New Hampshire Board of Medicine

121 SOUTH FRUIT STREET, SUITE 301, CONCORD, NH 03301-2412
Tel. (603) 271-1203 Fax (603) 271-6702
TDD Access: Relay NH 1-800-735-2964
WEB SITE: www.nh.gov/medicine

November 6, 2014

NICOLA L MOORE MD

Dear Dr. Moore:

Congratulations. The New Hampshire Board of Medicine has granted your application for licensure. Your license, numbered 16838 is dated November 6, 2014 and is enclosed with this letter.

You are required to renew your license on a biennial basis and forms for that purpose will be forwarded to you at the address on file with the Board in April of the year in which your renewal is set to occur. For this reason, a form is enclosed which should be returned to us if and when you change your home or business address. Please be aware that you are required to inform the Board of any change of address within 30 days of that change.

An engrossed certificate of licensure will be provided to you within the next six months. This certificate is for display purposes only and does not constitute a legal document which verifies current licensure. The enclosed pocket size card should be used for that purpose.

Please feel free to contact this office if you have any questions.

Sincerely,

Penny Taylor

Penny Taylor
Administrator

Encl.

Uniform Application for Physician Licensure

UA Username nicolamoore
FCVS Status Applicant has an FCVS Packet

Date Submitted 9/22/2014

9/22/14

1. Name: Indicate your full legal name. If your name has changed at any time during your life and you are not using FCVS, you must submit a copy of the legal document (marriage certificate, divorce decree, etc.) supporting your name change.

1. Full Name (use no initials)

Last Name	Moore
First Name	Nicola
Middle Name	Louise
Suffix	
Maiden Name	
M.D.	[X]
D.O.	[ ]

All other names used

First	Middle	Last	Suffix
Nicola	Louise	Moore	
Nicola	Lousie	Moore	
Nicola	L	Moore	
Nicola		Moore	

2. Address/Phone: Please complete all sections and indicate which address you wish to be used for public access and which is to be used for mailings from the medical board. Each state's law determines whether each address or phone number is a public record in the state in which you are applying. You may wish to contact the licensing authority for that state for further information. Many boards publish the "Public Access" address on their website, therefore you should consider what your preferred address is for these purposes.

2. Address/Phone

Business

[ ] **Public Access**
[X] **Mailing**

Street
City
State/Province
Zip Code
Country USA
Telephone
Fax
Email
Alternate Phone

Home

[X] **Public Access**
[ ] **Mailing**

Street 395 CONCORD AVE
City CAMBRIDGE
State/Province MA
Zip Code 02138-1213
Country USA
Telephone
Fax
Email
Alternate Phone

INDEX NICOLA

3. Identification: If you are not using FCVS, you must submit either a notarized copy of your birth certificate or a notarized copy of your current, valid passport.

3. Identification

Date of Birth (mm/dd/yyyy)	Birth City	Birth State/Province	Birth Country

Gender | Social Security Number | NPI | Are you a U.S. Citizen? [X] Yes [ ] No

Your social security number is required to facilitate reporting to the federal Healthcare Integrity & Protection Data Bank (42 U.S.C. Sections 1320a-7e(b), 5 U.S.C. Section 552a, and 45 C.F.R. pt. 61) and for accurate identification under the federal and state child support enforcement law (42 U.S.C. Section 666 and applicable state law). It may also be used for reporting to the National Practitioner Data Bank (42 U.S.C. Section 11101 and 45 C.F.R. pt. 60) and for other investigative/enforcement purposes in compliance with state laws governing physician discipline or as otherwise required by state or federal law.

The National Provider Identifier (NPI) is a Health Insurance Portability and Accountability Act (HIPAA) Administrative Simplification Standard. For more information on the NPI, please go to http://www.cms.hhs.gov/NationalProvidentStand/.

4. Medical School: List all medical schools you have attended, even those from which you did not graduate, in chronological order. Attach an additional sheet if necessary. If you are not using FCVS, you must complete the attached "Medical Education Verification" form and send it to all medical schools you have attended. You must include a copy of your diploma to which the medical school must attach their seal prior to forwarding it to this Board. Additionally, the medical school must provide this Board with an official copy of your transcripts. The medical school must forward all documentation directly to this Board.

4. Medical School

1 **School Name** Albert Einstein College of Medicine of Yeshiva University
Address 1300 Morris Park Avenue

City Bronx
State/Province NY
ZIP Code 10461
Country USA
Attendance Dates **From (mm/yyyy)** 08/1995 **To (mm/yyyy)** 06/1999
Graduation Date 6/3/1999
Degree MD

5. Fifth Pathway: If you attended a Fifth Pathway program and are not using FCVS, you must complete the attached "Fifth Pathway Verification" form and send it to your medical school and to the institution where you completed your rotations. You must include a copy of your diploma. The medical school and institution must forward all documentation directly to this Board.

