

TEL. (603) 271-1203

# State of New Hampshire

### BOARD OF REGISTRATION IN MEDICINE

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

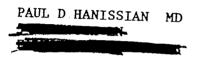
TDD Access: Relay NH 1-800-735-2964

BOARD MEMBERS
ALBERT M. DRUKTEINIS, M.D., J.C.
PRESIDENT

LAWRENCE W. O'CONNELL, Ph. D VICE PRESIDENT, PUBLIC MEMBER

MARCEL R. DUPUIS, M.D. ROBERT C. CHARMAN, M.D. CYNTHIA S. COOPER, M.D. PAUL F. RACICOT, M.D. MAUREEN P. KNEPP, PA-C PARAMEDICAL PROFESSIONAL

July 5, 1995



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.

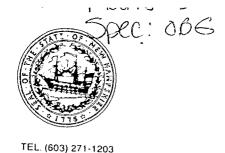
As soon as your engrossed certificate is received in this office, which should take approximately one year, it will be forwarded to you. Until such time, this letter is your full authorization for the privilege of practicing medicine in this state.

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

Sincerely,

Karen laCroix Administrator

KL/dg Enc.



# 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

BOARD MEMBERS ALBERT M. DRUKTEINIS, M.D., J.D. PRESIDENT

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MARCEL R. DUPUIS, M.D. ROBERT C. CHARMAN, M.D. CYNTHIA S. COOPER, M.D. MAUREEN P. KNEPP, PA-C PARAMEDICAL PROFESSIONAL

Application	No. 10357
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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 Pauld First Middle	(1005.107)	
intagle	Last	Maiden
Home Address		
Office Address 77 Bremhall St.		
- Portland, ME OC	NOZ	
Date of Birth	_Place of Birth	
Social Security Number		
2. ACADEMIC EDUCATION:		·
Name and Location of Institutions	Dates Attended	Degree Awarded
Golgale University	8/83 - 5/87	AR Physics
UMDN)- RW) Medical School	1912 - 18/18	_ M O.
		· · · · · · · · · · · · · · · · · · ·

3. MEDICAL	EDUCATION:
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Name and Location of Institutions	Dates Attended	Degree Awarded
UMONJ-RUJ Medical School	8187-5191	M O
(Piscataway, NJ)		
Main Medical Center	7/91 - 6/95	Residency
(Partland, ME)		

5.	FOREIGN	MEDICAL	GRADUATES
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- (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.
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(a)	Internship
-----	------------

Program	Portland, ME Location	7191- 6192
(b) Residency		Dates
Maine medical Center	Portland ME	7/92-6/95
Program	Location	
NH Requires at loom o		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:

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 Prouss)	
YOU must obtain	

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?	ES	\ nc
	If yes, please provide a notarized photocopy of such certifi		on.
		Yes	s 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?		_ \
	Have you ever applied for licensure or to sit for an examination, or taken an examination, under a different name?	<del></del>	
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?		
	Have you ever been denied a medical license, whether full, limited or temporary, for any reason?	<del></del> -	
	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?		

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 29. A total of 4 reference letters are required. Letters of reference shall be provided by the following individuals: AFFIDAVIT OF THE APPLICANT: 30. STATE OF Maine COUNTY OF I. Paul Hamisian 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

Sworn to before me this

[SEAL]

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



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 $\frac{7/5/9z}{}$	<u> </u>	

# THIS MUST BE SENT TO THE SCHOOL FROM WHICH YOU GRADUATED

MAY 17 1995

oard of Registration & Medicine

4.	1. Certificate of Medical Education:	Stration & Medicine
	It is hereby certified that <u>Paul Da</u> (Your	- · - · · · · · · · · · · · · · · · · ·
	(Name of Institution) at Piston (Lo	occion of institution!
	8/87 - 5/91 and received a diploma	from this institution
con	onferring the degree of Doctor of Medicine or D	octor of Osteopathy.
		President Secretary or Dean Cohal Rosalski Assi Regiss
	SCHOOL SEAL	Mond Mogaliki [155]. They is)
***	************	*********
\fte	ter completing, please return this form to the	following address:
	BOARD OF REGISTRATION IN ME 2 INDUSTRIAL PARK DRIV CONCORD, NEW HAMPSHIRE	EDICINE

# Paul D. Hanissian

**EDUCATION:** 

Maine Medical Center, Portland, ME, Residency training in Obstetrics

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

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)

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.

ROF

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,

Hector M. Tarraza, M.D.

Interim Chief, Department of Obstetrics and Gynecology

HMT/lmb

f:hanissnh.ltr

EXPIRES: 06/30/1997

STATE OF NEW HAMPSHIRE

Board of Medicine

Please check appropriate mailing address.

