RECEIVED
DEPARTMENT OF HEALTH SERVICES

JUN 6 1981

DIVISION OF MEDICAL QUALITY ASSURANCE

120 CK 8/6/81

CK #150 on 11/20/82 TM #52

Connecticut Medical Examining Board
79 Elm Street, Hartford, Connecticut 06115

APPLICATION FOR LICENSE TO PRACTICE MEDICINE WITHOUT EXAMINATION

By Endorsement of National Board of Medical Examiners or Federation of Medical Boards Certification

OR By Endorsement of State License or License of the Medical Council of Canada

MB-10 New 4-74

Physicians who have received the degree of Doctor of Medicine from medical schools and:

1. are certified by the National Board of Medical Examiners OR
2. are certified by the Federation of State Medical Boards of the United States, Inc. after passing the FLEX examinations OR
3. have been licensed in any state or territory of the United States or the District of Columbia, after written examination of as high grade as that required for a certificate of registration in the State of Connecticut OR
4. are licentiates of the Medical Council of Canada, after written examination AND
5. are 5th Pathway Program candidates who are graduates of a medical school located outside the United States which school is recognized by the American Medical Association or the World Health Organization, and who has satisfactorily completed in any hospital recognized by the American Medical Association or the World Health Organization one academic year of supervised clinical training and such post-graduate training as is required by the American Medical Association and have complied with #3 (above) who are of good moral character and professional standing, are eligible to be recommended for licensure without examination. The fee for the endorsement of state licenses under the provisions of this paragraph is one hundred and fifty dollars ($150.00). (Check to be made payable to Treasurer State of Connecticut.)

REQUIRED DOCUMENTS

Diplomates of the National Board of Medical Examiners must apply to that Board for Certification of Record which will be sent directly to the Connecticut Medical Examining Board. (Address: N.B.M.E., 3930 Chestnut Street, Philadelphia, Pa. 19104) Medical Doctors who passed the FLEX examinations must request the Federation of Medical Boards of the United States, Inc. to send the grades obtained directly to the Connecticut Medical Examining Board.

Licentiates of the Medical Council of Canada must obtain a "Certificate of Standing" from The Medical Council and attach it to this application.

NOTE: The license to practice medicine in the State of Connecticut is granted by the Connecticut Department of Health upon presentation of the certificate issued by the Connecticut Medical Examining Board. Connecticut law does not provide for the issuance of temporary or limited license.

I hereby apply to the Connecticut Medical Examining Board for certification without examination for licensure to practice medicine in the State of Connecticut, by:

(check A or B and complete that section)

A. ☒ Endorsement of my certificate, issued by the National Board of Medical Examiners.

NAT. BOARD MED. EXAM. CERTIF. NUMBER	DATE CERTIFICATE ISSUED
221078	7/1/80

B. ☐ Endorsement of my license, issued after written examination by the licensing authority named below.

LICENSE NUMBER	ISSUING STATE OR DOMINION OF CADADA

ISSUED BY (Licensing Board or Dept.)	DATE LICENSE ISSUED

DATE OF THIS APPLICATION 7/20/81

In support of this application I submit the following information:

SWORN STATEMENT

1. NAME (Last, First, Middle): RICHMAN, SUSAN M.
DATE OF BIRTH:
SEX: MALE ☐ FEMALE ☐
2. PRESENT ADDRESS (Street, Town, Zip): 30 HUNGRY HILL CIRCLE, GUILFORD 06437
3. PLACE OF BIRTH (Town, State or Country): ROSLYN, N.Y.

4. CITIZENSHIP

I am a citizen of the United States	☒ Yes ☐ No	IF NATURALIZED: Give date, place, and certificate number.
I have filed a declaration of intention to become a citizen of the United States	☐ Yes ☐ No	IF YES, Give date, place of filing, and certificate number.
I have a petition approved by the United States Immigration and Naturalization Service	☐ Yes ☐ No	IF YES, Give file number, date of notice, and petition date.