5. Fifth Pathway (if applicable)

Medical School Name			
Address			
City			
State/Province			
ZIP Code			
Country			
Attendance Dates	**From (mm/yyyy)**	**To (mm/yyyy)**	**In Progress**
Graduation Date			
Degree			
Institution name where rotations performed			
Address			
City			
State/Province			
ZIP Code			
Country			
Rotation Dates	**From (mm/yyyy)**	**To (mm/yyyy)**	**In Progress**
Certification Date			

6. Postgraduate Training: List **all** postgraduate programs you have attended, even those you did not complete. Attach an additional sheet if necessary. If you are not using FCVS, you must complete the attached "Postgraduate Training Verification" form and send it to **all** postgraduate training programs you have attended. You must submit a copy of your certificate of program completion to this Board. The postgraduate program must forward all documentation directly to this Board.

6. Postgraduate Training

1 **Hospital Name** Highland Family Medicine Center
Hospital Address 777 Clinton Avenue South

City Rochester
State/Province New York
ZIP Code 14620
Country USA

PGY: (e.g., 1, 2, 3, etc.) [X] **Internship** [X] **Residency** [ ] **Fellowship** [ ] **Research** [ ] **Other**

Department/Specialty Family Medicine

From: 06 /1999 **To:** 09 /2002 **Successfully Completed?** [X] **Yes** [ ] **No** **In Progress** [ ]
Month Year Month Year

2 **Hospital Name** Highland Hospital
Hospital Address 777 South Clinton Avenue

City rochester
State/Province New York
ZIP Code 14620
Country USA

PGY: (e.g., 1, 2, 3, etc.) [ ] **Internship** [ ] **Residency** [X] **Fellowship** [ ] **Research** [ ] **Other**

Department/Specialty Family Planning

From: 09 /2002 **To:** 06 /2003 **Successfully Completed?** [X] **Yes** [ ] **No** **In Progress** [ ]
Month Year Month Year

7. Examination History: If you are not using FCVS, you are responsible for contacting the appropriate examination entity and having a certified transcript of your scores sent directly to this Board.

7. Examination History

List each licensure examination, U.S. or international, you have taken (USMLE, NBME, NBOME, LMCC, Etc.).If additional space is necessary, please enclose a separate sheet with your application and include all the information below

Examination	State	Most Recent Date taken(Month/Year)	Passed (P) or Failed (F)		Number of attempts
USMLE Step 1		06/1997	[X] P	[ ] F	1
USMLE Step 2		08/1998	[X] P	[ ] F	1
USMLE Step 3		07/2000	[X] P	[ ] F	1

8. ECFMG: If ECFMG is applicable and you are not using FCVS, you are responsible for contacting ECFMG and having a certified "Status Report" forwarded directly to this Board. There is a separate fee for this report. Reports can be obtained through the ECFMG web site at www.ecfmg.org.

8. ECFMG (if applicable)		
Certificate Number	Issue Date	Valid Through Date

9. State or Professional Licensure: List all state and Canadian provinces where you currently hold or have ever held any type of medical/osteopathic license. You must also complete the attached "Licensure Verification" form (Form #1) and forward it to all states in which you have held any health care license or certification. The verifying entity must forward all documentation directly to this Board. Some state boards charge a fee for this information. Contact the state board where you hold or held a license to determine their requirements.

9. State Licensure

1	State/Province	IA	Practitioner Type (MD, DO, etc.)	MD	Type of License (Full, Temporary, etc.)		
	License Number	37992	Status	Active	Issue Date	8/1/2008	
2	State/Province	CA	Practitioner Type (MD, DO, etc.)	MD	Type of License (Full, Temporary, etc.)		
	License Number	89646	Status	Inactive	Issue Date	12/1/2004	
3	State/Province	MA	Practitioner Type (MD, DO, etc.)	MD	Type of License (Full, Temporary, etc.)		
	License Number	223184	Status	Active	Issue Date	2/1/2005	
4	State/Province	NE	Practitioner Type (MD, DO, etc.)	MD	Type of License (Full, Temporary, etc.)		
	License Number	24762	Status	Inactive	Issue Date	7/1/2008	
5	State/Province	NY	Practitioner Type (MD, DO, etc.)	MD	Type of License (Full, Temporary, etc.)		
	License Number	219226	Status	Inactive	Issue Date	9/1/2000	
6	State/Province	SD	Practitioner Type (MD, DO, etc.)	MD	Type of License (Full, Temporary, etc.)		
	License Number	8353	Status	Active	Issue Date	4/1/2012	
7	State/Province	MI	Practitioner Type (MD, DO, etc.)	MD	Type of License (Full, Temporary, etc.)		
	License Number	4301105546	Status	Active	Issue Date	5/1/2014	
8	State/Province	MS	Practitioner Type (MD, DO, etc.)	MD	Type of License (Full, Temporary, etc.)		
	License Number	21316	Status	Inactive	Issue Date	11/1/2010	

