OFFICE OF THE PROFESSIONS
NEW YORK STATE EDUCATION DEPARTMENT

Registration Renewal - Transaction Summary

Main Page | Logout

License Number : 224830
Profession : MEDICINE
Renewal Period : 02/01/2008 through 01/31/2010

We recommend that you print and keep this transaction summary. Thank you for using OP Registration Online.

WHITE KATHARINE O'CONNELL
Baystate Medical Cent
759 Chestnut St
Springfield MA 01199 - 0000

Renewal Status : **Paid On-line - OP Review Required**

Offices Selected for Renewal:

	Address	Fee
1)	Baystate Medical Cent, 759 Chestnut St, Springfield, MA, 01199,US	$ 600

Response to Questions :

Question	Response
1) Have you been found guilty after trial, or pleaded guilty, no contest, or nolo contendere to a crime (felony or misdemeanor) in any court?	No
2) Has any licensing or disciplinary authority revoked, annulled, cancelled, accepted surrender of, suspended, placed on probation, or refused to issue or renew a professional license or certificate held by you now or previously, or fined, censured, reprimanded or otherwise disciplined you?	No
3) Are criminal charges pending against you in any court?	No
4) Are charges pending against you in any jurisdiction for any sort of professional misconduct?	No
5) Has any hospital or licensed facility restricted or terminated your professional training, employment, or privileges, or have you voluntarily or involuntarily resigned or withdrawn from such association to avoid the imposition of such action due to professional misconduct, unprofessional conduct, incompetency, or negligence?	No
6) Are you under an obligation to pay child support?	No
7) Are you a U.S. citizen or an alien lawfully admitted for permanent residence in the U.S.?	No

License Renewal Payment Details:

Receipt No :VTHN1ECE0B63
Payment Date :01/04/2008
Amount Paid :$ 600

IMPORTANT:

- Based on one or more of your responses, Office of the Professions review is required before your registration is renewed.
- We will contact you regarding this (these) matter(s) and, once satisfactorily resolved, your registration will be renewed, posted at www.op.nysed.gov "Online Verifications," and a new registration certificate mailed.
- Your registration will not be renewed for the new time period until the following issue(s) is (are) resolved:

7) Are you a U.S. citizen or an alien lawfully admitted for permanent residence in the U.S.?

26 **STUDENT LOAN DISCLOSURE:**

(a) Do you have any outstanding loans made or guaranteed by the New York State Higher Education Services Corporation? ☐ Yes ■ No

(b) If you have such a loan(s), is any part in default? ☐ Yes ☑ No

NOTE: Education Law (Section 6501-a) requires the State Education Department to ask the questions above and forward any "yes" responses to question (b) to the New York State Higher Education Services Corporation. **Your license application is not complete without this information.**

27 **GENDER AND ETHNICITY: (This item is optional. See note below.)**

NOTE: Information on gender and ethnicity is sought solely to allow the Education Department to collect and analyze data concerning representation in the licensed professions. The ethnic and gender data you provide will be used only for statistical, research, and program evaluation purposes. It will not be released to the public. This information has absolutely no bearing on your qualification for licensure.

ETHNICITY: ■ White (not Hispanic) ☐ Black (not Hispanic) ☐ Asian ☐ Hispanic ☐ Native American

GENDER: ☐ Male ■ Female

28 **CHILD ABUSE IDENTIFICATION AND REPORTING: (check only one of the following.)**

☐ I graduated from a New York State medicine program after September 1, 1990.

■ I completed the child abuse coursework and have enclosed a certificate of completion from an approved provider.

☐ I am filing for an exemption to the requirement and have enclosed the exemption form.

29 **PHOTOGRAPH REQUIREMENT:** ----------►

Date of photo: 3-4-2002

I give permission to the New York State Education Department to release my examination results to my professional school for the confidential purposes of program review and institution research and planning. I may rescind this authority at any time by notifying, in writing, the Division of Professional Licensing Services.

■ Yes ☐ No Please initial: VO

Under penalties of perjury, I declare and affirm that the statements made in this application, including accompanying documents, are true, complete and correct. I understand that any false or misleading information in, or in connection with, my application may be cause for denial or loss of licensure.

Signature of applicant: [redacted] *Date:* 2/22/02

Mail this form and appropriate fee to: New York State Education Department, Office of the Professions, Fee Section, Division of Professional Licensing Services, Cultural Education Center, Albany, NY 12230. DO NOT SEND CASH. Make check or money order payable to the New York State Education Department.

