**Jim Doyle**
Governor

**Celia M. Jackson**
Secretary

# WISCONSIN DEPARTMENT OF REGULATION & LICENSING

1400 E Washington Ave
PO Box 8935
Madison WI 53708-8935
Email: web@drl.state.wi.us
Voice: 608-266-2112
FAX: 608-261-7083
TTY: 608-267-2416

## VERIFICATION

DATE: 09/16/2010

| | |
|---|---|
| THIS IS TO VERIFY THAT: | CARYN R DUTTON<br>202 NEW CASTLE WAY<br>MADISON WI 53704<br>UNITED STATES |
| WAS ISSUED LICENSE NO: | 44747 - 020 |
| ON: | 07/24/2002 |
| CREDENTIAL TYPE: | MEDICINE AND SURGERY |
| LICENSE EXPIRATION DATE: | 10/31/2011 |

According to our records, this credential holder has not been disciplined.

The information above is the only registration information provided by this Department. If other information is needed, it must be obtained from the above-named individual.

THIS VERIFICATION FORM CANNOT BE USED TO OBTAIN LICENSURE IN ANOTHER STATE.

Cathy Pond
Division Administrator

# WISCONSIN DEPARTMENT OF REGULATION & LICENSING
## Detail Information with all History



| License No. | Reg. Type | Status | Grant Date | Renewal by Date |
|---|---|---|---|---|
| 44747 | 020 | A | 07/24/2002 | 10/31/2011 |

**Date of Birth:** 03/31/1970
**Title:**
**First Name:** CARYN
**Middle Name:** R
**Last Name:** DUTTON
**Following Name:**

**Opt Out:** Y
**Attention:**
**Mailing1:** 202 NEW CASTLE WAY
**Mailing2:**
**City:** MADISON
**State:** WI **Zip:** 53704
**Country:**

### History Items by Event Date

| Date | Type | Description | FJ |
|---|---|---|---|
| 07/15/2010 | ENDORSEMENT SENT | ENDORSEMENT SENT BY RNL111. MA TO LICENSEE | |
| 09/02/2009 | STANDARDREQUIREMENTADDED | STANDARD REQUIREMENT ADDED: CLS | |
| 09/02/2009 | STANDARDREQUIREMENTADDED | STANDARD REQUIREMENT ADDED: FEE | |
| 09/02/2009 | STANDARDREQUIREMENTADDED | STANDARD REQUIREMENT ADDED: SIG | |
| 09/14/2007 | BLUELICENSEPRINTED | | |
| 09/07/2007 | STANDARDREQUIREMENTADDED | STANDARD REQUIREMENT ADDED: FEE | |
| 09/07/2007 | STANDARDREQUIREMENTADDED | STANDARD REQUIREMENT ADDED: SIG | |
| 11/02/2006 | DUPLICATECERTIFICATE | DUPLICATE BLUECERT PRINTED BY CSD ON 02-NOV-06 | N |
| 07/24/2002 | ENDORSEDFROM | ENDORSED FROM USMLE | N |
| 07/24/2002 | FROMAPPLICATIONMETHODINFORMATION | FROM APPLICATION: 151574 BY METHOD: ENDORSEMEN ENDORSEMENT | N |
| 05/23/1996 | GRADUATEDFROM | GRADUATED FROM UNIV OF CONN | N |

# Department of Regulation & Licensing

**STATE OF WISCONSIN**
Information requested is required
for processing your application.
This is not a license.

P.O. Box 8935, Madison, WI 53708-8935
Phone# (608) 261-7925

TTY# (608) 267-2416 ┐ Hearing or Speech
TRS# 1-800-947-3529 ┘ Impaired only

CARYN R DUTTON MD
465 S MADISON AVE APT 119
PASADENA CA 91101

The following is a list of requirements that need to be met before licensure can be completed. You can check the current status of your application at any time by phone with the Interactive Voice Response System or by the Internet. To check the status by phone, call (608) 261-7925 and follow the prompts. The Interactive Voice Response System will inform you of any requirements not yet met. To check the current status by Internet, key in the following address: http://drlchq.state.wi.us/application

## MEDICINE AND SURGERY
## CHECK FORM

**Application Number:** 151574 **As of:** 05/21/2002 **Reg Type:** 20

| DESCRIPTION | COMPLETION DATE | COMPLETE | IS REQUIRED | COMMENTS |
|---|---|---|---|---|
| WI Statute & Rules Examination Booklet & Answer Sheet | | X | X | received waiting results PASSED |
| Is name on all credentials the same? If not, submit copy of marriage certificate, divorce decree, etc. | 05/17/2002 | X | | |
| Application Fee | 05/17/2002 | X | | |
| Pages One and Two - Applicable blanks completed | 05/17/2002 | X | | |
| Pre-Professional and Professional Education | 05/17/2002 | X | | |
| All activities and practice accounted for | 05/17/2002 | X | | |
| Pages Three, Four and Five - Applicable blanks completed | 05/17/2002 | X | | |
| All questions answered and relevant copies attached | 05/17/2002 | X | | |
| Affidavit of applicant, signed and notarized | 05/17/2002 | X | | |
| USMLE (Step 1, Step 2, Step 3) | | X | X | |
| Authorization and Waiver, signed and notarized | 05/17/2002 | X | | |
| Copy of Medical diploma | 05/17/2002 | X | | |
| Physicians Profile Data Report from AOA or AMA | | | X | |
| Disciplinary Inquiry Report from Federation (Form #1445) | | | X | |
| Work History (Form #1934) | 05/17/2002 | X | | |
| Medical Education Verification Form (Form #2164) | | X | X | |
| Certificate of Post-Graduate Training (Form #2165) | | X | X | ~~ned kaiser permante~~ |
| Employment Verification Form (Form #2166) | | X | X | ~~ved thepermante med group~~ CA |
| Verification of state license(s) directly from State Board office(s) | | X | X | ved CA |
| National Practitioner Data Bank Report/Self-query | | X | X | |
| Social Security Number Collection Form (#2380) | 05/17/2002 | X | | |
| Oral Exam to be deterimined after application is completed | | | X | |

# Department of Regulation & Licensing

State of Wisconsin
(608) 266-2811
TTY# (608) 267-2416 } hearing or speech
TRS# 1-800-947-3529 } impaired only

P.O. Box 8935, Madison, WI 53708-8935
E-Mail: web@drl.state.wi.us
Website: http://www.drl.state.wi.us/
FAX #: (608) 261-7083

## MEDICAL EXAMINING BOARD E

APPLICATION FOR LICENSE TO PRACTICE MEDICINE AND SURGERY
Information requested is required for processing.

151574

**PLEASE TYPE OR PRINT IN INK**

**Last Name:** Dutton **First Name:** Caryn **MI:** R

**Former Name(s) - (If Applicable):** (Dutton - maiden name; Dutton Bean - married name)

**Street Address:** 465 S. Madison Ave, Apt. 119
(A Post Office Box is NOT Acceptable)

**City:** Pasadena (626) 577-7346 (after 7/1/02) **State:** CA **Zip:** 91101

**Phone (days):** (323) 226 3433 (until 6/30/02) **Date of Birth:** 3/31/1970

Ethnic and gender status information is optional, and is for research and reporting to the Equal Employment Opportunity Commission.

**Race:**
- ✓ (1) White, not of Hispanic origin
- _____ (2) Black, not of Hispanic origin
- _____ (3) Hispanic
- _____ (4) American Indian or Alaskan
- _____ (5) Asian or Pacific Islander
- _____ (6) Other

**Sex:** _____ M ✓ F

**Medical School:** Univ. of Connecticut School of Medicine
**School Address:** Farmington (City) CT (State)

**Specialty:** Ob-Gyn
**Specialty Code:** 12

**Date Diploma Granted:** 5/23/96 (month/day/year)

**Degree:** M.D.

**BOARD OFFICE USE ONLY**
School Code: _____
Procedure Code: _____

**APPLICATION FEES** Please check applicable blank: (Make check payable to Department of Regulation and Licensing and attach to application.)

_____ **To Write PART III USMLE**
$ 53.00 Initial Credential Fee
$ 57.00 State Law Exam
$ 15.00 Contract Exam Fee
**$ 125.00 Total Fee Attached***

_____ **Endorsement of National Boards**
$ 53.00 Initial Credential Fee
$ 57.00 State Law Exam
**$ 110.00 TOtal Fee Attached***

_____ **Endorsement of FLEX**
$ 53.00 Initial Credential Fee
$ 57.00 State Law Exam
**$ 110.00 Total Fee Attached***

_____ **Reciprocity of State Board Exam** (Taken Prior to 1972)*
$ 106.00 Initial Credential Fee
$ 57.00 State Law Exam
**$ 163.00 Total Fee Attached***

_____ **Endorsement of LMCC** (Taken after 1/1/78)
$ 53.00 Initial Credential Fee
$ 57.00 State Law Exam
**$ 110.00 Total Fee Attached***

✓ **Endorsement of Steps 1, 2, & 3 of USMLE**
$ 53.00 Initial Credential Fee
$ 57.00 State Law Exam
**$ 110.00 Total Fee Attached***

_____ **LOCUM TENENS***
$ 106.00 Initial Credential Fee
$ 57.00 State Law Exam
**$ 163.00 Total Fee Attached***

**For Receipting Use Only**

Trn# 100403 05/16/02 02.01
CHECK
020-RECIPROCAL 53.00
020-EXAM 57.00
TOTAL 110.00

***ORAL EXAMINATION FEE: $266.00**
If you should be selected for an oral examination, the additional oral examination fee will be required prior to being scheduled for the exam.

#570 (Rev. 11/01)
Ch. 448, Stats.

# State of Wisconsin Department of Regulation & Licensing

**APPLICATION IS NOT COMPLETE UNTIL ALL OF THE FOLLOWING DOCUMENTS HAVE BEEN RECEIVED:**

Notarized copy of ECFMG certificate if a Foreign Graduate.

Copy of Professional Diploma and translation if necessary.

Medical Education Verification Form (Form #2164).

Certificate of Post-graduate Training (Form #2165).

Employment Verification Form (Form #2166).

Hospital Verification-Privileges, Employment or Appointment (Form #2167).

Addendum to Application Form (Form # 2380).

Copies of malpractice suit. Court documents with allegations and settlement.

National Board, FLEX, State Board, USMLE or LMCC scores.

Signed Authorization and Waiver Form (Form #571).

Work History (Form 1934).

National Practitioner Data Bank Report

Fee attached to application (Form #570).

Physician Profile Data Report from the American Medical Association.

Disciplinary Inquiry Report from the Federation of State Medical Boards (Form #1445).

Wisconsin Statutes and Rules Examination Booklet with answer sheet.

Letters from all State Boards where licensed (includes active and inactive licenses).

