Medicine Form 1

The University of the State of New York
THE STATE EDUCATION DEPARTMENT
Office of the Professions
Division of Professional Licensing Services
www.op.nysed.gov

[redacted]

Department Use Only

Application for Licensure

Applicants Must Complete All Six Pages Of This Application *In Ink*

1 ☐ 60 $735 ER

NYS License Number

Date Issued

Initials

2 **Social Security Number**
(Leave this blank if you do not have a U.S. Social Security Number) [redacted]

3 **Birth Date** [redacted]

4 **Print Full Name**

Last BARON

First KATE

Middle SHAW

Licensee business address, phone and e mail address are public information. Failure to indicate business or home on this form for each item will deem it public information.

5 **Mailing Address:** ☒ Home or ☐ Business
(You must notify the Department promptly of any address or name changes.)

Line 1 [redacted]
Line 2
Line 3
City BROOKLYN
State NY Zip Code [redacted]
Country/ Province USA

7 **New York State DMV ID Number**
(Driver or Non-Driver ID)

(Leave this blank if you do not have a New York State DMV ID Number)

6 **Telephone/E-Mail Address**

Daytime Phone: ☒ Home or ☐ Business [redacted]
Area Code Phone Number

E-Mail Address (Please print clearly): ☒ Home or ☐ Business [redacted]

8 Name as it appears on degree or other credentials (if different from above): _____

9 I wish to become licensed on the basis of:

[redacted] Acceptable examination scores *(see page 3 of this form)*

[redacted] Endorsement of another license
(See "Applicants Licensed in Another State" section of instructions.)

I am using FCVS to collect my credentials: [redacted] YES [redacted] NO

10 Have you previously applied for a New York State License or a limited permit to practice medicine? [redacted]

11 Have you ever been found guilty after trial, or pleaded guilty, no contest, or nolo contendere to a crime (felony or misdemeanor) in any court?

12 Is any criminal charge pending against you in any court in any jurisdiction?

13 Has any licensing or disciplinary authority refused to issue you a license or ever revoked, annulled, cancelled, accepted surrender of, suspended, placed on probation, refused to renew a professional license or certificate held by you now or previously, or ever fined, censured, reprimanded or otherwise disciplined you?

14 Are charges pending against you in any jurisdiction for any sort of professional misconduct?

15 Has any hospital or licensed facility restricted or terminated your professional training, employment, or privileges or have you ever voluntarily or involuntarily resigned or withdrawn from such association to avoid imposition of such measures?

NOTE: If you answer "Yes" to any questions numbered 11-15, submit a letter giving a complete detailed explanation. Include copies of any court records including a Certificate of Disposition. If there are offenses in multiple courts, please provide the same for each action. If the court can no longer provide documentation, you must request, from the court, a letter stating why they cannot provide the documents. While your application is pending, you must notify the Division of Professional Licensing Services if the answers to any of these questions have changed.

16 In the spaces below, give an accurate record of your educational preparation. Be sure to complete items A-E for each school. Please print. List diploma or degree titles in original language and translate. If no diploma or degree, indicate number of credits earned. Attach additional sheets if necessary.

A. NAME OF SCHOOLS ATTENDED AND LOCATIONS	B. NUMBER OF YEARS ATTENDED	C. ATTENDANCE		D. TITLE OF DIPLOMA OR DEGREE OBTAINED (INDICATE MONTH/YEAR OBTAINED)	E. IF NO DIPLOMA OR DEGREE, INDICATE NUMBER OF CREDITS EARNED
		Entrance Date	Leaving Date		
High School or Secondary School [redacted]	[redacted]	[redacted]	[redacted]	[redacted]	E
Postsecondary Preprofessional School(s) (Exclusive of Medical School) [redacted]	[redacted]	[redacted]	[redacted]	[redacted]	[redacted]
Columbia University School Name New York NY, USA City State/Country	D 2	08, 2008 mo yr	06, 2010 mo yr	Post-baccalaureate Premedical program certificate.	E
Medical Education (Professional, list all medical schools attended) University of Texas Southwestern Medical Schoo School Name Dallas TX, USA City State/Country A School Name City State/Country	4 B	08, 2012 mo yr C mo yr	06, 2016 mo yr mo yr	M.D. D	E