10. Chronology of Activities: List ALL activities (medical, non-medical, and postgraduate training) in chronological order beginning with medical school graduation to the PRESENT date, using **MONTH** and **YEAR**. *For any non-working time, you MUST state on the form exactly what your activities were, such as "vacation" or "seeking employment," as well as your permanent address.* If you worked for a physician-staffing group or did locum tenens, you must list all facilities where you worked and include complete dates and addresses. **DO NOT SUBSTITUTE ANY OTHER RESUME FOR THIS FORM**. Be sure to indicate the percentage of working time spent in clinical administrative duties.

10. Chronology of Activities

Dates: From/To	Practice/Employment
1 From: Month: 09 Year: 2002 To: Month: 06 Year: 2003 In Progress ☐	**Practice/Employment Name** Westside Health Services (or list non-working time as indicated above) **Practice/Employment Address** 480 Genesee Street **City** Rochester **State/Province** New York **ZIP Code** 14611 **Country** USA **Position and Department** Physician-Family Medicine **Percent Clinical:** 100% **Percent Administrative:** 0% **Employment** ☒ **Staff Privileges** ☒ **Affiliation** ☐ **Other**

Dates: From/To	Practice/Employment
2 From: Month: 07 Year: 2003 To: Month: 08 Year: 2003 In Progress ☐	**Practice/Employment Name** Vacation (or list non-working time as indicated above) **Practice/Employment Address** **City** **State/Province** **ZIP Code** **Country** **Position and Department** **Percent Clinical:** 0% **Percent Administrative:** 0% **Employment** ☐ **Staff Privileges** ☐ **Affiliation** ☐ **Other**

Dates: From/To	Practice/Employment
3 From: Month: 09 Year: 2003 To: Month: 10 Year: 2003 In Progress ☐	**Practice/Employment Name** Seeking employment and moving to Sudan (or list non-working time as indicated above) **Practice/Employment Address** **City** **State/Province** **ZIP Code** **Country** **Position and Department** **Percent Clinical:** 0% **Percent Administrative:** 0% **Employment** ☐ **Staff Privileges** ☐ **Affiliation** ☐ **Other**

Dates: From/To	Practice/Employment
4 From: Month: 11 Year: 2003 To: Month: 07 Year: 2004 In Progress ☐	**Practice/Employment Name** Mpilo Central Hospital (or list non-working time as indicated above) **Practice/Employment Address** Vera Road Mzilikazi **City** Bulawayo **State/Province** **ZIP Code** **Country** Zimbabwe **Position and Department** Physician-General Practice **Percent Clinical:** 100% **Percent Administrative:** 0% **Employment** ☒ **Staff Privileges** ☒ **Affiliation** ☐ **Other**

Dates: From/To	Practice/Employment
5 From: Month: 08 Year: 2004 To: Month: 09 Year: 2004 In Progress ☐	**Practice/Employment Name** (or list non-working time as indicated above) **Practice/Employment Address** **City** **State/Province** **ZIP Code** **Country** **Position and Department** **Percent Clinical:** 0% **Percent Administrative:** 0% **Employment** ☐ **Staff Privileges** ☐ **Affiliation** ☐ **Other**

Dates: From/To	Practice/Employment
6 From: Month: 10 Year: 2004 To: Month: 02 Year: 2005 In Progress ☐	**Practice/Employment Name** Medicins Sans Frontieres/Doctors Without Borders, Ler Hospital (or list non-working time as indicated above) **Practice/Employment Address** Ler Hospital **City** Ler **State/Province** **ZIP Code** **Country** South Sudan **Position and Department** Physician-General Practice **Percent Clinical:** 100% **Percent Administrative:** 0% **Employment** ☒ **Staff Privileges** ☒ **Affiliation** ☐ **Other**

Dates: From/To	Practice/Employment
7 From: Month: 03 Year: 2005 To: Month: 06 Year: 2005 In Progress ☐	**Practice/Employment Name** Diploma in Tropical Medicine and Hygiene, Liverpool School of Tropical Medic (or list non-working time as indicated above) **Practice/Employment Address** University of Liverpool **City** Liverpool **State/Province** **ZIP Code** **Country** England **Position and Department** Student-Tropical Medicine and Hygiene **Percent Clinical:** 0% **Percent Administrative:** 100% **Employment** ☐ **Staff Privileges** ☐ **Affiliation** ☐ **Other**

