO THE DEAN

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 complete this form and forward it to FCVS to the address at the bottom of page 2.**

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).**

VERIFICATION OF MEDICAL EDUCATION

Name of Institution: University of New England College of Osteopathic Medicine

Complete Address: _____

Street Address: [redacted]

City: Biddeford **State:** ME **ZIP Code (Postal Code):** 04005

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

_____

Premedical Education:

Years of education required for admission to your medical school: 16

Credential/degree presented by the applicant for admission to your medical school: B.A.

Enrollment and Participation: Our records indicate that DeGood, Catherine A.
(type/print individual's name: Last, First, Middle, Suffix)
attended our medical school for total of _____ weeks of medical education on the following dates (mm/dd/yy):

From 08 / 02 / 00 (Month / Date / Year) **To** 06 / 05 / 04 (Month / Date / Year)

This individual:

Was awarded the degree of Doctor of Osteopathic Medicine on 06 / 05 / 04 (Month / Date / Year)

was NOT awarded a degree because: _____
(please explain – attach additional pages if necessary)

Certification: By my signature, I Catherine S. Durette, certify that the above
(type/print name)
information is an accurate account of the above named individual's official records maintained in this and is true and correct to my knowledge. The signature line must contain the original signature, or the electronic typed signature, of the authorized signatory.

SEAL VERIFIED

Affix Institutional Seal Here.

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

Signature: [signature]

Title: Interim Registrar

Date of Signature: 09 / 21 / 09

Phone: (207 288-0171 **Fax:** (207) 602-5927

Email: _____

PID 108999 RID 21329115 Analyst DVK MSM Code 020010

VERIFICATION OF MEDICAL EDUCATION (continued)

Unusual Circumstances: The following questions apply to unusual circumstances that occurred during any part of the individual's medical education. Please check the appropriate response and provide dates and requested information. "Yes" responses to any of these questions require a copy of explanatory records or a written explanation (attach additional pages as necessary).

1. Do this individual's official records reflect (an) interruption(s) or extension(s) in his/her medical education?
   Response YES ☐ NO ☑

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

	From Mo/Yr	To Mo/Yr	Approved	Unapproved
Personal/Family			☐	☐
Academic remediation			☐	☐
Health			☐	☐
Financial			☐	☐
Participation in joint degree Program (e.g., MD/PhD)			☐	☐
Participation in non-research special study (e.g., fellowship, international experience)			☐	☐
Participation in non-degree research			☐	☐
Other			☐	☐

   Please Specify:

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

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

	From Mo/Yr	To Mo/Yr
Academic Probation		
Probation for unprofessional conduct/behavioral		
Probation for other reason		

   Please specify 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? Response YES ☐ 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? Response YES ☐ 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?
   Response YES ☐ NO ☑

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

Please complete both pages of this form, sign, date and seal on the front page then return to:
Federation Credentials Verification Service/ P.O. Box 619850/ Dallas, TX 75261-9850
or e-mail to: fcvsforms@fsmb.org

Dan Leclerc - RE: Dr. Catherine DeGood (Follow Up Request-108999)

From: "Deandra Koontz" <dkoontz@fsmb.org>
To: <sgagnon@une.edu>, <dleclerc@une.edu>
Date: 10/1/2009 9:13 AM
Subject: RE: Dr. Catherine DeGood (Follow Up Request-108999)
Attachments: diploma.TIF; release form.TIF; auth form.TIF

The Federation of State Medical Boards of the United States, Inc.
Federation Credentials Verification Service
P.O. Box 619850
Dallas, TX 75261-9850
Telephone (817) 868-5000
Fax (817) 868-4294

October 1, 2009

University of New England College of Osteopathic Medicine
11 Hills Beach Road
Biddeford ME 04005

Re: Packet ID 108999

The form you recently submitted to FCVS for **Dr. Catherine DeGood** was either incomplete or requires further clarification. Please address these items listed below and return by fax to the above number.

1. Weeks: The total number of weeks of medical education was omitted from the Verification Form. Please report the total number of weeks below.