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

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

17 Are you licensed or have you ever been licensed as a physician in any other state or country? Yes ☐ No ☒

If yes, list each jurisdiction. If appropriate, you must also submit a Form 3A or 3B. *See Examination Requirements section of instructions.*

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

18 Are you applying for licensure on the basis of a Fifth Pathway program? [redacted]

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

Name and Location of Medical School or Hospital	Inclusive Dates of Attendance
[redacted]	

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

Name of Qualifications	Name and location of organization issuing credential

20 [redacted] I will be applying to the Federation of State Medical Boards (FSMB) for USMLE Step 3

OR

I have successfully completed the examination combination indicated below:

EXAMINATION COMBINATIONS

[redacted]

- USMLE Steps 1, 2, and 3
- FLEX Parts I, II, and III
- FLEX Components I and II
- NBME Parts I, II, and III
- NBME Parts I and II and USMLE Step 3
- NBME Part I, USMLE Step 2 and NBME Part III
- NBME Part I, and USMLE Steps 2 and 3
- USMLE Step 1, and NBME Parts II and III

[redacted]

- USMLE Step 1, NBME Part II, and USMLE Step 3
- USMLE Steps 1 and 2 and NBME Part III
- USMLE Step 1, NBME Part II, and FLEX Component II
- NBME Part I, USMLE Step 2, and FLEX Component II
- USMLE Steps 1 and 2 and FLEX Component II
- NBME Parts I and II and FLEX Component II
- FLEX Component I and USMLE Step 3
- NBOME Parts I, II, and III
- Other: [redacted]

Date examination sequence was completed [redacted]

21 Provide a chronological list of all activities since graduation from professional school to the present. Include residency, employment and vacation periods. Be sure there are no gaps in time from the ending date of one activity to the beginning date of the next activity. Any gap in time will cause a delay in the processing of your application. Attach additional sheets if necessary.

Graduation Date from Medical School: 06 (mo.) / 01 (day) / 2016 (yr.)

1. Beginning 07 (month) / 2016 (year) Ending 06 (month) / 2019 (year) Type of activity ☒ Residency ☐ Employment ☐ Vacation (if residency or employment, fill out name and address below)

   Name of Employer/Facility Mount Sinai Downtown Residency in Urban Family Medicine.

   Address Institute for Family Health, 230 W. 17th St, New York, NY 10011 (Street / City / State / ZIP Code)

2. Beginning ____ / ____ (month / year) Ending ____ / ____ Type of activity ☐ Residency ☐ Employment ☐ Vacation (if residency or employment, fill out name and address below)

   Name of Employer/Facility _____

   Address _____ (Street / City / State / ZIP Code)

3. Beginning ____ / ____ (month / year) Ending ____ / ____ Type of activity ☐ Residency ☐ Employment ☐ Vacation (if residency or employment, fill out name and address below)

   Name of Employer/Facility _____

   Address _____ (Street / City / State / ZIP Code)

4. Beginning ____ / ____ (month / year) Ending ____ / ____ Type of activity ☐ Residency ☐ Employment ☐ Vacation (if residency or employment, fill out name and address below)

   Name of Employer/Facility _____

   Address _____ (Street / City / State / ZIP Code)

5. Beginning ____ / ____ (month / year) Ending ____ / ____ Type of activity ☐ Residency ☐ Employment ☐ Vacation (if residency or employment, fill out name and address below)

   Name of Employer/Facility _____

   Address _____ (Street / City / State / ZIP Code)

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

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

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

- ☐ I graduated from a medical school in New York State after September 1, 1990.
- ☒ I completed the child abuse coursework and have enclosed a certificate of completion from an approved provider.
- ☐ I am filing for an exemption to the requirement and have enclosed the exemption form.
- ☐ I am going to take the Child Abuse Identification course and submit the required form.