**IS NAME ON ALL CREDENTIALS THE SAME? IF NOT, SUBMIT CERTIFIED COPY OF MARRIAGE CERTIFICATE, DIVORCE DECREE, ETC.**

**PRE-PROFESSIONAL EDUCATION: (schools, locations, dates of graduation and degrees) (list all schools attended)**

| | SCHOOL | DEGREE | DATES OF GRADUATION |
|---|---|---|---|
| 1. | Amherst College, Amherst MA | B.A. | May 1992 |
| 2. | | | |
| 3. | | | |

**PROFESSIONAL EDUCATION: (schools, locations, dates of graduation and degrees) (list all schools attended)**

| | SCHOOL | DEGREE | DATES OF GRADUATION |
|---|---|---|---|
| 1. | Univ. of Connecticut School of Medicine, Farmington CT | M.D. | May 1996 |
| 2. | | | |
| 3. | | | |
| 4. | | | |

**POST-GRADUATE TRAINING AND FELLOWSHIPS: Outline in chronological order.**

| | NAME OF HOSPITAL OR CLINIC | LOCATION | DATES (from - to) mo/yr |
|---|---|---|---|
| 1. | Kaiser Permanente, Santa Clara, CA | (residency) | June 1996 - June 2000 |
| 2. | LAC-USC Medical Center, Los Angeles CA | | July 2000 to present |
| 3. | (fellowship in Family Planning Clinical Care + Research) | | |

**PRACTICE AND OTHER ACTIVITIES: Outline in chronological order from the date of completion of your training/fellowship to the present time. (Must include professional and nonprofessional activities. All activities must be accounted for.)**

| | NAME OF HOSPITAL OR CLINIC | LOCATION | DATES (from - to) mo/yr |
|---|---|---|---|
| 1. | Planned Parenthood of Los Angeles, CA | (moonlighting) | (9/2000 - present) |
| 2. | USC ob/Gyn Inc., Los Angeles, CA | (moonlighting) | (7/2001 - 12/2001) |
| 3. | The Permanente Medical Group, Santa Clara, CA | (moonlighting) | (7/1999 - 6/2000) |
| 4. | | | |
| 5. | | | |

(attach additional sheets if necessary)

| ECFMG EXAM TAKEN | CERTIFICATE ISSUED | CERTIFICATE NO. | DATE ISSUED |
|---|---|---|---|
| ____ Yes X No | ____ Yes ____ No | | |

SPECIALTY BOARD CERTIFICATIONS — DATE CERTIFIED

Pending - Active candidate for Am. Board of ob/Gyn

# State of Wisconsin Department of Regulation & Licensing

**LIST ALL HOSPITALS THAT YOU HAVE HAD STAFF PRIVILEGES, EMPLOYMENT OR APPOINTMENTS DURING THE LAST 5 YEARS:**

| | NAME OF HOSPITAL | LOCATION | DATES (from-to) mo/yr/ |
|---|---|---|---|
| 1. | LAC-USC Medical Center | Los Angeles CA 90033 | 7/2000 to presal |
| 2. | Queen of Angels · Hollywood Presbyterian Medical Center | Los Angeles CA 90027 | 7/2001 to presal |
| 3. | | | |
| 4. | | | |
| 5. | | | |
| 6. | | | |
| 7. | | | |
| 8. | | | |

**I AM CURRENTLY OR HAVE BEEN LICENSED IN THE FOLLOWING STATES (UNLIMITED): INCLUDE ACTIVE AND INACTIVE CREDENTIALS.**

By Written Exam: CA

By Endorsement/Reciprocity: _____

**YOU ARE REQUIRED TO HAVE EACH STATE BOARD IN WHICH YOU HAVE EVER BEEN LICENSED SUBMIT LETTERS OF VERIFICATION TO THE WISCONSIN MEDICAL EXAMINING BOARD. THE LETTERS MUST INDICATE YOUR DATE OF BIRTH, LICENSE NUMBER, DATE OF ISSUANCE, AND A STATEMENT REGARDING DISCIPLINARY ACTIONS. THESE LETTERS WILL BE REQUIRED IN ORDER TO COMPLETE YOUR APPLICATION FOR LICENSURE.**

**ANSWER THE FOLLOWING QUESTIONS:** (Attach additional sheets if necessary.

| | | YES | NO |
|---|---|---|---|
| 1. | Are you familiar with the state health laws and rules and regulations of the Wisconsin Department of Health and Family Services regarding communicable diseases? | ☒ | ☐ |
| 2. | Have you ever surrendered, resigned, cancelled or been denied a professional license or other credential in Wisconsin or any other jurisdiction? If yes, give details on an attached sheet, including the name of the profession and the agency. | ☐ | ☒ |
| 3. | Have you ever failed to pass any state board examination, national board examination, or USMLE, or FLEX examination? If yes, give details on an attached sheet. | ☐ | ☒ |
| 4. | Has any licensing or other credentialing agency ever taken any disciplinary action against you, including but not limited to, any warning, reprimand, suspension, probation, limitation, revocation? If yes, attach a sheet providing details about the action, including the name of the credentialing agency and date of action. | ☐ | ☒ |
| 5. | Is disciplinary action pending against you in any jurisdiction? If yes, attach a sheet providing details about pending action, including the name of the agency and status of action. | ☐ | ☒ |
| 6. | Do you have any felony or misdemeanor charges pending against you? If yes, attach a sheet providing details about the pending charge, copy of the court documents and status of the charge. (Please do not give details on minor traffic charges, but do include information relating to Driving While Intoxicated (DWI) charges.) | ☐ | ☒ |
| 7. | Have you ever been convicted of a misdemeanor or a felony? If yes, attach a sheet providing details about the crime, including date of conviction, penalty and a copy of the court documents. (Please do not give details on minor traffic convictions, but do include information relating to Driving While Intoxicated (DWI) charges.) | ☐ | ☒ |
| 8. | Are you incarcerated, on probation or on parole for any conviction? If applicable, attach a sheet providing details including the terms of incarceration and a copy of a report from your probation or parole officer. | ☐ | ☒ |

# State of Wisconsin Department of Regulation & Licensing

| | | YES | NO |
|---|---|---|---|
| 9. | Have any suits or claims ever been filed against you as a result of professional services? If yes, submit a copy of the claim or suit and a copy of the final settlement or disposition. | ☐ | ☒ |
| 10. | Have your hospital privileges ever been limited or removed? If yes, give details on an attached sheet. | ☐ | ☒ |
| 11. | Are you registered or licensed in any other profession(s)? If yes, state what profession(s) and in what states(s). | ☐ | ☒ |
| 12. | Have you ever been credentialed under any other name(s)? If yes, state name(s) credentialed under. | ☐ | ☒ |
| 13. | Has the Drug Enforcement Administration ever withdrawn your DEA number or warned you, or have you been denied a DEA number? If yes, give details on an attached sheet. | ☐ | ☒ |

For the purposes of these questions, the following phrases or words have the following meanings:

"Ability to practice medicine" is to be construed to include all of the following:

1. The cognitive capacity to make appropriate clinical diagnoses and exercise reasoned medical judgments and to learn and keep abreast of medical developments; and
2. The ability to communicate those judgments and medical information to patients and other health care providers, with or without the use of aids or devices, such as voice amplifiers; and
3. The physical capability to perform medical tasks such as physical examination and surgical procedures, with or without the use of aids or devices, such as corrective lenses or hearing aids.

"Medical condition" includes physiological, mental or psychological conditions or disorders, such as, but not limited to orthopedic, visual, speech, and hearing impairments, cerebral palsy, epilepsy, muscular dystrophy, multiple sclerosis, cancer, heart disease, diabetes, mental retardation, emotional or mental illness, specific learning disabilities, HIV disease, tuberculosis, drug addiction and alcoholism.

"Chemical substances" is to be construed to include alcohol, drugs or medications, including those taken pursuant to a valid prescription for legitimate medical purposes and in accordance with the prescriber's direction, as well as those used illegally.

"Currently" does not mean on the day of, or even in the weeks or months preceding the completion of this application. Rather, it means recently enough so that the use of drugs may have an ongoing impact on one's functioning as a licensee, or **within the past two years.**

"Illegal use of controlled dangerous substances" means the use of controlled dangerous substances obtained illegally (e.g. heroin or cocaine) as well as the use of controlled dangerous substances which are not obtained pursuant to a valid prescription or not taken in accordance with the directions of a licensed health care practitioner.

| | | YES | NO |
|---|---|---|---|
| 14. | Do you have a medical condition which in any way impairs or limits your ability to practice medicine with reasonable skill and safety? If yes, please explain. | ☐ | ☒ |
| 15. | Does your use of chemical substance(s) in any way impair or limit your ability to practice medicine with reasonable skill and safety? If yes, please explain. | ☐ | ☒ |
| 16. | Are the limitations or impairments caused by your medical condition reduced or ameliorated because you receive ongoing treatment (with or without medications) or participate in a monitoring program? If yes, please explain. | ☐ | ☒ N/A |
| 17. | Are the limitations or impairments caused by your medical condition reduced or ameliorated because of the field of practice, the setting or the manner in which you have chosen to practice? If yes, please explain. | ☐ | ☒ N/A |
| 18. | Have you ever been diagnosed as having or have you ever been treated for pedophilia, exhibitionism or voyeurism? If yes, please explain. | ☐ | ☒ |
| 19. | Are you currently engaged in the illegal use of controlled dangerous substances? | ☐ | ☒ |
| 20. | If yes, are you currently participating in a supervised rehabilitation program or professional assistance program which monitors you in order to assure that you are not engaging in the illegal use of controlled dangerous substances? If yes, please explain. | ☐ | ☒ |

# State of Wisconsin Department of Regulation & Licensing

## AFFIDAVIT OF APPLICANT

I, the above-named applicant, state that I am the person referred to in this application and that all the statements herein contained are each and all strictly true in every respect. I understand that false or forged statements made in connection with this application may be grounds for revocation of my credential or other disciplinary action. I also understand that if I am issued a credential, failure to comply with the laws or rules of either the Medical Examining Board or the Department of Regulation and Licensing will be cause for disciplinary action.

C Dutter
Applicant Signature

May 14, 2002
Date

Subscribed and sworn to before me this 14th day of

May , 2002

Ana B. Mack
Notary Public

California
State

My Commission Expires: July 16, 2002

**SEAL**

ANA B. MACK
Commission # 1190206
Notary Public - California
Los Angeles County
My Comm. Expires Jul 16, 2002

**NOTE: This affidavit must be signed by the applicant in the presence of the notary public on the same date.**

4
print plainly
manent black

e every item

STATE OF CONNECTICUT
DEPARTMENT OF PUBLIC HEALTH AND ADDICTION SERVICES
Vital Records Section — Hartford, Connecticut 06106

CERTIFIED COPY

## LICENSE AND CERTIFICATE OF MARRIAGE: Town of WESTPORT

**GROOM**

| GROOM'S NAME (First) | (Middle) | (Last) | AGE |
|---|---|---|---|
| 1 BRIAN | DAVID | BEAN | 2 24 |

| BIRTHPLACE (State or Foreign Country) | DATE OF BIRTH (Mo. Day Year) | RESIDENCE (No. and Street) | CITY OR TOWN |
|---|---|---|---|
| 3 MICHIGAN | 4 12/18/71 | 5 1 D MCFARLAND | 6 STANFORD |

| COUNTY | STATE | SUPERVISION OR CONTROL OF ("X" One) | YES | NO |
|---|---|---|---|---|
| 7 SANTA CLARA | 8 CALIFORNIA | 9 GUARDIAN OR CONSERVATOR | ☐ | ☒ |

| FATHER'S NAME | BIRTHPLACE (State or Foreign Country) |
|---|---|
| 10 DAVID BEAN | 11 MICHIGAN |
| MOTHER'S MAIDEN NAME | BIRTHPLACE (State or Foreign Country) |
| 12 SUE BRITTEN | 13 MICHIGAN |

| RACE | NO. OF THIS MARRIAGE | IF PREVIOUSLY MARRIED, LAST MARRIAGE ENDED BY | EDUCATION (No. Yrs. Completed) | | |
|---|---|---|---|---|---|
| | | | ELEMENTARY (1-8) | HIGH SCHOOL (1-4) | COLLEGE (1-5—) |
| 14 CAUC | 15 1 | 16 ☐ DEATH 17 ☐ DIVORCE 18 ☐ ANNULMENT | 19 | 20 | 21 5+ |

**BRIDE**

| BRIDE'S NAME (First) | (Middle) | (Last) | AGE |
|---|---|---|---|
| 22 CARYN | RUTH | DUTTON | 23 26 |

| BIRTHPLACE (State or Foreign Country) | DATE OF BIRTH (Mo Day Year) | RESIDENCE (No. and Street) | CITY OR TOWN |
|---|---|---|---|
| 24 WASHINGTON DC | 25 3/31/70 | 26 25 LANCASTER RD | 27 W HARTFORD |

| COUNTY | STATE | SUPERVISION OR CONTROL OF ("X" One) | YES | NO |
|---|---|---|---|---|
| 28 HARTFORD | 29 CONNECTICUT | 30 GUARDIAN OR CONSERVATOR | ☐ | ☒ |

| FATHER'S NAME | BIRTHPLACE (State or Foreign Country) |
|---|---|
| 31 ROBERT DUTTON | 32 GEORGIA |
| MOTHER'S MAIDEN NAME | BIRTH PLACE (State or Foreign Country) |
| 33 CAROL VAN DE BEE | 34 NEW JERSEY |

| RACE | NO. OF THIS MARRIAGE | IF PREVIOUSLY MARRIED, LAST MARRIAGE ENDED BY | EDUCATION (No. Yrs. Completed) | | |
|---|---|---|---|---|---|
| | | | ELEMENTARY (1-8) | HIGH SCHOOL (1-4) | COLLEGE (1-5—) |
| 35 CAUC | 36 1 | 37 ☐ DEATH 38 ☐ DIVORCE 39 ☐ ANNULMENT | 40 | 41 | 42 5+ |

