STATE OF CONNECTICUT

DEPARTMENT OF PUBLIC HEALTH

February 13, 2015

LICENSURE VERIFICATION

Please be advised that Connecticut General Statutes, certain matters involving the investigation and rehabilitation of Physician/Surgeon remain confidential. Therefore, in response to your inquiry regarding the status of the Physician/Surgeon identified below, at this time we are providing only publically disclosable information. In order for this office to confirm or deny whether there is any confidential information relevant to your inquiry, a release form from such Physician/Surgeon must be provided.

IF YOU WISH TO ESTABLISH WHETHER CONFIDENTIAL INFORMATION EXISTS CONCERNING THIS Physician/Surgeon, PLEASE HAVE HIM/HER SIGN THE REVERSE SIDE OF THIS FORM, WHICH CONSTITUTES A RELEASE FOR SUCH INFORMATION, AND RETURN IT TO THIS OFFICE. PLEASE NOTE THAT ONLY THIS DEPARTMENT'S RELEASE FORM WILL BE ACCEPTED.

This is to certify that the records of the Connecticut Department of Public Health indicate that:

SUSAN BOWERS MD

Was issued Connecticut:	Physician/Surgeon License
Date of Issuance:	05/12/1981
License Number:	22788
Expiration Date:	03/31/2015
Status of License:	ACTIVE IN RENEWAL, RENEWAL APPLICATION SENT
Past or Pending Disciplinary History:	No

Sincerely,

Stephen B. Carragher

Stephen B. Carragher
Health Program Supervisor
Office of Practitioner Licensing and Investigation

Printed by: Meghan Bennett

Phone: (860) 509-7603
Telephone Device for the Deaf (860) 509-7191
410 Capitol Avenue - MS # 12 APP
P.O. Box 340308 Hartford, CT 06134
An Equal Opportunity Employer

STATE OF CONNECTICUT

DEPARTMENT OF PUBLIC HEALTH

STATE OF CONNECTICUT

DEPARTMENT OF PUBLIC HEALTH

CONSENT FOR RELEASE OF CONFIDENTIAL RECORDS

This is to certify that I hereby give my consent and authorize the Department of Public Health to confirm the existence of any pending petitions and to release any records of disciplinary action maintained by that department (with the exception of any documents identified below) to:

SEND VERIFICATION TO:
(Company Name and Address) _____

_____

_____

_____

I understand that these records are confidential pursuant to the provisions of Connecticut General Statutes 20-13e and may not be disclosed without my permission. This information will only be disclosed when this release is executed by me. I also understand that if I am a participant in a rehabilitation program sponsored by a county medical association or by the Connecticut State Medical Society that I have the right to contact the association or society prior to signing this release. Please honor a mechanically reproduced copy of this release.

Documents the department is not authorized to release include:

_____ _____

Signature Date

SUSAN BOWERS MD Lic. No.:

Phone: (860) 509-7603
Telephone Device for the Deaf (860) 509-7191
410 Capitol Avenue - MS # 12 APP
P.O. Box 340308 Hartford, CT 06134
An Equal Opportunity Employer

Renewal - 1.022788

Name	SUSAN BOWERS MD
Credential	1.022788

Fee Details

Renewal Application Fee	$570.00
	$570.00

Demographic Information

1. First Name
   SUSAN

2. Middle Initial

3. Last Name
   BOWERS

4. Personal Suffix
   MD

5. Maiden Name

6. Please provide your Date of Birth.
   03/16/1947

7. Gender
   Female

8. Ethnicity: Please choose one:
   Not Hispanic or Latino

9. Race
   White

Workforce Survey Introduction

Dear Licensee:

Thank you for renewing your license online.

The purpose of the next several questions is to allow the Department of Public Health to collect valuable workforce data that is currently unavailable but critical in identifying and addressing healthcare workforce shortage issues.

Thank you for assisting the Department in this important initiative.

Current Workforce Status in Medicine

10. What is your current work status in Medicine?
    Retired from the profession

Workforce Survey

11. In the next 12 months, do you plan to (please mark all that apply):

12. If you are **NOT** working in your licensed profession, please indicate your plans for returning to work in your licensed field.

13. Please provide the number of hours per week that you provide DIRECT PATIENT CARE in your primary professional position.

If you do not provide hours in this category, please indicate 0.

14. Please provide the number of hours per week that you work as an ADMINISTRATOR/MANAGER in your primary professional position.

If you do not provide hours in this category, please indicate 0.

15. Please provide the number of hours per week that you work as an EDUCATOR/FACULTY in your primary professional position. If you do not provide hours in this category, please indicate 0.

16. Please provide the number of hours per week that you work as a RESEARCHER in your primary professional position. If you do not provide hours in this category, please indicate 0.

