

Linda Prine, MD

Licensed Physician #MD2014-0953

Issue Date	Expiration Date
12/01/2014	07/01/2015
Signature of Holder	

This license is controlled by the New Mexico Board of Medical Practice and is subject to the provisions of the Medical Practice Act.

**New Mexico Medical Board
Triennial Renewal Certificate**

This is to certify that

Linda Prine, MD

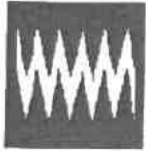
License Number: MD2014-0953

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: 12/01/2014 Date Expires: 07/01/2015*

**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

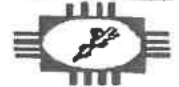


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THE NEW MEXICO
MEDICAL SOCIETY



Physician (MD) Application

Rough 10/14/14

Date of Application: October 10, 2014

Application Fee: \$400.00

TOTAL: \$400.00

Name: Linda Prine

#1645790

Will you be applying by endorsement? Yes No

Maiden or Other Names Used

Applying using: NMMB HSC FCVS

What are your NM practice plans? Plan to work there in the winter

Endorse

Gender: Female Citizenship: United States Place of Birth: Pittsburgh, PA
 Social Security Number: [REDACTED] Date of Birth: [REDACTED]
 State Tax ID#: [REDACTED] Pending Fed. Tax ID#: [REDACTED] Pending
 Medicare #: 65J771 Pending Medicaid #: 03116913 Pending
 Unique Physician Identification Number (UPIN): E74360 Pending
 National Provider Identifier Number (NPI): 1881688133 Applied
 CLIA Number (if applicable): _____ Approval Level: _____ Expiration Date: _____

Home address

Street Address: [REDACTED]
 City, State/Province and Zipcode: New York NY 10025
 Country: United States
 Telephone Number: [REDACTED] Pager Number: _____
 Cell Phone Number: [REDACTED] Spouse's Name (Optional): _____

Credentials Correspondence Address

Department: _____
 Street Address: 175 West 92nd Street 4B
 City, State/Province and Zipcode: New York NY 10025
 Country: United States Email: lindaprine@mac.com
 Telephone Number: 9175202889 Facsimile Number: _____

Military Service

Branch: _____ Type of Discharge: _____
 Dates: From: _____ To: _____ Current Rank: _____

Immigration

Status: _____ Certification Number: _____

ECFMG (Educational Commission for Foreign Medical Graduates)

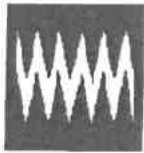
Number (if applicable): _____ Date Issued: _____ (Please attach a copy of your ECFMG certificate)

Languages

Foreign Languages (spoken fluently by practitioner): _____

Certifications

ACLS CERTIFICATION	ATLS CERTIFICATION	PALS CERTIFICATION
Certified? <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No	Certified? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	Certified? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No
Expires: <u>05/25/2015</u>	Expires: _____	Expires: _____



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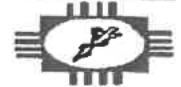
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HOSPITAL AND HEALTHCARE AFFILIATIONS

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 course of verification. Attach a separate page if necessary.

Facility Name: Mount Sinai Medical Center Is this your primary admitting facility
 Department: Family Medicine and Community Health
 Street Address: Icahn School of Medicine at Mt. Sinai
1425 Madison Avenue
 City: New York State/Province: NY Zip Code: 10029
 Country: United States
 Phone Number: 2126591411 Facsimile: 2126599071
 Appointment Dates From: 04/2012 To: Present
 Type of Appointment: Associate Professor Privileges Assigned:

Facility Name: Beth Israel Medical Center Is this your primary admitting facility
 Department: Family Medicine
 Street Address: 10 Nathan D Perlmans Place
 City: New York State/Province: NY Zip Code: 10003
 Country: United States
 Phone Number: 2122065252 Facsimile: 2126912786
 Appointment Dates From: 09/1994 To: Present
 Type of Appointment: Active 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: Planned Parenthood of NYC From: To:
 Department: Family Planning Present

Revised: June, 2012

Name: Linda Prine

Date: October 10, 2014

Page: 2/10



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Street Address: 26 Bleecker Street
City: New York State/Province: NY Zip Code: 10012
Country: United States
Phone Number: _____ Contact: _____
Type of Practice: Per-Diem

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

Organization: Sidney Hillman/Phillips Family Practice From: _____ To: _____
Department: Family Medicine Present
Street Address: 16 East 16th Street
City: New York State/Province: NY Zip Code: 10003
Country: United States
Phone Number: _____ Contact: _____
Type of Practice: Ambulatory Medicine

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

Organization: East Somerville Health Centr From: _____ To: _____
Department: Family Medicine Present
Street Address: 42 Cross Street
City: Somerville State/Province: MA Zip Code: 02145
Country: United States
Phone Number: _____ Contact: _____
Type of Practice: Ambulatory Medicine

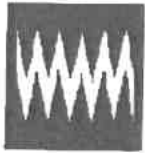
Please provide written explanation for any gaps in work history of six (6) months or more.

Organization: Dorchester House Multi-Service Center From: _____ To: _____
Department: Medicine Present
Street Address: 1353 Dorchester Ave
City: Boston State/Province: MA Zip Code: 02122
Country: United States
Phone Number: _____ Contact: _____
Type of Practice: Ambulatory Medicine

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

PRACTICE LOCATIONS

Group Name: Family Practice Center of Harlem Effective Date: 09/15/2012
Department: Family Medicine
Street Address: 1824 Madison Ave
City: New York State/Province: NY Zip Code: 10035



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Physician (MD) Application



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Country: United States

Phone Number: 2124234500 Facsimile Number: 2124231417

Email Address: ajones@institute2000.org Answering Service Number: 2124234500

Foreign Languages (spoken fluently at practice): English, Spanish

Office Manager or Contact Person: Adrienne Jones Phone: 2124234500

Billing Address

Contact Person: Adrienne Jones Tax ID #: _____

Department: Family Medicine

Street Address: 1824 Madison Ave,

City: New York State/Province: NY Zip Code: 10035

Country: United States

Phone Number: 2124234500 Facsimile Number: 2124231417

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

_____ / _____

_____ / _____

_____ / _____

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

M-F 8A-10P, S&S 8A-8P

What provisions have been made for after hours?:

answering service

Group Name: Sidney Hillman/Phillips Family Practice Effective Date: 09/10/1994

Department: Family Medicine

Street Address: 16 East 16th Street

City: New York State/Province: NY Zip Code: 10003

Country: United States

Phone Number: 2122065200 Facsimile Number: 2122065279

Email Address: cestevez@institute2000.org Answering Service Number: 2122065200

Foreign Languages (spoken fluently at practice): english, spanish, russian

Office Manager or Contact Person: Cynthia Estevez Phone: 2122065213

Billing Address

Contact Person: Cynthia Estevez Tax ID #: 133273402

Department: Family Medicine

Street Address: 16 East 16th Street,

City: New York State/Province: NY Zip Code: 10003

Country: United States

Phone Number: 2122065200 Facsimile Number: 2122065279

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

_____ / _____

_____ / _____

_____ / _____



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Physician (MD) Application



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Name and Title: Ruth Lesnewski MD MD Specialty: Family Medicine
 Department: _____ Email: rlesnewski@institute2000.org
 Street Address: 113 East 13th Street
 City: New York State/Province: NY Zip Code: 10003
 Country: United States
 Phone Number: 2122531830 Facsimile Number: 2122531914

LICENSURE REGISTRATION INFORMATION

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

State Professional License/Certification Number: 175059 Pending
 State: NY Issue Date: 06/30/1990 Expiration Date: 08/31/2015

LICENSING EXAM

Please check all that apply:

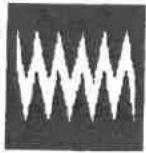
State Board Exam (Prior to 1973) Which State? NY Date(s) passed? _____
 FLEX Part/Step 1 Date Passed _____ MM/YY
 LMCC Part/Step 1 Date Passed _____ MM/YY
 National Board (NBME) Part/Step 1 Date Passed _____ Part/Step 2 Date Passed _____ Part/Step 3 Date Passed _____
 USMLE Part/Step 1 Date Passed _____ Part/Step 2 Date Passed _____ Part/Step 3 Date Passed 04/01/1987
 MM/YY MM/YY MM/YY

DRUG CERTIFICATION INFORMATION

Federal Drug Enforcement Administration (DEA) Registration: N/A
 DEA Number: BP2464218 Expiration Date: 03/31/2017 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.



