TEL. (603) 271-1203

State of New Hampshire

BOARD OF REGISTRATION IN MEDICINE

2 INDUSTRIAL PARK DRIVE SUITE 8
CONCORD, NH 03301-8520

TDD Access: Relay NH 1-800-735-2964

July 5, 1995

PAUL D HANISSIAN MD
[redacted]

Dear Dr. Hanissian:

This is to certify that you have been granted licensure to practice medicine in the State of New Hampshire. Your license number 9485 is dated July 5, 1995.

As soon as your engrossed certificate is received in this office, which should take approximately one year, it will be forwarded to you. Until such time, this letter is your full authorization for the privilege of practicing medicine in this state.

Please keep this office informed of any change in home or office address.

Sincerely,

Karen laCroix
Administrator

KL/dg
Enc.

Spec: OBG

State of New Hampshire

BOARD OF REGISTRATION IN MEDICINE

2 INDUSTRIAL PARK DRIVE SUITE 8
CONCORD, NH 03301-8520

TEL. (603) 271-1203

TDD Access: Relay NH 1-800-735-2964

Application No. 10357

I hereby apply for a license to practice medicine in the State of New Hampshire as a Doctor of Medicine or as a Doctor of Osteopathy and submit the following proofs, as required by the rules and regulations, formulated in accordance with the laws of the State of New Hampshire, and enclosed a certified check or postal or express money order for the application fee of $250.00, check made payable to the "Treasurer, State of New Hampshire" - U.S. Funds only. Application fees are non-refundable.

1. PERSONAL INFORMATION:

Name Paul (First) David (Middle) Nanissian (Last) _____ (Maiden)

Home Address [redacted]

[redacted]

Office Address 22 Bramhall St.

Portland, ME 04102

Date of Birth [redacted] Place of Birth [redacted]

Social Security Number [redacted]

2. ACADEMIC EDUCATION:

Name and Location of Institutions	Dates Attended	Degree Awarded
Colgate University	8/83 - 5/87	AB Physics
UMDNJ - RWJ Medical School	8/87 - 5/91	M.D.

3. MEDICAL EDUCATION:

Name and Location of Institutions	Dates Attended	Degree Awarded
UMDNJ-RWJ Medical School (Piscataway, NJ)	8/87 - 5/91	M.D.
Main Medical Center (Portland, ME)	7/91 - 6/95	Residency

5. FOREIGN MEDICAL GRADUATES.

(a) Foreign graduates must submit a transcript of grades and proof of graduation from medical school. Certified copies of these documents with certified english translation is required.

(b) Foreign medical graduates must also submit original verification directly from ECFMG documenting that the applicant currently holds standard certification by ECFMG.

6. POST GRADUATE EDUCATION.

(a) Internship

Maine Medical Center	Portland, ME	7/91 - 6/92
Program	Location	Dates

(b) Residency

Maine Medical Center	Portland ME	7/92 - 6/95
Program	Location	Dates

NH Requires at least 2 years of post graduate training. An official, original letter from the residency program verifying internship and/or residency is required.

7. EXAMINATION:

National Board	[redacted]	[redacted]
Name of Examination	Date of Completion	Score

A National Board or FLEX score report form is enclosed. Please have an official transcript of your scores sent directly to the Board. If examination is by USMLE, LMCC or state examination, you must contact these organizations and have an official transcript of your scores sent directly to the Board.

8. LICENSURE:

Please list all states where you hold or have ever held a physician's license.

Maine (Temporary)

Maine (Permanent in Process)

You must obtain a verification from all states where you hold, or have ever held a license. Verifications must be received directly from the licensing authority. A form is enclosed for your convenience. Please make copies as necessary.

9. Are you certified by an American Specialty Board? _____YES ______NO

If yes, please provide a notarized photocopy of such certification.

	Yes	No
10. Have you ever, for any reason, lost American Specialty Board Certification?	___	______
11. Have you been denied required recertification by any specialty boards? If yes, list each such boards and dates denied._____ _____	___	______
12. Has any medical malpractice claim been made against you in the last ten years (whether or not a lawsuit was filed in relation to the claim)? If so, how many?_____	___	______
13. Have you ever applied for licensure or to sit for an examination, or taken an examination, under a different name?	___	______
14. Have you ever been denied the privilege of taking or finishing an examination or been accused of cheating or improper conduct during an examination since you graduated from high school?	___	______
15. Have you ever failed any of the following examinations: the USMLE, the FLEX examination, any state board examination or have you ever failed to gain certification from the National Board of Medical Examiners?	___	______
16. Have you ever failed a foreign licensing or certification examination?	___	______
17. Have you ever been denied a medical license, whether full, limited or temporary, for any reason?	___	______
18. Have you ever had staff privileges, employment or appointment in a hospital or other health care institution denied, limited, suspended or revoked, or have you ever resigned from a medical staff in lieu of disciplinary action?	___	______

	Yes	No
19. Is any investigation or disciplinary action pending, or has any investigation or disciplinary action been taken against you in the last ten years by any governmental authority, by any hospital or health care facility, or by any professional medical association (international, national, state or local)?	___	\ ___
20. Have you ever voluntarily surrendered a license to practice medicine or any healing art or allowed such a license to lapse in lieu of facing disciplinary investigation or action?	___	\ ___
21. Have you ever withdrawn an application for medical licensure, hospital privileges or appointment, for any reason?	___	\ ___
22. Have you ever been a defendant in a criminal proceeding including driving while under the influence or driving while suspended, but not including traffic offenses not classified as misdemeanors?	___	\ ___
23. Has your privilege to possess, dispense or prescribe controlled substances ever been suspended, revoked, denied, restricted or surrendered, or have you ever been charged, investigated or warned by a state or federal agency based on controlled substance issues?	___	\ ___
24. Have you ever had any emotional disturbance or mental illness which has impaired or would be likely to impair your ability to practice medicine?	___	\ ___
25. Are you now, or have you, during the past 5 years, been dependent upon alcohol or habituating drugs?	___	\ ___

NOTE ON QUESTIONS 23-25: The harm that befalls physicians and patients alike when impairment goes undetected and untreated by the medical profession is devastating. The Board wants impaired physicians treated in the early stages of impairment before irreparable harm to the physician or patient occurs.

If you have answered "yes" to any of the above, please explain on the reverse side. Attach additional 8 1/2" x 11" sheets if necessary.

26. A current curriculum vitae is required.

27. An official certified copy of your birth certificate is required.

28. Applicants must provide proof of commitment to practice medicine in N.H. An original, signed letter on letterhead must be submitted from a N.H. hospital/health care facility or private practice where applicant will be practicing.

