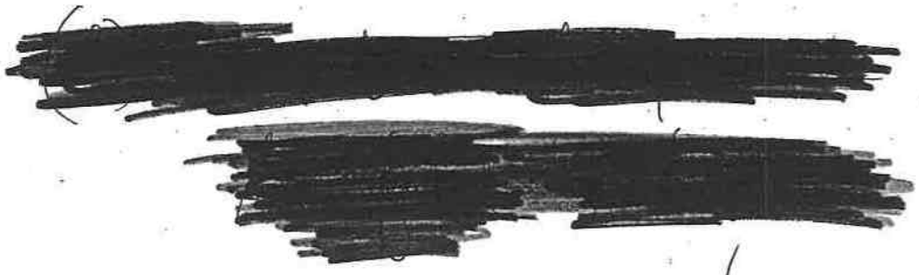
L-7291

Gary A. Wasserman MD

New (O) 150 Jaffrey Rd
Manch NH 03103



7/8

The State of New Hampshire

Board of Registration in Medicine

spec: OB/GYN (BC)
plan: Man - OB/GYN
Wayne L. Goldner, MD.

Application No. 8011

I hereby apply* for license to practice Medicine in the State of New Hampshire as a Doctor of Medicine [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 enclose a certified check or postal or express money order for the regular fee of $150.00 (U. S. Funds). No Refunds.

1. Personal Particulars

Name in full Gary Alan Wasserman
(Do not use initials) First Middle names in full Last

Present residence: No. [redacted], [redacted] Street, [redacted]
(City or town) (County) (State) Zip Code

Post office address [redacted]

Date of birth [redacted], Birthplace [redacted]
(City town or county) (State or foreign country)

If foreign born, date and place of naturalization as a citizen of the United States: Date [redacted]

[redacted] Place [redacted]

Age at last birthday [redacted] Sex male Single, Married, Widowed, or Divorced (*write the word*) [redacted] Color or race [redacted]

2. Academic Education:

Name and Location of Institutions attended.	Period of Study
State University, N.Y. at Buffalo	Sept/1969 - June/1973

Academic degree of B.A., received from SUNY at Buffalo 1973

3. Medical Education:

Name and Location of All Institutions attended.	Years attended with Date
SUNY at Buffalo Medical School	1973-1977

Degree of Doctor of Medicine [Osteopathy] received from SUNY at Buffalo Medical School at Buffalo, New York 1977

Period and places of practice Hanover Ob-Gyn, Inc., 135 Webster St., Hanover, Mas 1981-1985 ; Medical East, 304 Wood Road, Braintree, Mass., 1985-1986

Examined and licensed in the States of Massachusetts
(Name all states in which examined or licensed)

4. Certificate of Medical Education‡:

It is hereby certified that ..... of .....

matriculated in ..... at .....
(Name of institution) (place)

on ..... 19 ....., attended ..... courses of lectures, and

on ..... 19 ..... received a diploma from this institution conferring the degree of Doctor of Medicine [Osteopathy].

Notarized Photocopy Enclosed

President, Secretary or Dean. [SEAL]

The seal of the institution must be affixed

*This form is to be used for applicants for examination and for applicants for registration without examination.

**In filling out this blank indicate clearly whether the application is for a doctor of medicine or doctor of osteopathy by striking out the appropriate words as indicated herein.

‡ The Board may at its discretion require a slip or leaf from Prospectus of College or School showing what preliminary education is required to enter, and what medical study and standard are required for graduation.

*5. **Certified Copy of State or National Board License or Certificate.**

(Give a verbatim copy of License or Certificate certified by the Secretary with seal.)

Certification enclosed

I hereby certify that the above is a true copy of certificate or license No. ..... issued ..... A. D. .....

[SEAL] .....
Secretary.

The seal of the board must be affixed

6. **Affidavit of Secretary.**

STATE OF .....

County of ..... ss.

.....of .....

being duly sworn, says that he is Secretary of .....

.....and that the original of the preceding certified copy of State or National Board License or Certificate No. ..... was issued to Dr. .....

