HSC

The New Mexico Physician and Practitioner Credentials Application ©

Physician Application

THE NEW MEXICO MEDICAL SOCIETY

Applying for Telemedicine Licensure? ☐ Applying for first ever Full Physician License in any state? ☐

****ALL FEES ARE NON-REFUNDABLE****

If this application is incomplete upon one (1) year of receipt, the application and supporting documentation will become dormant, and application will become null and void.

Date of Application: 1/28/2022 Application Fee: $400.00

PayPal Confirmation: AJ0A4CA6DB44 TOTAL: $400.00

Name: Stephanie Mischell

Title: MD Other: Maiden or Other Names Used

CC 5351 #4C
R# 244540

Applying using: ☑ NMMB ☐ HSC ☐ FCVS

What are your NM practice plans? I have employment at an independent clinic in Albuquerque. I plan to split my time between TX and NM providing care.

EXAM

Gender: Female Citizenship: United States Place of Birth:

Social Security Number: [redacted] Date of Birth: [redacted]990

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

Medicare#: ☐ Pending Medicaid #: ☐ Pending

Unique Physician Identification Number (UPIN): ☐ Pending

National Provider Identifier Number (NPI): 1104350412 ☐ Pending

Home Address

Street Address: [redacted]

City, State/Province and Zipcode: Dallas, TX, 75206

Country: United States

Telephone Number: [redacted] Pager Number:

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

Credentials Correspondence Address

Department:

Street Address: 6119 Greenville Ave, #169, #169 #169

City, State/Province and Zipcode: Dallas, TX, 75206

Country: United States Email: stmischell@gmail.com

Telephone Number: 609-240-7297 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): English

Certifications

ACLS CERTIFICATION			ATLS CERTIFICATION			PALS CERTIFICATION		
Certified?	☐ Yes	☑ No	Certified?	☐ Yes	☑ No	Certified?	☐ Yes	☑ No
Expires:			Expires:			Expires:		

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.

I have an agreement with Allison Gilbert, MD of Southwestern Women's Surgery Center, detailed in the attached letter.

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 source of verification. Attach a separate page if necessary.

No affiliation information provided

Facility Name: ☐ Is this your primary admitting facility
Department:
Street Address:
City: State/Province: Zip Code:
Country:
Phone Number: Facsimile:
Appointment Dates From: To: ☐ Present
Type of Appointment: 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: Southwestern Women's Surgery Center From: 08/2021 To: ☑ Present
Department:
Street Address: 8616 Greenville Ave
City: Dallas State/Province: TX Zip Code: 75206
Country: United States Phone Number:

Contact:
Fax Number:
Type of Practice: Active

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

Organization: Rutgers Robert Wood Johnson Medical School From: 07/2020 To: 06/2021 ☐ Present
Department: Family and Community Medicine
Street Address: 317 George St
City: New Brunswick State/Province: NJ Zip Code: 08901
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: Montefiore Medical Center From: 07/2017 To: 06/2020 ☐ Present
Department:
Street Address: 111 East 210th St
City: Bronx State/Province: NY Zip Code: 10467
Country: United States Phone Number:
Contact: Fax Number: 718-920-8375
Type of Practice: Resident Physician

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

Work history gap explanations follow:

From: 8/1/2013 To: 6/1/2017 Explanation: Medical School at Rutgers Robert Wood Johnson Medical School
From: 7/1/2012 To: 7/1/2013 Explanation: Year of Service at La Clinica del Pueblo in Washington, DC
From: 8/1/2008 To: 5/1/2012 Explanation: Undergraduate College at Vassar College

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PRACTICE LOCATIONS

Group Name: Southwestern Women's Surgery Center Effective Date: 8/2021
Department:
Street Address: 8616 Greenville Ave Ste 101
City: Dallas State/Province: TX Zip Code: 75206
Country: United States
Phone Number: 121-474-2931 Facsimile Number: 214-969-9468
Email Address: Answering Service Number:
Foreign Languages (spoken fluently at practice):

Office Manager or Contact Person: Phone:

Billing Address

Billing Information same as practice information

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 attach documentation of all continuing education hours you have obtained in the last two(2) years or complete the attached statement of continuing medical education.

