



**Interstate  
Medical Licensure  
Compact**

A faster pathway to medical licensure



## MEDICAL LICENSE ISSUANCE INFORMATION

Physician's Name Ghazaleh Kinney Moayed  
First Middle Last

Please fill in your respective Member Board's information for the qualified Physician named above.

National Provider Identifier Number 1639435662

Medical Board Name NEW HAMPSHIRE BOARD OF MEDICINE

Member Board License Number 22382

Date License Issued 2/7/2022  
mm/dd/yyyy

Date of Expiration 6/30/2024  
mm/dd/yyyy

Member Board Signature *Jennifer Welcome-Miller*

Name Jennifer Welcome-Miller  
Date 2/7/2022

**STATE OF NEW HAMPSHIRE**  
**OFFICE OF PROFESSIONAL LICENSURE AND CERTIFICATION**  
**DIVISION OF HEALTH PROFESSIONS**

Board of Medicine  
7 Eagle Square  
Concord, N.H. 03301  
Telephone 603-271-1203 Fax 603-271-6702



February 7, 2022

GHAZALEH KINNEY MOAYEDI, DO  
1408 N. RIVERFRONT BLVD  
SUITE 333  
DALLAS TX 75207

Dear Dr. MOAYEDI:

Congratulations. The New Hampshire Board of Medicine has granted your application for licensure. Your license number is 22382 and is dated February 7, 2022.

You are required to renew your license on a biennial basis and forms for that purpose will be forwarded to you at the email address on file with the Board in April of the year in which your renewal is set to occur. Please be aware that you are required to inform the Board of any change of address within 30 days of that change.

**IMPORTANT: As a licensee in New Hampshire, you are required to register for the NH Prescription Drug Monitoring Program ("NH PDMP") within 90 days from the date your license was issued. (Med 501.02(I)) Please visit the website at <https://newhampshire.pmpaware.net/login> and register using the attached instructions. The NH PDMP Help Desk information is 855-353-9903.**

Please feel free to contact this office if you have any questions.

Encl.

Sincerely,  
Christine Senko  
Administrator



RECEIVED  
FEB 07 2022  
NH BOARD

PHYSICIAN'S CORE DATA SHEET

(Must be the *physician's* accurate information to avoid delay or rejection)

Full Legal Name Ghazaleh, Kinney, Moayed,

Other names used (maiden, birth) Ghazaleh,  Moayed-Esfahani

Residential address [REDACTED]

Office address 1408 N Riverfront Blvd, Suite 333, Suite 333, Dallas, TEXAS, 75207,

Where do you wish to receive mail. Office

Physician's cellular or alternative telephone number [REDACTED]

Physician's office or practice telephone number of public record (512) 643 - 4760

Date of Birth [REDACTED] Gender: Female

Applicants personal email address [REDACTED]

Email address delegated by applicant to receive correspondence [REDACTED]

Social Security Number: XXX XX XXXX [REDACTED]

Physician's National Provider Identifier Number 1639435662



Are you a graduate of a medical school accredited by the Liaison Committee on Medical Education or the Commission on Osteopathic College Accreditation, or a medical school listed in the International Medical Education Directory or its equivalent? **Yes**

Medical School University of North Texas, Texas College of Osteopathic Medicine Date of Degree Issued 5/19/2012 Medical Degree Received: D.O.

Have you passed each component or step of the USMLE, or the COMLEX-USA within three (3) attempts, or any of their predecessor examinations accepted by your SPL medical board as an equivalent examination for licensure purposes (if in question contact your SPL)? **Yes**

Which licensing exam did you pass? NBOME

Have you successfully completed graduate medical education approved by the ACGME or the AOA? **Yes**

Residency Program Texas Tech Health Sciences Center El Paso Completion Date 6/30/2016

What is the specialty of the program Obstetrics and Gynecology

Do you hold specialty certification or a time-unlimited specialty certificate recognized by the American Board of Medical Specialties (ABMS) or the American Osteopathic Association's Bureau of Osteopathic Specialists (AOABOS)? (Board eligibility does not qualify) **Yes**

Name of Specialty Board Certification American Board of Obstetrics and Gynecology

Lifetime No If not lifetime, Expiration Date 12/31/2021

Have you ever been convicted, received adjudication, community supervision, or deferred disposition for any offense by a court of appropriate jurisdiction? **No**