PN 3/21/02 ink fear 7

FORM 1
MEDICINE

The University of the State of New York
THE STATE EDUCATION DEPARTMENT
Office of the Professions
Division of Professional Licensing Services
Cultural Education Center
Albany, NY 12230

RECEIVED PROFESSIONAL LICENSING UNIT 2002 MAR 19 AM 10:

APPLICATION FOR LICENSE AND FIRST REGISTRATION

DEPARTMENT USE ONLY

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☑ 735 FR

☐

NYS License Number 224830 5/21/02

1 SOCIAL SECURITY NUMBER: [redacted]
(Leave this blank if you have no U.S. Social Security Number)

2 BIRTH DATE: [redacted] *mo. day yr.*

3 PRINT FULL NAME AS YOU WISH IT TO APPEAR ON YOUR LICENSE:

Last O'CONNELL
First KATHARINE
Middle JEAN

4 MAILING ADDRESS CHECK ONE: ■ HOME ADDRESS ☐ WORK ADDRESS

Care of
Street [redacted]
City NORTHAMPTON
State MA Zip Code [redacted]
Province/Country If not U.S.

The above address is: ☐ permanent address of record ■ temporary mailing address

5 TELEPHONE
HOME [redacted]
Area Code Number
WORK [redacted]
Area Code Number
Katharine94@yahoo.com
E-Mail Address

IMPORTANT: The applicant is responsible for notifying the Department of any name or address changes.

6 Name as it appears on diploma or other credentials (if different from above): high school + college: KARI ANN O'CONNELL

7 Citizenship: ■ United States ☐ Alien lawfully admitted for permanent residence in the United States. (Attach a copy of the front and back of the alien registration card) ☐ Other Immigration

8 Mother's Maiden Name *(family name before her marriage)*: BONOMO

9 I wish to become licensed on the basis of: ■ acceptable examination scores *(see page 3 of this form)* ☐ endorsement of another license *(See Pg. 11.)*
I am using FCVS to collect my credentials: ■ YES ☐ NO

10	Have you previously applied for a New York State license or a limited permit to practice medicine?	☐ YES ■ NO
11	Have you ever been convicted of a crime (felony or misdemeanor) in any state or country?	☐ YES ■ NO *See note*
12	Have you ever been charged with a crime (felony or misdemeanor) in any state or country, the disposition of which was other than by acquittal or dismissal?	☐ YES ■ NO *See note*
13	Have you ever surrendered your license or been found guilty of professional misconduct, unprofessional conduct, incompetence or negligence in any state or country?	☐ YES ■ NO *See note*
14	Are charges pending against you for professional misconduct, unprofessional conduct, incompetence or negligence in any state or country?	☐ YES ■ NO *See note*
15	Has any hospital or licensed facility restricted or terminated your professional training, employment, or privileges or have you ever voluntarily or involuntarily resigned or withdrawn from such association to avoid imposition of such measures ?	☐ YES ■ NO *See note*

NOTE: If any answer to any question 11-15 is "Yes," submit a letter giving complete explanation. Include copies of any court records, and if you possess one, a copy of the "Certificate of Relief from Disabilities" or your "Certificate of Good Conduct."

16 In the space below, give a complete record of your education preparation. Attach additional sheets if necessary.

SCHOOLS ATTENDED AND LOCATION (including country) List schools in original language and translate.	Number of Years Attended	Diploma or Degree Obtained *List diploma or degree titles in original language and translate. Indicate year obtained*	If no diploma or degree, number of credits earned
High School or Secondary JACKSON MEMORIAL HIGH SCHOOL JACKSON, NJ 08527	4	high school diploma	
Postsecondary Preprofessional (Exclusive of Medical School) DUKE UNIVERSITY DURHAM, NC	4	bachelors of science, Psychology (B.S.)	
Medical Education (Professional) (List all medical schools attended) UMDNJ- NEW JERSEY MED SCHOOL NEWARK, NJ	4	doctorate of medicine (M.D.)	

17 If you completed clinical clerkships in a country other than where your medical school is located, give the dates and location of these clerkships. Attach additional sheets if necessary.

Inclusive Clerkship Dates	Clinical Area	Name of Health Care Facility And Address	Medical School with which Clerkship Affiliated and Address

18 Provide a chronological list of all activities since graduation from professional school to the present. Include vacation periods and periods of employment. Attach additional sheets if necessary.