.....

of ..... on ..... 1 .....

after a written examination by this Board in the following branches and upon obtaining a rating averaging ..... per cent .....

.....

.....

.....

.....

.....

.....

.....

The subjects of examination and rating of each must be stated in full

..... M. D. [D. O.], Secretary.

Sworn to before me this ..... day of ..... 19.....

..... Notary Public. [SEAL]

*If used for examination application items 5 and 6 do not need to be executed.

7. **Affidavit of Internship.** Diploma enclosed

STATE OF ..... [SEAL]

County of ..... ss.

..... being duly sworn, says that he is

..... of the ..... Hospital located

at ..... and that .....

..... M. D. [D. O.], has been an intern at said hospital at least

12 months from ..... 19..... to ..... 19.....

Type of service (straight or rotating)
Division of service (medical, surgical, etc.)
If rotating, specify (in months) time devoted to:

Medicine	Dermatology	Pathology
Surgery	Oto-laryngo-rhinology	Neurology
Obstetrics	Ophthalmology	Clinical laboratory
Gynecology	Roentgenology	
Pediatrics	Psychiatry	

....., M. D. [D. O.]
(Medical Director) (Chief of Staff)

Sworn to before me this ..... day of ..... 19 .....

..... Notary Public.

(affix seal above line)

8. **Affidavit of Internship Residency** Diploma enclosed

STATE OF .....

County of ..... ss.

..... being duly sworn, says that he is

..... of the ..... Hospital located

at ..... and that .....

..... M. D. [D. O.], has been an $\frac{\text{intern}}{\text{resident}}$ at said hospital from

..... 19..... to ..... 19.....

Type of service (straight or rotating)
Division of service (medical, surgical, etc.)
If rotating, specify (in months) time devoted to:

Medicine	Dermatology	Pathology
Surgery	Oto-laryngo-rhinology	Neurology
Obstetrics	Ophthalmology	Clinical laboratory
Gynecology	Roentgenology	
Pediatrics	Psychiatry	

..... M. D. [D. O.]
(Medical Director) (Chief of Staff)

Sworn to before me this ..... day of ..... 19 .....

..... Notary Public. [SEAL]

9. **Affidavit of Registrar** Copy enclosed

STATE OF .....

County of ..... ss.

..... being

duly sworn says that he is the ..... of the Town (of the Village,
(title of official executing this affidavit)

City, County, Registration District, Province, State) of .....

and custodian of the records of birth thereof, and that an official record of birth bearing the name of

..... born
(give name exactly as it appears on the record)

on ....., 1....., at Number ..... Street in
(month) (day)

the Town / City of ..... County of..... State of .....,

child of .....
(name of father exactly as it appears on the record)

and ..... is on file in the office of said official, and further that it
(name of mother exactly as it appears on the record)

appears that said official record of birth was filed on ....., 1.....
(month) (day)

(Signature) .....

Sworn to before me this ..... day of ..... 19.....

..... (SEAL)

Notary Public

10. **Affidavit of Physician.**

STATE OF New Hampshire

County of ..... ss.

I, Wayne Goldner, ... M. D. [~~D. O.~~] of Bedford, New Hampshire being duly sworn do hereby certify: that I am acquainted with applicant and have known him (her) for 7 years; that I hold license No. 2440 to practice medicine [osteopathy] in the State [Province] of New Hampshire; and that I know applicant personally to be a physician [~~osteopathic physician~~] of good moral character and in good professional standing.

Wayne LeGoldner ..... M. D. [~~D. O.~~]

Sworn to before me this 27th day of January 19 86

GERALDYN C. ARCHAMBAULT, Notary Public
My Commission Expires June 26, 1990

Geraldyn C. Archambault ..... Notary Public. [SEAL]

11. **Affidavit of Physician.** **Notarized affidavit enclosed**

STATE OF .....

County of ..... ss.

I, ... M. D. [D. O.] of .....

being duly sworn do hereby certify: that I am acquainted with applicant and have known him (her) for ..... years; that I hold license No. ..... to practice medicine [osteopathy] in the State [Province] of .....; and that I know applicant personally to be a physician [osteopathic physician] of good moral character and in good professional standing.