Total number of weeks: 160

2. Diploma Certified: You did not certify the enclosed diploma. Please review this diploma and certify it by affixing a stamp or seal of the issuing institution and a signature of an authorized representative.

Completion of the following is certification that the information above is an accurate account of the individual's records and is true and correct. This section MUST be signed by an authorized representative.

Signature | Interim Registrar (Title) | 10-1-09 (Date)

Number of Pages Sent:
[020010]

DVF

020010

Medical Education

PROVIDED BY APPLICANT

School	The University of New England College of Osteopathic Medicine
Address	11 Hills Beach Road
	Biddeford, ME 04005
	USA
Phone	207-283-0171
Dates	07/2000 - 06/2004
Grad Date	06/05/2004
Degree	DO - Doctor of Osteopathy
Program 8+ years:	N
Completed clinical clerkship in a country other than where my medical school was located:	N
Clinical Training	
Unusual Circumstances	
Leaves/Extensions	N
Probation	N
Disciplined	N
Negative Reports	N
Limitations	N

University of New England

Biddeford and Portland, Maine

Student No: 910108674

Date Issued: 24-SEP-2009
OFFC

Page: 1

Record of: Catherine A DeGood
Current Name: Catherine A DeGood
Issued To: Federation Cred. Verif. Serv.
P.O Box 619850
Dallas, TX 75261-9850
USA

Course Level: First Professional Degree
Only Admit: Fall Semester 2000
Matriculated: Fall Semester 2000

Current Program
College : Osteopathic Medicine
Major : Doctor of Osteopathy

Degrees Awarded Doctor of Osteopathic Medicine 05-JUN-2004
Ehrs: 110.00 GPA-Hrs: 0.00 QPts: 0.00 GPA: 0.00

Primary Degree
Major : Doctor of Osteopathy

SUBJ	NO.	COURSE TITLE	CRED	GRD	PTS	R
INSTITUTION CREDIT:						
Fall Semester 2000						
Osteopathic Medicine						
Doctor of Osteopathy						
COM	501	Medical Gross Anatomy	10.00	[redacted]	0.00	
COM	503	Medical Histology	5.00		0.00	
COM	505	Medical Embryology	2.00		0.00	
COM	511	MF:Biochem & Cell Biology	8.00		0.00	
COM	523	Medical Immunology	2.00		0.00	
COM	597	Foundations of Doctoring	5.00		0.00	
COM	591	Osteopathic Princ. & Prac. I	2.00		0.00	
Ehrs: 34.00 GPA-Hrs: 0.00 QPts: 0.00 GPA: 0.00						
Spring Semester 2001						
Osteopathic Medicine						
Doctor of Osteopathy						
COM	514	Nutrition I	1.00	[redacted]	0.00	
COM	524	Medical Virology	2.00		0.00	
COM	526	Medical Bacteriology	3.00		0.00	
COM	530	Medical Parasitology	1.00		0.00	
COM	532	MF:Cellular & Organ Sys. Phys.	5.00		0.00	
COM	542	Medical Pharmacology	2.00		0.00	
COM	552	Intro. to Pathology	3.00		0.00	
COM	558	Dermatological System	1.00		0.00	

********** CONTINUED ON NEXT COLUMN **********

SUBJ	NO.	COURSE TITLE	CRED	GRD	PTS	R
Institution Information continued:						
COM	568	Medical Jurisprudence	1.00	[redacted]	0.00	
COM	586	Basic Life Support	0.00		0.00	
COM	598	Princ. of Population Health	2.00		0.00	
Ehrs: 21.00 GPA-Hrs: 0.00 QPts: 0.00 GPA: 0.00						
Good Standing						
Fall Semester 2001						
Osteopathic Medicine						
Doctor of Osteopathy						
COM	601	Nervous System	6.00	[redacted]	0.00	
COM	603	Medical Neuroanatomy	2.00		0.00	
COM	605	Psychiatry System	2.00		0.00	
COM	611	Musculoskeletal System	4.00		0.00	
COM	623	Respiratory System	3.00		0.00	
COM	633	Hematology System	3.00		0.00	
COM	673	Experiences in Doctoring	5.00		0.00	
COM	697	Pharmacology & Therapeutics	2.00		0.00	
COM	691	Osteopathic Principles & Pract	5.00		0.00	
Ehrs: 32.00 GPA-Hrs: 0.00 QPts: 0.00 GPA: 0.00						
Spring Semester 2002						
Osteopathic Medicine						
Doctor of Osteopathy						
COM	642	Cardiovascular System	5.00	[redacted]	0.00	
COM	652	Renal System	3.00		0.00	
COM	660	Endocrine System	1.00		0.00	
COM	662	Gastrointestinal System	3.00		0.00	
COM	664	Reproductive System	5.00		0.00	
COM	668	Adv Cardiac Life Support ACLS	1.00		0.00	
COM	670	Emergency Medicine	1.00		0.00	
COM	688	Pharmacology & Therapeutics II	2.00		0.00	
COM	693	Clinical Decision Making	2.00		0.00	
Ehrs: 23.00 GPA-Hrs: 0.00 QPts: 0.00 GPA: 0.00						
Good Standing						

