

Application Summary

4/1/19 12:18 PM

Page 1 of 6

License Type: **Physician's and Surgeon's**
Application: **Physician's and Surgeon's - Initial Application**
Application Number: **14645138**
Application Date: **04/01/2019 (mm/dd/yyyy)**

Application Questions

Are you applying with an Individual Taxpayer Identification Number (ITIN)?



✓

Have you served or are you currently serving in the military?

✓

Are you requesting expediting of this application for spouses or domestic partners of an active duty member of the U.S. Armed Forces?

✓

Are you requesting expediting of this application for honorably discharged members of the U.S. Armed Forces?

✓

Are you requesting expediting of this application to practice in a medically underserved area or population?

✓

Are you currently enrolled in an ACGME/RCPSC-accredited postgraduate training program in the United States or Canada?

No

✓

Personal Detail

First Name: **Nicole**
Last Name: **Fanarjian**
Birthdate: ****/**/******
Gender: **Female**
SSN/ITIN: *********

CV ✓
LIF ✓

Addresses

License Related Addresses

Address of Record (Required)

Warning:

In order to protect your privacy and identity, address will not be displayed.

Previous Application or License

9. Have you served or are you currently serving in the U.S. Military?



2135 NYOBA
1554146288923

10. Are you requesting expediting of this application as a spouse or domestic partner of an active duty member of the U.S. Armed Forces?



✓
✓
✓

11. Have you ever filed an application for a Physician's and Surgeon's License or a PTAL in California that has been withdrawn, abandoned, or denied?

12. Have you previously held a Physician's and Surgeon's License in California?

No

Examinations

13. Are you certified by the Educational Commission for Foreign Medical Graduates?

No

✓

Examinations 1

Examination:

United States Medical Licensing Examination (USMLE) Step 1

Date Passed:



✓

Examinations 2

Examination:

United States Medical Licensing Examination (USMLE) Step 2CK

Date Passed:



✓

FCVS

Examinations 3

Examination:

United States Medical Licensing Examination (USMLE) Step 3

Date Passed:



✓

Education History

Medical School Name

Albany Medical College

Mailing Address of the Medical School

43 New Scotland Ave.
Albany, NY 12208

Attendance Start Date

08/01/1998 (mm/dd/yyyy)

Attendance End Date

05/25/2002 (mm/dd/yyyy)

Were You Awarded a Degree?

Yes

Title of Degree Awarded

MD - Doctor of Medicine

Issue Date of Degree

05/25/2002 (mm/dd/yyyy)

L2 ✓
Transcripts ✓
Diploma ✓
FCVS ✓

ACGME or RCPSC Accredited Postgraduate Training Programs

16. Have you participated in any ACGME-accredited postgraduate training in the United States or RCPSC-accredited postgraduate training in Canada?

Yes

✓

17. Have you ever received partial or no credit for a postgraduate training program?



✓

18. Have you ever taken a leave of absence or break from your training?

✓

19. Have you ever been terminated, dismissed or expelled from a program?

✓

20. Have you ever been placed on probation for any reason?

✓

21. Have you ever been disciplined or placed under investigation?

✓

22. Have you ever had any limitations or special requirements placed upon you for clinical performance professionalism, medical knowledge, discipline, or for any other reason?

✓

23. Have you ever had a postgraduate training program contract not be renewed or offered for a following year?

✓

ACGME or RCPSC Accredited Postgraduate Training Programs

Program Facility Name **University of South Florida**

City: **Tampa**

State/Province: **Florida**

Specialty: **obstetrics & gynecology**

✓

Training Start Date: **07/01/2002 (mm/dd/yyyy)**

Training End Date: **06/30/2006 (mm/dd/yyyy)**

FLCS

Medical License(s)

24. Have you ever held or do you currently hold a medical license in any U.S. state, U.S. territory, or Canadian province? **Yes**

✓

Medical License(s)

U.S. State, U.S. Territory or Canadian Province: **Florida**

License Number: **ME107878**

✓

Practice Start Date: **08/01/2010 (mm/dd/yyyy)**

ABMS Certification

25. Are you currently certified by a Member Board of the American board of Medical Specialties? **Yes**

✓

Malpractice History

26. Has a claim or an action ever been filed against you for the practice of medicine that resulted in a malpractice settlement, judgement, or arbitration?