17. If your primary profesional position is in a category other than those above, please provide that category in the box below and indicate the number of hours per week.

If you do not provide hours in this category, please indicate 0.

18. Please indicate the setting of your primary professional employment.

Enter comments if "Other" is selected.

Practice Location

If you are providing direct patient care, please identify the location of the primary site where you spend the most time providing direct patient care.

19. Address 1

20. Address 2

21. City

22. State

23. Zip Code

Primary Source of Payment

What percent of your patients have the following source of Payment?

24. Medicare

25. Medicaid

26. Self-Pay

27. Private Insurance

28. Other

Attestation

29. Have you been convicted of a felony since your last application?
No

30. If yes, please provide details here

31. Have you had any disciplinary action taken against you or any such actions pending by another State's licensing/certification authority since your last application?
No

32. If yes, please provide details here

By completing this renewal online, I verify that all the information I have provided is accurate and that I satisfy the renewal requirements that apply to my license.

33. I attest that on this date I completed this renewal application online and that all of the statements made by me on this renewal are accurate.
01/15/2014

Important Note

Please note that you will receive your new licensing documents (2 wallet-sized cards and 1 suitable for posting) during the third week of next month.

To continue processing your renewal, please click "Next" below (read the rest of this information first).

On the review screen, click **"Add to Invoice."**

On the top right of the invoice screen, select **"Pay Invoice".**

Thank you for processing your renewal online.

Review

Credential Profile - 1.022788

This profile contains information that may be used as a starting point in evaluating a health care provider. This profile should not, however, be the sole basis for selecting a health care provider. Please direct questions and comments about this profile to: Connecticut Department of Public Health, Physician Profiles, 410 Capitol Ave., M.S. 12 APP, P.O. Box 340308, Hartford, CT 06134-0308, oplc.dph@ct.gov.

Name SUSAN BOWERS MD
Credential 1.022788

Current Practice Locations

1. Are you currently practicing medicine in Connecticut?
   Yes

2. Are you actively involved in Patient Care?
   No

3. Enter your practice locations

Practice Name	Address 1	Address 2	Address 3	City	State	Zip Code	Primary Practice	Languages Spoken at this Location
Planned Parenthood Of CT	50 Fitch St.			New Haven	Connecticut	06515	Yes	

Connecticut Staff Privileges

4. Indicate the Connecticut Hospitals or Nursing Homes for which you have Staff privileges.

Facility Name	City	State

Medical School

5. Medical School
   University of California

6. Enter the Year of Graduation from Medical School
   1976

Post Graduate Training

7. List your postgraduate training:

Site Name	City	State	Country	Start Date	End Date	Level	Type
Magee-Women's Hospital	Pittsburgh	Pennsylvania	UNITED STATES	07/01/1976	06/30/1977	Intern	
Magee-Women's Hospital	Pittsburgh	Pennsylvania	UNITED STATES	07/01/1977	06/30/1980	Resident	
Magee-Women's Hospital	Pittsburgh	Pennsylvania	UNITED STATES	07/01/1980	06/30/1981	Fellowship	

Specialty Area/American Board Certification

8. Please indicate practice specialties, subspecialties and the date you were certified by ABMS or ABOMS.

Specialty	Subspecialty	Certifying Board	Certification Date

Medical Education Responsibilities

9. Are you a member of the faculty of a Connecticut medical school?
   No

10. Select the state medical schools at which you are a member of the faculty.

11. Do you have current responsibility for graduate medical education?
    No

Publications, Professional Services, Activities, and Awards

12. Publications, Professional Services, Activities, and Awards

Publisher/Issuer	Title/Award Name	Date

Medical Malpractice Information

13. Indicate your malpractice insurance carrier:

14. Indicate the Medical Malpractice Payments you have made within the past ten years.

Some studies have shown that there is no significant correlation between malpractice history and a physician's competence. At the same time, consumers should have access to malpractice information. This profile contains information about the malpractice payment history of the physician. Payment amounts have been placed into three statistical categories: below average, average and above average. To make the best health care decisions, you should view this information in perspective. You could miss an opportunity for high quality care by selecting a doctor based solely on malpractice history.

When considering malpractice data, please keep in mind:

- *Malpractice histories tend to vary by specialty. Some specialties are more likely than others to be the subject of litigation. This report compares physicians only to the members of their specialty, not all physicians, in order to make an individual physician's history more meaningful.*
- *This malpractice information reflects data for the last 10 years of the physician's practice. For physicians practicing less than 10 years, the data covers their total years of practice. You should take into account how long the doctor has been in practice when considering malpractice averages.*
- *The incident causing the malpractice claim may have happened years before payment is finally made. Sometimes it takes a long time for a malpractice lawsuit to move through the legal system.*
- *Some physicians work primarily with high-risk patients. These physicians may have malpractice histories that are higher than average because they specialize in cases or patients who are at very high risk of problems.*
- *Settlement of a claim may occur for a variety of reasons that do not necessarily reflect negatively on the professional competence or conduct of the physician. A payment in settlement of a medical malpractice action or claim should not be construed as creating a presumption that medical malpractice has occurred. For example, an insurer may choose to settle a case even if the physician opposes such settlement.*

You may wish to discuss the information provided in this report, and malpractice generally, with your physician.