..... M. D. [D. O.]

Sworn to before me this ..... day of ..... 19 .....

..... Notary Public. [SEAL]

12. **Affidavit of Officer of Medical [Osteopathic] Society:**

STATE OF .....

County of ..... ss.

..... M. D. [D. O.] of .....

being duly sworn, says that he is President or Secretary of the .....

Medical [Osteopathic] Society, and that ..... M. D. [D. O.] of

..... is at present a member in good standing of the

said Medical [Osteopathic] Society and that he is an ethical practitioner of good moral character.

..... M. D. [D. O.]

Sworn to before me this ..... day of ..... 19.....

[SEAL] ..... Notary Public.

13. **Affidavit of the Applicant:**

STATE OF Massachusetts

County of [redacted] ss.

Gary A. Wasserman, M.D. of [redacted] Massachusetts

being duly sworn says that he is the person referred to in the above application for a license to practice medicine as a Doctor of Medicine [as a Doctor of Osteopathy] in the State of New Hampshire; that he is a citizen of the United States [of Canada in the province of .....

.....] as shown by the above Affidavit of Registrar, wherein his name appears as

Gary A. Wasserman

[or proof of citizenship ..... hereto attached]; that he has studied the treatment of human ailments not less than four school years prior to receiving the degree of Doctor of Medicine [Osteopathy]; that all the statements herein contained respecting age, citizenship, residence, academic and medical education, internship, state or national board examination and license, good professional standing, and any other statements made on said application or attached hereto are each and all true in every respect, and that no disciplinary action has been brought against him by any State, county or local medical society.

He further says that he has never been an inmate in an institution for treatment for insanity, drug addiction, or inebriety, except as follows: None; and that he has never been convicted, nor fined, nor imprisoned, nor placed on probation, nor has he ever forfeited collateral for breach or violation of any law or police regulation or ordinance whatsoever except as follows: None

Gary A. Wasserman M. D. [~~D. O.~~]

Sworn to before me this 27th day of January 1986

[SEAL] Geraldyn C. Archambault Notary Public.

GERALDYN C. ARCHAMBAULT, Notary Public
My Commission Expires June 26, 1990

THE STATE OF NEW HAMPSHIRE
BOARD OF REGISTRATION IN MEDICINE

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

Application received 1-31-86 19....

Application examined .... 19....

Candidate interviewed 2/8/86 19....

by Dr S. Fiamalvos

Fee paid 1-31-86 19....

Application approved [denied] .... 19....

Examination .... 19....

Accepted without examination .... 19....

License granted NB/End

Date 4-1-86 19....

License No. 7291

Form of fee

P.O. order	Check	Cash	Express Order	Other
	150			

Remarks: ....

Applicant Please do not write above this line

The affixed photograph is of

Gary G. Vasseur

(Signature of Applicant)

Curriculum Vitae

Gary A. Wasserman
[redacted]
Phone [redacted]

PERSONAL

Born: [redacted]
Place of Birth: [redacted]
Height: [redacted] Weight: [redacted]
[redacted]

EDUCATION

East Meadow High School, East Meadow, N.Y. Graduated 1969

State University of New York at Buffalo, 1969-1973
B.A. in Psychology, Pre-Med, Phi Beta Kappa eligible

State University of New York at Buffalo Medical School 1973-1977

Baystate Medical Center, Springfield, Mass. 1977-1981
OB_GYN Internship and Residency

LICENSES and AWARDS

National Board of Medical Examiners 1974, 1977, 1978

Board Certification of American College of OB_GYN 1983

Fellow of American College of OB-GYN 1984

Mass. License Registration No. 43646

ASSOCIATIONS

Mass. Medical Society

Norfolk County Medical Society

American College of OB-GYN

WORK EXPERIENCE and APPOINTMENTS

Externship in Family Practice 1974

Instructor, Tufts Medical School 1980-1981

Private Practice, Hanover OB-GYN, INC. 1981-1985
135 Webster Street, Hanover, Mass. 02039

Medical East 1985- present
340 Wood Road, Braintree, Mass.