Have you ever held a license authorizing the practice of medicine subjected to discipline by a licensing agency in any state, federal or foreign jurisdiction, excluding any action related to non-payment of fees related to a license? **No**

Have you ever had a controlled substance license or permit suspended or revoked by a state or the United States Drug Enforcement Administration? **No**

Are you under investigation by a licensing agency or law enforcement authority in any state, federal or foreign jurisdiction? **No**



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**Application for Expedited Licensure**

I have read and understood the Qualifications to practice medicine in the Compact states. I attest that I am qualified and understand that pursuant to the IMLCC's rules, all fees are non-refundable. **Yes**

If you have questions please call your State of Principle License

I understand that inaccurate or missing information may be grounds for rejection of my application.

Please carefully review the Application documents before applying. **Yes**

I have reviewed the criteria to select a State of Principal License (SPL) and confirm eligibility to designate a Compact state as my SPL. **Yes**

I have a full and unrestricted license in a Compact State **Yes**

SPL ALABAMA BOARD OF MEDICAL EXAMINERS License # DO-1678

**AND** at least one of the below must APPLY (Please select all that apply)

- a. Your primary residence is in the SPL (State of Principal License) No
- b. At least 25% of your practice of medicine occurs in the SPL Yes
- c. Your employer is located in the SPL No
- d. You use the SPL as your state of residence for U.S. federal income tax purposes No

Please provide below information:

Residence Street address \_\_\_\_\_

Residence City State Zip \_\_\_\_\_, \_\_\_\_\_, \_\_\_\_\_

Please describe your practice and location in the SPL selected \_\_\_\_\_ I provide telemedicine obstetrics and gynecology care through Gennev for 25% of my practice and I am the Alabama provider for Gennev.

Please be prepared to provide documentation to the designated SPL for further verification. If you have any question please contact your SPL.

You or your employer may be asked for additional documentation about your Employment.

Name of Employer \_\_\_\_\_ Employer Contact Phone \_\_\_\_\_

Employer Street address \_\_\_\_\_

Employer City State Zip \_\_\_\_\_, \_\_\_\_\_, \_\_\_\_\_

Please provide your Tax ID # (SS#, EIN) \_\_\_\_\_ (must be most recent return) Please be prepared to provide documentation to the designated SPL for further verification.



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**AFFIDAVIT AND AUTHORIZATION FOR RELEASE OF INFORMATION FOR APPLICATION FOR AN IMLC LETTER OF QUALIFICATION  
AND MEDICAL LICENSES IN IMLC MEMBER STATES**

I, Ghazaleh Kinney Moayed ( full legal name) the undersigned, being duly sworn, hereby certify under oath that I am the person named in this Application for an IMLC Letter of Qualification and Medical Licenses in IMLC Member States ("Application"), that all statements I have made or shall make with respect thereto are true, that I am the original and lawful possessor of and person named in the various forms and credentials furnished or to be furnished with respect to my Application, and that all documents, forms, or copies thereof, furnished or to be furnished with respect to my application, are strictly true in every aspect.

I acknowledge that I have read and understand the Interstate Medical Licensure Compact ("Compact") and the Application, and have answered all questions contained in the Application truthfully and completely. I further acknowledge failure on my part to answer questions truthfully and completely may lead to disciplinary action against one or more medical licenses or permits I hold, as well as potential prosecution under appropriate federal and state laws.

I hereby apply to ALABAMA BOARD OF MEDICAL EXAMINERS (state) as my State of Principal License ("SPL") for a Letter of Qualification ("LOQ") to be issued a medical license in one or more Compact Member States. To permit the SPL to process my application for an LOQ, I authorize and request every person, entity, hospital, clinic, government agency (local, state, federal, or foreign), court, association, institution, or law enforcement agency having custody or control of any documents, records, and other information pertaining to me, to furnish to the SPL 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 SPL, or any of its agents or representatives, to inspect and make, or receive, copies of such documents, records, and other information in connection with this Application. I also authorize the SPL to perform or obtain a criminal history background check with law enforcement on me as part of the determination of my eligibility to be licensed through the Compact

I hereby release, discharge, and exonerate the SPL and the Interstate Medical Licensure Compact Commission ("Commission"), their agents or representatives, and any person, entity, hospital, clinic, government agency (local, state, federal, or foreign), court, association, institution, or law enforcement agency having custody or control of any documents, records, and other information pertaining to me, of any and all liability of every nature and kind, arising out of an investigation made by the SPL.