Dates: From/To	Practice/Employment
8 From: Month: 06 Year: 2005 To: Month: 07 Year: 2005 In Progress ☐	**Practice/Employment Name** Seeking Employment and awaiting credentialing in order to start work (or list non-working time as indicated above) **Practice/Employment Address** **City** **State/Province** **ZIP Code** **Country** **Position and Department** **Percent Clinical:** 0% **Percent Administrative:** 0% **Employment** ☐ **Staff Privileges** ☐ **Affiliation** ☐ **Other**

Dates: From/To	Practice/Employment
9 From: Month: 08 Year: 2005 To: Month: 12 Year: 2005 In Progress ☐	**Practice/Employment Name** Outer Cape Health Services (or list non-working time as indicated above) **Practice/Employment Address** 49 Harry Kemp Way **City** Provincetown **State/Province** Massachusetts **ZIP Code** 02657 **Country** USA **Position and Department** Physician-General Practice **Percent Clinical:** 100% **Percent Administrative:** 0% **Employment** ☒ **Staff Privileges** ☒ **Affiliation** ☐ **Other**

Dates: From/To	Practice/Employment
10 From: Month: 01 Year: 2006 To: Month: 05 Year: 2006 In Progress ☐	**Practice/Employment Name** St. Francis Hospital (or list non-working time as indicated above) **Practice/Employment Address** Katete **City** Katete **State/Province** **ZIP Code** **Country** Zambia **Position and Department** Physician-General Practice **Percent Clinical:** 100% **Percent Administrative:** 0% **Employment** ☒ **Staff Privileges** ☒ **Affiliation** ☐ **Other**

Dates: From/To	Practice/Employment
11 From: Month: 06 Year: 2006 To: Month: 09 Year: 2006 In Progress ☐	**Practice/Employment Name** Outer Cape Health Services (or list non-working time as indicated above) **Practice/Employment Address** 49 Harry Kemp Way **City** Provincetown **State/Province** Massachusetts **ZIP Code** 02657 **Country** USA **Position and Department** Physician-General Practice **Percent Clinical:** 100% **Percent Administrative:** 0% **Employment** ☒ **Staff Privileges** ☒ **Affiliation** ☐ **Other**

Dates: From/To	Practice/Employment
12 From: Month: 10 Year: 2006 To: Month: 05 Year: 2009 In Progress ☐	**Practice/Employment Name** St. Luke's Mission Hospital (or list non-working time as indicated above) **Practice/Employment Address** Lupane **City** Lupane **State/Province** **ZIP Code** **Country** Zimbabwe **Position and Department** Physician-General Practice **Percent Clinical:** 100% **Percent Administrative:** 0% **Employment** ☒ **Staff Privileges** ☒ **Affiliation** ☐ **Other**

Dates: From/To	Practice/Employment
13 From: Month: 06 Year: 2009 To: Month: 01 Year: 2013 In Progress ☐	**Practice/Employment Name** Planned Parenthood of the Heartland (or list non-working time as indicated above) **Practice/Employment Address** 1000 East Army Post Road **City** Des Moines **State/Province** Iowa **ZIP Code** 50315 **Country** USA **Position and Department** Physician-General Practice **Percent Clinical:** 100% **Percent Administrative:** 0% **Employment** ☐ **Staff Privileges** ☐ **Affiliation** ☐ **Other**

Dates: From/To	Practice/Employment
14 From: Month: 08 Year: 2010 To: Month: 10 Year: 2010 In Progress ☐	**Practice/Employment Name** Community Health Center of Cape Cod (or list non-working time as indicated above) **Practice/Employment Address** 107 Commercial Street **City** Mashpee **State/Province** Massachusetts **ZIP Code** 02649 **Country** USA **Position and Department** Physician-General Practice **Percent Clinical:** 100% **Percent Administrative:** 0% **Employment** ☐ **Staff Privileges** ☐ **Affiliation** ☐ **Other**

Dates: From/To	Practice/Employment
15 From: Month: 11 Year: 2010 To: Month: 03 Year: 2011 In Progress ☐	**Practice/Employment Name** Jackson Women's Health Organization (or list non-working time as indicated above) **Practice/Employment Address** 2903 North State Street **City** Jackson **State/Province** Mississippi **ZIP Code** 39216 **Country** USA **Position and Department** Physician-General Practice **Percent Clinical:** 100% **Percent Administrative:** 0% **Employment** ☒ **Staff Privileges** ☐ **Affiliation** ☐ **Other**

