Lara Christine Hanlon, MD

Licensed Physician #MD2005-0307

Issue Date	Expiration Date
06/01/2005	07/01/2006

Signature of Holder

New Mexico Medical Board

Triennial Renewal Certificate

This is to certify that

Lara Christine Hanlon, MD

License Number: MD2005-0307

Having complied with the provisions of the Medical Practice Act is hereby granted a license to practice in the State of New Mexico as a Physician.

Issue Date: 06/01/2005 Date Expires: 07/01/2006

This License Must Be Conspicuously Posted In Each Practice Location

THE NEW MEXICO MEDICAL SOCIETY

Scanned 3/14/05

NMH&HSA
New Mexico Hospitals & Health Systems Association

$ 320.-
$ 100.-

RECEIVED
MAR 11 2005
695704
NM BOARD OF MEDICAL EXAMINERS

The New Mexico Statewide Application for Physician/Practitioner Appointment©

New Mexico Medical Board

17927

Date of Application: 1/31/2005

Demographics

Name	HANLON (Last)	LARA (First)	CHRISTINE (Middle)
Other Names Used	N/A		

Please check all that apply:

Physician (MD)		**Physician Assistant (PA)**		**Documents Obtained By**	
Initial NM License	✓	Initial NM License	____	FCVS	____
Telemedicine	____	Reinstatement	____	HSC	✓ by exam
Public Service	____			NMMB	____
NM License Reinstatement	____				

Will you be applying by endorsement (See Page 1 of Instructions)? Yes ____ No ✓

Are you requesting to be credentialed as a PCP if Family Practice, Internal Medicine, or Pediatrics?	Yes____ No____ N/A		
Gender M (F) **Citizenship**	USA	**Place of Birth**	Syracuse, NY
Immigration Status	N/A	**Certification #**	N/A
***Social Security Number**	[redacted]	**Date of Birth**	[redacted]
***NM Tax ID#**		Pending ☐	
***Fed. Tax ID#**		Pending ☐	
Practice Name	Navajo Area Indian Health Service / Gallup Indian Medical Center		
Practice Limited to: (Clinical Specialty)	Ob/Gyn		
Street	516 East Nizhani Blvd.	P.O. Box 1337	
City	Gallup	State NM	Zip Code 87301
Telephone Number	(505) 722-1402	Facsimile	
Answering Service		Effective Date	to begin 8/1/2005
Foreign Languages (spoken fluently by practitioner)	Spanish		
Foreign Languages (spoken fluently at Practice)			
***E-Mail Address** (confidential)	lara_hanlon@ [redacted]		
***Current Mailing Address** (if different from above -confidential unless no practice address indicated)			
*Street	[redacted]		
*City	Rochester	*State NY	*Zip Code 14620
Telephone Number	[redacted]	csimile	
Answering Service		Effective Date	current
*CLIA Number (if applicable)		Approval Level	Expiration Date
*Office Manager or Contact Person	Ob/Gyn Education office [redacted]		

* Information Confidential

Billing Address (if different from above)	Street	N/A			
City		State		Zip Code	
Telephone Number		Facsimile			
Answering Service		Effective Date			
Billing Manager or Contact Person					
***Home Address**		*Telephone Number	[redacted]		
*Street	[redacted]				
*City	Rochester	*State	NY	*Zip Code	14620

Practice Associates	**Call Coverage** (if different)
N/A	N/A

Other Practice Locations					
Practice Name	N/A				
Street					
City		State		Zip Code	
Telephone Number		Facsimile			
Answering Service		Effective Date			
Practice Name	N/A				
Street					
City		State		Zip Code	
Telephone Number		Facsimile			
Answering Service		Effective Date			

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

Undergraduate Education					
College or University	CORNELL UNIVERSITY				
City	ITHACA	State/Country	NY	Zip Code:	
Dates Attended	**From:** 08/1987 **To:** 05/1990	Degree	BA	Graduation Date	05/1990
Graduate Education					
College or University					
City		State/Country		Zip Code:	
Dates Attended	**From:** **To:**	Degree		Graduation Date	
Post-Graduate Education					
College or University	CALIFORNIA STATE HAYWARD				
City	HAYWARD	State/Country	CA	Zip Code:	
Dates Attended	**From:** 1992 **To:** 1994	Degree	none	Graduation Date	N/A
Professional / Medical Education					
College or University	DARTMOUTH MEDICAL SCHOOL				
City	HANOVER	State/Country	NH	Zip Code:	03755
Dates Attended	**From:** 08/1996 **To:** 05/2001	Degree	M.D.	Graduation Date	05/2001
Other Professional Education					
College or University					
City		State/Country		Zip Code:	
Dates Attended	**From:** **To:**	Degree		Graduation Date	

Internship	☐ Not Applicable				
Institution Name	University of Rochester Strong Memorial Hospital				
City	Rochester	State/Country	NY	Zip Code:	14642
Dates Attended	**From:** 06/2001 **To:** 06/2002	Type	Ob/Gyn, year 1		
Residency/Fellowship	☐ Not Applicable				
(1) Institution Name	University of Rochester Strong Memorial Hospital				
City	Rochester	State/County	NY	Zip Code	14642
Dates Attended	**From:** 06/2002 **To:** present	Type	Ob/Gyn years 2 → 4		
(2) Institution Name					
City		State/Country		Zip Code:	
Dates Attended	**From:** **To:**	Type			
(3) Institution Name					
City		State/Country		Zip Code:	
Dates Attended	**From:** **To:**	Type			

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

Location	N/A	From		To	
Street		Phone Number			
City		State		Zip Code	
Type of Practice		Contact Person			
Type of Discharge		Rank Achieved			
Location		From		To	
Street		Phone Number			
City		State		Zip Code	
Type of Practice		Contact Person			
Type of Discharge		Rank Achieved			
Location		From		To	
Street		Phone Number			
City		State		Zip Code	
Type of Practice		Contact Person			
Type of Discharge		Rank Achieved			
Location		From		To	
Street		Phone Number			
City		State		Zip Code	
Type of Practice		Contact Person			
Type of Discharge		Rank Achieved			

Hospital and Healthcare Affiliations (other than postgraduate training) ☒ **N/A**

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

(1) Current Primary Admitting Facility (Hospital Name)					
Street					
City		State		Zip Code	
Telephone Number		Facsimile			
Appointment Dates	**From:** **To:**				
Type of Appointment					
Privileges Assigned					

