FORM 1
MEDICINE

The University of the State of New York
THE STATE EDUCATION DEPARTMENT
Office of the Professions
Professional Licensing Services
Cultural Education Center
Albany, NY 12230

DEPARTMENT USE ONLY

[redacted]

APPLICATION FOR LICENSE AND FIRST REGISTRATION

APPLICANTS MUST COMPLETE ALL FOUR PAGES OF THIS FORM.

6 0

7 3 5 ER

270 270

N.Y.S. License Number [redacted]

206684 5/19/97

[redacted]

1 SOCIAL SECURITY NUMBER [redacted]

2 FIRST 3 LETTERS OF LAST NAME: J A C

3 BIRTH DATE [redacted] mo day yr

4 PRINT NAME EXACTLY AS YOU WISH IT TO APPEAR ON YOUR LICENSE. (IMPORTANT: A request that contains only initials and the surname cannot be honored.)

Last: JACOBS
First: ADAM
Middle: RICK

5 ADDRESS

Care of [redacted]
Street [redacted]
City: NEW YORK
State: NY
Zip Code [redacted]

6 TELEPHONE
Home [redacted] area code number
Work ( ) - area code number

The above address is: [X] Permanent address of record [ ] Temporary mailing address

7 Citizenship (check one) [redacted] United States [redacted] Alien lawfully admitted for permanent residence in the United States (Attach a copy of the front and back of the alien registration card) [redacted] Other immigration status [redacted]

8 Name as it appears on diploma or other credentials if different from above: ____

9 I wish to become licensed on the basis of: [redacted] acceptable examination scores (see page 2) [redacted] endorsement of another license

10 Have you previously applied for a New York license or a limited permit to practice medicine?

11 Have you ever been convicted of a crime (felony or misdemeanor) in any state or country?

12 Have you ever been charged with a crime (felony or misdemeanor) in any state or country, the disposition of which was other than acquitted or dismissed?

13 Have you ever surrendered your license or been found guilty of professional misconduct, unprofessional conduct, incompetence or negligence in any state or country?

14 Have you ever had charges against you for professional misconduct, unprofessional conduct, incompetence or negligence in any state or country?

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your professional training, employment, or privileges or have you ever voluntarily or involuntarily resigned or withdrawn from such association to avoid imposition of such measures?

[redacted]

If any answer to questions 11-15 is "Yes," submit a letter giving complete explanation. Include copies of any court records, and if you possess one, a copy of the "Certificate of Relief from Disabilities" or your "Certification of Good Conduct."

MORE CONTINUED ON PAGE 2 →

16 IN THE SPACES BELOW, GIVE AN ACCURATE RECORD OF YOUR EDUCATIONAL PREPARATION.
(If necessary - attach a separate sheet.)

SCHOOLS ATTENDED-Location including country Write names of schools in original language and translate	Number Of Years Attended	ATTENDANCE Entrance Date	ATTENDANCE Leaving Date	Diploma or degree obtained (Quote titles in original language and translate.)
[redacted]				
Medical Education (Professional) (List all medical schools attended)				
NEW JERSEY MEDICAL SCHOOL NEWARK, NJ	4	1990	199Y	M.D.

17 If clinical clerkships were completed in a country other than where your medical school is located, give the dates and location of these clerkships *(If necessary - attach a separate sheet.)*

Inclusive Clerkship Dates	Clinical Area	Name of Health Care Facility and Address	Medical School in Which Taken/Address

18 Provide a chronological list of all activities since graduation from professional school to the present. Include vacation periods and periods of unemployment. *(If necessary - attach a separate sheet.)*

DATE From	DATE To	Type of Professional Activity, including Name and Address of Employer. Beginning with Date of Graduation from Professional School
July 94	NOW	ALBERT EINSTEIN College OF
		MEDICINE: OB/Gyn Department
		RESIDENCY PROGRAM.

[redacted]

MORE CONTINUED ON PAGE 3 →

19 Complete Item 19 if you are a graduate of NON-New York State registered or a NON-LCME or NON-AOA accredited program.

Have you completed all portions of the examination requirements for ECFMG certification? [redacted]

Do you currently hold a valid ECFMG certificate?

Please submit the ECFMG form contained in this handbook

20 Did you ever take the MSKP examination? [redacted]

If Yes, give the date ____ / ____ / ____ and score ____ _____.

21 Are you applying 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

22 List all specialty qualifications. (I.e. Board Specialty Certification or Diplomate Certificate)

Name of qualification	Name and location of organization issuing credential

23 [redacted] I am applying for USMLE Step 3

OR

I have completed the examination combination indicated below.

EXAMINATION COMBINATIONS

[redacted]

- FLEX Parts I, II, and III
- FLEX Components I and II
- NBME Parts I, II, and III
- USMLE Steps 1, 2, and 3
- 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
- Other. [redacted]

Date examination sequence was completed [redacted]

[redacted]

MORE CONTINUED ON PAGE 4 ➔

24 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. In addition, a Form 3A must be submitted for each license listed (including all inactive licenses).

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

25 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 licensure
_____	_____	___/___/___
_____	_____	___/___/___

I give permission to the New York State Education Department to release my examination results to my professional school on a confidential basis for the purposes of program review and institutional research. ☒ Yes ☐ No Please initial [redacted]

AFFIDAVIT

I hereby certify that I have read the statutory provisions, Rules of the Board of Regents and Regulations of the Commissioner of Education distributed to me by the State Education Department.

Under penalties of perjury, I declare and affirm that the statements made in the 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 license.

[redacted] 5/5/97

Signature of Candidate Date

[redacted]

5, 5, 97

Date of Photograph

August 1995

RETURN TO: Division of Professional Licensing Services, Cultural Education Center, Albany, New York [redacted]

[redacted]

END

[redacted]

[redacted]

FORM 1

MEDICINE

ALL CANDIDATES MUST COMPLETE BOTH SIDES OF THIS APPLICATION EXCEPT THOSE FILING FOR LIMITED PERMIT ONLY.