Home Tel: Home Address \_ Business Tel: 603 650 5000 Name in full Paul Hanssian Place of employment Dazimouth Hitchwck Medical Cecter

PAUL D HANISSIAN MD

6/30/98

EXPIRES:

STATE OF NEW HAMPSHIRE

Board of Medicine

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

Please check appropriate mailing address. Name in full Cowl Hanssian

Place of employment \_\_\_

ONNO

Business Tel:

Home Address

650-7625

Home Tel:

Telephone #: 603-271-6934



BOARD OF MEDICINE

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

### RENEWAL APPLICATION

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For expiration on:	6/30/1999				Renewal Fee: \$100.	.00
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Licensed in the s	states of: (2 letter	r state abbre ME		•		
Please mark the box ne.	ext to the address	s you would	l prefer to lis	et as your mailing	address.	
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Work Address:				#: 10357  Home Address:		
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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
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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) Please list ABMS Board Specialty: OBG Licensed in the states of: (2 letter state abbrev.) Please mark the box next to the address you would prefer to list as your mailing address. License #: 9485 File #: 10357 Work Address Home Address PAUL D HANISSIAN, MD DARTMOUTH-HITCHCOCK MED 1 MEDICAL CENTER DR LEBANON, NH 03756-Phone: Phone: 603\*650-5000

Hospital	Affiliations: (If not a NH hos	pital, please l	list city a	nd state	where hosp	ital is located.)
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BOARD OF MEDICINE
2 Industrial Park Drive, Suite 8
Concord, NH 03301-8520

Telephone #: 603-271-6934

	RENEWA	AL APPLICATION	
For expiration on: (	(date) 6/30/2002		Renewal Fee: \$150.00
If you choos	OT wish to renew your license e not to renew, your license wil lie a reinstatement application.	e, check here.	To reactivate the license, you
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Licensed in t	he states of: (2 letter state abbre ME	ev.)	
Please mark the box	next to the address you would	prefer to list as your mailing	address.
License #: 9485		File #: 10357	
W	ork Address	Home Address	
DA 1 M	AUL D HANISSIAN, MD ARTMOUTH-HITCHCOCK MED MEDICAL CENTER DR EBANON, NH 03756-	Phone:	
Ph	one: 603*650-5000		
Hospital Affil	iations: (If not a NH hospital,	please list city and state whe	re hospital is located )
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BOARD OF MEDICINE

2 Industrial Park Drive, Suite 8 415 15 8
Concord, NH 03301 9530 Concord, NH 03301-8520

# Telephone #: 603-271-6934

For expiration on	RE	ENEWAL APPLICATION
1 of expiration on	6/30/2003	Renewal Fee: \$150.00
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P	hone: 603*650-5000	Phone:
Hospital Affi	liations: ( <b>If not a NH hos</b> ARTMOUTH-HITCHCOCK -	spital, please list city and state where hospital is located.) LEBANON,NH
<u> </u>	Vetern Administration	Hoppital, White River Jundian, U1
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Telephone #: 603-271-6934



## BOARD OF MEDICINE

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

### RENEWAL APPLICATION

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make any	necessary c	hanges Dieses	ts the informatio	on on file for you	with the Board	of Medicine. Please
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Telephone #: 603-271-6934 APR 2 1 2005

### **BOARD OF MEDICINE** 2 Industrial Park Drive, Suite 8

Concord, NH 03301-8520

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# STATE OF NEW HAMPSHIRE Telephone #: 603-271-6934 **MAR 3 0 2007**

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BOARD OF MEDICINE

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2 Industrial Park Drive, Suite 8 MAR 28 Concord, NH 03301-8520

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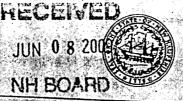
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The following information represents the informa	ormation on file for you with the Board of Medicine, <u>Please makeursuant to RSA 329:16-f</u> , all licensees must inform the Board of ddress within 30 days of the change
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# JUN 0.9 2009