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Degree Level: Residency/Fellowship
 Institution: Residency Program in Social Medicine Dates Attended:
 Department: Family Medicine From: 07/1990
 Street Address: 3544 Jerome Avenue, To: 06/1994
 City: Bronx State/Province: NY Zip Code: _____
 Country: United States Graduation Date: 1994
 Degree Earned: Residency/Fellowship or Specialty: Family Medicine
 If teaching appointment: Department/Position: _____

Degree Level: Doctor of Medicine
 Institution: Cornell University Medical College Dates Attended:
 Department: Office of Student Affairs From: 09/1983
 Street Address: 525 East 68th Street, To: 05/1987
 City: New York State/Province: NY Zip Code: _____
 Country: United States Graduation Date: 1987
 Degree Earned: Doctor of Medicine or Specialty: General Medicine
 If teaching appointment: Department/Position: _____

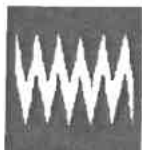
SPECIALTY BOARD CERTIFICATIONS

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: American Board of Family Practice
 Date Certified: 07/13/1990 Date Last Recertified: 04/19/2014 Expiration Date: 04/19/2024 Lifetime
 Certification Number: 1011125154 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: One Beacon Limits: _____
 Department: _____
 Address: 199 Scott Swamp Road Pending
 City: Farmington State/Province: _____ Zip Code: _____
 Country: United States
 Dates Insured: From: 08/01/2007 To: 12/31/2014 Policy Number: MFL0041780814



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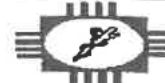
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Carrier: Federal Tort Claims Act Limits: 0.00 0.00
 Department: Malpractice
 Address: 16 East 16th Street Pending
 City: New York State/Province: _____ Zip Code: _____
 Country: United States
 Dates Insured: From: 01/15/2004 To: 12/31/2014 Policy Number: No Policy Number



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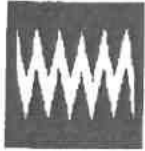


PROFESSIONAL PRACTICE QUESTIONS

1161

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 voluntarily or involuntarily limited (stipulations), suspended, revoked, restricted, or are there currently challenges to any of these items? 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? Yes No



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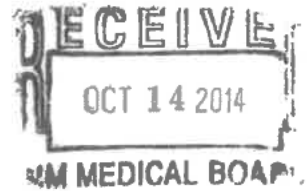


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- 17b Are you being treated with opiates for chronic pain? If yes, please provide to the Board upon application a current evaluation from your treating pain provider (MD or DO) [REDACTED]
- 18 In the five (5) years prior to this application, have you 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

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



APPLICANT'S OATH

I, Linda W. Prine MD, 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.



Linda W. Prine MD
Applicant Signature

10/10/14
Date

*Passport-quality color photograph taken within six months prior to filing the application 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 (printed) Linda W. Prine MD Date 10/10/14



American Board of Family Medicine, Inc.

Quality Healthcare, Public Trust . . . Setting the Standards in Family Medicine

October 10, 2014

To Whom It May Concern:

This letter verifies Linda Whisler Prine, M.D. (NPI: 1881688133) is currently certified with the American Board of Family Medicine (ABFM).

Family Medicine Certification History:

Jul 13, 1990 - Jul 10, 1997
Jul 11, 1997 - Jul 16, 2004
Jul 17, 2004 - Apr 18, 2014
Apr 19, 2014 - *

Certification Number: 1011125154

* Certification is continuous as long as MC-FP Requirements are maintained.

Maintenance of Certification for Family Physicians (MC-FP):

Current Status: ✨ Meeting Requirements

Beginning in 2011 certification by the American Board of Family Medicine is maintained through successful completion of the Maintenance of Certification for Family Physicians (MC-FP) process. The MC-FP process is a continuous process that requires maintaining a currently valid, full, and unrestricted license to practice medicine in the United States or Canada, completing MC-FP activities in a timely fashion, and performing successfully on the examination every ten years. Failure to maintain any of these requirements will result in the loss of certification status with the ABFM. Physicians whose certificate has expired may renew their certification at such time as they fulfill all of the MC-FP requirements in effect at that time. Based upon the continuous nature of MC-FP, no end date for certification is presented above.

Certification in Family Medicine was for a period of seven years. From 1970 through 2002, certification was renewed by completion of requirements for Recertification. Each physician (Diplomate) fulfilled these requirements by maintaining a medical license to practice medicine in the United States or Canada, earning 300 hours of continuing medical education (CME), completing a computerized office record review, and performing successfully on the recertification examination.

In 2003 family physicians who performed successfully on the Certification and Recertification examinations began a gradual transition from Recertification to MC-FP. MC-FP was designed to transition all Diplomates into the program by 2010, enrolling all physicians who certified or recertified as they successfully passed the examination.



American Board of Family Medicine, Inc.

Quality Healthcare, Public Trust . . . Setting the Standards in Family Medicine

The ABFM website serves as primary source verification. Details of the MC-FP process are available online at www.theabfm.org.

Sincerely,

Mary McIntosh

Mary McIntosh

Verification Coordinator and Candidate Assistant



AMA Physician Profile

Name and Mailing Address

LINDA WHISLER PRINE MD
[REDACTED]
NEW YORK NY 10003-3105

Primary Office Address

SIDNEY HILLMAN HEALTH CENTER
16 E 16TH ST
NEW YORK NY 10003-3169

Phone

[REDACTED]

Birth date

[REDACTED]

Physician's major professional activity OFFICE BASED PRACTICE

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
1881688133	09/01/2005	NOT RPTD	NOT RPTD	NOT RPTD	10/04/2014

Current and/or historical medical school

WEILL CORNELL MEDICAL COLLEGE OF CORNELL UNIVERSITY, NEW YORK, NY 10021
Degree Awarded: Yes
Degree Year: 1987



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.

Sponsoring Institution: MONTEFIORE M C-H&L MOSES DIV
Sponsoring State: NEW YORK
Specialty: FAMILY MEDICINE
Dates: 07/1987 - 06/1990 (Verified)

If you have discrepant information, please submit a Request for Investigation to the AMA so that we may verify the information with the primary source(s). See the last page of this Profile for instructions on how to report a data discrepancy.

NATIONAL BOARD OF MEDICAL EXAMINERS (NBME) CERTIFICATION YEAR: MD: 1988

Current and/or historical medical licensure

Jurisdiction	MD/DO	Date granted	Expiration date	Status	License type	Last reported
MASSACHUSETTS	MD	08/15/1990	NOT RPTD	INACTIVE	UNLIMITED	08/25/2003
NEW YORK	MD	07/01/1988	08/31/2015	ACTIVE	UNLIMITED	09/30/2014

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/>



U.S. Drug Enforcement Administration (DEA)

DEA number	Schedule	Expiration date	Last Reported date	Address:
XXXXXX218	[REDACTED]	03/31/2017	09/02/2014	[REDACTED]

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.

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
MOC+	04/19/2014		02/15/2015	RE-CERT	10/03/2014
TIME LIMITED	07/17/2004	12/31/2014		RE-CERT	10/03/2014
TIME LIMITED	07/11/1997	12/31/2004		RE-CERT(**)	10/03/2014



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

Duration	Effective Date	Expiration Date	Reverification Date	Occurrence	Last Reported Date
TIME LIMITED	07/13/1990	12/31/1997		INITIAL(**)	10/03/2014

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.