24 **CITIZENSHIP/IMMIGRATION STATUS**

Federal law and the Regulations of the Commissioner of Education (8 NYCRR §59.4) limit the issuance of professional licenses, registrations and limited permits to United States citizens or qualified aliens. To comply with Federal law and Commissioner's regulation, you must complete this section of this form and check the appropriate box below which indicates your citizenship/immigration status.

I am:

[redacted]

A United States citizen or National.

An alien lawfully admitted for permanent residence in the United States.

An alien granted asylum under Section 208 of the Immigration and Nationality Act.

A refugee granted asylum under Section 207 of the Immigration and Nationality Act.

An alien paroled into the United States under Section 212 (d)(5) of the Immigration and Nationality Act for a period of at least 1 year.

An alien whose deportation is being withheld under Section 241 (b)(3) of the Immigration and Nationality Act.

An alien granted conditional entry pursuant to Section 203 (a)(7) of the Immigration and Nationality Act as in effect prior to April 1980.

Non Immigrant (Temporarily in U.S.) Please list Visa type or immigration status or attach a copy of your passport if you are not required to have a Visa to enter the United States: [redacted]

I am an alien not unlawfully present in the United States pursuant to the Deferred Action for Childhood Arrivals (DACA) relief or similar relief from deportation. Please specify: [redacted]

I do not reside in the United States.

If you checked any of the boxes from B-I, enter your alien registration number or control number issued by the United States Citizenship and Immigration Services (USCIS): USCIS number: [redacted]

QUESTIONS ABOUT YOUR IMMIGRATION STATUS AND WHETHER OR NOT IT IS A QUALIFYING STATUS UNDER FEDERAL LAW SHOULD BE DIRECTED TO THE U.S. CITIZENSHIP AND IMMIGRATION SERVICES (USCIS) BY CALLING 1-800-375-5283, OR VISIT THEIR WEB SITE AT WWW.USCIS.GOV.

25

CHILD SUPPORT OBLIGATION:

Everyone applying for a professional license, permit, or registration, or any renewal thereof, must file a written statement that, as of the date of the filing, she or he is, or is not, under an obligation to pay child support*. **Individuals who are four months or more in arrears in child support or who have failed to comply with a summons, subpoena or warrant relating to a paternity or child support proceeding may be subject to suspension of their business, professional, drivers and/or recreational licenses and permits.** The intentional submission of false written statements for the purpose of frustrating or defeating the lawful enforcement of sup-port obligations is punishable under section 175.35 of the Penal Law.

You must complete this section before we can issue the credential for which you have applied. Individuals who are not in compliance with their obligation to pay child support can be issued a credential for no more than six months in order to comply with their child support obligations.

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

[redacted]

A I am not under an obligation to pay child support;

OR

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

[redacted]

I am current and am not four months or more in arrears in the payment of child support; or,

I am making payments by income execution or by court agreed payment plan or by a plan agreed to by the parties; or,

The child support obligation is the subject of a pending court proceeding; or,

I am receiving public assistance or supplemental security income; or,

None of the above four statements apply.

*New York State General Obligations Law, section 3-503

26 **GENDER AND ETHNICITY:** (This item is optional.)

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

GENDER: [redacted] Male [redacted] Female

ETHNICITY: [redacted] White (not Hispanic)
Black (not Hispanic)
Asian
Hispanic
Native American

27 **EDUCATION REVIEW**

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

☒ Yes ☐ No Please initial: [redacted]

28 **AFFIDAVIT WITH ACKNOWLEDGMENT** (Notarization required.)

APPLICANT

I declare and affirm that the statements made in this application, including accompanying documents, are true, complete and correct. I understand that any false or misleading information in, or in connection with, my application may be cause for denial or loss of licensure and may result in criminal prosecution. **This form must be signed and dated in the presence of a Notary Public.**

Signature of the applicant: [redacted]

Date 03 / 05 / 2019 (Month / Day / Year)

NOTARY

State of New York County of New York

On the 5th day of March in the year 2019 before me, the above signed,

personally appeared KATE SHAW BACON (*Applicant Name*), personally known to me or proved to me on the basis of satisfactory evidence to be the individual whose name is subscribed to this application and acknowledged to me that he/she executed the application and swore that the statements made by him/her in the application and all supporting materials are true, complete, and correct.