**LICENSE**

We, the above named in this Marriage License do solemnly swear that the statements herein made are true.

| GROOM (Signature) | SWORN TO ME (Registrar) | THIS DAY OF (Mo., Day, Yr.) |
|---|---|---|
| 43 Brian David Bean | 44 Ruth M. Cavayero ASST | 45 5/24/96 |
| BRIDE (Signature) | SWORN TO ME (Registrar) | THIS DAY OF (Mo., Day, Yr.) |
| 46 Caryn Ruth Dutton | 47 Ruth M. Cavayero ASST | 48 5/24/96 |

**Town Registrar of Vital Statistics CERTIFICATIONS**

This license certifies that the above-named persons have complied with the laws of Connecticut relating to a marriage license, and any person authorized to celebrate marriage may join the above-named in marriage in the town of:

| 49 WESTPORT | 50 THIS LICENSE MUST BE USED ON OR BEFORE DATE (Mo., Day, Yr.) 7/26/96 |
|---|---|

| ISSUING OFFICIAL (Signature) | TITLE | DATE ISSUED (Mo., Day, Yr.) |
|---|---|---|
| 51 Ruth M. Cavayero | 52 ASST REGISTRAR VS | 53 5/24/96 |

**OFFICIATOR**

| I HEREBY CERTIFY THAT | AND |
|---|---|
| 54 Mr. BRIAN DAVID BEAN | 55 Ms. CARYN RUTH DUTTON |

| THE ABOVE-NAMED PARTIES WERE LEGALLY JOINED IN MARRIAGE BY ME IN THE TOWN OF | IN THE COUNTY OF | THIS DAY OF (Mo., Day, Yr.) |
|---|---|---|
| 56 WESTPORT | 57 FAIRFIELD | 58 June 22, 1996 |

| SIGNATURE OF PERSON PERFORMING CEREMONY | OFFICIAL CAPACITY | TYPE OF CEREMONY |
|---|---|---|
| 59 A. Donald Hodges | 60 Minister | 61 Religious |

**REGISTRAR**

| THIS CERTIFICATE RECEIVED FOR RECORD ON Date (Mo., Day, Yr.) | BY (Signature) |
|---|---|
| 62 July 9, 1996 | 63 Joan M. Hyde |

I certify that this is a true transcript of the information on the marriage record as recorded in this office.

Attest: Joyce E. Cotto
Joyce E. Cotto, Asst.
Registrar of Vital Statistics
Town of Westport, Connecticut

Dated July 9, 1996

NOT GOOD WITHOUT SEAL OF CERTIFYING OFFICIAL

465 S. Madison Ave., Apt. 119
Pasadena, CA 91101
May 13, 2002

Department of Regulation and Licensing
Wisconsin Medical Examining Board
PO Box 8935
Madison, WI 53708-8935

To Whom It May Concern:

Please find enclosed completed forms related to my application for licensure as a Physician and Surgeon.

I have also included a copy of my marriage certificate. My legal name as registered with the Social Security Administration includes my married name (Caryn Ruth Dutton Bean). However, all other documents related to my medical practice are in my maiden name. I would like to continue to use my maiden name professionally, and would ask that my license and any public records display the name Caryn Dutton, MD.

Thank you in advance for your review of my application. Please contact me at my current home number (626) 577-7346, if further clarification is needed on any matter.

Sincerely,

Caryn Dutton, MD

# Department of Regulation & Licensing

State of Wisconsin
(608) 266-2812
TTY# (608) 267-2416 ] hearing or speech
TRS# 1-800-947-3529 ] impaired only

P.O. Box 8935, Madison, WI 53708-8935
E-Mail: dorl@drl.state.wi.us
Website: http://www.drl.state.wi.us/
FAX #: (608) 261-7083

## MEDICAL EXAMINING BOARD

## WORK HISTORY
## MEDICINE AND SURGERY

Information requeseted is required for processing.

**COMPLETE WORK HISTORY.** If you have never been employed, stop at box 7. Photocopy this form if additional space is required.

| 1. NAME/LAST | FIRST | MI | 2. DATE OF BIRTH | 3. SOCIAL SECURITY NUMBER |
|---|---|---|---|---|
| Dutton | Caryn | R | 03/31/70 | [redacted] |

4. ADDRESS (Street, City, State, Zip Code): 465 S. Madison Ave, Apt 119, Pasadena CA 91101

| 5. MAIDEN OR GIVEN SURNAME | 6. CHECK HERE IF YOU HAVE NEVER BEEN EMPLOYED: | 7. DATE FORM COMPLETED: |
|---|---|---|
| Dutton (married name: Dutton Bean) | | May 12, 2002 |

8. RECORD WORK HISTORY CHRONOLOGICALLY - Complete Work History beginning with present employment and concluding with graduation. You must account for the entire time period including periods of unemployment and volunteer work, etc.

**A. NAME OF BUSINESS INSTITUTION:** Planned Parenthood of Los Angeles

**JOB TITLE:** Independent contractor - physician

**ADDRESS: (Street, City, State, Zip Code)**
1920 Marengo Street
Los Angeles CA 90033

**SUPERVISOR NAME:** Mary Gatter MD

**DESCRIPTION OF DUTIES PERFORMED:**
- performed 1st and early 2nd trimester abortions
- consultations with staff and mid-level providers on various aspects of reproductive health care

**DATE OF EMPLOYMENT/ ATTENDANCE:**
From: 10/21/00 (Month/Day/Year)
To: present (Month/Day/Year)

**HOURS WORKED PER WEEK:** moonlighting only
3 full days in 2000

**TYPE OF EMPLOYMENT:**
___ Full-time
x Part-time

**TOTAL TIME WORKED (Yr./Mo.)** 3 full days in 1 year

**B. NAME OF BUSINESS INSTITUTION:** USC Ob/Gyn Inc.

**JOB TITLE:** Independent Contractor - physician

**ADDRESS: (Street, City, State, Zip Code)**
1640 Marengo St. Suite 505
Los Angeles CA 90033

**SUPERVISOR NAME:** Cynde Brewer or David Miller MD

**DESCRIPTION OF DUTIES PERFORMED:**
- supervised resident physicians in Labor + Delivery & Emergency room; including performing cesarean section, vaginal delivery, ultrasound, and gynecological surgery / patient management.

**DATE OF EMPLOYMENT/ ATTENDANCE:**
From: 07/01/01 (Month/Day/Year)
To: 12/31/01 (Month/Day/Year)

**HOURS WORKED PER WEEK:** 48-54 hours per month

**TYPE OF EMPLOYMENT:**
___ Full-time
X Part-time

**TOTAL TIME WORKED (Yr./Mo.)** ~52 hrs/mo x 6 months

# State of Wisconsin Department of Regulation & Licensing

**C. NAME OF BUSINESS INSTITUTION:** The Permanente Medical Group / Dept. of Ob/Gyn, Kaiser Santa Clara

**JOB TITLE:** Per diem physician

**ADDRESS: (Street, City, State, Zip Code)** 900 Kiely Blvd. Santa Clara CA 95051

**DESCRIPTION OF DUTIES PERFORMED:**
- Cared for patients presenting to an evening gynecology clinic for urgent and routine appointments

**SUPERVISOR NAME:** Yvonne Cortes MD

**DATE OF EMPLOYMENT/ ATTENDANCE:**
From: 07 / 01 / 99 (Month / Day / Year)
To: 06 / 30 / 00 (Month / Day / Year)

**HOURS WORKED PER WEEK:** variable

**TYPE OF EMPLOYMENT:**
____ Full-time
x Part-time

**TOTAL TIME WORKED (Yr./Mo.)** approx 48 hours/year

---

**D. NAME OF BUSINESS INSTITUTION:**

**JOB TITLE:**

**ADDRESS: (Street, City, State, Zip Code)**

**DESCRIPTION OF DUTIES PERFORMED:**

**SUPERVISOR NAME:** _____

**DATE OF EMPLOYMENT/ ATTENDANCE:**
From: __ __ / __ __ / __ __ (Month / Day / Year)
To: __ __ / __ __ / __ __ (Month / Day / Year)

**HOURS WORKED PER WEEK:** _____

**TYPE OF EMPLOYMENT:**
____ Full-time
____ Part-time

**TOTAL TIME WORKED (Yr./Mo.)**

---

**E. NAME OF BUSINESS INSTITUTION:**

**JOB TITLE:**

**ADDRESS: (Street, City, State, Zip Code)**

**DESCRIPTION OF DUTIES PERFORMED:**

**SUPERVISOR NAME:** _____

**DATE OF EMPLOYMENT/ ATTENDANCE:**
From: __ __ / __ __ / __ __ (Month / Day / Year)
To: __ __ / __ __ / __ __ (Month / Day / Year)

**HOURS WORKED PER WEEK:** _____

**TYPE OF EMPLOYMENT:**
____ Full-time
____ Part-time

**TOTAL TIME WORKED (Yr./Mo.)**

# Department of Regulation & Licensing

State of Wisconsin
(608) 266-2811
TTY# (608) 267-2416 hearing or speech
TRS# 1-800-947-3529 impaired only

P.O. Box 8935, Madison, WI 53708-8935
E-Mail: dorl@drl.state.wi.us
Website: http://www.drl.state.wi.us/
FAX #: (608) 261-7083

## MEDICAL EXAMINING BOARD

### MEDICAL EDUCATION VERIFICATION FORM

Information requested is required for processing.

***IMPORTANT:*** *PLEASE FORWARD THIS FORM TO YOUR MEDICAL SCHOOL*

The **State of Wisconsin** requests that you complete this form concerning the following individual:

APPLICANT'S NAME: Caryn Ruth Dutton Soc. Sec. #* [redacted]

MEDICAL SCHOOL: Univ. of Connecticut School of Medicine

MEDICAL SCHOOL ADDRESS: 263 Farmington Ave, Farmington CT 06030

| | | YES | NO |
|---|---|---|---|
| 1. | Did this physician attend the medical school noted above? | ☑ | ☐ |
| 2. | What were the applicant's dates of enrollment in this medical school? 8/21/92 - 5/23/96 | | |
| 3. | Did this physician graduate from this medical school? If no, please attach explanation on a separate sheet. | ☑ | ☐ |
| | Degree Granted MD | | |
| | Date Degree Granted 5/23/96 | | |
| 4. | Did this individual take a leave of absence during his/her attendance at this medical school? If yes, please attach explanation on a separate sheet. | ☐ | ☑ |
| 5. | Did this individual have a record of unexcused absences during his/her attendance at this medical school? | ☐ | ☑ |
| 6. | Was this individual ever disciplined or under investigation during his/her attendance at this medical school? If yes, please attach explanation on a separate sheet. | ☐ | ☑ |
| 7. | Were any special requirements imposed on this individual that were not required of all other students at his/her level of education? If yes, please attach explanation on a separate sheet. | ☐ | ☑ |
| 8. | Was this individual recommended for post-graduate training? | ☑ | ☐ |

Print name of ~~Dean~~ Registrar Deborah Gibb

Signature of ~~Dean~~ Deborah Gibb

Date form was completed 5/31/02

*For use in school locating your records

**SEAL OF MEDICAL SCHOOL**

**Please return directly to:**

Department of Regulation and Licensing
Medical Examining Board
1400 East Washington Avenue
P.O. Box 8935
Madison, WI 53708-8935

#2164 (Rev. 2/01)
Ch. 448, Stats.

