

## Medicine Form 1

The University of the State of New York  
 THE STATE EDUCATION DEPARTMENT  
 Office of the Professions  
 Division of Professional Licensing Services  
 89 Washington Avenue  
 Albany, NY 12234-1000  
 www.op.nysed.gov

Department Use Only

5-1011 MIP  
 MIP

### Application for Licensure and First Registration

RECEIVED  
 PROFESSIONAL LICENSING  
 2011 MAY -6 P 9:01

60  \$735  ER

Applicants Must Complete All Six Pages Of This Application In Ink

DB cleared 8/17/11

NYS License Number  
 262807

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

Date Issued  
 8-31-11

2 Birth Date Month Day Year

Initials  
 MIP

3 Print Name Exactly As You Wish It To Appear On Your License

Last MARASHI  
 First AMIR  
 Middle

5 Telephone/E-Mail Address

Daytime Phone  
 Area Code Phone Number

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

Apt./Bldg.  
 Street  
 City  
 State NY Zip Code  
 Province/Country If not U.S.

E-Mail Address (Please print clearly)

6 Name as it appears on degree or other credentials (if different from above): Amir T. Sadat Marashi / Amir Teymour Sadat Marashi

7 Citizenship:  United States  Alien lawfully admitted for a permanent residence in the United States  Other Immigration  
 Citizen of:  
 Attach a photocopy of the front and back of your Alien Registration Card

8 I wish to become licensed on the basis of:  
 Acceptable examination scores (see page 3 of this form)  Endorsement of another license  
 (See "Applicants Licensed in Another State" section of instructions.)  
 I am using FCVS to collect my credentials:  YES  NO

9	Have you previously applied for a New York State License or a limited permit to practice medicine?	Acceptable Moral Character	Public Information
10	Have you ever been found guilty after trial, or pleaded guilty, no contest, or nolo contendere to a crime (felony or misdemeanor) in any court?	YES	NO
11	Are criminal charges pending against you in any court?	YES	NO
12	Has any licensing or disciplinary authority refused to issue you a license or ever revoked, annulled, cancelled, accepted surrender of, suspended, placed on probation, refused to renew a professional license or certificate held by you now or previously, or ever fined, censured, reprimanded or otherwise disciplined you?	YES	NO
13	Are charges pending against you in any jurisdiction for any sort of professional misconduct?	YES	NO
14	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?	YES	NO


NOTE: If you answer "Yes" to any questions numbered 10-14, 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."

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

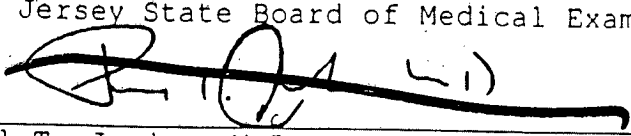
A. NAME OF SCHOOLS ATTENDED AND LOCATIONS	B. NUMBER OF YEARS ATTENDED	C. ATTENDANCE		D. TITLE OF DIPLOMA OR DEGREE OBTAINED (INDICATE YEAR OBTAINED)	E. IF NO DIPLOMA OR DEGREE, INDICATE NUMBER OF CREDITS EARNED
		Entrance Date	Leaving Date		
<p><i>High School or Secondary School</i>            School Name: <u>Dr Hessabi High school</u>            City: <u>Tehran</u> State/Country: <u>IRAN</u></p>	1	9/94 mo yr	4/95 mo yr	Diploma in Math & Physics 1995	
<p><i>Postsecondary Preprofessional School(s) (Exclusive of Medical School)</i>            School Name: <u>N/A</u>            City: _____ State/Country: _____            School Name: _____            City: _____ State/Country: _____</p>		mo yr	mo yr		
<p><i>Medical Education (Professional, list all medical schools attended)</i>            School Name: <u>Islamic Azad University, Tehran Medical Branch</u>            City: <u>Tehran</u> State/Country: <u>IRAN</u>            School Name: _____            City: _____ State/Country: _____</p>	7	9/95 mo yr	2/2004 mo yr	MD Diploma (Professional) Dedrate 2004	

If you completed clinical clerkships in a country located, give the dates and location of these clerkships. Attach additional sheets if necessary.		
Inclusive Clerkship Dates	Name of Health Care Facility And Address	
		
	<th>Medical School with which Clerkship Affiliated and Address</th>	Medical School with which Clerkship Affiliated and Address

of this matter.

Very truly yours,  
New Jersey State Board of Medical Examiners

By:

  
\_\_\_\_\_  
Paul T. Jordan, M.D.  
President

cc: William V. Roeder, Executive Director, BME  
Tara Adams Ragone, D.A.G.

Steven I. Kern, Esq.  
Kern, Augustine, Conroy & Schoppmann, P.C.  
1120 Route 22 East  
Bridgewater, New Jersey 08807  
Attorney for Dr. Marashi



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

If yes, list each jurisdiction. If appropriate, you must also submit a Form 3A or 3B. See pages 14 - 15.

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

17 Complete this section only if you are a graduate of a program not registered by New York State or LCME or AOA accredited.

Have you completed all portions of the examination requirements for ECFMG certification?  Yes  No  
 Do you currently hold a valid ECFMG certificate?  Yes  No

Please complete and forward the ECFMG form.

