Kira Paisley, MD

Licensed Physician #MD2016-0619

Issue Date	Expiration Date
08/16/2016	07/01/2017

Signature of Holder

The bearer is prohibited by law from using this identification card to give the impression that they are in any way connected with a governmental agency

New Mexico Medical Board

Triennial Renewal Certificate

This is to certify that

Kira Paisley, MD

License Number: MD2016-0619

Having complied with the provisions of the Medical Practice Act is hereby granted a license to practice in the State of New Mexico as a Physician.

Issue Date: 08/16/2016 Date Expires: 07/01/2017*

**A New Mexico medical license that has not been renewed by July 1 of the renewal year will remain temporarily active with respect to medical practice until September 30 of the renewal year at which time, the status will be changed to lapsed. A lapsed license is not valid for practice in New Mexico.*

This License Must Be Conspicuously Posted In Each Practice Location

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Physician (MD) Application

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THE NEW MEXICO MEDICAL SOCIETY

Date of Application: June 10, 2016

R# 1214334

Application Fee: $400.00

TOTAL: $400.00

Name: Kira Paisley

liam

Maiden or Other Names Used

Will you be applying by endorsement? ☐ Yes ☑ No Applying using: ☑ NMMB ☐ HSC ☐ FCVS

What are your NM practice plans? Working for the University of New Mexico Family Medicine department

Gender: Female Citizenship: United States Place of Birth:

Social Security Number: [redacted]4447 Date of Birth: [redacted]984

State Tax ID#: ☐ Pending Fed. Tax ID#: ☐ Pending

Medicare #: ☐ Pending Medicaid #: ☐ Pending

Unique Physician Identification Number (UPIN): ☐ Pending

National Provider Identifier Number (NPI): [redacted] ☐ Applied

CLIA Number (if applicable): Approval Level: Expiration Date:

Home address

Street Address: [redacted]

City, State/Province and Zipcode: Portland [redacted] 97214

Country: United States

Telephone Number: [redacted] Pager Number:

Cell Phone Number: Spouse's Name (Optional):

Credentials Correspondence Address

Department:

Street Address: 2912 SE Ankeny St

City, State/Province and Zipcode: Portland OR 97214

Country: United States Email: [redacted]

Telephone Number: [redacted] Facsimile Number:

Military Service

Branch: Type of Discharge:

Dates: From: To: ☐ Current Rank:

Immigration

Status: Certification Number:

ECFMG (Educational Commission for Foreign Medical Graduates)

Number (if applicable): Date Issued: (Please attach a copy of your ECFMG certificate)

Languages

Foreign Languages (spoken fluently by practitioner):

Certifications

ACLS CERTIFICATION

Certified? ☑ Yes ☐ No

Expires: 01/01/2018

ATLS CERTIFICATION

Certified? ☐ Yes ☑ No

Expires:

PALS CERTIFICATION

Certified? ☑ Yes ☐ No

Expires: 04/30/2018

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HOSPITAL AND HEALTHCARE AFFILIATIONS

☑ Are you a PCP? ☑ Do you deliver babies? ☑ Are you an MD, DO, or DPM

If you answered yes to any question above, you must:

(a) Have admitting privileges at a hospital (list below) OR
(b) Provide a written explanation as to the arrangements you have made with a physician to admit your patients, along with a signed letter from that physician confirming the arrangements, and the name of the facility where your patients will be admitted.

☑ Do you have courtesy or consulting privileges at this facility.

☑ If yes, do these courtesy or consulting privileges allow you to admit patients.

If no, provide a written explanation as to the arrangements you have made with a physician to admit your patients, along with a signed letter from that physician confirming the arrangements, and the name of the facility where your patients will be admitted.

Please list all hospital staff membership and/or healthcare organization affiliations in the past fifteen (15) years, and your status (active, courtesy, consulting, etc.) If an institution is no longer in existence, please provide an alternative cource of verification. Attach a separate page if necessary.

Facility Name: Oregon Health and Science University ☑ Is this your primary admitting facility

Department: School of Medicine

Street Address: 3181 SW Sam Jackson Park Rd.

City: Portland State/Province: OR Zip Code: 97239

Country: United States

Phone Number: 5034947725 Facsimile:

Appointment Dates From: 07/2012 To: ☑ Present

Type of Appointment: Resident/Fellow Privileges Assigned:

WORK HISTORY

Please list all previous experience for the past fifteen (15) years, including months and years, listing the most recent first. Attach a separate page if necessary. Please attach a current CV or resume.

Organization: OHSU Hospital From: 07/2012 To:

Department: ☑ Present

Street Address:

City: State/Province: Zip Code:

Country: United States Phone Number:

Contact: Fax Number:

Type of Practice: Resident/Fellow

Please provide written explanation for any gaps in work history of six (6) months or more.

Organization: Legacy Meridian Park Hospital From: 07/2006 To: 06/2008

Department: Medical Staff Office ☐ Present

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Street Address: 19300 SW 65th Ave
City: Tualatin State/Province: OR Zip Code: 97062
Country: United States Phone Number: 5036921212
Contact: Fax Number: 5036922574
Type of Practice: Research Assistant
Please provide written explanation for any gaps in work history of six (6) months or more.

PRACTICE LOCATIONS

Group Name: Oregon Health and Science University Effective Date: 07/01/2012
Department: Family Medicine
Street Address: 3181 SW Sam Jackson Park Rd
City: Portland State/Province: OR Zip Code: 97239-3098
Country: United States
Phone Number: 5034948652 Facsimile Number: 5034948513
Email Address: Answering Service Number:
Foreign Languages (spoken fluently at practice):
Office Manager or Contact Person: Phone:

Billing Address

Contact Person: Tax ID #:
Department:
Street Address:
City: State/Province: UN Zip Code:
Country: United States
Phone Number: Facsimile Number:

Practice Associates (if applicable):	Call Coverage (if applicable)
	/
	/
	/

What are the office hours for your Practice or Group Practice? (Provide days/hours):

What provisions have been made for after hours?:

CONTINUING EDUCATION

1. If you are applying for privileges at a hospital or clinic, please send documentation of all continuing education hours you have obtained in the last two (2) years or complete and send the statement of continuing medical education.

2. If you are applying for privileges at a hospital or clinic, please complete and send the privilege request form and ensure that you include any additional privileges that you are requesting. This will ensure your application is considered based upon the most accurate information available.

PROFESSIONAL REFERENCES

Please list five (5) professional peers with the same type of license, or a higher level of licensure, who are familiar with your professional performance in the past three (3) years.