5. PREMEDICAL EDUCATION

DEGREES REC'D	NAMES OF SCHOOLS	DATES DEGREES REC'D
BA	QUEENS COLLEGE	6/73
	QUEENS, NEW YORK	

LIST NAMES AND ADDRESSES OF ALL PREMEDICAL SCHOOLS ATTENDED	DATE ENTER. (Mo., Yr.)	DATE DEPART. (Mo., Yr.)
	9/69	6/73
UNIV. OF CHICAGO - GRAD. DEPT OF ANATOMY	9/73	6/74

(Continued on next page)

PREMEDICAL EDUCATION (Continued from front page)

LIST NAMES AND ADDRESSES OF ALL PREMEDICAL SCHOOLS ATTENDED	DATE ENTER. (Mo., Yr.)	DATE DEPART. (Mo., Yr.)
PACE UNIVERSITY - GRAD SCHOOL OF NURSING	9/74	6/75

6. MEDICAL EDUCATION — Doctor of Medicine degree received from: — NAME OF SCHOOL — DATE DEGREE REC'D

LIST NAMES AND ADDRESSES OF ALL MEDICAL SCHOOLS ATTENDED	DATE ENTER. (Mo., Yr.)	DATE DEPART. (Mo., Yr.)
ALBERT EINSTEIN COLLEGE OF MEDICINE	9/75	6/79
BRONX, NEW YORK		

7. MEDICAL LICENSURE — List the states you have been licensed to practice medicine in:

STATE	DATE LICENSE ISSUED	LICENSED BY:	STATE	DATE LICENSE ISSUED	LICENSED BY:
		☐ EXAM. ☐ ENDORSM'T			☐ EXAM. ☐ ENDORSM'T
		☐ EXAM. ☐ ENDORSM'T			☐ EXAM. ☐ ENDORSM'T

8. Have you ever been declined a license after a written examination ☐ Yes ☒ No — IF YES, List states

9. Have you ever been brought before a Medical Examining Board, Medical Society or a criminal court on charges of unprofessional conduct or criminal behavior, or had a license to practice medicine suspended or revoked? ☐ Yes ☒ No IF YES, EXPLAIN BELOW

10. MEDICAL PRACTICE — Since graduation from medical school I have been engaged in medical practice as follows: Include Internship & Residency

LOCATION (Town & State or Country)	HOSPITALS ASSOCIATED WITH AT THIS LOCATION	DATE MOV. HERE (Mo., Yr.)	DATE DEPART. (Mo., Yr.)
NEW HAVEN, CT	YALE NEW HAVEN HOSPITAL	6/79	current position

If applicable, please enclose copy of Specialty Board Certificate

11. SPECIALTY — I am a Diplomate of the American Board of: — NAME OF AMERICAN BOARD

NAMES OF ANY OTHER SPECIAL SOCIETIES

12. Have you enclosed one hundred and fifty dollars ($150.00), the fee required by Connecticut law? ☒ Yes ☐ No

13. AFFIDAVIT OF APPLICANT The above named applicant, being duly sworn, says that (s)he is the person referred to in this application for certification for licensure to practice medicine in the State of Connecticut and that the statements herein contained are each and all true in every respect.

SIGNED IN THE STATE OF: Connecticut

COUNTY OF: New Haven

SEAL of Notary Public

SIGNATURE OF APPLICANT	SIGNATURE OF NOTARY PUBLIC	DATE OF SIGNATURE
Susan M. Pilcher MD.	Mary G. DeCrosta	August 4, 1981

14. CERTIFICATE OF MEDICAL LICENSURE — Answer ONLY if applying for endorsement of state license. **This section MUST be completed by an official of the State Board which granted license.**

It is hereby certified that said applicant is a medical school graduate and after written examination was granted a Certificate of Licensure to practice medicine in this state. This license has never been revoked or suspended and said applicant has never been summoned to appear before this board, on charges of unprofessional conduct except as indicated below.

It is further certified that the data presented below applies to the above statement.