Dates: From/To	Practice/Employment
16 From: Month: 07 Year: 2012 To: Month: Year: In Progress [X]	**Practice/Employment Name** Planned Parenthood of Minnesota, North Dakota and South Dakota (or list non-working time as indicated above) **Practice/Employment Address** 6511 West 41st Street **City** Sioux Falls **State/Province** South Dakota **ZIP Code** 57106 **Country** USA **Position and Department** Physician-General Practice **Percent Clinical:** 100% **Percent Administrative:** 0% **Employment** [X] **Staff Privileges** [ ] **Affiliation** [ ] **Other**

Dates: From/To	Practice/Employment
17 From: Month: 04 Year: 2013 To: Month: Year: In Progress [X]	**Practice/Employment Name** Clinton Health Access Initiative (or list non-working time as indicated above) **Practice/Employment Address** 383 Dorchester Avenue 4th Floor **City** Boston **State/Province** Massachusetts **ZIP Code** 02127 **Country** USA **Position and Department** Women's Health Clinical Advisor-Family Planning **Percent Clinical:** 0% **Percent Administrative:** 100% **Employment** [X] **Staff Privileges** [ ] **Affiliation** [ ] **Other**

11. Malpractice: List of all claims or suits for medical malpractice made against you. A claim is any formal or informal demand for payment to any person or organization. If you do not have any such claims or suits, this section will be blank. Please have your information available before reviewing this section and contact the state board or FCVS to make changes.

11. Malpractice Liability Claims Information

Name of patient involved:

In which state did the action take place? **Case number (if applicable)**

Which court?
(If private compromise or settled before initiation of civil action, state here)

Current status of claim:

☐ Open (pending) ☐ Closed (settled or judgment) ☐ Dismissed (no money paid out) ☐ Other

Amount of judgement or settlement $ **Amount paid on your behalf $**

Month and year of event precipitating claim:

Month and year of lawsuit:

Insurance carrier at time:

What is/or was your status? ☐ **Primary defendant** ☐ **Co-defendant** ☐ **Other**

Please provide specifics in reference to the adverse event including the allegations and your role in the event:

UA UNIFORM APPLICATION FOR PHYSICIAN STATE LICENSURE

Affidavit and Authorization for Release of Information

Applicant: Follow the instructions in the left sidebar.
Send this to the state board you are applying to for licensure, NOT to FCVS/FSMB.

Applicant:

This is a separate form from the FCVS affidavit and release.

If you are using FCVS, you must complete both FCVS and UA affidavits. Send the FCVS affidavit to FCVS.

Sign this form with attached photo in the presence of a notary public. Send this notarized affidavit to the board you are applying to for licensure. See http://www.fsmb.org/state-medical-boards/contacts for a directory of state medical boards.

DO NOT SEND THIS FORM TO FCVS/FSMB. Doing so will delay your state licensure.

I, the undersigned, being duly sworn, hereby certify under oath that I am the person named in this application, that all statements I have made or shall make with respect thereto are true, that I am the original and lawful possessor of 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 Uniform Application for Physician State Licensure 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 Board 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 Board 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 Board, its agents or representatives, and any 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 of any and all liability of every nature and kind arising out of investigation made by the Board.

I will immediately notify the Board in writing of any changes to the answers to any of the questions contained in this application if such a change occurs at any time prior to a license to practice medicine being granted to me by the Board.

I understand my failure to answer questions contained in this application truthfully and completely may lead to denial, revocation, or other disciplinary sanction of my license or permit to practice medicine.

Nicola L Moore
Applicant's signature (must be signed in the presence of a notary)

MOORE
Applicant's printed last name

NICOLA L.
Applicant's printed first name, middle initial, and suffix (e.g., Jr.)

9/25/2014
Date of signature (must correspond to date of notarization)

-fold up- -fold up-

After folding the bottom portion upward, bring the new bottom edge to the top edge and fold to fit in a standard envelope.

Notary

State of MA., County of _____,

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 25 day of Sept, 2014.