This information is proprietary data maintained in a copyrighted database compilation owned by the American Board of Medical Specialties (ABMS). Copyright 2014 American Board of Medical Specialties. All right reserved.

+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.

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 Public Health Service.



Additional Information

To date, there is no additional information for this physician on file.

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 onto our website (www.ama-assn.org/go/amaprofiles) and go to the order detail page. Select the 'D' following the physician's name and enter the data in questions. Or you can mark the issues on a copy of the profile and mail or fax to:

American Medical Association
Division of Database Products
Attn: Physician Products Portfolio
AMA Plaza
330 N. Wabash Ave., Suite 39300
Chicago, IL 60611-5885

Fax: (312) 464-5900

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

PRACTITIONER PROFILE

Prepared for: New Mexico Medical Board As of Date:10/15/2014

PRACTITIONER INFORMATION

Name: Linda Whisler Prine
DOB: [REDACTED]
Medical School: Cornell University Medical College
New York, New York, UNITED STATES
Year of Grad: 1987
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 Reported
NEW YORK	175059	7/1/1988	8/31/2015	10/6/2014

PLEASE NOTE: For more information regarding the above data, please contact the reporting board or reporting agency. The information contained in this report was supplied by the respective state medical boards and other reporting agencies. The Federation makes no representations or warranties, either express or implied, as to the accuracy, completeness or timeliness of such information and assumes no responsibility for any errors or omissions contained therein. Additionally, the information provided in this profile may not be distributed, modified or reproduced in whole or in part without the prior written consent of the Federation of State Medical Boards.



Office of the Professions

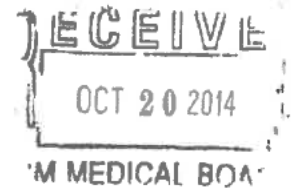
Verification Searches

The information furnished at this web site is from the Office of Professions' official database and is updated daily, Monday through Friday. The Office of Professions considers this information to be a secure, primary source for license verification.

License Information *

10/14/2014

Name : PRINE LINDA WHISLER
Address : NEW YORK NY
Profession : MEDICINE
License No: 175059
Date of Licensure : 07/01/88
Additional Qualification :
Status : REGISTERED
Registered through last day of : 08/15
Medical School: CORNELL UNIV MEDICAL COLL **Degree Date :** 05/28/1987



(Use your browser's back key to return to licensee list.)

* Use of this online verification service signifies that you have read and agree to the [terms and conditions of use](#). See [HELP glossary](#) for further explanations of terms used on this page.

Note: The Board of Regents does not discipline *physicians(medicine), physician assistants, or specialist assistants*. The status of individuals in these professions may be impacted by information provided by the NYS Department of Health. To search for the latest discipline actions against individuals in these professions, please check the New York State Department of Health's [Office of Professional Medical Conduct](#) homepage.

Further information on physicians may be found on the following external sites (The State Education Department is not responsible for the accuracy or completeness of information located on external Internet addresses.):

[American Board of Medical Specialties](#)

[American Medical Association:](#)

- For the general public: [AMA Physician Select, On-line Doctor Finder](#)
- For organizations that verify physician credentials: [AMA Physician Profiles](#)

[American Osteopathic Association, AOA-Net](#)

[Association of State Medical Board Executive Directors-\(A.I.M. "DOCFINDER"\)](#)

[New York State Department of Health Physician Profiles](#)

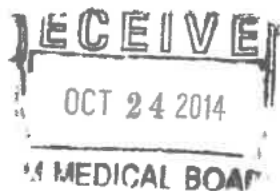
The following sites provide additional information concerning the medical profession:

[CLEAR \(Council on Licensure, Enforcement and Regulation\)](#)

[Federation of State Medical Boards](#)



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.

Linda W. Prine MD
 Applicant Name

 Address
New York NY 10025
 City/State/Zip

Linda W. Prine MD
 Applicant Signature
2/2/13 - 2/1/15
 *Dates of Privilege/Employment mm/yy to mm/yy (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.

Nikki Langford
 Type or Print Name of person completing this form
Professional Appointments Manager
 Title
The Institute for Family Health
 Name of Institution
22 West 19th Street, 8th Floor
 Address
New York, Ny 10011
 City / State / Zip

1. This evaluation is based on: 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 No
3. To your knowledge, is there any mental or physical reason why this applicant should not be licensed? Yes No
4. To your knowledge, is there any derogatory/disciplinary information regarding this applicant? Yes No
5. Are the dates of privilege/employment provided by the applicant on this form accurate? * Yes No

*If not, please provide correct dates: Beginning 2/13 Ending 2/15 (current)
 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.

Please affix hospital or notary seal here

Nikki Langford Nikki Langford 10/17/14
 Printed name of person completing this form Signature Date
Nikki Langford 10/17/14
 Signature of Notary (if applicable) Date

My commission expires: October 3, 2015

NIKKI LANGFORD
 Notary Public, State of New York
 No. 011A6248066
 Qualified in New York County
 Commission Expires October 3, 2015

Please note on this form if there is no hospital or facility seal. Please return this form directly to the address above. Thank you for your cooperation.



NATIONAL BOARD OF MEDICAL EXAMINERS® (NBME®)
Endorsement of Certification

RECEIVED

OCT 16 2014

This document was prepared by
 National Board of Medical Examiners® (NBME®)
 3750 Market Street, Philadelphia, PA 19104-3190 - Telephone (215) 590-9700

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

Date: 10/13/2014

Examinee: Linda Whisler Prine

Examinee ID: 3-346-737-4

Date of Birth: [REDACTED]

NBME Certification Date: 07/01/1988

Certificate#: 346737

It is certified that the physician named above successfully completed the examination, education and training requirements for certification by the NBME as of the certification date shown above. This record shows only passing scores for each NBME Part examination reported on this document. If applicable, results for all USMLE Steps taken by this examinee (and for which scores have been reported to date) are also shown.

NBME PART I

Test Date	Pass/Fail	Score Scale	Total		Individual Subject Scores						
			Score	(Min. Pass)	Anat	Phys	Bioc	Path	Micr	Phar	Beh-Sci
06/11/1985	Pass	Three-Digit	545	(380)	555	585	560	505	370	580	580
		Two-Digit	83	(75)	84	86	84	81	72	86	86

NBME PART II

Test Date	Pass/Fail	Score Scale	Total		Individual Subject Scores					
			Score	(Min. Pass)	Med	Surg	ObGyn	Prev	Peds	Psych
09/23/1986	Pass	Three-Digit	555	(290)	520	500	565	620	545	520
		Two-Digit	84	(75)	83	82	85	88	84	83

NBME PART III

Test Date	Pass/Fail	Score Scale	Total	
			Score	(Min. Pass)
03/02/1988	Pass	Three-Digit	535	(290)
		Two-Digit	83.4	(75)





NATIONAL BOARD OF MEDICAL EXAMINERS® (NBME®)

Record of Scores

CEIVE

OCT 16 2014

MEDICAL BOARD

This document was prepared by

National Board of Medical Examiners® (NBME®)

3750 Market Street, Philadelphia, PA 19104-3190 - Telephone (215) 590-9700

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

Date: 10/13/2014

Examinee: Prine, Linda W

Examinee ID: 3-346-737-4

Date of Birth: [REDACTED]

This record shows a complete Part history for this examinee.

NBME PART I

Test Date	Pass/Fail	Score Scale	Total Score	(Min. Pass)	Individual Subject Scores						
					Anat	Phys	Bioc	Path	Micr	Phar	Beh Sci
06/11/1985	Pass	Three-Digit	545	(380)	555	585	560	505	370	580	580
		Two-Digit	83	(75)	84	86	84	81	72	86	86

NBME PART II

Test Date	Pass/Fail	Score Scale	Total Score	(Min. Pass)	Individual Subject Scores					
					Med	Surg	ObGyn	Prev	Peds	Psych
09/23/1986	Pass	Three-Digit	555	(290)	520	500	565	620	545	520
		Two-Digit	84	(75)	83	82	85	88	84	83

NBME PART III

Test Date	Pass/Fail	Score Scale	Total Score	(Min. Pass)
		Two-Digit	83.4	(75)



Linda Prine, MD

Licensed Physician #MD2014-0953

Issue Date

10/28/2020

Expiration Date

07/01/2023

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
Reinstatement Certificate**

This is to certify that

Linda Prine, MD

License Number: MD2014-0953

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.