Name and Title: Lindsay Braun MD - Docto
Specialty: Family Medicine
Department:
Email: braunl07@gmail.com
Street Address: 3181 SW Sam Jackson Park Rd,
City: Portland
State/Province: OR
Zip Code: 97239
Country: United States
Phone Number: 9714046351
Facsimile Number: 5034183939

Name and Title: Rita Lahlou MD - Docto
Specialty: Family Medicine
Department:
Email: lahlou@ohsu.edu
Street Address: 3181 SW Sam Jackson Park Rd
City: Portland
State/Province: OR
Zip Code: 97239
Country: United States
Phone Number: 7038691296
Facsimile Number: 5034941967

Name and Title: Emily Myers MD - Docto
Specialty: Family Medicine
Department:
Email: myerem@ohsu.edu
Street Address: 3181 SW Sam Jackson Park Rd
City: Portland
State/Province: OR
Zip Code: 97239
Country: United States
Phone Number: 5034183900
Facsimile Number: 5034941967

Name and Title: Steve Wahls
Specialty: Family Medicine
Department:
Email: wahlss@ohsu.edu
Street Address: 3181 SW Sam Jackson Park Rd
City: Portland
State/Province: OR
Zip Code: 97239
Country: United States
Phone Number: 5034184260
Facsimile Number: 5034184223

Name and Title: Jessica Flynn MD - Docto
Specialty: Family Medicine
Department:
Email: flynnj@ohsu.edu
Street Address: 3181 SW Sam Jackson Park Rd
City: Portland
State/Province: OR
Zip Code: 97239
Country: United States
Phone Number: 5034946461
Facsimile Number: 5034944496

LICENSURE REGISTRATION INFORMATION

List all licenses held in all jurisdictions. Attach a separate page if necessary.

State Professional License/Certification Number: MD 173649 ☐ Pending
State: OR
Issue Date: 06/19/2015
Expiration Date: 12/31/2017

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Physician (MD) Application

THE NEW MEXICO MEDICAL SOCIETY

LICENSING EXAM

Please check all that apply:

☐ State Board Exam (Prior to 1973) Which State? OR Date(s) passed? ____ MM/YY

☐ FLEX
Part/Step 1 Date Passed ____ MM/YY

☐ LMCC
Part/Step 1 Date Passed ____ MM/YY

☐ National Board (NBME)
Part/Step 1 Date Passed ____ MM/YY Part/Step 2 Date Passed ____ MM/YY Part/Step 3 Date Passed ____ MM/YY

☑ USMLE
Part/Step 1 Date Passed 06/15/2010 MM/YY Part/Step 2 Date Passed 08/25/2011 MM/YY Part/Step 3 Date Passed 09/15/2013 MM/YY

DRUG CERTIFICATION INFORMATION

Federal Drug Enforcement Administration (DEA) Registration: ☐ N/A
DEA Number: [redacted] Expiration Date: 03/31/2018 ☐ Pending

State Controlled Substance Registration (CSR): ☐ N/A
CSR Number: ____ Expiration Date: ____ State: ____ ☐ Pending

EDUCATION

List all medical, osteopathic, dental or podiatric schools attended for graduate education and list all hospitals where you received training for post-graduate training. Attach a copy of your certificate. Disclose every residency program initiated, whether completed or not, and all completed programs. Attach a separate page if necessary. Check the type of education listed.

Degree Level: Fellowship
Institution: Oregon Health & Science University (GME) Dates Attended:
Department: Graduate Medical Education Office From: 07/2015
Street Address: 3181 SW Sam Jackson Park Rd, To:
City: Portland State/Province: OR Zip Code:
Country: United States Graduation Date: 2016
Degree Earned: Fellowship or Specialty:
If teaching appointment: Department/Position:

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Physician (MD) Application

THE NEW MEXICO MEDICAL SOCIETY

Degree Level: Residency
Institution: Oregon Health & Science University (GME) Dates Attended:
Department: Graduate Medical Education Office From: 07/2012
Street Address: 3181 SW Sam Jackson Park Rd, To: 06/2015
City: Portland State/Province: OR Zip Code:
Country: United States Graduation Date: 2015
Degree Earned: Doctor of Medicine or Specialty: Family Medicine
If teaching appointment: Department/Position:

Degree Level: Graduate
Institution: Oregon Health & Science University (GME) Dates Attended:
Department: Graduate Medical Education Office From: 08/2008
Street Address: 3181 SW Sam Jackson Park Rd, To: 06/2012
City: Portland State/Province: OR Zip Code:
Country: United States Graduation Date: 2012
Degree Earned: Doctor of Medicine or Specialty:
If teaching appointment: Department/Position:

Degree Level: Undergraduate
Institution: Tufts University Dates Attended:
Department: Registrars From: 08/2002
Street Address: 200 Boston Avenue To: 06/2006
City: Medford State/Province: MA Zip Code:
Country: United States Graduation Date: 2006
Degree Earned: Bachelor of Science or Specialty:
If teaching appointment: Department/Position:

SPECIALTY BOARD CERTIFICATIONS

If you are not Board certified by a Board recognized by the American Board of Medical Specialties, the American Osteopathic Association, the National Commission on Certification of Physician Assistants, the American Nurses' Credentialing Center, or the National Certification Commission, or accepted by examination in your specialty, please give a brief explanation on an attached sheet. Explain any gaps or delays in achieving Board certification by the recognized Board in your specialty area.

☑ Board or ☐ Specialty Board Name: Family Medicine
Date Certified: 06/19/2015 Date Last Recertified: Expiration Date: 12/31/2025 ☐ Lifetime
Certification Number: Accepted for Examination? ☐ Yes ☐ No
If not accepted, have you made application? ☐ Yes ☐ No ☐ N/A If no, provide an explanation:

MEDICAL MALPRACTICE INSURANCE

Do you have current medical malpractice insurance? ☑ Yes ☐ No

Please list medical malpractice insurance carriers for the past five (5) years. Attach a separate page if necessary.

Carrier: OHSU (Self-Insured) Limits: [redacted]
Department: 3181 Southwest Sam Jackson Park Road
Address: 3181 Southwest Sam Jackson Park Road ☐ Pending
City: Portland State/Province: Zip Code:
Country: United States
Dates Insured: From: 07/01/2015 To: 06/30/2016 Policy Number: [redacted]

Carrier: OHSU (Self-Insured) Limits: [redacted]
Department: 3181 Southwest Sam Jackson Park Road
Address: 3181 Southwest Sam Jackson Park Road ☐ Pending
City: Portland State/Province: Zip Code:
Country: United States
Dates Insured: From: 07/01/2014 To: 06/30/2015 Policy Number: [redacted]

Carrier: OHSU (Self-Insured) Limits: [redacted]
Department: 3181 Southwest Sam Jackson Park Road
Address: 3181 Southwest Sam Jackson Park Road ☐ Pending
City: Portland State/Province: Zip Code:
Country: United States
Dates Insured: From: 07/01/2013 To: 06/30/2014 Policy Number: [redacted]

Carrier: OHSU (Self-Insured) Limits: [redacted]
Department: 3181 Southwest Sam Jackson Park Road
Address: 3181 Southwest Sam Jackson Park Road ☐ Pending
City: Portland State/Province: Zip Code:
Country: United States
Dates Insured: From: 07/01/2012 To: 06/30/2014 Policy Number: [redacted]

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Physician (MD) Application

THE NEW MEXICO MEDICAL SOCIETY

PROFESSIONAL PRACTICE QUESTIONS 6418

Please answer all of the following Yes or No questions. If you answer YES to any question, you must give details including name, address, and telephone number of significant parties on a separate sheet of paper. You must respond to each question.