********** CONTINUED ON PAGE 2 **********

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University of New England

Biddeford and Portland, Maine

Student No: 910108674

Date Issued: 24-SEP-2009

OFFC

Record of: Catherine A DeGood

Level: First Professional Degree

Page: 2

SUBJ	NO.	COURSE TITLE	CRED	GRD	PTS	R

Institution Information continued:

Academic Year 2002-2003

Osteopathic Medicine

Doctor of Osteopathy

CORE	FM	Family Medicine-Core	0.00		0.00
CORE	IN	Internal Medicine-Core	0.00		0.00
CORE	IM	Internal Medicine-Core	0.00		0.00
CORE	OBG	Obstetrics & Gynecology-Core	0.00		0.00
CORE	P	Psychiatry-Core	0.00		0.00
CORE	PD	Pediatrics-Core	0.00		0.00

Ehrs: 0.00 GPA-Hrs: 0.00 QPts: 0.00 GPA: 0.00

Academic Year 2003-2004

Osteopathic Medicine

Doctor of Osteopathy

CORE	S	Surgery-Core	0.00		0.00
ELCT	AL	Alternative Medicine-Elective	0.00		0.00
ELCT	D	Dermatology-Elective	0.00		0.00
ELCT	FM	Family Medicine-Elective	0.00		0.00
ELCT	OMM	Osteopathic Manipulative Med-E	0.00		0.00
ELCT	RH	Reproductive Health	0.00		0.00
ELCT	AHEC	AHEC:Rural Primary Care-SE	0.00		0.00
ELCT	EM	Emergency Medicine-Selective	0.00		0.00
ELCT	ID	Infectious Disease-Selective	0.00		0.00
ELCT	OMM	Osteo Man Med- Selective	0.00		0.00
ELCT	S	Surgery-Urological	0.00		0.00

Ehrs: 0.00 GPA-Hrs: 0.00 QPts: 0.00 GPA: 0.00

Good Standing

********** TRANSCRIPT TOTALS **********

	Earned Hrs	GPA Hrs	Points	GPA
TOTAL INSTITUTION	110.00	0.00	0.00	0.00
TOTAL TRANSFER	0.00	0.00	0.00	0.00
OVERALL	110.00	0.00	0.00	0.00

********** END OF TRANSCRIPT **********

Catherine S. Durette, Interim Registrar

SEAL VERIFIED

Key to the Transcript University of New England

History

The University of New England was originally formed in 1978 by the combination of New England's only college of Osteopathic Medicine with UNE's predecessor, St. Francis College, which had been fully accredited since 1966. In 1996 the University merged with Westbrook College (WCC) of Portland, Maine, resulting in a wider range of programming between urban and suburban campuses, and a Charter date of 1831. UNE provides academic leadership in health promotion, education, and the quality of life, and consists of three colleges at the two locations: the College of Arts and Sciences (CAS), the College of Health Professions (CHP), and the College of Osteopathic Medicine (COM).

