APPLICATION for LICENSURE

JUN 10 2004
DIVISION OF OCCUPATIONAL & PROFESSIONAL LICENSING

GENERAL INFORMATION:

License(s) Applying For: X Physician and Surgeon

X Controlled Substance

Social Security Number: [redacted]

Last Name: Riley Maiden Name: Riley

First Name: Nicola Middle Name: Irene

Gender (Male or Female): Female Date of Birth: 3-27-1965

Have You Ever Held A Utah License Before? Yes ____ No X

If Yes, Name of Profession: ____

If Yes, License Number: ____

MAILING ADDRESS:

Street: [redacted]

City: Salt Lake City State: Utah Zip: [redacted]

County: Salt Lake County Telephone: 801-[redacted]

DO NOT WRITE IN THIS SECTION - FOR DIVISION USE ONLY

License/Certificate Number: 5665820-1205, 8905

Date License/Certificate Approved: 7/14/04

Approved By: Lori Buhler

Date License/Certificate Denied: ____

Denied By: ____

Reason For Denial/Other Comments: ____

Date: 06/10/2004
Receipt Number: 1174.70
Amount Paid: $290.00

DOPL-AP-001 REV 02/02/2004

Nicola Irene Riley

Division of Occupational and Professional Licensing
P.O. Box 146 741
Salt Lake City, Utah 84114-6741

June 4, 2004

Dear Sir/Ma'am,

Subject: Questions 25, 27, 29

I, Nicola Irene Riley, am applying for physician licensure for the state of Utah. I have answered yes to questions numbered 25, 27 and 29.

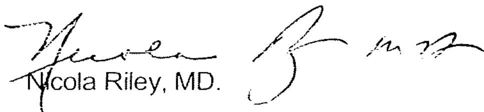
I was an officer in the US Army from 1987-1992 at Ft. Carson, Colorado. I was convicted of Conducted Unbecoming an Officer (Article 132) for the following reasons:

1. Two enlisted soldiers under my jurisdiction were convicted of credit card fraud and criminal impersonation in June 1991.
2. I pleaded not contest to my knowledge of the events and my failure to report their activity in a timely manner.
3. As a result of my position and failure to act in a reasonable amount of time, I was listed as an accomplice to their acts.
4. I was transferred to Fort Leavenworth Kansas for one year with a dishonorable discharge from the military.

I have not had any other military court or civilian convictions or infarctions since this event in June 1991.

I am currently a second year resident in good standing at the St. Mark's Family Practice Residency.

Thank you for your consideration,



Nicola Riley, MD.

MEDICAL SCHOOL: (Use additional sheets if necessary.)

Name: University of Utah School of Medicine Dates Attended: Aug 1997 To Dec 2002

Location: 30 North 1900 East Room 1C101, SLC, UT 84132-2101

Degree Received: MD Date of Graduation: Dec 2002

Name: ______ Dates Attended: ______ To ______

Location: ______

Degree Received: ______ Date of Graduation: ______

GRADUATE MEDICAL EDUCATION OR TRAINING:

Complete the information below and account for all periods of training or postgraduate work from the time you graduated from medical school. (Use additional sheets if necessary.)

Name of Hospital: St Marks Hospital / St. Marks Family Practice Residency

Address of Hospital: 1250 East 3900 South Suite 260, SLC, UT 84124

Department: Utah Healthcare Foundation

Date Began: Oct 2002 Date Ended: Present (Sept-2005)

Position (intern, resident, fellow): Intern (Oct 2002 - Sept 2003) Resident 2 (Oct-2003 - Sept 2004)

Name of Hospital: ______

Address of Hospital: ______

Department: ______

Date Began: ______ Date Ended: ______

Position (intern, resident, fellow): ______

IF YOU ARE APPLYING FOR LICENSURE BY ENDORSEMENT:

Please list your professional work experience showing that you have been actively engaged in the legal practice of medicine in the United States. Account for all periods of time since you completed your post-graduate training. (Use additional sheets if necessary.)

N/A

PROFESSIONAL EXAMINATION REQUIREMENT:

Number of Attempts	Examination	Date(s) Taken
3/4	USMLE part 1, Date(s) Taken:	Aug/Sept 2002, June 2002, 2001, 2000
1	USMLE part 2, Date(s) Taken:	Feb 2001
1	USMLE part 3, Date(s) Taken:	Dec 2003
	FLEX part I, Date(s) Taken:	
	FLEX part II, Date(s) Taken:	
	FLEX, Combined, Date(s) Taken:	
	NBME part I, Date(s) Taken:	
	NBME part II, Date(s) Taken:	
	NBME part III, Date(s) Taken:	
	LMCC part 1, Date(s) Taken:	
	LMCC part 2, Date(s) Taken:	
1	Utah Controlled Substances Exam, Date(s) Taken:	3/2004

LICENSES: N/A

List all licenses, registrations, or certifications issued by any state which you now hold or have ever held in any health care profession. (Use additional sheets if necessary.)

Issuing State: ____________________ Profession: ____________________

License Status: __________ License Number: __________ Effective Date: __________

Issuing State: ____________________ Profession: ____________________

License Status: __________ License Number: __________ Effective Date: __________

Issuing State: ____________________ Profession: ____________________

License Status: __________ License Number: __________ Effective Date: __________

AFFIDAVIT IF APPLYING FOR LICENSURE AS A RESIDENT WITHIN UTAH:

I have successfully completed 12 months of resident training in an ACGME approved program after receiving a degree of doctor of medicine. I am successfully participating in an ACGME progressive residency program within Utah with no disciplinary action. I agree to surrender my license to the Division without any proceedings under the Administrative Procedures Act and the Division will automatically revoke my license as a physician and surgeon if I fail to continue in good standing in the ACGME approved residency program within Utah.

