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RT-846

This is to certify that **Paula Bednarek, M.D.** has been granted a TRAINING LICENSE to practice as a Medical Resident at the Dartmouth Hitchcock Medical Center, Lebanon or off-site, under faculty supervision, as determined by the facility, as part of their training program.

Service begins 7/26/00 and ends ~~6/30/05~~. ended 6/25/04

Penny Taylor
Penny Taylor
Acting Administrator

(Seal)

This certificate does not entitle holder to practice after the specified date.

2 INDUSTRIAL PARK DRIVE SUITE 8 CONCORD, NH 03301-8520 TDD Access: Relay NH 1-800-735-2964 TEL. (603) 271-1203 FAX (603) 271-6702

RT-846

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NH BOARD OF MEDICINE

STATE OF NEW HAMPSHIRE

BOARD OF MEDICINE
2 INDUSTRIAL PARK DRIVE, SUITE 8
CONCORD, NEW HAMPSHIRE 03301-8520

APPLICATION FOR TRAINING LICENSE
RESIDENTS AND GRADUATE FELLOWS

****Please print legibly or type:**

NAME OF APPLICANT: PAULA H. BEDNAREK

CURRENT RESIDENCE ADDRESS: ______

______ PHONE NUMBER ______

BIRTH DATE ______ (Month / Day / Year) BIRTH PLACE ______ (City / State / Country)

MEDICAL SCHOOL(S) Northwestern University Medical School

DATES ATTENDED 08/96 - 06/00 YEAR M.D. RECEIVED 06/2000

CURRENT TRAINING HOSPITAL Dartmouth Hitchcock Medical Center

TRAINING PROGRAM Obstetrics and Gynecology

TRAINING BEGIN DATE 07/26/00 (Month / Day / Year) TRAINING FINISH DATE 06/30/2005 (Month / Day / Year)

USMLE STEPS 1 AND 2 (PLEASE INDICATE DATES TAKEN AND PASSED)

STEP 1 06/98 (Month / Year) STEP 2 03/00 (Month / Year)

(Certification received directly from the National Board of Medical Examiners (NBME) that the applicant has taken and passed USMLE steps 1 and 2 is required.) You must have this certification sent directly to the N.H. Board of Medicine.

STANDARD ECFMG Certificate Number (if applicable) ______

FEE FOR TRAINING LICENSE IS $10.00. PLEASE MAKE CHECK PAYABLE TO TREASURER, STATE OF NEW HAMPSHIRE.

SUPPLEMENT TO APPLICATION FOR TRAINING LICENSE AS RESIDENT/FELLOW

YOU ARE REQUIRED TO COMPLETE THE QUESTIONS BELOW:

		YES	NO
1.	Have you ever resigned from a medical education program or medical practice position?	___	✓
2.	Do you now or have you ever held a license in another state? If so, please list the states.________ **Original verification of all prior permanent licenses is required.**	___	✓
3.	Have you ever been reprimanded, sanctioned, restricted or disciplined in any activities involving medical education or practice?	___	✓
4.	Have you ever been convicted of a felony?	___	✓
5.	Are you now, or have you been in the past, dependent on alcohol or drugs?	___	✓

If you answered yes to any of the above questions, please provide a complete description on the reverse side. You may attach additional sheets as necessary.

I hereby certify, under penalty of perjury, that all of the information provided in this application is complete and accurate. I also hereby certify that I have read and understand the Medical Practice Act and the Rules of the New Hampshire Board of Medicine.

NAME (PLEASE PRINT) PAULA H. BEDNAREK

SIGNATURE Paula Bednarek DATE 4/24/00

VERIFICATION BY ACCREDITED PROGRAM

****

The above named applicant will be duly enrolled in the accredited residency or graduate fellowship program designated below, and the undersigned, an authorized agent of that program, hereby certifies that all of the above information concerning the applicant is correct.

[signature] Dr H. Worth Parker MD 5 26 00

Signature — Director, Graduate Medical Education — Date

I, Dr Emily Baker MD, have reviewed the personal and professional qualifications of the above named applicant and hereby certify that the applicant is approved for entry into OB GYN training program.

[signature] Dr. Emily Baker MD 5-26-00

Signature — Program Director — Date