Kahn, Chava 4301099940
Medical Doctor
December 27, 2011

Fee
App
Med Ed
PGT
Exam Scores
~~ECFMG~~
~~HOSP APPT~~
CBC

Rally
Event

Michigan Department of Licensing and Regulatory Affairs
Board of Medicine
P.O. Box 30192
Lansing, MI 48909
(517) 335-0918
www.michigan.gov/healthlicense

LARA/LMD-040 (04/11)

Tran Info:430101 1734662B-1 12/27/11
Chk#: 109 Amt: $150.00
ID: [redacted]

APPLICATION FOR MEDICAL DOCTOR LICENSE

Authority: Public Act 368 of 1978, as amended

If this form is not completed, a license will not be issued

A controlled substance license is required for every person who prescribes, manufactures, distributes, or dispenses any controlled substance in Michigan. Information on obtaining a Federal controlled substance license may be obtained by contacting the Regional Branch, DEA, 431 Howard Street, Detroit, MI 48226 (1-800-882-9539).

Board Use Only

License Number: 099940

Controlled Substance License Number:

Date of Licensure: 1/31/12

Type or Print Only

I AM APPLYING FOR THE FOLLOWING:

- [x] **License by Examination Fee: $150.00 71-4301-01**
- [ ] **Controlled Substance Fee: $85.00 43-01 71-5315**

Your check or money order drawn on a U.S. financial institution and made payable to the **STATE OF MICHIGAN** must accompany this application. **DO NOT SEND CASH.** Fees are deposited upon receipt and can only be refunded under refund rules promulgated by the Department.

Legal First Name	Legal Middle Name	Legal Last Name
Chava		Kahn
U.S. Social Security Number	Date of Birth	Daytime Phone Number
[redacted]	[redacted]	(201) [redacted]
Street Address		E-Mail Address
[redacted]		chavkahn@gmail.com
City	State	ZIP Code
New York	New York	10026

All Previous Names and/or Birth Name Used (if applicable):

Have you ever held a health professional license in Michigan?	Michigan Health Professional Permanent I.D. Number and Expiration Date
[ ] Yes [x] No	

Check the appropriate answer to each of the following questions. NOTE: Submit a detailed explanation for any YES answer you check on a separate sheet with your application.

1. Have you ever been convicted of a felony?	[ ] Yes	[x] No
2. Have you ever been convicted of a misdemeanor punishable by imprisonment for a maximum of 2 years?	[ ] Yes	[x] No
3. Have you ever been convicted of a misdemeanor involving the illegal delivery, possession, or use of alcohol or a controlled substance (including motor vehicle violations)?	[ ] Yes	[x] No
4. Have you been treated for substance abuse in the past 2 years?	[ ] Yes	[x] No
5. Have you had 3 or more malpractice settlements, awards, or judgments in any consecutive 5 year period?	[ ] Yes	[x] No
6. Have you had one or more malpractice settlements, awards, or judgments totaling $200,000 or more in any consecutive 5 year period?	[ ] Yes	[x] No
7. Have you ever had a federal or state health professional or controlled substance license revoked, suspended, or otherwise disciplined; been denied a license; or currently have disciplinary action pending against you?	[ ] Yes	[x] No
8. Have you ever been denied the privilege of taking an examination by any state medical board?	[ ] Yes	[x] No

The Department of Licensing and Regulatory Affairs will not discriminate against any individual or group because of race, sex, religion, age, national origin, color, marital status, disability or political beliefs. If you need assistance with reading, writing, hearing, etc., under the Americans with Disabilities Act, you may make your needs known to this agency.

Name
Chava Kahn

9. Have you ever been censured, or requested to withdraw from a health care facility's staff or had your health care facility staff privilege involuntarily modified? ☐ Yes ☒ No

10. Do you hold or have you ever held a permanent medical license in any state, U.S. Territory or Canadian Province? If yes, list the state(s) U.S. Territory or Province in which you hold or have held a medicine license, the license or registration number, the date issued, and how the license was obtained. DO NOT LIST TEMPORARY LICENSES. **You must have each licensing agency verify licensure directly to this board office. (Attach additional sheets, if necessary)** ☐ Yes ☒ No

State, U.S. Territory or Province	License Number	Date of Issue	How obtained (Endorsement or examination)

Provide a complete chronological record of your educational preparation.
Attach additional sheets if necessary.