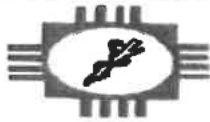
Issue Date: 10/28/2020 Date Expires: 07/01/2023*

**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

lapsed 7/1/18

**THE NEW MEXICO
MEDICAL SOCIETY**



NM-HSA
New Mexico Hospitals &
Health Systems Association

**The New Mexico Statewide Application
for Physician/Practitioner Appointment©**

Physician (MD) Application for Reinstatement

Date of Application: 9/11/20

Att#: 2328512

Demographics

Name	Prine	Linda	W
	Last	First	Middle
Other Names Used			

4MD2014-0953

Gender	M <input type="radio"/> F <input checked="" type="radio"/>	Place of Birth	Pittsburgh PA	Citizenship	US
Immigration Status		INS Certification #			
*Social Security Number		Date of Birth			
*NM Tax ID# (if applicable)		Pending	<input type="checkbox"/>		
*Fed. Tax ID# (if applicable)		Pending	<input type="checkbox"/>		
Current Practice Name	Institute for Family Health				
Practice Limited to: (Clinical Specialty)	Family Medicine				
Street	220 W. 17th St.				
City	NYC	State	NY	Zip Code	10011
Telephone Number	212-206-5200	Facsimile	212-206-5259		
*Office Manager or Contact Person:	Arielle Koutsoukos				
Foreign Languages (spoken fluently by practitioner)	Ø				
Foreign Languages (spoken fluently at Practice)	Spanish				
*E-Mail Address (confidential)	linda@prine@mac.com				
*Current Mailing Address (if different from above -confidential unless no practice address indicated)					
*Street	175 W. 92nd St.				
*City	NY	*State	NY	*Zip Code	10625
Telephone Number	917-520-2889	Facsimile			
What are your immediate or future Practice Plans in New Mexico?	to join: Full Circle Health Center 210 W. Las Cruces Ave Las Cruces NM 88005				
Home Address (Required)	*Telephone Number	917-520-2889			
Street	3052 Executive Hills Road Las Cruces				
*City	Las Cruces	*State	New Mexico	*Zip	88011

*Information Confidential

Practice Associates in NM (If Applicable)		Call Coverage in NM (If Applicable)	
Ruth Romo FNP			
Other Practice Locations (If Applicable)			
Practice Name			
Street			
City		State	Zip Code
Telephone Number		Facsimile	
Answering Service		Effective Date	

Education (Please attach a separate sheet, if necessary.)

Undergraduate Education			
College or University University of Wisconsin			
City	Madison	State/Country	WI Zip Code: 53701
Dates Attended	From: 9/1969	To: 6/1974	Degree BA Graduation Date 6/74
College or University Columbia University			
City	NYC	State/Country	NY Zip Code: 10026
Dates Attended	From: 9/1980	To: 6/1983	Degree pre-med Graduation Date no degree
Professional / Medical Education			
College or University Cornell University Medical School			
City	New York	State/Country	NY Zip Code: 10065
Dates Attended	From: 9/83	To: 6/1987	Degree MD Graduation Date 6/1987
College or University			
City		State/Country	Zip Code:
Dates Attended	From:	To:	Degree Graduation Date
Graduate Education			
College or University			
City		State/Country	Zip Code:
Dates Attended	From:	To:	Degree Graduation Date
College or University			
City		State/Country	Zip Code:
Dates Attended	From:	To:	Degree Graduation Date

Internship/ Residency/ Fellowship			
Institution Name Montefiore Residency Program in Family Medicine			
City	Bronx	State/Country	NY Zip Code: 10467
Dates Attended	From: 7/1987	To: 6/1990	Field Family Medicine
Institution Name			
City		State/Country	Zip Code:
Dates Attended	From:	To:	Field
Institution Name			
City		State/Country	Zip Code:
Dates Attended	From:	To:	Field
Institution Name			
City		State/Country	Zip Code:
Dates Attended	From:	To:	Field

Work History Please list all previous practice experience for the last 15 years, including military or government service, listing the most recent first. If military service, state type of discharge and rank achieved and attach copy of discharge or separation documents. Attach separate page, if necessary. Please provide written explanation for any gaps in work history of 6 months or more.

Location	Institute for Family Health	From	9/1994	To	Present
Street	230 W. 17th Street	Phone Number	212-206-5200		
City	New York	State	NY	Zip Code	10011
Type of Practice	Family Medicine	Contact Person	Arielle Koussoukos		
Type of Discharge	still employed	Rank Achieved	Professor		
Location		From		To	
Street		Phone Number			
City		State		Zip Code	
Type of Practice		Contact Person			
Type of Discharge		Rank Achieved			
Location		From		To	
Street		Phone Number			
City		State		Zip Code	
Type of Practice		Contact Person			
Type of Discharge		Rank Achieved			
Location		From		To	
Street		Phone Number			
City		State		Zip Code	
Type of Practice		Contact Person			
Type of Discharge		Rank Achieved			

Hospital and Health Facility Affiliation History (other than postgraduate training) N/A

Please list hospital staff membership and/or healthcare organization affiliations in the past fifteen (15) years. If an institution is no longer in existence, please provide an alternative source of verification. Use separate page, if necessary. Providers who do NOT have admitting privileges, please explain your procedures or the arrangements you make in instances when patients require admission to a hospital. If you are applying with a health plan, should arrangements include admitting coverage by another provider, a signed letter from the covering provider, including their primary admitting facility, is to be included with this application.

(1) Current Primary Admitting Facility (Hospital Name)	Mt. Sinai Medical Center				
Street	1468 Madison Ave				
City	NY	State	NY	Zip Code	10029
Telephone Number	212-659-1411		Facsimile	212-659-9071	
Appointment Dates	From: 2015	To: present			
Type of Appointment	community physician				
Privileges Assigned	admitting				
(2) Facility Name	Beth Israel Hospital				
Street	First Avenue at 16th Street				
City	New York	State	NY	Zip Code	10003
Telephone Number			Facsimile		
Appointment Dates	From: 1998	To: 2015			
Type of Appointment	community physician				
Privileges Assigned	admitting				
(3) Facility Name					
Street					
City		State		Zip Code	
Telephone Number			Facsimile		
Appointment Dates	From:	To:			
Type of Appointment					
Privileges Assigned					

Applicant Name Linda W. Prime Date 9/11/20

(4) Facility Name			
Street			
City	State	Zip Code	
Telephone Number	Facsimile		
Appointment Dates	From:	To:	
Type of Appointment			
Privileges Assigned			
(5) Facility Name			
Street			
City	State	Zip Code	
Telephone Number	Facsimile		
Appointment Dates	From:	To:	
Type of Appointment			
Privileges Assigned			
(6) Facility Name			
Street			
City	State	Zip Code	
Telephone Number	Facsimile		
Appointment Dates	From:	To:	
Type of Appointment			
Privileges Assigned			
(7) Facility Name			
Street			
City	State	ZIP Code	
Telephone Number	Facsimile		
Appointment Dates	From:	To:	
Type of Appointment			
Privileges Assigned			
(8) Facility Name			
Street			
City	State	Zip Code	
Telephone Number	Facsimile		
Appointment Dates	From:	To:	
Type of Appointment			
Privileges Assigned			

Professional References Please list three professional peers familiar with your professional performance in the past 5 years, (not including current or impending partners or associates in practice).