The University of the State of New York
THE STATE EDUCATION DEPARTMENT
Office of the Professions
Division of Professional Licensing Services
Cultural Education Center
Albany, New York 12230

[redacted]

APPLICATION FOR LICENSE AND FIRST REGISTRATION

DEPARTMENT USE ONLY

710.00.059

[redacted]

1 [redacted] SOCIAL SECURITY NUMBER*

2 JAC FIRST 3 LETTERS OF LAST NAME

3 BIRTH DATE [redacted] mo. day yr.

4 PRINT FULL NAME EXACTLY AS YOU WISH IT TO APPEAR ON YOUR LICENSE, IF DETERMINED ELIGIBLE. (*IMPORTANT: A request that contains only initials and the surname cannot be honored).

Last JACOBS

First ADAM

Middle RICK

5 ADDRESS

Care of [redacted]

Misc. (Bldg. & Apt., etc.)

Street [redacted]

City MILDRED

State NJ Zip Code [redacted]

This above address is: [X] Permanent address of record [ ] Temporary mailing address

N.Y.S. License Number

QUALS

APPROVED

6 TELEPHONE

At home [redacted] area code number

At work area code number

7 Citizen of [redacted] United States [redacted] Alien lawfully admitted for permanent residence in the United States. Alien Registration Number [redacted] (Attach a copy of alien registration card)
Citizen of

8 Name as it appears on diploma or other credentials. ADAM RICK JACOBS

Circle Below

9 Have you previously applied for a New York medical license or a limited permit? NO

10 Have you ever been convicted of a crime (felony or misdemeanor) in any state or country? NO

11 Have you ever been charged with a crime (felony or misdemeanor) in any state or country, the disposition of which was other than by acquittal or dismissal? NO

12 Have you ever surrendered your license or been found guilty of professional misconduct, unprofessional conduct, incompetence or negligence in any state or country? NO

13 Are charges pending against you for professional misconduct, unprofessional conduct, incompetence or negligence in any state or country? NO

14 Has any hospital or licensed facility restricted or terminated your professional training, employment, or privileges or have you or, or voluntarily or involuntarily resigned or withdrawn from such association to avoid imposition of such measures? NO

If the answer to questions 10-14 is "Yes," submit a letter giving complete explanation, include copies of any court records, and if you possess one, a copy of the "Certificate of Relief from Disabilities" or your "Certificate of Good Conduct."

15 I wish to be licensed in New York State on the basis of:

[redacted]

National Board Examination (See Licensure Requirements - Section IV)

National Board Examination/Osteopath (See Licensure Requirements - Section IV)

Admission to the licensing examination in New York State (See Licensure Requirements - Section IV)
Give date of FLEX examination requested: (Month and Year): [redacted]

Requested exam center: [redacted]

New York City Area (Includes Long Island)
Albany Area
Buffalo Area

February 1992

COMPLETE OTHER SIDE

[ ] Acceptance of Federation Licensing Examination (FLEX) taken outside New York State.
Give dates and locations of all FLEX examinations taken. _____

My FLEX identification number (FIN) is: _____

[ ] Endorsement of license from another State or Country.
Name State or Country: _____
Other: _____

[ ] 6th Pathway (Section 6526 of the Education Law.)

16 I am a graduate of the following medical program:

Name of Medical School Attended and Location	Number of Years Attended	Date Completed	Dates Of Attendance		Diploma or Degree Obtained (If other, is located Outside the United States, attach a copy)
			From	To	
NEW JERSEY MEDICAL (UMDNJ - NEWARK)	4	1994	8/90	5/94	MD

17 Are you licensed as a physician in any states or countries? [ ] Yes [X] No. (NOTE: Licensure in another jurisdiction is not a requirement for licensure in New York State.) If Yes, list each jurisdiction and appropriate information in the columns below. In addition, a Form 3A must be submitted for each license listed.

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

I give permission to the New York State Education Department to release my examination results to any professional school on a confidential basis for the purpose of program review and institutional research. [X] Yes [ ] No Please Initial: [redacted]

AFFIDAVIT

I hereby certify that I have read the statutory provisions, Rules of the Board of Regents and Regulations of the Commissioner of Education distributed to me by the State Education Department.

Under penalties of perjury, I declare and affirm that the statements made in the application, including accompanying statements and transcripts, 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.

[redacted]
Signature of Candidate

2/17/95
Date

July 94
Date of Photograph

FORM 2

MEDICINE

The University of the State of New York
THE STATE EDUCATION DEPARTMENT
Office of the Professions
Division of Professional Licensing Services
Cultural Education Center
Albany, New York 12230

ALL CANDIDATES MUST COMPLETE THIS FORM.

CANDIDATE EDUCATION AND TRAINING RECORD

1 [redacted] SOCIAL SECURITY NUMBER

2 [redacted] FIRST 3 LETTERS OF LAST NAME

3 BIRTH DATE [redacted] mo. day yr.

4 PRINT FULL NAME EXACTLY AS YOU WISH IT TO APPEAR ON YOUR LICENSE, IF DETERMINED ELIGIBLE. (IMPORTANT: A request that contains only initials and the surname cannot be honored.)

Last [redacted]
First [redacted]
Middle [redacted]

5 ADDRESS

Care of [redacted]
Misc. (Bldg. & Apt., etc.)
Street
City
State
Zip Code

6 Basis of Licensure sought (Form 1, #15): [redacted] National Board Endorsement [redacted] N.Y.S. Examination Limited Permit [redacted] FLEX Outside N.Y.S.

7 IN THE SPACES BELOW, GIVE AN ACCURATE RECORD OF YOUR EDUCATIONAL PREPARATION. If necessary - attach a separate sheet.

SCHOOLS ATTENDED-Location Write names of schools in original language and translate.	NUMBER OF YEARS ATTENDED	ATTENDANCE				Diploma or degree obtained (Quote titles in original language and translate.)
		Entrance		Leaving		
		Class	Date	Class	Date	
Elementary or Primary School	[redacted]					(Proof of completion need not be submitted.)
High School or Secondary School						(Proof of completion need not be submitted.)
Post Secondary Pre-Professional (Exclusive of Medical School)						Candidates using Form 2A need not verify preprofessional training. Candidates using Form 2N must arrange that verification of preprofessional training be submitted directly from the school.
Medical Education (Professional) (List all Medical Schools Attended) [illegible] School	4		1990		1994	(See Form 2A or 2N for verification requirements.)