Signature of Applicant: Nicole Irene Riley

Date of Signature: 6/8/04

AFFIDAVIT IF APPLYING FOR A CONTROLLED SUBSTANCE LICENSE:

I hereby agree to comply with the laws of Utah relating to the Controlled Substances Act and Rules.

Signature of Applicant: Nicole Irene Riley

Date of Signature: 6/8/04

PHYSICIAN AND SURGEON QUALIFYING QUESTIONNAIRE

Answer "**yes**" or "**no**" for each question. Do not leave any question blank.

1. ___NO___ Have you ever applied for or received a license, certificate, permit, or registration to practice in a regulated profession under any name other than the name listed on this application?

2. ___NO___ Have you ever been denied the right to sit for a licensure examination?

3. ___NO___ Have you ever had a license, certificate, permit, or registration to practice a regulated profession denied, conditioned, curtailed, limited, restricted, suspended, revoked, reprimanded, or disciplined in any way?

4. ___NO___ Have you ever been permitted to resign or surrender your license, certificate, permit, or registration to practice in a regulated profession while under investigation or while action was pending against you by any health care profession licensing agency, hospital or other health care facility, or criminal or administrative jurisdiction?

5. ___NO___ Are you currently under investigation or is any disciplinary action pending against you now by any licensing agency?

6. ___NO___ Have you ever had hospital or other health care facility privileges denied, conditioned, curtailed, limited, restricted, suspended, or revoked in any way?

7. ___NO___ Have you ever been permitted to resign or surrender hospital or other health care facility privileges, while under investigation or while action was pending against you by any licensing agency, hospital or other health care facility, or criminal or administrative jurisdiction?

8. ___NO___ Is any action related to your conduct or patient care pending against you now at any hospital or health care facility?

9. ___NO___ Have you ever had rights to participate in Medicaid, Medicare, or any other state or federal health care payment reimbursement program denied, conditioned, curtailed, limited, restricted, suspended, or revoked in any way?

(Questions continue on following page.)

10. NO Have you ever been permitted to resign from Medicaid, Medicare, or any other state or federal health care payment reimbursement program while under investigation or while action was pending against you by any licensing agency, hospital, or other health care facility, or criminal or administrative jurisdiction?

11. NO Is any action pending against you now by Medicaid, Medicare, or any other state or federal health care payment reimbursement program?

12. NO Have you ever had a federal or state registration to sell, possess, prescribe, dispense, or administer controlled substances denied, conditioned, curtailed, limited, restricted, suspended or revoked in any way by either the federal Drug Enforcement Administration or any state drug enforcement agency?

13. NO Have you ever been permitted to surrender your registration to sell, possess, prescribe, dispense, or administer controlled substances while under investigation or while action was pending against you by any health care profession licensing agency, hospital or other health care facility, or criminal or administrative jurisdiction?

14. NO Is any action pending against you now by either the Federal Drug Enforcement Administration or any state drug enforcement agency?

15. NO Have you been named as a defendant in a malpractice suit?

16. NO Have you ever had office monitoring, practice curtailments, individual surcharge assessments based upon specific claims history, or other limitations, restrictions, or conditions imposed by any malpractice carrier?

17. NO Have you ever had any malpractice insurance coverage denied, conditioned, curtailed, limited, suspended, or revoked in any way?

18. NO If you are licensed in the occupation/profession for which you are applying, would you pose a direct threat to yourself, to your patients or clients, or to the public health, safety, or welfare because of any circumstance or condition?

19. NO Have you ever been declared by any court of competent jurisdiction incompetent by reason of mental defect or disease and not restored?

20. NO Have you ever been terminated from a position because of drug use or abuse?

21. NO Are you currently using or have you recently (within 90 days) used any drugs (including recreational drugs) without a valid prescription, the possession or distribution of which is unlawful under the Utah Controlled Substances Act or other applicable state or federal law?

(Questions continue on following page.)

22. ~~NO~~ Have you ever used any drugs without a valid prescription, the possession or distribution of which is unlawful under the Utah Controlled Substances Act or other applicable state or federal law, for which you have not successfully completed or are not now participating in a supervised drug rehabilitation program, or for which you have not otherwise been successfully rehabilitated?

23. NO Have you ever had a documented case in which you were involved as the abuser in any incident of verbal, physical, mental, or sexual abuse?

24. NO Have you ever been **arrested for or charged with** a misdemeanor in any jurisdiction? Motor vehicle offenses such as driving while impaired or intoxicated must be disclosed but minor traffic offenses such as parking or speeding violations need not be listed.

25. yes Have you ever been **arrested for or charged with** a felony in any jurisdiction?

26. NO Have you ever pled guilty to, no contest to, or been convicted of a misdemeanor in any jurisdiction? Motor vehicle offenses such as driving while impaired or intoxicated must be disclosed but minor traffic offenses such as parking or speeding violations need not be listed.

27. yes Have you ever pled guilty to, no contest to, or been convicted of a felony in any jurisdiction?

28. NO Have you ever been allowed to plea guilty or no contest to any criminal charge that was later dismissed (i.e. plea in abeyance or deferred sentence)?

29. yes Have you ever been incarcerated for any reason in any federal, state or county correctional facility or in any correctional facility in any other jurisdiction?

If you answered "yes" to questions 24, 25, 26, 27, 28, or 29 above, you must include with your application a copy of the police report, court docket, any probation/parole officer report, and a narrative of the circumstances that occurred for EACH and EVERY arrest and/or conviction.

If you are unable to obtain any of the records required above, you must submit documentation on official letterhead from the police department and/or court indicating that the information is no longer available.

If you answered "yes" to any of the above questions, enclose with this application complete information with respect to all circumstances and the final result, if such has been reached.

A "yes" answer does not necessarily mean you will not be granted a license; however, the Division may request additional documentation if the information submitted is insufficient.

AFFIDAVIT and RELEASE AUTHORIZATION

I am the applicant described and identified in this application for licensure, certification, or registration in the State of Utah.