(1) Name and Title			
Address	[Redacted]		
City	NY	State	NY
Telephone Number	Facsimile		Zip Code 10032
(2) Name and Title			
Address	Amsterdam Family Practice [Redacted]		
City	NY	State	NY
Telephone Number	Facsimile		Zip Code 10025
(3) Name and Title			
Address	[Redacted]		
City	NY	State	NY
Telephone Number	Facsimile		Zip Code 10156

Applicant Name
Page 4

Linda Prince

Date 9/11/20

Licensure-Registration-Certification Information

ECFMG Number (if applicable)				
State Professional License/Certification Number				
State	NY	Issue Date	1994	Expiration Date 8/2021 Pending <input type="checkbox"/>
All Other State License Numbers (regardless of status - attach separate list if necessary.)				
State	Number	Issue Year	Expiration Date	
*Federal Drug Enforcement Admin. (DEA) Registration				N/A <input type="checkbox"/>
Number		Exp. Date	3-31-23	Pending <input type="checkbox"/>
*State Controlled Substance Registration (CSR)				N/A <input type="checkbox"/>
Number	State	Exp. Date		Pending <input type="checkbox"/>
*Medicare Unique Physician Identification Number (UPIN)				
Pending	<input type="checkbox"/>			
*State Medicaid Provider Number				
Pending	<input type="checkbox"/>			
*National Provider Identification Number				
Pending	<input type="checkbox"/>			

Specialty Board Certifications N/A

Are you Board Certified? Yes No **Note:** 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 for examination in your specialty, please give a brief explanation on an attached sheet.

Certified/Recertified by the: ABFM - American Board of Family Medicine			
1.	Date Certified	Date Last Recertified	Expiration Date
	7/13/90	4/19/14	4/19/24
2.	Date Certified	Date Last Recertified	Expiration Date
3.	Date Certified	Date Last Recertified	Expiration Date
Accepted for Examination by the:			
Until (expiration date)	If not accepted, have you made application?		Yes No
Certified/Recertified by the Subspecialty Board of			
1.	Date Certified	Date Last Recertified	Expiration Date
2.	Date Certified	Date Last Recertified	Expiration Date
Accepted for Examination by the Subspecialty Board of			

Professional Liability Insurance (confidential information)

Do you have current liability insurance? <input type="checkbox"/> Yes <input type="checkbox"/> No			
Current Carrier		Current <input type="checkbox"/> Pending <input type="checkbox"/>	
Address			
Dates Insured	From	To	Policy # Coverage Limits

Licensing Exam: Please check all that apply:

State Board Exam (Prior to 1973) Which state? _____ Date(s) passed? _____

FLEX LMCC National Board (NBME) USMLE

Part/Step 1 Date Passed 6/85 Part/Step 2 Date Passed 9/86 Part/Step 3 Date Passed 3/88

Month/Year Month/Year Month/Year

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

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 to physicians?	Yes <input type="checkbox"/>	No <input checked="" type="checkbox"/>
2. Have you ever been denied professional liability insurance coverage?	Yes <input type="checkbox"/>	No <input checked="" type="checkbox"/>
3. Has your professional liability carrier ever excluded any specific procedures from your coverage?	Yes <input type="checkbox"/>	No <input checked="" type="checkbox"/>
4. Have you ever been denied membership or renewal thereof, or been subject to disciplinary action in any professional organization?	Yes <input type="checkbox"/>	No <input checked="" type="checkbox"/>
5. Have you ever been excluded from or sanctioned by Medicare and/or Medicaid?	Yes <input type="checkbox"/>	No <input checked="" type="checkbox"/>
6. Have you ever been arrested? If so explain the circumstance, regardless of the outcome (i.e. expunged, dismissed, sealed, vacated). <u>1971-73 approx Anti-war protests</u>	Yes <input checked="" type="checkbox"/>	No <input type="checkbox"/>
7. Have you ever been named as a defendant in any criminal proceedings?	Yes <input type="checkbox"/>	No <input checked="" type="checkbox"/>
8. Have you ever 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?	Yes <input type="checkbox"/>	No <input checked="" type="checkbox"/>
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 <input type="checkbox"/>	No <input checked="" type="checkbox"/>
10. a. 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 <input type="checkbox"/>	No <input checked="" type="checkbox"/>
b. Have you ever agreed not to exercise your clinical privileges while under investigation?	Yes <input type="checkbox"/>	No <input checked="" type="checkbox"/>
c. Have you ever 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?	Yes <input type="checkbox"/>	No <input checked="" type="checkbox"/>
11. Have you ever resigned from a healthcare entity to avoid modification, suspension, or termination of privileges, or while under investigation?	Yes <input type="checkbox"/>	No <input checked="" type="checkbox"/>
12. a. 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 <input type="checkbox"/>	No <input checked="" type="checkbox"/>
b. Are any currently held licenses pending investigation or being challenged?	Yes <input type="checkbox"/>	No <input checked="" type="checkbox"/>
13. Have you ever been notified to appear before any licensing agency for a hearing or complaint of any nature?	Yes <input type="checkbox"/>	No <input checked="" type="checkbox"/>
14. Has your federal or state narcotics registration certificate in any jurisdiction ever been investigated, voluntarily or involuntarily limited, suspended, revoked, or restricted?	Yes <input type="checkbox"/>	No <input checked="" type="checkbox"/>

<p>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 on the attached Malpractice History form for each case:</p> <ul style="list-style-type: none"> • Name, age, sex of patient/claimant. • Date(s) and type of treatment and/or surgery, which 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. • Name of defense attorney. 	Yes <input type="checkbox"/>	No <input checked="" type="checkbox"/>
16. Have you ever been reported to the National Practitioner Data Bank?	Yes <input type="checkbox"/>	No <input checked="" type="checkbox"/>
<p>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?</p> <p>b) 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)</p>		
18. 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 and treatment and current status.	Yes <input type="checkbox"/>	No <input checked="" type="checkbox"/>
<p>19. Have you ever, for any reason:</p> <p>a) Resigned from a medical school or postgraduate training (PGT) program?</p> <p>b) Withdrawn from a medical school or postgraduate training program?</p> <p>c) Been suspended, dismissed, or expelled from a medical school or PGT program?</p> <p>d) Been placed on probation or remediation, including academic probation or remediation, by a medical school or PGT program?</p> <p>e) Taken a leave of absence or break from, or had any interruptions or extensions in, a medical school or PGT program for any personal or professional reason (including illness or disability, pregnancy or maternity, any academic issue, etc)?</p>	<p>Yes <input type="checkbox"/></p> <p>Yes <input type="checkbox"/></p> <p>Yes <input type="checkbox"/></p> <p>Yes <input type="checkbox"/></p> <p>Yes <input type="checkbox"/></p>	<p>No <input checked="" type="checkbox"/></p> <p>No <input checked="" type="checkbox"/></p> <p>No <input checked="" type="checkbox"/></p> <p>No <input checked="" type="checkbox"/></p> <p>No <input checked="" type="checkbox"/></p>
20. I attest that I will limit my practice to areas in which I am competent to practice.	Yes <input checked="" type="checkbox"/>	No <input type="checkbox"/>
21. Are you currently in arrears for payments of amounts required to be paid pursuant to an outstanding judgement and order for child support in New Mexico or any other state?	Yes <input type="checkbox"/>	No <input checked="" type="checkbox"/>

If you answer YES to any question, please give details including name, address, and telephone number of significant parties on a separate sheet of paper.

Applicant Signature
Page 7

Jindaw. Prine MD

Date 9/11/20

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

APPLICANT'S OATH

I, Linda W. Prine MD, 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.



Linda W. Prine MD
Applicant Signature

9/11/20
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.