8. If clinical clerkships were completed in a country other than where your medical school is located, give the dates and location of these clerkships.

Inclusive Clerkship Dates	Clinical Area	Name of Health Care Facility and Address	Medical School in Which Taken/Address

9. Provide a chronological list of all activities since graduation from professional school to the present. Include vacation periods and periods of employment.

Date From	Date To	Type of Professional Activity, Including Name and Address of Employer, Beginning with Date of Graduation from Professional School.
July 1994	FEB 1995	1ST YEAR RESIDENT AT ALBERT EINSTEIN
		OB/GYN PROGRAM

RECEIVED MAR 16 1995

10. Professional Certificates/Other Examinations

MSKP	Date:	Score:	Certificate Number:	
Proficiency Examination	Name:	Date Medicine Passed:	Date English Passed:	Certificate Number:
Proficiency Examination				
Fifth Pathway	Name and Location of Medical School	Name and Location of Hospital	Inclusive Dates of Attendance	

If more space is needed, please attach additional sheets of paper.

All applicants must submit Form 1, Form 10, [illegible] Division of Professional Licensing Services, Medicine Unit, Cultural Education Center, Albany, New York 12230.

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

[redacted]

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 form to 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, or permit.
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], Cultural Education Center, Albany, New York 12230.
   - **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, Cultural Education Center, Albany, New York 12230

1 Print name exactly as it currently appears on New York State Education Department records:

Last: [redacted]
First: [redacted]
Middle: [redacted]

2 Print your address.

Care of:
Mailing Address (Bldg. & Apt., etc.): [redacted]
Street:
City: [redacted]
State: [redacted] Zip Code: [redacted]

3 Date of Birth: [redacted] (Mo. Day Yr.)

4 Social Security number: [redacted]

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

Name of Profession(s): [redacted]
N.Y.S License Number:
N.Y.S License Number:
Permit #:

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

Certificate Title(s):

N.Y.S. Certificate Number (other than Social Security Number, if any):

Trainee's Signature: [redacted] Date: 3/28/97

PART B — CERTIFICATION BY APPROVED PROVIDER

1. Provider must complete Part B.
2. The EDUCATION DEPARTMENT-ORIGINAL COPY and TRAINEE COPY 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 the PROVIDER 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]
Name of Authorized Certifying Officer (Print or Type)

[redacted]
Signature of Authorized Certifying Officer

JMC
Approved Provider Name

4010
Identification Number

3/25/97
Date(s) of Coursework or Training

PE 2/93 MH

STATE EDUCATION DEPARTMENT COPY

Graduates of N.Y.S. Registered or LCME Accredited Programs must complete this Form.

LCGR EXAMINATIONS
Attn.: NY USMLE Step 3 Program
3815 South Allen Street
State College, PA 16801-5890
(800) 9[illegible]-EXAM

VERIFIED
MAR 10 1995

FORM 2A (LCGR)

MEDICINE

MAR 10 1995

LCGR #01

DATA ENTRY #3

CERTIFICATION OF PROFESSIONAL EDUCATION: REGISTERED OR ACCREDITED PROGRAMS

CANDIDATE INSTRUCTIONS

1. Complete Section I. Enter your name as it appears on the application Form 1 submitted to the New York State Education Department.
2. Send this form to the professional school you attended. Be sure to include any fee the school may require.
3. Certification is not acceptable unless dated after graduation.

SECTION I: CANDIDATE INFORMATION

[redacted] SOCIAL SECURITY NUMBER

Month Day Year [redacted] DATE OF BIRTH

Area Code Number [redacted] TELEPHONE NUMBER DURING THE DAY

JACOBS
LAST NAME

ADAM
FIRST NAME

RECK
MIDDLE NAME

MAIDEN NAME

[redacted]
ADDRESS

ADDRESS

NEWARK
CITY

NJ
STATE

[redacted] ZIP CODE

CANADIAN PROVINCE

[redacted]
RECEIVED
MAR 07 1995
EXAMINATION

DOCUMENT RECEIVED DIRECTLY FROM SCHOOL

1. Print name under which degree or diploma was awarded: ADAM RECK JACOBS

2. Professional School Attended: NEW JERSEY MEDICAL SCHOOL

Address: NEWARK, NJ Date degree was awarded: 5/94

January 1994 — CERTIFICATION BY PROFESSIONAL SCHOOL OFFICIAL IS TO BE MADE ON REVERSE SIDE

SECTION II: CERTIFICATION OF EDUCATION

INSTRUCTIONS TO SCHOOL: Please complete this section, sign the certifying statement, and return the form directly to LGR Examinations at the address shown below. This form will not be accepted if returned by the applicant.

CERTIFICATION BY N.Y.S. REGISTERED OR LCME ACCREDITED MEDICAL SCHOOL

1 Professional Education:

Was admitted to UMDNJ-New Jersey Medical School
Name of Medical School

on August 13, 1990 *Month/Day/Year* and satisfactorily completed the program on May 25, 1994 *Month/Day/Year* and was

awarded the degree of Doctor of Medicine *Degree* on May 25, 1994 *Month/Day/Year*

2 (Complete only if applicable.) If the applicant was credited with advanced standing based on prior academic work, give institution name and dates of attendance.

Name of Institution: _____

Dates of Attendance: _____

Attach the following to this form:

1. Official transcript of studies at your institution.
2. Copies of documentation in your file to support the granting of transfer credit.

Signature: [redacted]

Print or Type Name: Robert C. Checca

Title: Registrar

Medical School: UMDNJ-New Jersey Medical School

Address: 185 S. Orange Ave.
Newark, N.J. 07103-2714

Telephone Number: 201-982-4640

Date: February 27, 1995

(COLLEGE SEAL)

CERTIFICATION IS NOT ACCEPTABLE UNLESS DATED AFTER GRADUATION.