Notary Public Signature: Paige B. Pennypacker

My Notary Commission Expires: 10-16-2020

(NOTARY PUBLIC SEAL)

RECEIVED
SEP 2 9 2014
NH BOARD

ADDENDUM TO APPLICATION

Applicant Name NICOLA LOUISE MOORE **Date** 9/26/14

Please answer the following questions. **If you answer "yes" to any of these questions, please explain on the reverse side of this sheet, or attach an additional 8 ½" x 11" sheet(s) if necessary.**

1. Have you been actively engaged in the practice of clinical medicine within the past 12 months? Yes ☒ No ☐
2. Are you certified by an American Specialty Board? (If yes, provide a notarized copy of all certificates.) Yes ☒ No ☐
3. Have you ever, for any reason, lost American Specialty Board Certification? Yes ☐ No ☒
4. Have you been denied required recertification by any specialty boards? (If yes, list each board and dates denied.) Yes ☐ No ☒
5. Has any medical malpractice suit been brought against you or has any claim been settled on your behalf in the last ten years? (If so, list each suit/claim on the Malpractice Liability Claims Information page within the online Uniform Application.) Yes ☐ No ☒
6. Have you ever applied for licensure or to sit for an examination, or taken an examination, under a different name? Yes ☐ No ☒
7. Have you ever been denied the privilege of taking or finishing an examination or been accused of cheating or improper conduct during an examination since you graduated from high school? Yes ☐ No ☒
8. Have you ever failed any national medical licensure examination or any part of that examination, state board examination, or failed to gain certification from the National Board of Medical Examiners? **You must report all exam failures, even if you later passed the examination.** (This does not include specialty board certification examinations.) Yes ☐ No ☒
9. Have you ever failed a foreign licensing or certification examination? Yes ☐ No ☒
10. Have you ever been denied a medical license, whether full, limited, or temporary, for any reason? Yes ☐ No ☒
11. Have you ever had staff privileges, employment or appointment in a hospital or other health care institution denied, limited, suspended, or revoked, or have you ever resigned from a medical staff in lieu of disciplinary action? Yes ☐ No ☒
12. Is any investigation or disciplinary action pending, or has any investigation or disciplinary action been taken against you in the last ten years by any governmental authority, by any hospital or health care facility, or by any professional medical association (international, national, state, or local)? Yes ☐ No ☒
13. Have you ever voluntarily surrendered a license to practice medicine or any healing art or allowed such a license to lapse in lieu of facing disciplinary investigation or action? Yes ☐ No ☒
14. Have you ever withdrawn an application for licensure, hospital privileges, or appointment for any reason? Yes ☐ No ☒

Applicant Name NICOLA LOUISE MOORE **Date** 9/26/14

15. Have you ever been a defendant in a criminal proceeding including driving while under the influence or driving while suspended, which has not been annulled by a court, but not including traffic offenses not classified as misdemeanors or felonies? Yes ☐ No ☒

16. Has your privilege to possess, dispense, or prescribe controlled substances ever been suspended, revoked, denied, restricted, or surrendered, or have you ever been charged, investigated, or warned by a state or federal agency based on controlled substance issues? Yes ☐ No ☒

17. Have you ever had any physical, emotional, or mental illness which has impaired or would be likely to impair your ability to practice medicine? Yes ☐ No ☒

18. Are you now, or have you, during the past 5 years, been dependent upon alcohol or habituating drugs, or undergone treatment for such? Yes ☐ No ☒

Anticipated Practice Location(s) (if known):

Manchester Health Center
24 Pennacook Street
Manchester, New Hampshire 03104

Nicola Louise Moore MD — **Applicant's Signature**

MOORE — **Applicant's Printed Last Name**

9/26/14 — **Date of Signature**

For Board Use Only:

Application Received: Sept. 29, 2014 Fee Paid: $300 Check #: _____

License Number: _____ Date of Issue: _____

Nicola Louise Moore
email: _____

EDUCATION

UNIVERSITY OF LIVERPOOL	**Diploma in Tropical Medicine and Hygiene**	**2005**
UNIVERSITY OF ROCHESTER	**Fellowship in Family Planning**	**2003**
UNIVERSITY OF ROCHESTER	**Residency in Family Medicine**	**2002**
ALBERT EINSTEIN COLLEGE OF MEDICINE	**Doctor of Medicine**	**1999**
YALE UNIVERSITY	**Master of Public Health**	**1982**
YALE UNIVERSITY	**Bachelor of Arts**	**1976**

WORK EXPERIENCE

3/13-present **Clinton Health Access Initiative, Boston, Massachusetts**
WOMEN'S HEALTH CLINICAL ADVISOR (independent contractor).
Providing clinical technical assistance and support to Clinton Health Access Initiative (CHAI) country programs and government partners and to CHAI senior management in the development of CHAI programs.

7/12-present **Planned Parenthood of Minnesota, North Dakota and South Dakota: Sioux Falls, South Dakota**
DOCTOR.
Reproductive health services.

6/09-2/13 **Planned Parenthood of the Heartland, Sioux City, Iowa and Omaha, Nebraska**
DOCTOR.
Reproductive health services.

11/10-3/11 **Jackson Women's Health Organization, Jackson, Mississippi**
DOCTOR.
Reproductive health services.