AMA Physician Profile

PREPARED FOR

New Mexico Medical Board, Santa Fe, NM

Name and Mailing Address

LINDA WHISLER PRINE
[REDACTED]
NEW YORK, NY 10003-3105

Primary Office Address

WHOLE WOMAN'S HEALTH OF NEW MEXICO
3900 E LOHMAN AVE STE B
LAS CRUCES, NM 88011-8268
Phone (332) 209-5732

Birth date 09/28/1951

Physician's major professional activity

OFFICE BASED PRACTICE

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
[REDACTED]	09/01/2005	NOT RPTD	NOT RPTD	NOT RPTD	08/21/2020

Current and/or historical medical school

WEILL CORNELL MEDICAL COLLEGE

Degree Awarded: YES
Degree Year: 1987



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-HENRY AND LUCY MOSES
DIVISION
Sponsoring State: NEW YORK
Specialty: FAMILY MEDICINE
Training Type:
Dates: 7/1987 - 6/1990 (Verified)

NATIONAL BOARD OF MEDICAL EXAMINERS (NBME) CERTIFICATION YEAR: MD: 1988

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	Status	Effective Date	Expiration Date	Reverify Date	Occurrence	Last Reported	Participating in MOC
MOC ⁺	Active	04/19/2014	n/a	02/15/2021	RE-CERT	03/19/2020	Y
TIME LIMITED	Expired	07/17/2004	12/31/2014		RE-CERT	03/19/2020	Y
TIME LIMITED	Expired	07/11/1997	12/31/2004		RE-CERT	03/19/2020	Y
TIME LIMITED	Expired	07/13/1990	12/31/1997		INITIAL	03/19/2020	Y

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.

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+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

License No.	MD / DO	Jurisdiction	Date Granted	Expiration Date	Renewal Date	Status	License Type	Last Reported
73259	MD	MA	08/15/1990	NOT RPTD	09/28/1995	INACTIVE	UNLTD	08/25/2003
60175059	MD	NY	07/01/1988	08/31/2021		ACTIVE	UNLTD	09/01/2020
MD2014-0953	MD	NM	12/01/2014	07/01/2018		INACTIVE	UNLTD	09/18/2020

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
[REDACTED]		03/31/2023	09/11/2020	West 17th Street Family Practice 230 W 17th St New York, NY 10011-5325

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 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.ecfm.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.

PRACTITIONER PROFILE

Prepared for: **New Mexico Medical Board** As of Date: 10/8/2020

PRACTITIONER INFORMATION

Name: Prine, Linda Whisler
 DOB: [REDACTED]
 Medical School: Cornell University Medical College
 New York, New York, UNITED STATES
 Year of Grad: 1987
 Degree Type: MD
 NPI: 1881688133

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
1881688133	Individual			06/04/2018

LICENSE HISTORY

Jurisdiction	License Number	Issue Date	Expiration Date	Last Updated
NEW MEXICO	MD2014-0953	12/01/2014	07/01/2018	09/29/2020
NEW YORK	175059	07/01/1988	08/31/2021	10/07/2020

US DRUG ENFORCEMENT ADMINISTRATION (DEA)

DEA Number	Schedule	Address	Expiration Date	Last Reported
BP2464218	22N 33N 4	NEW YORK, NY 10011	03/31/2023	09/15/2020

PRACTITIONER PROFILE

Prepared for: New Mexico Medical Board As of Date:10/8/2020
 Practitioner Name: Prine, Linda Whisler

ABMS® CERTIFICATION HISTORY

Certifying Board: American Board of Family Medicine
 Certificate: Family Medicine
 Certification Type: General
 Certification Status: Certified
 Participating in MOC: Yes

Status	Duration	Effective Date	Expiration Date	Reverification Date	Occurrence	Last Reported
Active	MOC	04/19/2014		02/15/2021	Recertification	09/24/2020
Expired	Time Limited	07/17/2004	12/31/2014		Recertification	09/24/2020
Expired	Time Limited	07/11/1997	12/31/2004		Recertification	09/24/2020
Expired	Time Limited	07/13/1990	12/31/1997		Initial	09/24/2020

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.

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AOA® CERTIFICATION HISTORY

No AOA Certifications found.

PLEASE NOTE: For more information regarding the above data, please contact the reporting board or reporting agency. The information contained in this report was supplied by the respective state medical boards and other reporting agencies. The Federation makes no representations or warranties, either express or implied, as to the accuracy, completeness or timeliness of such information and assumes no responsibility for any errors or omissions contained therein. Additionally, the information provided in this profile may not be distributed, modified or reproduced in whole or in part without the prior written consent of the Federation of State Medical Boards.



Office of the Professions

Verification Searches

The information furnished at this web site is from the Office of Professions' official database and is updated daily, Monday through Friday. The Office of Professions considers this information to be a secure, primary source for license verification.

License Information *

10/21/2020

Name : PRINE LINDA WHISLER
Address : NEW YORK NY
Profession : MEDICINE
License No: 175059
Date of Licensure : 07/01/1988
Additional Qualification :
Status : REGISTERED
Registered through last day of : 08/21
Medical School: CORNELL UNIV MEDICAL COLL **Degree Date :** 05/28/1987

(Use your browser's back key to return to licensee list.)

* Use of this online verification service signifies that you have read and agree to the [terms and conditions of use](#). See [HELP glossary](#) for further explanations of terms used on this page.

Note: The Board of Regents does not discipline *physicians(medicine), physician assistants, or specialist assistants*. The status of individuals in these professions may be impacted by information provided by the NYS Department of Health. To search for the latest discipline actions against individuals in these professions, please check the New York State Department of Health's [Office of Professional Medical Conduct](#) homepage.

Further information on physicians may be found on the following external sites (The State Education Department is not responsible for the accuracy or completeness of information located on external Internet addresses.):

[American Board of Medical Specialties](#)

[American Medical Association:](#)

- For the general public: [AMA Physician Select, On-line Doctor Finder](#)
- For organizations that verify physician credentials: [AMA Physician Profiles](#)

[American Osteopathic Association, AOA-Net](#)

[Association of State Medical Board Executive Directors-\(A.I.M."DOCFINDER"\)](#)

[New York State Department of Health Physician Profiles](#)

The following sites provide additional information concerning the medical profession:

[CLEAR \(Council on Licensure, Enforcement and Regulation\)](#)

[Federation of State Medical Boards](#)



AIM

Association of State Medical Board Executive Directors



New Mexico Medical Board
2055 S. Pacheco, Building 400
Santa Fe, NM 87505
505-476-7220 fax 505-476-7237
(toll free within New Mexico 800-945-5845)

General Information

Licensee	Linda Prine	License Type	Medical Doctor
Business address	3900 East Lohman Ave	License Number	MD2014-0953
Business address		License Status	Lapsed DO NOT USE
Business city state zip	Las Cruces NM 88011	License Date	12/01/2014
Business phone	575-522-3122	**License Expires	07/01/2018
Medical School	Cornell Univ Medial Coll		
Graduation Date	05/01/1987		
*Specialty	Family Practice - Board Certified		

****For MD's only 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.**

*****For PA's only a New Mexico Medical license that has not been renewed by March 1 of the renewal year will remain temporarily active with respect to medical practice until April 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.**

* The Board does not verify current specialties. For more information please see the American Board of Medical Specialties website at: www.abms.org to determine if the physician has earned a specialty certification from this private agency.

** 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.



Mount Sinai Health System
Medical Staff Services
One Gustave L. Levy Place, Box 1116
New York, NY 10029

DECEMBER 24, 2019

Dear Linda W. Prine MD,

On behalf of the Board of Trustees of the Mount Sinai Health System, we take pleasure in informing you of your reappointment to the hospital staff(s) as indicated below.

The effective term of your appointment(s) is 01/01/2020 – 12/31/2021.

Institution	Department	Division	Rank
Mount Sinai Hospital	Family Medicine		Visiting Attending

As a reminder, this reappointment is contingent upon your compliance with the Bylaws, and Rules & Regulations of the hospital(s) to which you have been appointed. Please be aware that you are obligated to inform us immediately of any proceedings and/or disciplinary actions imposed by New York State, any other state, or any health facility with which you are/were affiliated.

In addition, the Department Chair(s) will evaluate your ongoing activity in various areas to determine future reappointment. Subsequent reappointment will be determined by the Chair and based on the level of your activity.