# United States Medical Licensing Examination™ (USMLE™)
# Certified Transcript of Scores

**This Transcript was prepared by the Federation of State Medical Boards**

**Date of Certification: 05/22/2002**

Wisconsin Medical Examining Board
ATTN: Deanna Zychowski, Administrative Asst
Dept of Regulation & Licensing
PO Box 8935
Madison, WI 53708-8935

**Examinee:** Dutton Bean, Caryn Ruth
**USMLE ID#:** 4-036-202-2
**DOB:** 03 / 31 / 1970
**Alt Name(s):** Dutton, Caryn Ruth

**Results for all Steps taken by this examinee (and for which results have been reported to date) are shown below. For Steps that span more than one day, the test date reflects the day on which the examination began. Scores are reported on two scales. The recommended minimum passing score ("Passing") on each scale is shown in parentheses.**

| STEP1 | Test Date | Pass/ Fail | Three-Digit Score | (Passing) | Two-Digit Score | (Passing) | Comments |
|---|---|---|---|---|---|---|---|
| | 6/8/1994 | PASS | 212 | (176) | 85 | (75) | |

| STEP2 | Test Date | Pass/ Fail | Three-Digit Score | (Passing) | Two-Digit Score | (Passing) | Comments |
|---|---|---|---|---|---|---|---|
| | 8/30/1995 | PASS | 212 | (167) | 84 | (75) | |

| STEP3 State Board | Test Date | Pass/ Fail | Three-Digit Score | (Passing) | Two-Digit Score | (Passing) | Comments |
|---|---|---|---|---|---|---|---|
| CALIFORNIA | 5/13/1997 | PASS | 211 | (177) | 85 | (75) | |

A search of the Board Action Data Bank of the Federation of State Medical Boards (FSMB) reveals no reported information on the above-named examinee.

# Department of Regulation & Licensing

**State of Wisconsin**
**(608) 266-2811**
TTY# (608) 267-2416 ] hearing or speech
TRS# 1-800-947-3529 ] impaired only

P.O. Box 8935, Madison, WI 53708-8935
E-Mail: dorl@drl.state.wi.us
Website: http://www.drl.state.wi.us/
FAX #: (608) 261-7083

## MEDICAL EXAMINING BOARD

### CERTIFICATE OF POSTGRADUATE TRAINING

Information requested is required for processing.

***IMPORTANT:*** *PLEASE FORWARD THIS FORM TO YOUR POSTGRADUATE TRAINING PROGRAMS (This form may be photocopied)*

The **State of Wisconsin** requests that you complete this form concerning the following individual:

PHYSICIAN'S NAME: Caryn R. Dutton M.D.

HOSPITAL NAME: Kaiser Permanente Medical Center, Santa Clara

HOSPITAL ADDRESS: 900 Kiely Blvd. Santa Clara CA 95051

HOSPITAL TELEPHONE: (408) 236-4921

1. In what type and level(s) of training did this physician participate at your facility? Check each level in which physician participated, provide starting and ending dates of his/her training in your program and type of training and whether credit was given for the training.

| DATES (MO/YR) | SPECIALTY | CREDIT | NO CREDIT | PARTIAL CREDIT |
|---|---|---|---|---|
| ✓ PGY 1 6/96 - 6/97 | Obstetrics and Gynecology | ✓ | | |
| ✓ PGY 2 7/97 - 6/98 | " | ✓ | | |
| ✓ PGY 3 7/98 - 6/99 | " | ✓ | | |
| ✓ PGY 4 7/99 - 6/00 | " | ✓ | | |
| ____ FELLOWSHIP ____ | | | | |
| ____ OTHER ____ | | | | |

| | YES | NO |
|---|---|---|
| 2. Was the residency/fellowship accredited by ACGME of the AMA or AOA? | ☒ | ☐ |
| 3. Did the physician complete the full training program in good standing? If no, please attach explanation on a separate sheet. | ☒ | ☐ |
| 4. Was the physician asked to or required to repeat any portion of the training at your facility? If yes, please attach explanation on a separate sheet. | ☐ | ☒ |

# State of Wisconsin Department of Regulation & Licensing

| | | YES | NO |
|---|---|---|---|
| 5. | Was the physician placed on probation, suspended or in any way sanctioned/disciplined while at your facility? If yes, please attach explanation on a separate sheet. | ☐ | ☒ |
| 6. | Was this physician recommended for the Board Certification examination in this specialty? | ☒ | ☐ |
| 7. | Was this physician granted a leave of absence while training at your facility? If yes, please attach explanation on a separate sheet. | ☐ | ☒ |
| 8. | Did this individual have a record of unexcused absences during his/her attendance at this training program? | ☐ | ☒ |
| 9. | Were any restrictions and/or special requirements placed on this physician's activities that were not placed on all other residents/fellows at his/her level of training? If yes, please attach explanation on a separate sheet. | ☐ | ☒ |
| 10. | Were any formal patient or staff complaints filed against this physician? If yes, please attach explanation on a separate sheet. | ☐ | ☒ |
| 11. | Were any incident reports filed involving the professional behavior or conduct of this physician? If yes, please attach explanation on a separate sheet. | ☐ | ☒ |
| 12. | Was this physician ever subject to non-routine monitoring while at your facility? If yes, please attach explanation on a separate sheet. | ☐ | ☒ |
| 13. | Were any malpractice actions filed naming this physician as a defendant that involved his/her period of training at your facility? If yes, please attach explanation on a separate sheet. | ☐ | ☒ |
| 14. | Is there any additional information in this physician's file that would assist the Board in determining this applicant's eligibility for licensure. If yes, please attach explanation on a separate sheet. | ☐ | ☒ |

Print name of Program Director DAVID K LEVIN MD

Signature of Program Director David K Levin MD

Date form was completed 5-22-02

**SEAL OF HOSPITAL**

(If hospital does not have a seal, a letter attesting to this fact, on hospital stationery, must accompany this certificate)

**Please return directly to:**

Department of Regulation and Licensing
Medical Examining Board
1400 East Washington Avenue
P.O. Box 8935
Madison, WI 53708-8935

# Department of Regulation & Licensing

State of Wisconsin
(608) 266-2811
TTY# (608) 267-2416
TRS# 1-800-947-3529 ] hearing or speech impaired only

P.O. Box 8935, Madison, WI 53708-8935
E-Mail: dorl@drl.state.wi.us
Website: http://www.drl.state.wi.us/
FAX #: (608) 261-7083

## MEDICAL EXAMINING BOARD

### CERTIFICATE OF POSTGRADUATE TRAINING

Information requested is required for processing.

***IMPORTANT:*** *PLEASE FORWARD THIS FORM TO YOUR POSTGRADUATE TRAINING PROGRAMS (This form may be photocopied)*

The **State of Wisconsin** requests that you complete this form concerning the following individual:

PHYSICIAN'S NAME: Caryn R. Dutton M.D.

HOSPITAL NAME: Women's + Children's Hospital, LAC + USC Medical Center

HOSPITAL ADDRESS: 1240 N. Mission Road, room L1009

HOSPITAL TELEPHONE: (323) 226-3416

1. In what type and level(s) of training did this physician participate at your facility? Check each level in which physician participated, provide starting and ending dates of his/her training in your program and type of training and whether credit was given for the training.

| DATES (MO/YR) | SPECIALTY | CREDIT | NO CREDIT | PARTIAL CREDIT |
|---|---|---|---|---|
| ____ PGY 1 ____ | | | | |
| ____ PGY 2 ____ | | | | |
| ____ PGY 3 ____ | | | | |
| ____ PGY 4 ____ | | | | |
| ✓ FELLOWSHIP 7/00 – 6/02 | Family Planning Clinical Care + Research | | | |
| ____ OTHER ____ | | | | |

| | YES | NO |
|---|---|---|
| 2. Was the residency/fellowship accredited by ACGME of the AMA or AOA? | ☐ | ☑ |
| 3. Did the physician complete the full training program in good standing? If no, please attach explanation on a separate sheet. | ☑ | ☐ |
| 4. Was the physician asked to or required to repeat any portion of the training at your facility? If yes, please attach explanation on a separate sheet. | ☐ | ☑ |

# State of Wisconsin Department of Regulation & Licensing

| | | YES | NO | |
|---|---|---|---|---|
| 5. | Was the physician placed on probation, suspended or in any way sanctioned/disciplined while at your facility? If yes, please attach explanation on a separate sheet. | ☐ | ☑ | |
| 6. | Was this physician recommended for the Board Certification examination in this specialty? | ☐ | ☐ | N/A |
| 7. | Was this physician granted a leave of absence while training at your facility? If yes, please attach explanation on a separate sheet. | ☐ | ☑ | |
| 8. | Did this individual have a record of unexcused absences during his/her attendance at this training program? | ☐ | ☑ | |
| 9. | Were any restrictions and/or special requirements placed on this physician's activities that were not placed on all other residents/fellows at his/her level of training? If yes, please attach explanation on a separate sheet. | ☐ | ☑ | |
| 10. | Were any formal patient or staff complaints filed against this physician? If yes, please attach explanation on a separate sheet. | ☐ | ☑ | |
| 11. | Were any incident reports filed involving the professional behavior or conduct of this physician? If yes, please attach explanation on a separate sheet. | ☐ | ☑ | |
| 12. | Was this physician ever subject to non-routine monitoring while at your facility? If yes, please attach explanation on a separate sheet. | ☐ | ☑ | |
| 13. | Were any malpractice actions filed naming this physician as a defendant that involved his/her period of training at your facility? If yes, please attach explanation on a separate sheet. | ☐ | ☑ | |
| 14. | Is there any additional information in this physician's file that would assist the Board in determining this applicant's eligibility for licensure. If yes, please attach explanation on a separate sheet. | ☐ | ☑ | |

Print name of Program Director John K. Jain M.D.

Signature of Program Director [signature]

Date form was completed 5/14/02

**SEAL OF HOSPITAL**

(If hospital does not have a seal, a letter attesting to this fact, on hospital stationery, must accompany this certificate)

**Please return directly to:**

Department of Regulation and Licensing
Medical Examining Board
1400 East Washington Avenue
P.O. Box 8935
Madison, WI 53708-8935

State of California Department of Consumer Affairs

MEDICAL BOARD OF CALIFORNIA
LICENSING PROGRAM
1426 HOWE AVE, SUITE 56
SACRAMENTO CA 95825-3236
TELEPHONE: (916) 263-2382
FAX: (916) 263-2944

www.medbd.ca.gov

July 18, 2002

WISCONSIN MEDICAL EXAMINING BOARD
DEPT OF REGULATION AND LICENSING
1400 E WASHINGTON AVE
MADISON WI 53703-3041

To Whom It May Concern:

In response to your inquiry a standard search of available records in this office has been performed. The following indicates the results of that search:

| | |
|---|---|
| Physician: | CARYN RUTH DUTTON |
| License No.: | A 65255 |
| Issued: | May 22, 1998 |
| Exam Type: | A written examination |
| Expiration Date: | March 31, 2004 |
| Status: | Renewed/current |

If a discipline status is listed, you may obtain information concerning this action by contacting the Board's Enforcement Program, Central File Room, 1426 Howe Avenue, Sacramento, CA 95825-3236 or by faxing your request to the Central File Room at (916) 263-2420.