(2) Facility Name	N/A				
Street					
City		State		Zip Code	
Telephone Number		Facsimile			
Appointment Dates	**From:**	**To:**			
Type of Appointment					
Privileges Assigned					
(3) Facility Name					
Street					
City		State		Zip Code	
Telephone Number		Facsimile			
Appointment Dates	**From:**	**To:**			
Type of Appointment					
Privileges Assigned					
(4) Facility Name					
Street					
City		State		Zip Code	
Telephone Number		Facsimile			
Appointment Dates	**From:**	**To:**			
Type of Appointment					
Privileges Assigned					
(5) Facility Name					
Street					
City		State		ZIP Code	
Telephone Number		Facsimile			
Appointment Dates	**From:**	**To:**			
Type of Appointment					
Privileges Assigned					
(6) Facility Name					
Street					
City		State		Zip Code	
Telephone Number		Facsimile			
Appointment Dates	**From:**	**To:**			
Type of Appointment					
Privileges Assigned					

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

(1) Name and Title	Dr Ruth Anne Queenan				
Address	Strong Memorial Hospital Ob/Gyn Dept. Box 668				
City	Rochester	State	NY	Zip Code	14642
Telephone Number	(585) 275-3733	Facsimile			
(2) Name and Title	Dr Eugene Toy				
Address	Strong Memorial Hospital Ob/Gyn Dept. Box 668				
City	Rochester	State	NY	Zip Code	14642
Telephone Number	(585) 442-8020	Facsimile			
(3) Name and Title	Dr. Christopher Glantz				
Address	Strong Memorial Hospital Ob/Gyn Dept. Box 668				
City	Rochester	State	NY	Zip Code	14642
Telephone Number	(585) 275-4200	Facsimile			

Licensure-Registration-Certification Information

ECFMG Number (if applicable)	N/A						
State Professional License/Certification Number	N/A						
State		Issue Date		Expiration Date		Pending ☐	

All Other State License Numbers (regardless of status - attach separate list if necessary.)

State	Number	Issue Year	Expiration Date

***Federal Drug Enforcement Admin. (DEA) Registration**				N/A ☐	
Number		Exp. Date		Pending ☐	
***State Controlled Substance Registration** (CSR)				N/A ☐	
Number		State	Exp. Date	Pending ☐	
***Medicare Unique Physician Identification Number (UPIN)**					
Pending ☐					
***State Medicaid Provider Number**					
Pending ☐					

Specialty Board Certifications ☒N/A

Are you Board Certified? ☐Yes ☒No **Note:** If you are not Board certified by a Board recognized by the American Board of Medical Specialties, the American Osteopathic Association, the National Commission on Certification of Physician Assistants, the American Nurses' Credentialing Center, or the National Certification Commission, or accepted for examination in your specialty, please give a brief explanation on an attached sheet. PENDING RESIDENCY GRADUATION EXAM

Certified/Recertified by the:					
1.					
Date Certified		Date Last Recertified		Expiration Date	
2.					
Date Certified		Date Last Recertified		Expiration Date	
3.					
Date Certified		Date Last Recertified		Expiration Date	
Accepted for Examination by the:					
Until (expiration date)		If not accepted, have you made application?		Yes No	
Certified/Recertified by the Subspecialty Board of					
1.					
Date Certified		Date Last Recertified		Expiration Date	
2.					
Date Certified		Date Last Recertified		Expiration Date	
Accepted for Examination by the Subspecialty Board of					

Professional Liability Insurance (confidential information)

Do you have current liability insurance? ☒ Yes ☐ No

(Please list liability insurance carriers for the past 5 years.)

Current Carrier	MCIC Vermont, Inc, an RRG			Current ☒	Pending ☐
Address	University of Rochester Medical Center Attn: Insurance Administrator 601 Elmwood Ave Box 31 Rochester NY 14642				
Dates Insured	From 1/1/05	To 1/1/06	Policy #	PR1105	
			Coverage Limits	Claims-made + tail coverage	
Carrier	see above, insurance through University of Rochester Medical Center				
Address					
Dates Insured	From	To	Policy #		
			Coverage Limits		

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

1. Has your professional liability coverage ever been terminated by action of the insurance company?	Yes ☐	No ☒
2. Have you ever been denied professional liability insurance coverage?	Yes ☐	No ☒
3. Has your professional liability carrier ever excluded any specific procedures from your coverage?	Yes ☐	No ☒
4. Have you ever been denied membership or renewal thereof, or been subject to disciplinary action in any professional organization?	Yes ☐	No ☒
5. Have you ever been excluded from or sanctioned by Medicare and/or Medicaid?	Yes ☐	No ☒
6. Have you ever been charged with, arrested for, convicted of, or pled no contest to a misdemeanor or felony, or have you ever been named as a defendant in any criminal proceedings or subject to investigation by a governmental entity that could result in sanctions or licensure adverse actions?	Yes ☐	No ☒
7. Have you ever been named in any formal requests for corrective actions filed by any healthcare entity where you have had an appointment (a request which could result in either formal or informal proceedings).	Yes ☐	No ☒
8. Have your privileges at any healthcare entity ever been voluntarily or involuntarily suspended, restricted, diminished, revoked or not renewed, except for medical records?	Yes ☐	No ☒
9. Have you ever resigned from a healthcare entity to avoid modification, suspension, or termination of privileges?	Yes ☐	No ☒
10. Has your application for licensure or license to practice in any jurisdiction ever been investigated, voluntarily or involuntarily limited, suspended, revoked, denied or are any currently held licenses pending investigation or being challenged?	Yes ☐	No ☒
11. Have you ever been notified to appear before any licensing agency for a hearing or complaint of any nature?	Yes ☐	No ☒
12. Has your federal or state narcotics registration certificate in any jurisdiction ever been voluntarily or involuntarily limited (stipulations), suspended, revoked, restricted, or are there currently challenges to any of these items?	Yes ☐	No ☒
13. Have you ever been involved in a settlement, medical malpractice claim or suit, or have you ever received written notice of intent to file such a suit? If yes, please provide the following information for each claim or suit. Please type on a separate sheet of paper for each case. • Name, age, sex of patient/claimant. • Date(s) and type of treatment and/or surgery, which led to the allegations against you. • Nature of allegations in claims/suits. Specify whether a suit was ever filed. • Names of other practitioners and hospital, if any, involved in claims or suit. • Disposition or current status of claim or suit (be specific). • Name of insurance carrier defending you. • Name of defense attorney.	Yes ☐	No ☒
14. Do you know of any reason why you cannot perform the essential duties of the clinical privileges/functions for which you are requesting with or without a reasonable accommodation according to acceptable standards of professional performance and without posing a direct threat to patients?	[redacted]	
15. Do you use illegal drugs or have you illegally used drugs in the past five years?	[redacted]	