The activities that may be monitored include:

1. Number of procedures
2. Teaching of residents
3. Clinical attendance and participation
4. Participation in departmental meetings
5. Medical records completion
6. Other, as appropriate

On behalf of the Board of Trustees we congratulate you on your reappointment(s), and we thank you for your ongoing contributions to patient care.

Sincerely,

Medical Staff Services

The Mount Sinai Health System



Mount Sinai Health System
Medical Staff Services
One Gustave L. Levy Place, Box 1116
New York, NY 10029

Linda W. Prine, MD
Mount Sinai Hospital • Family Medicine • Visiting Attending
Reappointment Period: 01/01/2020 to 12/31/2021

Based on your status as "Visiting Attending", a privilege form is not needed for your reappointment.

Specific delineated privileges are not required, rights and restrictions indicated below in accordance with that hospital's medical staff bylaws.

Mount Sinai Hospital

Rank: Visiting Attending

Rights and Restrictions: Members may visit their patients, review their patients' medical information, and advise the patient's attending physician, but may not have admitting privileges, write orders or notes, instruct house staff, or render direct patient care.

Approved By:

Approver	Role	Date
ROBERT M SCHILLER	DEPARTMENT APPROVAL	12/13/2019 12:37 pm

Sincerely,

Marsha M. Nelson

Marsha M. Nelson
Director
Office of Continuing Pharmacy Education
Department of Pharmacy Practice



University at Buffalo
Office of Continuing Pharmacy Education
School of Pharmacy and Pharmaceutical Sciences

2020-08-21

Linda Prine

8178

This letter verifies your successful completion of the continuing education program entitled **Opioid Prescriber Training Update Program Part I.**

This program satisfies four of the training requirements of the Public Health Law Article 33 §3309-a:

- Pain Management
- Appropriate Prescribing
- Managing acute pain
- State and federal requirement for prescribing controlled substances

Prescribers, attached is your ACCME accreditation document. Dentists please note, attached is your dental certification of attendance. Pharmacists your accreditation will be uploaded directly to the CPE Monitor.

Please see the website listed below for information on the Mandatory Prescriber Education attestation process
https://www.health.ny.gov/professionals/narcotic/mandatory_prescriber_education/heat.htm

We thank you for your participation in this program, if you require any further assistance please contact the continuing education office at pharmacyce@buffalo.edu.

Sincerely,

Marsha M. Nelson
Director
Office of Continuing Pharmacy Education
Department of Pharmacy Practice

Boston University School of Medicine
Barry M. Manuel Continuing Medical Education Office
72 East Concord Street, B208 Boston, MA 02118-2307
T (617) 358-5005 F (617) 358-5042 E cme@bu.edu
www.bucme.org



Linda Prine, MD

[REDACTED]
New York, NY 10025
United States

Boston University School of Medicine
certifies that

Linda Prine, MD

has participated in the enduring material titled

**SCOPE of Pain:
Safer/Competent Opioid Prescribing Education**

August 30, 2020

and is awarded 2.25 AMA PRA Category 1 Credits™.

Maximum Credits: 2.25
Total Credits Reported: 2.25
Risk Management Credit: 2.25
Opioid Credits: 2.25

Boston University School of Medicine is accredited by the Accreditation Council for Continuing Medical Education to provide continuing medical education for physicians.

Boston University School of Medicine designates this enduring material for a maximum of 2 AMA PRA Category 1 Credit(s)™. Physicians should claim only credit commensurate with the extent of their participation in the activity.

This program meets the criteria of the Massachusetts Board of Registration in Medicine for risk management study.

This program meets the criteria of the Massachusetts Board of Registration in Medicine for opioid education.

American Academy of Family Physicians (AAFP) Credits

This Enduring Material activity, SCOPE of Pain: Safer/Competent Opioid Prescribing Education, has been reviewed and is acceptable for up to 2.25 Prescribed credit(s) by the American Academy of Family Physicians. AAFP certification begins 04/01/2020. Term of approval is for one year from this date. Physicians should claim only the credit commensurate with the extent of their participation in the activity.

Accreditation Provider Number: 0000185

Daniel P. Alford, MD, MPH, FACP, DFASAM
Associate Dean
Professor of Medicine



University at Buffalo *The State University of New York*

Jacobs School of Medicine and Biomedical Sciences

APFME Office of Continuing Medical Education

Certifies that

Linda Prine

has participated in the *enduring activity titled*
Opioid Prescriber Training Program Part I

This program meets the New York State Mandated Training for

- Pain Management
- Appropriate Prescribing
- Managing acute pain
- State and federal requirement for prescribing controlled substances

2020-08-21

and is Awarded

2.0 AMA PRA Category 1 Credit(s)

Course code #9060A

Alicia M. Blodgett
Director of Continuing Medical Education
Jacobs School of Medicine and Biomedical Sciences
University at Buffalo
955 Main Street, Suite 7230
Buffalo, NY 14203
P (716) 829-3711
F (716) 829-3999



American Board of Family Medicine, Inc.

Quality Healthcare, Public Trust . . . Setting the Standards in Family Medicine

September 12, 2020

To Whom It May Concern:

This letter verifies Linda Whisler Prine, M.D. (NPI: 1881688133) is currently certified with the American Board of Family Medicine (ABFM).

Family Medicine Certification History:

Jul 13, 1990 - Jul 10, 1997
Jul 11, 1997 - Jul 16, 2004
Jul 17, 2004 - Apr 18, 2014
Apr 19, 2014 -

* Certification Number: 1011125154

* Certification is continuous as long as Family Medicine Certification Requirements are maintained.

Family Medicine Certification Requirements:

Current Status: Meeting Requirements

Current Clinical Status: Clinically Active

Clinical Status History:
Jun 28, 2018 - Clinically Active

Initial display of clinical status began June 2018 and history is only shown for certified periods.

Beginning in 2011 certification by the American Board of Family Medicine is maintained through successful completion of the Family Medicine Certification process. The Family Medicine Certification process is a continuous process that requires being in compliance with Guidelines for Professionalism, Licensure and Personal Conduct including maintaining a currently valid, full, and unrestricted license to practice medicine in the United States or Canada, completing certification activities in a timely fashion, and performing successfully on the examination every ten years. Failure to maintain any of these requirements will result in the loss of certification status with the ABFM. Based upon the continuous nature of Family Medicine Certification, no end date for certification is presented above.

Certification in Family Medicine was for a period of seven years. From 1970 through 2002, certification was renewed by completion of requirements for Recertification. Each physician (Diplomate) fulfilled these requirements by maintaining a medical license to practice medicine in the United States or Canada, earning 300 hours of continuing medical education (CME), completing a computerized office record review, and performing successfully on the recertification examination.

In 2003 family physicians who performed successfully on the Certification and Recertification examinations began a gradual transition from Recertification to MC-FP. MC-FP was designed to transition all Diplomates into the program by 2010, enrolling all physicians who certified or recertified as they successfully passed the examination.



American Board of Family Medicine, Inc.

Quality Healthcare, Public Trust . . . Setting the Standards in Family Medicine

The ABFM website serves as primary source verification. Details of the Family Medicine Certification process are available online at www.theabfm.org.