Payments made by or on behalf of this healthcare provider:

Resolved Date	Payment Category	Specialty

Connecticut Hospital Discipline

16. Hospital Discipline

Hospital Name	City	State	Country	Discipline Date	Disciplinary Action

Other State License

18. Indicate States outside of CT where licenses are held.

State

Connecticut Licensure Actions

Felony Convictions

19. Felony Convictions within the previous ten years.

Conviction Date	Conviction

Profile Attestation

I hereby certify that to the best of my knowledge, the information contained in this profile is true and accurate and understand that providing false information may be grounds for sanction, which may include suspension revocation of my license to practice medicine in Connecticut.

20. Enter the date.

Review

Physician Profile Survey
Please Print or Type and Provide All Information Requested in Each Section

(B)

1. Biographical and Current Practice Information

CT License Number: 022788 Social Security No.: [redacted]

Last Name: Bowers First Name: Susan MI: K.

Telephone No. (Where you may be reached, 8:30 a.m.-4:30 p.m. ([redacted]

Are you currently practicing medicine in Connecticut? ☒ YES ☐ NO

Primary Practice Location-Name of Practice: Planned Parenthood of CT

Address: 50 Fitch St

New Haven, CT

City, State Zip: 06515

List of languages, other than English, spoken at practice location:

Spanish	

Other Practice Location(s)-Name of Practice:

Address:

City, State Zip:

List of Languages, other than English, spoken at practice location:

Please list the Connecticut hospitals/nursing homes at which you have staff privileges:

Name/City, State	Name/City, State
None	

2. Medical School

Medical School: University of California, San Francisco Year of Graduation 1976

****

3. *Post Graduate Training* (Please list your postgraduate training)

Site: Univ. of Pittsburgh, Magee-Women's Hospital City: Pittsburgh, PA Country: USA

Inclusive Dates: From: 7 / 1 / 76 To: 6 / 31 / 77 ☒ Intern ☐ Resident ☐ Fellowship (Please check one)

Type of Training (i.e. Pediatrics, Internal Medicine): Obstetrics & Gynecology

****

Site: Univ. of Pittsburgh, Magee-Women's Hospital City: Pittsburgh, PA Country: USA

Inclusive Dates: From: 7 / 1 / 77 To: 6 / 31 / 80 ☐ Intern ☒ Resident ☐ Fellowship (Please check one)

Type of Training (i.e. Pediatrics, Internal Medicine): Ob-Gyn

****

Site: Univ of Pittsburgh, Magee-Women's Hospital City: Pittsburgh, PA Country: USA

Inclusive Dates: From: 7 / 1 / 80 To: 6 / 31 / 81 ☐ Intern ☐ Resident ☒ Fellowship (Please check one)

Type of Training (i.e. Pediatrics, Internal Medicine): Maternal-Fetal Medicine

****

Site: ______ City: ______ Country: ______

Inclusive Dates: From: ___/___/___ To: ___/___/___ ☐ Intern ☐ Resident ☐ Fellowship (Please check one)

Type of Training (i.e. Pediatrics, Internal Medicine): ______

****

Site: ______ City: ______ Country: ______

Inclusive Dates: From: ___/___/___ To: ___/___/___ ☐ Intern ☐ Resident ☐ Fellowship (Please check one)

Type of Training (i.e. Pediatrics, Internal Medicine): ______

****

Site: ______ City: ______ Country: ______

Inclusive Dates: From: ___/___/___ To: ___/___/___ ☐ Intern ☐ Resident ☐ Fellowship (Please check one)

Type of Training (i.e. Pediatrics, Internal Medicine): ______

****

4. *Specialty Area/American Board Certification*

Practice Specialty: Ob-Gyn Practice Sub-Specialty: ______
(Please use the attached table of specialties and sub-specialties for a list of acceptable specialties)

Practice Specialty: ______ Practice Sub-Specialty: ______
(Please use the attached table of specialties and sub-specialties for a list of acceptable specialties)

Please list current certifications held by the American Board of Medical Specialties or the American Board of Osteopathic Medical Specialties

American Board of: Obstetrics & Gynecology Date Certified: 11 / 20 / 83

American Board of: ______ Date Certified: ___/___/___

American Board of: ______ Date Certified: ___/___/___

****

5. *Medical Educational Responsibilities (This Section is Voluntary)*

Are you a member of the faculty of a Connecticut medical school? ☐ Yes ☒ No

If Yes, Please indicate which one.