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

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

Licensing Exam: (i.e State Board Exam, FLEX, LMCC, National Board or USMLE)

Exam Taken YES - USMLE Step 1 Date Passed June 1998 (Month/ Year)

Exam Taken YES - USMLE Step 2 Date Passed April 2000 (Month/ Year)

Exam Taken USMLE Step 3 Date Passed February 2005 (Month/ Year)

1 Have you been treated for mental illness during the past five (5) years? If yes, please have your treating physician provide the NM Medical Board with a letter regarding your diagnosis and treatment. [redacted]

2 Have you had personal or legal problems with narcotics, alcohol or other dangerous drugs during the past five (5) years? (You may answer "no" if you are a voluntary participant in a board approved monitoring program) ___Yes X No

3 Have you ever withdrawn from, or been suspended, dismissed, or expelled from, or have you ever been placed on probation or taken a leave of absence from a medical school or postgraduate training program? ___Yes X No

If you answered "Yes" to any of the above, please provide a complete written explanation with this application.

APPLICANT'S OATH

You must complete this Oath in the presence of a Notary Public.

I, LARA HANLON, hereby certify under oath that I am the person pictured below and named in this application for a license to practice as a Physician in the State of New Mexico; that all statements I have made herein are true; that I am the original and lawful possessor and person named in the various forms and credentials furnished to this Board with my application.

I acknowledge and state that I have read the Information and Instructions that accompanied this application and I have answered all questions truthfully. I understand that the fee I submitted is not refundable.

I hereby release, discharge, and exonerate the New Mexico Medical Board, and their agents or representatives, and any person furnishing information, from any and all liability of every nature and kind arising out of the furnishing or inspection of such documents, records, other information, or the investigation made by the New Mexico Medical Board. I authorize the New Mexico Medical Board to release information, material, documents, orders, or the like relating to me or to this application to any other agency of the State of New Mexico or the appropriate licensing agency of any other state or Territory of the United States or any agency of the United States government.

Applicant Signature 2/23/05 Date

(***must be signed and dated in the presence of the notary public***)

County of Monroe)

State of New York)

Subscribed and sworn to before me this 23 day of February, 2005

Notary Public Signature

LESIA KUKURUDZA
Notary Public, State of N.Y., Monroe Co.
My Commission Expires March 14, 2006

Applicant's Attestation

I, LARA HANLON, certify that the information I have provided and the statements I have made on this application are correct, true, and complete to the best of my knowledge. I will abide by the applicable bylaws, rules and regulations, and policies and procedures of the designated health care entity. I acknowledge that I have received and reviewed a copy of the bylaws if applicable of the designated health care entity. I further agree that, in the event there should arise an adverse ruling with respect to my status and/or clinical privileges, I will exhaust the administrative remedies afforded by the entity's bylaws before resorting to litigation.

Signature

1/31/2005
Date

Note: A cover letter should accompany this form identifying the requesting organization so that applicants can return the form to the appropriate organization.

All applicants have the right to be informed of their application status. Application status inquiries may be directed to either HSC or the appropriate health care organization.

(This attestation may be replaced by the healthcare organization's own attestation.)

This form may be downloaded from any of the following web-sites:

www.nmhsc.com
www.nmms.org
www.gamamed.org/gama

HSC

P.O. Box 92200
Albuquerque, NM 87199-2200
505-343-0070
Facsimile 505-346-0288
Office Hours M-F 800 a.m. - 500 p.m.
cvs@nmhsc.com
www.nmhsc.com

Hospital Services Corporation, a subsidiary of the New Mexico Hospitals and Health Systems Association, maintains this form, as well as a users' mailing list, to distribute any subsequent revisions. If you have any questions about this form or if you would like to be included on the users' list, please contact one of our credentials analysts at 1-800-577-2121 or 505- 343-0070, or by e-mail to cvs@nmhsc.com.

Applicants using HSC for source documents must complete this form.

CREDENTIALS VERIFICATION SERVICE

DESIGNATION AND AUTHORIZATION FOR RELEASE AND REDISCLOSURE OF INFORMATION ("Release")

Authority to Release: I have applied to participate as a provider for Navajo Area Indian Health Service / Gallup Indian Medical Center

Print the names of all organizations to which you are applying.

and its authorized representatives (hereafter "Health Care Entity") which has designated the Hospital Services Corporation's Credentials Verification Service ("HSC/CVS") as their agent. I consent to complete disclosure by the recipient of this release to HSC/CVS of all relevant information pertaining to my professional qualifications, moral character, physical and mental health (hereinafter "qualifications"). I authorize the recipient to make available and/or disclose to HSC/CVS all such information in its files from any university, professional school, licensing authority, accreditation board, hospital, physician, dentist, professional society, insurance carrier, law enforcement agency, military service, or any other person or entity deemed necessary or appropriate in the investigation and processing of my application.

I request and authorize the recipient to release the requested information and I expressly waive any claim of privilege or privacy with respect to the released information bearing on my admission to, retention or termination of medical staff appointment or clinical privileges. I release and discharge HSC/CVS, the Health Care Entity and the medical, dental, podiatry and ancillary staffs or panels, credentials committees, administrators, review and approval boards or committees, governing boards, whether or not designated by these titles, and their agents, servants or employees authorized by representatives and all other persons or entities supplying information to them from liability or claims of any kind or character in any way arising out of inquires concerning me or disclosures made in good faith in connection with my application for appointment to the Health Care Entity's Medical Staff or Provider Panel.

Authority to Redisclose: Unless I have denied authority by initialing here _____, I authorize the Health Care Entity, the Health Care Entity's Authorized Representatives, and HSC/CVS to redisclose information concerning my qualifications, or credentials and privileges to third parties who have a need to know the information (1) based upon New Mexico or federal laws or regulations, or (2) pursuant to any health care provider agreement to which I am or will be a party and in which I have an interest as an individual health care provider.

