Renewal - 1.017586

Name	MARK A BLUMENFELD MD
Credential	1.017586

Fee Details

Renewal Application Fee	$565.00
	$565.00

Address Maintenance

Demographic Information

2. Please provide your Date of Birth.
02/06/1945

Workforce Survey Introduction

Dear Licensee:

Thank you for renewing your license online. It IS NOT necessary that you mail your hardcopy renewal application to the Department after you have renewed online.

The purpose of the next several questions is to allow the Department of Public Health to collect valuable workforce data that is currently unavailable but critical in identifying and addressing healthcare workforce shortage issues.

Thank you for assisting the Department in this important initiative.

Current Workforce Status

3. What is your current work status in Medicine?
Part-time (less than 30 hours per week)

Workforce Survey

4. In the next 12 months, do you plan to (please mark all that apply):
Significantly reduce patient care hours?

5. If you are **NOT** working in your licensed profession, please indicate your plans for returning to work in your licensed field.
I plan to return to work in my licensed profession within the next year

6. Please provide the number of hours per week that you provide DIRECT PATIENT CARE in your primary professional position.

If you do not provide hours in this category, please indicate 0.
15

7. Please provide the number of hours per week that you work as an ADMINISTRATOR/MANAGER in your primary professional position.

If you do not provide hours in this category, please indicate 0.
10

8. Please provide the number of hours per week that you work as an EDUCATOR/FACULTY in your primary professional position.
If you do not provide hours in this category, please indicate 0.
5

9. Please provide the number of hours per week that you work as a RESEARCHER in your primary professional position. If you do not provide hours in this category, please indicate 0.
0

10. If your primary profesional position is in a category other than those above, please provide that category in the box below and indicate the number of hours per week.

If you do not provide hours in this category, please indicate 0.
0

11. Please indicate the setting of your primary professional employment.

Enter comments if "Other" is selected.
Outpatient Clinic

12. Gender
Male

13. Race: Choose all that apply:

14. Ethnicity: Please choose one:
Not Hispanic or Latino

Practice Location

If you are providing direct patient care, please identify the location of the primary site where you spend the most time providing direct patient care.

15. Address 1
360 Market Street

16. Address 2

17. City
Hartford

18. State
CT

19. Zip Code
06120

Primary Source of Payment

What percent of your patients have the following source of Payment?

20. Medicare
less than 10%

21. Medicaid
51 - 75%

22. Self-Pay
less than 10%

23. Private Insurance
11 - 25%

24. Other
None

Attestation

25. Have you been convicted of a felony since your last application?
No

26. Have you had any disciplinary action taken against you or any such actions pending by another State's licensing/certification authority since your last application?

No

By completing this renewal online, I verify that all the information I have provided is accurate and that I satisfy the renewal requirements that apply to my license.

Important Note

Please note that you will receive your new licensing documents (2 wallet-sized cards and 1 suitable for posting) during the third week of next month. DO NOT submit the hardcopy renewal application with an additional fee.

To continue processing your renewal, please click "Next" below.

On the review screen, click **"Add to Invoice."**

On the top right of the invoice screen, you will be given the option to **"Pay Invoice"** or **"Print Invoice."** When you are ready to pay the renewal fee, choose **"Pay Invoice"** to process your credit card payment.

Thank you for processing your renewal online.

Review

Renewal - 1.017586

Name	MARK A BLUMENFELD MD
Credential	1.017586

Fee Details

Renewal Application Fee	$565.00
	$565.00

Address Maintenance

Demographic Information

2. Please provide your Date of Birth.
02/06/1945

Workforce Survey Introduction

Dear Licensee:

Thank you for renewing your license online. It IS NOT necessary that you mail your hardcopy renewal application to the Department after you have renewed online.

The purpose of the next several questions is to allow the Department of Public Health to collect valuable workforce data that is currently unavailable but critical in identifying and addressing healthcare workforce shortage issues.

Thank you for assisting the Department in this important initiative.

