



# ARKANSAS STATE MEDICAL BOARD

2100 Riverfront Drive, Little Rock, Arkansas 72202-1435 (501) 296-1802

## APPLICATION FOR MEDICAL LICENSURE IN ARKANSAS and Centralized Credentials Verification Service

www.armedicalboard.org

Medicine/Surgery  Osteopathic Medicine/Surgery

1. Name SUSAN CELINA ROBINSON Social Security # \_\_\_\_\_  
2. Address BUSINESS 759 SOUTH STATE ST PMB 72, UKIAH, CA 95482  
(Legibly Print full Legal Name) (APPLICATION MUST BE COMPLETED IN INK)

3. Address you wish license to be mailed \_\_\_\_\_

4. Phone (Res.) \_\_\_\_\_ (Work) SAME (Fax) \_\_\_\_\_ (email) \_\_\_\_\_

5. Male  Female  Birth Date \_\_\_\_\_ Birth Place NEW YORK, NY  
If born outside of U.S., how long have you lived in U.S. N/A Years \_\_\_\_\_ Months \_\_\_\_ Are you a citizen of U.S.  Yes  No  
If yes, and foreign born, attach proof of citizenship. If no, indicate your status with U.S. Immigration N/A  
(Attach copy of Visa/Work Permit)

6. ECFMG Certificate # N/A Date Issued \_\_\_\_\_  
Have certified verification mailed directly from ECFMG to this office.

7. Intended practice location in Arkansas Undecided Give name and address of hospital, clinic, group or private: \_\_\_\_\_

8. Specialty OB-GYN Subspecialty N/A  
Board Certified (Date) NOV, 1986 Board Certified (Date) N/A  
Recertification JUNE, 1995 Recertification N/A  
Have enclosed form completed by your Specialty Board and returned directly to this office.

9. Drug Enforcement Administration Number AR 1905972 State (Federal) Expiration Date none  
Submit a copy of your DEA Registration Card to this office.

10. UPIN # B75137 Medicaid Provider # 8794232 Medicare Provider # 00G398520  
Accept Medicaid Patients?  Yes  No Accept Medicare Patients?  Yes  No

11. Professional Liability Insurance (CURRENT Carrier Name) NATIONAL UNION FIRE INSURANCE, MARSH USA  
Policy # 6791711 Date of Expiration 12/31/03 Amount of Coverage 1 MILLION/OCCURRENCE  
Send enclosed form to your insurance carrier and have them return directly to this office. 3 MILLION/year

12. Medical School. Date Graduate JUNE Mo 18 Day 1978 yr Degree M.D.

	Name of Institution	Address	Date from	Date to
1 <sup>st</sup> Year	U. Cal, San Diego	9500 GILMAN DR	9/74	6/75
2 <sup>nd</sup> Year	" School of Medicine	" La Jolla, CA. 92093	9/74	6/76
3 <sup>rd</sup> Year	"	"	7/76	6/77
4 <sup>th</sup> Year	"	"	7/77	6/78

Have Verification of Medical Education Form and an official Transcript mailed directly to this office.

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FOR USE OF SECRETARY ONLY

License No. E-4038  
Name Susan Celina Robinson, MD  
Application for License through endorsement by MBME

Application received SEP 22 2003  
Fee \$500.00 Date 9-29-03  
License issued 4/2/2004  
Application Declined \_\_\_\_\_  
Fee returned \_\_\_\_\_ 20 \_\_\_\_\_

NOTE: Application must be legible and completed in INK or Typed

13. Post Graduate Training (list chronologically). Send Enclosed Verification Form - Refer to instruction Sheet

Name of Institution	Address	Type of Program	Dates From/To	Completed? Yes/No
UC San Diego Med Ctr	200 W. Arbor Dr. San Diego	<sup>intern</sup> (gen surg/urology)	7/79-6/79	yes
Tufts. New England Med Ctr.	171 Harrison Av. Boston	resident (OB/GYN)	7/79-6/82	yes

14. Fellowships (list chronologically). Send Enclosed Verification Form - Refer to instruction Sheet

Name of Institution	Address	Type of Program	Dates From/To	Completed? Yes/No
Tufts NEMC DEPT MFM	750 Washington ST B330 Boston MA. 02111	Maternal Fetal Med	7/82-6/84	yes

15. Have you taken the National Board (NBME) exams?  Yes  No. If yes, have certified copy of scores mailed directly to this office. done
16. Have you taken the State Board Examination?  Yes  No. Where? NA When? NA  
If yes, have certified copy of scores mailed directly to this office.
17. Have you taken the National Board of Osteopathic Medicine?  Yes  No. If yes, have certified copy of scores mailed directly to this office.
18. Have you taken the FLEX Exam?  Yes  No. If yes, have certified copy of scores mailed directly to this office.
19. Have you taken the United States Medical Licensing Exam (USMLE)?  Yes  No. If yes, have certified copy of scores mailed directly to this office.
20. Have you taken the LMCC Exam?  Yes  No. If yes, have certified copy of scores mailed directly to this office.
21. Have you taken the SPEX within the last five years?  Yes  No. If yes, have a certified copy of scores mailed directly to this office.
22. Indicate the name and date of your most recent written exam AMERICAN BOARD OF OBGYN  
RE-CERTIFICATION: 6/26/95
23. Continuing Medical Education 5/01-5/03

List Continuing Medical Education for the last two years excluding Residency/Fellowship training.