# STATE OF NEW HAMPSHIRE

Telephone'#: 603-271-6934



### BOARD OF MEDICINE

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

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### MAY 10 2011

STATE OF NEW HAMPSHIRE

MAY 06 2011 Telephone #: 603-271-6934



### BOARD OF MEDICINE

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

#### NH BQARDWA For expiration on: 06/30/2013 Renewal Fee \$300.00 If you DO NOT wish to renew your dicense, check here. if you choose not to renew, your beense will be placed on inactive status. To reactivate the license, you will be required to file a reinstatement applies from The following information represents the information on the for you with the Board of Medicine. Pleasemake any necessary changes. Please note that pursuant to IRSA 329:16-13 all licensees must inform the Board of any change in address within 30 days of the change **OBG** Speciality Currently Board Cottingly (1970) Please his ABMS Board Specialty OHE Charently hospitality the sound of (2 letter nine upbrow) You must provide both home and business street arbitrass, PO Boxes are not acceptable. THEMSEMMATISTICETOOSTI<mark>ES</mark>KONTUS AUGITESSS VOID SVOITIUJ PEGITET TO USTALS VOIDT AUGUTESS AUGITESSS. File# tor: 37 Work Address Stories Ashtress PACIL D BLANTSSIAN, MD DENTICLOBIGNEN ONE MEDICAL CENTER DR ILIBRIANON, NET OF 156 Phone: 605-650-5000 Phone Business Pax Number Business Breatly Address Hospital Atifitations: \*\*\*Please list ofty and state where hospital is located. Check off type of palvileges you hold for each Hospital Hospital Putvilege Poll Counterly Consult DARTMOUTHHINGHEELE LEBANON V. Ò VAHOSPITAL WHITE RIVER IC' Ø MIT ASCUTINEM HOSPELA ASCIDITATELY 0 CEESIEIRE MEDICAL (C) KEDNE abla

### In the past 24 months:

YES NO

- L. 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 literase to practice medicine in any state other than New Hampshus?
- Reave you been subject to any investigation or to a denial, restriction, suspension, toss or revocation of your DPA destinate?
- 4. Places you begon regued, other dissertaining the Players on Plants Program, for stance or manies of any chamical automores, including alcaline.
- 3 Flave you had any emotional distingual or nemain or playsted things which has required by your stability to provide memorial to
- 6 Physycan bean found guilty or entered a pleas of no contest to now follows amedianterion of about the dispersion of about the product of facts of the lan and bean according to a count?
- To blum on their regions of he Common Beauthroun's Delt Funder. If yes picase authors a rugsy of the region
- S likewe con been the antisen of an investigation of disciplinary proceeding regarding the proceedings conditions and disciplinary proceedings conditioned by the New Planapsince Board of Matheme.
- 9. Blave my hospital parvilages been suspended, honted or demed office than for medical regions within the form of the post second within the post second or administrative of incident leave?
- 10. Have any medical malpraotice claims been made against you? See attached reporting form.

 $^{**}$ Pursumit in RSA 125-25-c., it, please attent a list of AUL diagnostic and diagraps the services in which you have an ownership interest.

I HEREBY OF FIFTY UNDER PENALTY OF PERILIRY THAT ALL IMPORMATION ON ITHIS FORM IS CURRENILLY ACCURATE. I adenomising that I am governed by the Metheri Practice Act (RSA 329), the New Hampshire Code of Administrative Rules (Med 100-300), and the American Medical Association's Code of Medical Education and insurance myself with these documents and insurance that develop from the sentiands set therein may subject me to disciplinary author by the New Hampshire Board of Medicine.

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### In the past 24 months:

YES NO

- I. With regard to any and all Boards or licensing bodies with which you hold or have held a theorem preduces medicine, have you been subject to any disciplinary action. Imitation or restriction on your license, or entered into any agreement with a hierarmy body for any reason, including but not himited to retabilitation?
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- 3. Have you teen subject to any investigation of to a donail, restriction, suspension, loss of execution of your DEA costillence?
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- " Blue you bego aported to the Sufficient Britishfound's Dain Bank" if yes please submit a copy of the jepon.
- 3. Place you been the subject of an investigation or decemberry proceeding regarding the practice of medicine. Please exclude investigations and disciplinary proceedings conducted by the New Blampshise Board of Wedning.
- 9) Have any hospital privileges been suspended, firmed or demed other than for medical records whitems, or have you been placed on administrative or medical leave?
- (ki), thave any medical malpractice claims been made against you? See attached reporting to an

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UHEREBY CERTIFY UNDER PENALTY OF PERFURY THAT ALL INFORMATION ON THIS FORM IS CURRENTLY ACCURATE

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<u>In the past 24 months:</u>	YES	· NO
1. Have you been subject to any disciplinary action, limitation, restriction or agreement for ar reason, including rehabilitation, by a licensing board?	A STAN SAN AND A STAN AND ASSAULT	<b>7</b> 2 3 2 3
2. Have you been denied, or have you sumendered, a literase in any state other than for relocation returns.	iion	
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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?		<u>\</u>
2. Have you been denied, or have you surrendered, a license in any state other than for relocation or retirement?		<u>~</u>
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2.	Have you been denied, or have you surrendered, a license in any state other than for relocation or retirement?		
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4.	Have you been treated for use or misuse of any chemical substance?		<u>\</u>
_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?		<u>\</u>
7.	Have you been reported to the National Practitioner's Data Bank? If yes, please submit a copy of the report.	· · · · .	<u>&gt;</u>
8.	Have you been the subject of an investigation or disciplinary proceeding?		<u>`</u>
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Signature of Licensee (Signature Stamp Not Accepted)  Date	

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Signature of Licensee (Signature Stamp Not Accepted)  Date		