Current Workforce Status in Medicine

3. What is your current work status in Medicine?
Inactive in the profession

Workforce Survey

4. In the next 12 months, do you plan to (please mark all that apply):

5. If you are **NOT** working in your licensed profession, please indicate your plans for returning to work in your licensed field.

6. Please provide the number of hours per week that you provide DIRECT PATIENT CARE in your primary professional position.

If you do not provide hours in this category, please indicate 0.

7. Please provide the number of hours per week that you work as an ADMINISTRATOR/MANAGER in your primary professional position.

If you do not provide hours in this category, please indicate 0.

8. Please provide the number of hours per week that you work as an EDUCATOR/FACULTY in your primary professional position. If you do not provide hours in this category, please indicate 0.

9. Please provide the number of hours per week that you work as a RESEARCHER in your primary professional position. If you do not provide hours in this category, please indicate 0.

10. If your primary profesional position is in a category other than those above, please provide that category in the box below and indicate the number of hours per week.

If you do not provide hours in this category, please indicate 0.

11. Please indicate the setting of your primary professional employment.

Enter comments if "Other" is selected.

12. Gender

13. Race: Choose all that apply:

14. Ethnicity: Please choose one:

Practice Location

If you are providing direct patient care, please identify the location of the primary site where you spend the most time providing direct patient care.

15. Address 1

16. Address 2

17. City

18. State

19. Zip Code

Primary Source of Payment

What percent of your patients have the following source of Payment?

20. Medicare
None

21. Medicaid
None

22. Self-Pay
None

23. Private Insurance
None

24. Other
None

Attestation

25. Have you been convicted of a felony since your last application?
No

26. Have you had any disciplinary action taken against you or any such actions pending by another State's licensing/certification authority since your last application?
No

By completing this renewal online, I verify that all the information I have provided is accurate and that I satisfy the renewal requirements that apply to my license.

Important Note

Please note that you will receive your new licensing documents (2 wallet-sized cards and 1 suitable for posting) during the third week of next month. DO NOT submit the hardcopy renewal application with an additional fee.

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Thank you for processing your renewal online.

Review

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

1. Biographical and Current Practice Information

CT License Number: 017586 Social Security No.: [redacted]

Last Name: BLUMENFELD First Name: MARK MI: A

Telephone No. (Where you may be reached, 8:30 a.m.-4:30 p.m. (860) 233 - 8769

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

Primary Practice Location-Name of Practice: Summit Medical Center

Address: 360 Market St.
~~Hartford~~, CT 06120

City, State Zip: Hartford, CT 06120

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

Spanish	

Other Practice Location(s)-Name of Practice:

Address:

City, State Zip:

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

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

Name/City, State	Name/City, State
St Francis, Hartford, CT	
Mt Sinai, Hartford, CT	

2. Medical School

Medical School: Universidad Autonoma de Guadalajara Year of Graduation 1974

****

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

Site: Dalhousie Medical School City: Halifax Country: Canada

Inclusive Dates: From: 7 / 1 / 74 To: 6 / 30 / 75 ☒ Intern ☐ Resident ☐ Fellowship (Please check one)

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

****

Site: St Francis Hosp. City: Hartford Country: USA

Inclusive Dates: From: 7 / 1 / 75 To: 6 / 30 / 78 ☐ Intern ☒ Resident ☐ Fellowship (Please check one)

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

****

Site: ______ City: ______ Country: ______

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

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

****

Site: ______ City: ______ Country: ______

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

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

****

Site: ______ City: ______ Country: ______

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

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

****

Site: ______ City: ______ Country: ______

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

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

****

4. *Specialty Area/American Board Certification*

Practice Specialty: Obstetrics and Gynecology 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: ______ Date Certified: ___/___/___

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

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

****

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

****

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. _____
2. _____
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	

****

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 Date

1/18/00

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.

Credential Profile - 1.017586

This profile contains information that may be used as a starting point in evaluating a health care provider. This profile should not, however, be the sole basis for selecting a health care provider. Please direct questions and comments about this profile to: Connecticut Department of Public Health, Physician Profiles, 410 Capitol Ave., M.S. 12 APP, P.O. Box 340308, Hartford, CT 06134-0308, oplc.dph@ct.gov.