Notary Public signature [signature]

Notary ID number 01NG6374012

Expiration date 04 / 23 / 2022 (Month / Day / Year)

MY H NGUYEN
NOTARY PUBLIC, STATE OF NEW YORK
Registration No. 01NG6374012
Qualified in Queens County
My Commission Expires April 23, 2022
Notary Stamp

Mail this form and appropriate fee to: New York State Education Department, Office of the Professions, PO Box 22063, Albany, NY 12201. DO NOT SEND CASH. Make check or money order payable to the New York State Education Department.

The University of the State of New York
THE STATE EDUCATION DEPARTMENT

Certification of Completion

(Coursework/Training in Identification and Reporting of Child Abuse and Maltreatment)

Part A: Trainee Information

1. Trainee must complete all items in Part A. Return to provider for completion of Part B, "Certification by Approved Provider"
2. The provider will return the Certification form, with Part B completed, to the trainee. It is the trainee's responsibility to submit the original copy of this Certification for the New York State Education Department at the appropriate time. It should be submitted along with other relevant forms when the trainee applies initially for, or renews, a license, registration certificate, permit, or teaching certificate.
3. Address for submitting form is as follows:
   - Professional License or Permit: New York State Education Department, Division of Professional Licensing Services, [give name of profession], 89 Washington Avenue, Albany, NY 12234.
   - Reregistering Licensees: Your certificate should be included with your reregistration application in the envelope provided with those materials.
   - Teacher Certification: New York State Education Department, Office of Teaching, 89 Washington Avenue, Albany, NY 12234.

1 SOCIAL SECURITY NUMBER: [redacted] 2 BIRTH DATE: [redacted]

(Leave this blank if you do not have a U.S. Social Security Number)

3 PRINT YOUR FULL NAME EXACTLY AS IT CURRENTLY APPEARS ON NEW YORK STATE EDUCATION DEPARTMENT RECORDS

Last: BAROM
First: Kate
Middle:

4 MAILING ADDRESS (You must notify the Department promptly of any address or name changes.)

Line 1: [redacted]
Line 2:
Line 3:
City: BROOKLYN
State: NY Zip Code: [redacted]

5 Complete information below if you hold, or are applying for professional license(s) or a permit:

Name of Profession(s):

New York State License Number:

New York State License Number:

Permit Number:

6 Complete information below, if you hold, or are applying for a teaching certificate:

Certificate Title(s):

New York State Certificate Number (other than Social Security Number, if any):

Trainee's Signature: [redacted] Date: 3 (mo.) / 5 (day) / 19 (yr.)

Part B: Certification by Approved Provider

1. Provider must complete Part B.
2. Two copies should be returned to the trainee within ten calendar days of the completion of the coursework or training.
3. The provider of the coursework or training must retain a copy. This copy must be retained in the provider's files for not less than five years from the date the course was completed.

Pursuant to Chapter 544 of the Laws of 1988, I certify that the person indicated in Part A has completed the required coursework or training regarding the identification and reporting of child abuse and maltreatment.

[redacted] Katherine T. Grimm, MD

Signature of Authorized Certifying Officer — Name of Authorized Certifying Officer

Mount Sinai School of Medicine — 30257 — 7/1/2016

Approved Provider Name — Identification Number — Date(s) of Coursework or Training

FORM 2
MEDICINE

The University of the State of New York
THE STATE EDUCATION DEPARTMENT
Office of the Professions
www.op.nysed.gov

CERTIFICATION OF PROFESSIONAL AND PREPROFESSIONAL EDUCATION

APPLICANT INSTRUCTIONS

Use this form only if you attended a New York State registered or LCME/AOA accredited medical school.