I am qualified in all respects for the license, certificate, or registration for which I am applying in this application.

To the best of my knowledge, the information contained in the application and its supporting document(s) is free of fraud, misrepresentation, or omission of material fact.

To the best of my knowledge, the information contained in the application and its supporting document(s) is truthful, correct, and complete; and, discloses all material facts regarding the applicant and associated individuals necessary to properly evaluate the applicant's qualifications for licensure.

I will ensure that any information subsequently submitted to the Division in conjunction with this application or its supporting documents meet the same standard as set forth above.

I understand that it is unlawful and punishable as a class A misdemeanor to apply for or obtain a license or to otherwise deal with the Division or a licensing board through the use of fraud, forgery, or intentional deception, misrepresentation, misstatement, or omission.

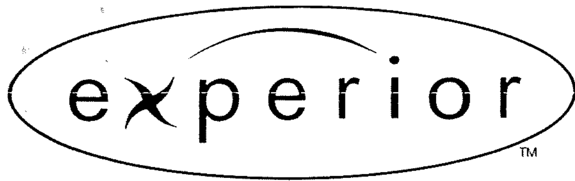
I understand that this application will be classified as a public record and will be available for inspection by the public, except with regard to the release of information which is classified as controlled, private, or protected under the Government Records Access and Management Act or restricted by other law.

I authorize all persons, institutions, organizations, schools, governmental agencies, employers, references, or any others not specifically included in the preceding characterization, which are set forth directly or by reference in this application, to release to the Division of Occupational and Professional Licensing, State of Utah, any files, records, or information of any type reasonably required for the Division to properly evaluate my qualifications for licensure/certification/registration by the State of Utah.

Signature of Applicant: Nicola Irene Riley

Printed Name of Applicant: NICOLA IRENE RILEY

Date of Signature: 6/8/04



Examination Score Report

June 3, 2004

Nicola Riley

Division of Occupational and Professional Licensing

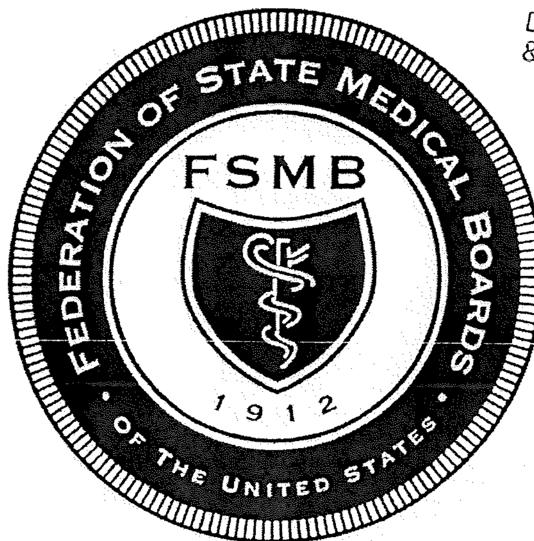
Date	Exam	Minimum Pass	Score	Status
03/19/2004	UT Controlled Substances Law and General Law	75	77	Pass

Experior Assessments, LLC • 5486 South 1900 West, Suite C • Taylorsville, UT 84118-9023
Ph: 801.355.5009 • Fax: 801.355.4008 • www.experioronline.com

The Federation of State Medical Boards of the United States, Inc.
Federation Credentials Verification Service
P.O. Box 619850
Dallas, Texas 75261-9850
Telephone: (817) 868-4000
Fax: (817) 868-4099

RECEIVED
JUN 21 2004
DIVISION OF OCCUPATIONAL & PROFESSIONAL LICENSING

Physician Information Profile



This report is compiled exclusively for:

Name:	Nicola Irene Riley
SSN:	[redacted]
DOB:	03/27/1965
Packet ID:	39737
Recipient:	**Utah Physicians Licensing Board**

NOTICE:

The Federation Credentials Verification Service (FCVS) was retained by the above referenced physician to verify his/her medical credentials for submission to your agency/organization. Unless noted otherwise, all documents contained in this report were received directly from the issuing institution per written request made by FCVS. All documents bearing the official FCVS seal are ceritified to be an exact reproduction of the original. Where required, original documents are provided according to the agreements with the institution issuing such document. FCVS maintains all original documents (excluding third-party examination transcripts) in the physician's source file.

Physician Information Profile is compiled and published by the Federation of State Medical Boards of the United States, Inc. as a reference source for its member boards and other authorized entities. Physician Information Profile may not be republished, sold, resold or duplicated, in whole or in part, for commercial or any other purposes, or for purposes of compiling lists or files without the express written consent of the Federation's Executive Vice President as authorized by its Board Of Directors. The use of this Physician Information Profile to establish independent data files or compendiums or information is strictly prohibited.

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Section I

FCVS Reports

FEDERATION CREDENTIALS VERIFICATION SERVICE

Physician Information Report

Identity:

Name:	Nicola Irene Riley	
Other Name Used:	Nicola Riley-Coyle	
Gender:	Female	
Date of Birth:	03/27/1965	
Place of Birth:	Jersey City, NJ USA	
SSN:	[redacted]	
Current Address:	[redacted]	
Permanent Address:	Same	
Telephone Numbers:	Bus:	801-265-2000
	Fax:	801-265-2008
	Home:	[redacted]
	Other:	801-267-7738
Physical Description:	Height:	5' 06"
	Weight:	160 lbs
	Eye Color:	Brown
	Hair Color:	Brown
Physical Marks:	Description:	N/A
	Location:	N/A

Premedical Education (Reported by physician. Not verified by FCVS):

Institution: **United States Military Academy, West Point, NY 10996**

Dates of Attendance: **06/1983 - 05/1987**
Degree Awarded: **Bachelor of Science**

Medical Education:

Medical School: **University of Utah School of Medicine**
50 North Medical Drive
Salt Lake City, UT 84112