DATE (mm/dd/yy) From	DATE (mm/dd/yy) To	Type of Activity, Beginning with Date of Graduation from Professional School. Include Name and Address of Employers.
7/1998	present	residency, OB/GYN BAYSTATE MEDICAL CENTER Springfield, MA 01199

19 **Complete item 19 only if you are a graduate of a program not registered by New York State or LCME or AOA accredited.**

Have you completed all portions of the examination requirements for ECFMG certification? ☐ Yes ☐ No

Do you currently hold a valid ECFMG certificate? ☐ Yes ☐ No

Please complete and forward the ECFMG form enclosed with this application packet.

20 Are you applying for licensure on the basis of a Fifth Pathway program? ☐ Yes ■ No

If Yes, list name and location of medical school or hospital and the inclusive dates of attendance.

Name and Location of Medical School or Hospital	Inclusive Dates of Attendance

21 List in English, all specialty qualifications you have earned. (i.e., Board Specialty Certification or Diplomate Certificate)

Name of Qualifications	Name and location of organization issuing credential

22 ☐ I will be applying for USMLE Step 3

OR

■ I have successfully completed the examination combination indicated below:

EXAMINATION COMBINATIONS

- ■ USMLE Steps 1, 2, and 3
- ☐ FLEX Parts I, II, and III
- ☐ FLEX Components I and II
- ☐ NBME Parts I, II, and III
- ☐ NBME Parts I and II and USMLE Step 3
- ☐ NBME Part I, USMLE Step 2 and NBME Part III
- ☐ NBME Part I, and USMLE Steps 2 and 3
- ☐ USMLE Step 1, and NBME Parts II and III
- ☐ USMLE Step 1, NBME Part II, and USMLE Step 3
- ☐ USMLE Steps 1 and 2 and NBME Part III
- ☐ USMLE Step 1, NBME Part II, and FLEX Component II
- ☐ NBME Part I, USMLE Step 2, and FLEX Component II
- ☐ USMLE Steps 1 and 2 and FLEX Component II
- ☐ NBME Parts I and II and FLEX Component II
- ☐ FLEX Component I and USMLE Step 3
- ☐ NBOME Parts I, II, and III
- ☐ Other: _____

Date examination sequence was completed MAY 1999

23 Are you licensed or have you ever been licensed as a physician in any other state or country? Yes ■ No

If yes, list each jurisdiction. In addition, you must have a Form 3A or 3B, as appropriate, submitted. See pages 14 - 15.

State or Country	Date License Issued	Number	Basis of Licensure			Any Limitations on License
			Examination (Date passed)	Endorsement	Other	

24 If you hold a New York State license in another profession, indicate the profession, your license number and date of licensure below.

Profession	License Number	Date of Initial Licensure (mm/dd/yy)
_____	_____	____/____/____
_____	_____	____/____/____
_____	_____	____/____/____
_____	_____	____/____/____

25 **CHILD SUPPORT OBLIGATION:**

New York State General Obligations Law, section 3-503, requires every applicant for a professional license, permit, or registration, or any renewal there of, to file a written statement that, as of the date of the filing, he or she is, or is not, under an obligation to pay child support. **Individuals who are four months or more in arrears in child support may be subject to suspension of their business, professional and/or drivers licenses.** The intentional submission of false written statements for the purpose of frustrating or defeating the lawful enforcement of support obligations is punishable pursuant to section 175.35 of the Penal Law.

You must complete this section before we can issue the credential for which you have applied. Individuals who are under an obligation to pay child support but are not in compliance with the General Obligations Law can be issued a credential for no more than six months to discharge child support obligations consistent with that law.

Check only A or B below. If you check B, you must check one of the five statements listed below it.

A ■ I **am not** under an obligation to pay child support:

OR

B ☐ I **am** under an obligation to pay child support *and* (please check only one of the following)

- ☐ I am current and **am not** four months or more in arrears in the payment of child support: or,
- ☐ I am making payments by income execution or by court agreed payment plan or by a plan agreed to by the parties; or,
- ☐ The child support obligation is the subject of a pending court proceeding; or,
- ☐ I am receiving public assistance or supplemental security income; or,
- ☐ None of the above four statements apply.