This Release does not authorize HSC/CVS to disclose information about my qualifications to any claimant. If a claimant requests information from HSC/CVS about me or if a subpoena duces tecum is served upon HSC/CVS seeking information about me, which is in HSC/CVS' possession, I understand I will be notified immediately. If I direct HSC/CVS to resist the subpoena, I hereby agree to indemnify and hold harmless HSC/CVS, its officers, directors, employees and agents for all attorney fees, costs, fines, and expenses incurred in resisting the subpoena at my request.

This authorization is limited to the acquisition and disclosure of information required by state or federal law, and information which is acquired or disclosed pursuant to activities protected by the New Mexico Review Organizational Immunity Act and the Health Care Quality Improvement Act of 1986. A photocopy of this Designation and Authorization for release and redisclosure of information shall be considered by the recipient to be a signed original, as long as it is transmitted to the recipient by HSC's Credentialing Verification Service and is received within five years of its date.

The certain definitions used in this Release and set forth on its reverse side are incorporated by reference. I understand that I may withdraw or modify this authorization at any time in writing by submitting a written request to the HSC/CVS. PHOTOCOPY BOTH PAGES OF THIS FORM.

Applicant Signature

LARA HANLON

Printed Name

1/31/2005

Date

American Medical Association

Physicians dedicated to the health of America

Division of Database Products and Licensing
515 North State Street
Chicago, Illinois 60610
http://www.ama-assn.org/go/amaprofiles

AMA Physician Profile

Name and Mailing Address:

LARA CHRISTINE HANLON MD
STRONG MEMORIAL HOSPITAL
[redacted]
ROCHESTER NY 14642-0002

Primary Office Address:

SAME AS MAILING ADDRESS

Phone: UNKNOWN

Birthdate: [redacted]
Birthplace: SYRACUSE, NY UNITED STATES OF AMERICA

Physician's Major Professional Activity: HOSPITAL BASED RESIDENTS - ALL YEARS

Practice Specialties Self Designated by the Physician*:

Primary Specialty: OBSTETRICS & GYNECOLOGY

Secondary Specialty: UNSPECIFIED

**Self-Designated Practice Specialties/Areas of Practice (SDPS) listed on the AMA Physician Profile do not imply "recognition" or "endorsement" of any field of medical practice by the Association, nor does it imply, certification by a Member Medical Specialty Board of the American Board of Medical Specialties, or that the physician has been trained or has special competence to practice the SDPS.*

AMA membership: NON MEMBER

All Information from this Point Forward is Provided by the Primary Source

Current and/or Historical Medical School:

DARTMOUTH MED, HANOVER NH 03755
Degree Awarded: Yes
Reported Year of Graduation 2001

American Medical Association

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Division of Database Products and Licensing
515 North State Street
Chicago, Illinois 60610
http://www.ama-assn.org/go/amaprofiles

AMA Physician Profile

Current and/or Historical Post Graduate Medical Training Programs Accredited by the Accreditation Council for Graduate Medical Education (ACGME):

Future training dates, as reported by the program, should be interpreted as "in progress" or "current" with projected date of completion. If the training program indicates that training for a physician in a particular specialty was not completed at their institution, the training segment will be identified as "INCOMPLETE TRAINING".

Institution: STRONG MEM HSP U ROCHESTER **State:** NEW YORK
Specialty : OBSTETRICS & GYNECOLOGY 06/2001 - 06/2005
(VERIFIED)

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

Current and/or Historical Medical Licensure:

Jurisdiction	MD/ DO	Date Granted	Expiration Date	Status	License Type	Last Reported
NONE REPORTED TO DATE						

Note: When the specific month and day are unknown, the date will display the default value of "01." Not all licensing boards maintain or provide full date values. Please contact the appropriate licensing board directly for this information.

ECFMG Certfication:

Applicant Number:

Note: The Educational Commission for Foreign Medical Graduates (ECFMG) applicant identification number does not imply current ECFMG certification status. To verify ECFMG status, contact the ECFMG Certification Verification Service in writing at P.O. Box 13679, Philadelphia, PA 19101.

Federal Drug Enforcement Administration:

** Only the last three characters of active DEA number(s) are displayed.*

DEA Number *	Schedule	Expiration Date	Last Reported
None	Reported		

Note: Many states require their own controlled substances registration/license. Please check with your state licensing authority for requirement information as the AMA does not maintain this information.

American Medical Association

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Division of Database Products and Licensing
515 North State Street
Chicago, Illinois 60610
http://www.ama-assn.org/go/amaprofiles

AMA Physician Profile

Specialty Board Certification(s)*:

Specialty Board Certification(s) by one or more of the 24 boards recognized by the American Board of Medical Specialties (ABMS) and the American Medical Association (AMA) through the Liaison Committee on Specialty Boards, as reported by the ABMS:

The AMA Physician Profile has been designated by the ABMS as an official "display agent" of the ABMS Specialty Board Certification data. Therefore, the ABMS Board Certification information on the AMA Physician Profile is considered a designated equivalent source in regard to credentialing standards set forth by accrediting bodies such as the Joint Commission on the Accreditation of Healthcare Organizations (JCAHO) and National Committee for Quality Assurance (NCQA).

Certifying Board: TO DATE, THERE HAVE BEEN NO BOARD CERTIFICATIONS REPORTED.
Certificate:
Certificate Type:

Duration	Effective	Expiration	Occurrence	Last Reported

Note: For certification dates, a default value of "01" appears in the day or month field if data were not provided to AMA. Please contact the appropriate specialty board directly for this information. (**) Indicates an expired certificate.

Medicare/Medicaid Sanction(s):

TO DATE, THERE HAVE BEEN NO SUCH SANCTIONS REPORTED TO THE AMA BY THE DEPARTMENT OF HEALTH AND HUMAN SERVICES.

Other Federal Sanction(s):

TO DATE, THERE HAVE BEEN NO FEDERAL SANCTIONS REPORTED TO THE AMA BY ANY BRANCH OF THE US MILITARY, THE VETERAN'S ADMINSTRATION OR THE US PUBLIC HEALTH SERVICE.