29. A total of 4 reference letters are required. Letters of reference shall be provided by the following individuals:

[redacted]

[redacted]

[redacted]

[redacted]

30. **AFFIDAVIT OF THE APPLICANT:**

STATE OF Maine

COUNTY OF [redacted]

I, Paul Hamisian of [redacted]

being duly sworn say that I am the person referred to in the above application for a license to practice medicine as a Doctor of Medicine or Doctor of Osteopathy in the state of New Hampshire; that I have studied the treatment of human ailments not less than four school years, received a degree of Doctor of Medicine or Doctor of Osteopathy; and that all the statements herein respecting age, academic and medical education, internship, state or national board examination and license, good professional standing, and all other statements made on said application are true in every respect, and that no investigation or disciplinary action is pending or has been brought against me by any state, county or local medical society, hospital or health care facility or professional medical association, except as disclosed on this application.

Paul Hamisian, M.D., D.O.

Sworn to before me this 11th day of May, 1995

[SEAL]

Elizabeth Beecher Notary Public

ELIZABETH BEECHER
NOTARY PUBLIC, MAINE
MY COMMISSION EXPIRES APRIL 12, 1997

Paul Harrison
Signature of Applicant

****

THE STATE OF NEW HAMPSHIRE

BOARD OF REGISTRATION IN MEDICINE

(the following is to be filled out by the board)

Application received 5/15 1995

Fee paid 5/15 1995

Check Number 524

License Number 9485

Date of Issue 7/5/95

THIS MUST BE SENT TO THE SCHOOL FROM WHICH YOU GRADUATED

RECEIVED
MAY 17 1995
Board of
Registration & Medicine

4. Certificate of Medical Education:

It is hereby certified that Paul David Hanissian (Your Name) matriculated in UMDNJ-RWJ Medical School (Name of Institution) at Piscataway, NJ (Location of Institution) on 8/87 - 5/91 and received a diploma from this institution conferring the degree of Doctor of Medicine or Doctor of Osteopathy.

John Rogalski
President, Secretary or Dean
John Rogalski, Asst. Regis

SCHOOL SEAL

****

After completing, please return this form to the following address:

BOARD OF REGISTRATION IN MEDICINE
2 INDUSTRIAL PARK DRIVE
CONCORD, NEW HAMPSHIRE 03301

MAY 1995

Paul D. Hanissian

[redacted]

EDUCATION:

Maine Medical Center, Portland, ME, Residency training in Obstetrics and Gynecology, 1991-1995.
University of Medicine and Dentistry of New Jersey - Robert Wood Johnson Medical School - M.D., 1991.
Colgate University - A.B., Physics, May 1987.

HONORS & AWARDS

Armenian Student's Association Scholarship Recipient - 1984-1990.
Armenian General Benevolent Union Scholarship Recipient - 1990.
Salutatorian of Colgate University's Class of 1987.
Summa Cum Laude (undergraduate).
Member of Colgate's Eta Chapter of Phi Beta Kappa.
Charles Dana Foundation Scholar - 1984-1985, 1985-1986, 1986-1987.
Awarded the Kingsbury Prize in Physics - 1985.
Valedictorian of Memorial High School's Class of 1983, Cedar Grove, NJ.

CERTIFICATION:

NBME Part I, II, II
Temporary Maine State License

MEMBERSHIPS:

ACOG Junior Fellow
American Medical Association

RESEARCH:

Investigation of the effects that microwave radiation has on the surface resistance of superconductors under Joseph Amato, Ph.D. of physics at Colgate University - 1987.

Case report and retrospective study on the use of the McSwain Dart, a prehospital device for relief of hemo- or pneumothorax under Brent Amey, M.D. - 1986.

ADDITIONAL PROFESSIONAL ACTIVITIES:

A recent trip to Yerevan, Armenia, to work at Erebuni Hospital on the Obstetrics service, as part of a two year ongoing project to improve the state of women's reproductive health in Armenia.

EMPLOYMENT:

House Staff, Maine Medical Center, Dept. of Ob/Gyn, 1991-present.
Member of the technical staff at NASA-JPL (Jet Propulsion Laboratory) summers - 1987, 1988, 1989.
Research Assistant, State University of New York at Stony Brook Nuclear Structures Laboratory - summer 1986.

PERSONAL DATA

Outside interests include running, wood working, reading, hiking, kayaking, and travel.

MAINE MEDICAL CENTER

RO

June 16, 1995

Department of Registration in Medicine
2 Industrial Park Drive
Concord, NH 03301-8520

RE: Certification that Paul Hanissian will complete his residency program on June 30, 1995.

Dear Sir or Madam:

As Chairman of the Program of Obstetrics and Gynecology and Residency Program Director, I can certify that Dr. Paul Hanissian will have completed a residency program in obstetrics and gynecology here at Maine Medical Center. If I can be of any further assistance, please do not hesitate to get in touch with me.

I remain sincerely yours,

H.M. Tarraza

Hector M. Tarraza, M.D.
Interim Chief, Department of Obstetrics and Gynecology

HMT/lmb

f:hanissnh.ltr

JUN 2 0 1996

EXPIRES: 06/30/1997

PAUL D HANISSIAN MD
[redacted]

STATE OF NEW HAMPSHIRE

Board of Medicine

10357

Please check appropriate mailing address.

✓ Name in full Paul Hanissian

____ Place of employment Dartmouth Hitchcock Medical Center

Business Tel: 603 650 5000

____ Home Address [redacted]

Home Tel: [redacted]

MAY 0 6 1997

STATE OF NEW HAMPSHIRE

Board of Medicine

10357

EXPIRES: 6/30/98

PAUL D HANISSIAN, MD
DARTMOUTH-HITCHCOCK MED CTR
1 MEDICAL CENTER DR
LEBANON NH 03756-

Please check appropriate mailing address.

Name in full Paul Hanissian

✓ Place of employment DHMC

Business Tel: 603 650-7625

Home Address [redacted]

Home Tel: [redacted]

MAY 27 1998

STATE OF NEW HAMPSHIRE

Telephone #: 603-271-6934

BOARD OF MEDICINE
2 Industrial Park Drive, Suite 8
Concord, NH 03301-8520

RENEWAL APPLICATION

For expiration on: 6/30/1999

Renewal Fee: $100.00

If you do not wish to renew your license, check here. ☐

If you choose not to renew, your license will be placed on inactive status. To reactivate the license, you will be required to file a reinstatement application.