☐ Yale University Medical School ☐ University of Connecticut School of Medicine

Do you have current responsibility for graduate medical education? ☐ Yes ☒ No

****

6. Publications in Peer Reviewed Journals/Professional Services Offered/Activities and Awards (This Section is Voluntary, but provides you an opportunity to highlight accomplishments, ABMS Board Eligible status or special interests.)

If you include publications or awards, please use the following format:

For publications: Include name of journal, title of article and date published.

For awards: Include name of entity issuing award, title of award, and date received.

1. _____
2. _____
3. _____
4. _____
5. _____
6. _____
7. _____
8. _____
9. _____
10. _____

7. Medical Malpractice History

Date Resolved	Amount Paid	Practice Specialty Related To Payment
None, to my knowledge.		

8. Hospital Discipline Within Last Ten (10) Years - In Any State

Hospital, City, State, Country	Date	Disciplinary Action
None		

9. Felony Convictions Within Last Ten (10) Years - In Any State

Date of Conviction	Conviction
None	

****

ATTESTATION

I hereby certify that to the best of my knowledge, the information contained in this profile is true and accurate and understand that providing false information may be grounds for sanction, which may include suspension or revocation of my license to practice medicine in Connecticut.

Susan K Bowers
Signature

1-17-00
Date

Please return as soon as possible, but no later than 60 days from the postmarked date of this survey. You may send it via facsimile to "Physician Profiles" at (860) 509-8457 or by mail (please use the enclosed, addressed envelope) to:

Department of Public Health
Physician Profiles
410 Capitol Ave., MS # 12 APP
PO Box 340308
Hartford, CT 06134

If you have questions, please contact this office at (860) 509-7557.

DATA SHEET

APPLICATION FOR LICENSURE WITHOUT EXAMINATION

Reciprocity ..... Endorsement NBME, 166516, 1977

NAME BOWERS, SUSAN KATHLEEN
Last First Middle

1. Premedical Education UNIV. OF WASHINGTON, 9/65-6/69
2. Medical Education UNIV. OF CALIFORNIA, 9/72-6/76
MD DEGREE 1976
3. State License by Written Examination ..... State Year Grade
4. National Board Certificate 166516 1977
Number Year Grade
5. State Board of Healing Arts Certificate .....
6. A.M.A. Approval Requested ..... Received .....
7. Photograph Furnished YES
8. Fee Paid $150.00, Tn#64, 3/30/81
9. References T. TERRY HAYASHI, MD., PA.
EUGENE D. SHAPIRO, MD., PA.
10. Citizenship BY BIRTH
11. Probable Location ..... Specialty .....
12. Alphabetical Index Checked YES Correspondence File Reviewed YES

Application Complete .....

Issuance of Certificates authorized by Lawrence K. Pickett Date 5/1/81
LAWRENCE K. PICKETT, M.D., CHAIRMAN

Certificate Number 22788 Issued 5/1/81

Med. Bd. 8 (2-75) 2500

Return Incomplete #14

CR#150.00
3/3/81
Tn#64

MAR 09 1981

Connecticut Medical Examining Board
79 Elm Street, Hartford, Connecticut 06115

RECEIVED
STATE DEPT. OF HEALTH SERVICES
MAR 2 1981
DIVISION OF MEDICAL QUALITY ASSURANCE

APPLICATION FOR LICENSE TO PRACTICE MEDICINE WITHOUT EXAMINATION

By Endorsement of National Board of Medical Examiners or Federation of Medical Boards Certification

OR By Endorsement of State License or License of the Medical Council of Canada

MB-10~~New~~ 4-74

Physicians who have received the degree of Doctor of Medicine from medical schools and:

1. are certified by the National Board of Medical Examiners OR
2. are certified by the Federation of State Medical Boards of the United States, Inc. after passing the FLEX examinations OR
3. have been licensed in any state or territory of the United States or the District of Columbia, after written examination of as high grade as that required for a certificate of registration in the State of Connecticut OR
4. are licentiates of the Medical Council of Canada, after written examination AND
5. are 5th Pathway Program candidates who are graduates of a medical school located outside the United States which school is recognized by the American Medical Association or the World Health Organization, and who has satisfactorily completed in any hospital recognized by the American Medical Association or the World Health Organization one academic year of supervised clinical training and such post-graduate training as is required by the American Medical Association and have complied with #3 (above) who are of good moral character and professional standing, are eligible to be recommended for licensure without examination. The fee for the endorsement of state licenses under the provisions of this paragraph is one hundred and fifty dollars ($150.00). (Check to be made payable to Treasurer State of Connecticut.)