PLEASE MAIL TO: LGR Examinations, NY USMLE Step 3 Program, 1315 South Allen Street, State College, PA 16801-5992

[redacted]

FORM 2PGT

MEDICINE

ALL CANDIDATES MUST COMPLETE THIS FORM

The University of the S[redacted]
THE STATE EDUCATION[redacted]
Office of the Prof[redacted]
Professional License[redacted]
Cultural Education[redacted]
Albany, NY 12[redacted]

[redacted] if it is to consist of [redacted] month prior to the [redacted] of this training [redacted] result is sought.

CERTIFICATION OF APPROVED POSTGRADUATE TRAINING

(To be used only for U.S. and Canadian approved postgraduate training programs)

CANDIDATE INSTRUCTIONS

1. Complete Section I. Enter your name as it appears on your application Form 1.
2. Please send this form to the director of medical education of the hospital(s) in which you completed postgraduate training. One [redacted] may photocopy the form.
3. If you completed more than one residency, you may photocopy this form.
4. 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 the verification came directly from the hospital, the post graduate hospital training will not be credited.

SECTION I: CANDIDATE INFORMATION

1 SOCIAL SECURITY NUMBER [redacted]

2 FIRST 3 LETTERS OF LAST NAME: JAC

3 BIRTH DATE [redacted] mo. day yr.

4 PRINT FULL NAME

[redacted]

Last: JACOBS
First: ADAM
Middle: RICK

5 ADDRESS

Care of [redacted]
Street [redacted]
City: MADISON
State: NJ Zip Code [redacted]

6 Print name under which postgraduate training was completed: ADAM RICK JACOBS

7 Hospital in which postgraduate training was completed: ALBERT EINSTEIN HOSPITAL

Address: PELHAM PARKWAY SOUTH AND EASTCHESTER ROAD BRONX, NEW YORK 10461

August 1995

CERTIFICATION BY AN OFFICIAL IS TO BE MADE ON REVERSE SIDE

SECTION II: CERTIFICATION OF POSTGRADUATE TRAINING

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

This is to certify that ADAM RICK JACOBS
(Physician's Name)

a graduate of NEW JERSEY MEDICAL SCHOOL
(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

ALBERT EINSTEIN HOSPITAL, BRONX, NEW YORK
(Name and Location of Hospital)

Level of Training (example PGY-1)	Clinical Area	Inclusive Dates	Successfully Completed
PGY-1	OB/GYN	07 / 94 / ___ to 06 / 95 / ___	☑ Yes ☐ No
		___ / ___ / ___ to ___ / ___ / ___	☐ Yes ☐ No
		___ / ___ / ___ to ___ / ___ / ___	☐ Yes ☐ No
		___ / ___ / ___ to ___ / ___ / ___	☐ Yes ☐ No
		___ / ___ / ___ to ___ / ___ / ___	☐ Yes ☐ No

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

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.

[redacted]

Signature of Director/Chair: [redacted]

Print or Type Name of Director/Chair: Brian L. Cohen, MD

Title or Official Position: Coordinator of Resident Education

Institution: Albert Einstein College of Medicine

Address: Belfer, Room 510
1300 Morris Park Avenue
Bronx, NY 10461

Telephone Number: (718) 430-4031

Date: March 26, 1996

RETURN TO: Division of Professional Licensing Services, Medicine Unit, Cultural Education Center, Albany, New York 12230.

REGISTRATION RENEWAL DOCUMENT
THE STATE EDUCATION DEPARTMENT
Professional Licensing Services
89 Washington Avenue
Albany, NY 12234-1000

01/13/03
LIC: 206684
NME: JAC4
YR: 03
OFF: 1
DOB: [redacted]
SSN:
EIN:

JACOBS ADAM RICK
[redacted]
NEW YORK NY [redacted]

IA HOLD

PROFESSION: 60 MEDICINE
PERIOD: 02/01/03 - 01/31/05

Complete and sign reverse side of this application

$ 0
AMOUNT DUE

THE STATE EDUCATION DEPARTMENT
Division of Professional Licensing Services Albany, New York 12234-1000 (518) 474-3817
www.op.nysed.gov
OP4INFO@MAIL.NYSED.GOV

We have received an application and fee from you. Although we have processed the fee, we cannot issue the reregistration certificate as you failed to submit the application or did not answer all required items and/or sign the application.

You should carefully read the application printed on reverse side, answer all questions, sign and date.
The application should be returned to us using the enclosed envelope.
Upon receipt, the registration certificate will be issued.

Required information must be returned as soon as possible to avoid accruing delayed registration penalties.

PF53648
60 - 206684

Information:

Licensee Data: Be certain that this application is for your license and is for the correct profession. If your name, address, date of birth (DOB), social security number (SSN), or other identifying information is incorrect above, please make the changes on the face of the above remittance document. **Changes of name and/or address must be reported within 30 days.** If you are an employer and have a Federal Employer Identification Number, this should appear above as an EIN number; if this number is not on file, please add or change the above remittance document. We are required by New York State Tax Law to collect social security numbers and employer identification numbers for tax administration.
Deceased Notification: If you are acting on behalf of a deceased licensee, please write the word DECEASED across the face of the remittance document and enclose a photocopy of the death certificate.

Registration: This is your application to reregister your professional license for the period indicated on the top portion of this form. Registration is required if you intend to practice your profession in NEW YORK STATE during the period indicated. If you will not be practicing in NEW YORK STATE, you may, WITHOUT FEE inactivate your registration by answering **"NO"** to Question 1 on the reverse side of this form. This will not affect your license. If you become inactive, a registration certificate WILL NOT be issued, and future notices will not be sent to you until you REACTIVATE your registration. To do so, you must contact the Department and request a registration application. To be registered, you must send both the completed application form and registration fee.