18 Are you applying for licensure on the basis of a Fifth Pathway program?  Yes  No  
 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

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

Name of Qualifications	Name and location of organization issuing credential

20  I will be applying for USMLE Step 3  
 OR  
 I have successfully completed the examination combination indicated below:

EXAMINATION COMBINATIONS

- USMLE Steps 1, 2, and 3
- FLEX Parts I, II, and III
- FLEX Components I and II
- NBME Parts I, II, and III
- NBME Parts I and II and USMLE Step 3
- NBME Part I, USMLE Step 2 and NBME Part III
- NBME Part I, and USMLE Steps 2 and 3
- USMLE Step 1, and NBME Parts II and III
- USMLE Step 1, NBME Part II, and USMLE Step 3
- USMLE Steps 1 and 2 and NBME Part III
- USMLE Step 1, NBME Part II, and FLEX Component II
- NBME Part I, USMLE Step 2, and FLEX Component II
- USMLE Steps 1 and 2 and FLEX Component II
- NBME Parts I and II and FLEX Component II
- FLEX Component I and USMLE Step 3
- NBOME Parts I, II, and III
- Other: \_\_\_\_\_

Date examination sequence was completed 6/3/2010

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21 Provide a chronological list of all activities since graduation from medical school to the present. Include vacation periods and periods of employment. Attach additional sheets if necessary.		
DATE (mm/dd/yy)		Type of Activity, Beginning with Date of Graduation from Medical School. Include Name and Address of Employers.
From	To	
03/2002	08/2002	ER Physician; Arya General Hospital; Tehran, Iran
09/2002	03/2003	Observer; Sports Medicine Dept; Sheffield Hallam University; Sheffield, UK
04/2003	07/2004	student; Kaplan USMLE course
08/2004	05/2006	Observer/Research Assistant; Minimally Invasive Surgery Clinic; Stanford Hosp.; California
06/2006	01/2008	Resident; OB/GYN; Newark Beth Isreal Medical Center; Newark, NJ
02/2008	03/2008	Observer; OB/GYN; St.John's Queens Hospital; Queens, NY
04/2008	05/2008	student; Kaplan USMLE-step 3 course
07/2008	08/2008	Resident; OB/GYN; Morristown Memorial Hospital; Overlook Hospital
08/2008	present	Instructor; pathology, anatomy, physiology; Academy of Massage Therapy; Jersey City, NJ
12/2008	03/2009	Resident; OB/GYN; New York Medical College of Brooklyn Queens Program; NY
03/2009	present	Resident; OB/GYN; New York Methodist Hospital; NY
07/2010	Present	Chief Resident; ob-gyn, New York Methodist Hospital; NY

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

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

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

I graduated from a medical school in New York State after September 1, 1990.

I completed the child abuse coursework and have enclosed a certificate of completion from an approved provider.

I am filing for an exemption to the requirement and have enclosed the exemption form.

I am going to take the Child Abuse Identification course and submit the required form.

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

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

GENDER:  Male  Female

ETHNICITY:  White (not Hispanic)  Black (not Hispanic)  Asian  Hispanic  Native American

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**STUDENT LOAN DISCLOSURE:**

The State Education Department is required\* to ask these questions about any student loans made or guaranteed by the New York State Higher Education Services Corporation, and to forward any "yes" responses to the New York State Higher Education Services Corporation. Your license application is not complete without this information.

- (a) Do you have any outstanding loans made or guaranteed by the New York State Higher Education Services Corporation?  Yes  No
- (b) If you have such a loan(s), is any part in default?  Yes  No

\*New York State Education Law, section 6501-a

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**CHILD SUPPORT OBLIGATION:**

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

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

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

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

OR

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

- I am current and am not four months or more in arrears in the payment of child support; or,
- I am making payments by income execution or by court agreed payment plan or by a plan agreed to by the parties; or,
- The child support obligation is the subject of a pending court proceeding; or,
- I am receiving public assistance or supplemental security income; or,
- None of the above four statements apply.

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

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27 EDUCATION PROGRAM REVIEW

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

Yes

No

Please initial: AM

28 AFFIDAVIT WITH ACKNOWLEDGMENT (Notarization required.)

APPLICANT

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

Signature of the applicant: [Signature]

Date: 04, 28, 2011  
Month Day Year

NEBRENDA McELVEEN  
Notary Public, State of New York  
No. 01MC5077378  
Qualified in Kings County  
Commission Expires 10/11/2011

NOTARY

State of N.Y. County of Kings

On the 28 day of April in the year 2011 before me, the undersigned, personally appeared \_\_\_\_\_ personally known to me or proved to me on the basis of satisfactory evidence to be the individual whose name is subscribed to this application and acknowledged to me that he/she executed the application and swore that the statements made by him/her in the application and all supporting materials are true, complete, and correct.

Notary Public signature [Signature]

Notary ID number 01MC5077378

Expiration date: 10, 11, 2011  
Month Day Year

NEBRENDA McELVEEN  
Notary Public, State of New York  
No. 01MC5077378  
Qualified in Kings County  
Commission Expires 10/11/2011

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

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