Curriculum Vitae of Professional Activities

Gary A. Wasserman

August, 1974; Externship in Family Practice (During Med. School)

July, 1981-June, 1985: Private practice

Hanover Ob-Gyn, Inc.
135 Webster Street, Hanover, Mass. o2339

July, 1985-present Health Maintenance Organization

Medical East
340 Wood Road, Braintree, Mass.

Hospital Affiliations

South Shore Hospital
Fogg Road
Weymouth, Mass.
July, 1981-present Active Staff

Quincy City Hospital
114 Whitewell Street
Quincy, Mass.
July, 1985-present Active Staff- Associate

Postgraduate Training and Courses

Basic Ultrasonography
Yale New Haven Hospital 1979

Cutaneous Diseases of the Vulvar
Columbia-Presbyterian Hospital, N.Y. 1981

Board Certification in Ob/Gyn andFellow of A.C.O.G.
Chicago, Illinois Dec.,1983

Gyn. and Ob. Pathological Review
St. BarnabasHospital 1983

Basic Microsurgery
NJ. Medical School, Newark 1985

Advanced Colposcopy and Laser Surgery
Columbia-Presbyterian Hospital, NY 1984

Advanced Microsurgery and Laser
U. Mass. Med. School, Worcestor, Mass. 1985

Active Staff- South Shore Hospital, Weymouth, Mass.

Quincy City Hospital, Quincy, Mass.

Courtesy Staff- St. Margarets Hospital, Dorchestor, Mass.

Carney Hospital, Milton, Mass.

PUBLICATIONS

None

MILITARY SERVICE

None

REFERENCES

Laurence Lundy, M.D.
Chairman, Dept. OB-GYN
Baystate Medical Center
749 Chestnut Street
Springfield, Mass.

Wayne Goldner, M.D.
[redacted]

Other references upon request

American Board of Obstetrics and Gyn

DIPLOMATE

COMPOSED OF MEMBERS NOMINATED BY THE
AMERICAN GYNECOLOGICAL AND OBSTETRICAL SOCIETY
AMERICAN MEDICAL ASSOCIATION
AMERICAN COLLEGE OF OBSTETRICIANS AND GYNECOLOGISTS
ASSOCIATION OF PROFESSORS OF GYNECOLOGY-OBSTETRICS
CERTIFIES THAT

GARY ALAN WASSERMAN

HAVING PURSUED AN ACCEPTED COURSE OF GRADUATE STUDY AND CLINICAL WORK, HAS MET THE S
AND QUALIFICATIONS AND PASSED THE EXAMINATIONS REQUIRED BY THE AMERICAN BOARD OF OB
AND GYNECOLOGY, INC. HE HAS THEREBY DEMONSTRATED TO THE SATISFACTION OF THIS BOAR
HE IS POSSESSED OF SPECIAL KNOWLEDGE, AND BY THE AWARD OF THIS DIPLOMA HIS PROFICIE
IN THE SPECIALTY OF OBSTETRICS AND GYNECOLOGY IS RECOGNIZED AND HE IS AN ACKNOWLE
DIPLOMATE OF THIS BOARD
DECEMBER 9, 1983

Leo J. Dunn
Gloria E. Sarto, MD
Charles B. Hammond, M.D.

PRESIDENT

T. Terry Hayashi
John H. Isaacs, MD
Leo D. Ingraham
David N. Danforth

Roy M.
Ruth W.
William J. Dignam

STATE UNIVERSITY OF NEW Y

STATE UNIVERSITY OF NEW YORK AT BU

ON THE RECOMMENDATION OF THE FACULTY
AND BY VIRTUE OF THE AUTHORITY VESTED IN THEM
THE TRUSTEES OF THE STATE UNIVERSITY OF NEW YOR
HAVE CONFERRED ON