[Redacted]

✓

Disciplinary History

27. Have you ever had your DEA privileges denied, suspended, restricted, or terminated?

✓

28. Have you ever entered into any arrangement, agreement or plea in lieu of federal prosecution with the DEA to resolve an alleged violation of a federal or state drug statute or regulation?

✓

29. Have you ever withdrawn an application for medical licensure in lieu of denial, disciplinary action, or for any other similar reason?

✓

30. Have you ever been denied a license to practice medicine?

✓

31. Is any denial pending against you?

✓

32. Have you ever had any license to practice medicine subjected to any disciplinary action?

✓

33. Is any disciplinary action pending against any of your licenses to practice medicine?

✓

34. Have you ever surrendered a license to practice medicine?

✓

35. Have you ever had any license to practice medicine revoked, suspended, or placed on probation?

✓

36. Have you ever had any license to practice medicine subjected to any action including, but not limited to, informal or confidential discipline, consent orders, letters of warning, letters of reprimand, or citation?

✓

37. Have you ever been charged with, or been found to have committed unprofessional conduct, professional incompetence, gross negligence, or repeated negligent acts by any medical licensing board or hospital?

✓

38. Have you ever resigned from a medical staff in lieu of disciplinary or administrative action?

✓

39. Is any disciplinary action pending against your hospital or staff privileges?

✓

40. Have you ever had staff privileges in a hospital terminated, denied, suspended, limited, revoked, or not renewed?

✓

41. Have you ever had any healing arts license or certificate disciplined by another state or federal territory?



✓

Criminal Record History

42. Have you ever been convicted of, or pled guilty or nolo contendere to ANY offense in the United States, its territories, or a foreign country?



✓

43. Exclusive of juvenile court adjudications and criminal charges dismissed under section 1000.3 of the California Penal Code or equivalent non-California laws, or convictions under California Health and Safety Code section 11357 (b), (c), (d), (e), or section 11360 (b) which are two years or older, have you had a conviction that was set aside or later expunged from the record of the court?

✓

44. Is any criminal action pending against you, or are you currently awaiting judgment and sentencing following entry of a plea or jury verdict?

✓

45. Are you a registered Sex Offender?

✓

Practice Impairment or Limitations

46. Have you ever been enrolled in, required to enter into, or participated in any drug, alcohol, or substance abuse recovery program or impaired practitioner program?



✓

47. Have you ever been treated for or had a recurrence of a diagnosed addictive disorder?

✓

48. Have you ever been diagnosed with an emotional, mental, or behavioral disorder that may impair your ability to practice medicine safely?

✓

49. Have you ever been diagnosed with a neurological or other physical condition that may impair your ability to practice medicine safely?

✓

50. Do you have any other condition that may in any way impair or limit your ability to practice medicine safely?

✓

51. Do you suffer from a progressive disorder or a health condition that will likely result in a general decline in health or function that may impair or limit your ability to practice medicine safely?

✓

Family Physician Training Program Voluntary Fee

Would you like to contribute?

Attachments

Fees

Application Fee	\$442.00
Department of Justice (DOJ) Fee	\$32.00
Federal Bureau of Investigation (FBI) Fee	\$17.00
Initial License Fee	\$783.00
Stephen M. Thompson LRP	\$25.00
Total Amount Due:	\$1299.00

Applications are not considered submitted for processing until payment is received.

Attestation

I attest I am the person herein named subscribing to this application; that I have read the complete application, know the full content thereof, and declare under penalty of perjury, that all of the information contained herein and evidence or other credentials submitted herewith are true and correct; that I am the lawful holder of the degree of Doctor of Medicine as prescribed by this application, that the same was procured in the regular course of instruction and examination, and that it, together with all the credentials submitted, were procured without fraud or misrepresentation or any mistake of which I am aware and that I am the lawful holder thereof. Further, I hereby authorized all hospitals, institutions or organizations, my references, personal physicians, employers (past, present and future), or business and professional associates (past, present and future), and all government agencies (local, stated, federal, or foreign) to release to the Medical Board of California or its successors any information, files or records, including medical records, educational records, and records of psychiatric treatment and treatment for drug and/or alcohol abuse or dependency, requested by that Board in connection with this application; or any further or future investigation by that Board necessary to determine any medical competence, professional conduct, or physical or mental ability to safely engage in the practice of medicine. I further authorize the Medical Board of California or its successors to release to the organizations, individuals or groups listed above any information which is material to this application or any subsequent licensure.

I understand that falsification or misrepresentation of any item or response on this application or any attachment hereto is a sufficient basis for denying or revoking a license.