1. Send this form to the professional school you attended to complete Section II. Be sure to include any fee required.
2. If you attended a medical school that has been closed, send this form to the official repository of the records for that school (e.g., SEESCYT).
3. This form must be signed by the Registrar of the medical school and sent back directly to the Office of the Professions by that school official in an official school envelope to the address at the end of this form. **This form will not be accepted if returned by the applicant or any other party.**

SECTION I: APPLICANT INFORMATION

1 **Social Security Number** [redacted]
(Leave this blank if you have no U.S. Social Security Number)

2 **Birth Date** [redacted]
Month Day Year

3 **Print Full Name Exactly as It Appears on Your Application for Licensure (Form 1), Or Application for Limited Permit (Form 5B)**

Last BARON
First KATE
Middle SHAW

4 **Mailing Address:** (You must notify the Department promptly of any address or name changes.)

Line 1 [redacted]
Line 2
Line 3
City BROOKLYN
State NY Zip Code [redacted]
Country/ Province USA

5 **Telephone/E-Mail**

Daytime Phone [redacted]
Area Code Phone Number

E-Mail Address (Please print clearly) [redacted]

6 Print name under which your degree or diploma was awarded *(if different from above)*: _____

7 Professional School Attended: University of Texas SouthWestern Medical School
Address: 5323 Harry Hines Blvd. Dallas, TX 75390

8 Name of Degree/Diploma: Medical Doctor Date awarded: 06/2016

9 I request and give my permission to the school listed in item 7 above to complete Section II of this form and mail it to the New York State Education Department at the address at the end of this form, and to release any other information requested by the State Education Department in connection with my application for licensure.

Applicant's signature: [redacted] Date: 2 (mo.), 19 (day), 2019 (yr.)

SECTION II: CERTIFICATION OF PROFESSIONAL EDUCATION

INSTRUCTION TO REGISTRAR: Please complete this section, sign certifying statement, attach any required information and send directly to the Office of the Professions at the address at the end of the form. **This form will not be accepted if returned by the applicant or any other party.**

1 Applicant Name: Kate Shaw Baron

For Applicants from N.Y.S. Registered or LCME/AOA Accredited Medical Schools:

Applicant met LCME/AOA requirements for admission to medical/osteopathic school? ☑ YES ☐ NO

If No, number of preprofessional postsecondary credit hours completed by applicant prior to admission to medical school _____ semester hours or _____ quarter hours

2 Did the applicant receive advanced standing based on prior academic work? ☐ YES ☑ NO

If yes, indicate when the prior work was completed below and submit an official transcript of studies at your institution, and copies of documentation in your file to support the granting of transfer credit.

Name of Institution: _____

Dates of attendance: _____ to _____

3 Applicant's Entrance date: 08 (mo.) / 13 (day) / 2012 (yr.) Completion Date: 05 (mo.) / 27 (day) / 2016 (yr.)

4 Degree/diploma conferred: Doctor of Medicine

Date of conferral: 05 (mo.) / 27 (day) / 2016 (yr.)

I certify that to the best of my knowledge and belief the foregoing is a true statement of the record of the individual named on this form.

Signature: [redacted] *Date:* 2 (mo.) / 27 (day) / 2019 (yr.)

Type or print name: Stephanie Miller

Title: Assistant Registrar

Medical school: UT Southwestern Medical Center

Address: 5323 Harry Hines Blvd.
Dallas, TX 75390-9096

(SEAL)

Telephone: (214) 648-3606

Fax (214) 648-3289

E-mail address: STUINFO@utsouthwestern.edu

CERTIFICATION IS NOT ACCEPTABLE UNLESS DATED AFTER GRADUATION.

Return this form Directly to: → New York State Education Department, Office of the Professions, Division of Professional Licensing Services, Medicine Unit, 89 Washington Avenue, Albany, NY 12234-1000.

FORM 2PGT

MEDICINE

The University of the State of New York
THE STATE EDUCATION DEPARTMENT
Office of the Professions
Division of Professional Licensing Services
www.op.nysed.gov

Certification of completion of approved postgraduate training will be accepted only if it is signed no more than one month prior to the completion date of the training period in which credit is sought.