Lucinda James

Lucinda James
Chief, Division of Licensing

SEAL

State of California Department of Consumer Affairs

The Medical Board of California
1426 Howe Avenue, Suite 54
Sacramento, California 95825-3236

*PHYSICIAN AND SURGEON*

CERTIFICATE NO. **A65255** EXPIRATION **03/31/2004**

**CARYN RUTH DUTTON**
**PO BOX 50658**
**PASADENA, CA 91105**

ORIGINAL ISSUANCE DATE
**05/22/1998**

RECEIPT NO.
**36500211**

**CONTROLLED SUBSTANCE REGISTRATION CERTIFICATE**
**UNITED STATES DEPARTMENT OF JUSTICE**
**DRUG ENFORCEMENT ADMINISTRATION**
WASHINGTON, D.C. 20537

**Sections 304 and 1008 (21 U.S.C. 824 and 958) of the Controlled Substances Act of 1970, as amended, provide that the Attorney General may revoke or suspend a registration to manufacture, distribute, dispense, import or export a controlled substance.**

| DEA REGISTRATION NUMBER | THIS REGISTRATION EXPIRES | FEE PAID |
|---|---|---|
| BL6209909 | 06-30-2004 | $210.00 |

| SCHEDULES | BUSINESS ACTIVITY | DATE ISSUED |
|---|---|---|
| 3,3N,4,5 | PRACTITIONER | 07-12-2001 |

* CORRECTED CERTIFICATE *
(NOT A RENEWAL)

DUTTON, CARYN RUTH MD
1240 N MISSION ROAD
ROOM L1009
LOS ANGELES, CA 90033

Form DEA-223 (10/96)

THIS CERTIFICATE IS NOT TRANSFERABLE ON CHANGE OF OWNERSHIP, CONTROL, LOCATION, BUSINESS ACTIVITY, OR VALID AFTER THE EXPIRATION DATE.

# Department of Regulation & Licensing

**State of Wisconsin**
**(608) 266-~~2112~~ 2811**
TTY# (608) 267-2416, hearing or speech impaired only
TRS# 1-800-947-3529

P.O. Box 8935, Madison, WI 53708-8935
E-Mail: dorl@drl.state.wi.us
Website: http://www.drl.state.wi.us/
FAX #: (608) xxx-xxxx

## MEDICAL EXAMINING BOARD

EMPLOYMENT VERIFICATION FORM
Information requested is required for processing.

***IMPORTANT:*** *PLEASE FORWARD THIS FORM TO ALL EMPLOYERS DURING THE LAST 5 YEARS (This form may be photocopied).*

The **State of Wisconsin** requests that you complete this form concerning the following individual:

PHYSICIAN'S NAME: Caryn Dutton MD

EMPLOYER'S NAME: The Permanente Medical Group

EMPLOYER'S ADDRESS: Kaiser Santa Clara ~~900 Kiely Blvd.~~, Santa Clara CA 95051

EMPLOYER'S TELEPHONE: (408) 236-~~6400~~

1. What position did this physician hold when employed by you? per-diem physician
2. What were this physician's dates of employment? 7/1/1999 - 6/30/00

| | | YES | NO |
|---|---|---|---|
| 3. | Did this physician leave your employ in good standing? If no, please attach explanation on a separate sheet. | ☒ | ☐ |
| 4. | Was the physician on probation, suspended or in any way sanctioned/disciplined while employed by you? If yes, please attach explanation on a separate sheet. | ☐ | ☒ |
| 5. | Was this physician granted a leave of absence while employed by you? If yes, please attach explanation on a separate sheet. | ☐ | ☒ |
| 6. | Were any restrictions or special requirements placed on this physician's activities which were not placed on all other employees holding similar positions? If yes, please attach explanation on a separate sheet. | ☐ | ☒ |
| 7. | Was this physician denied hospital privileges while employed by you? If yes, please attach explanation on a separate sheet. | ☐ | ☒ |
| 8. | Were any restrictions or special requirements placed on this physician's hospital privileges? If yes, please attach explanation on a separate sheet. | ☐ | ☒ |
| 9. | Were any formal patient or staff complaints filed against this physician? If yes, please attach explanation on a separate sheet. | ☐ | ☒ |

# The Permanente Medical Group, Inc.

900 KIELY BOULEVARD
SANTA CLARA, CALIFORNIA 95051-5386
(408) 236-6400




July 15, 2002

Department of Regulation and Licensing
Medical Examining Board
1400 East Washington Avenue
P.O. Box 8935
Madison, Wisconsin 53708-8935

To Whom It May Concern:

I worked with Caryn throughout her residency from 1996-2000, and as an attending perinatologist, was able to closely monitor her performance in high risk clinics and antepartum inpatient care as well as L&D call.

Caryn established herself before the end of her internship year as one of the brightest and hardworking of our residents. Caryn consistently increased her knowledge and familiarity with current literature, and worked very well with attending staff, residents and nurses. She was well accepted by my patients, who frequently asked to follow up with her after hospitalization. Her ethics are unimpeachable. Caryn was a great asset to our program.

I very highly recommend Caryn Dutton. If you should have any need to contact me, I can be reached at 408-236-4362.

Sincerely

Yvonne M. Crites, M.D.
Maternal-Fetal Medicine
Chief, SCL 1998-2002

YMC/mbw

# Department of Regulation & Licensing

State of Wisconsin
(608) 266-~~2812~~ 2811
TTY# (608) 267-2416 ] hearing or speech
TRS# 1-800-947-3529 ] impaired only

P.O. Box 8935, Madison, WI 53708-8935
E-Mail: dorl@drl.state.wi.us
Website: http://www.drl.state.wi.us/
FAX #: (608) xxx-xxxx

## MEDICAL EXAMINING BOARD

EMPLOYMENT VERIFICATION FORM
Information requested is required for processing.

***IMPORTANT:*** *PLEASE FORWARD THIS FORM TO ALL EMPLOYERS DURING THE LAST 5 YEARS (This form may be photocopied).*

The **State of Wisconsin** requests that you complete this form concerning the following individual:

PHYSICIAN'S NAME: Caryn Dutton MD

EMPLOYER'S NAME: Planned Parenthood of Los Angeles

EMPLOYER'S ADDRESS: 1920 Marengo St, Los Angeles CA 90033

EMPLOYER'S TELEPHONE: (323) 223-4462

1. What position did this physician hold when employed by you? Contract Physician
2. What were this physician's dates of employment? July 11/2000 — 8/2002 (Projected)

| | | YES | NO |
|---|---|---|---|
| 3. | Did this physician leave your employ in good standing? If no, please attach explanation on a separate sheet. | X | |
| 4. | Was the physician on probation, suspended or in any way sanctioned/disciplined while employed by you? If yes, please attach explanation on a separate sheet. | | X |
| 5. | Was this physician granted a leave of absence while employed by you? If yes, please attach explanation on a separate sheet. | | X |
| 6. | Were any restrictions or special requirements placed on this physician's activities which were not placed on all other employees holding similar positions? If yes, please attach explanation on a separate sheet. | | X |
| 7. | Was this physician denied hospital privileges while employed by you? If yes, please attach explanation on a separate sheet. | | X |
| 8. | Were any restrictions or special requirements placed on this physician's hospital privileges? If yes, please attach explanation on a separate sheet. | | X |
| 9. | Were any formal patient or staff complaints filed against this physician? If yes, please attach explanation on a separate sheet. | | X |

# State of Wisconsin Department of Regulation & Licensing

| | | YES | NO |
|---|---|---|---|
| 10. | Were any incident reports filed involving the professional conduct or behavior of this physician?<br>If yes, please attach explanation on a separate sheet. | ☐ | ☒ |
| 11. | Was this physician ever subject to a non-routine monitoring while in your employ?<br>If yes, please attach explanation on a separate sheet. | ☐ | ☒ |
| 12. | Was this physician removed from a call schedule for cause?<br>If yes, please attach explanation on a separate sheet. | ☐ | ☒ |

Print name of Employer Supplying Information MARY GATTER MD

Signature of Employer Supplying Information Mary Gatter

Date form was completed 5/17/02

PLEASE ATTACH LETTERHEAD FROM THE FACILITY WHERE THE APPLICANT WORKED OR SUPPLY SOME FORM OF IDENTIFICATION FOR INDIVIDUAL SUPPLYING INFORMATION.

**Please return directly to:**

Department of Regulation and Licensing
Medical Examining Board
1400 East Washington Avenue
P.O. Box 8935
Madison, WI 53708-8935

Planned Parenthood®
Los Angeles

5/10/12

Dr. Carolyn Dutton worked for us from 7/00 to present.

Mary Gatter MD
Medical Director
PPLA

1920 Marengo Street • Los Angeles, California 90033-1317
(323) 223-4462 • Fax (323) 225 -5844
www.plannedparenthood.org
Affiliated with Planned Parenthood Federation of America, Inc.

# Department of Regulation & Licensing

**State of Wisconsin**
**(608) 266-2811**
TTY# (608) 267-2416 hearing or speech
TRS# 1-800-947-3529 impaired only

P.O. Box 8935, Madison, WI 53708-8935
E-Mail: dorl@drl.state.wi.us
Website: http://www.drl.state.wi.us/
FAX #: (608) 261-7083

## MEDICAL EXAMINING BOARD

HOSPITAL VERIFICATION - PRIVILEGES, EMPLOYMENT OR APPOINTMENT

Information requested is required for processing.

***IMPORTANT:*** *PLEASE FORWARD THIS FORM TO ALL HOSPITALS THAT YOU HAVE HAD STAFF PRIVILEGES DURING THE LAST 5 YEARS (This form may be photocopied).*

The **State of Wisconsin** requests that you complete this form concerning the following individual:

PHYSICIAN'S NAME: Caryn R. Dutton MD

HOSPITAL/FACILITY: LAC + USC Medical Center

HOSPITAL/FACILITY ADDRESS: 1200 N. State Street, Los Angeles CA 90033

HOSPITAL/FACILITY TELEPHONE: (323) 226-6225

1. What position did this physician hold at your facility? VOLUNTARY ATTENDING PHYSICIAN
2. What were this physician's dates of employment or staff privileges at your facility? 7/1/00 to present

| | | YES | NO |
|---|---|---|---|
| 3. | Was the physician placed on probation, suspended or in any way sanctioned/disciplined while at your facility? If yes, please attach explanation on a separate sheet. | ☐ | ☒ |
| 4. | Was this physician granted a leave of absence while employed at your facility? If yes, please attach explanation on a separate sheet. | ☐ | ☒ |
| 5. | Did this individual have a record of unexcused absences during his/her attendance at this facility? | ☐ | ☒ |
| 6. | Were any restrictions or special requirements placed on this physician's activities that were not placed on all other employees/staff holding similar positions? If yes, please attach explanation on a separate sheet. | ☐ | ☒ |
| 7. | Were any restrictions placed on this physician's privileges? If yes, please attach explanation on a separate sheet. | ☐ | ☒ |
| 8. | Were any formal patient or staff complaints filed against this physician? If yes, please attach explanation on a separate sheet. | ☐ | ☒ |
| 9. | Were any incident reports filed involving the professional conduct or behavior of this physician? If yes, please attach explanation on a separate sheet. | ☐ | ☒ |

05 MAR 58 PM 3:45 RECEIVED

#2167 (Rev. 2/01)
Ch. 448, Stats.

-OVER-

# State of Wisconsin Department of Regulation & Licensing

| | | YES | NO |
|---|---|---|---|
| 10. | Was this physician ever subject to non-routine monitoring while at your facility? If yes, please attach explanation on a separate sheet. | ☐ | ☒ |
| 11. | Was this physician involuntarily removed from a call schedule for cause? If yes, please attach explanation on a separate sheet. | ☐ | ☒ |
| 12. | Was this physician subject to non-routine quality assessment review? If yes, please attach explanation on a separate sheet. | ☐ | ☒ |
| 13. | Was this physician the subject of a negative review by a quality assurance or departmental committee? If yes, please attach explanation on a separate sheet. | ☐ | ☒ |

Name and Title of Certifying Official
CHIEF MEDICAL OFFICER

5-16-02
Date

SEAL OF HOSPITAL
(If hospital does not have a seal, a letter attesting to this fact, on hospital stationery, must accompany this certificate)

**Please return directly to:**

Department of Regulation and Licensing
Medical Examining Board
1400 East Washington Avenue
P.O. Box 8935
Madison, WI 53708-8935

REGULATION & LICENSING
RECEIVED
02 MAY 28 PM 3:42

# Department of Regulation & Licensing

State of Wisconsin
(608) 266-~~2812~~ 2811
TTY# (608) 267-2416 ] hearing or speech
TRS# 1-800-947-3529 ] impaired only

P.O. Box 8935, Madison, WI 53708-8935
E-Mail: dorl@drl.state.wi.us
Website: http://www.drl.state.wi.us/
FAX #: (608) xxx-xxxx

## MEDICAL EXAMINING BOARD

EMPLOYMENT VERIFICATION FORM
Information requested is required for processing.