Name	MARK A BLUMENFELD MD
Credential	1.017586

Current Practice Locations

1. Are you currently practicing medicine in Connecticut?
   Yes

2. Are you actively involved in Patient Care?
   Yes

3. Enter your practice locations

Practice Name	Address 1	Address 2	Address 3	City	State	Zip Code	Primary Practice	Languages Spoken at this Location
Summit Medical Center	360 Market St.			Hartford	Connecticut	06120	Yes	

Connecticut Staff Privileges

4. Indicate the Connecticut Hospitals or Nursing Homes for which you have Staff privileges.

Facility Name	City	State
SAINT FRANCIS HOSPITAL AND MEDICAL CENTER		
MT SINAI HOSP		

Medical School

5. Medical School
   Universidad Autonomao De Guadalajara

6. Enter the Year of Graduation from Medical School
   1974

Post Graduate Training

7. List your postgraduate training:

Site Name	City	State	Country	Start Date	End Date	Level	Type
Saint Francis Hospital and Medical Center	Hartford	Connecticut	UNITED STATES	07/01/1975	06/30/1978	Resident	
Dalhousie Medical School	Halifax		CANADA	07/01/1974	06/30/1975	Intern	

Specialty Area/American Board Certification

This physician has reported the Certification information below. For more information regarding Board Certification please contact:

- *The American Board of Medical Specialties at www.abms.org, or*
- *The American Osteopathic Association at www.am-osteo-assn.org.*

8. Please indicate practice specialties, subspecialties and the date you were certified by ABMS or ABOMS.

Specialty	Subspecialty	Certifying Board	Certification Date

Medical Education Responsibilities

9. Are you a member of the faculty of a Connecticut medical school?

10. Select the state medical schools at which you are a member of the faculty.
University of Connecticut School of Medicine

11. Do you have current responsibility for graduate medical education?
Yes

Publications, Professional Services, Activities, and Awards

12. Publications, Professional Services, Activities, and Awards

Publisher/Issuer	Title/Award Name	Date

Medical Malpractice Information

13. Indicate your malpractice insurance carrier:

14. Indicate the Medical Malpractice Payments you have made within the past ten years.

Some studies have shown that there is no significant correlation between malpractice history and a physician's competence. At the same time, consumers should have access to malpractice information. This profile contains information about the malpractice payment history of the physician. Payment amounts have been placed into three statistical categories: below average, average and above average. To make the best health care decisions, you should view this information in perspective. You could miss an opportunity for high quality care by selecting a doctor based solely on malpractice history.

When considering malpractice data, please keep in mind:

- *Malpractice histories tend to vary by specialty. Some specialties are more likely than others to be the subject of litigation. This report compares physicians only to the members of their specialty, not all physicians, in order to make an individual physician's history more meaningful.*
- *This malpractice information reflects data for the last 10 years of the physician's practice. For physicians practicing less than 10 years, the data covers their total years of practice. You should take into account how long the doctor has been in practice when considering malpractice averages.*
- *The incident causing the malpractice claim may have happened years before payment is finally made. Sometimes it takes a long time for a malpractice lawsuit to move through the legal system.*
- *Some physicians work primarily with high-risk patients. These physicians may have malpractice histories that are higher than average because they specialize in cases or patients who are at very high risk of problems.*
- *Settlement of a claim may occur for a variety of reasons that do not necessarily reflect negatively on the professional competence or conduct of the physician. A payment in settlement of a medical malpractice action or claim should not be construed as creating a presumption that medical malpractice has occurred. For example, an insurer may choose to settle a case even if the physician opposes such settlement.*

You may wish to discuss the information provided in this report, and malpractice generally, with your physician.