Name and Address of Institution	Dates of Attendance From	To	Degree
① Stern College of Yeshiva University 245 Lexington Ave. New York, NY 10016	1998	2002	B.A.
② Albert Einstein College of Medicine 1300 Morris Park Ave. Bronx, NY 10461	2003	2008	M.D.

Provide a description of your professional medical experience.
Attach additional sheets if necessary.

Name and Address of Employer	Dates of Practice From	To	Duties
Albert Einstein College of Medicine (see address above)	2008	2009	Intern - Obstetrics + Gynecology
Albert Einstein College of Medicine (see address above)	2009	Present	Resident - Obstetrics + Gynecology

CERTIFICATION

I understand that it is the policy of this agency to secure a criminal conviction history as part of the pre-licensure screening process. I authorize this agency to use the information provided in this application to obtain a criminal conviction history file search from the Central Records Division of the Michigan Department of State Police or other law enforcement or judicial record-keeping organization.

I further consent to the release of information to this agency regarding any disciplinary investigations conducted by a similar licensure, registration, or specialty certification board of this or any other state, of the United States military, of the federal government, or of another country.

The statements in this application are true and correct. I have not withheld information that might affect the decision to be made on this application. In signing this application, I am aware that a false statement or dishonest answer may be grounds for denial of my application or revocation of my license and that such misrepresentation is punishable by law.

Signature of Applicant [signature] Date 12/23/11

Michigan Department of Licensing and Regulatory Affairs
Board of Medicine
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CERTIFICATION OF MEDICAL EDUCATION FOR GRADUATES OF MEDICAL SCHOOLS LOCATED IN THE UNITED STATES, ITS TERRITORIES, THE DISTRICT OF COLUMBIA, OR THE DOMINION OF CANADA

Authority: Public Act 368 of 1978, as amended
If this form is not completed, a license will not be issued.

INSTRUCTIONS TO APPLICANT:

Complete Section I. Type or print your legal name exactly as it appears on your application. For Section II, send this form to be completed by the Dean of the medical school you attended. This certification must be submitted directly to the Michigan Board of Medicine by the medical school.

SECTION I - APPLICANT INFORMATION

First Name	Middle Name	Last Name
Chava		Kahn
Social Security Number	Date of Birth	Daytime Telephone Number
[redacted]		201-[redacted]
Street Address: [redacted]		
City: New York	State: NY	ZIP Code: 10026
All Previous Names and/or Birth Name Used (if applicable)		
Date of Admission: August 2003		Date of Graduation: June 2008

Signature of Applicant	Date
	12/11/2011

APPLICANT: UPON COMPLETION OF SECTION I, SEND THIS FORM TO THE DEAN OF YOUR MEDICAL SCHOOL FOR COMPLETION OF SECTION II.

Name
Chava Kahn

TO BE COMPLETED BY THE DEAN OR REGISTRAR OF THE MEDICAL SCHOOL

INSTRUCTIONS FOR COMPLETING SECTION II:
Please complete the following information. Return this completed certification directly to the Michigan Board of Medicine at the address shown on Page 1 of this form.

SECTION II - CERTIFICATION OF MEDICAL EDUCATION

Name of Medical School
Albert Einstein College of Medicine

Street Address of Medical School
1300 Morris Park Avenue

City, State and ZIP Code
Bronx, NY 10461

I certify that Chava Kahn (Applicant's Name) attended the medical school named above from 8/20/03 (Month/Day/Year) to 5/30/08 (Month/Day/Year).

and was/will be granted the degree of Doctor of Medicine on June 5, 2008 (Month/Day/Year).