2. If you are applying for privileges at a hospital or clinic, please complete the enclosed 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: Allison Gilbert MD Specialty: OB/GYN
Department: Southwestern Women's Surgery Center
Street Address: 8616 Greenville Ave Ste 101
City: Dallas State/Province: TX Zip Code: 75206
Country: United States Email: agilbert@southwesternwomens.com
Phone Number: 121-474-2931 Facsimile Number:

Name and Title: Anna Sliwowska MD Specialty: Family Medicine
Department:
Street Address: 317 George Street, Suite 100
City: New Brunswick State/Province: NJ Zip Code: 08901
Country: United States Email: anna.sliwowska@rwjms.rutgers.edu
Phone Number: 908-265-8953 Facsimile Number:

Name and Title: Cresandra Corbin MD | Specialty: Family Medicine
Department:
Street Address: 832 Brunswick Avenue
City: Trenton | State/Province: NJ | Zip Code: 08638
Country: United States | Email: ccorbin@capitalhealth.org
Phone Number: 516-581-1998 | Facsimile Number:

Name and Title: Jeffrey Levine MD | Specialty: Family Medicine
Department:
Street Address: 317 George Street, Suite 100
City: New Brunswick | State/Province: NJ | Zip Code: 08901
Country: United States | Email: levinejp@rwjms.rutgers.edu
Phone Number: 732-235-8993 | Facsimile Number:

Name and Title: Jennifer Amico MD | Specialty: Family Medicine
Department:
Street Address: 317 George Street, Suite 100
City: New Brunswick | State/Province: NJ | Zip Code: 08901
Country: United States | Email: amicojr@rwjms.rutgers.edu
Phone Number: 201-889-3357 | Facsimile Number:

LICENSURE REGISTRATION INFORMATION

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

State Professional License/Certification Number: T2684 | ☐ Pending
State: Texas | Issue Date: 8/31/2021 | Expiration Date: 8/31/2022

LICENSING EXAM

Please check all that apply:

☐ State Board Exam (Prior to 1973) | Which State? | Date(s) passed?

☐ FLEX

Part/Step 1 Date Passed | Part/Step 2 Date Passed | Part/Step 3 Date Passed

☐ LMCC

Part/Step 1 Date Passed | Part/Step 2 Date Passed | Part/Step 3 Date Passed

☐ NBME (MD Only):

Part/Step 1 Date Passed | Part/Step 2 Date Passed | Part/Step 3 Date Passed

☐ NBOE (DO Only):

	Part/Step 1 Date Passed		Part/Step 2 Date Passed		Part/Step 3 Date Passed
☐	COMPLEX (DO Only):				
	Part/Step 1 Date Passed		Part/Step 2 Date Passed		Part/Step 3 Date Passed
☑	USMLE				
	Part/Step 1 Date Passed	6/15/2015	Part/Step 2 Date Passed	8/14/2016	Part/Step 3 Date Passed 11/15/2019

DRUG CERTIFICATION INFORMATION

Federal Drug Enforcement Administration (DEA) Registration: ☐ N/A

DEA Number: [redacted]3 Expiration Date: 1/31/2024 ☐ Pending

State Controlled Substance Registration (CSR): ☑ N/A

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: Rutgers Robert Wood Johnson Medical School — Dates Attended:

Department: Family and Community Medicine — From: 7/2020

Street Address: 317 George St — To: 6/2021

City: New Brunswick State/Province: NJ Zip Code: 08901

Country: United States Graduation Date: 2021

Degree Earned: FEL - Fellowship or Specialty: Family Medicine

If teaching appointment: Department/Position

Degree Level: Residency

Institution: Montefiore Medical Center — Dates Attended:

Department: Medical Staff Office — From: 7/2017

Street Address: 111 E 210th St — To: 6/2020

City: Bronx State/Province: NY Zip Code: 10467-2490

Country: United States Graduation Date: 2020

Degree Earned: RES - Residency or Specialty: Family Medicine

If teaching appointment: Department/Position

Degree Level: Undergraduate
Institution: Rutgers Robert Wood Johnson Medical School — Dates Attended:
Department: Family and Community Medicine — From: 8/2013
Street Address: 317 George St — To: 6/2017
City: New Brunswick — State/Province: NJ — Zip Code: 08901
Country: United States — Graduation Date: 2017
Degree Earned: MD - Doctor of Medicine — or Specialty: Medicine
If teaching appointment: Department/Position

SPECIALTY BOARD CERTIFICATIONS

NOTE: If you are not board certified by the American Board of Medical Specialties or the American Osteopathic Association, or accepted for examination in your specialty, please give brief explanation on the attached sheet.