1	Has your professional liability coverage ever been terminated by action of the insurance company (except as a result of the company ceasing to offer insurance coverage to physicians or other practitioners)?	☐ Yes ☑ No
2	Have you ever been denied professional liability insurance coverage?	☐ Yes ☑ No
3	Has your professional liability carrier ever excluded any specific procedures from your coverage?	☐ Yes ☑ No
4	Have you ever been denied membership or renewal thereof, or been subject to disciplinary action in any professional organization?	☐ Yes ☑ No
5	Have you ever been excluded from or sanctioned by Medicare and/or Medicaid?	☐ Yes ☑ No
6	Have you ever been arrested? If so explain the circumstance, regardless of the outcome (i.e. expunged, dismissed, sealed, vacated).	☐ Yes ☑ No
7	Have you ever been named as a defendant in any criminal proceedings?	☐ Yes ☑ No
8	Have you ever been subject to investigation by a governmental entity or Board that either could have resulted, or did result, in licensure sanctions or other adverse actions, irrespective of the outcome?	☐ Yes ☑ No
9	Have you ever been named in any formal requests for corrective actions filed by any healthcare entity where you have had an appointment (a request which could result in either formal or informal proceedings)?	☐ Yes ☑ No
10a	Have your privileges at any healthcare entity ever been voluntarily or involuntarily suspended, restricted, diminished, revoked, surrendered, or not renewed, except for medical records delinquency?	☐ Yes ☑ No
10b	Have you ever agreed not to exercise your clinical privileges while under investigation?	☐ Yes ☑ No
11	Have you ever resigned from a healthcare entity to avoid modification, suspension, or termination of privileges, or while under investigation?	☐ Yes ☑ No
12a	Has your application for licensure or license to practice in any jurisdiction ever been investigated, voluntarily or involuntarily limited, suspended, revoked, surrendered or denied?	☐ Yes ☑ No
12b	Are any currently held licenses pending investigation or being challenged?	☐ Yes ☑ No
13	Have you ever been notified to appear before any licensing agency for a hearing or complaint of any nature?	☐ Yes ☑ No
14	Has your federal or state narcotics registration certificate in any jurisdiction ever been investigated, or voluntarily or involuntarily limited, suspended, revoked, or restricted?	☐ Yes ☑ No
15	Have you ever been involved in a settlement, medical malpractice claim or suit, or have you ever received written notice of intent to file such a suit? If yes, please provide the following information for each claim or suit. Please list on a separate sheet of paper for each case: Name, age, sex of patient/claimant, Date(s) and type of treatment and/or surgery that led to the allegations against you, Nature of allegations in claims/suits. Specify whether a suit was ever filed, Names of other practitioners and hospital, if any, involved in claims or suit, Disposition or current status of claim or suit (be specific), Name of insurance carrier defending you.	☐ Yes ☑ No
16	Have you ever been reported to the National Practitioner Data Bank?	☐ Yes ☑ No
17a	Are you now, or were you in the past, addicted to, abusive of, or in treatment for abuse of any controlled substances, habit-forming drugs, illegal drugs, prescription medication or alcohol?	[redacted]

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Physician (MD) Application

THE NEW MEXICO MEDICAL SOCIETY

17b	Are you being treated with opiates for chronic pain? If yes, please provide to the Board upon application a current evaluation from your treating pain provider (MD or DO)	[redacted]
18	In the five (5) years prior to this application, have you had any physical injury or disease, or mental illness or impairment, which you are currently under treatment for or could reasonably be expected to affect your on-going ability to practice medicine safely and competently? If yes, please have your treating physician send the NM Medical Board a letter regarding your diagnosis and treatment.	[redacted]
19a	Have you ever, for any reason, resigned from a medical school or postgraduate training (PGT) program?	☐ Yes ☑ No
19b	Have you ever, for any reason, withdrawn from a medical school or postgraduate training (PGT) program?	☐ Yes ☑ No
19c	Have you ever, for any reason, been suspended, dismissed, or expelled from a medical school or postgraduate training (PGT) program?	☐ Yes ☑ No
19d	Have you ever, for any reason, been placed on probation or remediation, including academic probation or remediation, by a medical school or postgraduate training (PGT) program?	☐ Yes ☑ No
19e	Have you ever, for any reason, taken a leave of absence or break from, or had any interruptions or extensions in, a medical school or postgraduate training (PGT) program for any personal or professional reason (including illness or disability, pregnancy or maternity, any academic issues, etc)?	☐ Yes ☑ No
20	I attest that I will limit my practice to areas in which I am competent to practice.	☑ Yes ☐ No
21	Are you currently in arrears for payments of amounts required to be paid pursuant to an outstanding judgment and order for child support in New Mexico or in any other state?	☐ Yes ☑ No

New Mexico Medical Board
2055 S. Pacheco St. Bldg. 400
Santa Fe, NM 87505 (505) 476-7220

APPLICANT'S OATH

I, Kira Paisley, **hereby certify that I am the person pictured below and named in this application for a license to practice as a Physician in the State of New Mexico; that all statements I have made herein are true; that I am the original and lawful possessor and person named in the various forms and credentials furnished to the New Mexico Medical Board (Board) with my application.**

I acknowledge and state that I have read the Information and Instructions that accompanied this application and I have answered all questions truthfully. I understand that the fee I submitted is not refundable.

I authorize and request every person, hospital, clinic, community, governmental agency, court, association, institution or other organization having 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 their 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, and their agents or representatives, and any person furnishing information, from any and all liability of every nature and kind arising out of the furnishing or inspection of such documents, records, other information, or the investigation made by the Board. I authorize the Board to release information, material, documents, orders, or the like relating to me or to this application to any other agency of the State of New Mexico or the appropriate licensing agency of any other state or Territory of the United States or any agency of the United States government.

Kira Paisley — Applicant Signature

6/9/2016 — Date

*Passport-quality color photograph taken within six months prior to filing the application, approximate size 2 x 2 inches, head and shoulders only, full face, front view, plain white or off-white background, standard photo stock paper, scanned or computer-generated photographs should have no visible pixels or dots.

Applicant Name Kira Paisley **Date** 6/9/2016

American Board of Family Medicine

hereby declares that

Kira Paisley, M.D.

is certified in Family Medicine
and issued this certificate as a

Diplomate

of the American Board of Family Medicine, Inc.
Ongoing certification is contingent upon meeting the requirements of
Maintenance of Certification for Family Physicians

AMA Physician Profile

PREPARED FOR

New Mexico Medical Board, Santa Fe, NM

Name and Mailing Address

[redacted]

Birth date [redacted]984

Primary Office Address

3181 SW SAM JACKSON PARK RD
PORTLAND, OR 97239-3011

Phone UNKNOWN

Physician's major professional activity HOSPITAL BASED RESIDENTS - ALL YEARS

AMA membership status NON MEMBER

All information from this point forward is provided by the primary source

Current and/or historical NPI information

National Provider Identifier (NPI)	Enumeration Date	Deactivation Date	Reactivation Date	Replacement Number	Last Reported Date
[redacted]	03/27/2012	NOT RPTD	NOT RPTD	NOT RPTD	05/31/2016

Current and/or historical medical school

OREGON HEALTH & SCIENCE UNIVERSITY SCHOOL OF MEDICINE

Degree Awarded: YES
Degree Year: 2012

Current and/or historical post graduate medical training programs accredited by the Accreditation Council for Graduate Medical Education (ACGME)

Beginning with the 2010 cycle of the National GME Census, post-graduate training segments will include the name of the program attended in addition to the sponsoring institution. Program-level information prior to 2010 will not be available for reporting. Future training dates, as reported by the program, should be interpreted as "in progress" or "current" with the projected date of completion.