The following information represents the information on file for you with the Board of Medicine. Please make any necessary changes. Please note that pursuant to RSA 329:16-f, all licensees must inform the Board of any change in address within 30 days of the change.

Specialty: OBG * Board Certified: (Y/N) N

Please list ABMS Board Specialty: OB/GYN

Licensed in the states of: (2 letter state abbrev.)

ME

Please mark the box next to the address you would prefer to list as your mailing address.

License #: 9485

File #: 10357

☒ Work Address:

PAUL D HANISSIAN, MD
DARTMOUTH-HITCHCOCK MED
1 MEDICAL CENTER DR
LEBANON, NH 03756-

☐ Home Address:

[redacted]

Hospital Affiliations: **(If not a NH hospital, please list city and state where hospital is located.)**

DARTMOUTH-HITCHCOCK MED CTR ~~CENTER~~ THE CHESHIRE MEDICAL

(RENEWAL APPLICATION CONTINUED ON REVERSE SIDE)

STATE OF NEW HAMPSHIRE

Telephone #: 603-271-6934

BOARD OF MEDICINE
2 Industrial Park Drive, Suite 8
Concord, NH 03301-8520

RENEWAL APPLICATION

For expiration on: 6/30/2000

Renewal Fee: $100.00

If you do not wish to renew your license, check here. ☐

If you choose not to renew, your license will be placed on inactive status. To reactivate the license, you will be required to file a reinstatement application.

The following information represents the information on file for you with the Board of Medicine. Please make any necessary changes. Please note that pursuant to RSA 329:16-f, all licensees must inform the Board of any change in address within 30 days of the change.

Specialty: OBG

Board Certified: (Y/N) X (YES)

Please list ABMS Board Specialty: 06/64

Licensed in the states of: (2 letter state abbrev.)

ME

Please mark the box next to the address you would prefer to list as your mailing address.

License #: 9485 ☒

File #: 10357 ☐

PAUL D HANISSIAN, MD
DARTMOUTH-HITCHCOCK MED
1 MEDICAL CENTER DR
LEBANON, NH 03756-
Phone: 603*650-5000

[redacted]

[redacted]

Phone: [redacted]

Hospital Affiliations: **(If not a NH hospital, please list city and state where hospital is located.)**

DARTMOUTH-HITCHCOCK MED CTR CENTER

~~THE CHESHIRE MEDICAL~~ no longer affiliated

(RENEWAL APPLICATION CONTINUED ON REVERSE SIDE)

STATE OF NEW HAMPSHIRE

Telephone #: 603-271-6934

BOARD OF MEDICINE
2 Industrial Park Drive, Suite 8
Concord, NH 03301-8520

RENEWAL APPLICATION

For expiration on: 6/30/2001

Renewal Fee: $100.00

If you do not wish to renew your license, check here. ☐

If you choose not to renew, your license will be placed on inactive status. To reactivate the license, you will be required to file a reinstatement application.

The following information represents the information on file for you with the Board of Medicine. Please make any necessary changes. Please note that pursuant to RSA 329:16-f, all licensees must inform the Board of any change in address within 30 days of the change.

Specialty: OBG

Board Certified: (Y/N) Y

Please list ABMS Board Specialty: OBG

Licensed in the states of: (2 letter state abbrev.)

ME

Please mark the box next to the address you would prefer to list as your mailing address.

License #: 9485

File #: 10357

☑ **Work Address**

PAUL D HANISSIAN, MD
DARTMOUTH-HITCHCOCK MED
1 MEDICAL CENTER DR
LEBANON, NH 03756-
Phone: 603*650-5000

☐ **Home Address**

[redacted]

Phone: [redacted]

Hospital Affiliations: **(If not a NH hospital, please list city and state where hospital is located.)**

DARTMOUTH-HITCHCOCK MED CTR -DARTMOUTH HITCHCOCK ~~MEDICAL CENTER,LEBANON,NH~~

(RENEWAL APPLICATION CONTINUED ON REVERSE SIDE)

JUN 2 8 2001

STATE OF NEW HAMPSHIRE

Telephone #: 603-271-6934

BOARD OF MEDICINE
2 Industrial Park Drive, Suite 8
Concord, NH 03301-8520

RENEWAL APPLICATION

For expiration on: (date) 6/30/2002

Renewal Fee: $150.00

If you **DO NOT** wish to renew your license, check here. ☐

If you choose not to renew, your license will be placed on inactive status. To reactivate the license, you will be required to file a reinstatement application.

The following information represents the information on file for you with the Board of Medicine. Please make any necessary changes. Please note that pursuant to RSA 329:16-f, all licensees must inform the Board of any change in address within 30 days of the change.

Specialty: OBG

Board Certified: (Y/N) Y

Please list ABMS Board Specialty: OBG

Licensed in the states of: (2 letter state abbrev.)

ME

Please mark the box next to the address you would prefer to list as your mailing address.

License #: 9485

File #: 10357

☒ Work Address

PAUL D HANISSIAN, MD
DARTMOUTH-HITCHCOCK MED
1 MEDICAL CENTER DR
LEBANON, NH 03756-

Phone: 603*650-5000

☐ Home Address

[redacted]

Phone: [redacted]

Hospital Affiliations: **(If not a NH hospital, please list city and state where hospital is located.)**

DARTMOUTH-HITCHCOCK - LEBANON,NH

(RENEWAL APPLICATION CONTINUED ON REVERSE SIDE)

APR 1 0 2002

STATE OF NEW HAMPSHIRE

Telephone #: 603-271-6934

BOARD OF MEDICINE
2 Industrial Park Drive, Suite 8
Concord, NH 03301-8520

#15158

RENEWAL APPLICATION

For expiration on: 6/30/2003

Renewal Fee: $150.00

If you **DO NOT** wish to renew your license, check here. ☐

If you choose not to renew, your license will be placed on inactive status. To reactivate the license, you will be required to file a reinstatement application.

The following information represents the information on file for you with the Board of Medicine. Please make any necessary changes. Please note that pursuant to RSA 329:16-f, all licensees must inform the Board of any change in address within 30 days of the change.

Specialty: OBG

Board Certified: (Y/N) Y

Please list ABMS Board Specialty: OBG

Licensed in the states of: (2 letter state abbrev.)

Vermont - active ME - inactive.

Please mark the box next to the address you would prefer to list as your mailing address.