American Medical Association

Physicians dedicated to the health of America

Division of Database Products and Licensing
515 North State Street
Chicago, Illinois 60610
http://www.ama-assn.org/go/amaprofiles

AMA Physician Profile

Additional Information:

TO DATE, THERE IS NO ADDITIONAL INFORMATION FOR THIS PHYSICIAN ON FILE.

The content of the AMA Physician Profile is intended to assist with credentialing. Appropriate use of the AMA Physician Masterfile data contained on this Profile by an organization would meet the primary source verification requirements of the Joint Commission on Accreditation of Healthcare Organizations (JCAHO) and the American Accreditation HealthCare Commission/URAC. The Physician Masterfile meets the National Committee for Quality Assurance (NCQA) standards for verification of medical education, post graduate medical training, board certification, DEA status, and Medicare/Medicaid sanctions.

If you note any discrepancies, please log onto our web site and go to the order detail page, select the D following the physician's name and enter the data in question. Or you can mark the issues on a copy of the profile and mail or fax to:

Division of Database Products and Licensing
Attn: Credentialing Products
515 N. State Street
Chicago, IL 60610
800- 665-2882
312 464-5900 (fax)

HSC

Credentials Verification Services
P.O. Box 92200
Albuquerque, NM 87199-2200
2121 Osuna Road, NE, 87113
(505) 343-0070

PROFESSIONAL RECOMMENDATION

The New Mexico Board of Medical Examiners requires the completion of this Professional Recommendation by a physician or a Chief of Staff or a Department chief with whom the practitioner has worked and who has personal knowledge of the practitioner's character and competence to practice medicine. This form is required as part of the practitioner's application for licensure. All elements in the section below must be completed. The lower half of the form may be used for narrative comment. Please provide all information in your files, favorable or otherwise, so that it may be considered by the New Mexico Board of Medical Examiners.

Applicant's Name: Lara Christine Hanlon, MD (22960)
Date of Birth: [redacted]

Reference From: [redacted]
Rochester, NY 14642

ALL ELEMENTS IN THIS SECTION MUST BE COMPLETED BY THE RECOMMENDING PHYSICIAN.
The information on this form is NOT a public document but may be released to the applicant upon request.

1. Date and type of services; This individual served with me as Resident
from 7/02 (Month/Year) to present (Month/Year) at University of Rochester, Strong Memorial Hospital (location)

2. Please evaluate:

(Please indicate with a check mark)	Poor	Fair	Good	Superior
Professional knowledge				✓
Clinical judgment				✓
Relationship with patients				✓
Ethical/professional conduct				✓
Ability to communicate				✓
Clinical skills				✓

3. Recommendation:

	(Please indicate with a check mark)
Recommend highly and without reservation	✓
Recommend as qualified and competent	
Recommend with some reservation (explain)	
Concerns (explain)	

Explanation: _____

4. Of particular value in evaluating the candidate is information regarding any notable strengths and weaknesses (including personal demeanor). We would appreciate your comments.

Lara has consistently demonstrated compassion and dedication to her patients and supervising expectations as a resident. She will truly be an asset to your practice.

5. The above report is based on:

	(Please indicate with a check mark)
Close personal observation	✓
General impression	
A composite of evaluations	
Other	

Name (Please Print): [redacted]
Date: 4/11/05
Signature: [redacted]
Title: asst. professor
Phone: [redacted]

HSC
APR 15 2005
CVS

Please return this form to:

Hospital Services Corporation
Credentials Verification Services
P. O. Box 92200
Albuquerque, NM 87199-2200

HSC

NEW MEXICO BOARD OF MEDICAL EXAMINERS

Credentials Verification Services
P.O. Box 92200
Albuquerque, NM 87199-2200
2121 Osuna Road, NE, 87113
(505) 343-0070

PROFESSIONAL RECOMMENDATION

The New Mexico Board of Medical Examiners requires the completion of this Professional Recommendation by a physician or a Chief of Staff or a Department chief with whom the practitioner has worked and who has personal knowledge of the practitioner's character and competence to practice medicine. This form is required as part of the practitioner's application for licensure. All elements in the section below must be completed. The lower half of the form may be used for narrative comment. Please provide all information in your files, favorable or otherwise, so that it may be considered by the New Mexico Board of Medical Examiners.

Applicant's Name: Lara Christine Hanlon MD (22960)
Date of Birth: 10/29/1968
Reference From: [redacted]
Rochester, NY 14642

ALL ELEMENTS IN THIS SECTION MUST BE COMPLETED BY THE RECOMMENDING PHYSICIAN.
The information on this form is NOT a public document but may be released to the applicant upon request.

1. Date and type of services; This individual served with me as resident (OBGYN)
from 7/2001 (Month/Year) to 4/2005 (Month/Year) at University of Rochester Medical Center (Strong Memorial Hospital) (location)

2. Please evaluate:

(Please indicate with a check mark)	Poor	Fair	Good	Superior
Professional knowledge				X
Clinical judgment				X
Relationship with patients				X
Ethical/professional conduct				X
Ability to communicate				X
Clinical skills				X

3. Recommendation:

	(Please indicate with a check mark)
Recommend highly and without reservation	X
Recommend as qualified and competent	
Recommend with some reservation (explain)	
Concerns (explain)	

Explanation: _____

4. Of particular value in evaluating the candidate is information regarding any notable strengths and weaknesses (including personal demeanor). We would appreciate your comments.

Dr. Hanlon is an outstanding clinician and very personable - I've always enjoyed working with her

5. The above report is based on:

	(Please indicate with a check mark)
Close personal observation	X
General impression	
A composite of evaluations	
Other	

Name (Please P[redacted]) Date: 4/14/05

Signature: [redacted] Title: Associate Professor of OBGYN

Phone: [redacted]

Please return this form to:

Hospital Services Corporation
Credentials Verification Services
P. O. Box 92200
Albuquerque, NM 87199-2200

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CVS

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Credentials Verification Services
P.O. Box 92200
Albuquerque, NM 87199-2200
2121 Osuna Road, NE, 87113
(505) 343-0070

MEDICAL EDUCATION VERIFICATION

Dartmouth Medical School
Office of the Registrar
7060 Remsen Building
Hanover, NH 037553833

Re: Lara Christine Hanlon (22960)
SSN: [redacted]
Doctor of Medicine, , 2001

DEAN OR DESIGNATED OFFICIAL OF MEDICAL SCHOOL INSTRUCTIONS:

Please include the dean's letter (if available) and a **COPY OF THE OFFICIAL TRANSCRIPT** (which indicates courses taken, dates and hours of attendance, and scores, grades, or evaluations).