Linda Gillespie
Signature of Dean or Registrar

12/14/11
Date of Signature

(SEAL)
If school has no seal, please indicate

Linda Gillespie
Print or Type Name of Dean or Registrar

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CERTIFICATION OF POSTGRADUATE TRAINING

Authority: Public Act 368 of 1978, as amended
If this form is not completed, a license will not be issued

INSTRUCTIONS TO APPLICANT:

Complete Section I. Type or print your legal name exactly as it appears on your application. For completion of Section II, send this form to the Director of Medical Education where you completed your postgraduate training. This certification must be submitted directly to the Michigan Board of Medicine by the Director of Medical Education.

SECTION I - APPLICANT INFORMATION

First Name	Middle Name	Last Name
Chava		Kahn
Social Security Number	Date of Birth	
[redacted]		
Street Address		
[redacted]		
City	State	ZIP Code
New York	New York	10026
Daytime Telephone Number	All Previous Names and/or Birth Name Used (if applicable)	
201-[redacted]		

Signature of Applicant	Date
	12/11/2011

APPLICANT: UPON COMPLETION OF SECTION I, SEND THIS FORM TO THE DIRECTOR OF MEDICAL EDUCATION FOR COMPLETION OF SECTION II.

Name Chava Kahn

TO BE COMPLETED BY THE DIRECTOR OF MEDICAL EDUCATION

INSTRUCTIONS FOR COMPLETING SECTION II:

Please complete the following information. Return this completed certification directly to the Michigan Board of Medicine at the address shown on Page 1 of this form.

SECTION II - CERTIFICATION OF POSTGRADUATE TRAINING

Name of Hospital

ALBERT EINSTEIN COLLEGE OF MEDICINE

Street Address of Hospital

1300 MORRIS PARK AVENUE

City, State and ZIP Code

BRONX, NY 10461

I certify that CHAVA KAHN, MD (Applicant's Name) **a graduate of the** ALBERT EINSTEIN COLLEGE OF MEDICINE **medical school, has successfully completed postgraduate clinical training offered by the hospital named above from** 7/1/08 (Month/Day/Year) **, to** 7/30/12 (ANTICIPATED) (Month/Day/Year) **in the clinical area of** OBSTETRICS AND GYNECOLOGY.

Is this an active training program accredited by the ACGME, the College of Family Physicians of Canada, the Royal College of Physicians and Surgeons of Canada, or by the National Joint Committee on Accreditation of Preregistration Physician Training Programs of the Canadian Medical Association? ☒ Yes ☐ No

Signature of Director of Medical Education

12/14/11

Date of Signature

ERIKA BANKS, MD

Print or Type Name of Director of Medical Education

(SEAL)

If hospital has no seal, please indicate

NOTE: Certification of Postgraduate Training will not be accepted if signed and submitted more than 15 days prior to actual completion.

United States Medical Licensing Examination® (USMLE®)
Certified Transcript of Scores

This document was prepared by the
Federation of State Medical Boards of the United States, Inc.
Federation Place, 400 Fuller Wiser Road, Suite 300, Euless, TX 76039-3856 -- Telephone (817) 868-4041

Date : 12/12/2011

Recipient:

Michigan Board of Medicine
ATTN: Carole Hakala Engle, Licensing Director
611 W Ottawa
1st Floor
Lansing, MI 48933

Examinee: Kahn, Chava
Alt Name(s):

Examinee ID#: 5-163-836-9
Date of Birth: [redacted]

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. Where numeric scores are reported, there are two scales used and the recommended minimum passing score ("MP") on each scale is shown in parentheses.

USMLE STEP 1

	Test Date	Pass/Fail	Three-Digit Score Total	Three-Digit Score MP	Two-Digit Score Total	Two-Digit Score MP	Comments
	06/10/2005	Pass	[redacted]				

USMLE STEP 2

Clinical Knowledge (CK)

	Test Date	Pass/Fail	Three-Digit Score Total	Three-Digit Score MP	Two-Digit Score Total	Two-Digit Score MP	Comments
	08/17/2006	Pass	[redacted]				

Clinical Skills (CS)*

	Test Date	Pass/Fail	Three-Digit Score Total	Three-Digit Score MP	Two-Digit Score Total	Two-Digit Score MP	Comments
	01/02/2008	Pass					

USMLE STEP 3

	Test Date	Pass/Fail	Three-Digit Score Total	Three-Digit Score MP	Two-Digit Score Total	Two-Digit Score MP	Comments
CONNECTICUT	04/22/2009	Pass	[redacted]				

NOTE: A search of the Board Action Data Bank of the Federation of State Medical Boards (FSMB) reveals no reported information on this examinee.