Accreditation, Memberships, and Other Notices

The University of New England is accredited by the New England Association of Schools and Colleges, Inc. Accreditation by the Association indicates that the institution has been carefully evaluated and found to meet standards agreed upon by qualified educators. The education program leading to elementary certification is approved by the State of Maine Department of Education. The Physical Therapy program is accredited by the American Physical Therapy Association. The Occupational Therapy program is accredited by the American Occupational Therapy Association. Nursing programs are accredited by the National League of Nursing. The Dental Hygiene programs are accredited by the American Dental Association Commission on Dental Accreditation. The Social Work program is accredited by the Commission on Accreditation on the Council of Social Work Education. The School of Nurse Anesthesia is accredited by the Council on Accreditation of Nurse Anesthesia Educational Programs. The Physician Assistant program is accredited by the Commission on Accreditation of Allied Health Education Programs. The College of Osteopathic Medicine is accredited by the Bureau of Professional Education of the American Osteopathic Association.

Most programs offered at the University of New England have been approved for the training of veterans through various GI Bill programs and meet the educational requirements for officer candidacy in branches of the armed forces.

The University holds, among others, membership in: the New England Association of Schools and Colleges, the Maine Consortium of Health Professionals, the Council of Independent Colleges and Universities, the National Association of College Auxiliary Services, the College Entrance Examination Board, the National Collegiate Athletic Association, the National Association of College Admissions Counselors, the New England Association of College Admissions Counselors, the American Association of Collegiate Registrars and Admissions Officers, the National Association of College and University Business Officers, the American Association of Colleges of Osteopathic Medicine, and the Greater Portland Alliance of Colleges and Universities.

The University of New England operates under a positive program of nondiscrimination to insure equal opportunity to all students and applicants regardless of race, sex, creed or national origin. For information regarding student disciplinary action, please contact the Dean of Students, 207-283-0171 ext. 2372.

Academic Calendar

CAS and CHP academic calendars are based on the semester system. The COM academic calendar extends from August through mid-June.

Course Numbering

Course numbers up to 099 are pre-college and do not count towards a degree *(two exceptions: LAC 011, 012 - Peer Tutoring Workshop/Practicum do count towards a degree.)* Course numbers 100-499 are undergraduate level. Course numbers 500 and above are graduate or professional level. *Other exceptions may apply; see program descriptions.*

Grading System -- CAS and CHP

At the University Campus (UC), from 1953-1976 only grades of A, B, C or Pass were recorded; grade point average was not computed.

1987 - Present (UC)		1976-1987 (UC)		1972-Summer '97 (WCC)		Prior to Fall '72 (WCC)	
(From fall 1997 on – includes WCC)				A	4.0		
A	4.00	A	4.00	A-	3.7	A	4.0
A-	3.75	A-	3.67	B+	3.3	B	3.0
B+	3.50	B+	3.33	B	3.0	C	2.0
B	3.00	B	3.00	B-	2.7	D	1.0
B-	2.75	B-	2.67	C+	2.3	F	0.0
C+	2.50	C+	2.33	C	2.0	W	0.0
C	2.00	C	2.00	C-	1.7	INC	Incomplete
C-	1.75	C-	1.67	D+	1.3		
D	1.00	D	1.00	D	1.0		
F	0.00	F	0.00	D-	0.7		
				F	0.00		

Grades which do not calculate into the grade point average unless otherwise noted:

PS or P	Passed course on a Pass/No Pass basis
PL or NP	Failed on a Pass/No pass basis (NP calculates 0.0 quality points)
W	Withdrew without penalty during first 2/3 of semester
WP	Withdrew passing after 2/3 semester
WF	Withdrew failing after 2/3 semester (calculates 0.0 quality points)
I	Incomplete
*F	Administrative "F" (calculates 0.0 quality points)*
AU or AD	Audit, no credit
NG	No grade submitted
S	Satisfactory
TR	Transfer course(s)
U	Unsatisfactory (calculates as 0.0 quality points)
YL	Year long course in progress
E *(to right of course listing)*	Repeated course, only the last instance will calculate into gpa

*Notes: Some programs within CAS and CHP may apply different calculations or interpretations to the grades identified above. *Assigned to incompletes not completed within designated time or to non-attending students enrolled in courses but not withdrawn officially.*

The College of Osteopathic Medicine

Curriculum Outline

The University of New England College of Osteopathic Medicine curriculum is divided into three sections: On-campus Basic and Clinical Sciences, Preceptor Training, and Clerkship Training.