GRADUATE OF (Name of Medical School)	CERTIFICATE OF LIC. NO.	MEDICAL EXAMINING BOARD, STATE OF ISSUED BY:	DATE LICENSE ISSUED

EXPLAIN ANY CHARGES OF UNPROFESSIONAL CONDUCT

It is further certified that said applicant was examined in the following subjects and has received the following grades:

GENERAL AVERAGE	PASSING GRADE

SUBJECT	GRADE	SUBJECT	GRADE

It is also certified that physicians who are licensed in the State of Connecticut and whose educational qualifications meet the requirements of this board, will, upon proper application, be approved without examination for licensure to practice medicine in this state.

SIGNATURE OF OFFICIAL

TITLE | MEDICAL EXAM. BOARD, STATE OF

SEAL of Medical Examining Board

Answer ONLY if applying for endorsement of Medical Council of Canada license.

15. Have you attached a "Certificate of Standing" with scores from the Medical Council of Canada? ☐ Yes ☐ No

16. CERTIFICATE OF MEDICAL EDUCATION

It is hereby certified that the above named applicant has received the degree of Doctor of Medicine. See Pg. 4 if Foreign Medical Graduate.

This section MUST be completed by the Dean, Secretary, or Registrar of Medical School.

NAME OF MEDICAL SCHOOL	NO. COURSES TAKEN	NO. OF MOS. PER COURSE
ALBERT EINSTEIN COLLEGE OF MEDICINE	all 4 years	11

ADDRESS OF MEDICAL SCHOOL	DATE OF MATRICULATION
1300 MORRIS PARK AVENUE-BRONX, NY 10461	9/2/75

NAME OF SCHOOL OFFICIAL (Printed)	TITLE	DATE DEGREE CONFER.
Dr. Stephen H. Lazar	Assistant Dean	6/6/79

SIGNATURE OF SCHOOL OFFICIAL	DATE OF SIGNATURE
	7/28/81

SEAL of Medical School

17. CERTIFICATE OF IDENTIFICATION:
By official of County or State Medical Society, or of a Medical School or Hospital superior.

It is hereby certified that the above named applicant is an ethical practitioner of good moral and professional character and is recommended without reservation for certification for licensure to practice medicine in the State of Connecticut. It is further certified that the photograph attached hereto is a true likeness of said applicant.

BY:	NAME OF MED. SOCIETY OFFICIAL (Printed)	NAME OF MEDICAL SOCIETY

Is this applicant a member of this Medical Society? ☐ Yes ☐ No

	NAME OF MED. SCHOOL OFFICIAL (Printed)	NAME OF MEDICAL SCHOOL
OR:	Dr. Stephen H. Lazar	Albert Einstein College
OR:	NAME OF HOSPITAL SUPERIOR (Printed)	NAME OF HOSPITAL

SIGNATURE OF OFFICIAL OR SUPERIOR	TITLE

18. CERTIFICATE OF MORAL CHARACTER I certify that I am acquainted with the above named applicant and that to the best of my knowledge and belief said applicant is a suitable person to be a licensed to practice medicine in the State of Connecticut. (Two names are required)

	NAME (Printed)	NO. YRS. ACQUAINTED	ADDRESS
1.	DONALD R. COUSTAN	2	YALE NEW HAVEN HOSPITAL
	SIGNATURE Donald R. Coustan MD		
2.	NAME (Printed) Howard Simon MD	NO. YRS. ACQUAINTED 1 +	ADDRESS YALE NEW HAVEN HOSPITAL
	SIGNATURE Howard Simon		

In addition to signing the reference sections, ask each doctor who is licensed in U. S. to write a separate character reference letter and mail it directly to this office. These doctors must have known you for one year or more.