***IMPORTANT:*** *PLEASE FORWARD THIS FORM TO ALL EMPLOYERS DURING THE LAST 5 YEARS (This form may be photocopied).*

The **State of Wisconsin** requests that you complete this form concerning the following individual:

PHYSICIAN'S NAME: Caryn R. Dutton MD

EMPLOYER'S NAME: USC OB/Gyn Inc.

EMPLOYER'S ADDRESS: 1640 Marengo Street, suite 505, Los Angeles CA 90033

EMPLOYER'S TELEPHONE: (323) 226 3206

1. What position did this physician hold when employed by you? _____
2. What were this physician's dates of employment? 7/1/01 - 12/31/01

| | | YES | NO |
|---|---|---|---|
| 3. | Did this physician leave your employ in good standing? If no, please attach explanation on a separate sheet. | ☑ | ☐ |
| 4. | Was the physician on probation, suspended or in any way sanctioned/disciplined while employed by you? If yes, please attach explanation on a separate sheet. | ☐ | ☑ |
| 5. | Was this physician granted a leave of absence while employed by you? If yes, please attach explanation on a separate sheet. | ☐ | ☑ |
| 6. | Were any restrictions or special requirements placed on this physician's activities which were not placed on all other employees holding similar positions? If yes, please attach explanation on a separate sheet. | ☐ | ☑ |
| 7. | Was this physician denied hospital privileges while employed by you? If yes, please attach explanation on a separate sheet. | ☐ | ☑ |
| 8. | Were any restrictions or special requirements placed on this physician's hospital privileges? If yes, please attach explanation on a separate sheet. | ☐ | ☑ |
| 9. | Were any formal patient or staff complaints filed against this physician? If yes, please attach explanation on a separate sheet. | ☐ | ☑ |

# State of Wisconsin Department of Regulation & Licensing

| | YES | NO |
|---|---|---|
| 10. Were any incident reports filed involving the professional conduct or behavior of this physician? If yes, please attach explanation on a separate sheet. | ☐ | ☑ |
| 11. Was this physician ever subject to a non-routine monitoring while in your employ? If yes, please attach explanation on a separate sheet. | ☐ | ☑ |
| 12. Was this physician removed from a call schedule for cause? If yes, please attach explanation on a separate sheet. | ☐ | ☑ |

Print name of Employer Supplying Information David M. Iler

Signature of Employer Supplying Information

Date form was completed 5-16-02

PLEASE ATTACH LETTERHEAD FROM THE FACILITY WHERE THE APPLICANT WORKED OR SUPPLY SOME FORM OF IDENTIFICATION FOR INDIVIDUAL SUPPLYING INFORMATION.

**Please return directly to:**

Department of Regulation and Licensing
Medical Examining Board
1400 East Washington Avenue
P.O. Box 8935
Madison, WI 53708-8935

REGULATION & LICENSING
RECEIVED
02 MAY 20 AM 9:15

# Department of Regulation & Licensing

State of Wisconsin
(608) 266-2811
TTY# (608) 267-2416 ]- hearing or speech
TRS# 1-800-947-3529 ] impaired only

P.O. Box 8935, Madison, WI 53708-8935
E-Mail: dorl@drl.state.wi.us
Website: http://www.drl.state.wi.us/
FAX #: (608) 261-7083

## MEDICAL EXAMINING BOARD

HOSPITAL VERIFICATION - PRIVILEGES, EMPLOYMENT OR APPOINTMENT

Information requested is required for processing.

***IMPORTANT:*** *PLEASE FORWARD THIS FORM TO ALL HOSPITALS THAT YOU HAVE HAD STAFF PRIVILEGES DURING THE LAST 5 YEARS (This form may be photocopied).*

The **State of Wisconsin** requests that you complete this form concerning the following individual:

PHYSICIAN'S NAME: Caryn Dutton-Bean MD

HOSPITAL/FACILITY: Queen of Angels - Hollywood Presbyterian Medical Center

HOSPITAL/FACILITY ADDRESS: 1300 N. Vermont Avenue
Los Angeles CA 90027

HOSPITAL/FACILITY TELEPHONE: (213) 413 3000

1. What position did this physician hold at your facility? Obstetrician Gynecologist

2. What were this physician's dates of employment or staff privileges at your facility? 7/1/01 to present

| | | YES | NO |
|---|---|---|---|
| 3. | Was the physician placed on probation, suspended or in any way sanctioned/disciplined while at your facility? If yes, please attach explanation on a separate sheet. | ☐ | ☑ |
| 4. | Was this physician granted a leave of absence while employed at your facility? If yes, please attach explanation on a separate sheet. | ☐ | ☑ |
| 5. | Did this individual have a record of unexcused absences during his/her attendance at this facility? | ☐ | ☑ |
| 6. | Were any restrictions or special requirements placed on this physician's activities that were not placed on all other employees/staff holding similar positions? If yes, please attach explanation on a separate sheet. | ☐ | ☑ |
| 7. | Were any restrictions placed on this physician's privileges? If yes, please attach explanation on a separate sheet. | ☐ | ☑ |
| 8. | Were any formal patient or staff complaints filed against this physician? If yes, please attach explanation on a separate sheet. | ☐ | ☑ |
| 9. | Were any incident reports filed involving the professional conduct or behavior of this physician? If yes, please attach explanation on a separate sheet. | ☐ | ☑ |

# State of Wisconsin Department of Regulation & Licensing

| | | YES | NO |
|---|---|---|---|
| 10. | Was this physician ever subject to non-routine monitoring while at your facility? If yes, please attach explanation on a separate sheet. | ☐ | ☑ |
| 11. | Was this physician involuntarily removed from a call schedule for cause? If yes, please attach explanation on a separate sheet. | ☐ | ☑ |
| 12. | Was this physician subject to non-routine quality assessment review? If yes, please attach explanation on a separate sheet. | ☐ | ☑ |
| 13. | Was this physician the subject of a negative review by a quality assurance or departmental committee? If yes, please attach explanation on a separate sheet. | ☐ | ☑ |

Name and Title of Certifying Official

5/15/02
Date

**SEAL OF HOSPITAL**
(If hospital does not have a seal, a letter attesting to this fact, on hospital stationery, must accompany this certificate)

**Please return directly to:**

Department of Regulation and Licensing
Medical Examining Board
1400 East Washington Avenue
P.O. Box 8935
Madison, WI 53708-8935

Queen of Angels -
Hollywood Presbyterian
Medical Center
Tenet HealthSystem

1300 North Vermont Avenue
Los Angeles, CA 90027
Tel 213.413.3000

Medical Staff
Tel 323.913.4831
Fax 323.953.6338

May 15, 2002

Department of Regulation and Licensing
Medical Examining Board
1400 East Washington Avenue
P.O. Box 8935
Madison, WI 53708-8935

Dear Sir/Madam:

This is to notify you that the Tenet Health Systems do not have a hospital seal. If you have any questions, please contact the Medical Staff Office at (323) 913-4831.

Thank you,

Mary Scott
Credentials Coordinator
Medical Staff Services

# American Medical Association

**Physicians dedicated to the health of America**

**Division of Survey and Data Resources**
**515 North State Street**
**Chicago, Illinois 60610**
**http://www.ama-assn.org/amaprofiles**

## AMA Physician Profile

*Name and Mailing Address:*

CARYN RUTH DUTTON MD
465 S MADISON AVE APT 119
PASADENA CA 91101-3309

*Primary Office Address:*

SAME AS MAILING ADDRESS

**Phone:** UNKNOWN

**Birthdate:** 03/31/1970
**Birthplace:** WASHINGTON, DC UNITED STATES OF AMERICA

**Physician's Major Professional Activity:** NOT CLASSIFIED

**Practice Specialties Self Designated by the Physician:**

**Primary Specialty:** OBSTETRIC & GYNECOLOGY
**Secondary Specialty:** UNSPECIFIED

**AMA membership:** NON MEMBER

**Following Data Provided by the Primary Sources**

**Medical School:**

UNIV OF CT SCH OF MED, FARMINGTON CT 06032 (VERIFIED)

**Reported Year of Graduation:** 1996 (VERIFIED)

**Current and/or Prior Medical Training Programs Accredited by the Accreditation Council for Graduate Medical Education (ACGME):**

**Institution:** KAISER PERMANENTE MED GRP — **State:** CALIFORNIA
**Specialty :** OBSTETRIC & GYNECOLOGY — 06/1996 - 06/2000 (VERIFIED)

**Note:** **Additional information, used for appointments and privileges, is not solicited, nor is it received from the residency program director(s). If additional information is required, please contact the program director(s).**

**National Board of Medical Examiners (NBME) Certification Year:** NONE REPORTED TO DATE

# American Medical Association

**Physicians dedicated to the health of America**

**Division of Survey and Data Resources**
**515 North State Street**
**Chicago, Illinois 60610**
**http://www.ama-assn.org/amaprofiles**

## AMA Physician Profile

| License(s): State | MD/ DO | Date Granted | Expiration Date | Status | License Type | Last Reported |
|---|---|---|---|---|---|---|
| CALIFORNIA | MD | 05/22/1998 | 03/31/2004 | ACTIVE | UNLIMITED | 04/12/2002 |

**Note:** **When the specific month and day are unknown, the date will display the default value of "01." Not all licensing boards maintain or provide full date values. Please contact the appropriate licensing board directly for this information.**

**ECFMG Certfication:**

**Applicant Number:**

**Note:** **The Educational Commission for Foreign Medical Graduates (ECFMG) applicant identification number does not imply current ECFMG certification status. To verify ECFMG status, contact the ECFMG Certification Verification Service in writing at P.O. Box 13679, Philadelphia, PA 19101.**

**Federal Drug Enforcement Administration:**

FEDERAL DEA REGISTRATION INFORMATION WAS LAST REPORTED TO THE AMA ON 03/08/2002.
DEA REGISTRATION IS VALID THROUGH 06/30/2004.

**Note:** **Many states require their own controlled substances registration/license.**
**Please check with your state licensing authority as the AMA does not maintain this information.**

**Specialty Board Certification(s):**

Specialty Board Certification(s) by one or more of the 24 boards recognized by the American Board of Medical Specialties (ABMS) and the American Medical Association (AMA) through the Liaison Committee on Specialty Boards, as reported by the ABMS:

**Certifying Board:** TO DATE, THERE HAVE BEEN NO BOARD CERTIFICATIONS REPORTED.

**Certificate:**

**Certificate Type:**

**Effective:** **Expiration:** **Last Reported:**

**Note:** **For certfication dates, a default value of "01" appears in the month field if data was not provided to AMA. Please contact the appropriate specialty board directly for this information.**

**Medicare/Medicaid Sanction(s):**

TO DATE, THERE HAVE BEEN NO SUCH SANCTIONS REPORTED TO THE AMA BY THE DEPARTMENT OF HEALTH AND HUMAN SERVICES.

**Other Federal Sanction(s):**

TO DATE, THERE HAVE BEEN NO FEDERAL SANCTIONS REPORTED TO THE AMA BY ANY BRANCH OF THE US MILITARY, THE VETERAN'S ADMINSTRATION OR THE US PUBLIC HEALTH SERVICE.

# American Medical Association

**Physicians dedicated to the health of America**

**Division of Survey and Data Resources**
**515 North State Street**
**Chicago, Illinois 60610**
**http://www.ama-assn.org/amaprofiles**

## AMA Physician Profile

**Additional Information:**

TO DATE, THERE IS NO ADDITIONAL INFORMATION FOR THIS PHYSICIAN ON FILE.