I also hereby apply to the Compact Member States' medical boards ("Member Boards") I have designated in this Application. Additionally, I further authorize the SPL to process and release my application for medical licensure by one or more Member Boards including, but not limited to, personally-identifiable information including my Social Security Number to be used for querying the National Practitioner Data Bank and in child support enforcement actions. I hereby release, discharge, and exonerate the SPL and the Commission, and their employees, agents, or representatives, of any, and all liability of every nature and kind, arising out of any disclosure to the Member Boards.

I will immediately notify the SPL and the Commission in writing of any changes to the answers to any of the questions contained in this application, if such a change occurs at any time prior to a medical license being issued by one or more of the Member Boards.

I understand my failure to answer questions contained in this Application truthfully and completely may lead to denial of my application for a LOQ, revocation, or other disciplinary sanctions of my license(s) or permit(s) to practice medicine, in one or more Compact Member States.

Applicant Signature

*Ghazaleh Moayed*

Type Applicant's Name

Ghazaleh Moayed

Applicant's NPI

1639435662

Date

11/1/2021



## Letter of Qualification

Date: 1/5/2022

Name: Ghazaleh Kinney Moayed

Address: [REDACTED]

CityStZip: [REDACTED]

Dear Dr.: Ghazaleh Kinney Moayed

RE: Your application for IMLC Letter of Qualification

The ALABAMA BOARD OF MEDICAL EXAMINERS ("Board"), on behalf of the State of Principal Licensure ("SPL") you selected, has received and reviewed your application for a Letter of Qualification ("LOQ") for licensure through the Interstate Medical Licensure Compact ("IMLC").

Based upon the information you submitted with your application, data in the Board's files regarding your licensure by the Board, verifications of your credentials, and the results of the check of national databases, the Board has determined that you are ELIGIBLE to be licensed through the IMLC. Therefore, this notice will serve as your LOQ for licensure in IMLC Member States through the IMLC, and will remain in effect for 365 days from date of issuance, set out above.

An email has been sent to you with instructions regarding how to select the IMLC Member State(s) where you wish to be licensed. After you make your selection(s) and make payment for each license, your information will be forwarded to the selected board(s) ("Member Boards") for issuance of a medical license in by each.

All medical licenses issued by Member Boards through the IMLC are full and unrestricted licenses. You will be responsible for complying with all laws and regulations pertaining to holding each license and the practice of medicine in those jurisdictions including, but not limited to, each Member Board's continuing medical education requirements. It is also your obligation to keep your SPL, the Member Boards which have licensed you, and the IMLC Commission informed of any changes in your contact information or qualifications and eligibility for licensure through the IMLC.

Authorized Signature from SPL

Type Name Ashley Jehle  
Title of Authorized SPL Credentialing Specialist  
Date 1/5/2022

## Welcome-Miller, Jennifer

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**From:** Welcome-Miller, Jennifer  
**Sent:** Monday, February 7, 2022 11:03 AM  
**To:** [REDACTED]  
**Subject:** Photo verification needed - Compact Application

Dr. Moayedi,

Per Administrative rules Med 301.03(a)(27) all applicants are required to have a recent full face 2 x 3 inch photo with their application. Please send one to the Board at the address below. Please attach a note with your name so we can get it to the right file or you can email it to me.

Thank you,

Jenn Welcome-Miller  
Licensing Clerk I  
7 Eagle Square  
Ste 300  
Concord, NH 03301  
Phone: (603) 271-2152

**PLEASE NOTE:** Board staff are not authorized to provide any legal advice, but are able to refer you to the statutes/rules. You should seek advice regarding its applicability to your specific situation from your personal or corporate legal counsel.