Dates of Attendance: **09/01/1997 - 08/09/2002**
Graduation Date: **08/09/2002**
Degree Awarded: **Doctor of Medicine**
Unusual Circumstance: **Not reported by the Primary Source**

Post Graduate Medical Education:

Institution:	**St Marks Hospital** **Department of Family Medicine** **1250 East 3900 South # 260** **Salt Lake City, UT 84124**
Post Graduate Year:	**1**
Program Type:	**Internship**
Department:	**Family Practice**
Dates of Attendance:	**10/01/2002 - 09/30/2003**
Completion:	**Yes**
Accreditation:	**ACGME**
Post Graduate Year:	**2**
Program Type:	**Residency**
Department:	**Family Practice**
Dates of Attendance:	**10/01/2003 - 09/30/2004**
Completion:	**To Be Completed On 09/30/2004**
Accreditation:	**ACGME**
Unusual Circumstance:	**None**

letter ok

Fifth Pathway:

N/A

Examination History:

Transcripts Enclosed For:	**USMLE Step 1** **USMLE Step 2** **USMLE Step 3**

Board Action:

A Report of the results from a search of the Board Action Data Bank is enclosed.

Credentials Analysis Report

The Credentials Analysis Report is a comparative report of a physician's credentials as reported to FCVS by the physician applicant and the primary source (Medical School, PGT program, etc.). It will also list particular missing documentation, if any, as outlined in the FCVS Policies and Procedures.

Physician Identification:

Name:	Nicola Irene Riley
DOB:	03/27/1965
SSN:	[redacted]
Packet ID:	39737
Request ID:	13118430

REPORT OF OMISSIONS

Omission 1:

Section of Profile: **Medical Education**

Omission: The University of Utah responded to the Unusual Circumstance section of Verification of Medical Education form; however, did not answer Yes or No.

Follow-Up: See Comments on Verification of Medical Education Form. A copy of the application page from the applicant is included immediately following the Verification of Medical Education Form.

CREDENTIALS ANALYSIS

Discrepancy 1:

Section of Profile: **Medical Education**

Discrepancy: The applicant reports attendance at University Of Utah School of Medicine from 08/1997 to 12/2002. The institution reports attendance from 09/1997 to 08/2002.

Follow-Up: Left to Recipient's discretion.

Discrepancy 2:

Section of Profile: **Medical Education**

Discrepancy: The applicant reports graduation from University Of Utah School of Medicine on 12/01/2002. The institution reports graduation date is 08/09/2002.

Follow-Up: FCVS reports the issue/conferral date of the medical school diploma as the official graduation date on the Physician Information Report.

Discrepancy 3:

Section of Profile: **Examination History**

Discrepancy: The applicant reports sitting for USMLE Step 1 and 2 in 08/2002 and 02/2001, respectively. The USMLE transcript indicates the examination dates were 09/2002 and 02/2002.

Follow-Up: Left to Recipient`s discretion.

MISCELLANEOUS INFORMATION

Miscellaneous 1:

Section of Profile: **Post-Graduate Education**

Issue: The attendance dates reported for St Marks Hospital are irregular, beginning in October and ending in September.

Follow-Up: Provided as information only. No follow up performed.

Miscellaneous 2:

Section of Profile: **Continuity of Education**

Issue: There is a gap of approximately 10 years between completion of premedical education at United State Military Academy (ends 05/1987) and entrance into medical school at University of Utah (begins 09/1997).

Follow-Up: Provided as information only. No follow up performed.

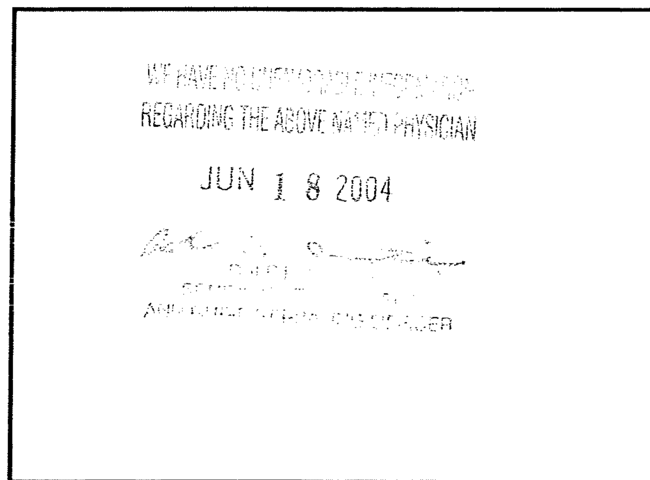
End of report for Nicola Irene Riley

Packet Id: 39737 Request Id: 13118430 Report Created By: JAB

Board Action Databank Search

State Queried For:	**Utah Physicians Licensing Board**
Physician's Name:	**Riley, Nicola Irene**
Date of Birth:	**03/27/1965**
Medical School:	**045010 - Univ Of Utah Sch Med**
Year of Graduation:	**2002**
Social Security Number:	
ECFMG Number:	**N/A**

Results:



Section II

Identity

AFFIDAVIT AND RELEASE

I, the undersigned, hereby certify under oath that I am the person named in this application, that all statements I have or shall make with respect thereto are true, that I am the original and lawful possessor and person named in the various forms and credentials furnished or to be furnished with respect to my application and that all documents, forms or copies thereof furnished or to be furnished with respect to my application are strictly true in every aspect.

I acknowledge that I have read and understand the "INSTRUCTIONS FOR COMPLETING THE FCVS APPLICATION" and have answered all questions contained in the application truthfully and completely. I further acknowledge that failure on my part to answer questions truthfully and completely may lead to my being prosecuted under appropriate federal and state laws.

I authorize and request every person, hospital, clinic, government agency (local, state, federal or foreign), court, association, institution or law enforcement agency having custody or control of any documents, records and other information pertaining to me to furnish to the Federation Credentials Verification Service any such information, including documents, records regarding charges or complaints filed against me, formal or informal, pending or closed, or any other pertinent data and to permit the Federation Credentials Verification Service or any of its agents or representatives to inspect and make copies of such documents, records, and other information in connection with this application.