APPLICANT'S EDUCATIONAL DEGREE AND DATE AWARDED HISTORY
If name of institution was different from the above named institution when applicant attended, please enter name: _____

Enrollment and Participation: Our records indicate that Lara Christine Hanlon attended our medical school on the following dates (indicate the month, day and year in the section below):

Attendance Dates:	From	To	From	To
	8/21/96	6/16/97	6/28/99	9/03/99
	9/25/97	5/23/98	9/3/99	5/13/01
	7/6/98	6/27/99	__/__/____	__/__/____

The applicant attended 171 total weeks of continuing on-campus education, not less than 32 weeks in each academic year and:

Check One: ✓ Was awarded a degree in Doctor of Medicine on 6/10/2001
___ Was NOT awarded degree. Please explain reason(s): _____

Unusual Circumstances: The following questions apply to unusual circumstances that occurred during any part of the applicant's medical education. ***All questions must be answered. If you answer "YES" to any of the questions below, please enclose an explanation.***

1. Did the applicant take any leaves of absence or breaks from his/her medical education? Yes___ No ✓
2. Was the applicant ever placed on probation? Yes___ No ✓
3. Was the applicant ever disciplined or under investigation? Yes___ No ✓
4. Were any negative reports ever filed by instructors regarding the applicant? Yes___ No ✓

Comments: _____

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CVS

Dartmouth Medical School

Re: Lara Christine Hanlon (22960)

AFFIX INSTITUTIONAL SEAL HERE

Signature: Joan M. Monahan

Print Name: Joan M Monahan

Title: Registrar DMS

Date: 4-11-05

International medical schools **must** attach a copy of the medical school diploma and a transcript or provide an explanation.

This form *will not* be accepted unless it is stamped with the institutional seal.
Thank you for helping us process this application for licensure.

Please complete this form and forward it to:

Hospital Services Corporation
Credentials Verification Services
P. O. Box 92200
Albuquerque, NM 87199-2200

Dartmouth Medical School

Office of the Registrar - Lebanon, New Hampshire 03756

Record of: Lara C. Hanlon Student No. [redacted]

Issued To: Hospital Serives Corp.

Degree Awarded: Doctor of Medicine 10-JUN-2001
Major: Medicine
Honors: with honors

Course Level: Medical

Current Major: Medicine
Comments: Alpha Omega Alpha

SUBJ NO.	COURSE TITLE	CREDITS	GRADE
INSTITUTION CREDIT:			
Academic Year 1996-97			
ANAT 101	Human Anatomy & Embryology	7.0	P
ANAT 102	Cells, Tissues & Organs	3.0	P
BIOC 111	Cell & Molecular Biology	5.0	P
BIOC 122	Metabolism	1.0	P
CFM 104	Biostatistics & Epidemiology	1.0	P
ELEC 001	Survival Spanish Elective	0.0	NRC
ELEC 001	Hlthcare for the Underserved	0.0	NRC
MICR 103	Microbiology	4.0	P
NEWD 105	Medical Genetics	1.0	H
NEWD 115	Neurosciences	3.0	P
NEWD 116	Longitudinal Clin. Experience	7.0	H
PATH 121	General Pathology	3.0	P
PHSL 112	Medical Physiology	5.0	P
	Total Earned Credits: 40.00		
Academic Year 1997-98			
ELEC 001	Women's Health Elective	0.0	NRC
ELEC 005	Drawing: Beg. to Adv.	0.0	NRC
ELEC 013	Women's Health	0.0	NRC
NEWD 201	Respiration	2.0	P
NEWD 202	Cardiology	3.0	P
NEWD 203	Hematology	2.0	P
NEWD 204	Psychiatry	2.0	H
NEWD 205	Neurology	2.0	H
NEWD 206	Reproduction	2.0	P
NEWD 207	Endocrinology	2.0	P
NEWD 208	Oncology	2.0	H
NEWD 209	Gastroenterology	3.0	H
NEWD 210	Connective Tissue & Bone	2.0	H
NEWD 211	Dermatology	2.0	H
NEWD 212	Fluids, Electrolytes/Kidney	1.0	P
NEWD 213	Infectious Diseases	2.0	P
NEWD 214	Nutrition	1.0	PAS
NEWD 215	Medical Pharmacology	3.0	P
NEWD 216	Longitudinal Clin.Experience	8.0	H
	Total Earned Credits: 39.00		
Summer Term 1998			
MEDI 401	Clerkship: Neurology	4.0	HP
	Total Earned Credits: 4.00		
Fall Term 1998			
CFM 306	Clerkship: Family Medicine	8.0	HP
PSCH 302	Clerkship: Psychiatry	8.0	HP
	Total Earned Credits: 16.00		

Date Issued: 11-Apr-05

DARTMOUTH MEDICAL SCHOOL

Dartmouth Medical School

Office of the Registrar - Lebanon, New Hampshire 03756

Record of: **Lara C. Hanlon** Student No: [redacted]

SUBJ NO	COURSE TITLE	CREDITS	GRADE
Winter Term 1999			
MEDI 307	Clerkship: Outpatient Medicine	4.0	HP
PEDS 308	Clerkship: Outpatient Peds.	4.0	HP
SURG 303	Clerkship: Surgery	8.0	HP
	Total Earned Credits: 16.00		
Spring Term 1999			
MEDI 506	Elec: Clin. Pediatric Neuro	4.0	H
PEDS 304	Clerkship: Inpatient Peds.	4.0	H
	Total Earned Credits: 8.00		
Summer Term 1999			
MEDI 301	Clerkship: Inpatient Medicine	8.0	H
	Total Earned Credits: 8.00		
Fall Term 1999			
	9/99 Split of Year 4 approved.		
OBGY 305	Clerkship: OB-GYN	4.0	H
PATH 601	Elec: Anatomic Pathology	4.0	H
	Total Earned Credits: 8.00		
Winter Term 2000			
CFM 404	Health, Society & the Physicia	3.0	PAS
OBGY 402	Clerkship: Women's Health	4.0	H
PHAR 405	Clinical Pharm & Therapeutics	3.0	HP
	Total Earned Credits: 10.00		
Spring Term 2000			
NEWD 406	Advanced Medical Sciences	1.0	PAS
NEWD 407	Advanced Cardiac Life Support	1.0	PAS
OBGY 411	Subi: Gyn. Surgery & Oncology	4.0	H
	Total Earned Credits: 6.00		
Summer Term 2000			
MEDI 510	Elec: Emergency Medicine	2.0	H
MEDI 513	Elec: Endo & Metabolism	1.0	H
SURG 526	Elec: Urology	2.0	H
	Total Earned Credits: 5.00		
Fall Term 2000			
ANES 503	Elec: Critical Care Medicine	3.0	H
MEDI 504	Elec: Clin. Infect. Disease	2.0	H
MEDI 505	Elec: Clin. Nephrology	1.0	H
OBGY 504	Elec: High Risk Obstetrics	3.0	H
	Total Earned Credits: 9.00		
Winter Term 2001			
OBGY 601	Research: Ob/Gyn	0.0	**
	Total Earned Credits: .00		
Spring Term 2001			
OBGY 601	Research: Ob/Gyn	2.0	H
	Total Earned Credits: 2.00		
	Grand Total Earned Credits:	171.0	