Payments made by or on behalf of this healthcare provider:

Resolved Date	Payment Category	Specialty
06/05/2003	Average	Obstetrics and Gynecology

Connecticut Hospital Discipline

This section contains categories disciplinary actions taken by hospitals during the past ten years which are specifically required by law to be released in the physician's profile.

16. Hospital Discipline

Hospital Name	City	State	Country	Discipline Date	Disciplinary Action

Other State License

18. Indicate States outside of CT where licenses are held.

State	Disciplinary Action
New York	No

Connecticut Licensure Disciplinary Actions

19. The following lists any past disciplinary actions taken against this licensee. If there is no data present, there have been no disciplinary action taken.

Date of Action	Action	License Status
09/19/2000	Consent Order	ACTIVE
05/21/1996	Consent Order	ACTIVE

Felony Convictions

20. Felony Convictions within the previous ten years.

Conviction Date	Conviction

Profile 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 revocation of my license to practice medicine in Connecticut.

21. Enter the date.
01/22/2011

Review

CERTIFIED MAIL - RETURN RECEIPT REQUESTED NO. _____

STATE OF CONNECTICUT
DEPARTMENT OF PUBLIC HEALTH
BUREAU OF HEALTH SYSTEM REGULATION
DIVISION OF MEDICAL QUALITY ASSURANCE

In Re: Mark Blumenfeld, M.D. Petition No. 930720-01-130

CONSENT ORDER

WHEREAS, Mark Blumenfeld of Hartford, CT (hereinafter "respondent") has been issued license number 017586 to practice as a physician by the Department of Public Health (hereinafter "the Department") pursuant to Chapter 370 of the Connecticut General Statutes, as amended;

WHEREAS, respondent's license has been subject to an Interim Consent Order, approved and accepted by the Connecticut Medical Examining Board (hereinafter "the Board") on September 19, 1995, and extended from time to time thereafter (true and complete copies of the Order and extensions are attached hereto marked Attachment "A");

WHEREAS, the Department alleges that:

1. While undertaking two surgical procedures, respondent in one instance provided pre-operative and in another instance post-operative care which deviated from the minimal standard of care in this State.

2. The above described facts constitute grounds for disciplinary action pursuant to Connecticut General Statutes Section 20-13c(4); and,

WHEREAS, respondent, in consideration of this Consent Order, has chosen not to contest the above allegations of wrongdoing but, while denying guilt or wrongdoing, agrees that for purposes of this or any future proceedings before the Board the above allegations in this Consent Order shall have the same effect as if proven and ordered after a full hearing held pursuant to §19a-9, §19a-14, and §20-13c(4) of the General Statutes of Connecticut.

NOW THEREFORE, pursuant to §19a-17 and §20-13c(4) of the Connecticut General Statutes, as amended, and taking into consideration respondent's compliance with the Interim Consent Order, the parties hereby stipulate and agree to the following:

1. Respondent's license number 071586 is hereby reprimanded.
2. Respondent shall at all times refrain from performing more procedures than he can safely and competently perform within acceptable standards.
3. Respondent shall comply with all state and federal statutes and regulations applicable to his licensure.
4. Respondent shall understand that this Consent Order is a matter of public record.
5. That this Consent Order is effective on the day it is accepted and ordered by the Board.
6. That the Department's allegations as contained in this Consent Order shall be deemed true in any subsequent proceeding before the Board in which his

6. That the Department's allegations as contained in this Consent Order shall be deemed true in any subsequent proceeding before the Board in which his compliance with §20-13c(4) of the General Statutes of Connecticut, as amended, is at issue.

7. That this Consent Order is not subject to reconsideration, collateral attack or judicial review under any form or in any forum. Further, that this Order is not subject to appeal or review under the provisions of Chapters 54 or 368a of the General Statutes of Connecticut, provided that this stipulation shall not deprive respondent of any rights that he may have under the laws of the State of Connecticut or of the United States.

8. That this Consent Order is a revocable offer of settlement which may be modified by mutual agreement or withdrawn by the Department at any time prior to its being executed by the last signatory.