Fees and Penalties: If you are registering, enclose the amount due, payable by check or money order to the NEW YORK STATE EDUCATION DEPARTMENT, in US funds drawn on a US bank. Do not send cash. A $25 penalty fee will be charged, in addition to the original fee owed, to anyone who submits a bad check for payment of registration fees. Replacement fees must be paid by certified check, bank check, or money order. If replacement fees are not submitted within 60 days of the notice of a bad check, registration will be voided. Licensees who fail to reregister by the expiration of their current registration period and who continue to practice are subject to a $10 per month late registration fee. Willful failure to reregister constitutes professional misconduct. Registration fees are not refundable once the registration period has begun.

PLSS:1001

(Continued on other side)

1. Do you wish to register for the period indicated? X Yes ___ No
2. Since your last registration application,
   a. Have you been found guilty after trial, or pleaded guilty, no contest, or nolo contendere to a crime (felony or misdemeanor) in any court?
   b. 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?
   c. Are criminal charges pending against you in any court?
   d. Are charges pending against you in any jurisdiction for any sort of professional misconduct?
   e. 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?
3. a. Are you under an obligation to pay child support?
   b. If you are under such an obligation, do you meet one of the four requirements listed in the Child Support Law section below?
4. Are you a U.S. citizen or a qualified alien as defined below?

[redacted]

I certify that the statements made in this application and any accompanying documentation are true, complete and correct. I understand that any misrepresentation or any false or misleading information made in connection with my application may **result in criminal prosecution and** may be cause for disciplinary action, including the loss of my license; and that the wilful failure to register while continuing to practice my profession constitutes professional misconduct.

Signature [redacted] Business phone (212) 241-6718 Date 1/18/03

(Information, continued)

Convictions and Charges: Provide a brief explanation of the action and circumstances, list any other states where you hold a current license to practice (include license numbers and effective date of licensure), and submit the appropriate documentation identified below:

- If you have been convicted of a felony or misdemeanor in any jurisdiction (including New York), submit a certified copy of the court records. Minor traffic violations, charges that were dismissed, and acquittals do not come under this category.
- If you have been the subject of professional misconduct charges in any jurisdiction (including New York), enclose a copy of any disciplinary charges and/or decisions for each action.
- If you have been the subject of hospital or institutional actions, provide the institution's name and address, and enclose a copy of any documentation of the action.

Child Support Law: The General Obligations Law requires that every applicant for a professional license, permit, or registration, or any renewal thereof, must file a written statement that, as of the date of the filing, he or she is or is not under an obligation to pay child support. **Individuals who are four months or more in arrears in child support may be subject to suspension of their business, professional, and/or drivers licenses.** The intentional submission of false written statements for the purpose of frustrating or defeating the lawful enforcement of support obligations is punishable pursuant to section 175.35 of the Penal Law. You must answer whether or not you are under an obligation to pay child support; if you are under such an obligation and you cannot attest to one of the four requirements listed below, ***the registration of*** your license may only be renewed for a period of six months. If at the end of that period you are still unable to attest to meeting one of the four requirements, your license may be suspended following due process. If you are under an obligation to pay child support, you must be able to attest to one of the following **four requirements:** 1) you are not four or more months in arrears in the payment of child support; 2) you are making payments by income execution or by a court agreed payment or repayment plan or by a plan agreed to by the parties; 3) your child support obligation is the subject of a pending court proceeding; or 4) you are receiving public assistance or supplemental security income.

Infection Control Course Work: Licensees in this profession who are engaged in practice in New York State must comply with the statutory requirement for completion of approved course work in infection control and barrier precautions to prevent the transmission of the human immunodeficiency virus (HIV) and hepatitis B virus (HBV) in health care settings. Compliance is achieved by completion of course work offered by a provider approved by the Department of Health and/or the State Education Department or by obtaining an exemption from the training requirement from the New York State Department of Health. Courses offered to fulfill the mandate of the federal Occupational Safety and Health Administration (OSHA) Bloodborne Pathogen Standard do not fulfill the infection control training requirement. Criteria for exemption include: retirement from professional practice; out-of-state practice; no direct contact with patients or potentially contaminated materials; or no direct supervision of others who do have direct patient contact or contact with potentially contaminated materials. Graduation from a New York State registered licensure qualifying professional education program after September 1993 qualifies for completion of the required course work for a period of four years. Licensees in this profession are required to report compliance with this requirement to credentialling organizations with which they are affiliated (e.g. hospitals, nursing home); non-affiliated professionals must provide documentation to the Department of Health on forms provided by an approved course work training provider. To obtain exemption request forms or a list of approved providers, you may write to the **New York State Department of Health, P.O. Box 2051, Empire State Plaza Station, Albany, NY 12220-0051** or call **(518) 474-0925.**

Citizenship/Immigration Status: The Personal Responsibility and Work Opportunity Act of 1996, HR 3437, limits the issuance of professional licenses, registrations and limited permits to United States Citizens or qualified aliens. Answer **"YES"** to Question 4 above if you are a U.S. citizen or: an alien lawfully admitted for permanent residence in the U.S.; an alien granted asylum under Section 207 or 208 of the Immigration and Nationality Act; an alien paroled into the U.S. 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 243 (h) 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; or non-immigrant with INS approved VISA.

206684JAC4006000060105

REGISTRATION RENEWAL DOCUMENT
THE STATE EDUCATION DEPARTMENT
Professional Licensing Services
89 Washington Avenue
Albany, NY 12234-1000

09/01/04
LIC: 206684
NME: JAC4
YR: 05
OFF: 1
EIN:

JACOBS ADAM RICK
[redacted]
NEW YORK NY [redacted]

PROFESSION: 60 MEDICINE
PERIOD: 02/01/05 - 01/31/07

Complete and sign reverse side of this application

Name/address change
Complete only if change has occurred

Name
Street
City
State/Zip

$ 600
AMOUNT DUE

1. Do you wish to register for the period indicated? ✓ Yes ___ No

2. Since your last registration application,
   a. Have you been found guilty after trial, or pleaded guilty, no contest, or nolo contendere to a crime (felony or misdemeanor) in any court?
   b. 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?
   c. Are criminal charges pending against you in any court?
   d. Are charges pending against you in any jurisdiction for any sort of professional misconduct?
   e. 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?

