2015 Renewal

Renewal - 1.020580

Name	JANICE L LEE
Credential	1.020580

Fee Details

Renewal Application Fee	$570.00
	$570.00

Demographic Information-Renewal

1. First Name
   JANICE

2. Middle Initial
   L

3. Last Name
   LEE

4. Maiden Name

5. Please provide your Date of Birth.
   01/11/1951

6. Gender
   Female

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

8. 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

9. What is your current work status in Medicine?
   Part-time (less than 30 hours per week)

Workforce Survey

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

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

12. 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.

20

13. 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.
0

14. 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.
8

15. 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.
0

16. 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.
0

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

Enter comments if "Other" is selected.
Outpatient Clinic

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.

18. Address 1
Hartford Gyn Center, 1 Main St.

19. Address 2

20. City
Hartford

21. State
CT

22. Zip Code
06106

Primary Source of Payment

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

23. Medicare
less than 10%

24. Medicaid
76 - 100%

25. Self-Pay
less than 10%

26. Private Insurance

less than 10%

27. Other
None

Connecticut Prescription Monitoring and Reporting System

All prescribing practitioners possessing a Connecticut controlled substance registration (CSP) issued by the Connecticut Department of Consumer Protection (DCP) must register with the Connecticut Prescription Monitoring and Reporting System (CPMRS) online at www.ctpmp.com.

After you have completed this transaction, please visit the DCP's website at www.ct.gov/dcp and select 'Programs & Services' then 'Prescription Monitoring Program' for information regarding registration.

28. I acknowledge that I have read the information regarding registration in the Connecticut Prescription Monitoring and Reporting System.
01/12/2015

Attestation

29. Within the last year, have you been convicted of a felony?
No

30. If yes, please provide details here

31. Within the last year, have you had any disciplinary action taken against you or any such actions pending by another State's licensing/certification authority?
No

32. If yes, please provide details here

33. **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.**
01/12/2015

34. 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.
01/12/2015

Important Note

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".**

PLEASE NOTE THAT WHEN ENTERING YOUR CREDIT CARD NUMBER, DO NOT ENTER SPACES OR DASHES AS IT WILL RESULT IN A FAILED TRANSACTION.

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.

Thank you for processing your renewal online.

Review

2014 Renewal

Renewal - 1.020580

Name	JANICE L LEE
Credential	1.020580

Fee Details

Fee Increase Effective 7/12/13	$5.00
Renewal Application Fee	$565.00
	$570.00

Demographic Information

1. First Name
   JANICE

2. Middle Initial

3. Last Name
   LEE

4. Personal Suffix

5. Maiden Name

6. Please provide your Date of Birth.
   01/11/1951

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?
    Part-time (less than 30 hours per week)

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.
15

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.
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.
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.
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.
0

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

Enter comments if "Other" is selected.
Outpatient Clinic

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
1 Main St., Suite N1

20. Address 2

21. City
Hartford

22. State
Connecticut

23. Zip Code
06106

Primary Source of Payment

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

24. Medicare
less than 10%

25. Medicaid
76 - 100%

26. Self-Pay
11 - 25%

27. Private Insurance
11 - 25%

28. Other
None

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.
12/10/2013

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 - 1.020580

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 JANICE L LEE
Credential 1.020580

Current Practice Locations

1. Are you currently practicing medicine in Connecticut?
   Yes

2. Are you actively involved in Patient Care?
   Yes

3. Enter your practice locations

Practice Name	Address 1	Address 2	Address 3	City	State	Zip Code	Primary Practice	Languages Spoken at this Location
HARTFORD GYN CENTER	1 MAIN STREET			HARTFORD	Connecticut	06070	Yes	

Connecticut Staff Privileges

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

Facility Name	City	State
HARTFORD HOSPITAL		
SAINT FRANCIS HOSPITAL AND MEDICAL CENTER		

Medical School

5. Medical School
   ALBANY MEDICAL COLLEGE

6. Enter the Year of Graduation from Medical School
   1974

Post Graduate Training

7. List your postgraduate training:

Site Name	City	State	Country	Start Date	End Date	Level	Type
MT SINAI HOSPITAL	HARTFORD	Connecticut	UNITED STATES	07/01/1985	06/30/1987	Fellowship	OB/GYN
HARTFORD HOSPITAL	HARTFORD	Connecticut	UNITED STATES	07/01/1975	06/30/1978	Resident	OB/GYN
BERKSHIRE MEDICAL CENTER	PITTSFIELD	Massachusetts	UNITED STATES	07/01/1974	06/30/1975	Intern	Internal Medicine

Specialty Area/American Board Certification

This physician has reported the Certification information below. For more information regarding Board Certification please contact:

- *The American Board of Medical Specialties at www.abms.org, or*
- *The American Osteopathic Association at www.am-osteo-assn.org.*

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

Specialty	Subspecialty	Certifying Board	Certification Date
Obstetrics and		American Board of Obstetrics and	12/01/1984

Gynecology	Subspecialty	Certification Date	Gynecology	

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

This section contains categories disciplinary actions taken by hospitals during the past ten years which are specifically required by law to be released in the physician's profile.

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	Disciplinary Action

Connecticut Licensure Disciplinary Actions

19. The following lists any past disciplinary actions taken against this licensee. If there is no data present, there have been no disciplinary action taken.

Date of Action	Action	License Status

Felony Convictions

20. 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.

21. Enter the date.

Review

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

. Biographical and Current Practice Information

CT License Number: 020580 Social Security No.: ___-___-___

Last Name: Lee ~~Janice~~ First Name: Janice MI: L

Telephone No. (Where you may be reached, 8:30 a.m.-4:30 p.m. (860) 525-1900

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

Primary Practice Location-Name of Practice: Hartford Gyn Center

Address: 1 Main St.
Hartford, CT 06070

City, State Zip: Hart Ford, CT 06070

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

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
Hartford Hospital	
St. Francis Hospital	

2. Medical School

Medical School: Albany Medical College Year of Graduation 1974

****

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

Site: Berkshire Medical Center City: Pittsfield, Mass Country: USA

Inclusive Dates: From: 7/1/74 To: 6/31/75 ☑ Intern ☐ Resident ☐ Fellowship (Please check one)

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

****

Site: Hartford Hospital City: Hartford, CT Country: USA

Inclusive Dates: From: 7/1/75 To: 6/31/78 ☐ Intern ☑ Resident ☐ Fellowship (Please check one)

Type of Training (i.e. Pediatrics, Internal Medicine): Obstetrics- gynecology

****

Site: City: Country:

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

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

****

Site: Mt. Sinai Hospital City: Hartford, CT Country: USA

Inclusive Dates: From: 7/1/85 To: 6/31/87 ☐ Intern ☐ Resident ☑ Fellowship (Please check one)

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

****

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: Obstetrics & Gynecology 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: Dec / 1 / 1984

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 none

Date Resolved	Amount Paid	Practice Specialty Related To Payment

8. Hospital Discipline Within Last Ten (10) Years - In Any State none

Hospital, City, State, Country	Date	Disciplinary Action

9. Felony Convictions Within Last Ten (10) Years - In Any State none

Date of Conviction	Conviction

****

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.

Janice Lee MD — Signature

2/21/00 — 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.