THE STATE EDUCATION DEPARTMENT / THE UNIVERSITY OF THE STATE OF NEW YORK / ALBANY, NY 12230

OFFICE OF THE PROFESSIONS
DIVISION OF PROFESSIONAL LICENSING SERVICES
Public Information Unit
Tel. (518) 474-3817 EXT: 330
Fax (518) 473-0578
E-mail: DPLSDSU@MAIL.NYSED.GOV

STATE OF NEW YORK)
SS:
COUNTY OF ALBANY)

In accordance with the **Civil Practice Law and Rules Article 45**, I, Connie F. Mitchell, Clerk II in the Division of Professional Licensing Services of the New York State Education Department, have caused this certificate to be prepared. I certify that I have legal custody of the official original records of the Division of Professional Licensing Services and I attest that the attached are true and correct copies of the original documents in our files relating to KATHARINE O'CONNELL WHITE a/k/a KATHARINE JEAN O'CONNELL.

Witness my hand and the seal of the New York State Education Department this 3 February, 2010.

Connie F. Mitchell, Clerk II
Professional Licensing Services

167 So St., #1 Phone 413-887-9263

PN 3/21/02 ink year 7

FORM 1
MEDICINE

The University of the State of New York
THE STATE EDUCATION DEPARTMENT
Office of the Professions
Division of Professional Licensing Services
Cultural Education Center
Albany, NY 12230

RECEIVED PROFESSIONAL LICENSING UNIT 2002 MAR 19 AM 10:

NOA: 2 PPs 2/28/02 SCR

DEPARTMENT USE ONLY

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735 FR

APPLICATION FOR LICENSE AND FIRST REGISTRATION

1 SOCIAL SECURITY NUMBER: [redacted]
(Leave this blank if you have no U.S. Social Security Number)

2 BIRTH DATE: [redacted] mo. day yr.

3 PRINT FULL NAME AS YOU WISH IT TO APPEAR ON YOUR LICENSE:

Last O'CONNELL
First KATHARINE
Middle JEAN

NYS License Number 224830 5/21/02 PN

5 TELEPHONE 5/20/02 Cleared

HOME [redacted]
Area Code Number

WORK [redacted]
Area Code Number

Katharine94@yahoo.com
E-Mail Address

4 MAILING ADDRESS CHECK ONE: ■ HOME ADDRESS ☐ WORK ADDRESS

Care of
Street [redacted]
City NORTHAMPTON
State MA Zip Code [redacted]
Province/Country If not U.S

The above address is: ☐ permanent address of record ■ temporary mailing address

IMPORTANT: The applicant is responsible for notifying the Department of any name or address changes.

6 Name as it appears on diploma or other credentials (if different from above): high school + college: KARI ANN O'CONNELL

7 Citizenship: ■ United States ☐ Alien lawfully admitted for permanent residence in the United States. (Attach a copy of the front and back of the alien registration card) ☐ Other Immigration

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11 Have you ever been convicted of a crime (felony or misdemeanor) in any state or country? ☐ YES ■ NO *See note*

12 Have you ever been charged with a crime (felony or misdemeanor) in any state or country, the disposition of which was other than by acquittal or dismissal? ☐ YES ■ NO *See note*

13 Have you ever surrendered your license or been found guilty of professional misconduct, unprofessional conduct, incompetence or negligence in any state or country? ☐ YES ■ NO *See note*

14 Are charges pending against you for professional misconduct, unprofessional conduct, incompetence or negligence in any state or country? ☐ YES ■ NO *See note*

15 Has any hospital or licensed facility restricted or terminated your professional training, employment, or privileges or have you ever voluntarily or involuntarily resigned or withdrawn from such association to avoid imposition of such measures ? ☐ YES ■ NO *See note*

NOTE: If any answer to any question 11-15 is "Yes," submit a letter giving complete explanation. Include copies of any court records, and if you possess one, a copy of the "Certificate of Relief from Disabilities" or your "Certificate of Good Conduct."