3. a. Are you under an obligation to pay child support?
   b. If you are under such an obligation, do you meet one of the four requirements listed in the Child Support Law section below?

4. Are you a U.S. citizen or an alien admitted for permanent residence in the U.S.?

[redacted]

123 12672894

DO NOT WRITE IN THIS BOX
FOR OFFICIAL USE ONLY

I certify that the statements made in this application and any accompanying documentation are true, complete and correct. I understand that any misrepresentation or any false or misleading information made in connection with my application may **result in criminal prosecution and** may be cause for disciplinary action, including the loss of my license; and that the willful failure to register while continuing to practice my profession constitutes professional misconduct.

Signature [redacted] Daytime phone [redacted] Date 10/07/04

2-1

206684JAC4006000060107

REGISTRATION RENEWAL DOCUMENT
THE STATE EDUCATION DEPARTMENT
Professional Licensing Services
89 Washington Avenue
Albany, NY 12234-1000

09/01/05
LIC: 206684
NME: JAC4
YR: 07
OFF: 1
EIN:

JACOBS ADAM RICK
[redacted]
NEW YORK NY [redacted]

PROFESSION: 80 MEDICINE
PERIOD: 02/01/07 - 01/31/08

Cat 2 HP-032204

Complete and sign reverse side of this application

Name/address change
Complete only if change has occurred

Name

Street

City

State/Zip

$ 600
AMOUNT DUE

1. Do you wish to register for the period indicated? ..... ☒ Yes ☐ No

2. Since your last registration application,
   a. Have you been found guilty after trial, or pleaded guilty, no contest, or nolo contendere to a crime (felony or misdemeanor) in any court? .....
   b. 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? .....
   c. Are criminal charges pending against you in any court? .....
   d. Are charges pending against you in any jurisdiction for any sort of professional misconduct? .....
   e. 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? .....

3. a. Are you under an obligation to pay child support? .....
   b. If you are under such an obligation, do you meet one of the four requirements listed in the Child Support Law section below? .....

4. Are you a U.S. citizen or an alien admitted for permanent residence in the U.S.? .....

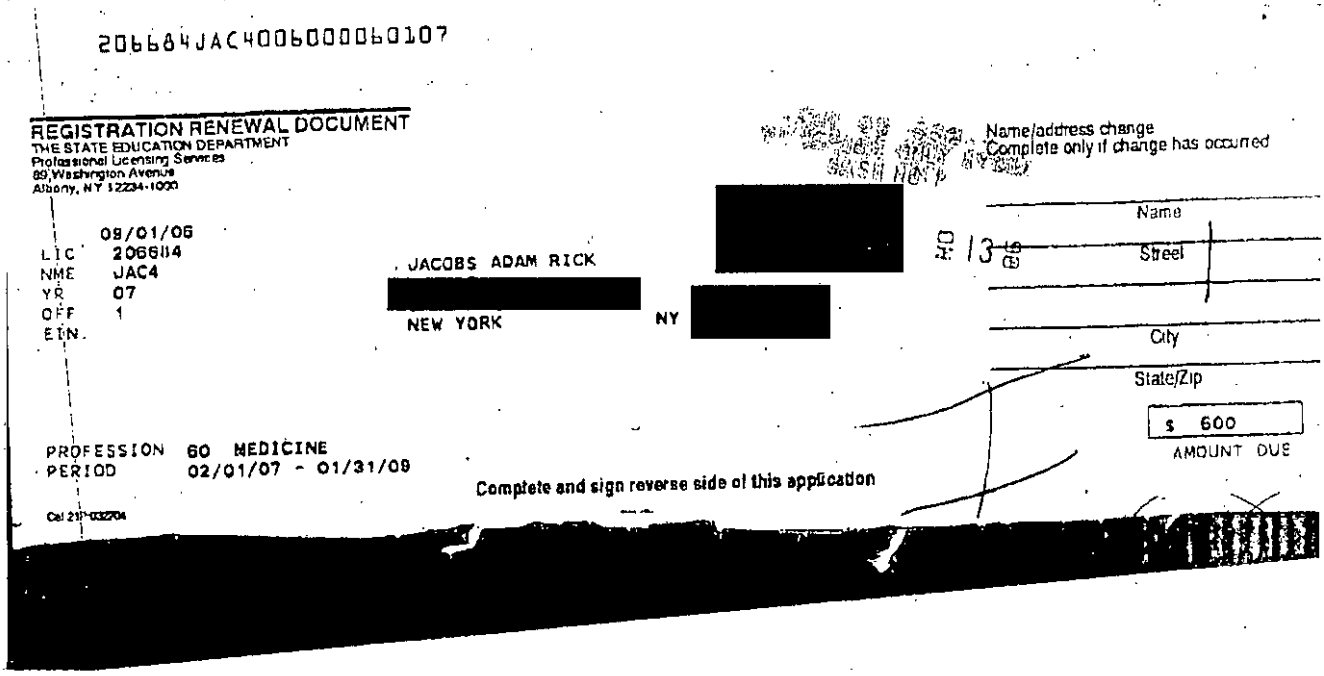
[redacted]

DO NOT WRITE IN THIS BOX
FOR OFFICIAL USE ONLY

I certify that the statements made in this application and any accompanying documentation are true, complete and correct. I understand that any misrepresentation or any false or misleading information made in connection with my application may **result in criminal prosecution and** may be cause for disciplinary action, including the loss of my license; and that the willful failure to register while continuing to practice my profession constitutes professional misconduct.