CERTIFICATION OF APPROVED POSTGRADUATE TRAINING

To be used only by applicants:

- ***not using FCVS who need to verify approved postgraduate training programs in the US and Canada;***
- ***using FCVS who had not completed training when their FCVS profile was submitted to the Office of the Professions.***

APPLICANT INSTRUCTIONS

1. Complete Section I. Enter your name as it appears on your Licensure Application (Form 1). Be sure to sign and date item 7.
2. Please send this form to the director of medical education of the hospital(s) in which you completed postgraduate training. One form must be submitted to verify each residency. If you have completed more than one residency, you may photocopy this form.
3. This form must be sent directly to the Department by the hospital in which you did your residency. If the hospital in which you did your residency does not have a Director of Medical Education, the forms may be completed by the Department Chair. If the Department cannot determine that this verification came directly from the hospital, the postgraduate hospital training will not be credited.

SECTION I: APPLICANT INFORMATION

1 SOCIAL SECURITY NUMBER: [redacted]

(Leave this blank if you do not have a U.S. Social Security Number)

2 BIRTH DATE: [redacted] *Month Day Year*

3 PRINT FULL NAME EXACTLY AS IT APPEARS ON YOUR APPLICATION (FORM 1):

Last: BARON
First: KATE
Middle: SHAW

4 MAILING ADDRESS:

Line 1: [redacted]
Line 2:
Line 3:
City: BROOKLYN
State: NY Zip Code: [redacted]
Country/ Province: USA

5 Print name under which postgraduate training was completed: KATE SHAW BARON

6 Hospital in which postgraduate training was completed: Mount Sinai Downtown Residency in Urban Family Medicine
Address: 230 W. 17th St, New York, NY 10011

7 I request and give my permission to the hospital listed in item 6 above to complete Section II of this form and mail it to the New York State Education Department at the address at the end of this form, and to release any other information requested by the State Education Department in connection with my application for licensure.

Applicant's signature: [redacted] Date: 2, 19, 2019

Rev. 6/15

SECTION II : CERTIFICATION OF POSTGRADUATE TRAINING

INSTRUCTION TO HOSPITAL: Please complete this section, sign certifying statement, and return the form ***directly*** to the Division of Professional Licensing Services at the address shown below. **This form will not be accepted if returned by the applicant.**

This is to certify that KATE BAKER, MD
(Physician's name)

a graduate of Univ. of Texas Southwestern Medical Center @ Dallas
(Medical school)

was enrolled in a postgraduate training program(s) approved by the Accreditation Council on Graduate Medical Education, the American Osteopathic Association, or Royal College of Physicians and Surgeons of Canada at

Mount Sinai Hospital 1468 Madison Ave NY, NY 10029 [redacted]
(Name and location of Hospital) *(Accreditation Number)*

Level of Training (example: PGY-1)	Clinical Area	Inclusive dates (mm/dd/yy)	Successfully completed
PGY 1	Family Medicine	7/1/16 to 6/30/17	☒ YES ☐ NO ☐ In progress; satisfactory to date
PGY 2	Family Medicine	7/1/17 to 6/30/18	☒ YES ☐ NO ☐ In progress; satisfactory to date
PGY 3	Family Medicine	7/1/18 to 6/30/19	☐ YES ☐ NO ☒ In progress; satisfactory to date
		___/___/___ to ___/___/___	☐ YES ☐ NO ☐ In progress; satisfactory to date
		___/___/___ to ___/___/___	☐ YES ☐ NO ☐ In progress; satisfactory to date

If this physician did not successfully complete the postgraduate training program, please attach a letter of explanation with this form.

☐ Explanation is attached

I am the director of medical education or department chair of the clinical area. I was the program director for the physician named above during the postgraduate training indicated and have carefully read and completed this form and hereby attest that the statements made herein are strictly true in every respect and are supported by hospital records.