Post-graduate training performed at accredited osteopathic institutions or in Canada are updated on the AMA Physician Masterfile only upon verification by the program. US licensing authorities accept graduate medical education from both entities as equivalent to training performed in a US program accredited by ACGME.

If a segment below is indicated as "being re-verified", it typically means that the physician is a current resident and the AMA is confirming with the residency program that the physician is still enrolled - this standard process occurs on an annual basis.

Sponsoring Institution:	OREGON HEALTH & SCIENCE UNIVERSITY HOSPITAL
Sponsoring State:	OREGON
Program name:	OREGON HEALTH & SCIENCE UNIVERSITY PROGRAM
Specialty:	FAMILY MEDICINE
Dates:	7/2012 - 6/2015 (Verified)

Specialty Board Certification

Specialty Board Certification(s) by one or more of the 24 boards recognized by the American Board of Medical Specialties (ABMS) and the American Medical Association (AMA) through the Liaison Committee on Specialty Boards, as reported by the ABMS:

The AMA Physician Profile has been designated by the ABMS as an Official ABMS Display Agent of Member Board Certification data. Therefore, the ABMS Board Certification information on the AMA Physician Profile is considered a designated equivalent source in regard to credentialing standards set forth by Joint Commission. The AMA is also an NCQA-approved source for verification of medical school, postgraduate medical training, ABMS Board certification, and Federal DEA registration.

Certifying board:	AMERICAN BOARD OF FAMILY MEDICINE
Certificate:	FAMILY MEDICINE
Certificate type:	GENERAL

Duration	Effective Date	Expiration Date	Reverification Date	Occurrence	Last Reported Date	Participation Status
MOC+	07/01/2015	n/a	02/15/2017	INITIAL	06/07/2016	

For certification dates, a default value of "01" appears in the day or month field if data were not provided to AMA. Please contact the appropriate specialty board directly for this information. (**) Indicates an expired certificate.

AMA
AMERICAN MEDICAL ASSOCIATION

+The above certifying board has implemented standards which specify that the board certification is contingent upon meeting ongoing requirements of Maintenance of Certification (MOC). Only certificates issued by a MOC participating board will reflect a reverification date.

Current and/or historical medical licensure

Jurisdiction	MD / DO	Date Granted	Expiration Date	Status	License Type	Last Reported
Oregon	MD	06/19/2015	12/31/2017	ACTIVE	UNLIMITED	05/12/2016
Oregon	MD	07/01/2014	07/31/2015	INACTIVE	RESIDENT	07/08/2015
Oregon	MD	07/01/2013	07/31/2014	INACTIVE	RESIDENT	07/22/2014
Oregon	MD	07/01/2012	07/31/2013	INACTIVE	RESIDENT	05/16/2013

Action Notifications

To date, there have been no actions reported to the AMA by any US state licensing agency.

To date, there have been no Medicare/Medicaid sanctions reported to the AMA by the Department of Health and Human Services.

To date, there have been no federal sanctions reported to the AMA by any branch of the US military, the Veteran's Administration or the US Department of Justice.

U.S. Drug Enforcement Administration (DEA)

DEA number	Schedule	Expiration Date	Last Reported Date	Address

None Reported

Only the last three characters of active DEA numbers are displayed

Many states require their own controlled substances registration/license. Please check with your state licensing authority for requirement information as the AMA does not maintain this information.

ECFMG Certfication

Applicant Number:

The Educational Commission for Foreign Medical Graduates (ECFMG) applicant identification number does not imply current ECFMG certification status. To verify ECFMG status, contact the ECFMG Certification Verification Service online at https://cvsonline2.ecfmg.org/

Profile Information

The content of the AMA Physician Profile is intended to assist with credentialing. An organization's appropriate use of the data contained in the AMA Physician Masterfile meets selected primary source verification requirements of the Joint Commission, the Accreditation Association for Ambulatory Health Care (AAAHC) and the American Accreditation Health Care Commission(AAHCC)/Utilization Review Accreditation Commission (URAC). The AMA Physician Masterfile is also an NCQA-approved source for verification of medical school, post-graduate medical training, ABMS Board Certification and federal DEA registration.

If any of the data in this Profile is believed to be incorrect, please log in to your account on our profiles website, go to the profile manager tab, find the provider for whom you think we have inaccurate information and click on the "Report" button in the "Report a Discrepancy" column. Enter any of the information that you feel needs to be researched. The AMA will contact the primary source of the data to determine which data is correct. We will notify you of the outcome of our research. If any changes are made to the profile we will update the link in profile manager for this provider so that you can access the new, updated information.

If you have any questions or need additional information about the AMA Physician Profile Service, please call (800) 665-2882.

PDC PHYSICIAN DATA CENTER

Federation of STATE MEDICAL BOARDS

PRACTITIONER PROFILE

Prepared for:	New Mexico Medical Board	As of Date:6/15/2016

PRACTITIONER INFORMATION

Name:	Kira Anne Paisley
Alternate Name(s):	Kira Paisley
DOB:	[redacted]1984
Medical School:	Oregon Health and Science University School of Medicine Portland, Oregon, UNITED STATES
Year of Grad:	2012
Degree Type:	MD

BOARD ACTIONS

To date, there have been no actions reported to the FSMB

LICENSE HISTORY

Jurisdiction	License Number	Issue Date	Expiration Date	Last Updated
OREGON	PG158169	7/1/2012	6/30/2013	6/15/2016
OREGON	PG163678	7/1/2013	7/31/2014	6/15/2016
OREGON	PG168705	7/1/2014	6/19/2015	6/15/2016
OREGON	MD173649	6/19/2015	12/31/2017	6/15/2016

PRACTITIONER PROFILE

Prepared for: New Mexico Medical Board As of Date:6/15/2016

Practitioner Name: Kira Anne Paisley

ABMS® CERTIFICATION HISTORY

Certifying Board: American Board of Family Medicine
Certificate: Family Practice
Certification Type: General
Certification Status: Certified
Meeting MOC Requirements: Yes

Status	Duration	Effective Date	Expiration Date	Reverification Date	Occurrence	Last Reported
Active	MOC	07/01/2015		02/15/2017	Initial	5/26/2016

The presence and display of ABMS certification data in no way constitutes any affiliation, association with or endorsement of any advertising, promotion or sponsorship by ABMS, its Member Boards and the Board Certified Physicians listed in this directory. ABMS disclaims any responsibility or affiliation for other data that is provided in the directory that is not ABMS sourced information.

Oregon

Kate Brown, Governor

Medical Board
1500 SW 1st Avenue, Ste 620
Portland, OR 97201-5847
(971) 673-2700
FAX (971) 673-2670
www.oregon.gov/OMB

June 13, 2016

New Mexico Medical Board
2055 S. Pacheco St., Bldg. 400
Santa Fe, NM 87505-0503

Fax

REPORT NAME:	**LICENSE VERIFICATION**
REPORT SUBJECT:	**Kira Anne Paisley, MD**
LICENSE #:	**MD173649**

The Oregon Medical Board is responding to your inquiry regarding verification of licensure for the above-referenced Licensee. Enclosed is a License Verification Report for this Licensee.