Sincerely,

Mary McIntosh

Mary McIntosh
Verification Coordinator and Candidate Assistant

Cornell University

Be it known that

Alinda Whisler Prime

having satisfied in full the requirements for the degree of

Doctor of Medicine

has been admitted to that degree with all
the rights, privileges and honors pertaining thereto

in witness of this action the seal of the University and the signatures
authorized by the Board of Trustees are affixed below

Given at New York, New York, on the twenty-eighth day of May,
in the year one thousand nine hundred and eighty-seven

Attest
Secy



Samuel J. Davis
President



Linda W Prine MD, FAAFP

New York, NY 10025-7522
US
Current as of 9/22/2020

2020

Date	Title	P Credits	E Credits	
05/15/2020	Scholarly Activity: Ectopic Pregnancy: Diagnosis and Management	20.00	0.00	
08/21/2020	Formal Activity - AMA/AOA Approved: Opioid Prescriber Training Program * Required by DEA	0.00	2.00	
		Prescribed	Elective	Total P&E
	Live Credits:	0.00	0.00	0.00
	Total Credits:	20.00	2.00	22.00

2019

Date	Title	P Credits	E Credits
01/02/2019	Teaching : Resident and Fellow teaching	200.00	0.00
01/17/2019	Scientific Assembly - Winter Weekend New York AFP	19.00	0.00
04/26/2019	52nd STFM Annual Spring Conference Society of Teachers of Family Medicine	30.75	0.00
07/10/2019	Women's Health : USPSTF and Choosing Wisely: Focus on Women Part 1 American Academy of Family Physicians	0.75	0.00
07/10/2019	Women's Health : Question and Answer/Panel Discussion #3 American Academy of Family Physicians	0.25	0.00
07/10/2019	Women's Health : Hot Topics/Question and Answer/Panel Discussion #2 American Academy of Family Physicians	0.25	0.00
07/12/2019	Women's Health : Question and Answer/Panel Discussion #1 American Academy of Family Physicians	0.25	0.00
07/12/2019	Women's Health : Sexual Dysfunction in Women American Academy of Family Physicians	0.50	0.00
09/24/2019	2019 Family Medicine Experience (FMX) : Preconception Counseling: What Is Supported by Evidence? American Academy of Family Physicians	1.00	0.00

Linda W Prine MD, FAAFP

09/26/2019	2019 Family Medicine Experience (FMX) : Safe Medical Abortion Care American Academy of Family Physicians	1.00	0.00
09/26/2019	2019 Family Medicine Experience (FMX) : Insertions and Removals of IUDs: Fundamentals American Academy of Family Physicians	2.00	0.00
09/27/2019	2019 Family Medicine Experience (FMX) : Navigating the Complexities of Contraceptive Care American Academy of Family Physicians	1.00	0.00
09/27/2019	2019 Family Medicine Experience (FMX) : Advanced Concepts: First Trimester Pregnancy Complications - Managing Ectopics, Gestational Trophoblastic Disease, and Spontaneous Abortion Diagnostic Challenges American Academy of Family Physicians	1.00	0.00
09/27/2019	2019 Family Medicine Experience (FMX) : Main Stage: Top 10: EBM Updates American Academy of Family Physicians	1.00	0.00
10/17/2019	Formal Live Activity - AMA/AOA Approved: Annual Meeting Society of Family Planning	0.00	25.00

	Prescribed	Elective	Total P&E
Live Credits:	258.75	258.75	283.75
Total Credits:	258.75	25.00	283.75

AMERICAN ACADEMY OF FAMILY PHYSICIANS

Total Prescribed Credits: 278.75

Total Elective Credits: 27.00

Total Live Credits: 283.75

Total Credits: 305.75

Provided to AAFP members
on a complimentary basis
as a membership service.



R. Shawn Martin
Executive Vice President/CEO
American Academy of Family Physicians

The University of the State of New York
Education Department
Office of the Professions

REGISTRATION CERTIFICATE
Do not accept a copy of this certificate

License Number: 175059-01

Certificate Number: 0680904

PRIME LINDA WHISLER
INSTITUTE FAMILY HLTH

[REDACTED] NY 10011-0000



is registered to practice in New York State through 08/31/2021 as a(n)
PHYSICIAN

Jordan Fine
LICENSE SECRETARY
Stephanie Bone
EXECUTIVE SECRETARY

Maury Ellen Elin
COMMISSIONER OF REGULATION

Dee E. Hill
DEPUTY COMMISSIONER
FOR THE PROFESSIONS

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10003683.2/000627-1/1-0

1:2 PRINE, LINDA W
809/656 230 W 17TH ST
NEW YORK, NY 10011-5325



DEA REGISTRATION NUMBER	THIS REGISTRATION EXPIRES	FEE PAID
[REDACTED]	03-31-2023	\$731
SCHEDULES	BUSINESS ACTIVITY	ISSUE DATE
2,2N, 3,3N,4	PRACTITIONER-DW/30	02-19-2020
PRINE, LINDA W WEST 17TH STREET FAMILY PRACTICE 230 W 17TH ST NEW YORK, NY 10011-5325		

CONTROLLED SUBSTANCE REGISTRATION CERTIFICATE
UNITED STATES DEPARTMENT OF JUSTICE
DRUG ENFORCEMENT ADMINISTRATION
WASHINGTON D.C. 20537

Sections 304 and 1008 (21 USC 824 and 958) of the Controlled Substances Act of 1970, as amended, provide that the Attorney General may revoke or suspend a registration to manufacture, distribute, dispense, import or export a controlled substance.

THIS CERTIFICATE IS NOT TRANSFERABLE ON CHANGE OF OWNERSHIP, CONTROL, LOCATION, OR BUSINESS ACTIVITY, AND IT IS NOT VALID AFTER THE EXPIRATION DATE.

CONTROLLED SUBSTANCE REGISTRATION CERTIFICATE
UNITED STATES DEPARTMENT OF JUSTICE
DRUG ENFORCEMENT ADMINISTRATION
WASHINGTON D.C. 20537

DEA REGISTRATION NUMBER	THIS REGISTRATION EXPIRES	FEE PAID
[REDACTED]	03-31-2023	\$731
SCHEDULES	BUSINESS ACTIVITY	ISSUE DATE
2,2N, 3,3N,4	PRACTITIONER-DW/30	02-19-2020
PRINE, LINDA W WEST 17TH STREET FAMILY PRACTICE 230 W 17TH ST NEW YORK, NY 10011-5325		

Sections 304 and 1008 (21 USC 824 and 958) of the Controlled Substances Act of 1970, as amended, provide that the Attorney General may revoke or suspend a registration to manufacture, distribute, dispense, import or export a controlled substance.

THIS CERTIFICATE IS NOT TRANSFERABLE ON CHANGE OF OWNERSHIP, CONTROL, LOCATION, OR BUSINESS ACTIVITY, AND IT IS NOT VALID AFTER THE EXPIRATION DATE.

Form DEA-223 (9/2016)

DEA REGISTRATION	THIS REGISTRATION	FEE
[REDACTED]	EXPIRES	PAID
	31-2023	\$731
SCHEDULES	BUSINESS ACTIVITY	ISSUE DATE
2,2N, 3,3N,4	PRACTITIONER-DW/30	02-19-2020
PRINE, LINDA W WEST 17TH STREET FAMILY PRACTICE 230 W 17TH ST NEW YORK, NY 10011-5325		

**CONTROLLED SUBSTANCE/REGULATED CHEMICAL
REGISTRATION CERTIFICATE**
 UNITED STATES DEPARTMENT OF JUSTICE
 DRUG ENFORCEMENT ADMINISTRATION
 WASHINGTON D.C. 20537

Sections 304 and 1008 (21 USC 824 and 868) of the Controlled Substances Act of 1970, as amended, provide that the Attorney General may revoke or suspend a registration to manufacture, distribute, dispense, import or export a controlled substance.

THIS CERTIFICATE IS NOT TRANSFERABLE ON CHANGE OF OWNERSHIP, CONTROL, LOCATION, OR BUSINESS ACTIVITY, AND IT IS NOT VALID AFTER THE EXPIRATION DATE.

Form DEA-223/511 (9/2016)

**REPORT
CHANGES
PROMPTLY**

**REQUESTING MODIFICATIONS TO YOUR
REGISTRATION CERTIFICATE**

To request a change to your registered name, address, the drug schedule or the drug codes you handle, please

1. visit our web site at deaddiversion.usdoj.gov - or
2. call our customer Service Center at 1-(800) 892-8639 - or
3. submit your change(s) in writing to:
 Drug Enforcement Administration
 P.O. Box 2838
 Springfield, VA 22162-2838

See Title 21 Code of Federal Regulations, Section 1301.51 for complete instructions.

----- You have been registered to handle the following chemical/drug codes: -----