State of New Hampshire

BOARD OF REGISTRATION IN MEDICINE

2 INDUSTRIAL PARK DRIVE SUITE 8

CONCORD, NH 03301-8520

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

TEL. (603) 271-1203

BOARD MEMBERS

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

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

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

March 1, 1995

VIRGINIA A SIEGFRIED MD
[redacted]

Dear Dr. Siegfried:

This is to certify that you have been granted licensure to practice medicine in the State of New Hampshire. Your license number 9388 is dated March 1, 1995.

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

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

Sincerely,

Karen laCroix
Administrator

KL/dg
Enc.

Dec. OBG (BC)

State of New Hampshire

BOARD OF REGISTRATION IN MEDICINE

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CYNTHIA S. COOPER, M.D.
MAUREEN P. KNEPP, PA-C
PARAMEDICAL PROFESSIONAL

Application No. 10256

I hereby apply for a license to practice medicine in the State of New Hampshire as a Doctor of Medicine or as a Doctor of Osteopathy and submit the following proofs, as required by the rules and regulations, formulated in accordance with the laws of the State of New Hampshire, and enclosed a certified check or postal or express money order for the application fee of $250.00, check made payable to the "Treasurer, State of New Hampshire" - U.S. Funds only. Application fees are non-refundable.

1. **PERSONAL INFORMATION:**

Name VIRGINIA ANN SIEG-FRIED
First Middle Last Maiden

Home Address _____

_____

Office Address 150 No. Robertson Blvd. #206
Beverly Hills, Calif. 90211

Date of Birth _____ Place of Birth _____

Social Security Number _____

2. **ACADEMIC EDUCATION:**

Name and Location of Institutions	Dates Attended	Degree Awarded
Santa Clara University Santa Clara, Calif	9/71 - 6/73	
Stanford University Stanford, Calif.	9/73 - 6/75	B.S.

3. MEDICAL EDUCATION:

Name and Location of Institutions	Dates Attended	Degree Awarded
Columbia University NY NY	9/75-6/79	M.D.

5. FOREIGN MEDICAL GRADUATES.

(a) Foreign graduates must submit a transcript of grades and proof of graduation from medical school. Certified copies of these documents with certified english translation is required.

(b) Foreign medical graduates must also submit original verification directly from ECFMG documenting that the applicant currently holds standard certification by ECFMG.

6. POST GRADUATE EDUCATION.

(a) Internship

Program	Location	Dates
UCLA	LA, CALIF	6/79 - 6/80

(b) Residency

Program	Location	Dates
UCLA	LA, CALIF	7/80 - 6/83

NH Requires at least 2 years of post graduate training. An official, original letter from the residency program verifying internship and/or residency is required.

7. EXAMINATION:

Name of Examination	Date of Completion	Score
National Board		

A National Board or FLEX score report form is enclosed. Please have an official transcript of your scores sent directly to the Board. If examination is by USMLE, LMCC or state examination, you must contact these organizations and have an official transcript of your scores sent directly to the Board.

8. LICENSURE:

Please list all states where you hold or have ever held a physician's license.

California		

You must obtain a verification from all states where you hold, or have ever held a license. Verifications must be received directly from the licensing authority. A form is enclosed for your convenience. Please make copies as necessary.

9. Are you certified by an American Specialty Board? X YES ____ NO

If yes, please provide a notarized photocopy of such certification.

	Yes	No
10. Have you ever, for any reason, lost American Specialty Board Certification?	___	X
11. Have you been denied required recertification by any specialty boards? If yes, list each such boards and dates denied. _____ _____	___	X
12. Has any medical malpractice claim been made against you in the last ten years (whether or not a lawsuit was filed in relation to the claim)? If so, how many? 3	X	___
13. Have you ever applied for licensure or to sit for an examination, or taken an examination, under a different name?	___	X
14. Have you ever been denied the privilege of taking or finishing an examination or been accused of cheating or improper conduct during an examination since you graduated from high school?	___	X
15. Have you ever failed any of the following examinations: the USMLE, the FLEX examination, any state board examination or have you ever failed to gain certification from the National Board of Medical Examiners?	___	X
16. Have you ever failed a foreign licensing or certification examination?	___	X
17. Have you ever been denied a medical license, whether full, limited or temporary, for any reason?	___	X
18. Have you ever had staff privileges, employment or appointment in a hospital or other health care institution denied, limited, suspended or revoked, or have you ever resigned from a medical staff in lieu of disciplinary action?	___	X