DATA SHEET

APPLICATION FOR LICENSURE WITHOUT EXAMINATION

Reciprocity ..... Endorsement NBME#221078 7/1/80

NAME RICHMAN (Last) SUSAN (First) M. (Middle)

1. Premedical Education Queens College, 9/69-6/73, Univ. of Chicago, 9/73-6/74 B.A.
2. Medical Education Albert Einstein College of Medicine, 9/75-6/79 M.D. Degree
3. State License by Written Examination ..... (State) (Year) (Grade)
4. National Board Certificate 221078 (Number) 7/1/80 (Year) (Grade)
5. State Board of Healing Arts Certificate .....
6. A.M.A. Approval Requested ..... Received .....
7. Photograph Furnished YES
8. Fee Paid ~~No Check encl.~~ $150.00 1/26/82 Tn#56
9. References Donald R. Coustan, M.D.
   Howard Simon, M.D.
10. Citizenship BY BIRTH
11. Probable Location ..... Specialty .....
12. Alphabetical Index Checked YES ..... Correspondence File Reviewed YES

Application Complete .....

Issuance of Certificates
authorized by ..... Date 2/5/82
Lawrence K. Pickett, M.D., Chairman
Certificate Number 23330 ..... Issued 2/5/82

Med. Bd. 8 (2-75) 2500

NATIONAL BOARD OF MEDICAL EXAMINERS® • 3930 CHESTNUT STREET, PHILADELPHIA, PENNA. 19104

ENDORSEMENT OF CERTIFICATION

RECEIVED
DEPARTMENT OF HEALTH SERVICES
JUL 16 1981
DIVISION OF MEDICAL QUALITY ASSURANCE

NATIONAL BOARD OF MEDICAL EXAMINERS
OF THE
UNITED STATES OF AMERICA

Susan M. Richman, M.D.

having satisfied all the requirements and having successfully passed the examinations is hereby declared a Diplomate of the National Board of Medical Examiners

Attest: WILLIAM B. HOLDEN
Chairman of the Board

SEAL

EDITHE J. LEVIT
President of the Board

Philadelphia, Pa.
07/01/80

Cert # 221078

It is certified that the above is a copy of the Diplomate Certificate issued to the named physician, a graduate of ALBERT EINSTEIN COL MED in JUNE 1979 whose birth date is 01/21/1952 following successful completion of all examinations required for Certification by the National Board of Medical Examiners.

The grades obtained are as follows:

	Standard Score	Scale Score
PART I passed 06/77		
Anatomy, incl. Histology and Embryology	685	89
Physiology	485	80
Biochemistry	540	81
Pathology	540	83
Microbiology, incl. Immunology	490	76
Pharmacology and Materia Medica	540	81
Behavioral Sciences	385	73
(Minimum Passing Grade 380/75) TOTAL GRADE/AVERAGE**	505	81
Part II passed 04/78		
Internal medicine and the medical specialties	560	85
Surgery and the surgical specialties	585	84
Obstetrics and Gynecology	640	89
Public Health and Preventive Medicine	585	85
Pediatrics	535	84
Psychiatry	550	85
(Minimum Passing Grade 290/75) TOTAL GRADE/AVERAGE**	580	85
PART III passed 03/80		
A General Test of Clinical Competence		
(Minimum Passing Grade 290/75) AVERAGE	605	85.9
GENERAL AVERAGE (Parts I, II, and III)		84.0 (Scale Score)

*Examinations taken since June 1971 are reported with both Standard and Scale Score Equivalents.

**Since 1966 National Board criteria for certification are based upon candidate's Total Grade in Part I, Part II, and Part III, and not scores of individual subjects within each Part.

Secretary for Certification

07/09/81

SEAL

Part II

STATE OF CONNECTICUT

DEPARTMENT OF HEALTH SERVICES

DIVISION OF MEDICAL QUALITY ASSURANCE

It is the responsibility of an applicant for licensure to send this letter to the Chief of Staff of the hospital in which the applicant served his/her residency training. The form should be completed by the hospital and returned directly to the Division of Medical Quality Assurance.

Dear Chief of Staff:

The Connecticut Statutes governing the licensure of physicians/surgeons now require at least two years of residency training in a program approved by the AMA Liaison Committee on Graduate Medical Education. Please verify that this applicant was indeed in such a program at your institution. Your assistance will be greatly appreciated.

Applicant's Name: Dr. Susan Richman

Residency Program: OBSTETRICS GYNECOLOGY

Dates of Residency: (From) 7/79 (To) 7/81

I verify that the above named individual was in the residency training program named during the time noted above. I also confirm that this program was approved by the Liaison Committee on Graduate Medical Education at the time of the training.

