

Kahn, Chava 4301099940
Medical Doctor
December 27, 2011

Fee
App.
Med. Ed.
PGT
Exam Score
~~ECMG~~
~~HOSP APP~~
CBC

Only
Exam

Michigan Department of Licensing and Regulatory Affairs

LARA/LMD-040 (04/11)

Page 1 of 2

Board of Medicine

P.O. Box 30192

Lansing, MI 48909

(517) 335-0918

www.michigan.gov/healthlicense

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).

Type or Print Only

I AM APPLYING FOR THE FOLLOWING:

- ☒ 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 Chava	Legal Middle Name	Legal Last Name Kahn
U.S. Social Security Number [REDACTED]	Date of Birth [REDACTED]	Daytime Phone Number (201) [REDACTED]
Street Address [REDACTED]		E-Mail Address ChavKahn@gmail.com
City New York	State New York	ZIP Code 10026
All Previous Names and/or Birth Name Used (if applicable)		
Have you ever held a health professional license in Michigan? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		Michigan Health Professional Permanent I.D. Number and Expiration Date

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?	<input type="checkbox"/> Yes <input checked="" type="checkbox"/> No
2. Have you ever been convicted of a misdemeanor punishable by imprisonment for a maximum of 2 years?	<input type="checkbox"/> Yes <input checked="" type="checkbox"/> 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)?	<input type="checkbox"/> Yes <input checked="" type="checkbox"/> No
4. Have you been treated for substance abuse in the past 2 years?	<input type="checkbox"/> Yes <input checked="" type="checkbox"/> No
5. Have you had 3 or more malpractice settlements, awards, or judgments in any consecutive 5 year period?	<input type="checkbox"/> Yes <input checked="" type="checkbox"/> No
6. Have you had one or more malpractice settlements, awards, or judgments totaling \$200,000 or more in any consecutive 5 year period?	<input type="checkbox"/> Yes <input checked="" type="checkbox"/> 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?	<input type="checkbox"/> Yes <input checked="" type="checkbox"/> No
8. Have you ever been denied the privilege of taking an examination by any state medical board?	<input type="checkbox"/> Yes <input checked="" type="checkbox"/> 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.

Tran Info: 430101 17346628-1 12/27/11
Chk#: 109 Amt: \$150.00
ID: [REDACTED]

Board Use Only

License Number **099940**
Controlled Substance License Number
Date of Licensure **1/31/12**

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

Ch

Date

12/23/11

Michigan Department of Licensing and Regulatory Affairs

Board of Medicine

P.O. Box 30192

Lansing, MI 48909

(517) 335-0918

www.michigan.gov/healthlicense

**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.**RECEIVED**
DEC 22 2011
DEPT OF CIS**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 Chava	Middle Name	Last Name Kahn
Social Security Number [REDACTED]	Date of Birth [REDACTED]	Daytime Telephone Number 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 [Signature]	Date 12/11/2011
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**APPLICANT: UPON COMPLETION OF SECTION I, SEND THIS FORM TO THE DEAN OF
YOUR MEDICAL SCHOOL FOR COMPLETION OF SECTION II.**

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.

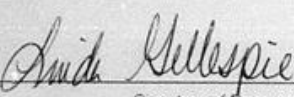
Name
Chava Kahn

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 attended the	
(Applicant's Name)	
medical school named above from 8/20/03	to 5/30/08
(Month/Day/Year)	(Month/Day/Year)
and was/will be granted the degree of Doctor of Medicine on	
June 5, 2008	
(Month/Day/Year)	
	12/14/11
Signature of Dean or Registrar	Date of Signature
Linda Gillespie	(SEAL)
Print or Type Name of Dean or Registrar	If school has no seal, please indicate

Board of Medicine

P.O. Box 30192

Lansing, MI 48909

(517) 335-0918

www.michigan.gov/healthlicense

CERTIFICATION OF POSTGRADUATE TRAINING

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

RECEIVED
JAN 03 2012
DEPT. OF CIS

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

Signature of Applicant [Signature]	Date 12/11/2011
---------------------------------------	--------------------

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

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.

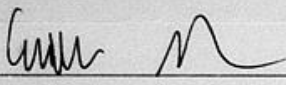
Name Chava Kahn

TO BE COMPLETED BY THE DIRECTOR OF MEDICAL EDUCATION**INSTRUCTIONS FOR COMPLETING SECTION II:**

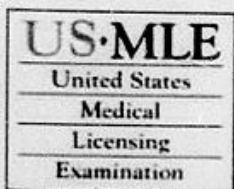
Please complete the following information. Return this completed certification directly to the Michigan Board of Medicine at the address shown on Page 1 of this form.

SECTION II - CERTIFICATION OF POSTGRADUATE TRAINING

Name of Hospital	
<u>ALBERT EINSTEIN COLLEGE OF MEDICINE</u>	
Street Address of Hospital	
<u>1300 MORRIS PARK AVENUE</u>	
City, State and ZIP Code	
<u>BRONX, NY 10461</u>	