	Yes	No
19. Is any investigation or disciplinary action pending, or has any investigation or disciplinary action been taken against you in the last ten years by any governmental authority, by any hospital or health care facility, or by any professional medical association (international, national, state or local)?	____	X
20. Have you ever voluntarily surrendered a license to practice medicine or any healing art or allowed such a license to lapse in lieu of facing disciplinary investigation or action?	____	X
21. Have you ever withdrawn an application for medical licensure, hospital privileges or appointment, for any reason?	____	X
22. Have you ever been a defendant in a criminal proceeding including driving while under the influence or driving while suspended, but not including traffic offenses not classified as misdemeanors?	____	X
23. Has your privilege to possess, dispense or prescribe controlled substances ever been suspended, revoked, denied, restricted or surrendered, or have you ever been charged, investigated or warned by a state or federal agency based on controlled substance issues?	____	X
24. Have you ever had any emotional disturbance or mental illness which has impaired or would be likely to impair your ability to practice medicine?	____	X
25. Are you now, or have you, during the past 5 years, been dependent upon alcohol or habituating drugs?	____	X

NOTE ON QUESTIONS 23-25: The harm that befalls physicians and patients alike when impairment goes undetected and untreated by the medical profession is devastating. The Board wants impaired physicians treated in the early stages of impairment before irreparable harm to the physician or patient occurs.

If you have answered "yes" to any of the above, please explain on the reverse side. Attach additional 8 1/2" x 11" sheets if necessary.

26. A current curriculum vitae is required.

27. An official certified copy of your birth certificate is required.

28. Applicants must provide proof of commitment to practice medicine in N.H. An original, signed letter on letterhead must be submitted from a N.H. hospital/health care facility or private practice where applicant will be practicing.

29. A total of 4 reference letters are required. Letters of reference shall be provided by the following individuals:

_____ (Chief of Staff)
_____ MD (Chairman OB/GYN)
_____, MD
_____ (Hospital Administration)

30. AFFIDAVIT OF THE APPLICANT:

STATE OF California

COUNTY OF Los Angeles

I, Virginia Siegfried of _____, _____

being duly sworn say that I am the person referred to in the above application for a license to practice medicine as a Doctor of Medicine or Doctor of Osteopathy in the state of New Hampshire; that I have studied the treatment of human ailments not less than four school years, received a degree of Doctor of Medicine or Doctor of Osteopathy; and that all the statements herein respecting age, academic and medical education, internship, state or national board examination and license, good professional standing, and all other statements made on said application are true in every respect, and that no investigation or disciplinary action is pending or has been brought against me by any state, county or local medical society, hospital or health care facility or professional medical association, except as disclosed on this application.

Virginia Siegfried, M.D., D.O.

Sworn to before me this 29th day of December, 1994

[SEAL] H. Barbara Silver Notary Public

OFFICIAL SEAL
H. BARBARA SILVER
Notary Public-California
LOS ANGELES COUNTY
My Commission Expires
September 28, 1996

Virginia Nesbitt
Signature of Applicant

****

THE STATE OF NEW HAMPSHIRE

BOARD OF REGISTRATION IN MEDICINE

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

Application received 1/4 1995

Fee paid 1/4 1995

Check Number 198

License Number 9388

Date of Issue 3/1/95

CURRICULUM VITAE
VIRGINIA SIEGFRIED, M.D.

Current Position

Attending Obstetrician/Gynecologist
Cedars-Sinai Medical Center (CSMC)
Los Angeles, California

Clinical Instructor
University of California, Los Angeles (UCLA)

Committee Appointments, CSMC

- Medical Executive Committee (1993-present)
- Advisory Committee, Department of Obstetrics and Gynecology (1988-1989, 1993-present)
- Risk Management Committee (1993-present)
- Joint Practice Committee, Departments of Obstetrics and Gynecology/Pediatrics/Nursing (1987-1988, 1993-present)
- Reappointment and Peer Review Committee (1991-1992)