**The content of the AMA Physician Profile is intended to assist with credentialing. Appropriate use of the AMA Physician Masterfile data contained on this Profile by an organization would meet the primary source verification requirements of the Joint Commission on Accreditation of Healthcare Organizations (JCAHO) and the American Accreditation HealthCare Commission/URAC. The Physician Masterfile meets the National Committee for Quality Assurance (NCQA) standards for verification of medical education, residency training, board certification, DEA status, and Medicare/Medicaid sanctions.**

**If you note any discrepancies, please mark them on a copy of the profile and mail or fax to:**

**Division of Survey and Data Resources**
**Attn: Physician Profile Unit**
**515 N. State Street**
**Chicago, IL 60610**
**312 464-5199**
**312 464-5900 (fax)**

# Department of Regulation & Licensing

State of Wisconsin
(608) 266-2812
TTY# (608) 267-2416 ] hearing or speech
TRS# 1-800-947-3529 ] impaired only

P.O. Box 8935, Madison, WI 53708-8935
E-Mail: dorl@drl.state.wi.us
Website: http://www.drl.state.wi.us/
FAX #: (608) 261-7083

## MEDICAL EXAMINING BOARD

## DISCIPLINARY INQUIRIES

Information requested is required for processing.

**APPLICANT MUST COMPLETE THIS FORM AND FORWARD TO THE FEDERATION OF STATE MEDICAL BOARDS AT THIS ADDRESS:**

FEDERATION OF STATE MEDICAL BOARDS
400 FULLER WISER RD.
EULESS, TX 76039-3855
Web-Site: www.fsmb.org

C Dutton — 5/13/02

APPLICANT'S SIGNATURE — DATE

**PLEASE PRINT**

Dutton — Caryn — RUTH — M.D.

NAME: (Last, First, Middle) — Degree

465 S. Madison Ave, Apt. 119

ADDRESS

Pasadena CA 91101

CITY, STATE AND ZIP

70/03/31 — [redacted]

DATE OF BIRTH: yy/mm/dd — SOCIAL SECURITY NUMBER

~~May 1996~~ University of Connecticut School of Medicine Farmington, CT

MEDICAL SCHOOL OF GRADUATION AND BRANCH LOCATION

May 1996 — USA

DATE OF GRADUATION — COUNTRY OF MEDICAL SCHOOL

ECFMG NUMBER (If foreign medical graduate)

## FEDERATION OF STATE MEDICAL BOARDS

The **State of Wisconsin** requests a disciplinary search concerning the above individual. **Please mail the response to the following address:**

Department of Regulation and Licensing
Medical Examining Board
1400 East Washington Avenue
P.O. Box 8935
Madison, WI 53708-8935

WE HAVE NO UNFAVORABLE INFORMATION REGARDING THE ABOVE NAMED PHYSICIAN

MAY 2 0 2002

Dale L. Austin
DALE L. AUSTIN
DEPUTY EXECUTIVE VICE PRESIDENT AND CHIEF OPERATING OFFICER

#1445 (Rev. 10/00)
Ch. 448, Stats.

**National Practitioner Data Bank**
**Healthcare Integrity and Protection Data Bank**

P.O. Box 10832
Chantilly, VA 20153-0832

**www.npdb-hipdb.com**



# RESPONSE TO INFORMATION DISCLOSURE REQUEST

## A. REQUESTOR IDENTIFICATION

Requestor Name: DUTTON BEAN, CARYN RUTH
Telephone: (626)577-7346
Address: USC KECK SCHOOL OF MEDICINE
465 SOUTH MADISON AVENUE, APT. 119
City, State, ZIP: PASADENA, CA 91101
Country:

## B. PAYMENT INFORMATION

Account Number: XXXXXXXXXXXX7573
Expiration Date: 10/2003
Transaction Date: 05/10/2002
Transaction Number: 5500000025577731
**Total Charge:** **$ 10.00**

## C. SUBJECT ON WHOM DISCLOSURE IS REQUESTED

Subject Name: DUTTON BEAN, CARYN RUTH
Gender: FEMALE
Date of Birth: 03/31/1970
Other Name(s) Used: DUTTON, CARYN RUTH
Organization Name: USC KECK SCHOOL OF MEDICINE
Organization Type: OTHER TYPE NOT CLASSIFIED - SPECIFY (999)
Organization Type Description: MEDICAL SCHOOL
Home or Work Address: 465 SOUTH MADISON AVENUE, APT. 119
City, State, ZIP: PASADENA, CA 91101
Country:
Social Security Numbers (SSN): 230-94-8687
Professional School(s) & Year (s) of Graduation: UNIVERSITY OF CONNECTICUT SCHOOL OF MEDI 1996
Occupation/Field of Licensure (Code): PHYSICIAN (MD) (010)
State License Numbers, State of Licensure: A65255, CA
Other, as Specified:
Physician Specialty: OBSTETRICS & GYNECOLOGY (50)
Drug Enforcement Administration (DEA) Numbers: BD6205909
National Provider Identifiers (NPI):
Federal Employer Identification Numbers (FEIN):

**CONFIDENTIAL DOCUMENT – FOR AUTHORIZED USE ONLY**

**National Practitioner Data Bank**
**Healthcare Integrity and Protection Data Bank**

P.O. Box 10832
Chantilly, VA 20153-0832

**www.npdb-hipdb.com**

**DCN:** 5500000025577731
Process Date: 05/10/2002


Unique Physician Identification Numbers (UPIN):

**D. SEARCH RESULT**

Based on the subject identification information provided by you in Section C above, a search of the NPDB has located the following 0 report(s).

Recipients should verify that the subject identified in Section C is, in fact, the subject of interest.

Copies of these reports are enclosed for restricted/limited use as prescribed by Title IV of Public Law 99-660, as amended. Recipients should verify that the subject identified in Section B of the report(s) is, in fact, the subject of interest. Information from the NPDB is confidential and must be used solely for the purpose for which it was disclosed. ANY PERSON WHO VIOLATES THE CONFIDENTIALITY PROVISIONS AS SPECIFIED IN TITLE IV IS SUBJECT TO A CIVIL MONEY PENALTY OF UP TO $11,000 FOR EACH VIOLATION. Subjects of reports who obtain information about themselves from the NPDB are permitted to share that information with anyone they choose.

**National Practitioner Data Bank**
**Healthcare Integrity and Protection Data Bank**
P.O. Box 10832
Chantilly, VA 20153-0832

**www.npdb-hipdb.com**

DCN: 5500000025577731
Process Date: 05/10/2002
Page: 1 of 1

**To:** DUTTON BEAN, CARYN RUTH
USC KECK SCHOOL OF MEDICINE
465 SOUTH MADISON AVENUE, APT. 119

PASADENA, CA 91101

**From:** **The National Practitioner Data Bank**

**Re:** **Response to Your Request for Information Disclosure (Self-Query)**

The enclosed information is released by the National Practitioner Data Bank (NPDB) for restricted use under the provisions of Title IV of Public Law 99-660, the Health Care Quality Improvement Act of 1986, as amended.

Title IV established the NPDB as an information clearinghouse to collect and release certain information related to malpractice payment history and professional competence or conduct of physicians, dentists, and other licensed health care practitioners. Regulations governing the NPDB are codified at 45 CFR part 60. Responsibility for operating the NPDB resides with the Secretary of the U.S. Department of Health and Human Services (HHS), HRSA, Division of Practitioner Data Banks.

Reports from the NPDB contain limited summary information and should be used in conjunction with information from other sources in granting clinical privileges, or in making employment affiliation or licensure decisions. The NPDB is a flagging system, and a report may be included for a variety of reasons that do not necessarily reflect adversely on the professional competence or conduct of the subject named in the report.

All information received from the NPDB is considered confidential and must be used solely for the purpose for which it was disclosed. ANY PERSON WHO VIOLATES THE CONFIDENTIALITY PROVISIONS AS SPECIFIED IN TITLE IV OF PUBLIC LAW 99-660, AS AMENDED, IS SUBJECT TO A CIVIL MONEY PENALTY OF UP TO $11,000 FOR EACH VIOLATION. Subjects of reports who obtain information about themselves from the NPDB are permitted to share that information with anyone they choose.

If you require additional assistance, visit the NPDB-HIPDB web site (www.npdb-hipdb.com) or contact the NPDB-HIPDB Customer Service Center at 1-800-767-6732 (TDD: 1-703-802-9395). Information Specialists are available to speak with you weekdays from 8:30 a.m. to 6:00 p.m. (5:30 p.m. on Fridays) Eastern Time. The NPDB-HIPDB Customer Service Center is closed on all Federal holidays.

**National Practitioner Data Bank**
**Healthcare Integrity and Protection Data Bank**

P.O. Box 10832
Chantilly, VA 20153-0832

**www.npdb-hipdb.com**



# RESPONSE TO INFORMATION DISCLOSURE REQUEST

## A. REQUESTOR IDENTIFICATION

Requestor Name: DUTTON BEAN, CARYN RUTH
Telephone: (626)577-7346
Address: USC KECK SCHOOL OF MEDICINE
465 SOUTH MADISON AVENUE, APT. 119
City, State, ZIP: PASADENA, CA 91101
Country:

## B. PAYMENT INFORMATION

Account Number: XXXXXXXXXXXX7573
Expiration Date: 10/2003
Transaction Date: 05/10/2002
Transaction Number: 5500000025577731
**Total Charge:** $ 10.00

## C. SUBJECT ON WHOM DISCLOSURE IS REQUESTED

Subject Name: DUTTON BEAN, CARYN RUTH
Gender: FEMALE
Date of Birth: 03/31/1970
Other Name(s) Used: DUTTON, CARYN RUTH
Organization Name: USC KECK SCHOOL OF MEDICINE
Organization Type: OTHER TYPE NOT CLASSIFIED - SPECIFY (999)
Organization Type Description: MEDICAL SCHOOL
Home or Work Address: 465 SOUTH MADISON AVENUE, APT. 119
City, State, ZIP: PASADENA, CA 91101
Country:
Social Security Numbers (SSN): 230-94-8687
Professional School(s) & Year (s) of Graduation: UNIVERSITY OF CONNECTICUT SCHOOL OF MEDI 1996
Occupation/Field of Licensure (Code): PHYSICIAN (MD) (010)
State License Numbers, State of Licensure: A65255, CA
Other, as Specified:
Physician Specialty: OBSTETRICS & GYNECOLOGY (50)
Drug Enforcement Administration (DEA) Numbers: BD6205909
National Provider Identifiers (NPI):
Federal Employer Identification Numbers (FEIN):

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**National Practitioner Data Bank**
**Healthcare Integrity and Protection Data Bank**

P.O. Box 10832
Chantilly, VA 20153-0832

**www.npdb-hipdb.com**

**DCN:** 5500000025577731
Process Date: 05/10/2002


Unique Physician Identification Numbers (UPIN):

**D. SEARCH RESULT**

Based on the subject identification information provided by you in Section C above, a search of the HIPDB has located the following 0 report(s).

Recipients should verify that the subject identified in Section C is, in fact, the subject of interest.

Copies of these reports are enclosed for restricted/limited use as prescribed by Section 1128E of the Social Security Act. Recipients should verify that the subject identified in Section B of the report(s) is, in fact, the subject of interest. Information from the HIPDB is confidential and must be used solely for the purpose for which it was disclosed. Subjects of reports who obtain information about themselves from the HIPDB are permitted to share that information with anyone they choose.

**National Practitioner Data Bank**
**Healthcare Integrity and Protection Data Bank**
P.O. Box 10832
Chantilly, VA 20153-0832

**www.npdb-hipdb.com**

**DCN: 5500000025577731**
Process Date: 05/10/2002
Page: 1 of 1

**To:** DUTTON BEAN, CARYN RUTH
USC KECK SCHOOL OF MEDICINE
465 SOUTH MADISON AVENUE, APT. 119

PASADENA, CA 91101

**From:** **The Healthcare Integrity and Protection Data Bank**

**Re:** **Response to Your Request for Information Disclosure (Self-Query)**

Section 1128E was established by Section 221(a) of Public Law 104-191, the Health Insurance Portability and Accountability Act of 1996, as amended. The statute established the HIPDB to combat fraud and abuse in health insurance and health care delivery and to improve the quality of patient care. The HIPDB serves as a source of final adverse action information on health care practitioners, providers, and suppliers; collecting and releasing information related to adverse licensure actions; health care-related convictions and judgments; exclusions from Federal and State health care programs; and other adjudicated actions or decisions. Responsibility for operating the HIPDB resides with the Secretary of the U.S. Department of Health and Human Services (HHS), Office of Inspector General, and HRSA, Division of Practitioner Data Banks. Regulations governing the HIPDB are codified at 45 CFR Part 61.