Explanation of the Systems/Segments Format (On-campus)

The on-campus curriculum is presented in an organ systems format. That is, there are two methods of presenting a medical school curriculum. In the more traditional approach, each of approximately twenty different basic and clinical science departments presents information in separate autonomous courses. In the organ systems approach used at COM, the information from the basic and clinical science departments is integrated and organized around the organ systems of the human body. These units of instruction are commonly called "systems."

Preceptor Training

The College's preceptorship program is designed to give students opportunity to observe the techniques and practices about which they are learning, and to observe the roles of other health care providers.

Clinical Clerkships

Students rotate through clinical clerkships during the final one-and-one-half years of predoctoral education *(final 2 years for students entering fall '97 and thereafter).*

COM Grading System, *for students entering prior to fall of 1998*

Grade	Value	Numeric Equivalent
A+	4.00	97-100
A	3.75	94-96
A-	3.50	90-93
B+	3.25	87-89
B	3.00	84-87
B-	2.75	80-83
C+	2.50	77-79
C	2.25	74-76
C-	2.00	70-73
R	0.00	below 70
P	Pass	
HP	High Pass	(upper 10% of class)
PA	Advanced Standing Credit	
W	Withdrawn	
WP	Withdraw Passing	
WF	Withdraw Failing	
I	Incomplete	

Note: Beginning with the COM entering class in fall 1998, the following grading system is in effect:

HP	Honors/High Pass
P	Pass
F	Fail
PA	Advanced Standing
W	Withdrawn
WP	Withdraw Passing
WF	Withdraw Failing
I	Incomplete

Note: Beginning with the COM entering class in fall 2004, the following grading system is in effect:

H	Honors
P	Pass
F	Fail
PA	Advanced Standing
W	Withdrawn
WP	Withdraw Passing
WF	Withdraw Failing
I	Incomplete

Confidentiality and Security of Student Information

The accompanying academic record has been forwarded to you with the implied understanding that you will respect its confidential nature in accordance with Public Law 93-380 Section 438 and not permit any other party to have access to the transcript without written consent of the subject of the transcript. If your institution or agency cannot comply with this request, the transcript is to be returned to the University of New England.

This is valid as an official record only when signed by the University Registrar, embossed with the University of New England seal, and delivered in a secured or sealed envelope. The University will pursue vigorously allegations of security breaches with respect to transcripts.

University of New England

College of Osteopathic Medicine

To all who read these letters, greeting.

The Board of Trustees of the University of New England, upon the recommendation of the Faculty of the College of Osteopathic Medicine, hereby confers upon

SEAL VERIFIED

Catherine Ann DeGood

the degree of

Doctor of Osteopathic Medicine

together with all the honors, rights, privileges and responsibilities thereunto appertaining.

In testimony whereof we have granted this diploma under the seal of the University of New England at Biddeford, Maine, on this fifth day of June in the year two thousand four.

Academic Dean

President, University of New England

Chairman, University of New England Board of Trustees

Section IV

Postgraduate Training

Federation of STATE MEDICAL BOARDS

F[redacted]ation Credentials Verification Service (FCV[redacted])

Federation Place, P.O. Box 619850, Dallas, TX 75261-9850
Tel: (817) 868-5000 Fax: (817) 868-5099

Verification of Postgraduate Medical Education

Institution: Montefiore Medical Center
Address: Department of Family Practice
Bronx, NY 10467

Attention: **Program Director**
Affiliated University: Albert Einstein College of Medicine

RECEIVED
OCT 02 2009
BY:

Verification For:

Name: **DeGood, Catherine Ann**
DOB: [redacted]
Individual's Name on Record (If different from above): _____

Program Participation:
Important:
Report incomplete postgraduate years (PGY) separate from those that were successfully completed.

If the postgraduate year 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/Specialty is rotating or transitional, please provide a schedule of rotations.