☐ Board or ☑ Specialty Specialty: Family Practice
Certification Number: Accepted for Examination? ☑ Yes ☐ No
If not accepted, have you made application? ☐ Yes ☑ No ☐ N/A If no, provide an explanation: Application submitted and pending

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: General Star Indemnity — Limits: ,
Department:
Street Address: 2600 Eastpoint Pkwy — ☐ Pending
City, State/Province and Zipcode: Lousiville, KY, 40253
Country: United States
Dates Insured: From: 08/02/2021 To: 10/21/2022 Policy Number:

Carrier: Rutgers Professional Liability Program of Self-Insurance — Limits: ,
Department:
Street Address: 30 Bergen St — ☐ Pending
City, State/Province and Zipcode: Newark, NJ, 07107
Country: United States
Dates Insured: From: 07/01/2020 To: 06/30/2021 Policy Number:

PROFESSIONAL PRACTICE QUESTIONS

Read carefully before answering questions.

A. You must answer all questions. You must provide explanatory information –

- for any "yes" answer to questions numbered 1-18 and
- for any "no" answer to questions numbered 19-23.

Your failure to provide full and accurate details for any or all of those answers may result in disciplinary action or denial of your application. If in doubt, disclose.

B. The Board expects full and accurate disclosure of all information. You must update any information that changes while your application is pending.

C. The term "you" means you personally and any healthcare entity for which you serve as a business owner, officer or medical director.

Licensing & Professional Membership		
1.a. *Regardless of the outcome,* have you been subject to investigation by a licensing board or other government entity that resulted or could have resulted in any type of sanction (e.g., fine, reprimand, suspension, revocation, limitation, probation)?	☐ Yes	☑ No
1.b. Is any license you now hold under investigation or being challenged?	☐ Yes	☑ No
2. Have you ever been denied membership or renewal, or been subject to investigation or discipline, by a professional organization?	☐ Yes	☑ No
3. Has a federal or state controlled substance registration issued to you ever been voluntarily or involuntarily restricted, limited, suspended, or revoked?	☐ Yes	☑ No
Education		
4. Have you, for any reason, ever		
4.a. been suspended, dismissed, terminated, resigned or withdrawn from a medical school or postgraduate training (PGT) program?	☐ Yes	☑ No
4.b. been placed on probation or remediation by a medical school or PGT program?	☐ Yes	☑ No
4.c. taken a leave of absence or break from, had any interruption to, or any extension of a medical school or PGT program (reasons might include illness, disability, pregnancy or parental leave, academics, military service)?	☐ Yes	☑ No
Privileges/Appointments		
5.a. For any reason, have your privileges at any healthcare entity ever been subject to investigation, which resulted in a voluntary or involuntary restriction, reduction, suspension, surrender, revocation or non-renewal of your privileges?	☐ Yes	☑ No
5.b. Have you ever agreed to limit or not to exercise your clinical privileges while under investigation?	☐ Yes	☑ No
6. Have you ever been disciplined or suspended by any healthcare entity with which you have been employed, or resigned in lieu of investigation or other action?	☐ Yes	☑ No
7. Have you ever been subject to a request for corrective action by a healthcare entity where you held appointment as a member of the medical staff?	☐ Yes	☑ No
Insurance/Health Care Plans		
8. Has any private or government health plan or network, e.g., a private healthcare insurance provider, Medicare, Medicaid, ever limited, sanctioned or terminated you as a provider?	☐ Yes	☑ No
Liability		
9. 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 to physicians?	☐ Yes	☑ No
10. Have you ever been denied professional liability insurance coverage?	☐ Yes	☑ No
11. Has your professional liability insurance carrier ever excluded any procedures from your coverage?	☐ Yes	☑ No