Date	Description	Sponsor/Location	AMA Cat. 1 Hours	Cat. Other Hours
5/10/02.	NAF Guide to Medical Abortion	National Abortion Federation Washington DC.	3	
8/02 1/03, 3/03	The Contraception Report V12, V13	BAYLOR COLLEGE of MED HOUSTON TX	8	
10/11/02.	OB/GYN CLINICAL ALERT V15 #1-6	AMERICAN HEALTH CONSULTANTS, ATLANTA GA	10	
2/21/03	Education for Physicians on End-of-Life CARE (EPEC)	CAL. HOSPICE FOUNDATION SACRAMENTO CA.	12.	
4/03	NAF ANNUAL MEETING	NATIONAL ABORTION Federation, Washington DC	13	

If you have trained in additional procedures, submit certificates of training or other documentation.

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24. Professional Activities

List in chronological order all your professional activities, institutional affiliations or places of employment since graduation from Medical School. This includes hospitals, teaching institutions, HMO's, private practice, corporations, military assignments, government agencies, and Locum Tenens assignments. Exclude Residency and Fellowship. You may attach additional sheets after completing this section, if space is not sufficient. Do not submit curriculum vitae (CV) in lieu of completing this section.

From	To	Status	Location & Complete Address	Position
7/84	6/87	inactive	Maternal Fetal Medicine, St. Margaret's Hospital 90 Cushing Ave Boston. Hospital now closed * ①	Associate Director.
②* 9/87	9/88	"	Center for Women's Health, Quincy Hospital 114 Whitwell St. Quincy MA. 02169	Medical Director.
③* 4/89	6/90	"	Kaiser Permanente, 31 Hall Drive Amherst MA 01002	office gynecologist (per diem).
7/90	7/97	"	Lahey Hitchcock Clinic 21 E Hollis St, Nashua NH 03060. (Southern NH Regional Med Center, 8 Prospect St. Nashua NH)	staff OB GYN
2/97	8/97	"	Planned Parenthood - Preterm Health Services 1055 Commonwealth Ave. Boston MA 02215.	abortions (contract)
④* 11/23/97	11/30/97	"	Martha's Vineyard Hospital Linton Lane, Oak Bluffs MA 02557.	Locum Tenens Thru Comp Health. (OB/GYN).
12/23/97	1/5/98	"	St Joseph's Hospital 1915 Lake Ave. Plymouth IN, 46563	Locum Tenens Thru Comp Health. (OB/GYN).
1/26/98	6/26/98	"	The Permanente Medical Group 280 West MacArthur Blvd. Oakland CA 94611	Locum Tenens Thru Comp Health (office gyn).
10/25/98	11/1/98	"	Miles Memorial Hospital RR 2 PO Box 4500. Damariscotta, ME 04543.	Locum Tenens Thru Comp Health (OB/GYN).
⑤* 9/14/98	May 2000	"	Mendocino Coast District Hosp. 700 River Rd. Fort Bragg CA 95437	Intermittent Locum Tenens (independent) OB GYN

- Please review this list carefully. If there are gaps in your chronological history you are required to provide a brief explanation. Send enclosed Verification Hospital/Clinic forms to each facility. (See Instruction Sheet)
- Complete all forms in black or blue ink ONLY.

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**24. Professional Activities (continued)**

From	To	Status	Location and address	position
3/2/99	7/30/01	inactive	Sutter Lakeside Hospital 5671 Hill Road East, Lakeport, CA 95453	Intermittent independent Locum tenens OB GYN
5/99	Current	active	Planned Parenthood Golden Gate	Contract doc at various clinic locations

**\*1 Details, Maternal Fetal Medicine Fellowship address:**

The Fellowship program was located at  
St. Margaret's Hospital  
90 Cushing Ave, Boston, MA.  
St Margaret's Hospital has closed and merged with  
St. Elizabeth's Hospital,  
736 Cambridge St, Boston, MA, 02135

The program chair was Curtis Cetrulo MD whose current contact  
information is:

Department of Maternal Fetal Medicine  
750 Washington Street  
New England Medical Center Box 360  
Boston, MA 02111  
617 636 4625

**\*2** I spent this three-month hiatus preparing to open new practice at Quincy  
Hospital.

**\*3** I spent this seven-month hiatus in recreation and recuperation from burn-out  
(secondary to the dreadful experience of attempting to run an OB GYN practice).