PGY: 1
☑ Internship ☐ Residency ☐ Chief Residency ☐ Fellowship ☐ Research
Specialty/Subspecialty: Family Medicine
From: 7/1/2004 To: 6/30/05
Successfully Completed?: ☑ Yes ☐ No ☐ In Progress
Accredited by: ☑ ACGME ☐ AOA ☐ LCGME ☐ RSC ☐ CFPC ☐ RCPSC ☐ APPAP ☐ None of these

PGY: 2
☐ Internship ☑ Residency ☐ Chief Residency ☐ Fellowship ☐ Research
Specialty/Subspecialty: Family Medicine
From: 7/1/05 To: 6/30/06
Successfully Completed?: ☑ Yes ☐ No ☐ In Progress
Accredited by: ☑ ACGME ☐ AOA ☐ LCGME ☐ RSC ☐ CFPC ☐ RCPSC ☐ APPAP ☐ None of these

PGY: 3
☐ Internship ☑ Residency ☐ Chief Residency ☐ Fellowship ☐ Research
Specialty/Subspecialty: Family Medicine
From: 7/1/06 To: 6/30/07
Successfully Completed?: ☑ Yes ☐ No ☐ In Progress
Accredited by: ☑ ACGME ☐ AOA ☐ LCGME ☐ RSC ☐ CFPC ☐ RCPSC ☐ APPAP ☐ None of these

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 break from his/her training?	☐ Yes	☐ No
2. Was this individual ever placed on probation?	☐ Yes	☐ No
3. Was this individual ever disciplined or placed under investigation?	☐ Yes	☐ No
4. Were any negative reports for behavioral reasons ever filed by instructors?	☐ Yes	☐ No
5. Were any limitations or special requirements placed upon this individual because of questions of academic incompetence, disciplinary problems or any other reason?	☐ Yes	☐ No

Please explain any "Yes" response from above:

SEAL VERIFIED

Certification:

Affix your institutional seal in this space. If no seal is available, you must have this form notarized

Completion of the following is certification that the information above is an accurate account of this individual's records and is true and correct. The signature line must contain the original signature, or the electronic typed signature, of the program director (M.D./D.O. only).

Name: Mary Duggan, MD
Title: Program Director
Signature:
Date of Signature: 9/24/09
Tel: 718-920-5521 Fax: 718-515-5416 E-Mail: mduggan@montefiore.org

Rev. 09/07/05 Packet ID: 108999 Request ID: 21329115 DVK IFM CODE[18851]

Postgraduate Medical Education

Hospital	Montefiore Medical Center
Affiliated School	Albert Einstein College of Medicine
	3544 Jerome Ave
	Bronx, NY 10467

PROVIDED BY APPLICANT

Year(s)	PGY1	**Program Type**	Internship/Residency
Complete?	Yes	**Specialty/Subspecialty**	Family Medicine
Dates	07/2004 - 06/2005		
Year(s)	PGY2	**Program Type**	Residency
Complete?	Yes	**Specialty/Subspecialty**	Family Medicine
Dates	07/2005 - 06/2006		
Year(s)	PGY3	**Program Type**	Residency
Complete?	Yes	**Specialty/Subspecialty**	Family Medicine
Dates	07/2006 - 06/2007		

Unusual Circumstances

Leaves/Extensions	N
Probation	N
Disciplined	N
Negative Reports	N
Limits	N

ALBERT EINSTEIN
COLLEGE OF MEDICINE
of YESHIVA UNIVERSITY

MONTEFIORE

MONTEFIORE
MEDICAL CENTER

This is to certify that

Catherine DeGood, D.O.

has satisfactorily fulfilled the training program requirements of

Family Medicine

in the capacity of: Resident

for the period of: July 1, 2004 to June 30, 2007

In Witness whereof, the undersigned have affixed their signatures this 30th day of June, 2007

Dean, Albert Einstein College of Medicine

President, Montefiore Medical Center

Department Chairman

Program Director

Section V

Examination History/Score Transcripts

COMPREHENSIVE OSTEOPATHIC MEDICAL LICENSING EXAMINATION-USA

Official Transcript

Federation Credentials Verification Svcs
Federation Place
400 Fuller Wiser Rd., Ste. 300
Euless, TX 76039-3855