12. Within the past ten (10) years, have you ever been involved in a public or private settlement, or a medical malpractice claim or suit, or been notified in writing of the intent to file a malpractice suit? **If yes, please complete the attached Malpractice History Form for each case.**	☐ Yes	☑ No
13. Have you ever been reported to the National Practitioner Data Bank (NPDB)?	☐ Yes	☑ No
Ethics/Impairment		
14. Regardless of the outcome and the status of the proceeding, have you ever been arrested or named as a defendant in any criminal action, e.g., convicted, acquitted, dismissed, vacated, sealed, expunged, appealed?	☐ Yes	☑ No
15.aDuring the past five (5) years, have you engaged in any behavior(s) or used any substance(s) (e.g., alcohol, street drugs, prescription medications) in a manner characteristic of an addiction disorder?	[redacted]	
15.bAre you now engaging in any behavior(s) or using any substance(s) (e.g., alcohol, street drugs, prescription medications) in a manner characteristic of an addiction disorder?	[redacted]	
15.cHave you been diagnosed with or treated for an addiction disorder at any time during the past five years (including the present)?	[redacted]	
16. Are you now, being treated with any opioid analgesic(s) for chronic pain? If yes, please provide a current neuropsychological evaluation and written clearance to practice from your treating physician. See Rule 16.10.14.10.	[redacted]	
17. Do you have, or 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? **If yes, please have your treating physician send the NM Medical Board a letter regarding your diagnosis, treatment, and current status.**	[redacted]	
18. Are you currently out of compliance with a judgment and order for child support in New Mexico?	☐ Yes	☑ No
Attestations		
19. I attest I will limit my practice to areas in which I am competent to practice.	☑ Yes	☐ No
20. I attest I understand I have a continuing duty to report any adverse action taken against me or my license as required by Board Rule Part 16.10.10 NMAC.	☑ Yes	☐ No
21. I attest I have reviewed the completed form and the information it contains is complete and accurate.	☑ Yes	☐ No
22. I attest I have provided a reliable and reasonable address for correspondence to be sent to me by the Board and will notify the Board of any address changes.	☑ Yes	☐ No
23. I attest I will adhere to AMA's ethical standards and the principles of professionalism, honesty and respect for the law at all times.	☑ Yes	☐ No

If you answered "YES" to questions 1-18, and/or "NO" to questions 19-23, please provide a detailed written explanation for each of those answers with this application.

PDC PHYSICIAN DATA CENTER

fsmb

PRACTITIONER PROFILE

Prepared for:	New Mexico Medical Board	As of Date:2/11/2022

PRACTITIONER INFORMATION

Name:	Mischell, Stephanie Grace
DOB:	[redacted]990
Medical School:	Rutgers R W Johnson Piscataway Piscataway, New Jersey, UNITED STATES
Year of Grad:	2017
Degree Type:	MD
NPI:	1104350412

BOARD ACTIONS

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

NATIONAL PROVIDER IDENTIFIER (NPI)

NPI	NPI Type	Deactivation Date	Reactivation Date	Last Reported
1104350412	Individual			02/10/2022

LICENSE HISTORY

Jurisdiction	License Number	Issue Date	Expiration Date	Last Updated
TEXAS	BP10069621	01/13/2020	02/10/2020	02/01/2022
	FSMB License Status: Terminated			
TEXAS	BP20073595	02/01/2021	06/30/2021	02/01/2022
	FSMB License Status: Terminated			
TEXAS	T2684	07/23/2021	08/31/2022	02/01/2022
	FSMB License Status: Active			

ACTIVE US DRUG ENFORCEMENT ADMINISTRATION (DEA)

PDC PHYSICIAN DATA CENTER

fsmb

PRACTITIONER PROFILE

Prepared for:	New Mexico Medical Board	As of Date:2/11/2022
Practitioner Name:	Mischell, Stephanie Grace	

DEA Number	Schedule	Address	Expiration Date	Last Reported
[redacted]3	22N 33N 4 5	DALLAS,TX 75243	01/31/2024	01/05/2022

400 FULLER WISER ROAD EULESS, TX 76039 | TEL(817)868 4000 | FAX (817)868 4099

PDC PHYSICIAN DATA CENTER

fsmb

PRACTITIONER PROFILE

Prepared for:	New Mexico Medical Board	As of Date:2/11/2022
Practitioner Name:	Mischell, Stephanie Grace	

ABMS® CERTIFICATION HISTORY

No ABMS Certifications found.

AOA® CERTIFICATION HISTORY

No AOA Certifications found.

400 FULLER WISER ROAD EULESS, TX 76039 | TEL(817)868 4000 | FAX (817)868 4099

AMA Physician Profile

PREPARED FOR

New Mexico Medical Board, Santa Fe, NM

Name and Mailing Address

STEPHANIE GRACE MISCHELL
MONTEFIORE MED CTR
DEPT OF FAMILY MED
3544 JEROME AVE
BRONX, NY 10467-1005

Primary Office Address

SAME AS MAILING ADDRESS

Phone UNKNOWN

Birth date [redacted]1990

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

Self-designated practice specialty FAMILY MEDICINE (primary)
UNSPECIFIED (secondary)

Self-designated practice specialties (SDPS) listed on the AMA Physician Profile do not imply recognition or endorsement of any field of medical practice by the Association nor does it imply verification by a member board of the American Board of Medical Specialties (ABMS) or that the physician has been trained or has special competence to practice the SDPS.