There are no Board Orders on file for this Licensee.

If you have any questions regarding this License Verification Report, please contact the Board at (971) 673-2700, or toll free in Oregon at (877) 254-6263.

Sincerely,

JerrellAnn Farmer
Public Information Specialist

Enclosure

License Verification Details

SUBJECT TO TERMS AND CONDITIONS
Information current as of: 06/13/2016
Session: 2016-06-13 04:14:21.557 | 172.21.5.181 /y1jql4s43aigamdqcquahl3a

This site is a primary source for verification of license credentials consistent with Joint Commission and NCQA standards.

Paisley, Kira Anne MD

Gender: Female
Year of Birth: 1984

Address Type	City	County	State	Phone
Practice	Portland	Multnomah	Oregon	503-494-8652

License

Number: MD173649
License Type: MD License
Originally Issued: 06/19/2015
Current Status: Active
Status Effective: 1/1/2016
Expires: 12/31/2017
Expedited
Endorsement: No
Basis: USMLE
Specialty : Family Medicine

Specialty is self-reported by the licensee. It does not necessarily indicate specialty board certification. Check directly with the Specialty Member Board for current certification status.

Other Licenses

License Number	Effective Date	Expiration Date	License Type
PG168705	07/01/2014	06/19/2015	MD Postgraduate License
PG163678	07/01/2013	07/31/2014	MD Postgraduate License
PG158169	07/01/2012	06/30/2013	MD Postgraduate License

Education

School Name	Location	Degree Date	Degree Earned
OREGON HLTH AND SCI UNIV SCH OF MED	PORTLAND, OREGON USA	06/04/2012	MD

Post-Graduate Training	School Name	Location	From	To	Specialty
Internship	Oregon Health & Science University Prog	Portland, OR United States	07/2012	06/2013	Family Medicine
Residency	Oregon Health & Science University Prog	Portland, OR United States	07/2013	06/2015	Family Medicine

The licensee may have completed additional education or training programs. Only those that have been verified with the primary source are shown.

Board Orders

Board Orders and Agreements are public records. Please note that Corrective Action Orders, Corrective Action Agreements, and Consent Agreements are not disciplinary and are removed from this website upon completion. Copies of any Orders or Agreements are available through a license verification request .

There are no current or prior Board orders or agreements on file for this licensee.

New Mexico Medical Board
2055 S. Pacheco St.
Building 400
Santa Fe, NM 87505
(505) 476-7220

N.M MEDICAL BOA

MEDICAL EDUCATION VERIFICATION

APPLICANT INSTRUCTIONS: Please complete the waiver for release of information and forward this form to your university/medical school(s) or university of graduation for verification.

Waiver for Release of Information

I authorize the medical school/university listed below to provide any and all information pertaining to my medical education at your institution.

Applicant's Signature: Kira Paisley Date of Birth [redacted] 1984

Print or Type Name: Kira Paisley Soc Sec # [redacted]4447

Other Name(s) _____

Name of Medical School: Oregon Health and Science University

Address: 3181 SW Sam Jackson Rd City Portland State OR Country USA

DEAN OR DESIGNATED OFFICIAL OF MEDICAL SCHOOL INSTRUCTIONS:

Please complete this form and forward it DIRECTLY to NMMB, 2055 S. Pacheco St., Bldg. 400, Santa Fe, NM 87505. Please include dean's letter (if available) and a **COPY OF THE OFFICIAL TRANSCRIPT** (which indicates courses taken, dates and hours of attendance, and scores, grades, or evaluations).

APPLICANT'S EDUCATIONAL DEGREE AND DATE AWARDED HISTORY
If name of institution was different from the above named institution when applicant attended, please enter name below:

_____

Enrollment and Participation: Our records indicate that

Paisley (Last Name) Kira (First Name) _____ (MI)

(type or print the applicant's name):

attended our medical school on the following dates (indicate the month, day and year in the section below):

ATTENDANCE DATES:	FROM	TO	FROM	TO
	8/28/08	6/19/09	6/6/11	6/4/12
	8/31/09	6/18/10	/ /	/ /
	6/2/10	5/27/11	/ /	/ /

The applicant attended 161 total weeks of continuing on-campus education, not less than 32 weeks in each academic year and:

Check One

X Was awarded a degree in Doctor of Medicine on 06/04/2012 (mm/dd/yr)

___ Was NOT awarded degree. Please explain reasons(s): _____

Unusual Circumstances: The following questions apply to unusual circumstances that occurred during any part of the applicant's medical education. ***All questions must be answered. If you answer "YES" to any of the questions below, please enclose an explanation.***

1. Did the applicant take any leaves of absence or breaks from his/her medical education? ___Yes X No
2. Was the applicant ever placed on probation? ___Yes X No
3. Was the applicant ever disciplined or under investigation? ___Yes X No
4. Were any negative reports ever filed by instructors regarding the applicant ? ___Yes X No

COMMENTS:_____

_____

_____

_____

AFFIX INSTITUTIONAL SEAL HERE

Signature: Bethany Kauba

Print Name: Bethany Kauba

Title: Admin Coordinator

Date: 6/13/16

International medical schools must attach a copy of the medical school diploma and a transcript or provide and explanation.

This form *will not be accepted* unless it is stamped with the institutional seal.
Thank you for helping us process this application for licensure.

SSN: *****4447 Student No: U00041482

Date Issued: 13-JUN-2016

Record of: KIRA PAISLEY

Course Level: Medical
Matriculated: Summer 2008

Degree Awarded : Doctor of Medicine 04-JUN-2012
Major : Medicine

SUBJ NO.	COURSE TITLE	CRED GRD	PTS R
INSTITUTION CREDIT:			
Academic Year 2008-2009			
MSCI 611	Gross Anat/Imag/Emb	12.00 H	36.00
MSCI 612	Cell Structure & Function	8.00 S	8.00
MSCI 711	Principles of Clinical Med I	4.00 IP	0.00
JCON 705G	The Healer's Art	1.00 P	0.00
MSCI 613	System Processes & Homeostasys	9.00 NH	18.00
MSCI 712	Principles of Clinical Med II	4.00 IP	0.00
MSCI 614	Biological Basis of Disease	9.00 S	9.00
MSCI 713	Principles of Clinical Med III	12.00 NH	24.00
	Total Earned Credits 51.00		
Academic Year 2009-2010			
FAMP 709G	SW Community Health Center	1.00 P	0.00
FAMP 705H	Labor & Delivery Skills	1.00 P	0.00
MSCI 622	Circulation	8.00 NH	16.00
MSCI 624A	Metabolism I	2.00 NH	4.00
MSCI 714	Principles of Clinical Med IV	4.00 IP	0.00
PHPM 705F	Medical Spanish - Adv Beginner	2.00 P	0.00
JCON 707B	Comm Health & Educ Exchange	2.00 P	0.00
MSCI 621	Neuroscience & Behavior	8.00 H	24.00
MSCI 624B	Metabolism II	3.00 NH	6.00
MSCI 715	Principles of Clinical Med V	4.00 IP	0.00
MSCI 623	Blood	4.00 H	12.00
MSCI 626	Human Development	6.00 S	6.00
MSCI 716	Principles of Clinical Med VI	12.00 H	36.00
	Total Earned Credits 49.00		
Academic Year 2010-2011			
JCON 717A	Transition to Clerkship	3.00 P	0.00
JCON 720	Pediatrics I	9.00 S	9.00
SURG 720	Surgery I	9.00 S	9.00
FAMP 720	Family Medicine	9.00 NH	18.00
PSYC 720	Psychiatry	9.00 H	27.00
IMED 720	Internal Medicine I	18.00 H	54.00