Examinee: DeGood, Catherine

NBOME ID: 667975 **Date of Birth:** [redacted]

EXAMINATION	DATE COMPLETED	PASS / FAIL	3 - DIGIT STANDARD SCORE	3 - DIGIT MINIMUM PASSING	2 - DIGIT STANDARD SCORE	2 - DIGIT MINIMUM PASSING	NOTE
Level 1	04-Jun-2002	[redacted]	[redacted]	[redacted]	[redacted]	[redacted]	
Level 2-Cognitive Evaluation (CE)	13-Jan-2004						
Level 3	14-Jun-2005						

The National Board of Osteopathic Medical Examiners, Inc., does hereby certify the above to be a true report of the examinee.

Date Prepared: October 01, 2009

64541

-- please see reverse for information and description of notes --

National Board of Osteopathic Medical Examiners, Inc.
8765 West Higgins Road Suite 200 Chicago IL 60631
Phone: 773/714-0622 Fax: 773/714-0631

108999/DNL

System Automation
Enabling Responsive Government

MyLicense Transaction Reports

Reports Home Page

Renewal Questions for License Number do00652

POWERED BY MyLicense®

Question	Answer	Date
Since your last renewal has any Health Professional license, certificate, registration, or permit you hold or have held been disciplined or are formal charges pending?	N	05/11/2020
Since your last renewal has your health deteriorated to the point where you have been told you are not fit to practice medicine?	N	05/11/2020
Since your last renewal have you been convicted of, pleaded Nolo Contendere or entered a plea bargain to any federal, state or local statute, regulation or ordinance or are any felony charges pending? (other than misdemeanors or routine traffic violations)	N	05/11/2020
Since your last renewal have you been denied a license, certificate, registration, or permit in any state?	N	05/11/2020
Since your last renewal have you been denied staff membership or privileges in any hospital or health care facility or, have staff membership or privileges been revoked, suspended or subjected to any restriction, probation, or other type of discipline or limitations?	N	05/11/2020
Since your last renewal have you had any alcohol or drug related event that was reported to any government authority?	N	05/11/2020
I have completed all applicable CE (Continuing Education) requirements for this renewal period as stated in the Rules and Regulations for my profession. If your profession has been impacted by the COVID-19 pandemic your CE's may be waived for the 2020 renewal cycle ONLY. Please visit our website at https://health.ri.gov/about/customer-services-updates.php#cplb for the list of professions affected.	Y	05/11/2020
I have read the position statements of the Rhode Island Board of Medical Licensure and Discipline.	Y	05/11/2020
"I hereby swear or affirm under the penalties of perjury that I understand and have answered the questions true to the best of my knowledge. I understand that my Social Security Number and/or Federal Employer Identification Number will be transmitted to the Rhode Island Division of Taxation pursuant to Chapter 76 of Title 5 of the Rhode Island General Laws as amended."	Y	06/02/2010
Has any Health Professional license, certificate, registration, or permit you hold or have held been disciplined or are formal charges pending?	N	06/02/2010
Have you been convicted of a violation, pled Nolo Contendere or entered a plea bargain to any federal, state or local statute, regulation or ordinance or are any formal charges pending?	N	06/02/2010
Have you been denied a license, certificate, registration, or permit in any state?	N	06/02/2010
Have you been denied staff membership or privileges in any hospital or health care facility or, have staff membership or privileges been revoked,	N	06/02/2010

