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

APPLICATION FOR LICENSE AND FIRST REGISTRATION

DEPARTMENT USE ONLY

FOR DEPARTMENT ONLY NYSED

089042 3/8/95

/ 600

465

1 SOCIAL SECURITY NUMBER [redacted]

2 FIRST 3 LETTERS OF LAST NAME: RAI

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: RAINER

First: ROBERT

Middle: EDWARD

5 ADDRESS

Care of: ROBERT RAINER MD

Misc. (Bldg & Apt., etc.) [redacted]

Street [redacted]

City [redacted]

State NY Zip Code [redacted]

The above address is: ☐ Permanent address of record ☑ Temporary mailing address

N.Y.S. License Number

198920 4/6/95

QUALS

APPROVED ....

6 TELEPHONE

At home [redacted] area code number

At work [redacted] area code number

7 Citizenship: ☑ United States ☐ Alien lawfully admitted for permanent residence in the United States. Alien Registration Number ________ Citizen of ________ (Attach a copy of alien registration card)

8 Name as it appears on diploma or other credentials: ROBERT EDWARD RAINER II M.D.

9 Have you previously applied for a New York medical license or a limited permit?

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

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?

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

13 Are charges pending against you for professional misconduct, unprofessional conduct, incompetence or negligence in any state or country?

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your professional training, employment, or privileges or have you ever voluntarily or involuntarily resigned or withdrawn from such association to avoid imposition of such measures?

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 "Certification of Good Conduct."

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

☑ 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): ________

Requested exam center:
☐ New York City Area (Includes Long Island)
☐ Albany Area
☐ Buffalo Area

☐ 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: ____________________

☐ 5th Pathway (Section 6528 of the Education Law.)

16 I am a graduate of the following medical program: UNIVERSITY OF MARYLAND SCHOOL OF MEDICINE

Name of Medical School Attended and Location	Number of Years Attended	Class Completed	Dates Of Attendance		Diploma or Degree Obtained (If school is located Outside the United States, attach a copy)
			From	To	
UNIVERSITY OF MARYLAND SCHOOL OF MEDICINE BALTIMORE, MARYLAND	5	1991	6-86	6-91	DOCTORATE OF MEDICINE M.D

17 Are you licensed as a physician in any states or countries? ☐ Yes ☑ 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 my professional school on a confidential basis for the purposes of program review and institutional research. ☑ Yes ☐ No Please Initial: RFR

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.

[signature] 2/23/95 7/20/95
Signature of Candidate — Date — Date of Photograph

[illegible] Licensing Services, [illegible] Cultural Education Center, Albany, New York, 12230.

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 R A I 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: RAINER
First: ROBERT
Middle: EDWARD

5 ADDRESS

Care of: ROBERT RAINER MD
Misc. (Bldg. & Apt., etc.): [redacted]
Street: [redacted]
City: [redacted]
State: NY Zip Code: [redacted]

6 Basis of Licensure sought (Form 1, #15): ☑ National Board ☐ Endorsement ☐ N.Y.S. Examination ☐ Limited Permit ☐ 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 title in original language and translate.)
		Entrance		Leaving		
		Class	Date	Class	Date	
Elementary or Primary School BALTIMORE, MD MCDONOGH SCHOOL & FORT GARRISON ELEMENTARY	7	1st grade	9/70	7th grade	6/77	(Proof of completion need not be submitted.)
High School or Secondary School PACIFIC GROVE JUNIOR HIGH AND HIGH SCHOOL PACIFIC GROVE, CALIFORNIA	5	8th grade	9/77	12th grade	6/82	(Proof of completion need not be submitted.)
Post Secondary Pre-Professional (Exclusive of Medical School) UNIVERSITY OF MARYLAND BALTIMORE COUNTY CATONSVILLE, MARYLAND	4	Freshman	9/82	Senior	6/86	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) UNIVERSITY OF MARYLAND SCHOOL OF MEDICINE BALTIMORE, MARYLAND	5	Freshman	8/86	Senior	6/91	(See Form 2A or 2N for verification requirements.)

February 1992

EDUCATIONAL PREPARATION BY APPLICANT IS TO BE MADE ON REVERSE SIDE

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

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

•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
7/1/91	2/23/95	INTERSHIP (7/1/91 - 7/1/92) AND
		RESIDENCY (7/1/92 - 2/23/95) IN OBSTETRICS AND
		GYNECOLOGY
		THE BROOKLYN HOSPITAL CENTER
		121 DEKALB AVE
		BROOKLYN NY 11201

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.

RETURN this Form 2 together with Form 1, Form 1D, [illegible] Division of Professional Licensing Services, Medicine Unit, Cultural Education Center, Albany, New York 12230.