END OF TRANSCRIPT

DARTMOUTH MEDICAL SCHOOL

UNIVERSITY OF
ROCHESTER
MEDICAL CENTER

EASTMAN DENTAL CENTER
SCHOOL OF MEDICINE AND DENTISTRY
SCHOOL OF NURSING
STRONG MEMORIAL HOSPITAL
UNIVERSITY MEDICAL FACULTY GROUP

OFFICE OF GRADUATE MEDICAL EDUCATION

April 13, 2005

HSC
Credentialing Verification Services
PO Box 92200
Albuquerque, NM 87199-2200

Re: Laura Christine Hanlon, MD

To Whom It May Concern:

This will serve as verification that the above-named physician served at Strong Memorial Hospital of the University of Rochester in the following capacity:

PGY-1 Resident in OB/GYN	6/25/01 - 6/24/02
PGY-2 Resident in OB/GYN	6/25/02 - 6/24/03
PGY-3 Resident in OB/GYN	6/25/03 - 6/24/04
PGY-4 Resident in OB/GYN	6/25/04 - 6/24/05

Sincerely,

Bonnie Prince

Bonnie Prince
GME Assistant

/bp

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601 Elmwood Avenue, Box 601
Rochester, New York 14642
(585) 275-4607
Fax: (585) 473-5694

United States Medical Licensing Examination™ (USMLE™)
Certified Transcript of Scores

This document was prepared by the
Federation of State Medical Boards of the United States, Inc.
Federation Place, PO Box 619850, Dallas, TX 75261-9850 -- Telephone (817) 868-4041

Date : 03/25/2005

Recipient:

New Mexico Medical Board
ATTN: Barbara Mohler, Lic Manager
Bldg 400
2055 South Pacheco
Santa Fe, NM 87505

Examinee ID#: [redacted]
Date of Birth:

Examinee: Hanlon, Lara
Alt Name(s): Hanlon, Lara Christine

Results for Steps taken by this examinee (and for which results have been reported to date) are shown below. For Steps that span more than one day, the test date reflects the day on which the examination began. Where numeric scores are reported, there are two scales used and the recommended minimum passing score ("MP") on each scale is shown in parentheses.

USMLE STEP 1

			Three-Digit Score		Two-Digit Score		
	Test Date	Pass/Fail	Total	MP	Total	MP	Comments
	06/09/1998	Pass	203	179	82	75	

USMLE STEP 2

Clinical Knowledge (CK)

			Three-Digit Score		Two-Digit Score		
	Test Date	Pass/Fail	Total	MP	Total	MP	Comments
	04/24/2000	Pass	232	170	89	75	

USMLE STEP 3

			Three-Digit Score		Two-Digit Score		
	Test Date	Pass/Fail	Total	MP	Total	MP	Comments
PENNSYLVANIA	02/02/2005	Pass	210	184	86	75	

NOTE: A search of the Board Action Data Bank of the Federation of State Medical Boards (FSMB) reveals no reported information on this examinee.

SEE REVERSE SIDE FOR EXPLANATION OF INFORMATION REPORTED ABOVE.

HSC

Credentials Verification Services

Provider Profile

New Mexico Medical Board

Process: License by Examination

22960 Hanlon, Lara Christine MD

SSN: 144-76-1704 **DOB:** 10/29/1968

Start Date:	04/01/2005	Completed Date:	05/03/2005
App Rec Date:	04/01/2005	Attestation:	01/31/2005
		Next Appt:	

Organization:
Navajo Area Indian Health Serv/GIMC
516 E Nizhoni Blvd
Gallup NM 87301
Phone: 505 722-1402 Fax:
Email: [redacted]
Contact: Ob/Gyn Education Office

Home Address:
[redacted]
Rochester NY 14620
Phone: [redacted]

Mailing Address:
[redacted]
Rochester NY 14620

UPIN:
Medicaid:
StTaxID:
FedTaxID:

* **LANGUAGES**
English
Spanish

* **BOARD CERTIFICATION:**
Obstetrics and Gynecology Certified: No Expiration: N/A

* **SPECIALTIES:**
N/A

* **LICENSES:**
N/A

* **DRUG REGISTRATIONS:**
N/A
N/A

* **INSURANCE**
MCIC Vermont, Inc. Policy Number: PR 1105
Claims History: No Limits: Expiration: 01/01/2006

* **NATIONAL PRACTITIONER DATA BANK**
N/A See Report: No

* **HEALTHCARE INTEGRITY AND PROTECTION DATA BANK**
N/A See Report: No

* **OIG**
N/A See Report: No

* **PROFESSIONAL PRACTICE QUESTIONS**
See Application: No

* **WORK HISTORY GAP**
See Application: No

* **PRIMARY ADMITTING FACILITY EXPLANATION**
See Application: No

New Mexico Medical Board

Process: License by Examination

22960 Hanlon, Lara Christine MD

*** EDUCATION:** **ECFMG NUMBER:** N/A

Dartmouth Medical School			Type:			
Major Doctor of Medicine	Level: Graduate	Graduation:	2001	From: 08/21/96	To:	06/10/01
Strong Memorial Hospital			Type:	Obstetrics/Gynecology		
Major Internship	Level: Internship	Graduation:	2002	From: 06/25/01	To:	06/24/02
Strong Memorial Hospital			Type:	Obstetrics/Gynecology		
Major Anticipated	Level: Residency	Graduation:		From: 06/25/02	To:	06/24/05

*** AFFILIATIONS**

N/A

*** REFERENCES**

Christopher Glantz MD	Rochester, NY
Eugene Toy MD	Rochester, NY

HSC Use Only

Completed by: S Kalwaji **Date:** 5-3-05

Reviewed by: Robert Ely **Date:** 5/3/05

Pending items to be forwarded upon receipt:

Comments:

Applicants using HSC for source documents must complete this form.