*The contents of this message are confidential. Any authorized disclosure, reproduction, use or dissemination (either whole or in part) is prohibited. If you are not the intended recipient of this message, please notify the sender immediately and delete the message and any attachments from your system*





**INTERSTATE MEDICAL LICENSURE COMMISSION**

ADDRESS: 121 South Fruit Street, Suite 301  
Concord, NH 03301-2412

PHONE: 603-271-1203  
FAX: 603-271-6702  
EMAIL: [sharon.canney@opl6.nh.gov](mailto:sharon.canney@opl6.nh.gov)

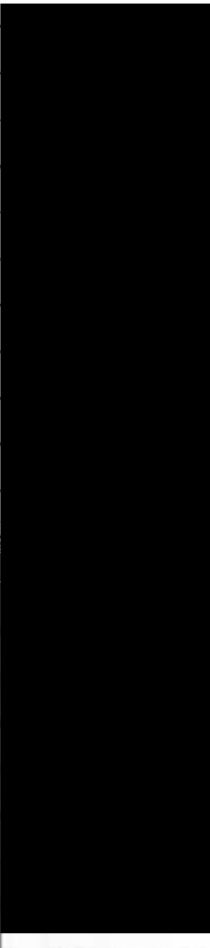
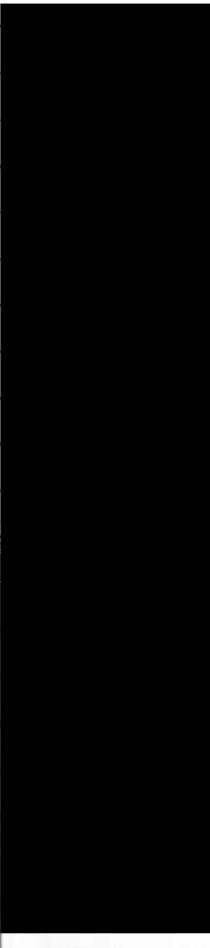
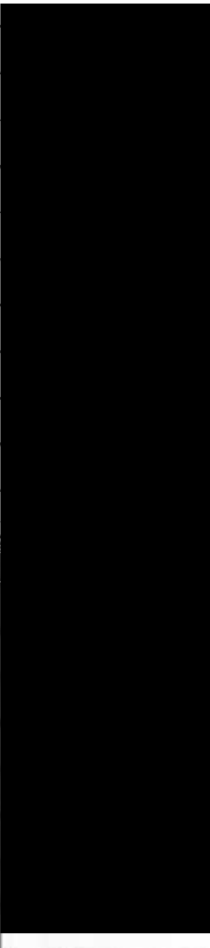
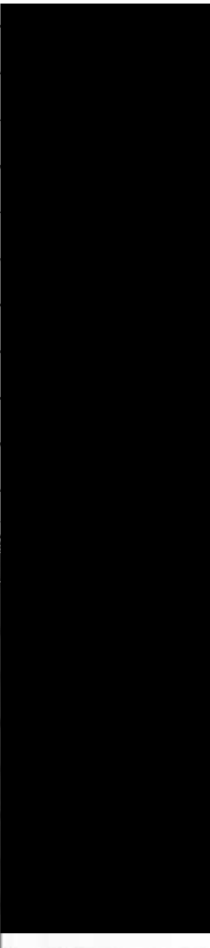
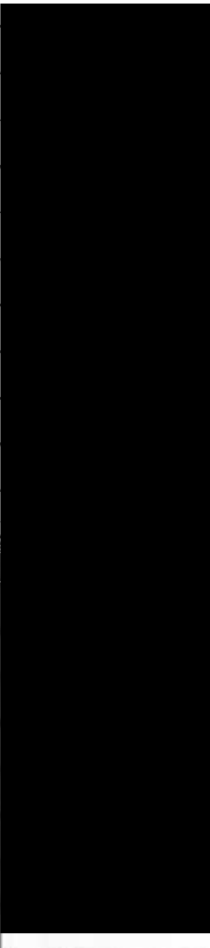
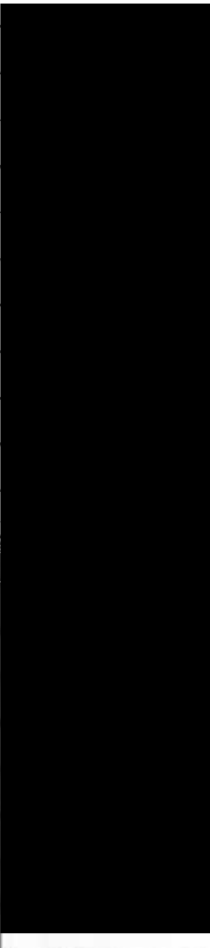
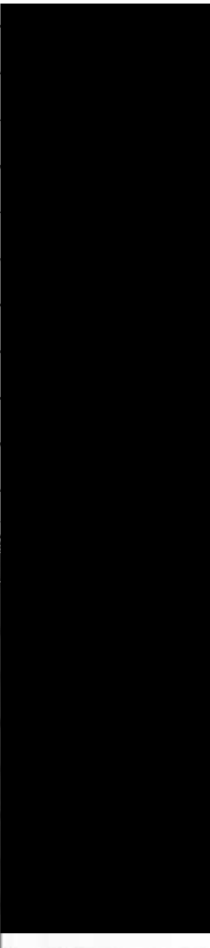
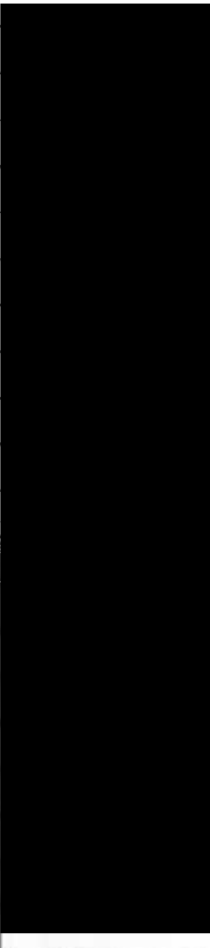
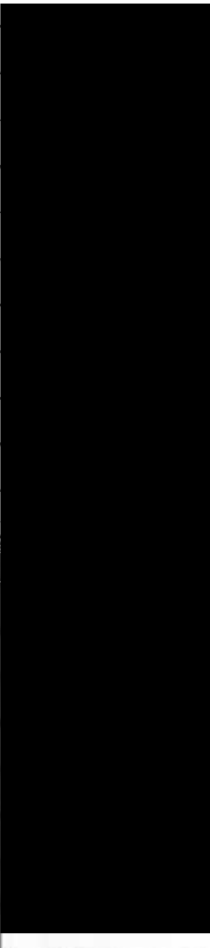