Signature, Chief of Staff

333 Cedar Street
Hospital Address

New Haven, CT.
City/State

PLEASE RETURN THIS FORM TO:
Connecticut Medical Examining Board
Division of Medical Quality Assurance
Department of Health Services
79 Elm Street
Hartford, CT 06115

Yale University *New Haven, Connecticut 06510*

SCHOOL OF MEDICINE
333 Cedar Street
Department of Obstetrics and Gynecology

January 21, 1982

Connecticut Medical Examining Board
79 Elm St.
Hartford, Connecticut 06115

Dear Sirs:

This letter is in support of the application for Dr. Susan Richman to receive a license to practice medicine in the State of Connecticut. Her character is exemplary and I know she will be a credit to our profession. I wholeheartedly endorse her application. I have known her for three years since she did an internship and is a resident in our department.

Sincerely,

Donald R. Coustan

Donald Coustan, M.D.
Associate Professor
DEPT OB GYN

DC:mr

County Obstetrics & Gynecology Group, P.C.

Paul J. Coppola, M.D. Michael R. Berman, M.D. Howard Simon, M.D.
C. E. Burke-Durrence M.S.N., C.N.M.

University Towers
100 York Street
New Haven, Conn. 06511
—
(203) 777-6293

687 Main Street
Branford, Conn. 06405
—
(203) 488-8306

110 East Main Street
Clinton, Conn. 06413
—
(203) 669-6522

To whom it may concern,

I have known Dr. Susan Richman for more than one year and would be honored to support her application for medical licensure.

Sincerely,

Howard Simon

Howard Simon, M.D.

CT. LIC. NO. 22025

STATE OF CONNECTICUT

DEPARTMENT OF HEALTH SERVICES

DIVISION OF MEDICAL QUALITY ASSURANCE

February 5, 1982

Susan M. Richman, M.D.
30 Hungry Hill Circle
Guilford, Ct. 06437

Dear Doctor:

On behalf of the Connecticut Medical Examining Board, I want to congratulate you upon the successful completion of all requirements for licensure as a Medical Doctor in the State of Connecticut.

Enclosed is a brief request for information necessary to complete the processing of your license. Please complete this and return to Mary Bayers, Chief of Licensure and Registration, at the address below. She will then issue you a formal license. Your license will not be issued until this information is returned.

I wish you success in your career and must inform you that it is your responsibility to keep this Department aware of your current address; otherwise the status of your license will be jeopardized.

Sincerely,

Gary W. DeWitt, Ph.D.
Examination Coordinator
Connecticut Medical Examining Board

GWD: cmb

Enclosure

Phone: 1-(203)566-5630
79 Elm Hartford, Connecticut 06115

Account: [redacted]
Your Field 1: 23330
Your Field 2: 44
Your Field 3: 01

Webster Web-Link®

BOX 1

SOC. SEC. NO. xxx-xx[redacted] FED. EMPLOYER ID. NO
IF SOC. SEC. NO. IS MISSING OR DIFFERENT THAN ABOVE PLEASE ENTER BELOW
___-___-____

IF FED. EMPLOYER ID NO. IS MISSING OR DIFFERENT THAN ABOVE PLEASE ENTER BELOW
___-___-____

IF YOU HAVE NEITHER A S.S.N. NOR A F.E.I.N., INDICATE REASON
____ APP. FOR NO. PENDING
____ NOT U.S. CITIZEN ____ OTHER _____

TYPE 01

BOX 3 RENEWAL FEE: $565.00 DUE DATE 01/31/12

023330

PHYSICIAN/SURGEON

LAST NAME (001) | FIRST NAME (002) | MI (003) | ADD 1 (011) | ADD 2 (012) | ADD 3 (013) | CITY (014) | ST (015) | ZIP (016) | COUNTRY

BOX 2 Make any changes or corrections below

0008724 FP **PRSRT T5 0 1563 06606
SUSAN M. PICHMAN, MD
3787 MAIN ST
BRIDGEPORT CT 06606-3612

Check appropriate address box: [X] Office [ ] Residence

STATE OF CONNECTICUT
DEPARTMENT OF PUBLIC HEALTH
DIVISION OF HEALTH SYSTEMS REGULATION
POST OFFICE BOX 1000 HARTFORD, CT 06143-1000

4402333001565000131201200058395152

INSTRUCTIONS ANSWER EACH QUESTION, READ THE STATEMENTS THAT FOLLOW AS THEY RELATE TO YOUR LICENSE, AND SIGN BELOW.