Signature [redacted] Daytime phone ([redacted] Date 10/20/06

21



206684JAC4006000060107

REGISTRATION RENEWAL DOCUMENT
THE STATE EDUCATION DEPARTMENT
Professional Licensing Services
89 Washington Avenue
Albany, NY 12234-1000

09/01/06
LIC 206684
NME JAC4
YR 07
OFF 1
EIN

JACOBS ADAM RICK
[redacted]
NEW YORK NY [redacted]

Name/address change
Complete only if change has occurred

Name
Street
City
State/Zip

$ 600
AMOUNT DUE

PROFESSION 60 MEDICINE
PERIOD 02/01/07 - 01/31/09

Complete and sign reverse side of this application

REGISTRATION RENEWAL DOCUMENT
THE STATE EDUCATION DEPARTMENT
Professional Licensing Services
80 Washington Avenue
Albany, NY 12234-1000

Address change
Complete only if change has occurred

LIC: 204284
NME:
YR: 07
OFF:
EIN:

Jacobs, Adam
[redacted]
New York, NY [redacted]

Street
City
State/Zip

PROFESSION: 60
PERIOD: 2/1/07

0
AMOUNT DUE

Complete and sign reverse side of this application

Cat 20-080408

↑ Detach here ↑ ↑ Detach here ↑

THE STATE EDUCATION DEPARTMENT
Division of Professional Licensing Services Albany, New York 12234-1000 (518) 474-3817
www.op.nysed.gov
OP4INFO@MAIL.NYSED.GOV

This is your application to register your professional license for the period indicated above.
Payment and form(s) should be received at least 30 days prior to the beginning of the new period.

Instructions (see detailed information below):

1. Change your address in the area provided in the upper right corner.
2. Answer all questions on the reverse side, sign and date the application. An affirmative answer to any part of Question 2 requires submission of additional documentation. (See convictions and charges section that follows). An incomplete application will delay registration.
3. Make your check or money order payable to: *NEW YORK STATE EDUCATION DEPARTMENT*. Payment must be made in US funds drawn on a US bank. Do *not* send cash. Your cancelled check is your receipt.
4. Detach the remittance document and submit it with your payment using the envelope provided.

Information:

Licensee Data: Be certain that this application is for your license and is for the correct profession. If your address is incorrect above, please make the changes on the face of the above remittance document. **Changes of name and/or address must be reported within 30 days.** If you are an employer and have a Federal Employer Identification Number, this should appear above as an EIN number; if this number is not on file, please add or change the above remittance document. We are required by New York State Tax Law to collect social security numbers and employer identification numbers for tax administration.

Deceased Notification: If you are acting on behalf of a deceased licensee, please write the word DECEASED across the face of the remittance document and enclose a photocopy of the death certificate.

Registration: This is your application to reregister your professional license for the period indicated on the top portion of this form. Registration is required if you intend to practice your profession in NEW YORK STATE during the period indicated. If you will not be practicing in NEW YORK STATE, you may, WITHOUT FEE inactivate your registration by answering "NO" to Question 1 on the reverse side of this form. This will not affect your license. If you become inactive, a registration certificate WILL NOT be issued, and future notices will not be sent to you until you REACTIVATE your registration. To do so, you must contact the Department and request a registration application. To be registered, you must send both the completed application form and registration fee.

Fees and Penalties: If you are registering, enclose the amount due, payable by check or money order to the NEW YORK STATE EDUCATION DEPARTMENT, in US funds drawn on a US bank. Do not send cash. A $25 penalty fee will be charged, in addition to the original fee owed, to anyone who submits a bad check for payment of registration fees. Replacement fees must be paid by certified check, bank check, or money order. If replacement fees are not submitted within 60 days of the notice of a bad check, registration will be voided. Licensees who fail to reregister by the expiration of their current registration period and who continue to practice are subject to a $10 per month late registration fee. Willful failure to reregister constitutes professional misconduct. Registration fees are not refundable once the registration period has begun.

Cat 20-080408

(Continued on other side)

[redacted]

[redacted]

THE STATE EDUCATION DEPARTMENT / THE UNIVERSITY OF THE STATE OF NEW YORK

OFFICE OF THE PROFESSIONS
REGISTRATION/FEE UNIT
Tel. (518) 474-3817 EXT. 410
Fax (518) 474-3004
E-mail: OPREGFEE@MAIL.NYSED.GOV

[redacted]

TELEFAX COVER SHEET
FAX # (518) 474-3004

DATE 1.4.07

ATTN:

RE: INCOMPLETE APPLICATION [redacted]

FROM: REGISTRATION UNIT

ATTENTION: REGISTRATION UNIT
NYS EDUCATION DEPARTMENT
DIVISION OF PROFESSIONAL LICENSING SERVICES
89 WASHINGTON AVE - 2ND FLOOR
ALBANY, NEW YORK 12234

TOTAL NUMBER OF PAGES INCLUDING COVER SHEET 3

Following is a copy of your renewal form. Question(s) All was/were not answered. Please complete the question(s), re-sign (we need your original signature), date the form and return it to the above address for processing.

If you need a letter of verification for yourself or your employer, send a written request along with your incomplete renewal form, with a $10.00 fee for this service, indicating the person or entity the letter is to be faxed to, along with the fax number (including area code). This letter allows practice while waiting for your certification by mail.

To check your registration on line, our web-site is www.op.nysed.gov, (on line verification). You may print this page for your reference.

[redacted]

OP Renewal Online Payment - By Registration Period

For Different Selection:

Professions	: MEDICINE	Address: [redacted]
Name	: JACOBS ADAM RICK	
Date of Birth	[redacted]	NEW YORK
License Number	: 206684 Coupon ID [redacted]	NY - [redacted]
Registration Period	: 02/01/2009 through 01/31/2011	US
Payment Date	: 01/25/2009	
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]		01/25/2009	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 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?	[redacted]
Moral Character	Since your last registration application, are criminal charges pending against you in any court?	
Citizenship	Are you a U.S. citizen?	
Child Support	Are you under an obligation to pay child support?	
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?	
Moral Character	Since your last registration application, are charges pending against you in any jurisdiction for any sort of professional misconduct?	
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?	