Reports from the HIPDB contain limited summary information and should be used in conjunction with information from other sources in granting clinical privileges or making employment affiliation, contracting, or licensure decisions. The HIPDB is a flagging system and a report may be included for a variety of reasons that do not necessarily reflect adversely on the professional competence or conduct of the subject named in the report.

All information received from the HIPDB is considered confidential and must be used solely for the purpose for which it was disclosed. Subjects of reports who obtain information about themselves from the HIPDB are permitted to share that information with anyone they choose.

If you require additional assistance, visit the NPDB-HIPDB web site (www.npdb-hipdb.com) or contact the NPDB-HIPDB Customer Service Center at 1-800-767-6732 (TDD: 1-703-802-9395). Information Specialists are available to speak with you weekdays from 8:30 a.m. to 6:00 p.m. (5:30 p.m. on Fridays) Eastern Time. The NPDB-HIPDB Customer Service Center is closed on all Federal holidays.

# Department of Regulation & Licensing

**State of Wisconsin**
**(608) 266-2812**
TTY# (608) 267-2416 } hearing or speech
TRS# 1-800-947-3529 } impaired only

P.O. Box 8935, Madison, WI 53708-8935
E-Mail: dorl@drl.state.wi.us
Website: http://www.drl.state.wi.us/
FAX #: (608) 261-7083

**MEDICAL EXAMINING BOARD**
BOTH FORMS MUST BE SIGNED AND NOTARIZED IN BOTH SPACES PROVIDED

**AUTHORIZATION AND WAIVER**
Information requested is required for processing.

I, Caryn Dutton born at Washington DC on 3/31/70, having filed an application for a license to practice medicine and surgery in the State of Wisconsin, hereby authorize and consent to have an investigation made as to my professional reputation and fitness for the practice of medicine and surgery. I agree to give any further information which may be required in reference to my past record. I understand that I may inspect and copy any reports received by the Board relating to my professional reputation and fitness for the practice of medicine and surgery and that I may submit evidence including documents which tend to mitigate or explain any adverse information received from other parties. I also understand that the contents of my report will be privileged as to all other persons unless determined otherwise by court order.

I also authorize and request every person, hospital, clinic, community, governmental agency, court, association or institution having control of any documents, records and other information pertaining to me, to furnish to the Wisconsin Medical Examining Board any such information, including documents, records regarding charges or complaints filed against me, formal or informal, pending or closed, or any of its pertinent data and to permit the Wisconsin Medical Examining Board or any of its agents or representatives to inspect and make copies of such documents, records and other information.

I hereby release, discharge, exonerate the Wisconsin Medical Examining Board, its agents and representatives, and any person so furnishing information from any and all liability of every nature and kind arising out of the furnishing or inspection of such documents, records and other information or the investigation made by the Wisconsin Medical Examining Board.

ANA B. MACK
Commission # 1190206
Notary Public - California
Los Angeles County
My Comm. Expires Jul 16, 2002

Subscribed and sworn to before me this 14th day of May, 19 2002.

Caryn Dutton
Signature of Applicant

Ana B. Mack
NOTARY PUBLIC

**AUTHORIZATION AND WAIVER**

I, Caryn Dutton born at Washington DC on 3/31/70, having filed an application for a license to practice medicine and surgery in the State of Wisconsin, hereby authorize and consent to have an investigation made as to my professional reputation and fitness for the practice of medicine and surgery. I agree to give any further information which may be required in reference to my past record. I understand that I may inspect and copy any reports received by the Board relating to my professional reputation and fitness for the practice of medicine and surgery and that I may submit evidence including documents which tend to mitigate or explain any adverse information received from other parties. I also understand that the contents of my report will be privileged as to all other persons unless determined otherwise by court order.

I also authorize and request every person, hospital, clinic, community, governmental agency, court, association or institution having control of any documents, records and other information pertaining to me, to furnish to the Wisconsin Medical Examining Board any such information, including documents, records regarding charges or complaints filed against me, formal or informal, pending or closed, or any of its pertinent data and to permit the Wisconsin Medical Examining Board or any of its agents or representatives to inspect and make copies of such documents, records and other information.

I hereby release, discharge, exonerate the Wisconsin Medical Examining Board, its agents and representatives, and any person so furnishing information from any and all liability of every nature and kind arising out of the furnishing or inspection of such documents, records and other information or the investigation made by the Wisconsin Medical Examining Board.

Subscribed and sworn to before me this 14th day of May, 19 2002.

ANA B. MACK
Commission # 1190206
Notary Public - California
Los Angeles County
My Comm. Expires Jul 16, 2002

Caryn Dutton
Signature of Applicant

Ana B. Mack
NOTARY PUBLIC

#571 (Rev. 10/00)
Ch. 448, Stats.

**Credential Holder**
Enter renewal information and click Save.

Info Center

Credential | Xref | Insurance | Firearms | Details | Certs | Holds | History | Notes « < Cred: 1 of 1 > »

**Name:** Dutton, Caryn MD

**Renewal Due:** 10/31/2011

**Profession:** Medicine and Surgery

**Credential #:**44747-20

Add Payment/Refund

**Payments/Refunds**

| | Year | Batch Date | Code | Batch Type | Batch# | Batch Location | Amt. Paid | Actions |
|---|---|---|---|---|---|---|---|---|
| * | 2009 | 10/19/2009 | P | E | 0 | 234 | 141 | |
| * | 2007 | 09/10/2007 | P | E | 0 | 82 | 106 | |
| | 2005 | 10/14/2005 | P | B | 16 | 291 | 106 | |
| | 2003 | 09/24/2003 | P | B | 91 | 1750 | 106 | |



2009 + 2007 were renewed online so there is no paper copy

2005 paper copy is attached

**Credential Expanded Details**
View expanded details on the credential holder. Click the Return link when finished.

**Info Center**

**Cred. Holder:** Dutton, Caryn
**Profession:** 44747-20 (Medicine and Surgery)

**Print Activity List**

| Requested Date | Print Activity | Printed | Printed Date | Renewal Year |
|---|---|---|---|---|
| 7/15/2010 | CERT | Yes | 7/15/2010 | 0 |
| 4/23/2008 | HEALTHCHK | Yes | 4/2/2010 | 0 |
| 9/12/2007 | HEALTHCHK | Yes | 4/2/2010 | 0 |
| 2/4/2008 | HEALTHCHK | Yes | 4/2/2010 | 0 |
| 3/26/2008 | HEALTHCHK | Yes | 4/2/2010 | 0 |

1 2

**PIN Number**
**PIN: DXXJJW DOB: 03/31/1970 SSN: 8687**

**Renewal Requirements List**

| Code | Renewal Year | Complied | Complied Date | Printed | Printed Date | Insert Date | Comments |
|---|---|---|---|---|---|---|---|
| FEE | 2009 | Met | 10/19/2009 | No | | 09/02/2009 | Met thru online renewal |
| SIG | 2009 | Met | 10/19/2009 | No | | 09/02/2009 | Met thru online renewal |
| CLS | 2009 | Met | 10/19/2009 | No | | 09/02/2009 | Met thru online renewal |
| SIG | 2007 | Met | 09/10/2007 | No | | 09/07/2007 | Met thru online renewal |
| FEE | 2007 | Met | 09/10/2007 | No | | 09/07/2007 | Met thru online renewal |
| SIG | 2005 | Met | 10/28/2005 | No | **10/18/2005** | 09/04/2007 | |
| FEE | 2005 | Met | 10/31/2005 | No | | 09/04/2007 | Added FEE for conversion |
| SIG | 2003 | Met | 09/24/2003 | No | | 09/04/2007 | |
| FEE | 2003 | Met | 09/26/2003 | No | | 09/04/2007 | Added FEE for conversion |

2009
2007

Return

**State of Wisconsin**
**DEPARTMENT OF REGULATION AND LICENSING**
**MEDICINE AND SURGERY**

DUE DATE 10/31/2005 | AMOUNT DUE 106.00
If late, add $25.00

Credential No. | Status
0044747-020 ACTIVE PIN: DXXJJW
SPECIALTY: OBSTETRICS AND GYNECOLOGY

Amt Pd. $ 106.00

Payment by Credit Card: ☐ VISA ☐ MASTERCARD ☐ AMEX ☐ DISCOVER Exp. Date _____

☐☐☐☐☐☐☐☐☐☐☐☐☐☐☐☐ Signature _____

PLEASE PRINT NAME/ADDRESS CHANGES IN SPACE BELOW

☒ PLEASE DO NOT DISCLOSE MY NAME /ADDRESS ON LISTS

STATE OF WISCONSIN
DEPARTMENT OF REGULATION AND LICENSING
PO BOX 2974
MILWAUKEE WI 53201-2974

CARYN R DUTTON MD
5249 E TERRACE DR STE 9952
MADISON WI 53718

DO NOT WRITE BELOW THIS POINT

02000447470001060000131000

TO AVOID A LATE PENALTY FEE, YOUR RENEWAL APPLICATION AND FEE MUST ACTUALLY BE RECEIVED BY THE DEPARTMENT ON OR BEFORE THE DUE DATE. THE DATE OF MAILING, AS INDICATED BY A POSTMARK, IS NOT EVIDENCE OF RECEIPT.

FULL PAYMENT INCLUDING ANY PENALTY FEES THAT MAY APPLY MUST BE RECEIVED BY THE DEPARTMENT BEFORE YOUR LICENSE WILL BE ISSUED. IF YOU DO NOT APPLY FOR RENEWAL BY THE RENEWAL DEADLINE, YOUR LICENSE WILL EXPIRE AND YOU MAY NO LONGER PRACTICE.

0000291 0044 07 000016 0003 101405 REGS & LICENSING 610

**PLEASE COMPLETE THE FOLLOWING INFORMATION WHICH IS REQUIRED IN ORDER TO RENEW YOUR LICENSE:**

**I have or will have completed *30 hours of AMA or AOA Category 1 continuing education beginning January 1, 2004 and ending December 31, 2005, and I have or will have evidence of this which I will furnish to the Medical Examining Board upon request.**

Date: _____ Signature: _____

***Three months of approved post-graduate training is equivalent to 30 hours of Category 1 credits.**

☐ **Please check here if you are willing to serve as an expert witness in disciplinary proceedings.**

MAKING A FALSE STATEMENT IN CONNECTION WITH ANY APPLICATION FOR CREDENTIAL IS GROUNDS FOR REVOCATION OR DENIAL.

# State of Wisconsin
# DEPARTMENT OF REGULATION AND LICENSING

DUE WITHIN 15 DAYS OF RECEIPT

## MEDICINE AND SURGERY

| Credential No. | Status |
|---|---|
| 44747-020 | ACTIVE |

PLEASE PRINT NAME/ADDRESS CHANGES IN SPACE BELOW

CARYN R DUTTON MD
5249 E TERRACE DR
MADISON WI 53718

STATE OF WISCONSIN
DEPARTMENT OF REGULATION AND LICENSING
PO BOX 8935
MADISON WI 53708

**PLEASE COMPLETE THE FOLLOWING INFORMATION WHICH IS REQUIRED IN ORDER TO RENEW YOUR LICENSE:**

**I have or will have completed *30 hours of AMA or AOA Category 1 continuing education beginning January 1, 2004 and ending December 31, 2005, and I have or will have evidence of this which I will furnish to the Medical Examining Board upon request.**

**Date:** 10/26/05 **Signature:** C Dutton

***Three months of approved post-graduate training is equivalent to 30 hours of Category 1 credits.**

☐ **Please check here if you are willing to serve as an expert witness in disciplinary proceedings.**

**MAKING A FALSE STATEMENT IN CONNECTION WITH ANY APPLICATION FOR CREDENTIAL IS GROUNDS FOR REVOCATION OR DENIAL.**