GARY ALAN WASSERMAN

THE DEGREE OF

DOCTOR OF MEDICINE

AND HAVE GRANTED THIS DIPLOMA AS EVIDENCE THERE
GIVEN IN THE CITY OF BUFFALO IN THE STATE OF NEW Y
IN THE UNITED STATES OF AMERICA ON THE FIRST DAY OF
ONE THOUSAND NINE HUNDRED AND SEVENTY-SEVEN

Chairman of the Board of Trustees

Chancellor of the State

William C. Baird
Chairman of the Council State University at Buffalo

President of State University

STATE UNIVERSITY OF NEW YORK
1948

Baystate Medical Cent

Springfield, Massachusetts

An Associated Hospital of Tufts University School of Medicin

University of Massachusetts Medical School

This certifies that

Gary A. Wasserman, M.D.

has faithfully served

First Postgraduate Year in Obstetrics-Gynecology 7-1-77 to 6-30-7

Second Postgraduate Year in Obstetrics-Gynecology 7-1-78 to 6-30-

Third Postgraduate Year in Obstetrics-Gynecology 7-1-79 to 6-30-8

Fourth Postgraduate Year in Obstetrics-Gynecology 7-1-80 to 6-30-

In Witness Whereof the undersigned have affixed their signatures and the seal of the hospital is hereunto attached this thirtieth day of June, 1981.

Chairman

President

Chairman, Obstet

MAY 19 1997

STATE OF NEW HAMPSHIRE

Board of Medicine

801

6/30/98

EXPIRES:

Please check appropriate mailing address.

Name in full Gary A. Wasserman, M

Place of employment 150 Tarrytown Ro

Manchester NH 0310

GARY A WASSERMAN, MD
150 TARRYTOWN RD

MANCHESTER NH 03103-2713

Business Tel: 603-622-3162

Home Address [redacted]

Home Tel: [redacted]

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? YES, 1983

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

LIST ALL HOSPITAL AFFILIATIONS: Elliot Hospital

IN WHAT OTHER STATES DO YOU HOLD LICENSE: —

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.

Gary A. Wainwright
Signature of Licensee (Signature Stamp Not Accepted)

4/28/97
Date

JUN 0 3 19

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, yo will be required to file a reinstatement application.

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

Specialty: OBG

Board Certified: (Y/N) Y

Please list ABMS Board Specialty: OB

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 #: 7291

File #: 8011

☒ Work Address:

GARY A WASSERMAN, MD
150 TARRYTOWN RD

MANCHESTER, NH 03103-2713

☐ Home Address:

[redacted]

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

ELLIOT HOSPITAL

CATHOLIC MEDICAL CENTER

(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 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. (~~Enclosed~~) ~~DO PREVIOUS~~	✓	
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.

Gary A. Waseman — 5/3/98

Signature of Licensee (Signature Stamp Not Accepted) — Date

APR 2 9 1999

STATE OF NEW HAMPSHIRE

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

Telephone #: 603-271-6934

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, y will be required to file a reinstatement application.

The following information represents the information on file for you with the Board of Medicine. Please ma any necessary changes. Please note that pursuant to RSA 329:16-f, all licensees must inform the Board of a 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.) NH

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

License #: 7291 File #: 8011

☒ ☐

GARY A WASSERMAN, MD
150 TARRYTOWN RD
[redacted]

MANCHESTER, NH 03103-2718 Phone: [redacted]
Phone: 603*622-3162

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

ELLIOT HOSPITAL CATHOLIC MEDICAL CENTER

(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 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.

Signature of Licensee (Signature Stamp Not Accepted) — Date: 4/22/99

MAR 13 2000

STATE OF NEW HAMPSHIRE

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

Telephone #: 603-271-6934

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, yo will be required to file a reinstatement application.

The following information represents the information on file for you with the Board of Medicine. Please mak any necessary changes. Please note that pursuant to RSA 329:16-f, all licensees must inform the Board of an 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.)

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

License #: 7291

File #: 8011

☐ Work Address

GARY A WASSERMAN, MD
150 TARRYTOWN RD

MANCHESTER, NH 03103-2713
Phone: 603*622-3162

☐ Home Address

[redacted]

Phone: [redacted]

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

ELLIOT HOSPITAL- MANCHESTER, NH
CATHOLIC MEDICAL CTR- MANCHESTER, 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 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.