**\*4** 9/97-11/98 my husband and I lived in our RV and drove around the country. I  
did intermittent locum tenens work for CompHealth, 4021 South 700 East, Suite  
300, Salt Lake City, UT 84107. When I wasn't working, we were having a great time  
seeing the USA.

**\*5** 9/98-7/01 I did intermittent independently contracted locum tenens work at  
Mendocino Coast District Hospital and Sutter Lakeside hospital, both of which are  
within driving distance of our new home in Ukiah, CA.

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25. Military Service? Yes X No If yes, which Branch? N/A  
 Dates of Service N/A Attach copy of separation papers and have records sent from Military Personnel Records Center. (See Instruction Sheet and Verification form.)

26. Medical Societies and Professional Organizations: Send enclosed Verification of Medical Society Membership Form to State or County Medical Society.

Organization	Address	From	To
none			

27. List all states/countries in which you have or have had a medical license. Have verification of each license mailed directly to this office. Send enclosed verification of Licensure Form. (Form may be copied if necessary.)

State/Country	License #	Date Issued	Active Y/N	State/Country	License #	Date Issued	Active Y/N
MA	46659	10/2/80	N	ME	TD-98-87	9/24/98	N
NH	8361	6/6/90	N	CA	G39852	7/2/79	Y
IN	01048096 <sup>A</sup>	1/26/98	N				
AZ	26306	4/13/98	N				

28. Professional References/Recommendations: Have three reference/recommendation letters mailed from their offices directly to this office. These cannot be current partners or related to you. They must have worked with you and directly observed your professional performance in the recent past. At least one of these references/recommendations must have had organizational responsibility for supervising your performance (i.e. department chief, service chief or training program director).

Name	Address	Association
SUZAN GOODMAN MD	PPGG 815 EDDY ST, #200, San Francisco CA 94106	COLLEAGUE
MAUREEN PAUL MD	PPGG 815 EDDY ST #200, SAN FRANCISCO CA. 12901	C.M.O. PPGG.
DIANE CABANA	210 CORNELIA ST SUITE 201 PLATTSBURGH NY	FORMER COLLEAGUE

Attach explanation of any "yes" answers. Refer to Instruction Sheet for the following questions. YES NO

- 29. Have you ever failed a licensing exam? Where? N/A Explain. YES NO X
- 30. Has your application for examination or licensure ever been rejected, denied or withdrawn? YES NO X
- 31. Has any medical licensing board ever placed your license on probation, suspension or has it revoked a license or certificate it had granted you? If yes, list name and address of board. YES NO X
- 32. Have you ever been ordered to appear before a state medical board for any reason other than licensure? YES NO X
- 33. Have disciplinary procedures ever been initiated toward you by either a medical board or hospital? Explain. YES NO X
- 34. Have your privileges at any hospital been denied, suspended, diminished, voluntarily or involuntarily relinquished, revoked or not renewed, or is any such action pending? YES NO X
- 35. Have you ever voluntarily surrendered your license in any state? YES NO X
- 36. Have you ever been charged or convicted (including a plea of nolo contendere) of a misdemeanor or felony? YES NO X
- 37. Have you ever been denied provider participation in any state or Federal Medicaid program? YES NO X
- 38. Have you ever previously made application to the Arkansas State Medical Board? YES NO X
- 39. Have you ever been warned, censured by, or requested to withdraw from, any hospital in which you have trained, been a staff member or held hospital privileges? If yes, explain. YES NO X