8/10-10/10 **Community Health Center of Cape Cod, Mashpee, Massachusetts**
FAMILY PRACTICE PHYSICIAN (locum tenens).
Primary care servicea.

10/06-5/09 **St. Luke's Mission Hospital, Lupane, Zimbabwe**
DOCTOR.
Full-spectrum outpatient and inpatient care in rural hospital.

1/06-5/06 **St. Francis Hospital, Katete, Zambia**
DOCTOR.
Full-spectrum outpatient and inpatient care in rural hospital.

8/05-12/05, 6/06-9/06 **Outer Cape Health Services, Provincetown and Wellfleet, Massachusetts**
FAMILY PRACTICE PHYSICIAN.
Primary care services.

10/04-02/05 **Medicins Sans Frontieres – Holland, Ler, Western Upper Nile, South Sudan**
DOCTOR.
Full-spectrum outpatient and inpatient care in rural hospital.

11/03-7/04 **Ministry of Health and Child Welfare, Bulawayo, Zimbabwe**
GOVERNMENT MEDICAL OFFICER – ORIENTEE (volunteer).
Clinical services in large referral hospital while receiving orientation to local protocols for medicine, pediatrics, obstetrics, gynecology and surgery.

9/02-6/03 **Westside Health Services – Brown Square Health Center, Rochester, New York**
FAMILY PRACTICE PHYSICIAN.
Full spectrum family practice.

9/02-6/03 **Department of Family Medicine, University of Rochester, Rochester, New York**
FAMILY PLANNING CLINICAL AND RESEARCH FELLOW.
Reproductive health services.

7/99-9/02 **Highland Hospital and Brown Square Health Center, Rochester, New York**
FAMILY MEDICINE RESIDENT.
Primary care, Obstetrics/Gynecology, Inpatient services, Emergency services

8/92-6/94 **Albert Einstein College of Medicine/Montefiore Medical Center, Bronx, New York**
PROJECT DIRECTOR, TUBERCULOSIS INITIATIVE.
Coordinated multiple tuberculosis-related activities for facilities associated with an urban medical center and its medical school affiliate (including hospitals, community health centers, methadone maintenance treatment facilities and a prison health service).

1/87-7/92 **Montefiore Medical Center, Moses Division, Bronx, New York**
DIRECTOR OF OPERATIONAL SERVICES.
Hired to improve support and ancillary services of 750-bed hospital.
- Established two support service departments: supervised 25 employees; responsible for $8 million supply and $1 million capital budgets.
- Redesigned major non-clinical services for 35 inpatient units: scheduling and coordination of diagnostic procedures; transport of patients; acquisition and distribution of supplies.
- Coordinated operations aspects of all inpatient facilities renovations.

6/81-12/86 **Arthur D. Little, Inc., Health Care Management, Cambridge, Massachusetts**
CONSULTANT.
Managed consulting projects for government, private and public health care clients. Provided planning, technical assistance, operations review for clinics, hospitals, HMOs and vendors of health care products.

10/79-6/81 **Yale University School of Medicine, Department of Epidemiology and Public Health, New Haven, Connecticut**
ASSISTANT IN RESEARCH.
Evaluated changes in quality of care of renal stone patients in Connecticut community hospitals: abstracting and coding medical records data, data analysis and report preparation.

10/78-5/79 **University of Connecticut Health Center, Department of Nuclear Medicine, Farmington, Connecticut**
RESEARCH ASSISTANT.
Performed animal experimentation with radioactive tracers for diagnostic scanning.

5/77-2/78 **Yale Psychiatric Institute, New Haven, Connecticut**
PSYCHIATRIC AIDE.
Coordinated treatment plans and daily activities for 20 schizophrenic adolescents in milieu therapy setting.

VOLUNTEER EXPERIENCE:

3/03-5/03 **Mpilo Central Hospital, Bulawayo, Zimbabwe**
Provided obstetrical and gynecological care in large referral hospital. Provided ante-natal, delivery and post-natal care and performed completion of incomplete abortions. Trained attending physicians and housemen in related procedures. Sponsored by Rotary International.

2/01-3/01 **Mondaña Clinic, Napo Province, Ecuador**
Provided primary care and participated in child survival outreach project in Amazon jungle.

6/00-11/00 **Finger Lakes Migrant Health, Ontario County, New York**
Provided screening, vaccinations and primary care services to laborers and their families at farm worker camps.

9/95-6/96 **New York Harm Reduction Educators, Inc. and Citiwide Needle Exchange, Bronx, New York**
Participated in street-based needle exchange programs for IVDUs. Provided clean needles, safe-sex and safe-injection education and medical and social service referrals. Organized on-going medical student participation in exchange and in influenza and pneumococcal vaccination programs; recruited and trained students.