Signature of Licensee (Signature Stamp Not Accepted) — Date: 4-4-00

APR 1 3 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, y will be required to file a reinstatement application.

The following information represents the information on file for you with the Board of Medicine. Please ma any necessary changes. Please note that pursuant to RSA 329:16-f, all licensees must inform the Board of a 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.)

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

License #: 7291

File #: 8011

☑ Work Address

GARY A WASSERMAN, MD
150 TARRYTOWN RD

MANCHESTER, NH 03103-2713

Phone: 603*622-3162

☐ Home Address

[redacted]

[redacted]

Phone: [redacted]

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

ELLIOT HOSPITAL- MANCHESTER, NH
CATHOLIC MEDICAL CTR- MANCHESTER, 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 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.

Gayle Vanmeter MD — Signature of Licensee (Signature Stamp Not Accepted)

2/5/09 — Date

MAR 13 2002

STATE OF NEW HAMPSHIRE

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

Telephone #: 603-271-6934

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, will be required to file a reinstatement application.

The following information represents the information on file for you with the Board of Medicine. Please n any necessary changes. Please note that pursuant to RSA 329:16-f, all licensees must inform the Board of 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.)

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

License #: 7291

☑ Work Address

GARY A WASSERMAN, MD
150 TARRYTOWN RD

MANCHESTER, NH 03103-2713

Phone: 603-622-3162

File #: 8011

☐ Home Address

[redacted]

Phone: [redacted]

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

ELLIOT HOSPITAL- MANCHESTER, NH

CATHOLIC MEDICAL CTR- MANCHESTER, 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 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.

Signature of Licensee (Signature Stamp Not Accepted) — Date: 3/5/02

MAR 19 2003

STATE OF NEW HAMPSHIRE

Telephone #: 603-271-6934

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

RENEWAL APPLICATION

#19145

For expiration on: 06/30/04

Renewal Fee: $150.00 of 900.00

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, yo will be required to file a reinstatement application.

The following information represents the information on file for you with the Board of Medicine. Please ma any necessary changes. Please note that pursuant to RSA 329:16-f, all licensees must inform the Board of a 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.) NH

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

License #: 7291

File #: 8011

☒ Work Address

GARY A WASSERMAN, MD
150 TARRYTOWN RD

MANCHESTER, NH 03103-2713

Phone: 603*622-3162

☐ Home Address

[redacted]

Phone: [redacted]

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

ELLIOT HOSPITAL - MANCHESTER, NH
MANCHESTER, NH

~~CATHOLIC MEDICAL CTR~~
Voluntarily gave up privileges so we could focus our practice to one hospital

(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 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.

Signature of Licensee (Signature Stamp Not Accepted) — Date: 3/4/08

MAR 23 2004

STATE OF NEW HAMPSHIRE

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

Telephone #: 603-271-6934

RENEWAL APPLICATION

#20683

For expiration on: 6/30/06

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, y will be required to file a reinstatement application.

The following information represents the information on file for you with the Board of Medicine. **Please m any necessary changes. Please note that pursuant to RSA 329:16-f, all licensees must inform the Boar 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.)

NONE

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

License #: 7291

File #: 8011

☒ Work Address

GARY A WASSERMAN, MD
150 TARRYTOWN RD

MANCHESTER, NH 03103-2713

Phone: 603*622-3162

☐ 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
ELLIOT HOSPITAL MANCHESTER NH		☑	☐	☐
Catholic Med Center Manchester 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 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.

Signature of Licensee (Signature Stamp Not Accepted)

Date: 3/11/04

STATE OF NEW HAMPSHIRE

Telephone # 603-271-6934 APR 2 0 2006

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

RECEI
APR 1 0 2
NH BOAR
#23959
87600 cc

RENEWAL APPLICATION

For expiration on: 6/30/08

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 reactivate the license, yo will be required to file a reinstatement application.