License #: 9485

File #: 10357

☒ Work Address

PAUL D HANISSIAN, MD
DARTMOUTH-HITCHCOCK MED
1 MEDICAL CENTER DR
LEBANON, NH 03756-

Phone: 603*650-5000

☐ Home Address

[redacted]

[redacted]

Phone: [redacted]

Hospital Affiliations: **(If not a NH hospital, please list city and state where hospital is located.)**

DARTMOUTH-HITCHCOCK - LEBANON,NH

Veteran Administration Hospital, White River Junction, VT

(RENEWAL APPLICATION CONTINUED ON REVERSE SIDE)

JUN 1 9 2005

STATE OF NEW HAMPSHIRE

Telephone #: 603-271-6934

BOARD OF MEDICINE
2 Industrial Park Drive, Suite 8
Concord, NH 03301-8520

1930
$300

RENEWAL APPLICATION

For expiration on: 06/30/05

Renewal Fee: $300.00

If you **DO NOT** wish to renew your license, check here. ☐
If you choose not to renew, your license will be place on inactive status. To reactive the license, you will be required to file a reinstatement application.

The following information represents the information on file for you with the Board of Medicine. Please make any necessary changes. Please note that pursuant to RSA 329:16-f, all licensees must inform the Board of any change in address within 30 days of the change.

Specialty: OBG

Board Certified: (Y/N) Y
Please list ABMS Board Specialty: OBG

Licensed in the states of: (2 letter state abbrev.)
ME, VT

Please mark the box next to the address you would prefer to list as your mailing address.

License #: 9485

File #: 10857

☒ Work Address

PAUL D HANISSIAN, MD
DARTMOUTH-HITCHCOCK MED
1 MEDICAL CENTER DR
LEBANON, NH 03756

Phone: 603-650-5000

☐ Home Address

[redacted]

Phone [redacted]

Hospital Affiliations: (If not a NH hospital, please list city and state where hospital is located)

DARTMOUTH-HITCHCOCK, LEBANON,NH; VA HOSPITAL, WHITE RIVER JUNCTION VT

(RENEWAL APPLICATION CONTINUED ON REVERSE SIDE)

STATE OF NEW HAMPSHIRE

Telephone #: 603-271-6934 APR 21 2005

BOARD OF MEDICINE
2 Industrial Park Drive, Suite 8
Concord, NH 03301-8520

RENEWAL APPLICATION

For expiration on: 06/30/07

#17189
Renewal Fee: $300.00
of 2400 cd

If you **DO NOT** wish to renew your license, check here. ☐
If you choose not to renew, your license will be place on inactive status. To reactivate the license, you will be required to file a reinstatement application.

The following information represents the information on file for you with the Board of Medicine. **Please make any necessary changes. Please note that pursuant to RSA 329:16-f, all licensees must inform the Board of any change in address within 30 days of the change.**

Specialty: OBG Board Certified: (Y/N) Y
Please list ABMS Board Specialty: OBG

Licensed in the states of: (2 letter state abbrev.)
ME, VT (ME license is inactive)

Please mark the box next to the address you would prefer to list as your mailing address.

License #: 9485 File #: 10357

☒ Work Address:

PAUL D HANISSIAN, MD
DARTMOUTH HITCHCOCK MED
1 MEDICAL CENTER DR
LEBANON, NH 03756

Phone: 603-650-5000
Business Fax Number: [redacted]
Business Email Address: [redacted]

☐ Home Address:

[redacted]

Phone: [redacted]

Hospital Affiliations: *** Please list city and state where hospital is located. Check off type of privileges you hold for each Hospital

Hospital			Privilege	Full	Courtesy	Consult
DARTMOUTH HITCHCOCK	LEBANON	NH		☑	☐	☐
VA HOSPITAL	WHITE RIVER J	VT		☑	☐	☐
				☐	☐	☐
				☐	☐	☐
				☐	☐	☐
				☐	☐	☐
				☐	☐	☐

(RENEWAL APPLICATION CONTINUED ON REVERSE SIDE)

STATE OF NEW HAMPSHIRE

Telephone #: 603-271-6934

MAR 3 0 2007

BOARD OF MEDICINE
2 Industrial Park Drive, Suite 8
Concord, NH 03301-8520

RECEIV

MAR 2 8

NH BOA

#26042

RENEWAL APPLICATION

For expiration on: 06/30/2009

Renewal Fee: $300.00

If you **DO NOT** wish to renew your license, check here. ☐
If you choose not to renew, your license will be placed on inactive status. To reactivate the license, you will be required to file a reinstatement application.

The following information represents the information on file for you with the Board of Medicine. Please make any necessary changes. Please note that pursuant to RSA 329:16-f, all licensees must inform the Board of any change in address within 30 days of the change.

Specialty: OBG

Board Certified: (Y/N) Y

Please list ABMS Board Specialty: OBG

Licensed in the states of (2 letter state abbrev.) ME, VT

OBG/GYN

Please mark the box next to the address you would prefer to list as your mailing address.

License #: 9485

File #: 10357

☒ Work Address

PAUL D HANISIAN, MD
DHMC-OBG/GYN
ONE MEDICAL CENTER DR
LEBANON, NH 03756

Phone: 603 650-5000
Business Fax Number: [redacted]
Business Email Address: [redacted]

☐ Home Address

[redacted]

Phone: [redacted]

Hospital Affiliations: *** Please list city and state where hospital is located. Check off type of privileges you hold for each Hospital

Hospital			Privilege: Full	Courtesy	Consult
DARTMOUTH-HITCHCO	LEBANON	NH	☑	☐	☐
VA HOSPITAL	WHITE RIVER J	VT	☑	☐	☐
			☐	☐	☐
			☐	☐	☐
			☐	☐	☐
			☐	☐	☐
			☐	☐	☐
			☐	☐	☐

(RENEWAL APPLICATION CONTINUED ON REVERSE SIDE)

JUN 09 2009

RECEIVED
JUN 08 2009
NH BOARD

STATE OF NEW HAMPSHIRE

Telephone #: 603-271-6934

BOARD OF MEDICINE
2 Industrial Park Drive, Suite 8
Concord, NH 03301-8520

RENEWAL APPLICATION

#4953

For expiration on: 06/30/2011

Renewal Fee: $300.00 10

If you **DO NOT** wish to renew your license, check here. ☐
If you choose not to renew, your license will be placed on inactive status. To reactivate the license, you will be required to file a reinstatement application.

The following information represents the information on file for you with the Board of Medicine. **Please make any necessary changes. Please note that pursuant to RSA 329:16-f, all licensees must inform the Board of any change in address within 30 days of the change.**

Specialty: OBG

Currently Board Certified? (Y/N) Y
Please list ABMS Board Specialty: OBG

Currently licensed in the states of: (2 letter state abbrev.) VT

You must provide both home and business street address. PO Boxes are not acceptable.
Please mark the box next to the address you would prefer to list as your mailing address.