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

SUBJ NO.	COURSE TITLE	CRED GRD	PTS R
Institution Information continued:			
JCON 719	Continuity Curriculum/CPX	2.00 P	0.00
JCON 722	Primary Care	9.00 NH	18.00
OBGY 720	Obstetrics/Gynecology	9.00 NH	18.00
	Total Earned Credits 77.00		
Academic Year 2011-2012			
IMED 709A	Ward Subintern - OHSU	6.00 NH	12.00
OBGY 709C	ObGyn Community	6.00 NH	12.00
DERM 709A	Clinical Dermatology	6.00 NH	12.00
FAMP 709A	Family Practice	6.00 H	18.00
JCON 721	Pediatrics II	6.00 H	18.00
ETOX 709X	Toxicology Poisoning/Overdose	6.00 H	18.00
NEUR 721	Neurology	6.00 NH	12.00
GMED 709G	Palliative Care - Legacy	3.00 NH	6.00
JCON 709Z	International Medicine Extern	9.00 H	27.00
JCON 718	Transition to Residency	3.00 P	0.00
ORTH 709E	Rehabilitation Medicine	6.00 NH	12.00
	Total Earned Credits 63.00		

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

OREGON HEALTH & SCIENCE UNIVERSITY

OHSU

Mickie S. Bush
Registrar

RECEIVED
JUN 16 2016
MEDICAL BOARD

New Mexico Medical Board
2055 S. Pacheco St.
Building 400
Santa Fe, NM 87505
(505) 476-7220

POSTGRADUATE TRAINING VERIFICATION

I am applying for a license to practice medicine in New Mexico and the Medical Board requires this form to be completed by each hospital where I participated in an approved postgraduate training program in the United States or Canada. This is your authorization to release any information in your files of record, favorable or otherwise, DIRECTLY to the NMMB, 2055 S. Pacheco St., Bldg. 400, Santa Fe, NM 87505. Your prompt response will be appreciated.

Name: Kira Paisley M.D.

Kira Paisley 6/9/2016

Signature Date (Month/Day/Year)

(DO NOT DETACH)

This section to be completed by the office of the Administrator of the institution or program wherein the applicant satisfactorily completed (or will complete) an approved postgraduate training program in the United States or Canada.

This is to certify that Kira Paisley, M.D. undertook and satisfactorily completed a full term approved program of 36 (number) months in the Oregon Health & Science University (Full name and complete address of facility) in the field of Family Medicine from 7/1/2012 (Date. Mo/Day/Yr) to 6/30/2015 (Date/Anticipated Date).

1. Was this program approved for postgraduate training during that period by the Accreditation Council for Graduate Medical Education, or the Royal College of Physicians and Surgeons of Canada? ✓ Yes ___ No
2. Was applicant ever placed on probation, restricted, or limited? ___ Yes ✓ No If *yes*, please attach written explanation.
3. Was there any reason not to continue applicant in the training program? ___ Yes ✓ No If *yes*, please attach written explanation.
4. Did the applicant have any medical condition, which in any way impaired or limited his/her ability to safely practice any field of medicine? ___ Yes ✓ No If *yes*, please attach written explanation.

   Ability to practice medicine is to be construed to include all of the following:

   The cognitive capacity to make appropriate clinical diagnoses and exercise reasoned medical judgments and to learn and keep abreast of medical developments; and

   The ability to communicate those judgments and medical information to patients and health care providers, with or without the use of aids or devices, such as voice amplifiers; and

   The physical capability to perform medical tasks such as physical examination and surgical procedures, with or without the use of aids or devices, such as corrective lenses or hearing aids

   "Medical condition" includes physiological, mental or psychological conditions or disorders, such as, but not limited to orthopedic, visual speech, and hearing impairments, cerebral palsy, epilepsy, muscular dystrophy, multiple sclerosis, cancer, heart disease, diabetes, mental retardation, emotional or mental illness, specific learning disabilities, HIV disease, tuberculosis, drug addition and alcoholism.
5. Was the applicant ever diagnosed with or treated for bipolar disorder, schizophrenia, paranoia, or any psychotic disorder? ___ Yes ✓ No If *yes*, please attach written explanation.
6. Were applicant's final evaluations in every category rated satisfactory? ✓ Yes ___ No If *no*, please attach written explanation.

Signed before me, Heather Sturgill, by Roger D. Garvin, MD on 6/14/16

Roger Garvin MD — Roger D Garvin — 6/14/16
Printed name of person completing this form — Signature — Date

Please affix hospital or notary seal here

Heather Sturgill — State of Oregon, County of Multnomah — 6/14/16
Signature of Notary (if applicable) — Date

OFFICIAL STAMP
HEATHER JO YONEY STURGILL
NOTARY PUBLIC – OREGON
COMMISSION NO. 950827
MY COMMISSION EXPIRES MAY 30, 2020

My commission expires: May 30, 2020

If there is no hospital or notary seal, this form is unacceptable.
Please return this form directly to the address above
Thank you for your cooperation.

New Mexico Medical Board
2055 S. Pacheco St.
Building 400
Santa Fe, NM 87505
(505) 476-7220

RECEIVED
JUL 18 2016
NM MEDICAL BOARD

POSTGRADUATE TRAINING VERIFICATION

I am applying for a license to practice medicine in New Mexico and the Medical Board requires this form to be completed by each hospital where I participated in an approved postgraduate training program in the United States or Canada. This is your authorization to release any information in your files of record, favorable or otherwise, DIRECTLY to the NMMB, 2055 S. Pacheco St., Bldg. 400, Santa Fe, NM 87505. Your prompt response will be appreciated.

Name: Kira Paisley M.D.

Kira Paisley 7/7/2016
Signature Date (Month/Day/Year)

(DO NOT DETACH)

This section to be completed by the office of the Administrator of the institution or program wherein the applicant satisfactorily completed (or will complete) an approved postgraduate training program in the United States or Canada.

This is to certify that Kira Paisley, M.D. undertook and satisfactorily completed a full term approved program of 12 (number) months in the OHSU Family Medicine Fellowship, 31 SW Sam Jackson Park Rd Portland, OR 97239 (Full name and complete address of facility)

in the field of Family Medicine from 7/1/2015 (Date: Mo/Day/Yr) to 6/30/2016 (Date/Anticipated Date).

1. Was this program approved for postgraduate training during that period by the Accreditation Council for Graduate Medical Education, or the Royal College of Physicians and Surgeons of Canada? ✓ Yes ___ No
2. Was applicant ever placed on probation, restricted, or limited? ___ Yes ✓ No If yes, please attach written explanation.
3. Was there any reason not to continue applicant in the training program? ___ Yes ✓ No If yes, please attach written explanation.
4. Did the applicant have any medical condition, which in any way impaired or limited his/her ability to safely practice any field of medicine? ___ Yes ✓ No If yes, please attach written explanation.