9. That respondent permits a representative of the Legal Office of the Office of Special Services of the Department to present this Consent Order and the factual basis for this Consent Order to the Board. Respondent understands that the Board has complete and final discretion as to whether an executed Consent Order is approved or accepted.

10. That respondent has the right to consult with an attorney prior to signing this document.

*

*

I, Mark Blumenfeld, have read the above Consent Order, and I stipulate and agree to the terms as set forth therein. I further declare the execution of this Consent Order to be my free act and deed.

Mark Blumenfeld, M.D.

Subscribed and sworn to before me this 10th day of May 1996.

Notary Public or person authorized by law to administer an oath or affirmation

My Commission expires: 7/31/97

The above Consent Order having been presented to the duly appointed agent of the Commissioner of the Department of Public Health on the 13th day of May 1996, it is hereby accepted.

Stanley K. Peck, Director
Division of Medical Quality Assurance

The above Consent Order having been presented to the duly appointed agent of the CMEB on the 21st day of May 1996, it is hereby ordered and accepted.

BY: Richard M. Ratzan MD

Richard M. Ratzan, M.D., Chairman
Connecticut Medical Examining Board

GDB
Blum7
5/96

STATE OF CONNECTICUT
DEPARTMENT OF PUBLIC HEALTH
BUREAU OF REGULATORY SERVICES

In re: Mark Blumenfeld, M.D. Petition No. 981113-001-206

CONSENT ORDER

WHEREAS, Mark A. Blumenfeld of West Hartford (hereinafter "respondent") has been issued license number 041-017586 to practice as a physician surgeon by the Department of Public Health (hereinafter "the Department") pursuant to Chapter 370 of the General Statutes of Connecticut, as amended; and,

WHEREAS, the Department alleges that:

1. During 1997, 1998 and 1999, respondent self prescribed Stadol nasal spray for diagnosed cluster migraine headaches.
2. During 1997 and 1998, respondent wrote over 90 prescriptions for the controlled substance Stadol to Connie Polomsky, an L.P.N. who worked for him.
3. During 1998 and 1999, respondent used an alias to write prescriptions for the controlled substance Stadol for his former wife, Karrie Ellis.
4. On approximately March 22, 1999, respondent wrote a prescription for the controlled substance Stadol for Ellen Markowitz at a fictitious address.
5. On approximately March 22, 1999, respondent picked up the prescription referred to in paragraph 4.
6. On approximately March 22, 1999, Ellen Markowitz was not a patient of respondent's.
7. On approximately March 29, 1999, respondent entered into an Agreement Concerning Connecticut Controlled Substance Certificate of Registration with the Connecticut

Department of Consumer Protection. The agreement provided that respondent would not dispense, administer or prescribe controlled substances to himself, members of his family or Connie Polomsky, except in the case of a medical emergency.

8. During the period from April through July of 1999, respondent self prescribed the controlled substance Stadol on at least nine occasions, in violation of the Agreement referenced to in paragraph 7.

9. On approximately August 19, 1999, respondent voluntarily surrendered his Connecticut controlled substance registration to the Department of Consumer Protection.

10. The above described facts constitute grounds for disciplinary action pursuant to the General Statutes of Connecticut, §20-13c, including, but not limited to

    a. §20-13c(3);
    b. §20-13c(4); and/or,
    c. §20-13c(5).

WHEREAS, respondent, in consideration of this Consent Order, has chosen not to contest this matter and agrees that for purposes of this or any future proceedings before the Connecticut Medical Examining Board (hereinafter "the Board"), this Consent Order shall have the same effect as if proven and ordered after a full hearing held pursuant to §§19a-10, 19a-14 and 20-13c of the General Statutes of Connecticut.

NOW THEREFORE, pursuant to §§19a-14, 19a-17 and 20-13c of the General Statutes of Connecticut, respondent hereby stipulates and agrees to the following:

1. Respondent waives his right to a hearing on the merits of this matter.

2. Respondent's license shall be placed on probation for a period of five years under the following terms and conditions:

    a. Respondent shall participate in regularly scheduled therapy at his own expense with a licensed psychiatrist or psychologist pre-approved by the Department (hereinafter "therapist")

(1) Respondent shall provide a copy of this Consent Order to his therapist.