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1 <u>90 NOT</u> INTEND TO RENEW MY LICENSE - PLEASE PLACE MY LICENSE ON INACTIVE STATUS.	
IN WHAT OTHER STATES DO YOU HOLD LICENSE.	
IN THE PAST 12 MONTHS.	
HAS ANY ACTION, INCLUDING ANY DISCIPLINABY ACTION, LIMITATION, RESTRICTION, OR AN AGREEMENT FOR ANY REASON INCLUDING REHABULITATION BEEN TAKEN OR ENTERIED BY A LICENSING BOARDY  2. HAVE YOU BEEN DEVINED OR HAVE YOU SUBRENCEDED. ALICENSE IN ANY STATE OTHER THAN FOR RELOCATION OR RETIREMENT?  3. HAS THERE BEEN ANY DENIAL, RESTRICTION, SUSPENSION OR LOSS/REVOCATION OF YOUR DEA?  4. HAVE YOU BEEN THEATED FOR USE OR MISUSE OF ANY CHEMICAL SUSSTRANCE?  5. HAVE YOU BEEN THEATED FOR USE OR MISUSE OF ANY CHEMICAL SUSSTRANCE?  6. HAVE YOU BEEN THEATED TO THE NATIONAL PRACTITIONER DATA BANK? IF YES, PLEASE SUBMIT A COPY OF THE REPORT.  7. HAVE YOU BEEN THE SUBJECT OF AN INVESTIGATION OR DISCIPLINARY PROCEEDINGS.  8. HAVE YOU BEEN THE SUBJECT OF AN INVESTIGATION OR DISCIPLINARY PROCEEDINGS.  9. HAVE ANY HOSPITAL PRIVILEGES BEEN WADE AGAINST YOU? SEE ATTACHED REPORTING FORM.  10. HAVE TOU BEEN PLACED ON ADMINISTRATIVE LEAVE?  11. HAVE TOU BEEN PLACED ON ADMINISTRATIVE LEAVE?  12. HAVE TOU BEEN PLACED ON ADMINISTRATIVE LEAVE?  13. HAVE TOU BEEN PLACED ON ADMINISTRATIVE LEAVE?  14. HAVE ANY WEDICAL MALPRACTICE CLAIMS BEEN MADE AGAINST YOU? SEE ATTACHED REPORTING FORM.	1. YES  1. YES  2. YES  3. YES  6. YES  10. YES
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10. HAVE ANY MEDICAL MALPRACTICE CLAIMS BEEN MADE AGAINST YOU? SEE ATTACHED REPORTING FORM HAS THERE BEEN ANY DENIAL, RESTRICTION, SUSPENSION OR LOSS/REVOCATION OF YOUR DEA?

HAVE YOU BEEN TREATED FOR USE OR MISUSE OF ANY CHEMICAL SUBSTANCE?

HAVE YOU REEN TRANDED DISTURBANCE OR MENTAL ILLNESS WHICH HAS IMPAIRED YOUR ABILITY TO PRACTICE MEDICINE?

HAVE YOU BEEN FOUND GUILITY OR ENTERED A PLEA OF NO CONTEST TO ANY FELONY, OR TO A MISDEMEANOR?

HAVE YOU BEEN REPORTED TO THE NATIONAL PRACTITIONER DATA BANK? IF YES, PLEASE SUBMIT A COPY OF THE REPORT 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? HAVE YOU BEEN DENIED OR HAVE YOU SURRENDERED A LICENSE IN ANY STATE OTHER THAN FOR RELOCATION OR RETIREMENT?. HAVE ANY HOSPITAL PRIVILEGES BEEN SUSPENDED, LIMITED, OR DENIED OTHER THAN FOR MEDICAL RECORDS VIOLATIONS, OR HAVE YOU BEEN CONTINUOUSLY ENGAGED IN THE ACTIVE PRACTICE OF MEDICINE? YES NO ... IF NO, PLEASE EXPLAIN . 1 <u>DO NOT</u> INTEND TO RENEW MY LICENSE - PLEASE PLACE MY LICENSE ON INACTIVE STATUS. I HEREBY CERTIFY UNDER PENALTY OF PERJURY, THAT ALL INFORMATION ON THIS FORM IS CURRENTLY ACCURATE. IF THE ANSWER IS YES TO ANY OF THESE QUESTIONS, PLEASE FILE A WRITTEN EXPLANATION. HAVE YOU BEEN THE SUBJECT OF AN INVESTIGATION OR DISCIPLINARY PROCEEDING? BOARD CERTIFIED? ছ ১ DHMC Signature of Licensee (Signature Stamp Not Accepted) IN WHAT OTHER STATES DO YOU HOLD LICENSE: an Namm 02/620 LIST ALL HOSPITAL AFFILIATIONS: IN THE PAST 12 MONTHS SPECIALTY .

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