ACADEMIC AND HOSPITAL APPOINTMENTS:

8/05-10/06 **Staff (Courtesy)**
Department of Medicine, Beth Israel Deaconess Medical Center, Boston, Massachusetts

10/03-9/04 **Clinical Instructor in Family Medicine**
School of Medicine and Dentistry, University of Rochester, Rochester, New York

10/02-9/03 **Associate Attending with Admitting Privileges**
Highland Hospital, Rochester, New York

10/02-9/03 **Associate Attending with Admitting Privileges**
Department of Pediatrics, Strong Memorial Hospital, Rochester, New York

9/02-9/03 **Instructor in Family Medicine (part time)**
School of Medicine and Dentistry, University of Rochester, Rochester, New York

11/00-6/02 **Associate in Family Medicine**
School of Medicine and Dentistry, University of Rochester, Rochester, New York

HONORS AND AWARDS

The Highland Hospital Family Medicine Women's Health Care Award for Outstanding Accomplishment in the Field of Women's Health, 2002.

LICENSING AND CERTIFICATION

Board Certified, American Board of Family Practice
Medical Registration, Zambia
Massachusetts License number 223184
Michigan License number 4301105546
Nebraska License number 24762
South Dakota License number 8353
Zimbabwe Medical Registration number M700312

LANGUAGES

Spanish, medical
Ndebele, medical

REFERENCES

Available on request.

American Board of Family Medicine, Inc.

Quality Healthcare, Public Trust . . . Setting the Standards in Family Medicine

RECEIVED
SEP 29 2014
NH BOARD

September 23, 2014

To Whom It May Concern:

This letter verifies Nicola Louise Moore, M.D. (NPI: 1134166184) is currently certified with the American Board of Family Medicine (ABFM).

Family Medicine Certification History:

Jul 10, 2004 - Apr 27, 2014
Apr 28, 2014 - * Certification Number: 1052530742

* Certification is continuous as long as MC-FP Requirements are maintained.

Maintenance of Certification for Family Physicians (MC-FP):

Current Status: Meeting Requirements

Beginning in 2011 certification by the American Board of Family Medicine is maintained through successful completion of the Maintenance of Certification for Family Physicians (MC-FP) process. The MC-FP process is a continuous process that requires maintaining a currently valid, full, and unrestricted license to practice medicine in the United States or Canada, completing MC-FP activities in a timely fashion, and performing successfully on the examination every ten years. Failure to maintain any of these requirements will result in the loss of certification status with the ABFM. Physicians whose certificate has expired may renew their certification at such time as they fulfill all of the MC-FP requirements in effect at that time. Based upon the continuous nature of MC-FP, no end date for certification is presented above.

In 2003 family physicians who performed successfully on the Certification and Recertification examinations began a gradual transition from Recertification to MC-FP. MC-FP was designed to transition all Diplomates into the program by 2010, enrolling all physicians who certified or recertified as they successfully passed the examination.

The ABFM website serves as primary source verification. Details of the MC-FP process are available online at www.theabfm.org.

Sincerely,

Mary McIntosh

Mary McIntosh
Verification Coordinator and Candidate Assistant

Attest to a true copy.
Nicola Louise Moore
9/25/2014
Then appeared Nicola Louise Moore

CATHIE HAMMATT
Notary Public
Commonwealth of Massachusetts
My Commission Expires September 23, 2016

Attest to a true copy
Nicola Louise Moore M.D.
9/25/2014

Then appeared Nicola L Moore
9/25/14

JAMIE HAMMATT
Notary Public
Commonwealth of Massachusetts
My Commission Expires September 23, 2016

DEA REGISTRATION NUMBER	THIS REGISTRATION EXPIRES	FEE PAID
	01-31-2015	$731

SCHEDULES	BUSINESS ACTIVITY	DATE ISSUED
2,2N,3 3N,4,5	PRACTITIONER	05-07-2012

MOORE. NICOLA L MD

CONTROLLED SUBSTANCE REGISTRATION CERTIFICATE
UNITED STATES DEPARTMENT OF JUSTICE
DRUG ENFORCEMENT ADMINISTRATION
WASHINGTON, D.C. 20537

Sections 304 and 1008 (21 U.S.C. 824 and 958) of the Controlled Substances Act of 1970, as amended, provide that the Attorney General may revoke or suspend a registration to manufacturer, distribute, dispense, import or export a controlled substance.

THIS CERTIFICATE IS NOT TRANSFERABLE ON CHANGE OF OWNERSHIP, CONTROL, LOCATION, OR BUSINESS ACTIVITY, AND IS NOT VALID AFTER THE EXPIRATION DATE.

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Form DEA-223 (05/04)