suspended or subjected to any restriction, probation, or other type of discipline or limitations?		
Have you had a malpractice judgment against you or settled a malpractice action?	N	06/02/2010
I have completed all applicable CE (Continuing Education) requirements for this renewal period as stated in the Rules and Regulations for my profession.	Y	06/02/2010
I have read the position statements of the Rhode Island Board of Medical Licensure and Discipline.	Y	06/02/2010
Since your last renewal has any Health Professional license, certificate, registration, or permit you hold or have held been disciplined or are formal charges pending?	N	06/04/2014
Since your last renewal has your health deteriorated to the point where you have been told you are not fit to practice medicine?	N	06/04/2014
Since your last renewal have you been convicted of, pleaded Nolo Contendere or entered a plea bargain to any federal, state or local statute, regulation or ordinance or are any felony charges pending? (other than misdemeanors or routine traffic violations)	N	06/04/2014
Since your last renewal have you been denied a license, certificate, registration, or permit in any state?	N	06/04/2014
Since your last renewal have you been denied staff membership or privileges in any hospital or health care facility or, have staff membership or privileges been revoked, suspended or subjected to any restriction, probation, or other type of discipline or limitations?	N	06/04/2014
Since your last renewal have you had any alcohol or drug related event that was reported to any government authority?	N	06/04/2014
I have completed all applicable CE (Continuing Education) requirements for this renewal period as stated in the Rules and Regulations for my profession.	Y	06/04/2014
I have read the position statements of the Rhode Island Board of Medical Licensure and Discipline.	Y	06/04/2014
Since your last renewal has any Health Professional license, certificate, registration, or permit you hold or have held been disciplined or are formal charges pending?	N	06/07/2016
Since your last renewal has your health deteriorated to the point where you have been told you are not fit to practice medicine?	N	06/07/2016
Since your last renewal have you been convicted of, pleaded Nolo Contendere or entered a plea bargain to any federal, state or local statute, regulation or ordinance or are any felony charges pending? (other than misdemeanors or routine traffic violations)	N	06/07/2016
Since your last renewal have you been denied a license, certificate, registration, or permit in any state?	N	06/07/2016
Since your last renewal have you been denied staff membership or privileges in any hospital or health care facility or, have staff membership or privileges been revoked, suspended or subjected to any restriction, probation, or other type of discipline or limitations?	N	06/07/2016
Since your last renewal have you had any alcohol or drug related event that was reported to any government authority?	N	06/07/2016
I have completed all applicable CE (Continuing Education) requirements for this renewal period as stated in the Rules and Regulations for my profession.	Y	06/07/2016

I have read the position statements of the Rhode Island Board of Medical Licensure and Discipline.	Y	06/07/2016
Since your last renewal has any Health Professional license, certificate, registration, or permit you hold or have held been disciplined or are formal charges pending?	N	06/14/2018
Since your last renewal has your health deteriorated to the point where you have been told you are not fit to practice medicine?	N	06/14/2018
Since your last renewal have you been convicted of, pleaded Nolo Contendere or entered a plea bargain to any federal, state or local statute, regulation or ordinance or are any felony charges pending? (other than misdemeanors or routine traffic violations)	N	06/14/2018
Since your last renewal have you been denied a license, certificate, registration, or permit in any state?	N	06/14/2018
Since your last renewal have you been denied staff membership or privileges in any hospital or health care facility or, have staff membership or privileges been revoked, suspended or subjected to any restriction, probation, or other type of discipline or limitations?	N	06/14/2018
Since your last renewal have you had any alcohol or drug related event that was reported to any government authority?	N	06/14/2018
I have completed all applicable CE (Continuing Education) requirements for this renewal period as stated in the Rules and Regulations for my profession.	N	06/14/2018
I have read the position statements of the Rhode Island Board of Medical Licensure and Discipline.	N	06/14/2018
I have completed all applicable CE (Continuing Education) requirements for this renewal period as stated in the Rules and Regulations for my profession.	Y	06/29/2012
I have read the position statements of the Rhode Island Board of Medical Licensure and Discipline.	Y	06/29/2012
Since your last renewal has any Health Professional license, certificate, registration, or permit you hold or have held been disciplined or are formal charges pending?	N	06/29/2012
Since your last renewal have you been convicted of a violation, pled Nolo Contendere or entered a plea bargain to any federal, state or local statute, regulation or ordinance or are any formal charges pending?	N	06/29/2012
Since your last renewal have you been denied a license, certificate, registration, or permit in any state?	N	06/29/2012
Since your last renewal have you been denied staff membership or privileges in any hospital or health care facility or, have staff membership or privileges been revoked, suspended or subjected to any restriction, probation, or other type of discipline or limitations?	N	06/29/2012
Since your last renewal have you had a malpractice judgment against you or settled a malpractice action?	N	06/29/2012