License #: 9485 File #: 10357

☒ Work Address:

PAUL D HANISSIAN, MD
DHMC OBGYN
ONE MEDICAL CENTER DR
LEBANON, NH 03756

☐ Home Address:

[redacted]

Phone: 603-650-5000
Business Fax Number: [redacted]
Business Email Address: [redacted]

Phone: [redacted]

Hospital Affiliations: ***Please list city and state where hospital is located. Check off type of privileges you hold for each Hospital

Hospital			Privilege	Full	Courtesy	Consult
DARTMOUTH-HITCHCO	LEBANON	NH		☑	☐	☐
VA HOSPITAL	WHITE RIVER J	VT		☑	☐	☐
MH Ascutney Hospital	Ascutney	VT		☐	☐	☐
Cheshire Medical Ctr	Keene	NH		☑	☐	☐
				☐	☐	☐
				☐	☐	☐
				☐	☐	☐

(RENEWAL APPLICATION CONTINUED ON REVERSE SIDE)

MAY 10 2011

RECEIVED

MAY 06 2011

NH BOARD

STATE OF NEW HAMPSHIRE

Telephone #: 603-271-6934

BOARD OF MEDICINE
2 Industrial Park Drive, Suite 8
Concord, NH 03301-8520

RENEWAL APPLICATION

For expiration on: 06/30/2013

Renewal Fee: $300.00

For Office Use Only:
Date Pd: 5/11 Check #: 57436

If you **DO NOT** wish to renew your license, check here. ☐
If you choose not to renew, your license will be placed on inactive status. To reactivate the license, you will be required to file a reinstatement application.

The following information represents the information on file for you with the Board of Medicine. Please make any necessary changes. Please note that pursuant to RSA 329:16-f, all licensees must inform the Board of any change in address within 30 days of the change.

Specialty: OBG

Currently Board Certified? (Y/N) Y

Please list ABMS Board Specialty: OBG

Currently licensed in the states of: (2 letter state abbrev.) VT

You must provide both home and business street address. PO Boxes are not acceptable.
Please mark the box next to the address you would prefer to list as your mailing address.

License #: 9485

File #: 10857

☐ Work Address

PAUL D HANISSIAN, MD
DHMC OBGYN
ONE MEDICAL CENTER DR
LEBANON, NH 03756

Phone: 603-650-5000
Business Fax Number: [redacted]
Business Email Address: [redacted]

☐ Home Address

[redacted]

Phone: [redacted]

Hospital Affiliations: *** Please list city and state where hospital is located. Check off type of privileges you hold for each Hospital

Hospital			Privilege	Full	Courtesy	Consult
DARTMOUTH-HITCHCOC	LEBANON	NH		☑	☐	☐
VA HOSPITAL	WHITE RIVER JC	VT		☑	☐	☐
MT ASCUTNEY HOSPITA	ASCUTNEY	VT		☑	☑	☐
CHESHIRE MEDICAL CE	KEENE	NH		☑	☐	☐
				☐	☐	☐
				☐	☐	☐
				☐	☐	☐

(RENEWAL APPLICATION CONTINUED ON REVERSE SIDE)

Please answer each of the following questions. If your answer to any question is "Yes", you must provide a complete written explanation of the circumstances including any required documents. DO NOT RESUBMIT INFORMATION REPORTED ON A PRIOR RENEWAL APPLICATION.

In the past 24 months:

	YES	NO
1. With regard to any and all Boards or licensing bodies with which you hold or have held a license to practice medicine, have you been subject to any disciplinary action, limitation or restriction on your license, or entered into any agreement with a licensing body for any reason, including but not limited to rehabilitation?		X
2. Have you been denied, or have you surrendered or allowed to lapse, a license to practice medicine in any state other than New Hampshire?		X
3. Have you been subject to any investigation or to a denial, restriction, suspension, loss or revocation of your DEA certificate?		X
4. Have you been treated, other than through the Physician Health Program, for abuse or misuse of any chemical substance, including alcohol?		X
5. Have you had any emotional disturbance or mental or physical illness which has impaired your ability to practice medicine?		X
6. Have you been found guilty or entered a plea of no contest to any felony, misdemeanor or alcohol or drug related offense that has not been annulled by a court?		X
7. Have you been reported to the National Practitioner's Data Bank? If yes, please submit a copy of the report.		X
8. Have you been the subject of an investigation or disciplinary proceeding regarding the practice of medicine? Please exclude investigations and disciplinary proceedings conducted by the New Hampshire Board of Medicine.		X
9. Have any hospital privileges been suspended, limited or denied other than for medical records violations, or have you been placed on administrative or medical leave?		X
10. Have any medical malpractice claims been made against you? See attached reporting form.		X

**Pursuant to RSA 125-25-c, I, please attach a list of ALL diagnostic and therapeutic services in which you have an ownership interest.

I HEREBY CERTIFY UNDER PENALTY OF PERJURY THAT ALL INFORMATION ON THIS FORM IS CURRENTLY ACCURATE. I acknowledge that I am governed by the Medical Practice Act (RSA 329), the New Hampshire Code of Administrative Rules (Med 100-500), and the American Medical Association's Code of Medical Ethics. I have familiarized myself with these documents and acknowledge that deviation from the standards set therein may subject me to disciplinary action by the New Hampshire Board of Medicine.

Signature of Licensee (Signature Stamp Not Accepted) Date 4/8/2011

Please answer each of the following questions. If your answer to any question is "Yes", you must provide a complete written explanation of the circumstances including any required documents. DO NOT RESUBMIT INFORMATION REPORTED ON A PRIOR RENEWAL APPLICATION.

In the past 24 months:

	YES	NO
1. With regard to any and all Boards or licensing bodies with which you hold or have held a license to practice medicine, have you been subject to any disciplinary action, limitation or restriction on your license, or entered into any agreement with a licensing body for any reason, including but not limited to rehabilitation?		
2. Have you been denied, or have you surrendered or allowed to lapse, a license to practice medicine in any state other than New Hampshire?		
3. Have you been subject to any investigation or to a denial, restriction, suspension, loss or revocation of your DEA certificate?		
4. Have you been treated, other than through the Physician Health Program, for abuse or misuse of any chemical substance, including alcohol?		
5. Have you had any emotional disturbance or mental or physical illness which has impaired your ability to practice medicine?		
6. Have you been found guilty or entered a plea of no contest to any felony, misdemeanor or alcohol or drug related offense that has not been annulled by a court?		
7. Have you been reported to the National Practitioner's Data Bank? If yes, please submit a copy of the report.		
8. Have you been the subject of an investigation or disciplinary proceeding regarding the practice of medicine? Please exclude investigations and disciplinary proceedings conducted by the New Hampshire Board of Medicine.		
9. Have any hospital privileges been suspended, limited or denied other than for medical records violations, or have you been placed on administrative or medical leave?		
10. Have any medical malpractice claims been made against you? See attached reporting form.		