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	YES	NO
40. Have you ever been disciplined or dismissed from any professional activity or training program? Have you ever received a warning, reprimand, or been placed on probation during and internship, residency, or fellowship program? If yes, explain.	_____	<u>X</u>
41. Have you ever, voluntarily or involuntarily, left a training institution program before completing it? If yes, explain.	_____	<u>X</u>
42. Have you ever been reported to the National Practitioners Data Bank or subject to NPDB adverse action report?	_____	<u>X</u>
43. Have you resigned or surrendered clinical privileges from any medical staff while under investigation for possible incompetence or improper professional conduct, or in return for such an investigation not being conducted?	_____	<u>X</u>
44. Have you ever been denied membership, renewal thereof, or been subject to disciplinary action in any medical organization, or is any such action pending?	_____	<u>X</u>
45. Have you ever been terminated, sanctioned, penalized or had to repay money to any State Medicaid or Federal Medicaid programs? If yes, name state _____	_____	<u>X</u>
46. Have any malpractice claims been filed against you? If yes, provide official documentation from your attorney or insurance company. a. How many? _____ b. How many were dismissed with settlement? c. How many were dismissed or dropped? d. How many are pending?		
47. Have you ever been cited by a peer review organization? Explain Give the name and address of the organization _____		
48. Have you ever had to discontinue practice for any reason for a period longer than one month? If yes, explain.		
49. Have you been, or are you presently, being treated for alcoholism, or substance abuse? If yes, was this voluntary or the result of a medical board action? Explain.		
50. Have you been, or are you presently, being treated for a mental health condition? If "Yes", was this voluntary or the result of a medical board action? Explain.		
51. Do you currently, or have you had, any physical or mental health condition, including alcohol or drug dependency, which with or without accommodation, affects or is reasonably likely to affect your ability to practice medicine or to perform professional or medical staff duties appropriately?		
52. Have you ever had a DWI? How many? <u>NA</u> Date(s) occurred <u>NA</u>		
53. Have you ever been treated for drug or substance abuse outside a hospital setting? Explain.		
54. Have you ever been treated for drug or substance abuse in a treatment center or hospital? Give name of institution, date and length of stay? <u>N/A</u>		
55. Are you currently being, or have you ever been, monitored by a Physician Health Committee in any state? If yes, give state(s) <u>NA</u> Ask your treating physician to send documentation of your status.		
56. Have you ever been rejected by a medical society?	_____	<u>X</u>
57. Has your license to practice medicine or Drug Enforcement Administration registration in any jurisdiction been denied, reduced, limited, suspended, revoked, placed on probation, not renewed voluntarily, or involuntarily relinquished, or is any such action pending? If yes, explain.	_____	<u>X</u>
58. Have you ever defaulted on any Health Education Assistance Loan? If yes, explain.	_____	<u>X</u>
59. To your knowledge, are you currently the subject of an investigation by any licensing board as of the date of this application? If yes, explain.	_____	<u>X</u>

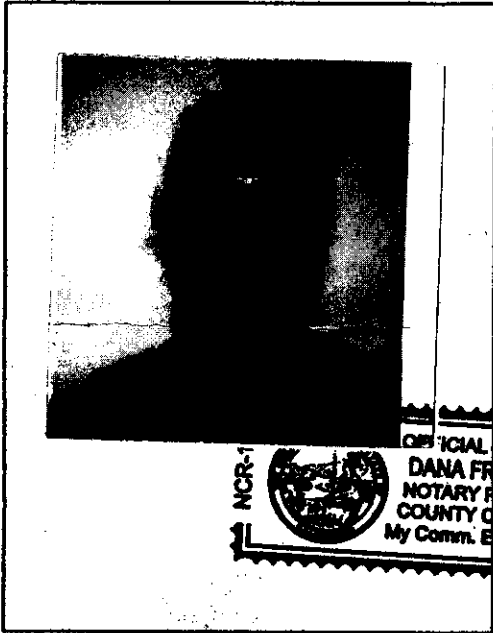
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If, during the application process, you become aware of any such investigation, you are required to report it to this office.

**AFFIDAVIT OF APPLICANT**

I, Susan C. Robinson

certify after being sworn, that all of the information supplied in the foregoing application is true, correct, current and complete to the best of my knowledge, that the photograph submitted herein is a true likeness of myself and was taken within sixty (60) days prior to the date of this application. I acknowledge that any false or untrue statement or representation made in this application may result in the revocation or denial of any license to practice medicine granted to me, and criminal prosecution to the fullest extent of the law.



Susan Robinson

Applicant's Signature (in INK)

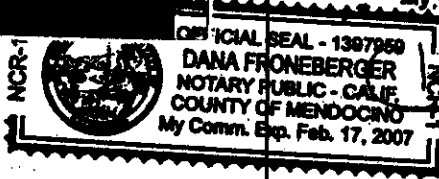
9/16/03

Date Signed

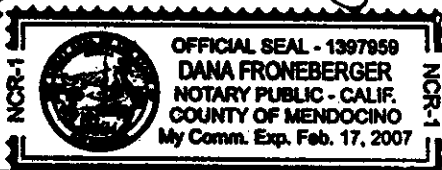
Sworn to and subscribed before me this 16

day of Sept, 20 03

My Commission Expires: 2/17/07



[Signature]  
Signature of Notary Public



DO NOT WRITE BELOW THIS LINE - FOR OFFICE USE ONLY

[Handwritten signatures]  
Dana Fronberger  
Douglas Smart  
Sue Chambers  
C. E. [unclear]

[Handwritten signatures]  
J. Zwick  
David C. [unclear]  
R. [unclear]

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