INSTRUCTIONS ANSWER EACH QUESTION, READ THE STATEMENTS THAT FOLLOW AS THEY RELATE TO YOUR LICENSE, AND SIGN BELOW.

1. WITHIN THE LAST YEAR HAVE YOU BEEN CONVICTED OF A FELONY OR HAVE YOU HAD ANY DISCIPLINARY ACTION TAKEN AGAINST YOU OR ANY SUCH ACTIONS PENDING BY ANOTHER STATE'S LICENSURE/CERTIFICATION AUTHORITY? NO ✓ YES _____
2. ARE YOU PRESENTLY WORKING IN YOUR LICENSED/CERTIFIED PROFESSION? NO _____ YES ✓ HOURS OF PRACTICE PER WEEK 20
3. WHAT IS THE ADDRESS OF YOUR PRIMARY PLACE OF EMPLOYMENT? STREET 1030 New Britain Ave
   CITY W. Hfd STATE Ct ZIP 06110 TYPE OF AGENCY Outpatient clinic PHONE # 860-947-2308
4. WHAT IS THE ADDRESS OF YOUR RESIDENCE? STREET 2 Belhaven CITY Cromwell STATE Ct ZIP 06416
   PHONE # 860-635-0005
5. HIGHEST DEGREE HELD MD 6. IF YOU HAVE BEEN CERTIFIED BY ANY AMERICAN SPECIALTY BOARD IN THE PAST YEAR, PLEASE SPECIFY BOARD AND DATE AM Board of OS/Gyn since 11/81.

↓ DO NOT WRITE IN THIS AREA ↓

2011

020004 0097 0193 01 022343 0056500 081211 S

7. IF YOU ARE AN **OPTOMETRIST**, ARE YOU QUALIFIED TO HOLD YOURSELF OUT AS AUTHORIZED TO PRACTICE ADVANCED OPTOMETRIC CARE? _____ YES _____ NO
8. IF YOU ARE AN **EMT, EMT-I,** OR **MRT,** OR HOLD A LICENSE/CERTIFICATE IN A **LEAD** OR **ASBESTOS** DISCIPLINE, PROVIDE REFRESHER COURSE COMPLETION DATE _____ AND COURSE APPROVAL NUMBER _____.
9. IF YOU ARE A **CHIROPRACTOR, DENTAL HYGIENIST, OCCUPATIONAL THERAPIST OR ASSISTANT, OPTICIAN, OPTOMETRIST, OR SOCIAL WORKER,** YOU MUST COMPLY WITH MANDATORY CONTINUING EDUCATION REQUIREMENTS FOR LICENSE RENEWAL; **PHYSICIAN ASSISTANTS AND ADVANCED PRACTICE RNs** MUST MAINTAIN CERTIFICATION FROM THE NATIONAL CERTIFYING BODY THAT QUALIFIED THEM FOR INITIAL LICENSURE, IN ORDER TO RENEW SUCH LICENSES.
10. IF YOU ARE LICENSED AS AN **APRN, DENTAL HYGIENIST, CHIROPRACTIC, NATUROPATHIC, PODIATRIC, OSTEOPATHIC OR HOMEOPATHIC PHYSICIAN, OPTOMETRIST OR PHYSICIAN/SURGEON** WHO PROVIDES DIRECT PATIENT CARE SERVICES, YOU MUST MAINTAIN PROFESSIONAL LIABILITY INSURANCE OR OTHER INDEMNITY AGAINST LIABILITY FOR PROFESSIONAL MALPRACTICE, IN ACCORDANCE WITH CT GENERAL STATUTES.

I HAVE REVIEWED THE INFORMATION PROVIDED AND REQUESTED ON THIS CARD. I VERIFY THAT IT IS ACCURATE AND THAT I SATISFY THE REQUIREMENTS LISTED ABOVE AS THEY APPLY TO MY LICENSE/CERTIFICATE.

Gene Kirschenbaum, MD — SIGNATURE

8/11/11 — DATE

INSTRUCTIONS ANSWER EACH QUESTION, READ THE STATEMENTS THAT FOLLOW AS THEY RELATE TO YOUR LICENSE, AND SIGN BELOW.

1. WITHIN THE LAST YEAR HAVE YOU BEEN CONVICTED OF A FELONY OR HAVE YOU HAD ANY DISCIPLINARY ACTION TAKEN AGAINST YOU OR ANY SUCH ACTIONS PENDING BY ANOTHER STATE'S LICENSURE/CERTIFICATION AUTHORITY? NO ✓ YES _____
2. ARE YOU PRESENTLY WORKING IN YOUR LICENSED/CERTIFIED PROFESSION? NO _____ YES ✓ HOURS OF PRACTICE PER WEEK 20
3. WHAT IS THE ADDRESS OF YOUR PRIMARY PLACE OF EMPLOYMENT? STREET 1030 New Britain Ave
   CITY West Hartford STATE Ct ZIP 06110 TYPE OF AGENCY Medical PHONE # 860-947-2308
4. WHAT IS THE ADDRESS OF YOUR RESIDENCE? STREET 2 Belhaven CITY Cromwell STATE Ct ZIP 064[illegible]
   PHONE # 860-635-0005
5. HIGHEST DEGREE HELD MD 6. IF YOU HAVE BEEN CERTIFIED BY ANY AMERICAN SPECIALTY BOARD IN THE PAST YEAR, PLEASE SPECIFY BOARD AND DATE _____

↓ DO NOT WRITE IN THIS AREA ↓

2012

020002 0072 0143 01 022343 0056500 082412 S

7. IF YOU ARE AN **OPTOMETRIST,** ARE YOU QUALIFIED TO HOLD YOURSELF OUT AS AUTHORIZED TO PRACTICE ADVANCED OPTOMETRIC CARE? _____ YES _____ NO
8. IF YOU ARE AN **EMT, EMT-I,** OR **MRT,** OR HOLD A LICENSE/CERTIFICATE IN A **LEAD** OR **ASBESTOS** DISCIPLINE, PROVIDE REFRESHER COURSE COMPLETION DATE _____ AND COURSE APPROVAL NUMBER _____.
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Gene Kirschenbaum, MD — SIGNATURE

8/22/12 — DATE