I hereby release, discharge and exonerate the Federation Credentials Verification Service, its agents or representatives and any person furnishing information, of any and all liability of every nature and kind arising out of investigation made by the Federation Credentials Verification Service. I authorize the Federation Credentials Verification Service to release information, material, documents, orders or the like relating to me or this application to any entity at my request.

Nicola I. Riley

Applicant's Signature (must be signed in the presence of a notary)

Riley

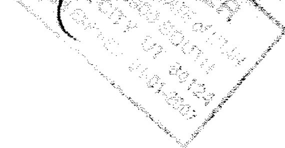
Applicant's **Printed** Last Name

NICOLA. I.

Applicant's **Printed** First Name, Middle Initial, and Suffix (e.g., Jr.)

3-2-04

Date of Signature (must correspond to date of notarization)



State of UTAH, County of SALT LAKE.

I certify that on the date set forth below the individual named above did appear personally before me and that I did identify this applicant by: (a) comparing his/her physical appearance with the photograph on the identifying document presented by the applicant and with the photograph affixed hereto, and (b) comparing the applicant's signature made in my presence on this form with the signature on his/her identifying document. The statements on this document are subscribed and sworn to before me by the applicant on this 2 day of MARCH, 2004.

Notary Public signature: J. B. Sadler

My commission expires: 9-1-07

Notary:
The Physician has been instructed to sign the front of the photograph. Your seal (or stamp) must be partly upon the photo and partly upon the signature of the applicant.

Federation Credentials Verification Service

STATE OF NEW JERSEY

D0000008170

CERTIFICATE OF BIRTH

Name of Child (*First, Middle, Last*): Nicola Irene Riley

Maiden Name of Mother (*First, Middle, Last*): Nicola Gaynor

Name of Father (*First, Middle, Last*): Ernest Anthony Riley

Sex: Fem.

Date of Birth (*Month/Day/Year*): March 27, 1965

Time of Birth (*if available*): 8:57 pm

Birthplace (*City/County*): Jersey City / Hudson

File Number: 299074

Date Filed: April 1, 1965

Date Amended (*if applicable*): N/A

Date Issued: Feb. 18,2004

Issued By: Jersey City Vital Statistics

SEAL VERIFIED

This is to certify that the above is correctly copied from a record on file in my office.

Certified copy not valid unless the raised Great Seal of the State of New Jersey or the seal of the issuing municipality or county, is affixed hereon.

Joseph A. Komosinski, State Registrar
Bureau of Vital Statistics

REG-42D
JAN 04

THIS DOCUMENT HAS MULTIPLE SECURITY FEATURES TO DETER FRAUD; VOID IF ALTERED

THE COMMONWEALTH OF MASSACHUSETTS

United States of America

COPY OF RECORD OF MARRIAGE

TOWN OF TISBURY

I, the undersigned, hereby certify that I am the clerk of the Town of Tisbury and as such I have custody of the records of marriages required by law to be kept in my office; that among such records is one relating to the marriage of:

DUSTIN ERIC COYLE AND NICOLA IRENE RILEY

DATE OF MARRIAGE	PLACE OF MARRIAGE
August 15, 2002	*Aquinnah, MA*

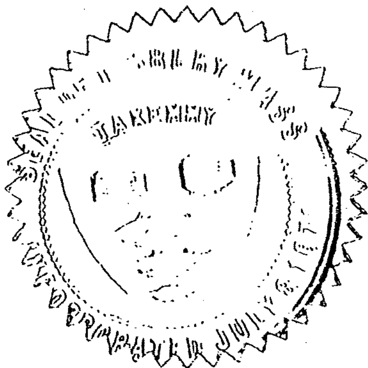
and that the following is a true copy of so much of said record as related to said marriage, namely:

	GROOM	BRIDE
Name	*Dustin Eric Coyle*	*Nicola Irene Riley*
SURNAME AFTER MARRIAGE	*Coyle*	*Riley-Coyle*
DATE OF BIRTH	*July 9, 1975*	*March 27, 1965*
OCCUPATION	*Doctor*	*Doctor*
RESIDENCE	*Salt Lake City, UT*	*Salt Lake City, UT*
# OF MARRIAGE	*1st*	*1st*
WIDOWED/DIVORCED	-----	-----
BIRTHPLACE	*Granger, UT*	*Jersey City, NJ*
MOTHER'S MAIDEN NAME	*Donna Jean Chaney*	*Nicola Lolita Gaynor*
FATHER'S NAME	*Harold Lester Coyle, Jr.*	*Ernest DuBois Riley*

OFFICIANT, RESIDENCE, AND OFFICIAL STATION OF PERSON BY WHOM MARRIED

John S. Alley, 1058 State Rd., West Tisbury, MA Justice of the Peace

RECORD NUMBER 26
DATE OF RECORD *August 28, 2002*



And I do hereby certify that the foregoing is a true copy from said records. Witness my hand and seal this Wednesday, August 28, 2002.

Marion N. Mudge

Tisbury Town Clerk

Section III

Medical Education

FEDERATION CREDENTIALS VERIFICATION SERVICE (FCVS)

VERIFICATION OF MEDICAL EDUCATION

(This form must be completed by the medical school)

INSTRUCTIONS TO THE DEAN

The individual identified on the attached Authorization For Release of Information, Documents and Records form has authorized your medical school to provide to the Federation Credentials Verification Service (FCVS) any and all information pertaining to their education at your institution. **Please complete this form and forward it to FCVS in the enclosed postage-paid, self-addressed envelope.**

Please note: If your institution processes transcript requests through another office, FCVS has likely made such a request under separate cover. **If your office also processes transcript requests, please attach the individual's official transcript (which indicates courses taken, dates and hours of attendance, and scores, grades, or evaluation).**

VERIFICATION OF MEDICAL EDUCATION

Name of Institution: University of Utah School of Medicine

Complete Address: Deans Office

Street Address: School of Medicine
University of Utah

City: 30 North 1900 East **State:** **ZIP Code (Postal Code):**

If name of institution was different when this individual attended, please note this name below: Salt Lake City, UT 84132-2101

Premedical Education:

Years of education required for admission to your medical school: A bachelor's degree and the completion of four years of college credit are required before entering the University of Utah School of Medicine.