OP Renewal Online Payment - By Registration Period

For Different Selection:

Professions	: MEDICINE	**Address:**
Name	: JACOBS ADAM RICK	[redacted]
Date of Birth	[redacted]	NEW YORK
License Number	: 206684 Coupon ID [redacted]	NY - [redacted]
Registration Period	: 02/01/2011 through 01/31/2013	US
Payment Date	: 01/23/2011	
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]		01/23/2011	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 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?	[redacted]
Moral Character	Since your last registration application, are criminal charges pending against you in any court?	
Citizenship	Are you a U.S. citizen?	
Child Support	Are you under an obligation to pay child support?	
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?	
Moral Character	Since your last registration application, are charges pending against you in any jurisdiction for any sort of professional misconduct?	
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?	

OP Renewal Online Payment - By Registration Period

For Different Selection:

Professions	: **MEDICINE**	**Address:**
Name	: JACOBS ADAM RICK	[redacted]
Date of Birth	[redacted]	NEW YORK
License Number	: 206684 Coupon ID : [redacted]	NY - [redacted]
Registration Period	: 02/01/2013 through 01/31/2015	US
Payment Date	: 01/06/2013	
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]		01/06/2013	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 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?	[redacted]
Moral Character	Since your last registration application, are criminal charges pending against you in any court?	
Citizenship	Are you a U.S. citizen or qualified alien as defined above?	
Child Support	Are you under an obligation to pay child support?	
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?	
Moral Character	Since your last registration application, are charges pending against you in any jurisdiction for any sort of professional misconduct?	
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?	

OP Renewal Online Payment - By Registration Period

For Different Selection:

Professions	: MEDICINE
Name	: JACOBS ADAM RICK
Date of Birth	: [redacted]
License Number	: 206684 Coupon ID : [redacted]
Registration Period	: 02/01/2015 through 01/31/2017
Payment Date	: 01/17/2015
E-mail	: [redacted]
Phone	:
Renewal Status	: **Paid On-line - Renewal Complete**

Address:
[redacted]
NEW YORK
NY - [redacted]
US

License Renewal Payment Details:

Evta Authorization Num	Evta Transaction Num	Date Paid	Office Number	Amount
[redacted]		01/17/2015	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 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?	[redacted]
Moral Character	Since your last registration application, are criminal charges pending against you in any court?	
Citizenship	Are you a U.S. citizen or qualified alien as defined above?	
Child Support	Are you under an obligation to pay child support?	
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?	
Moral Character	Since your last registration application, are charges pending against you in any jurisdiction for any sort of professional misconduct?	
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]

OP Renewal Online Payment - By Registration Period

For Different Selection:

Professions : MEDICINE
Name : JACOBS ADAM RICK
Date of Birth : [redacted]
License Number : 206684 Coupon ID : [redacted]
Registration Period : 02/01/2017 through 01/31/2019
Payment Date : 01/24/2017
E-mail : [redacted]
Phone :
Renewal Status : **Paid On-line - Renewal Complete**

Address: [redacted]
NEW YORK
NY - [redacted]
US

License Renewal Payment Details:

Evta Authorization Num	Evta Transaction Num	Date Paid	Office Number	Amount
[redacted]		01/24/2017	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 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?	[redacted]
Moral Character	Since your last registration application, are criminal charges pending against you in any court?	
Citizenship	Are you a U.S. citizen or qualified alien as defined above?	
Child Support	Are you under an obligation to pay child support?	
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?	
Moral Character	Since your last registration application, are charges pending against you in any jurisdiction for any sort of professional misconduct?	
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?	

OP Renewal Online Payment - By Registration Period

For Different Selection:

Professions	: **MEDICINE**
Name	: JACOBS ADAM RICK
Date of Birth	[redacted]
License Number	: 206684 Coupon ID : BH80097
Registration Period	: 02/01/2019 through 01/31/2021
Payment Date	: 01/26/2019
E-mail	: adamrj29@aol.com
Phone	: 917 355-9181
Renewal Status	: **Paid On-line - Renewal Complete**

Address:
[redacted]
NEW YORK
NY - [redacted]
US

License Renewal Payment Details:

Evta Authorization Num	Evta Transaction Num	Date Paid	Office Number	Amount
[redacted]		01/26/2019	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 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?	[redacted]
Moral Character	Since your last registration application, are criminal charges pending against you in any court?	
Citizenship	Are you a U.S. citizen or qualified alien as defined above?	
Child Support	Are you under an obligation to pay child support?	
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?	
Moral Character	Since your last registration application, are charges pending against you in any jurisdiction for any sort of professional misconduct?	
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?	

OP Renewal Online Payment - By Registration Period

For Different Selection:

Professions	: MEDICINE	**Address:**
Name	: JACOBS ADAM RICK	[redacted]
Date of Birth	[redacted]	NEW YORK
License Number	: 206684 Coupon ID : [redacted]	NY - [redacted]
Registration Period	: 02/01/2021 through 01/31/2023	US
Payment Date	: 01/17/2021	
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]		01/17/2021	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 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?	[redacted]
Moral Character	Since your last registration application, are criminal charges pending against you in any court?	
Citizenship	Are you a U.S. citizen or qualified alien as defined above?	
Child Support	Are you under an obligation to pay child support?	
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?	
Moral Character	Since your last registration application, are charges pending against you in any jurisdiction for any sort of professional misconduct?	
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?	

OP Renewal Online Payment - By Registration Period

For Different Selection:

Professions	: MEDICINE	Address:
Name	: JACOBS ADAM RICK	[redacted]
Date of Birth	[redacted]	NEW YORK
License Number	: 206684 Coupon ID [redacted]	NY - [redacted]
Registration Period	: 02/01/2023 through 01/31/2025	US
Payment Date	: 01/22/2023	
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]		01/22/2023	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 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?	[redacted]
Moral Character	Since your last registration application, are criminal charges pending against you in any court?	
Citizenship	Are you a U.S. citizen or qualified alien as defined above?	
Child Support	Are you under an obligation to pay child support?	
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?	
Moral Character	Since your last registration application, are charges pending against you in any jurisdiction for any sort of professional misconduct?	
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?	