(2) Respondent's therapist shall furnish written confirmation to the Department of his or her engagement in that capacity and receipt of a copy of this Consent Order within fifteen (15) days of the effective date of this Consent Order.

(3) If the therapist determines that therapy is no longer necessary, that a reduction in frequency of therapy sessions is warranted, or that respondent should be transferred to another therapist, the therapist shall advise the Department, and the Department shall pre-approve said termination of therapy, reduction in frequency of therapy sessions, and or respondent's transfer to another therapist.

(4) The therapist shall submit reports monthly for the duration of probation, which shall address, but not necessarily be limited to, respondent's ability to practice medicine in an alcohol and substance free state safely and competently. Said reports shall continue until the therapist determines that therapy is no longer necessary or the period of probation has terminated.

(5) The therapist shall immediately notify the Department in writing if the therapist believes respondent's continued practice poses a danger to the public, or if respondent discontinues therapy and/or terminates his or her services.

b. During the entire five year probation, respondent shall refrain from the ingestion of alcohol in any form and the ingestion, inhalation, injection or other use of any controlled substance and/or legend drug unless prescribed or recommended for a legitimate therapeutic purpose by a licensed health care professional authorized to prescribe medications. In the event a medical condition arises requiring treatment utilizing controlled substances, legend drugs, or alcohol in any form, respondent

shall notify the Department and, upon request, provide such written documentation of the treatment as is deemed necessary by the Department.

(1) During the first two years of the probationary period, respondent shall submit to random observed urine screens for alcohol, controlled substances, and legend drugs at least twice per week; during the third, fourth and fifth years, he shall submit to such screens at least once each week. Respondent shall submit to such screens on a more frequent basis if requested to do so by the therapist or the Department. Said screens shall be administered by a facility approved by the Department. All such random screens shall be legally defensible in that the specimen monitor and chain of custody shall be identified throughout the screening process. All laboratory reports shall state that the chain of custody procedure has been followed.

(2) Respondent shall cause to have the facility provide monthly reports to the Department on the urine screens for alcohol, controlled substances and legend drugs. All such screens shall be negative for alcohol, controlled substances, and legend drugs except for medications prescribed by respondent's physician. If respondent has a positive urine screen, the facility shall immediately notify the Department. All positive random drug and alcohol screens shall be confirmed by gas chromatography/mass spectrometer testing.

(3) Respondent understands and agrees that if he fails to submit a urine sample when requested by his monitor such missed screen shall be deemed a positive screen.

(4) Respondent shall notify each of his health care professionals of all medications prescribed for him by any and all other health care professionals.

(5) Respondent is hereby advised that the ingestion of poppy seeds and mouthwash has from time to time been raised as a defense to a positive screen result for morphine, opiates and/or alcohol. For that reason, respondent agrees to refrain from ingesting poppy seeds in any food substances, and mouthwash during the term of this Consent Order. In the event respondent has a positive screen for morphine, opiates and/or alcohol, respondent agrees that the ingestion of poppy seeds and/or mouthwash shall not constitute a defense to such a screen.

c. Respondent shall provide his employer, partner and/or associate at any hospital, clinic, partnership and/or association at which he is employed or with which he is affiliated or has privileges at each place where respondent practices as a physician/surgeon throughout the probationary period with a copy of this Consent Order within fifteen (15) days of its effective date, or within fifteen (15) days of commencement of employment at a new facility. Respondent agrees to provide reports from such employer monthly for the duration of probation, stating that respondent is practicing with reasonable skill and safety and in an alcohol and substance-free state.

d. During the period of probation, respondent shall only practice medicine in an office and practice setting that includes other physicians.

e. Respondent hereby agrees that the Department may provide a copy of this Consent Order to (1) the Department of Consumer Protection, Drug Control Division and (2) the Federal Drug Enforcement Administration, so long as they each agree to maintain the confidentiality of this Consent Order. The Department shall secure such agreements, in writing, and provide a copy of such agreements to respondent prior to releasing this Order to such entities.