The following information represents the information on file for you with the Board of Medicine. **Please mak any necessary changes. Please note that pursuant to RSA 329:16-f, all licensees must inform the Board o 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.)
NONE

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

License #: 7291

File #: 8011

☑ Work Address

GARY A WASSERMAN, MD
150 TARRYTOWN RD

MANCHESTER, NH 03103-2713

Phone: 603*622-3162
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
ELLIOT HOSPITAL MANCHESTER NH		X	X	☐
Catholic Medical Center Manchester NH		☐	X	☐
		☐	☐	☐
		☐	☐	☐
		☐	☐	☐
		☐	☐	☐
		☐	☐	☐

(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. 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 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?	___	✓
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.

Signature of Licensee (Signature Stamp Not Accepted)

Date 3/28/06

MAR 25 2008

RECEIVED

MAR 21 2008

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

#2

For expiration on: 06/30/2010

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, yo will be required to file a reinstatement application.

The following information represents the information on file for you with the Board of Medicine. **Please mak any necessary changes. Please note that pursuant to RSA 329:16-f, all licensees must inform the Board 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.) NONE

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

License #: 7291

File #: 8011

☒ Work Address

GARY A WASSERMAN, MD
150 LARRYTOWN RD

MANCHESTER, NH 03103-2715

Phone: 603-622-3162
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
ELLIOT HOSPITAL	MANCHESTER, NH		☒	☑	☐
Catholic Med Center	Manchester 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?		✓
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. Previously submitted 1996	✓	
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. NONE SINCE 1996	✓	

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

Elliot 1-Day Surgicenter

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

Gary A Wasserman — 3/13/08

Signature of Licensee (Signature Stamp Not Accepted) — Date

APR 12 2010 RECEIVED

STATE OF NEW HAMPSHIRE APR 09 2010

Telephone #: 603-271-6934 NH BOARD

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

RENEWAL APPLICATION

For expiration on: 06/30/2012

Renewal Fee: $300.00

For Office Use Only: Date Pd: 4-9-10 Check # 3050

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, yo will be required to file a reinstatement application.

any necessary changes. **Please note that pursuant to RSA 329:16-f, all licensees must inform the Board 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.) NONE

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 #: 7291 File #: 8011

☒ Work Address

GARY A WASSERMAN, MD
150 TARRYTOWN RD

MANCHESTER, NH 03103-2713

Phone: 603-622-3152
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
ELLIOT HOSPITAL	MANCHESTER	NH	☑	☑	☐
CATHOLIC MEDICAL CE	MANCHESTER	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?	___	✓
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 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.

Gary A Wasserman — 4/5/10

Signature of Licensee (Signature Stamp Not Accepted) — Date

APR 11 2012 RECEIVED APR 06 2012 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

Renewal Fee: $350.00

For expiration on: 06/30/2014

For Office Use Only: Date Pd: 4-6-12 Check #: 33103

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, y will be required to file a reinstatement application.

The following information represents the information on file for you with the Board of Medicine. **Please ma any necessary changes. Please note that pursuant to RSA 329:16-f, all licensees must inform the Board 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.) NONE

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 #: 7291

File #: 8011

☒ Work Address

GARY A WASSERMAN, MD
150 TARRYTOWN RD

MANCHESTER, NH 03103-2713

Phone: 603*622-3162
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	
ELLIOT HOSPITAL	MANCHESTER	NH		☒	☒	☐	
~~CATHOLIC MEDICAL CE~~	~~MANCHESTER~~	~~NH~~		☐	☒	☐	NO longer
				☐	☐	☐	
				☐	☐	☐	
				☐	☐	☐	
				☐	☐	☐	
				☐	☐	☐	

(RENEWAL APPLICATION CONTINUED ON REVERSE SIDE)

The Board will deny licensure if you refuse to submit your social security number (SSN). Your professional license will not display your SSN. Your SSN will not be made available to the public. The Board is required to obtain your SSN for the purpose of child support enforcement and in compliance with RSA 161-B:11. This collection of your SSN is mandatory.

Social Security Number: [redacted]

**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 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] 4-3-2012

Signature of Licensee (Signature Stamp Not Accepted) Date