1. WITHIN THE LAST YEAR HAVE YOU BEEN CONVICTED OF A FELONY OR HAVE YOU HAD ANY DISCIPLINARY ACTION TAKEN AGAINST YOU OR ANY SUCH ACTIONS PENDING BY ANOTHER STATE'S LICENSURE/CERTIFICATION AUTHORITY? NO ✓ YES ____
2. ARE YOU PRESENTLY WORKING IN YOUR LICENSED/CERTIFIED PROFESSION? NO ____ YES ✓ HOURS OF PRACTICE PER WEEK 40
3. WHAT IS THE ADDRESS OF YOUR PRIMARY PLACE OF EMPLOYMENT? STREET 3787 Main St
CITY Bridgeport STATE CT ZIP 06606 TYPE OF AGENCY private PHONE # 2033652661
4. WHAT IS THE ADDRESS OF YOUR RESIDENCE? STREET 29 Leighton Trail CITY Guilford STATE CT ZIP 06437
PHONE # 203 453 0316
5. HIGHEST DEGREE HELD MD 6. IF YOU HAVE BEEN CERTIFIED BY ANY AMERICAN SPECIALTY BOARD IN THE PAST YEAR, PLEASE SPECIFY BOARD AND DATE _____

↓ DO NOT WRITE IN THIS AREA ↓

020002 0040 0079 01 023330 0056500 111611 S

7. IF YOU ARE AN OPTOMETRIST, ARE YOU QUALIFIED TO HOLD YOURSELF OUT AS AUTHORIZED TO PRACTICE ADVANCED OPTOMETRIC CARE? ____ YES ____ NO
8. IF YOU ARE AN EMT, EMT-I, OR MRT, OR HOLD A LICENSE/CERTIFICATE IN A LEAD OR ASBESTOS DISCIPLINE, PROVIDE REFRESHER COURSE COMPLETION DATE _____ AND COURSE APPROVAL NUMBER _____
9. IF YOU ARE A CHIROPRACTOR, DENTAL HYGIENIST, OCCUPATIONAL THERAPIST OR ASSISTANT, OPTICIAN, OPTOMETRIST, OR SOCIAL WORKER, YOU MUST COMPLY WITH MANDATORY CONTINUING EDUCATION REQUIREMENTS FOR LICENSE RENEWAL; PHYSICIAN ASSISTANTS AND ADVANCED PRACTICE RNs MUST MAINTAIN CERTIFICATION FROM THE NATIONAL CERTIFYING BODY THAT QUALIFIED THEM FOR INITIAL LICENSURE, IN ORDER TO RENEW SUCH LICENSES.
10. IF YOU ARE LICENSED AS AN APRN, DENTAL HYGIENIST, CHIROPRACTIC, NATUROPATHIC, PODIATRIC, OSTEOPATHIC OR HOMEOPATHIC PHYSICIAN, OPTOMETRIST OR PHYSICIAN/SURGEON WHO PROVIDES DIRECT PATIENT CARE SERVICES, YOU MUST MAINTAIN PROFESSIONAL LIABILITY INSURANCE OR OTHER INDEMNITY AGAINST LIABILITY FOR PROFESSIONAL MALPRACTICE, IN ACCORDANCE WITH CT GENERAL STATUTES.

I HAVE REVIEWED THE INFORMATION PROVIDED AND REQUESTED ON THIS CARD. I VERIFY THAT IT IS ACCURATE AND THAT I SATISFY THE REQUIREMENTS LISTED ABOVE AS THEY APPLY TO MY LICENSE/CERTIFICATE.