CREDENTIALS VERIFICATION SERVICE
DESIGNATION AND AUTHORIZATION FOR RELEASE AND REDISCLOSURE OF INFORMATION
("Release")

Authority to Release: I have applied to participate as a provider for Navajo Area Indian Health Service / Gallup Indian Medical Center

Print the names of all organizations to which you are applying.

and its authorized representatives (hereafter "Health Care Entity") which has designated the Hospital Services Corporation's Credentials Verification Service ("HSC/CVS") as their agent. I consent to complete disclosure by the recipient of this release to HSC/CVS of all relevant information pertaining to my professional qualifications, moral character, physical and mental health (hereinafter "qualifications"). I authorize the recipient to make available and/or disclose to HSC/CVS all such information in its files from any university, professional school, licensing authority, accreditation board, hospital, physician, dentist, professional society, insurance carrier, law enforcement agency, military service, or any other person or entity deemed necessary or appropriate in the investigation and processing of my application.

I request and authorize the recipient to release the requested information and I expressly waive any claim of privilege or privacy with respect to the released information bearing on my admission to, retention or termination of medical staff appointment or clinical privileges. I release and discharge HSC/CVS, the Health Care Entity and the medical, dental, podiatry and ancillary staffs or panels, credentials committees, administrators, review and approval boards or committees, governing boards, whether or not designated by these titles, and their agents, servants or employees authorized by representatives and all other persons or entities supplying information to them from liability or claims of any kind or character in any way arising out of inquires concerning me or disclosures made in good faith in connection with my application for appointment to the Health Care Entity's Medical Staff or Provider Panel.

Authority to Redisclose: Unless I have denied authority by initialing here _____, I authorize the Health Care Entity, the Health Care Entity's Authorized Representatives, and HSC/CVS to redisclose information concerning my qualifications, or credentials and privileges to third parties who have a need to know the information (1) based upon New Mexico or federal laws or regulations, or (2) pursuant to any health care provider agreement to which I am or will be a party and in which I have an interest as an individual health care provider.

This Release does not authorize HSC/CVS to disclose information about my qualifications to any claimant. If a claimant requests information from HSC/CVS about me or if a subpoena duces tecum is served upon HSC/CVS seeking information about me, which is in HSC/CVS' possession, I understand I will be notified immediately. If I direct HSC/CVS to resist the subpoena, I hereby agree to indemnify and hold harmless HSC/CVS, its officers, directors, employees and agents for all attorney fees, costs, fines, and expenses incurred in resisting the subpoena at my request.

This authorization is limited to the acquisition and disclosure of information required by state or federal law, and information which is acquired or disclosed pursuant to activities protected by the New Mexico Review Organizational Immunity Act and the Health Care Quality Improvement Act of 1986. A photocopy of this Designation and Authorization for release and redisclosure of information shall be considered by the recipient to be a signed original, as long as it is transmitted to the recipient by HSC's Credentialing Verification Service and is received within five years of its date.

The certain definitions used in this Release and set forth on its reverse side are incorporated by reference. I understand that I may withdraw or modify this authorization at any time in writing by submitting a written request to the HSC/CVS. PHOTOCOPY BOTH PAGES OF THIS FORM.

Applicant Signature

LARA HANLON

Printed Name

1/31/2005

Date

HSC
APR 1 ** 2005
CVS

HSC

Credentials Verification Services
P.O. Box 92200
Albuquerque, NM 87199-2200
2121 Osuna Road, NE, 87113
(505) 343-0070

PROFESSIONAL RECOMMENDATION

The New Mexico Board of Medical Examiners requires the completion of this Professional Recommendation by a physician or a Chief of Staff or a Department chief with whom the practitioner has worked and who has personal knowledge of the practitioner's character and competence to practice medicine. This form is required as part of the practitioner's application for licensure. All elements in the section below must be completed. The lower half of the form may be used for narrative comment. Please provide all information in your files, favorable or otherwise, so that it may be considered by the New Mexico Board of Medical Examiners.

Applicant's Name: Lara Christine Hanlon, MD (22960)
Date of Birth: [redacted]

Reference From: [redacted]
601 Elmwood Ave
Rochester, NY 14642

ALL ELEMENTS IN THIS SECTION MUST BE COMPLETED BY THE RECOMMENDING PHYSICIAN.
The information on this form is NOT a public document but may be released to the applicant upon request.

1. Date and type of services; This individual served with me as anticipated an Obstetrics and Gynecology resident from 06/25/01 (Month/Year) to 06/30/05 (Month/Year) at University of Rochester Medical Center (location)

2. Please evaluate:

(Please indicate with a check mark)	Poor	Fair	Good	Superior
Professional knowledge				✓
Clinical judgment				✓
Relationship with patients				✓
Ethical/professional conduct				✓
Ability to communicate				✓
Clinical skills				✓

3. Recommendation:

	(Please indicate with a check mark)
Recommend highly and without reservation	✓
Recommend as qualified and competent	
Recommend with some reservation (explain)	
Concerns (explain)	

Explanation: _____

4. Of particular value in evaluating the candidate is information regarding any notable strengths and weaknesses (including personal demeanor). We would appreciate your comments.

Competent, compassionate physician, who will be a great addition to her new community.

5. The above report is based on:

	(Please indicate with a check mark)
Close personal observation	✓
General impression	✓
A composite of evaluations	✓
Other	

Name (Please Print): Ruth Anne Queen
Date: 4/12/05
Signature: [signature]
Title: Residency Program Dire
Phone: [redacted]

Please return this form to:

HSC
MAY 13 2005
CVS

Hospital Services Corporation
Credentials Verification Services
P. O. Box 92200
Albuquerque, NM 87199-2200