REQUIRED DOCUMENTS

Diplomates of the National Board of Medical Examiners must apply to that Board for Certification of Record which will be sent directly to the Connecticut Medical Examining Board. (Address: N.B.M.E., 3930 Chestnut Street, Philadelphia, Pa. 19104) Medical Doctors who passed the FLEX examinations must request the Federation of Medical Boards of the United States, Inc. to send the grades obtained directly to the Connecticut Medical Examining Board.

Licentiates of the Medical Council of Canada must obtain a "Certificate of Standing" from The Medical Council and attach it to this application.

NOTE: The license to practice medicine in the State of Connecticut is granted by the Connecticut Department of Health upon presentation of the certificate issued by the Connecticut Medical Examining Board. Connecticut law does not provide for the issuance of temporary or limited license.

I hereby apply to the Connecticut Medical Examining Board for certification without examination for licensure to practice medicine in the State of Connecticut, by:

(check A or B and complete that section)

A. [X] Endorsement of my certificate, issued by the National Board of Medical Examiners.

NAT. BOARD MED. EXAM. CERTIF. NUMBER	DATE CERTIFICATE ISSUED
166516	1977

B. [ ] Endorsement of my license, issued after written examination by the licensing authority named below.

LICENSE NUMBER	ISSUING STATE OR DOMINION OF CADADA	ISSUED BY (Licensing Board or Dept.)	DATE LICENSE ISSUED

In support of this application I submit the following information: DATE OF THIS APPLICATION February 26, 1981

SWORN STATEMENT

1. NAME (Last, First, Middle)	DATE OF BIRTH	SEX
Bowers, Susan Kathleen	3-16-47	MALE [ ] FEMALE [X]

2. PRESENT ADDRESS (Street, Town, Zip)	3. PLACE OF BIRTH (Town, State or Country)
3725 Beechwood Blvd. Pittsburgh, PA. 15217	Chicago, Illinois

4. CITIZENSHIP

I am a citizen of the United States	[X] Yes [ ] No	IF NATURALIZED: Give date, place, and certificate number.
I have filed a declaration of intention to become a citizen of the United States	[ ] Yes [ ] No	IF YES, Give date, place of filing, and certificate number.
I have a petition approved by the United States Immigration and Naturalization Service	[ ] Yes [ ] No	IF YES, Give file number, date of notice, and petition date.

5. PREMEDICAL EDUCATION

DEGREES REC'D	NAMES OF SCHOOLS	DATES DEGREES REC'D
B.S.	U. of Washington Seattle, Washington	1969

LIST NAMES AND ADDRESSES OF ALL PREMEDICAL SCHOOLS ATTENDED	DATE ENTER. (Mo., Yr.)	DATE DEPART. (Mo., Yr.)
U. of Washington Seattle, Washington	9-65	6-69

(Continued on next page)

PREMEDICAL EDUCATION (Continued from front page)

LIST NAMES AND ADDRESSES OF ALL PREMEDICAL SCHOOLS ATTENDED	DATE ENTER. (Mo., Yr.)	DATE DEPART. (Mo., Yr.)

6. MEDICAL EDUCATION — Doctor of Medicine degree received from: NAME OF SCHOOL: U. of California, San Francisco — DATE DEGREE REC'D: 1976

LIST NAMES AND ADDRESSES OF ALL MEDICAL SCHOOLS ATTENDED	DATE ENTER. (Mo., Yr.)	DATE DEPART. (Mo., Yr.)
U of California, San Francisco San Francisco, CA.	9-72	6-76

7. MEDICAL LICENSURE — List the states you have been licensed to practice medicine in:

STATE	DATE LICENSE ISSUED	LICENSED BY:	STATE	DATE LICENSE ISSUED	LICENSED BY:
Pennsylvania	1977	☐ EXAM. ☒ ENDORSM'T			☐ EXAM. ☐ ENDORSM'T
		☐ EXAM. ☐ ENDORSM'T			☐ EXAM. ☐ ENDORSM'T

8. Have you ever been declined a license after a written examination ☐ Yes ☒ No — IF YES, List states

9. Have you ever been brought before a Medical Examining Board, Medical Society or a criminal court on charges of unprofessional conduct or criminal behavior, or had a license to practice medicine suspended or revoked? ☐ Yes ☒ No IF YES, EXPLAIN BELOW

10. MEDICAL PRACTICE — Since graduation from medical school I have been engaged in medical practice as follows: Include Internship & Residency

LOCATION (Town & State or Country)	HOSPITALS ASSOCIATED WITH AT THIS LOCATION	DATE MOV. HERE (Mo.,Yr.)	DATE DEPART. (Mo., Yr.)
Pittsburgh, PA.	Magee Womens Hospital	6-76	6-81

If applicable, please enclose copy of Specialty Board Certificate

11. SPECIALTY — I am a Diplomate of the American Board of: NAME OF AMERICAN BOARD

NAMES OF ANY OTHER SPECIAL SOCIETIES

12. Have you enclosed one hundred and fifty dollars ($150.00), the fee required by Connecticut law? ☒ Yes ☐ No

13. AFFIDAVIT OF APPLICANT The above named applicant, being duly sworn, says that (s)he is the person referred to in this application for certification for licensure to practice medicine in the State of Connecticut and that the statements herein contained are each and all true in every respect.