   Ability to practice medicine is to be construed to include all of the following:

   The cognitive capacity to make appropriate clinical diagnoses and exercise reasoned medical judgments and to learn and keep abreast of medical developments; and

   The ability to communicate those judgments and medical information to patients and health care providers, with or without the use of aids or devices, such as voice amplifiers; and

   The physical capability to perform medical tasks such as physical examination and surgical procedures, with or without the use of aids or devices, such as corrective lenses or hearing aids

   "Medical condition" includes physiological, mental or psychological conditions or disorders, such as, but not limited to orthopedic, visual speech, and hearing impairments, cerebral palsy, epilepsy, muscular dystrophy, multiple sclerosis, cancer, heart disease, diabetes, mental retardation, emotional or mental illness, specific learning disabilities, HIV disease, tuberculosis, drug addition and alcoholism.

5. Was the applicant ever diagnosed with or treated for bipolar disorder, schizophrenia, paranoia, or any psychotic disorder? ___ Yes ✓ No If yes, please attach written explanation.
6. Were applicant's final evaluations in every category rated satisfactory? ___ Yes ___ No If no, please attach written explanation.

Roger Garvin, M.D. Roger E Garvin 7/11/16
Printed name of person completing this form Signature Date

Please affix hospital or notary seal here

OREGON HEALTH & SCIENCE UNIVERSITY

Signature of Notary (if applicable) Date

My commission expires: ___

If there is no hospital or notary seal, this form is unacceptable.
Please return this form directly to the address above

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 76039-3855 --Telephone (817)868-4000

Recipient: NEW MEXICO MEDICAL BOARD

Date: 06/13/2016

Examinee: Paisley, Kira Anne

Examinee ID: 52491412

Alt Name(s): Paisley, Kira

Date of Birth: [redacted]84

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, the recommended minimum passing score ("MP") is shown in parentheses. Pass/fail outcomes are based upon the minimum passing level in place at the time of test administration and are not altered by subsequent revisions to the minimum passing level. Effective April 1, 2013, test results are reported on a three-digit scale only; two-digit scores reported for prior administrations will no longer be reported. Test results reported as passing represent an exam score of 75 or higher on a two-digit scoring scale.

USMLE STEP 1

Test Date	Pass/Fail	Total	MP	Comments
6/15/2010	Pass	223	(188)	

USMLE STEP 2

Clinical Knowledge (CK)

Test Date	Pass/Fail	Total	MP	Comments
8/16/2011	Pass	227	(189)	

Clinical Skills (CS)*

Test Date	Pass/Fail	Total	MP	Comments
8/25/2011	Pass			

USMLE STEP 3

Test Date	Pass/Fail	Total	MP	Comments
9/15/2013	Pass	224	(190)	

NOTE A search of the Physician Data Center of the Federation of State Medical Boards (FSMB) reveals no reported information on this examinee.

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 76039-3855 --Telephone (817)868-4000

Examinee: Paisley, Kira Anne

Examinee ID: 52491412

Date of Birth: [redacted]984

INTERPRETATION OF RESULTS
USMLE transcripts include a complete examination history. On those Step examinations for which numeric scores are reported, a three-digit scale is used. Most scores fall between 140 and 260 on this scale. The recommended minimum passing score is shown on the front of the transcript next to the examinee's score for each administration along with a pass/fail outcome. Test results reported as passing represent an exam score of 75 or higher on a two-digit scoring scale. The level of proficiency required to meet the recommended minimum passing level for each USMLE Step is reviewed periodically and is subject to change. Such changes do not alter pass/fail outcomes from prior test administrations.

For examinations with reported scores, the Standard Error of Measurement (SEM) provides an index of the variation that would be expected to occur if an examinee were tested repeatedly using different sets of items covering similar content. The SEM is usually in the range of 4 to 8 points.

STEP 2 CLINICAL SKILLS (CS)
Step 2 CS results are reported as pass or fail, with no numeric score. Had the two-digit reporting scale been used, examinees would have had to achieve a score of 75 or higher in order to pass.

ANNOTATIONS APPEARING UNDER "COMMENTS"
Circumstances in connection with an administration shown on this transcript may result in one or more annotations listed next to the score. A description of each Comment is provided below:

Indeterminate - Results are at or above the passing level but cannot be certified as representing a valid measure of the examinee's knowledge or competence as sampled by the examination. No score is reported. Information regarding the nature of the indeterminate score is available. If such information is not enclosed with this transcript, it may be obtained by contacting the organization from which you received the transcript or the USMLE Secretariat, 3750 Market Street, Philadelphia, PA 19104, telephone (215) 590-9700.

Incomplete - The examinee sat for some, but not all, of the scheduled examination. No score is reported.

Irregular Behavior - The Committee for Individualized Review determined that the examinee engaged in irregular behavior. Examples of irregular behavior are described in the current edition of the USMLE Bulletin of Information. Information regarding the nature of the irregular behavior and the determination of the Committee is available. If such information is not enclosed with this transcript, it may be obtained by contacting the organization from which you received the transcript or the USMLE Secretariat, 3750 Market Street, Philadelphia, PA 19104, telephone (215) 590-9700.

Score Not Available - The score is not available. Further review and/or analysis may be pending, or it may have been determined that the score cannot be reported.

ANNOTATIONS APPEARING AS "NOTE"
Circumstances not in connection with an administration shown on this transcript may result in one or more annotations and an explanation or instructions to contact the appropriate individual or organization. The Note will appear at the end of the document.

PHYSICIAN DATA CENTER INFORMATION APPEARING AS "NOTE"
The Physician Data Center of the Federation of State Medical Boards (FSMB) contains actions reported to the FSMB by U.S. licensing and disciplinary boards, the U.S. Department of Health and Human Services, government regulatory entities and international licensing authorities. To be included in the Physician Data Center, an action must be a matter of public record or be legally releasable to state medical boards or other entities with recognized authority to review physician credentials. Certain actions reported to and released by the Physician Data Center are not disciplinary or otherwise prejudicial in nature. Such actions are reported to ensure that records are complete and to assist in preventing misrepresentation or the use of lost or stolen credentials by unauthorized persons. Once reported to the FSMB, an action becomes part of the permanent record of the individual physician, and the existence of such an action may be indicated on the USMLE transcript by a Note.