Pursuant to RSA 126-25-c, I, please attach a list of ALL diagnostic and therapeutic services in which you have an ownership interest.

I HEREBY CERTIFY UNDER PENALTY OF PERJURY THAT ALL INFORMATION ON THIS FORM IS CURRENTLY ACCURATE.

Signature of Licensee (Signature Stamp Not Accepted) Date 3/31/09

Please answer each of the following questions. If your answer to any question is "Yes", you must provide a complete written explanation of the circumstances including any required documents. DO NOT RESUBMIT INFORMATION REPORTED ON A PRIOR RENEWAL APPLICATION.

In the past 24 months:

	YES	NO
1. Have you been subject to any disciplinary action, limitation, restriction or agreement for any reason, including rehabilitation, by a licensing board?		X
2. Have you been denied, or have you surrendered, a license in any state other than for relocation or retirement?		X
3. Have you been subject to any denial, restriction, suspension or loss/revocation of your DEA certificate?		X
4. Have you been treated, other than through the Physician Health Program, for abuse or misuse of any chemical substance, including alcohol?		X
5. Have you had any emotional disturbance or mental or physical illness which has impaired your ability to practice medicine?		X
6. Have you been found guilty or entered a plea of no contest to any felony or misdemeanor that has not been annulled by a court?		X
7. Have you been reported to the National Practitioner's Data Bank? If yes, please submit a copy of the report.		X
8. Have you been the subject of an investigation or disciplinary proceeding? Please exclude investigations and disciplinary proceedings conducted by the New Hampshire Board of Medicine.		X
9. Have any hospital privileges been suspended, limited or denied other than for medical records violations, or have you been placed on administrative or medical leave?		X
10. Have any medical malpractice claims been made against you? See attached reporting form.		X

**Pursuant to RSA 125-25-c, I, please attach a list of ALL diagnostic and therapeutic services in which you have an ownership interest.

I HEREBY CERTIFY UNDER PENALTY OF PERJURY THAT ALL INFORMATION ON THIS FORM IS CURRENTLY ACCURATE.

Signature of Licensee (Signature Stamp Not Accepted) — Date: 3/8/07

Please answer each of the following questions. If your answer to any question is "Yes", you must provide a complete written explanation of the circumstances including any required documents. DO NOT RESUBMIT INFORMATION REPORTED ON A PRIOR RENEWAL APPLICATION.

In the past 24 months:

	YES	NO
1. Have you been subject to any disciplinary action, limitation, restriction, or agreement for any reason, including rehabilitation by a licensing board?		X
2. Have you been denied, or have you surrendered, a license in any state other than for relocation or retirement?		X
3. Have you been subject to any denial, restriction, suspension or loss/revocation of your DEA certificate?		X
4. Have you been treated, other than through the Physician Health Program, for abuse or misuse of any chemical substance, including alcohol?		X
5. Have you had any emotional disturbance or mental or physical illness which has impaired your ability to practice medicine?		X
6. Have you been found guilty or entered a plea of no contest to any felony or misdemeanor that has not been annulled by a court?		X
7. Have you been reported to the National Practitioner's Data Bank? If yes, please submit a copy of the report.		X
8. Have you been the subject of an investigation or disciplinary proceeding?		X
9. Have any hospital privileges been suspended, limited or denied other than for medical records violations, or have you been placed on administrative or medical leave?		X
10. Have any medical malpractice claims been made against you? See attached reporting form.		X

I HEREBY CERTIFY UNDER PENALTY OF PERJURY, THAT ALL INFORMATION ON THIS FORM IS CURRENTLY ACCURATE.

Signature of Licensee (Signature Stamp Not Accepted) — Date: 3/16/05

Please answer each of the following questions. If your answer to any question is "Yes", you must provide a complete written explanation of the circumstances including any required documents. DO NOT RESUBMIT INFORMATION REPORTED ON A PRIOR RENEWAL APPLICATION.

In the past 12 months:

	YES	NO
1. Have you been subject to any disciplinary action, limitation, restriction, or agreement for any reason, including rehabilitation by a licensing board?		✓
2. Have you been denied, or have you surrendered, a license in any state other than for relocation or retirement?		✓
3. Have you been subject to any denial, restriction, suspension or loss/revocation of your DEA certificate?		✓
4. Have you been treated, other than through the Physician Health Program, for abuse or misuse of any chemical substance, including alcohol?		✓
5. Have you had any emotional disturbance or mental or physical illness which has impaired your ability to practice medicine?		✓
6. Have you been found guilty or entered a plea of no contest to any felony or misdemeanor?		✓
7. Have you been reported to the National Practitioner's Data Bank? If yes, please submit a copy of the report.		✓
8. Have you been the subject of an investigation or disciplinary proceeding?		✓
9. Have any hospital privileges been suspended, limited or denied other than for medical records violations, or have you been placed on administrative or medical leave?		✓
10. Have any medical malpractice claims been made against you? See attached reporting form.		✓

I HEREBY CERTIFY UNDER PENALTY OF PERJURY, THAT ALL INFORMATION ON THIS FORM IS CURRENTLY ACCURATE.

Paul Hew 6/1/03

Signature of Licensee (Signature Stamp Not Accepted) Date

Please answer each of the following questions. If your answer to any question is "Yes", you must provide a complete written explanation of the circumstances including any required documents. DO NOT RESUBMIT INFORMATION REPORTED ON A PRIOR RENEWAL APPLICATION.

In the past 12 months:

	YES	NO
1. Have you been subject to any disciplinary action, limitation, restriction, or agreement for any reason, including rehabilitation by a licensing board?		↘
2. Have you been denied or have you surrendered a license in any state other than for relocation or retirement?		↘
3. Have you been subject to any denial, restriction, suspension or loss/revocation of your DEA certificate?		↘
4. Have you been treated for use or misuse of any chemical substance?		↘
5. Have you had any emotional disturbance or mental or physical illness which has impaired your ability to practice medicine?		↘
6. Have you been found guilty or entered a plea of no contest to any felony or misdemeanor?		↘
7. Have you been reported to the National Practitioner's Data Bank? If yes, please submit a copy of the report.		↘
8. Have you been the subject of an investigation or disciplinary proceeding?		↘
9. Have any hospital privileges been suspended, limited, or denied other than for medical records violations, or have you been placed on administrative or medical leave?		↘
10. Have any medical malpractice claims been made against you? See attached reporting form.		↘

I HEREBY CERTIFY UNDER PENALTY OF PERJURY, THAT ALL INFORMATION ON THIS FORM IS CURRENTLY ACCURATE.