SIGNED IN THE STATE OF: Pennsylvania
COUNTY OF: Allegheny

SEAL of Notary Public

SIGNATURE OF APPLICANT: Kerseen K Bowers
SIGNATURE OF NOTARY PUBLIC: June A. Druchi
DATE OF SIGNATURE: 03/05/81

14. CERTIFICATE OF MEDICAL LICENSURE — Answer ONLY if applying for endorsement of state license.
This section MUST be completed by an official of the State Board which granted license.

It is hereby certified that said applicant is a medical school graduate and after written examination was granted a Certificate of Licensure to practice medicine in this state. This license has never been revoked or suspended and said applicant has never been summoned to appear before this board, on charges of unprofessional conduct except as indicated below.

It is further certified that the data presented below applies to the above statement.

GRADUATE OF (Name of Medical School)	CERTIFICATE OF LIC. NO.	MEDICAL EXAMINING BOARD, STATE OF ISSUED BY:	DATE LICENSE ISSUED

EXPLAIN ANY CHARGES OF UNPROFESSIONAL CONDUCT

It is further certified that said applicant was examined in the following subjects and has received the following grades:

GENERAL AVERAGE	PASSING GRADE

SUBJECT	GRADE	SUBJECT	GRADE

It is also certified that physicians who are licensed in the State of Connecticut and whose educational qualifications meet the requirements of this board, will, upon proper application, be approved without examination for licensure to practice medicine in this state.

SIGNATURE OF OFFICIAL

TITLE | MEDICAL EXAM. BOARD, STATE OF

SEAL of Medical Examining Board

Answer ONLY if applying for endorsement of Medical Council of Canada license.

15. Have you attached a "Certificate of Standing" with scores from the Medical Council of Canada? ☐ Yes ☐ No

16. CERTIFICATE OF MEDICAL EDUCATION

It is hereby certified that the above named applicant has received the degree of Doctor of Medicine. See Pg. 4 if Foreign Medical Graduate.

This section MUST be completed by the Dean, Secretary, or Registrar of Medical School.

NAME OF MEDICAL SCHOOL	NO. COURSES TAKEN	NO. OF MOS. PER COURSE
U. of California, San Francisco	14	3

ADDRESS OF MEDICAL SCHOOL	DATE OF MATRICULATION
Parnassus and 3rd San Francisco, CA. 94143	Sept. 25, 1972

NAME OF SCHOOL OFFICIAL (Printed)	TITLE	DATE DEGREE CONFER.
Julius R. Krevans, M.D.	Dean	1976

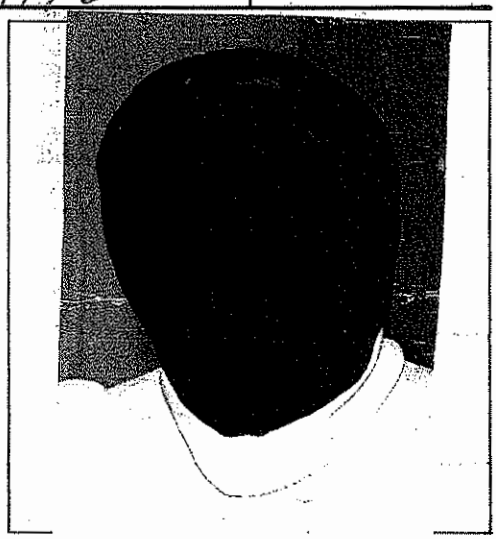
SIGNATURE OF SCHOOL OFFICIAL	DATE OF SIGNATURE
Julius R Krevans MD	March 23, 1981

SEAL of Medical School

17. CERTIFICATE OF IDENTIFICATION:

By official of County or State Medical Society, or of a Medical School or Hospital superior.

It is hereby certified that the above named applicant is an ethical practitioner of good moral and professional character and is recommended without reservation for certification for licensure to practice medicine in the State of Connecticut. It is further certified that the photograph attached hereto is a true likeness of said applicant.