I certify that <u>CHAVA KAHN, MD</u>	a graduate of the
(Applicant's Name)	
<u>ALBERT EINSTEIN COLLEGE OF MEDICINE</u> medical school, has successfully completed postgraduate	
clinical training offered by the hospital named above from <u>7/1/08</u>	to <u>7/30/12 (ASSOCIATED)</u>
(Month/Day/Year)	(Month/Day/Year)
in the clinical area of <u>OBSTETRICS AND GYNECOLOGY</u>	
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? <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No	
	<u>12/14/11</u>
Signature of Director of Medical Education	Date of Signature
<u>ERIKA BANKS, MD</u>	(SEAL)
Print or Type Name of Director of Medical Education	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		Two-Digit Score		Comments
			Total	MP	Total	MP	
	06/10/2005	Pass					
USMLE STEP 2							
Clinical Knowledge (CK)							
	Test Date	Pass/Fail	Three-Digit Score		Two-Digit Score		Comments
			Total	MP	Total	MP	
	08/17/2006	Pass					
Clinical Skills (CS)*							
	Test Date	Pass/Fail	Three-Digit Score		Two-Digit Score		Comments
			Total	MP	Total	MP	
	01/02/2008	Pass					
USMLE STEP 3							
	Test Date	Pass/Fail	Three-Digit Score		Two-Digit Score		Comments
			Total	MP	Total	MP	
CONNECTICUT	04/22/2009	Pass					

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

This document was printed from a secure website and accurately reflects score information maintained by the FSMB.

Michigan Department of Licensing and Regulatory Affairs
Board of Pharmacy
P.O. Box 30670
Lansing, MI 48909
(517) 335-0918
www.michigan.gov/healthlicense

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 manufactures, 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.

LARALPH-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

License Number

5315054464

Date of License

4-26-12

Type or Print Only

INSTRUCTIONS

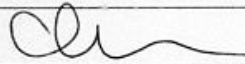
1. **CONTROLLED SUBSTANCE FEE:** Initial (first time) professional license or relicensure of your professional license - \$85.00.
If you already hold a professional license and your professional license expires in:

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 Chava	Middle Name	Last Name Kahn																																				
Street [REDACTED]	City New York	Telephone Number 201-[REDACTED]																																				
State NY	ZIP Code 10026																																					
TYPE OF PROFESSIONAL LICENSE (Please Check One)		STATUS:																																				
<table border="0"><tr><td><input type="checkbox"/> 29 - 01 D.D.S. 71-5315</td><td><input type="checkbox"/> Regular</td><td><input type="checkbox"/> Educ. Lmt.</td><td><input type="checkbox"/> Volunteer</td></tr><tr><td><input type="checkbox"/> 53 - 01 D.P.M. 71-5315</td><td><input type="checkbox"/> or</td><td><input type="checkbox"/> or</td><td><input type="checkbox"/></td></tr><tr><td><input type="checkbox"/> 69 - 01 D.V.M. 71-5315</td><td><input type="checkbox"/> or</td><td><input type="checkbox"/> or</td><td><input type="checkbox"/></td></tr><tr><td><input checked="" type="checkbox"/> 43 - 01 M.D. 71-5315</td><td><input checked="" type="checkbox"/> or</td><td><input type="checkbox"/> or</td><td><input type="checkbox"/></td></tr><tr><td><input type="checkbox"/> 51 - 01 D.O. 71-5315</td><td><input type="checkbox"/> or</td><td><input type="checkbox"/> or</td><td><input type="checkbox"/></td></tr><tr><td><input type="checkbox"/> 49 - 01 O.D. 71-5330</td><td><input type="checkbox"/></td><td></td><td></td></tr><tr><td><input type="checkbox"/> 53 - 01 Pharmacy Store 71-5301</td><td><input type="checkbox"/></td><td></td><td></td></tr><tr><td><input type="checkbox"/> 53 - 02 R.Ph. 71-5302</td><td><input type="checkbox"/></td><td></td><td></td></tr><tr><td><input type="checkbox"/> 53 - 06 Manuf./Wholesaler 71-5306</td><td><input type="checkbox"/></td><td></td><td></td></tr></table>		<input type="checkbox"/> 29 - 01 D.D.S. 71-5315	<input type="checkbox"/> Regular	<input type="checkbox"/> Educ. Lmt.	<input type="checkbox"/> Volunteer	<input type="checkbox"/> 53 - 01 D.P.M. 71-5315	<input type="checkbox"/> or	<input type="checkbox"/> or	<input type="checkbox"/>	<input type="checkbox"/> 69 - 01 D.V.M. 71-5315	<input type="checkbox"/> or	<input type="checkbox"/> or	<input type="checkbox"/>	<input checked="" type="checkbox"/> 43 - 01 M.D. 71-5315	<input checked="" type="checkbox"/> or	<input type="checkbox"/> or	<input type="checkbox"/>	<input type="checkbox"/> 51 - 01 D.O. 71-5315	<input type="checkbox"/> or	<input type="checkbox"/> or	<input type="checkbox"/>	<input type="checkbox"/> 49 - 01 O.D. 71-5330	<input type="checkbox"/>			<input type="checkbox"/> 53 - 01 Pharmacy Store 71-5301	<input type="checkbox"/>			<input type="checkbox"/> 53 - 02 R.Ph. 71-5302	<input type="checkbox"/>			<input type="checkbox"/> 53 - 06 Manuf./Wholesaler 71-5306	<input type="checkbox"/>			<p>1. Have you ever had any health professional license limited, suspended, revoked, denied, or surrendered? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No If Yes, please explain on separate sheet. ✓</p> <p>2. Is your current professional license limited as a result of Board disciplinary action? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No</p>
<input type="checkbox"/> 29 - 01 D.D.S. 71-5315	<input type="checkbox"/> Regular	<input type="checkbox"/> Educ. Lmt.	<input type="checkbox"/> Volunteer																																			
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		Michigan Permanent ID 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 		Date 4/15/12																																				

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