Credential/degree presented by the applicant for admission to your medical school: Bachelor of Science degree in Human Factors Engineering

Enrollment and Participation: Our records indicate that Nicola Riley
(type/print individual's name: Last, First, Middle, Suffix)

attended our medical school for total of required weeks of medical education on the following dates (mm/dd/yy):

From 9 / 1 / 97 (Month / Date / Year) To 8 / 9 / 2002 (Month / Date / Year)

This individual (check one):

[x] was awarded the degree of M.D. on 8 / 9 / 2002 (Month / Date / Year)

[ ] was NOT awarded a degree (please attach an explanation)

Certification: By my signature, I, Elizabeth M. Allen, M.D. (type/print name), certify that the above information is an accurate account of the above named individual's official records maintained in this and is true and correct to my knowledge.

SEAL VERIFIED

Signature: Elizabeth M Allen MD

Title: Associate Dean for Student Affairs and Education

Date of Signature: 5-12-04

Phone: (801) 581-7201 **Fax:** (801) 585-3300

Email:

VERIFICATION OF MEDICAL EDUCATION

Unusual Circumstances: The following questions apply to unusual circumstances that occurred during any part of the individual's medical education. Please check the appropriate response and provide dates and requested information. "Yes" responses to any of these questions require a copy of explanatory records or a written explanation (attach additional pages as necessary).

1. Do this individual's official records reflect (an) interruption(s) or extension(s) in his/her medical education?
   Response YES ☐ NO ☐ **Not applicable to verification of medical school degree.

   If YES, please select the reason(s) for, indicate the dates of the interruption(s) or extension(s) and check whether the interruption/extension was approved or unapproved.

	From Mo/Yr	To Mo/Yr	Approved	Unapproved
Personal/Family			☐	☐
Academic remediation			☐	☐
Health			☐	☐
Financial			☐	☐
Participation in joint degree Program (e.g., MD/PhD)			☐	☐
Participation in non-research special study (e.g., fellowship, international experience)			☐	☐
Participation in non-degree research			☐	☐
Other			☐	☐

   Please Specify: ______________________

2. Do this individual's official records reflect that he/she was ever placed on academic or disciplinary probation during his/her medical education? Response YES ☐ NO ☐ **Not applicable to verification of medical school degree.

   If YES, please select the reason(s) for the probation, indicate the date(s) of placement on and removal from probation and attach additional documentation to this report.

	From Mo/Yr	To Mo/Yr
Academic Probation		
Probation for unprofessional conduct/behavioral		
Probation for other reason		

   Please specify reason: ______________________

3. Do this individual's official records reflect that he/she was ever disciplined for unprofessional conduct/behavioral reasons by the medical school or parent university? Response YES ☐ NO ☐ **Not applicable to verification of medical school degree.

   If YES, please provide detailed documentation/information about the circumstances and outcome(s).

4. Do this individual's official records reflect that he/she was ever the subject of negative reports or an investigation by the medical school or parent university? Response YES ☐ NO ☐ **Not applicable to verification of medical school degree.

   If YES, please provide detailed documentation/information about the circumstances and outcome(s).

5. Do this individual's official records reflect that there were any limitations or special requirements imposed on the individual because of questions of academic imcompetence, disciplinary problems, or any other reason? **Not applicable to verification of medical school degree.
   Response YES ☐ NO ☐

   If YES, please provide detailed documentation/information about the nature of the limitations or special requirements.

PROVIDED BY APPLICANT

Applicant: Print your complete last name: RiLEY

17. U.S./Canadian Medical Education

Complete this page only if you have attended a medical school located in the U.S. or Canada.

List all the medical schools you attended in chronological order.

You may photocopy this page to report more than two (2) institutions if necessary.

If your medical school is outside of the United States, and/or you participated in a Fifth Pathway program, proceed to the next page.

If necessary, you may continue your explanation of Unusual Circumstances on a separate 8.5" x 11" sheet of paper. Your response may not exceed 100 words per question.

DOCUMENTATION: You must include a complete, legible photocopy of your medical school diploma.

If a break of six (6) months or more occurred between medical schools attended or between graduation from medical school and your first year PGT, please provide a written explanation outlining your activities during this "gap" period on the enclosed Gap Explanation Form.

UNIVERSITY OF UTAH
SCHOOL OF MEDICINE

Complete name of Institution #1 (Do not abbreviate)

SALT LAKE CITY — UT

City — State

From: 08 (Month) 1997 (Year) To: 12 (Month) 2002 (Year)

Degree: ☐ None ☒ MD ☐ DO ☐ MD/PhD combined ☐ Did not graduate

Exact date of graduation: 12 (Month) 01 (Day) 2002 (Year)

Unusual Circumstances (circle yes or no):

Question	Yes	No
Did you ever take a leave(s) of absence or break(s) from your medical education?	Yes	(No)
Were you ever placed on probation?	Yes	(No)
Were you ever disciplined or placed under investigation?	Yes	(No)
Were any negative reports ever filed against you?	Yes	(No)
Were any limitations or special requirements imposed on you because of academic, incompetence, disciplinary problems or for any other reason?	Yes	(No)

Please explain any "Yes" responses from above:

____

____

Complete name of Institution #2 (Do not abbreviate)

City — State

From: __ (Month) __ (Year) To: __ (Month) __ (Year)