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
None Reported					

Current and/or historical medical school

RUTGERS ROBERT WOOD JOHNSON MEDICAL SCHOOL

Degree Awarded: YES

Degree Year: 2017

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.

Beginning with the 2016/2017 cycle of the National GME Census post-graduate training segments will include a training type of specialty (residency) or subspecialty (fellowship). Training types for programs reported prior to 2016 will not include this designation.

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:	MONTEFIORE MEDICAL CENTER/ALBERT EINSTEIN COLL OF MED
Sponsoring State:	NEW YORK
Program name:	MONTEFIORE MEDICAL CENTER/ALBERT EINSTEIN COLLEGE OF MEDICINE PROGRAM
Specialty:	FAMILY MEDICINE
Training Type:	SPECIALTY
Dates:	7/2017 - 6/2020 (Being Reverified)

NATIONAL BOARD OF MEDICAL EXAMINERS (NBME) CERTIFICATION YEAR: MD: 0

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: TO DATE, THERE HAVE BEEN NO BOARD CERTIFICATIONS REPORTED.
Certificate:
Certificate type:

Duration	Status	Effective Date	Expiration Date	Reverify Date	Occurrence	Last Reported	Participating in MOC

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.

Current and/or historical medical licensure

License Number	MD / DO	Locale	Date Granted	Expiration Date	Renewal Date	Status	License Type	Last Reported	Name on License
BP20073595	MD	TX	02/01/2021	06/30/2021		INA	RES	09/30/2021	STEPHANIE GRACE MISCHELL
BP10069621	MD	TX	01/13/2020	02/10/2020		INA	RES	02/04/2020	STEPHANIE GRACE MISCHELL

Abbreviation key: ACT = Active, DEN = Denied, INA = Inactive, LIM = Limited, NRT = Not reported, RES = Resident, TEM = Temporary, UNK = Unknown, UNL = Unlimited

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*	Business Activity†	Drug Schedule	Activity	Expiration Date	Payment Indicator	Last Reported	Address

None Reported

** Only the last three characters of DEA numbers are displayed*

† The Business Activity code and subcode provide additional detail about the physician. For instance, Business Activity code-subcode combinations C-1, C-4, C-5, C-6, C-9, C-A, C-B, C-C, and C-D indicate the physician holds a DEA DATA waiver. Learn more about Business Activity code-subcode combinations.

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 Certification

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.

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

WORK EXPERIENCE VERIFICATION

I am applying for a medical license in the State of New Mexico. The New Mexico Medical Board requires this form to be completed by the Chief of Staff or facility's administrative staff. I hereby authorize release of all information in your files, favorable or otherwise, DIRECTLY to the NMMB, **2055 S. Pacheco St., Bldg. 400, Santa Fe, NM 87505**.

Stephanie Muschell

App[redacted]

A[redacted]

City/State/Zip

Applicant Signature

*Dat[redacted]y (must be provided)

Telephone Number

The section below should be completed by the chief of staff or facility's administrative staff.
Letters of Recommendation are ***NOT*** accepted in lieu of this form.

Alicia DeWitt-Dick, MS
Type or Print Name of person completing this form

ADMINISTRATOR
Title

Southwestern Women's Surgery Center
Name of Institution

8111 Greenville Ave. Ste 101 ~~Dallas~~ 01.05.22
Address

Dallas, TX 75243
City / State / Zip

1. This evaluation is based on: X Observation of applicant ___Review of personnel file
2. In your estimation, is there any reason why this applicant should not be licensed to practice? ___Yes X No
3. To your knowledge, is there any mental or physical reason why this applicant should not be licensed? ___Yes X No
4. To your knowledge, is there any derogatory/disciplinary information regarding this applicant? ___Yes X No
5. Are the dates of privilege/employment provided by the applicant on this form accurate?* X Yes ___No

If not, please provide correct dates: Beginning _____ Ending _____
Month/Year Month/Year

If you answered "YES" to questions 2, 3, and/or 4, please provide a written explanation and/or any supporting documentation that may be relevant.

Alicia DeWitt-Dick — Printed name of person completing this form
Signature
01.05.22 — Date

AMANDA JOSEPH
Notary Public, State of Texas
Comm. Expires 10-15-2025
Notary ID 133394897
Please affix hospital or notary seal here

Signature of Notary (if applicable)
1/5/2022 — Date

My commission expires: _____

Please note on this form if there is no hospital or notary seal available.

Please return this form directly to the address above
Thank you for your cooperation