Signature:

Date:

PHOTOGRAPH

Notice: All items in this application are mandatory. Failure to provide any of the requested information will delay the processing of your application. The information provided will be used to determine your qualifications for licensing per Section 2080 of the California Business and Professions Code, which authorizes the collection of this information. The information on your application may be transferred to other medical licensing authorities, the Federation of State Medical Boards, or other governmental law enforcement agencies. You have the right to review your application subject to the provisions of the Information Practices Act. The Chief of the Licensing Program is the custodian of records.

MBC Use Only

Rev L1A-F Staff Initials & Date

Smg
5/9/19

Photograph

Applicant Name & DOB

DECLARATION

The applicant, Nicole Joy Fanarjian PRINT LEGAL NAME (First, Middle, Last, Suffix) DATE OF BIRTH (mm/dd/yyyy)

being first duly sworn upon his/her oath deposes and says: that I am the person herein named subscribing to this application; that I have read the complete application, know the full content thereof, and declare under penalty of perjury, that all of the information contained herein and evidence or other credentials submitted herewith are true and correct; that I am the lawful holder of the degree of Doctor of Medicine as prescribed by this application, that the same was procured in the regular course of instruction and examination, and that it, together with all the credentials submitted, were procured without fraud or misrepresentation or any mistake of which I am aware and that I am the lawful holder thereof. Further, I hereby authorize all hospitals, institutions or organizations, my references, personal physicians, employers (past, present and future), or business and professional associates (past, present, and future), and all government agencies (local, state, federal, or foreign) to release to the Medical Board of California or its successors any information, files or records, including medical records, educational records, and records of psychiatric treatment and treatment for drug, alcohol and/or substance abuse or dependency, requested by that Board in connection with this application; or any further or future investigation by that Board necessary to determine any medical competence, professional conduct, or physical or mental ability to safely engage in the practice of medicine. I further authorize the Medical Board of California or its successors to release, in any investigation or proceeding, to the organizations, individuals or groups listed above any information which is material to this application or any subsequent licensure.

I UNDERSTAND THAT ANY OMISSION, FALSIFICATION OR MISREPRESENTATION OF ANY ITEM OR RESPONSE ON THIS APPLICATION OR ANY ATTACHMENT HERETO IS A SUFFICIENT BASIS FOR DENYING OR REVOKING A LICENSE.

SIGN LEGAL NAME: Nicole Fanarjian DATE: 4/18/2019

Applicant Signature & Date

NOTARY SECTION

SIGNATURE OF APPLICANT: Nicole Fanarjian (SIGN LEGAL NAME IN THE PRESENCE OF NOTARY)

Applicant Signature

A notary public or other officer completing this certificate verifies only the identity of the individual who signed the document to which this certificate is attached, and not the truthfulness, accuracy, or validity of that document.

State of Florida

County of Hillsborough

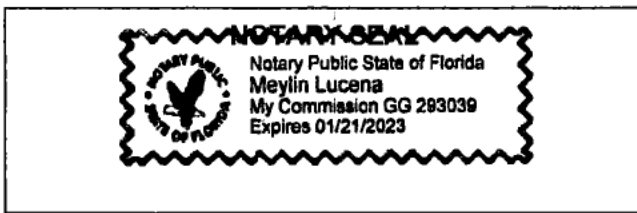
Subscribed and sworn to (or affirmed) before me on this 18 day of April, 2019.

by, Nicole Fanarjian proved to me on the basis of satisfactory evidence (PRINT APPLICANT'S LEGAL NAME)

Applicant Name & Notary Date

to be the person who appeared before me.

[Signature]
SIGNATURE OF NOTARY PUBLIC



Notary Signature & Seal

L1F



Department of Health



NICOLE JOY FANARJIAN

License Number: ME107878

Data As Of 5/9/2019

Profession	Medical Doctor
License	ME107878
License Status	CLEAR/ACTIVE
Qualifications	Dispensing Practitioner
License Expiration Date	1/31/2020
License Original Issue Date	07/29/2010
Address of Record	

Controlled Substance Prescriber (for the Treatment of Chronic Non-malignant Pain)

No

Discipline on File

No

Public Complaint

No

The information on this page is a secure, primary source for license verification provided by the Florida Department of Health, Division of Medical Quality Assurance. This website is maintained by Division staff and is updated immediately upon a change to our licensing and enforcement database.