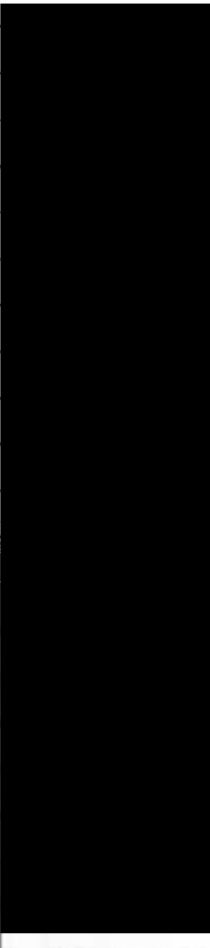
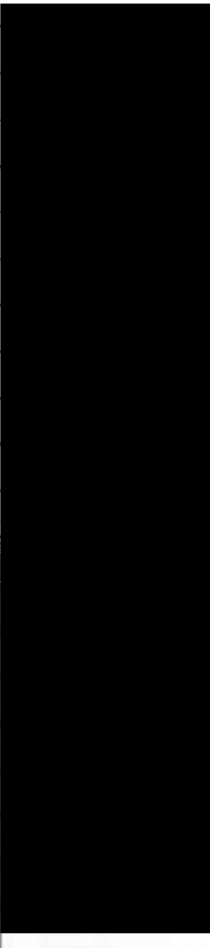
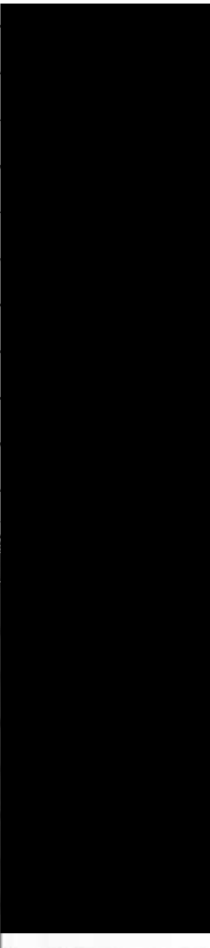
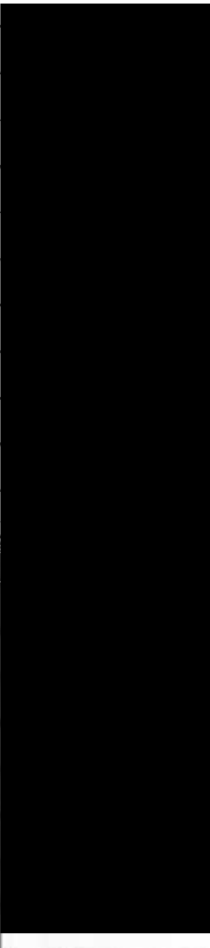
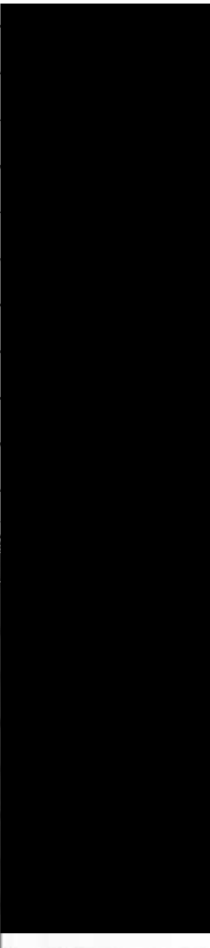
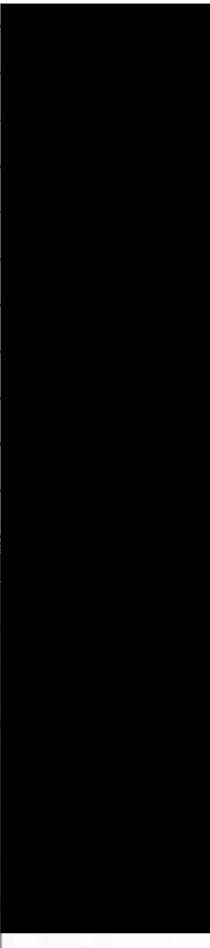
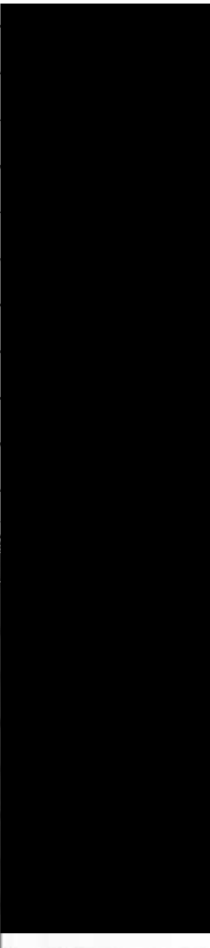
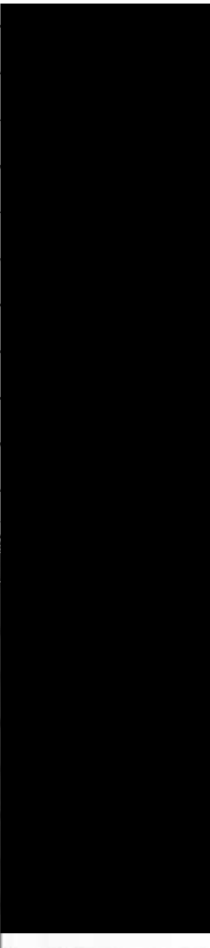
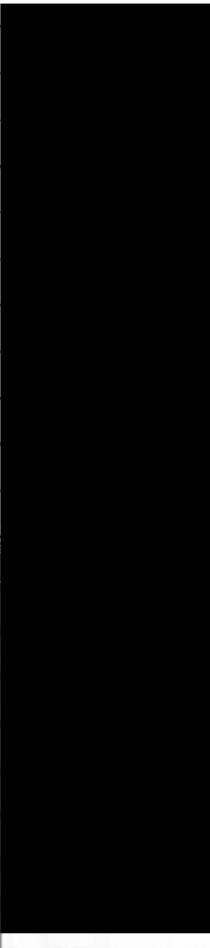
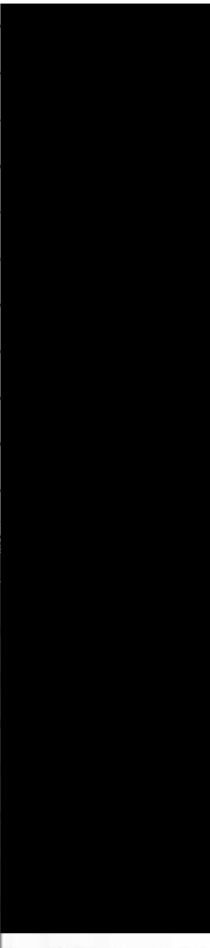
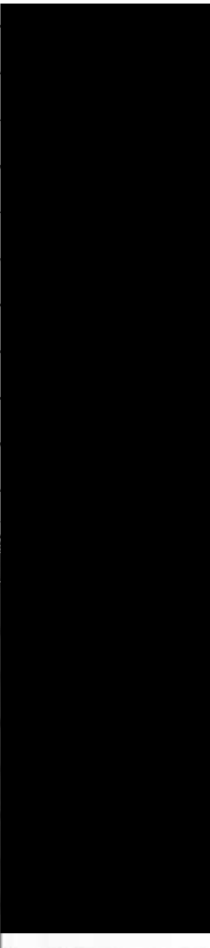