Paul Ha

Signature of Licensee (Signature Stamp Not Accepted)

3/21/02

Date

Please answer each of the following questions. If your answer to any question is "Yes", you must provide a complete written explanation of the circumstances including any required documents. DO NOT RESUBMIT INFORMATION REPORTED ON A PRIOR RENEWAL APPLICATION.

In the past 12 months:

	YES	NO
1. Have you been subject to any disciplinary action, limitation, restriction, or agreement for any reason, including rehabilitation by a licensing board?		\
2. Have you been denied or have you surrendered a license in any state other than for relocation or retirement?		\
3. Have you been subject to any denial, restriction, suspension or loss/revocation of your DEA certificate?		\
4. Have you been treated for use or misuse of any chemical substance?		\
5. Have you had any emotional disturbance or mental or physical illness which has impaired your ability to practice medicine?		\
6. Have you been found guilty or entered a plea of no contest to any felony or misdemeanor?		\
7. Have you been reported to the National Practitioner's Data Bank? If yes, please submit a copy of the report.		\
8. Have you been the subject of an investigation or disciplinary proceeding?		\
9. Have any hospital privileges been suspended, limited, or denied other than for medical records violations, or have you been placed on administrative or medical leave?		\
10. Have any medical malpractice claims been made against you? See attached reporting form.		\

I HEREBY CERTIFY UNDER PENALTY OF PERJURY, THAT ALL INFORMATION ON THIS FORM IS CURRENTLY ACCURATE.

Paul Harrison
Signature of Licensee (Signature Stamp Not Accepted)

6/25/01
Date

Please answer each of the following questions. If your answer to any question is "Yes", you must provide a complete written explanation of the circumstances including any required documents. DO NOT RESUBMIT INFORMATION REPORTED ON A PRIOR RENEWAL APPLICATION.

In the past 12 months:

	YES	NO
1. Have you been subject to any disciplinary action, limitation, restriction, or agreement for any reason, including rehabilitation by a licensing board?		✓
2. Have you been denied or have you surrendered a license in any state other than for relocation or retirement?		✓
3. Have you been subject to any denial, restriction, suspension or loss/revocation of your DEA certificate?		✓
4. Have you been treated for use or misuse of any chemical substance?		✓
5. Have you had any emotional disturbance or mental or physical illness which has impaired your ability to practice medicine?		✓
6. Have you been found guilty or entered a plea of no contest to any felony or misdemeanor?		✓
7. Have you been reported to the National Practitioner's Data Bank? If yes, please submit a copy of the report.		✓
8. Have you been the subject of an investigation or disciplinary proceeding?		✓
9. Have any hospital privileges been suspended, limited, or denied other than for medical records violations, or have you been placed on administrative or medical leave?		✓
10. Have any medical malpractice claims been made against you? See attached reporting form.		✓

I HEREBY CERTIFY UNDER PENALTY OF PERJURY, THAT ALL INFORMATION ON THIS FORM IS CURRENTLY ACCURATE.

PA

Signature of Licensee (Signature Stamp Not Accepted)

4/7/00

Date

Please answer each of the following questions. If your answer to any question is "Yes", you must provide a complete written explanation of the circumstances including any required documents. DO NOT RESUBMIT INFORMATION REPORTED ON A PRIOR RENEWAL APPLICATION.

In the past 12 months:

	YES	NO
1. Have you been subject to any disciplinary action, limitation, restriction, or agreement for any reason, including rehabilitation by a licensing board?		\
2. Have you been denied or have you surrendered a license in any state other than for relocation or retirement?		\
3. Have you been subject to any denial, restriction, suspension or loss/revocation of your DEA certificate?		\
4. Have you been treated for use or misuse of any chemical substance?		\
5. Have you had any emotional disturbance or mental or physical illness which has impaired your ability to practice medicine?		\
6. Have you been found guilty or entered a plea of no contest to any felony or misdemeanor?		\
7. Have you been reported to the National Practitioner's Data Bank? If yes, please submit a copy of the report.		\
8. Have you been the subject of an investigation or disciplinary proceeding?		\
9. Have any hospital privileges been suspended, limited, or denied other than for medical records violations, or have you been placed on administrative or medical leave?		\
10. Have any medical malpractice claims been made against you? See attached reporting form.		\

I HEREBY CERTIFY UNDER PENALTY OF PERJURY, THAT ALL INFORMATION ON THIS FORM IS CURRENTLY ACCURATE.

Paul Ham
Signature of Licensee (Signature Stamp Not Accepted)

4/28/99
Date

Please answer each of the following questions. If your answer to any question is "Yes", you must provide a complete written explanation of the circumstances including any required documents. DO NOT RESUBMIT INFORMATION REPORTED ON A PRIOR RENEWAL APPLICATION.

In the past 12 months:

	YES	NO
1. Have you been subject to any disciplinary action, limitation, restriction, or agreement for any reason, including rehabilitation by a licensing board?		✓
2. Have you been denied or have you surrendered a license in any state other than for relocation or retirement?		✓
3. Have you been subject to any denial, restriction, suspension or loss/revocation of your DEA certificate?		✓
4. Have you been treated for use or misuse of any chemical substance?		✓
5. Have you had any emotional disturbance or mental or physical illness which has impaired your ability to practice medicine?		✓
6. Have you been found guilty or entered a plea of no contest to any felony or misdemeanor?		✓
7. Have you been reported to the National Practitioner's Data Bank? If yes, please submit a copy of the report.	✓	
8. Have you been the subject of an investigation or disciplinary proceeding?		✓
9. Have any hospital privileges been suspended, limited, or denied other than for medical records violations, or have you been placed on administrative or medical leave?		✓
10. Have any medical malpractice claims been made against you? See attached reporting form.		✓

I HEREBY CERTIFY UNDER PENALTY OF PERJURY, THAT ALL INFORMATION ON THIS FORM IS CURRENTLY ACCURATE.