Degree: ☐ None ☐ MD ☐ DO ☐ MD/PhD combined ☐ Did not graduate

Exact date of graduation: __ (Month) __ (Day) __ (Year)

Unusual Circumstances (circle yes or no):

Question	Yes	No
Did you ever take a leave(s) of absence or break(s) from your medical education?	Yes	No
Were you ever placed on probation?	Yes	No
Were you ever disciplined or placed under investigation?	Yes	No
Were any negative reports ever filed against you?	Yes	No
Were any limitations or special requirements imposed on you because of academic, incompetence, disciplinary problems or for any other reason?	Yes	No

Please explain any "Yes" responses from above:

____

____

The University of Utah

upon the recommendation of the Faculty of

The School of Medicine

has conferred upon

Nicola J Riley

the Degree of

Doctor of Medicine

with all its Rights, Honors and Responsibilities

In Witness Thereof we have caused the Seal of the University to be affixed this ninth day of August, Two Thousand Two.

Commissioner of Higher Education

Chair, Utah State Board of Regents

J. Brant Machen
President of the University

James L. Macfarlane
Chair, Board of Trustees

Dean of the School of Medicine

SEAL VERIFIED

This is certified as a true copy of
Dr. Nicola J. Riley
official medical school diploma.
Anna Beckstrom
Anna Beckstrom
Director of Student Affairs
Date: 5-12-04

Section IV

Postgraduate Training

Federation Credentials Verification Service (FC
Federation Place, P.O. Box 619850, Dallas, TX 75261-9850
Tel: (817) 868-5000 Fax: (817) 868-5099

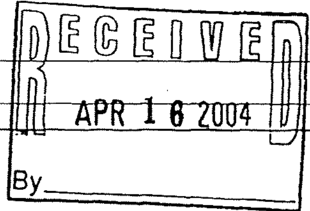
Verification of Postgraduate Medical Education

Institution: St Marks Hospital

Address: Department of Family Medicine
Salt Lake City, UT 84124

Attention: Program Director

University:



Verification For:

Name: Riley, Nicola Irene
SSN:
DOB: 03/27/1965

Individual's Name on Record (If different from above):

Program Participation:
Important:
Report Incomplete postgraduate years (PGY) separate from those that were successfully completed.

If the postgraduate year is currently in progress report the expected completion date in the "To" field.

Report Internships, Residencies and Fellowships separately.

Use one section per Department/Specialty. If the Department/Specialty is rotating or transitional, please provide a schedule of rotations

PGY: 1
✓ Internship
___ Residency
___ Chief Residency
___ Fellowship
___ Research

Specialty/Subspecialty: Family Practice
From: 10/1/2002 To: 9/30/2003
Successfully Completed?: ✓ Yes ___ No ___ In Progress
Accredited by: ✓ ACGME __ AOA __ LCGME __ RSC __ CFPC __ RCPSC __ APPAP __ None of these

PGY: 2
___ Internship
✓ Residency
___ Chief Residency
___ Fellowship
___ Research

Specialty/Subspecialty: Family Practice
From: 10/1/2003 To: 9/30/2004
Successfully Completed?: ___ Yes ___ No ✓ In Progress
Accredited by: ✓ ACGME __ AOA __ LCGME __ RSC __ CFPC __ RCPSC __ APPAP __ None of these

PGY: ______
___ Internship
___ Residency
___ Chief Residency
___ Fellowship
___ Research

Specialty/Subspecialty: ______
From: __/__/____ To: __/__/____
Successfully Completed?: ___ Yes ___ No ___ In Progress
Accredited by: __ ACGME __ AOA __ LCGME __ RSC __ CFPC __ RCPSC __ APPAP __ None of these

Unusual Circumstances:
Circle the correct response. Omitted responses require written explanation.

If necessary, you may continue your explanation on a separate sheet of paper.

SEAL VERIFIED

Question	Response
Did this individual ever take a leave of absence or break from his/her training?	Yes (No)
Was this individual ever placed on probation?	Yes (No)
Was this individual ever disciplined or placed under investigation?	Yes (No)
Were any negative reports ever filed by instructors?	Yes (No)
Were any limitations or special requirements placed upon this individual because of questions of academic incompetence, disciplinary problems or any other reason?	Yes (No)

Please explain any "Yes" response from above:

Certification:
Affix your institutional seal in this space. If no seal is available, you must have this form notarized.

Completion of the following is certification that the information above is an accurate account of this individual's records and is true and correct. This section MUST be signed by the Program Director (M.D./D.O. only).

Name: John W. Robinson, MD Signature: [signature] MD
Title: Residency Director Date of Signature: 4-9-2004
Tel: (801) 265-2000 Fax: (801) 265-2008 E-Mail: jrobinson@utahhealthcare.org

Rev. 07/02/02 Packet ID: 39737 Request ID: 13118430 TAG [23135]

PROVIDED BY APPLICANT

Applicant: Print your complete last name: Riley

20. Postgraduate Medical Education

List all of the postgraduate medical education programs you attended in chronological order. **Use one page per institution.**

You are provided two pages (p. 7 - 8) in this application to report this information. You must make a photocopy(ies) of this page to report more than two (2) institutions.

IMPORTANT: Report incomplete postgraduate years (PGY) separate from those that were successfully completed.

If your postgraduate year is currently in progress, indicate the *expected* completion date in the "To" field.

Report internships, residencies, fellowships and research programs separately.

Use one section per department.

(PGY) - Postgraduate years is also known as postgraduate training level.

If a break of six (6) months or more occurred between any of your postgraduate training activities, please provide a written explanation outlining your activities during this "gap" period on the enclosed Gap Explanation Form.

If necessary, you may continue your explanation of Unusual Circumstances on a separate 8.5" x 11" sheet of paper. Your response may not exceed 100 words per question.

Use one (1) page per institution. This page represents 1 of 1 institution(s).