03/2015

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

10/23/2017

Paisley, Kira **Medical Doctor** **MD2016-0619**

1. Since your last renewal has your professional liability coverage been terminated by action of the insurance company except as a result of the company ceasing to offer insurance to physicians?	N	06/06/2017
2. Since your last renewal have you been denied professional liability insurance coverage?	N	06/06/2017
3. Since your last renewal has your professional liability carrier excluded any specific procedures from your coverage?	N	06/06/2017
4. Since your last renewal have you been denied membership or renewal thereof, or been subject to disciplinary action in any professional organization?	N	06/06/2017
5. Since your last renewal have you been excluded from or sanctioned by Medicare and/or Medicaid?	N	06/06/2017
6. Since your last renewal, have you been arrested? If so explain the circumstance, regardless of the outcome (i.e. expunged, dismissed, sealed, vacated).	N	06/06/2017
7. Since your last renewal, have you been named as a defendant in any criminal proceedings?	N	06/06/2017
8. Since your last renewal, have you been subject to investigation by a governmental entity or Board that either could have resulted or did result in licensure sanction or other adverse actions, irrespective of the outcome?	N	06/06/2017
9. Since your last renewal have you been named in any formal requests for corrective actions filed by any healthcare entity where you have had an appointment (a request which could result in either formal or informal proceedings).	N	06/06/2017
10. a. Since your last renewal have your privileges at any healthcare entity been voluntarily or involuntarily suspended, restricted, diminished, revoked, surrendered, or not renewed, for any reason, except for medical records delinquency unrelated to your professional	N	06/06/2017
10. b. Since your last renewal have you agreed not to exercise your clinical privileges while under investigation?	N	06/06/2017
10. c. Since you last renewal, have you been investigated and/or terminated by a healthcare entity for cause, or without cause, related to your clinical competence or conduct, which could impact patient safety/care, or allowed to resign in lieu of termination for such reason?	N	06/06/2017
11. Since your last renewal have you resigned from a healthcare entity to avoid modification, suspension, or termination of privileges, or while under investigation?	N	06/06/2017
12. a. Since your last renewal has your application for licensure or license to practice in any jurisdiction been investigated, voluntarily or involuntarily limited, suspended, revoked, surrendered or denied?	N	06/06/2017
12. b. Are any currently held licenses pending investigation or being challenged?	N	06/06/2017
13. Since your last renewal have you been notified to appear before any licensing agency for a hearing or complaint of any nature?	N	06/06/2017
14. Since your last renewal has your federal or state narcotics registration certificate in any jurisdiction ever been investigated, voluntarily or involuntarily limited, suspended, revoked, or restricted?	N	06/06/2017
15. Since your last renewal have you been involved in a settlement, medical malpractice claim or suit, or have you ever received written notice of intent to file such a suit? If yes, please provide the following information for each claim or suit. Please type on a separate sheet	N	06/06/2017
16. Since your last renewal have you been reported to the National Practitioner Data Bank?	N	06/06/2017
17. Are you now, or were you in the past, addicted to, abusive of, or in treatment for abuse of any controlled substances, habit-forming drugs, illegal drugs, prescription medication or alcohol?	[redacted]	06/06/2017
18. In the five (5) years prior to this application, have you had any physical injury or disease, or mental illness or impairment, which you are currently under treatment for or could reasonably be expected to affect your on-going ability to practice medicine safely and	[redacted]	06/06/2017
19. I certify that I have completed a minimum of 75 AMA Category I hours of Continuing Medical Education as required by 16.10.4 NMAC	Y	06/06/2017
19a. I certify that 5 hours of the required 75 hours of CME are in Pain Management, as required by 16.10.14. 11 NMAC OR I certify that I do NOT hold a NM Controlled Substance Registration.	Y	06/06/2017
20. I attest that I will limit my practice to areas in which I am competent to practice.	Y	06/06/2017
21. Are you currently in arrears in payments of amounts required to be paid pursuant to an outstanding judgement and order for child support in New Mexico or in any other state?	N	06/06/2017

Paisley, Kira **Medical Doctor** **MD2016-0619**

1. Since your last renewal has your professional liability coverage been terminated by action of the insurance company except as a result of the company ceasing to offer insurance to physicians ?	N	05/04/2020
2. Since your last renewal have you been denied professional liability insurance coverage?	N	05/04/2020
3. Since your last renewal has your professional liability carrier excluded any specific procedures from your coverage?	N	05/04/2020
4. Since your last renewal have you been denied membership or renewal thereof, or been subject to disciplinary action in any professional organization?	N	05/04/2020
5. Since your last renewal have you been excluded from or sanctioned by Medicare and/or Medicaid?	N	05/04/2020
6. Since your last renewal, have you been arrested? If so explain the circumstance, regardless of the outcome (i.e. expunged, dismissed, sealed, vacated).	N	05/04/2020
7. Since your last renewal, have you been named as a defendant in any criminal proceedings?	N	05/04/2020
8. Since your last renewal, have you been subject to investigation by a governmental entity or Board that either could have resulted or did result in licensure sanction or other adverse actions, irrespective of the outcome?	N	05/04/2020
9. Since your last renewal have you been named in any formal requests for corrective actions filed by any healthcare entity where you have had an appointment (a request which could result in either formal or informal proceedings).	N	05/04/2020
10. a. Since your last renewal have your privileges at any healthcare entity been voluntarily or involuntarily suspended, restricted, diminished, revoked, surrendered, or not renewed, for any reason, except for medical records delinquency unrelated to your professional	N	05/04/2020
10. b. Since your last renewal have you agreed not to exercise your clinical privileges while under investigation?	N	05/04/2020
10. c. Since you last renewal, have you been investigated and/or terminated by a healthcare entity for cause, or without cause, related to your clinical competence or conduct, which could impact patient safety/care, or allowed to resign in lieu of termination for such reason?	N	05/04/2020
11. Since your last renewal have you resigned from a healthcare entity to avoid modification, suspension, or termination of privileges, or while under investigation?	N	05/04/2020
12. a. Since your last renewal has your application for licensure or license to practice in any jurisdiction been investigated, voluntarily or involuntarily limited, suspended, revoked, surrendered or denied?	N	05/04/2020
12. b. Are any currently held licenses pending investigation or being challenged?	N	05/04/2020
13. Since your last renewal have you been notified to appear before any licensing agency for a hearing or complaint of any nature?	N	05/04/2020

9/24/2020

14. Since your last renewal has your federal or state narcotics registration certificate in any jurisdiction ever been investigated, voluntarily or involuntarily limited, suspended, revoked, or restricted?	N	05/04/2020
	N	05/04/2020

15. Since your last renewal have you been involved in a settlement, medical malpractice claim or suit, or have you ever received written notice of intent to file such a suit? If yes, please provide the following information for each claim or suit. Please type on a separate sheet

16. Since your last renewal have you been reported to the National Practitioner Data Bank?	N	05/04/2020
	[redacted]	05/04/2020

17. Are you now, or were you in the past, addicted to, abusive of, or in treatment for abuse of any controlled substances, habit-forming drugs, illegal drugs, prescription medication or alcohol?

	[redacted]	05/04/2020
18. Since your last renewal have you been diagnosed with an illness or condition which impairs your judgment or affects your ongoing ability to practice medicine in a competent, ethical and professional manner? <b>If yes, please have your treating physician send the NM		
	Y	05/04/2020

19. I certify that I have completed a minimum of 75 AMA Category I hours of Continuing Medical Education as required by 16.10.4 NMAC

	Y	05/04/2020
19a. I certify that 5 hours of the required 75 hours of CME are in Pain Management, as required by 16.10.14. 11 NMAC OR I certify that I do NOT hold a NM Controlled Substance Registration.		
	Y	05/04/2020

20. I attest that I will limit my practice to areas in which I am competent to practice.

	N	05/04/2020
21. Are you currently in arrears in payments of amounts required to be paid pursuant to an outstanding judgement and order for child support in New Mexico or in any other state?		