BY: NAME OF MED. SOCIETY OFFICIAL (Printed) | NAME OF MEDICAL SOCIETY

Is this applicant a member of this Medical Society? ☐ Yes ☐ No

OR: NAME OF MED. SCHOOL OFFICIAL (Printed) | NAME OF MEDICAL SCHOOL

OR: NAME OF HOSPITAL SUPERIOR (Printed): T. Terry Hayashi | NAME OF HOSPITAL: Magee Womens Hospital

SIGNATURE OF OFFICIAL OR SUPERIOR: J. Terry Hayashi, MD | TITLE: Prof Chmn.

18. CERTIFICATE OF MORAL CHARACTER I certify that I am acquainted with the above named applicant and that to the best of my knowledge and belief said applicant is a suitable person to be a licensed to practice medicine in the State of Connecticut. (Two names are required)

	NAME (Printed)	NO. YRS. ACQUAINTED	ADDRESS
1.	T. Terry Hayashi	5	Chairman of Ob Gyn Magee Womens Hospital Pittsburgh, PA. 15213
	SIGNATURE: J. Terry Hayashi		
2.	Eugene B. Shapiro, M.D.	7	Children's Hospital of Pittsburgh 125 DeSoto St. Pittsburgh, PA. 15213
	SIGNATURE: Eugene D. Shapiro		

In addition to signing the reference sections, ask each doctor who is licensed in U. S. to write a separate character reference letter and mail it directly to this office. These doctors must have known you for one year or more.

Please submit the indicated documents (marked X) when filing this application.

_____ If your educational documents are in the English language — we will need copies of all your documents: Certificate from Secondary School, transcripts from the University and Medical schools showing years of attendance and subjects studied and Certificates indicating the dates of the M.B. examinations throughout your medical school years. These copies must be verified by your Consul located in an area most convenient to you. Include first, second, third MBBS score sheet and copy of medical diploma.

_____ Please attach OFFICIAL TRANSLATIONS of University and Medical School showing the years of attendance; subjects studied each year (course book) and M. D. Diploma. We do not accept photostats. These official translations must remain in our files permanently and cannot be returned to you.

_____ Please attach OFFICIAL TRANSCRIPTS of University and Medical School showing the years of attendance; subjects studied each year (course book) and M. D. Diploma. We do not accept photostats. The official transcripts must remain in our files permanently and cannot be returned to you.

_____ FIFTH PATHWAY PROGRAM REQUIREMENTS

1. Transcripts from your undergraduate studies.
2. A certified statement from the Educational Council for Foreign Medical graduates that you have passed the examinations with a specific average indicated.
3. Translations of your transcript of studies from medical school showing subjects studied and grades received each year and the diploma or certificate you received. These must be OFFICIAL TRANSLATIONS — photostats will not be accepted.
4. A certified statement from the medical school approved by the American Medical Association for a clinical clerkship/internship.
5. A certified statement from the American Medical Association that you have met all of their "5th Pathway" requirements and that you are eligible to continue your first year or further AMA approved training.

_____ For American Students who study abroad.

Send transcripts of your undergraduate studies and official translations from your Medical School showing years of attendance, subjects studied and grades, also, translation of your Medical Degree. These must be OFFICIAL TRANSLATIONS — photostats are not acceptable. They must remain in our files permanently.

STATE OF CONNECTICUT

DEPARTMENT OF HEALTH SERVICES

DIVISION OF MEDICAL QUALITY ASSURANCE

May 1, 1981

Susan Kathleen Bowers, M.D.
3725 Beechwood Blvd.
Pittsburgh, Pennsylvania 15217

Dear Doctor:

On behalf of the Connecticut Medical Examining Board, I want to congratulate you upon the successful completion of all requirements for licensure as a Medical Doctor in the State of Connecticut.

Enclosed is a brief request for information necessary to complete the processing of your license. Please complete this and return to Mary Bayers, Chief of Licensure and Registration, at the address below. She will then issue you a formal license. Your license will not be issued until this information is returned.

I wish you success in your career and must inform you that it is your responsibility to keep this Department aware of your current address; otherwise the status of your license will be jeopardized.

Sincerely,

Gary W. DeWitt/cg

Gary W. DeWitt, Ph.D.
Examination Coordinator
Connecticut Medical Examining Board

GWD: cg
Enclosure

Phone: 566-5630
Elm Street — Hartford, Connecticut 06115

University of Pittsburgh
SCHOOL OF MEDICINE
Department of Pediatrics
Division of Infectious Diseases

MAR 1 0 1981

March 6, 1981

Connecticut Medical Examining Board
Division of Medical Quality Assurance
Department of Health Services
79 Elm Street
Hartford, CT 06115

Dear Sir or Ms.:

I am writing in support of Dr. Susan Bowers' application for Connecticut Medical Licensure. I have known Susan for over seven years. As a student, a resident physician, and now a member of the University of Pittsburgh Medical Faculty Susan has consistently shown dedication, sensitivity, and excellence in her care of patients and relationships with her peers. She was so highly thought of during her residency that the chief of her department asked her to join his staff.