ST. MARKS FAMILY MEDICINE RESIDENCY
A DIVISION OF UTAH HEALTHCARE
Complete name of hospital where training was conducted (Do not abbreviate)

INSTITUTE

Complete name of affiliated university or college (Do not abbreviate)

1250 EAST 3900 SOUTH SUITE 260
Address line 1

Address line 2

SALT LAKE CITY UTAH — UT
City — State/Province

USA — 84124 -
Country — ZIP/Postal Code

PGY	Specialty/subspecialty	From (Month / Year)	To (Month / Year)	Successfully Completed?
PGY: 1 ☒ Internship ☐ Residency ☐ Chief Residency ☐ Fellowship ☐ Research	FAMILY PRACTICE	10 / 2002	09 / 2003	☒ Yes ☐ No ☐ In progress
PGY: 2 ☐ Internship ☒ Residency ☐ Chief Residency ☐ Fellowship ☐ Research	FAMILY PRACTICE	10 / 2003	09 / 2004	☐ Yes ☐ No ☒ In progress
PGY: ___ ☐ Internship ☐ Residency ☐ Chief Residency ☐ Fellowship ☐ Research		/	/	☐ Yes ☐ No ☐ In progress
PGY: ___ ☐ Internship ☐ Residency ☐ Chief Residency ☐ Fellowship ☐ Research		/	/	☐ Yes ☐ No ☐ In progress

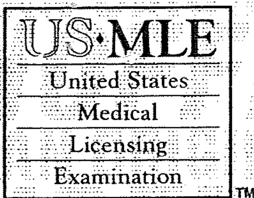
Unusual Circumstances (circle yes or no):

Question	Yes	No
Did you ever take a leave(s) of absence or break(s) from your medical education?	Yes	(No)
Were you ever placed on probation?	Yes	(No)
Were you ever disciplined or placed under investigation?	Yes	(No)
Were any negative reports ever filed against you?	Yes	(No)
Were any limitations or special requirements imposed on you because of academic, incompetence, disciplinary problems or for any other reason?	Yes	(No)

Please explain any "Yes" responses from above: ______

Section V

Examination History/Score Transcripts



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

This Transcript was prepared by the Federation of State Medical Boards

Date of Certification: 04/07/2004

Federation Credentials Verification Service
ATTN: Utah

Packet ID: 39737

Examinee: Riley, Nicola Irene
USMLE ID#: 5-051-425-6
DOB: 03 / 27 / 1965
Alt Name(s):

Results for all 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. Scores are reported on two scales. The recommended minimum passing score ("Passing") on each scale is shown in parentheses.

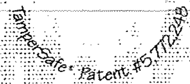
STEP1	Test Date	Pass/ Fail	Three-Digit Score	Three-Digit (Passing)	Two-Digit Score	Two-Digit (Passing)	Comments
	9/2/2002	PASS	197	(182)	80	(75)	
	6/5/2002	FAIL	181	(182)	74	(75)	
	10/10/2001	FAIL	171	(182)	70	(75)	
	1/27/2001	FAIL	181	(182)	74	(75)	

STEP2	Test Date	Pass/ Fail	Three-Digit Score	Three-Digit (Passing)	Two-Digit Score	Two-Digit (Passing)	Comments
	2/23/2002	PASS	200	(174)	82	(75)	

STEP3 State Board	Test Date	Pass/ Fail	Three-Digit Score	Three-Digit (Passing)	Two-Digit Score	Two-Digit (Passing)	Comments
UTAH	12/11/2003	PASS	190	(182)	78	(75)	

A search of the Board Action Data Bank of the Federation of State Medical Boards (FSMB) reveals no reported information on the above-named examinee.

Patent 5636874



American Medical Association

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Division of Survey and Data Resources
515 North State Street
Chicago, Illinois 60610
http://www.ama-assn.org/amaprofiles

AMA Physician Profile

Name and Mailing Address:

NICOLA IRENE RILEY MD

Primary Office Address:

STE 260
1250 E 3900 S
SALT LAKE CTY UT 84124-1371

Phone: UNKNOWN

Birthdate: 03/27/1965
Birthplace: JERSEY, NJ UNITED STATES OF AMERICA

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

Practice Specialties Self Designated by the Physician*:

Primary Specialty: FAMILY PRACTICE

Secondary Specialty:

**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:

UNIV OF UT SCH OF MED, SALT LAKE CTY UT 84132

Degree Awarded: Yes

Reported Year of Graduation 2002

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515 North State Street
Chicago, Illinois 60610
http://www.ama-assn.org/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: ST MARYS HLTH CARE FNDN | **State:** UTAH
Specialty : FAMILY PRACTICE | 10/2002 - 09/2005 (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:

TO DATE, FEDERAL DEA REGISTRATION STATUS IS UNKNOWN.

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.**

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Chicago, Illinois 60610
http://www.ama-assn.org/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.**

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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.

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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 mark them on a copy of the profile and mail or fax to:

Division of Survey and Data Resources
Attn: Physician Profile Unit
515 N. State Street
Chicago, IL 60610
312 464-5199
312 464-5900 (fax)

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State of Utah
Department of Commerce
Division of Occupational and Professional Licensing

OLENE S. WALKER, *Governor*
KLARE BACHMAN, *Executive Director*
J. CRAIG JACKSON, *Division Director*

June 30, 2004

NICOLA RILEY

Dear Dr. Riley:

The Utah Division of Occupational and Professional Licensing is in receipt of your physician/surgeon application. You are requested to meet with the Utah Physician's Licensing Board to discuss your application.

You have been scheduled to meet with the Board on July 14, 2004 at 11:30 a.m., Room 4A (fourth floor) 160 East 300 South, Salt Lake City Utah. Please contact me at (801) 530-6736 to confirm the appointment.

If you have any questions, please contact Diana Baker, Bureau Manager, at (801) 530-6179.

Sincerely,

Shirlene Kimball

Shirlene Kimball, Secretary
Division of Occupational and Professional Licensing