SIGNATURE _____ DATE _____

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

1. Biographical and Current Practice Information

CT License Number: 023330 Social Security No.: 058 - 44 - 8633

Last Name: RICHMAN First Name: SUSAN MI: M

Telephone No. (Where you may be reached, 8:30 a.m.-4:30 p.m. (203) 787 - 2264

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

Primary Practice Location-Name of Practice: ~~Greater New Haven Ob/Gyn Group, P.C.~~

Address: 2Church Street South #209

New Haven, CT 06519

City, State Zip:

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

~~Spanish~~	

Other Practice Location(s)-Name of Practice: ~~same~~

Address: ~~2447 Whitney Avenue~~

Hamden, CT 06518

City, State Zip:

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

~~Spanish~~	

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

Name/City, State	Name/City, State
~~Yale New Haven Hospital~~	New Haven, CT
Hospital of St Raphael's	New Haven, CT

2. Medical School

Medical School: Albert Einstein College of Medicine Year of Graduation 1979

****

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

Site: Yale New Haven Hospital City: New Haven Ct Country: U.S.A

Inclusive Dates: From: ___/___/1979 To: ___/___/1980 ☒ Intern ☐ Resident ☐ Fellowship (Please check one)

Type of Training (i.e. Pediatrics, Internal Medicine): Ob/GYN

****

Site: Yale New Haven Hospital City: New Haven Ct Country: U.S.A

Inclusive Dates: From: 6/___/1980 To: 7/___/1983 ☐ Intern ☒ Resident ☐ Fellowship (Please check one)

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

****

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: 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: ___/___/1986

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 Med Students

****

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. Resident Teaching Award to Community Physicians 1989
2. ACOG Fellow in Service to Native Americans 1996, 1998
3. - Shiprock, New Mexico 2000
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

2/2/00
Date

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.

YNHH Women's Center
20 York Street
New Haven, CT 06504

August 18, 2002

DPH
Physician Profiles
410 Capitol Ave
PO Box 340308
Hartford, CT 06134

Dear Sir or Madam:

Please note that I am no longer employed by Greater New Haven ObGyn Group PC at 2 Church St So, New Haven CT. My new address appears above, phone # 203-688-4101.

Thank you for your attention in this matter.
Sincerely,

Dr Susan Richman
Medical Director

#22330

Credential Profile - 1.023330

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	SUSAN M RICHMAN MD
Credential	1.023330

Current Practice Locations

1. Are you currently practicing medicine in Connecticut?
   Yes

2. Are you actively involved in Patient Care?
   No

3. Enter your practice locations

Practice Name	Address 1	Address 2	Address 3	City	State	Zip Code	Primary Practice	Languages Spoken at this Location
Yale-New Haven Hospital Women's Center	20 York Street			New Haven	Connecticut	06504	Yes	

Connecticut Staff Privileges

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

Facility Name	City	State
HOSPITAL OF SAINT RAPHAEL		
YALE-NEW HAVEN HOSPITAL, INC.		

Medical School

5. Medical School
   Albert Einstein College of Medicine

6. Enter the Year of Graduation from Medical School
   1979

Post Graduate Training

7. List your postgraduate training:

Site Name	City	State	Country	Start Date	End Date	Level	Type
Yale-New Haven Hospital	New Haven	Connecticut	UNITED STATES	07/01/1980	06/30/1983	Resident	
Yale-New Haven Hospital	New Haven	Connecticut	UNITED STATES	07/01/1979	06/30/1980	Intern	OB/GYN

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
Obstetrics and Gynecology	Subspecialty	Certification Date	American Board of Obstetrics and Gynecology	01/01/1986

Medical Education Responsibilities

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

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

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
Teaching Award to Community Physicians 1989	Resident	
Fellow in Service to Native Americans 1996, 1998, 2000	ACOG	

Medical Malpractice Information

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 occured. 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.

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.*
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- *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

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

Connecticut Licensure Actions

Felony Convictions

19. 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.

20. Enter the date.

Review