Paul Hamm
Signature of Licensee (Signature Stamp Not Accepted)

4/29/98
Date

HAVE YOU BEEN CONTINUOUSLY ENGAGED IN THE ACTIVE PRACTICE OF MEDICINE? YES ✓ NO ___ IF NO, PLEASE EXPLAIN

SPECIALTY Ob/Gyn BOARD CERTIFIED? board eligible

RENEWAL FEE: $100.00

___ I DO NOT INTEND TO RENEW MY LICENSE - PLEASE PLACE MY LICENSE ON INACTIVE STATUS.

LIST ALL HOSPITAL AFFILIATIONS: OHMC, TM Cumberland Medical Center

IN WHAT OTHER STATES DO YOU HOLD LICENSE: Maine

IN THE PAST 12 MONTHS:

1. HAS ANY ACTION, INCLUDING ANY DISCIPLINARY ACTION, LIMITATION, RESTRICTION, OR AN AGREEMENT FOR ANY REASON INCLUDING REHABILITATION BEEN TAKEN OR ENTERED BY A LICENSING BOARD? — 1. ___ YES ✓ NO
2. HAVE YOU BEEN DENIED OR HAVE YOU SURRENDERED A LICENSE IN ANY STATE OTHER THAN FOR RELOCATION OR RETIREMENT? — 2. ___ YES ✓ NO
3. HAS THERE BEEN ANY DENIAL, RESTRICTION, SUSPENSION OR LOSS/REVOCATION OF YOUR DEA? — 3. ___ YES ✓ NO
4. HAVE YOU BEEN TREATED FOR USE OR MISUSE OF ANY CHEMICAL SUBSTANCE? — 4. ___ YES ✓ NO
5. HAVE YOU HAD ANY EMOTIONAL DISTURBANCE OR MENTAL ILLNESS WHICH HAS IMPAIRED YOUR ABILITY TO PRACTICE MEDICINE? — 5. ___ YES ✓ NO
6. HAVE YOU BEEN FOUND GUILTY OR ENTERED A PLEA OF NO CONTEST TO ANY FELONY, OR TO A MISDEMEANOR? — 6. ___ YES ✓ NO
7. HAVE YOU BEEN REPORTED TO THE NATIONAL PRACTITIONER DATA BANK? IF YES, PLEASE SUBMIT A COPY OF THE REPORT — 7. ___ YES ✓ NO
8. HAVE YOU BEEN THE SUBJECT OF AN INVESTIGATION OR DISCIPLINARY PROCEEDING? — 8. ___ YES ✓ NO
9. HAVE ANY HOSPITAL PRIVILEGES BEEN SUSPENDED, LIMITED, OR DENIED OTHER THAN FOR MEDICAL RECORDS VIOLATIONS, OR HAVE YOU BEEN PLACED ON ADMINISTRATIVE LEAVE? — 9. ___ YES ✓ NO
10. HAVE ANY MEDICAL MALPRACTICE CLAIMS BEEN MADE AGAINST YOU? SEE ATTACHED REPORTING FORM — 10. ___ YES ✓ NO

IF THE ANSWER IS YES TO ANY OF THESE QUESTIONS, PLEASE FILE A WRITTEN EXPLANATION.

I HEREBY CERTIFY, UNDER PENALTY OF PERJURY, THAT ALL INFORMATION ON THIS FORM IS CURRENTLY ACCURATE.

Paul Hamm
Signature of Licensee (Signature Stamp Not Accepted)

4/24/97
Date

HAVE YOU BEEN CONTINUOUSLY ENGAGED IN THE ACTIVE PRACTICE OF MEDICINE? YES \ NO ___ IF NO, PLEASE EXPLAIN

RENEWAL FEE $100.00

SPECIALTY Ob/Gyn BOARD CERTIFIED? BE

___ I DO NOT INTEND TO RENEW MY LICENSE - PLEASE PLACE MY LICENSE ON INACTIVE STATUS.

LIST ALL HOSPITAL AFFILIATIONS: OHMC, will apply for privileges TM Cheshire Medical Center

IN WHAT OTHER STATES DO YOU HOLD LICENSE: ME

IN THE PAST 12 MONTHS:

1.	HAS ANY ACTION, INCLUDING ANY DISCIPLINARY ACTION, LIMITATION, RESTRICTION, OR AN AGREEMENT FOR ANY REASON INCLUDING REHABILITATION BEEN TAKEN OR ENTERED BY A LICENSING BOARD?	1. ___ YES \ NO
2.	HAVE YOU BEEN DENIED OR HAVE YOU SURRENDERED A LICENSE IN ANY STATE OTHER THAN FOR RELOCATION OR RETIREMENT?	2. ___ YES \ NO
3.	HAS THERE BEEN ANY DENIAL, RESTRICTION, SUSPENSION OR LOSS/REVOCATION OF YOUR DEA?	3. ___ YES \ NO
4.	HAVE YOU BEEN TREATED FOR USE OR MISUSE OF ANY CHEMICAL SUBSTANCE?	4. ___ YES \ NO
5.	HAVE YOU HAD ANY EMOTIONAL DISTURBANCE OR MENTAL ILLNESS WHICH HAS IMPAIRED YOUR ABILITY TO PRACTICE MEDICINE?	5. ___ YES \ NO
6.	HAVE YOU BEEN FOUND GUILTY OR ENTERED A PLEA OF NO CONTEST TO ANY FELONY, OR TO A MISDEMEANOR?	6. ___ YES \ NO
7.	HAVE YOU BEEN REPORTED TO THE NATIONAL PRACTITIONER DATA BANK? IF YES, PLEASE SUBMIT A COPY OF THE REPORT	7. ___ YES \ NO
8.	HAVE YOU BEEN THE SUBJECT OF AN INVESTIGATION OR DISCIPLINARY PROCEEDING?	8. ___ YES \ NO
9.	HAVE ANY HOSPITAL PRIVILEGES BEEN SUSPENDED, LIMITED, OR DENIED OTHER THAN FOR MEDICAL RECORDS VIOLATIONS, OR HAVE YOU BEEN PLACED ON ADMINISTRATIVE LEAVE?	9. ___ YES \ NO
10.	HAVE ANY MEDICAL MALPRACTICE CLAIMS BEEN MADE AGAINST YOU? SEE ATTACHED REPORTING FORM	10. ___ YES \ NO

IF THE ANSWER IS YES TO ANY OF THESE QUESTIONS, PLEASE FILE A WRITTEN EXPLANATION.

I HEREBY CERTIFY, UNDER PENALTY OF PERJURY, THAT ALL INFORMATION ON THIS FORM IS CURRENTLY ACCURATE.

Paul Hamm
Signature of Licensee (Signature Stamp Not Accepted)

6/6/96
Date