3. All correspondence and reports are to be addressed to:

Bonnie Pinkerton, Nurse Consultant
Department of Public Health
Division of Health Systems Regulation
410 Capitol Avenue, MS #12HSR
P.O. Box 340308
Hartford, CT 06134-0308

4 All reports required by the terms of this Consent Order shall be due according to a schedule to be established by the Department of Public Health.

5. Respondent shall comply with all state and federal statutes and regulations applicable to his licensure

6. Respondent shall pay all costs necessary to comply with this Consent Order.

7. Any alleged violation of any provision of this Consent Order may result in the following procedures at the discretion of the Department

a. The Department shall notify respondent in writing by first-class mail that the term(s) of this Consent Order have been violated, provided that no prior written consent for deviation from said term(s) has been granted

b. Said notification shall include the acts or omission(s) which violate the term(s) of this Consent Order.

c. Respondent shall be allowed fifteen (15) days from the date of the mailing of notification required in paragraph 7a above to demonstrate to the satisfaction of the Department that he has complied with the terms of this Consent Order or, in the alternative, that he has cured the violation in question

d. If respondent does not demonstrate compliance or cure the violation by the limited fifteen (15) day date certain contained in the notification of violation to the satisfaction of the Department, he shall be entitled to a hearing before the Board which shall make a final determination of the disciplinary action to be taken.

e. Evidence presented to the Board by either the Department or respondent in any such hearing shall be limited to the alleged violation(s) of the term(s) of this Consent Order.

8. In the event respondent violates any term of this Consent Order, respondent agrees immediately to refrain from practicing as a physician, upon request by the Department, with notice to the Board, for a period not to exceed 45 days. During that time period, respondent further agrees to cooperate with the Department in its investigation of the violation, and to submit to and complete a medical, psychiatric and/or psychological evaluation, if requested to do so by the Department; and, that the results of the evaluation shall be submitted directly to the Department. Respondent further agrees that failure to cooperate with the Department in its investigation during said 45 day period shall constitute grounds for the Department to seek a summary suspension of respondent's license. In any such summary action, respondent stipulates that his failure to cooperate with the Department's investigation shall constitute an admission that his conduct constitutes a clear and immediate danger as required pursuant to the General Statutes of Connecticut, sections 4-182(c) and 19a-17(c).

9. In the event respondent violates any term of this Consent Order, said violation may also constitute grounds for the Department to seek a summary suspension of his license before the Board.

10. Legal notice shall be sufficient if sent to respondent's last known address of record reported to the Licensure and Registration Section of the Division of Health Systems Regulation of the Department.

11. This Consent Order is effective on the first day of November 2000.

12. Respondent agrees that this Consent Order shall be deemed a public document, and the Department's allegations as contained in this Consent Order shall be deemed true in any subsequent proceeding before the Board in which his compliance with this Consent Order or with §20-13c of the General Statutes of Connecticut, as amended, is at issue.

13. Any extension of time or grace period for reporting granted by the Department shall not be a waiver or preclude the Department from taking action at a later time. The Department shall not be required to grant future extensions of time or grace periods.

14. This Consent Order and terms set forth herein are not subject to reconsideration, collateral attack or judicial review under any form or in any forum. Further, this Order is not subject to appeal or review under the provisions of Chapters 54 or 368a of the General Statutes of Connecticut, provided that this stipulation shall not deprive respondent of any rights that he may have under the laws of the State of Connecticut or of the United States.

15. This Consent Order is a revocable offer of settlement which may be modified by mutual agreement or withdrawn by the Department at any time prior to its being executed by the last signatory.

16. Respondent permits a representative of the Legal Office of the Bureau of Regulatory Services to present this Consent Order and the factual basis for this Consent Order to the Board. Respondent understands that the Board has complete and final discretion as to whether this executed Consent Order is approved or accepted.