**Statement**

STATEMENT#: 2022-032\_NH  
DATE: February 14, 2022  
STATE BOARD: NEW HAMPSHIRE BOARD OF MEDICINE

PAID BY: 

REMITTANCE AMOUNT ENCLOSED \$ 

PAYMENT NOTES  
Remittance paid when completed

TRANSACTION TYPE	PAYMENT DATE	AMOUNT	REGIDR NAME	
Additional	2/7/2022 3:38	\$		
Initial	2/7/2022 7:51	\$		
Additional	2/9/2022 5:45	\$		
Additional	2/4/2022 3:11	\$		
LOQ	2/4/2022 8:04	\$		
LOQ	2/10/2022 4:10	\$		
LOQ	2/8/2022 2:24	\$		
Additional	2/9/2022 5:52	\$		
LOQ	2/7/2022 8:04	\$		
LOQ	2/9/2022 2:28	\$		
LOQ	2/5/2022 12:34	\$		
LOQ	2/7/2022 8:27	\$		
Initial	2/9/2022 2:23	\$		
LOQ	2/9/2022 9:34	\$		
Additional	2/4/2022 5:54	\$		
Initial	2/10/2022 5:12	\$		
Additional	2/9/2022 5:58	\$		
LOQ	2/4/2022 2:04	\$		
LOQ	2/8/2022 8:27	\$		
LOQ	2/9/2022 6:35	\$		
				NOTES
				



**Wagner, Kristin**

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**From:** Ghazaleh Moayed [REDACTED]  
**Sent:** Friday, February 11, 2022 3:21 PM  
**To:** OPLC: Medicine  
**Subject:** Re: New License Letter

**EXTERNAL: Do not open attachments or click on links unless you recognize and trust the sender.**

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Ok, perfect, thank you!

**Ghazaleh Moayed, DO, MPH, FACOG**  
she/her/hers



On Fri, Feb 11, 2022 at 2:17 PM OPLC: Medicine <[Medicine@oplc.nh.gov](mailto:Medicine@oplc.nh.gov)> wrote:

Hi Dr Moayed,

If you are not obtaining a DEA license for the state of NH, then you would not need to register with the PDMP.

*Kristin Wagner*

*License Associate I*

*Office of Professional Licensure & Certification*

*7 Eagle Square*

*Concord, NH 03301*

**From:** Ghazaleh Moayed [REDACTED]  
**Sent:** Monday, February 7, 2022 4:11 PM  
**To:** DoIT: Licenses, NH <[NH.Licenses@doit.nh.gov](mailto:NH.Licenses@doit.nh.gov)>; OPLC: Customer Support <[CustomerSupport@oplc.nh.gov](mailto:CustomerSupport@oplc.nh.gov)>  
**Subject:** Re: New License Letter

**EXTERNAL: Do not open attachments or click on links unless you recognize and trust the sender.**

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Hello-

I am not intending to prescribe narcotics in New Hampshire and therefore am not also obtaining a DEA license for the state. It looks like a DEA number is required for the PDMP. Am I still required to register if I'm not planning on prescribing narcotics?

Thank you,

**Ghazaleh Moayedi, DO, MPH, FACOG**

she/her/hers



On Mon, Feb 7, 2022 at 1:34 PM <[NH.Licenses@doit.nh.gov](mailto:NH.Licenses@doit.nh.gov)> wrote:

An important attachment from the NH Office of Professional Licensure is attached to this email.

If you have any questions please contact [CustomerSupport@opl.nh.gov](mailto:CustomerSupport@opl.nh.gov)