Signature of Director/Chair: [redacted] Date: 2/20/19

Type or print name of Director/Chair: Andreas Cohrssen, MD

Title or official position: Program Director

Institution: Mount Sinai Downtown Residency in Urban Family Medicine

Address: 220 W 17th St 8th Floor
New York, NY 10011

Telephone: 212-206-5200 Fax: 212-206-5279

E-mail Address: acohrssen@institute.org

Return this form directly to: → New York State Education Department, Office of the Professions, Division of Professional Licensing Services, Medicine Unit, 89 Washington Avenue, Albany, NY 12234-1000

OP Renewal Online Payment - By Registration Period

For Different Selection:

Professions	: MEDICINE	**Address:**
Name	: BARON KATE SHAW	[redacted]
Date of Birth	[redacted]	DALLAS
License Number	: 297991 Coupon ID [redacted]	TX - [redacted]
Registration Period	: 03/01/2021 through 07/31/2022	US
Payment Date	: 11/30/2020	
E-mail	[redacted]	
Phone		
Renewal Status	: **Paid On-line - Renewal Complete**	

License Renewal Payment Details:

Evta Authorization Num	Evta Transaction Num	Date Paid	Office Number	Amount
[redacted]		11/30/2020	1	434

Photo Id Payment Details:

No Data Available

Response to Questions:

Question Type	Question Text	Response Ind
Moral Character	Since your last registration application, has any hospital or licensed facility restricted or terminated your professional training, employment, or privileges, or have you voluntarily or involuntarily resigned or withdrawn from such association to avoid the imposition of such action due to professional misconduct, unprofessional conduct, incompetency, or negligence?	[redacted]
Child Support	Are you under an obligation to pay child support?	
Moral Character	Since your last registration application, has any licensing or disciplinary authority revoked, annulled, cancelled, accepted surrender of, suspended, placed on probation, or refused to issue or renew a professional license or certificate held by you now or previously, or fined, censured, reprimanded or otherwise disciplined you?	
Moral Character	Since your last registration application, are criminal charges pending against you in any court?	
Moral Character	Since your last registration application, are charges pending against you in any jurisdiction for any sort of professional misconduct?	
Citizenship	Are you a U.S. citizen or qualified alien as defined above?	
Moral Character	Since your last registration application, have you been found guilty after trial, or pleaded guilty, no contest, or nolo contendere to a crime (felony or misdemeanor) in any court?	

OP Renewal Online Payment - By Registration Period

For Different Selection:

Professions	: MEDICINE	**Address:**
Name	: BARON KATE SHAW	[redacted]
Date of Birth	[redacted]	DALLAS
License Number	: 297991 Coupon ID [redacted]	TX - [redacted]
Registration Period	: 08/01/2022 through 07/31/2024	US
Payment Date	: 08/11/2022	
E-mail	[redacted]	
Phone		
Renewal Status	: **Paid On-line - Renewal Complete**	

License Renewal Payment Details:

Evta Authorization Num	Evta Transaction Num	Date Paid	Office Number	Amount
[redacted]		08/11/2022	1	600

Photo Id Payment Details:

No Data Available

Response to Questions:

Question Type	Question Text	Response Ind
Moral Character	Since your last registration application, has any hospital or licensed facility restricted or terminated your professional training, employment, or privileges, or have you voluntarily or involuntarily resigned or withdrawn from such association to avoid the imposition of such action due to professional misconduct, unprofessional conduct, incompetency, or negligence?	[redacted]
Child Support	Are you under an obligation to pay child support?	
Moral Character	Since your last registration application, has any licensing or disciplinary authority revoked, annulled, cancelled, accepted surrender of, suspended, placed on probation, or refused to issue or renew a professional license or certificate held by you now or previously, or fined; censured, reprimanded or otherwise disciplined you?	
Moral Character	Since your last registration application, are criminal charges pending against you in any court?	
Moral Character	Since your last registration application, are charges pending against you in any jurisdiction for any sort of professional misconduct?	
Citizenship	Are you a U.S. citizen or qualified alien as defined above?	
Moral Character	Since your last registration application, have you been found guilty after trial, or pleaded guilty, no contest, or nolo contendere to a crime (felony or misdemeanor) in any court?	