17. Respondent understands and agrees that he is responsible for satisfying all of the terms of this Consent Order during vacations and other periods in which he is away from his residence.

18. Respondent has the right to consult with an attorney prior to signing this document.

*

I, Mark A. Blumenfeld, have read the above Consent Order, and I stipulate and agree to the terms as set forth therein. I further declare the execution of this Consent Order to be my free act and deed.

Mark A. Blumenfeld

Subscribed and sworn to before me this 18th day of SEPTEMBER 2000.

Notary Public or person authorized
by law to administer an oath in this jurisdiction

DELORES A. ST. LOUIS
NOTARY PUBLIC
MY COMMISSION EXPIRES JUNE 30, 2002

The above Consent Order having been presented to the duly appointed agent of the Commissioner of the Department of Public Health on the 19th day of September 2000, it is hereby accepted.

Kathleen Zarrella, Director
Division of Health Systems Regulation

The above Consent Order having been presented to the duly appointed agent of the Connecticut Medical Examining Board on the 19th day of September 2000 it is hereby ordered and accepted.

Connecticut Medical Examining Board

S:\ mitc\blumenfeld\legal.co2 9.00

STATE OF CONNECTICUT

DEPARTMENT OF PUBLIC HEALTH

November 10, 2005

Mark Blumenfeld, MD
65 Pine Hill Road
Avon, CT 06001-2705

Re: Consent Order
Petition No. 981113-001-206
License No. 017586

Dear Dr. Blumenfeld:

Please accept this letter as notice that you have satisfied the terms of your license probation, effective November 1, 2005.

Notice will be sent to the Department's Licensure and Registration section to remove all restrictions from your license related to the above-referenced Consent Order.

Please be certain to retain this letter as documented proof that you have completed your license probation.

Thank you for your cooperation during this process.

Very truly yours,

Bonnie Pinkerton

Bonnie Pinkerton, RN, Nurse Consultant
Practitioner Licensing and Investigations Section

cc: J. Filippone

Phone: (860) 509-7400
Telephone Device for the Deaf (860) 509-7191
410 Capitol Avenue - MS # 12HSR
P.O. Box 340308 Hartford, CT 06134
An Equal Opportunity Employer

STATE OF CONNECTICUT

DEPARTMENT OF PUBLIC HEALTH

September 4, 2012

TO WHOM IT MAY CONCERN:

LICENSURE VERIFICATION

Please be advised that Connecticut General Statutes, certain matters involving the investigation and rehabilitation of Physician/Surgeon remain confidential. Therefore, in response to your inquiry regarding the status of the Physician/Surgeon identified below, at this time we are providing only publically disclosable information. In order for this office to confirm or deny whether there is any confidential information relevant to your inquiry, a release form from such Physician/Surgeon must be provided.

IF YOU WISH TO ESTABLISH WHETHER CONFIDENTIAL INFORMATION EXISTS CONCERNING THIS Physician/Surgeon, PLEASE HAVE HIM/HER SIGN THE REVERSE SIDE OF THIS FORM, WHICH CONSTITUTES A RELEASE FOR SUCH INFORMATION, AND RETURN IT TO THIS OFFICE. PLEASE NOTE THAT ONLY THIS DEPARTMENT'S RELEASE FORM WILL BE ACCEPTED.

This is to certify that the records of the Connecticut Department of Public Health indicate that:

MARK A BLUMENFELD MD

Was issued Connecticut:	Physician/Surgeon License
Date of Issuance:	03/15/1976
License Number:	17586
Expiration Date:	02/28/2013
Status of License:	ACTIVE, PRIOR DISCIPLINE
Past or Pending Disciplinary History:	Yes

Sincerely,

Stephen B. Carragher
Health Program Supervisor
Office of Practitioner Licensing and Investigation

Printed by: Jan Cordero

Phone: (860) 509-7603
Telephone Device for the Deaf (860) 509-7191
410 Capitol Avenue - MS # 12 APP
P.O. Box 340308 Hartford, CT 06134
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