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Physician Profile Survey

Please Print or Type and Provide All Information Requested in Each Section

1. Biographical and Current Practice Information

CT License Number: 013026   Social Security No: [redacted]

Last Name: Nobert   First Name: Gary   MI: F

Telephone No. (Where you may be reached, 8:30 a.m.-4:30 p.m. (860) 673 - 4670

Are you currently practicing medicine in Connecticut? ☒ YES ☐ NO

Primary Practice Location-Name of Practice: Farmington OBGyn Group

Address: 20 West Avon Rd.
Avon Ct 06001

City, State Zip:

List of languages, other than English, spoken at practice location:

NA	

Other Practice Location(s)-Name of Practice: 1 Mill lane

Address: Farmington Ct 06032

100 Retreat Ave Suite 506

City, State Zip: Hartford Ct 06106

List of Languages, other than English, spoken at practice location:

NA	

Please list the Connecticut hospitals/nursing homes at which you have staff privileges:

Name/City, State	Name/City, State
Hartford Hospital Hartford Ct	
John Dempsey Hospital,	
Farmington Ct	

2. Medical School

Medical School: Tufts University School of Medicine   Year of Graduation 1965

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3. *Post-Graduate Training* (Please list your postgraduate training)

Site: Hartford Hospital City: Hartford CT Country: USA

Inclusive Dates: From: 7 / 1 / 65 To: 6 / 30 / 66 ☒ Intern ☐ Resident ☐ Fellowship (Please check one)

Type of Training (i.e. Pediatrics, Internal Medicine): ~~OB~~ Rotating internship

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Site: Hartford Hospital City: Hartford CT Country: USA

Inclusive Dates: From: 7 / 1 / 66 To: 6 / 30 / 69 ☐ Intern ☒ Resident ☐ Fellowship (Please check one)

Type of Training (i.e. Pediatrics, Internal Medicine): OB-GYN Residency

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Site: ______ City: ______ Country: ______

Inclusive Dates: From: ___/___/___ To: ___/___/___ ☐ Intern ☐ Resident ☐ Fellowship (Please check one)

Type of Training (i.e. Pediatrics, Internal Medicine): ______

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Site: ______ City: ______ Country: ______

Inclusive Dates: From: ___/___/___ To: ___/___/___ ☐ Intern ☐ Resident ☐ Fellowship (Please check one)

Type of Training (i.e. Pediatrics, Internal Medicine): ______

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Site: ______ City: ______ Country: ______

Inclusive Dates: From: ___/___/___ To: ___/___/___ ☐ Intern ☐ Resident ☐ Fellowship (Please check one)

Type of Training (i.e. Pediatrics, Internal Medicine): ______

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Site: ______ City: ______ Country: ______

Inclusive Dates: From: ___/___/___ To: ___/___/___ ☐ Intern ☐ Resident ☐ Fellowship (Please check one)

Type of Training (i.e. Pediatrics, Internal Medicine): ______

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4. *Specialty Area/American Board Certification*

Practice Specialty: OB-GYN Practice Sub-Specialty: ______

(Please use the attached table of specialties and sub-specialties for a list of acceptable specialties)

Practice Specialty: ______ Practice Sub-Specialty: ______

(Please use the attached table of specialties and sub-specialties for a list of acceptable specialties)

Please list current certifications held by the American Board of Medical Specialties or the American Board of Osteopathic Medical Specialties

American Board of: Obstetrics & Gynecology Date Certified: ___/___/___

American Board of: ______ Date Certified: ___/___/___

American Board of: ______ Date Certified: ___/___/___

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5. *Medical Educational Responsibilities (This Section is Voluntary)*

Are you a member of the faculty of a Connecticut medical school? ☒ Yes ☐ No

If Yes, Please indicate which one.

☐ Yale University Medical School ☒ University of Connecticut School of Medicine

Do you have current responsibility for graduate medical education? ☒ Yes ☐ No

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6. *Publications in Peer Reviewed Journals/Professional Services Offered/Activities and Awards (This Section is Voluntary, but provides you an opportunity to highlight accomplishments, ABMS Board Eligible status or special interests.)*

If you include publications or awards, please use the following format:

For publications: Include name of journal, title of article and date published.

For awards: Include name of entity issuing award, title of award, and date received.

1. Teacher of the Year Award - Hartford Hospital,
2. Dept. of OB-GYN - 1991
3.
4.
5.
6.
7.
8.
9.
10.

7. Medical Malpractice History

Date Resolved	Amount Paid	Practice Specialty Related To Payment
none		

8. Hospital Discipline Within Last Ten (10) Years - In Any State

Hospital, City, State, Country	Date	Disciplinary Action
none		

9. Felony Convictions Within Last Ten (10) Years - In Any State

Date of Conviction	Conviction
none	

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ATTESTATION

I hereby certify that to the best of my knowledge, the information contained in this profile is true and accurate and understand that providing false information may be grounds for sanction, which may include suspension or revocation of my license to practice medicine in Connecticut.

Signature: [signature] Date: 2-9-00

Please return as soon as possible, but no later than 60 days from the postmarked date of this survey. You may send it via facsimile to "Physician Profiles" at (860) 509-8457 or by mail (please use the enclosed, addressed envelope) to:

Department of Public Health
Physician Profiles
410 Capitol Ave., MS # 12 APP
PO Box 340308
Hartford, CT 06134

If you have questions, please contact this office at (860) 509-7557.