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LAR/ALPH-090 (07/11)

Tran Info:430157 17673036-1 04/20/12
Chk#: 399 Amt: $20.00
ID: 4301099940

Tran Info:430137 17673036-2 04/20/12
Chk#: 399 Amt: $65.00
ID: 4301099940
[redacted]

License Number: 5315054464

Date of Licensure: 4-26-12

CONTROLLED SUBSTANCE LICENSE APPLICATION

Authority: Public Act 368 of 1978, as amended
If this form is not completed, a license will not be issued.

A controlled substance license is required for every person who manufacturers, distributes, prescribes, or dispenses any controlled substance in Michigan as described in Article 7 of Public Act 368 of 1978, as amended.

A separate controlled substance license is required for each business location from which you manufacture, distribute, or dispense controlled substances. If you only prescribe controlled substances at more than one location, you only need one controlled substance license.

Information on obtaining a Federal controlled substance license may be obtained by contacting the Regional Branch, Drug Enforcement Administration 431 Howard Street, Detroit, Michigan 48226 (telephone: 800-882-9539). The Michigan Board of Pharmacy is unable to answer questions about the federal licensing process.

Type or Print Only

INSTRUCTIONS

1. **CONTROLLED SUBSTANCE FEE: Initial (first time) professional license or relicensure of your professional license - $85.00.**
   If you already hold a professional license and your professional license expires in:

   0-12 months the fee is $85.00 (13757) **13-24 months the fee is $160.00 (23757)** **25-36 months the fee is $235.00 (33757)**

2. **M.D./D.O. Applicants: This application may not be used for physician methadone programs. Please request an application for the Physician Methadone Program.**

3. **Allow up to six weeks for your paper license to arrive.**

Your check or money order drawn on a U.S. financial institution and made payable to the **STATE OF MICHIGAN** must accompany this application. **DO NOT SEND CASH.** Fees are deposited upon receipt and can only be refunded under refund rules promulgated by the Department.

First Name	Middle Name	Last Name
Chava		Kahn

Street	Telephone Number
[redacted]	201-[redacted]

City	State	ZIP Code
New York	NY	10026

TYPE OF PROFESSIONAL LICENSE

(Please Check One)

	Regular		Educ. Lmt.		Volunteer
☐ 29 - 01 D.D.S. 71-5315	☐	or	☐		
☐ 59 - 01 D.P.M. 71-5315	☐	or	☐	or	☐
☐ 69 - 01 D.V.M. 71-5315	☐	or	☐		
☑ 43 - 01 M.D. 71-5315	☑	or	☐	or	☐
☐ 51 - 01 D.O. 71-5315	☐	or	☐	or	☐
☐ 49 - 01 O.D. 71-5330	☐				
☐ 53 - 01 Pharmacy Store 71-5301	☐				
☐ 53 - 02 R.Ph. 71-5302	☐				
☐ 53 - 06 Manuf./Wholesaler 71-5306	☐				

STATUS:

1. **Have you ever had any health professional license limited, suspended, revoked, denied, or surrendered?**
   ☐ **Yes** ☑ **No**

   If Yes, please explain on separate sheet.

2. **Is your current professional license limited as a result of Board disciplinary action?**
   ☐ **Yes** ☑ **No**

Michigan Permanent I.D. Number (as shown on your pocket card): 4301099940

Expiration Date of License: 01/31/2013

Social Security Number: [redacted]

I am applying for a controlled substance license in Michigan and certify that the statements and information above are true.

Signature: [signature]

Date: 4/15/12

The Department of Licensing and Regulatory Affairs will not discriminate against any individual or group because of race, sex, religion, age, national origin, color, marital status, disability or political beliefs. If you need assistance with reading, writing, hearing, etc., under the American's with Disabilities Act, you may make your needs known to this agency.