I highly recommend her and am sure that she will be a valuable addition to the medical community of your state.

Sincerely,

Eugene D. Shapiro

Eugene D. Shapiro, M.D.
Division of Infectious Diseases

EDS:dw

Mailing Address: Children's Hospital 125 DeSoto Street Pittsburgh, PA 15213 (412) 647-5075

University of Pittsburgh

SCHOOL OF MEDICINE
Department of Obstetrics and Gynecology
Office of the Chairman

April 21, 1981

Connecticut Medical Examining Board
Division of Medical Quality Assurance
Department of Health Services
79 Elm Street
Hartford, CT 06115

RE: Susan K. Bowers, M.D.

Dear Sir:

I have known Dr. Susan Bowers through her four years of residency plus an additional year of fellowship at Magee-Womens Hospital, University of Pittsburgh School of Medicine in the Department of Obstetrics and Gynecology. I can certainly attest to her moral character. Dr. Bowers is an outstanding, capable and thorough physician. I am happy to support her application, and I recommend her without hesitation.

Sincerely,

T. Terry Hayashi M.D

T. Terry Hayashi, M.D.
Professor and Chairman

TTH/cj

University of Pittsburgh

SCHOOL OF MEDICINE
Department of Obstetrics and Gynecology
Office of the Chairman

MAR 11 1981

March 6, 1981

Connecticut Medical Examining Board
Division of Medical Quality Assurance
Department of Health Services
79 Elm Street
Hartford, CT 06115

RE: Susan K. Bowers, M.D.

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Sincerely,

T. Terry Hayashi

T. Terry Hayashi, M.D.
Professor and Chairman

TTH/cj

STATE OF CONNECTICUT
CONNECTICUT MEDICAL EXAMINING BOARD
79 ELM STREET - HARTFORD, CONNECTICUT 06115

TELEPHONE 566-5630

March 31, 1981

Commonwealth of Pennsylvania
Dept. of State - State Board of
Medical Education & Licensure
P.O. Box 2649
Harrisburg, PA. 17120

Dear Sir:

The Connecticut Medical Examining Board has received an application for licensure to practice medicine in the State of Connecticut from:

NAME:	Susan Kathleen Bowers, M.D.
PRESENT ADDRESS:	3725 Beechwood Blvd., Pittsburgh, PA. 15217
DATE AND PLACE OF BIRTH:	3/16/47, Illinois
MEDICAL DEGREE:	Univ. of CA., 1976

We note on his application that he is licensed in the State of
Pennsylvania

Will you please give this Board any information you have concerning the moral, professional or ethical character of this physician? Has the captioned Doctor's license ever been restricted, suspended or revoked for any reason?

Sincerely yours,

Lawrence K. Pickett

Lawrence K. Pickett, M.D.
Chairman

Pa. Medical Board, Harrisburg, PA
License Number 19379-E
Issue Date 7/1/77
Expiration Date 12-31-82
Authorized Signature and Date
A Mooy 4-16-81

LKP: cg

STATE OF CONNECTICUT
CONNECTICUT MEDICAL EXAMINING BOARD
79 ELM STREET - HARTFORD, CONNECTICUT 06115

TELEPHONE 566-5630

March 31, 1981

Commonwealth of Pennsylvania
Dept. of State - State Board of
Medical Education & Licensure
P.O. Box 2649
Harrisburg, PA. 17120

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PRESENT ADDRESS: 3725 Beechwood Blvd., Pittsburgh, PA. 15217
DATE AND PLACE OF BIRTH: 3/16/47, Illinois
MEDICAL DEGREE: Univ. of CA., 1976

We note on his application that he is licensed in the State of
Pennsylvania

Will you please give this Board any information you have concerning the moral, professional or ethical character of this physician? Has the captioned Doctor's license ever been restricted, suspended or revoked for any reason?

Sincerely yours,

Lawrence K. Pickett, M.D.
Chairman

LKP: cg

Bowers Susan K.

March 9, 1981

Susan K. Bowers, M.D.
3725 Beechwood Blvd
Pittsburgh, PA 15217

Dear Dr. Bowers:

Enclosed you will find the application and fee you submitted for medical licensure in Connecticut.

I regret to inform you that Item #16 is incomplete. This section must be completed by your medical school. Please forward the application to the University of California so that they may complete as instructed. Upon their completion, please forward the application and fee directly to this office.

If you have any questions or concerns, please feel free to contact this office at the number below.

Sincerely,

Gary W. DeWitt, Ph.D.
Examination Coordinator

GWD:cmb
Enclosure

(203) 566-5630