1. Do you wish to register for the period indicated? ..... X Yes ___ No

2. Since your last registration application,
   a. Have you been found guilty after trial, or pleaded guilty, no contest, or nolo contendere to a crime (felony or misdemeanor) in any court? ..... ___ Yes X No
   b. Has any licensing or disciplinary authority revoked, annulled, cancelled, accepted surrender of, suspended, placed on probation, or refused to issue or renew a professional license or certificate held by you now or previously, or fined, censured, reprimanded or otherwise disciplined you? ___ Yes X No
   c. Are criminal charges pending against you in any court? ..... ___ Yes X No
   d. Are charges pending against you in any jurisdiction for any sort of professional misconduct? ..... ___ Yes X No
   e. Has any hospital or licensed facility restricted or terminated your professional training, employment, or privileges, or have you voluntarily or involuntarily resigned or withdrawn from such association to avoid the imposition of such action due to professional misconduct, unprofessional conduct, incompetency, or negligence? ..... ___ Yes X No

3. a. Are you under an obligation to pay child support? ..... ___ Yes X No
   b. If you are under such an obligation, do you meet one of the four requirements listed in the Child Support Law section below? ..... ___ Yes ___ No

4. Are you a U.S. citizen or a qualified alien as defined below? ..... X Yes ___ No

[redacted] DO NOT WRITE IN THIS BOX FOR OFFICIAL USE ONLY

I certify that the statements made in this application and any accompanying documentation are true, complete and correct. I understand that any misrepresentation or any false or misleading information made in connection with my application may **result in criminal prosecution and** may be cause for disciplinary action, including the loss of my license; and that the wilful [redacted] while continuing to practice my profession constitutes professional misconduct.

Signature [redacted] Business phone ([redacted] Date 3-29-0X

6

Cal.6A - 0503

312 343-2903?

1. Do you wish to register for the period indicated? ..... ✓ Yes ___ No

2. Since your last registration application,
   a. Have you been found guilty after trial, or pleaded guilty, no contest, or nolo contendere to a crime (felony or misdemeanor) in any court? ..... ___ Yes ✓ No
   b. Has any licensing or disciplinary authority revoked, annulled, cancelled, accepted surrender of, suspended, placed on probation, or refused to issue or renew a professional license or certificate held by you now or previously, or fined, censured, reprimanded or otherwise disciplined you? ___ Yes ✓ No
   c. Are criminal charges pending against you in any court? ..... ___ Yes ✓ No
   d. Are charges pending against you in any jurisdiction for any sort of professional misconduct? ..... ___ Yes ✓ No
   e. Has any hospital or licensed facility restricted or terminated your professional training, employment, or privileges, or have you voluntarily or involuntarily resigned or withdrawn from such association to avoid the imposition of such action due to professional misconduct, unprofessional conduct, incompetency, or negligence? ..... ___ Yes ✓ No

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   b. If you are under such an obligation, do you meet one of the four requirements listed in the Child Support Law section below? ..... ___ Yes ___ No

4. Are you a U.S. citizen or an alien admitted for permanent residence in the U.S.? ..... ✓ Yes ___ No

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Signature [redacted] Daytime phone (212) 305 - 4805 Date 11/1/05

Cal21R 03204

21

212-305-4805

2248300 C0005290060104

REGISTRATION RENEWAL DOCUMENT
THE STATE EDUCATION DEPARTMENT
Professional Licensing Services
89 Washington Avenue
Albany, NY 12234-1000

03/15/04
LIC: 224830
NME: O'CO
YR: 04
OFF: 1
DOB: 02/02/72
SSN: 140789192
EIN:

O'CONNELL KATHARINE JEAN
ROOM PH1680
630 W 168TH ST
NEW YORK NY [redacted]

****
*** 2ND REQUEST ***
****

PROFESSION: 60 MEDICINE
PERIOD: 05/01/04 - 01/31/06

Name/address change
Complete only if change has occurred

Name
Street
City
State/Zip

$ 529
AMOUNT DUE

Complete and sign reverse side of this application

Cat 6 - 1001

Room PH1680
630 W 168TH St
NY, NY

2248300 C0006000060106

REGISTRATION RENEWAL DOCUMENT
THE STATE EDUCATION DEPARTMENT
Professional Licensing Services
89 Washington Avenue
Albany, NY 12234-1000

09/01/05
LIC: 224830
NME: O'CO
YR: 06
OFF: 1
EIN:

O'CONNELL KATHARINE JEAN
ROOM PH1680
630 W 168TH ST
NEW YORK NY [redacted]

PROFESSION: 60 MEDICINE
PERIOD: 02/01/06 - 01/31/08

Name/address change
Complete only if change has occurred

Name
Street
City
State/Zip

$ 600
AMOUNT DUE

Cat 21P-032204

Complete and sign reverse side of this application