Professional Practice and Training

- Private Practice, Obstetrics and Gynecology (1983-present)
- Attending Obstetrician/Gynecologist, CSMC (1983-present)
- Clinical Instructor, UCLA (1983-present)
- Women's Clinic, Beverly Hills, CA (1983-84)
- Los Angeles County Prenatal Clinics (1981-1982)
- Planned Parenthood (1980-1982)
- Obstetrics and Gynecology Residency
  University of California, Los Angeles School of Medicine
  (July, 1980-June, 1983)
- Obstetrics and Gynecology Internship
  University of California, Los Angeles School of Medicine
  (July, 1979-June, 1980)
- Medical Education
  M.D. (1979)
  Columbia University
  College of Physicians and Surgeons
  New York, New York
- Undergraduate Education
  B.S. Biology (1975)
  Stanford University
  Palo Alto, California

Specialty Training

- Laser Surgery
- Pelviscopy

Teaching Experience

- Family Planning Clinic, Staff Physician, CSMC (1990-present)
- Gynecology Clinic, Staff Physician, UCLA (1983-1989)

Awards and Honors

- American Medical Women's Association Honors Citation (1985)
- Alpha Omega Alpha (1979)

Board Certification

- National Board of Medical Examiners (1980)
- American College of Obstetrics and Gynecology (1985)

Licensure

- California G42637

Organizations/Societies

- American Association of Gynecologic Laparoscopists
- Fellow, American College of Obstetrics and Gynecologists
- American Medical Association
- California Medical Association
- Los Angeles County Medical Association
- Los Angeles County Women's Medical Association
- Los Angeles County Obstetrical and Gynecologic Society

American Board of Obstetrics and Gynecology

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

VIRGINIA SIEGFRIED

HAVING PURSUED AN ACCEPTED COURSE OF GRADUATE STUDY AND CLINICAL WORK, HAS MET THE STANDARDS AND QUALIFICATIONS AND PASSED THE EXAMINATIONS REQUIRED BY THE AMERICAN BOARD OF OBSTETRICS AND GYNECOLOGY, INC. SHE HAS THEREBY DEMONSTRATED TO THE SATISFACTION OF THIS BOARD THAT SHE IS POSSESSED OF SPECIAL KNOWLEDGE, AND BY THE AWARD OF THIS DIPLOMA HER PROFICIENCY IN THE SPECIALTY OF OBSTETRICS AND GYNECOLOGY IS RECOGNIZED AND SHE IS AN ACKNOWLEDGED DIPLOMATE OF THIS BOARD

DECEMBER 13, 1985

No. 22305

MAY 28 1996

STATE OF NEW HAMPSHIRE

10256

Board of Medicine

EXPIRES: 06/30/1997

Please check appropriate mailing address.

X Name in full Virginia A Siegfried

Place of employment 3 Alumni Dr #302

Exeter, NH 03833

Business Tel: 603 778-0557

Home Address [redacted]

Home Tel: [redacted]

VIRGINIA A SIEGFRIED MD
EXETER HAMPTON OB-GYN
3 ALUMNI DR #302
EXETER NH 03833-

JUN 13 1997

STATE OF NEW HAMPSHIRE

10256

Board of Medicine

EXPIRES: 6/30/98

Please check appropriate mailing address.

X Name in full Virginia Siegfried MD

Place of employment 3 Alumni Dr. #302

Exeter, NH 03833

Business Tel: ~~722-17~~ 778-0557

Home Address [redacted]

Home Te

VIRGINIA A SIEGFRIED, MD
EXETER HAMPTON OB-GYN
3 ALUMNI DR 302
EXETER NH 03833-

HAVE YOU BEEN CONTINUOUSLY ENGAGED IN THE ACTIVE PRACTICE OF MEDICINE? YES X NO ___ IF NO, PLEASE EXPLAIN

SPECIALTY OB/GYN BOARD CERTIFIED? YES 12/85

RENEWAL FEE: $100.00

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

LIST ALL HOSPITAL AFFILIATIONS: Exeter Hospital

IN WHAT OTHER STATES DO YOU HOLD LICENSE: California Massachusetts

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 X NO
2.	HAVE YOU BEEN DENIED OR HAVE YOU SURRENDERED A LICENSE IN ANY STATE OTHER THAN FOR RELOCATION OR RETIREMENT?	2. ___ YES X NO
3.	HAS THERE BEEN ANY DENIAL, RESTRICTION, SUSPENSION OR LOSS/REVOCATION OF YOUR DEA?	3. ___ YES X NO
4.	HAVE YOU BEEN TREATED FOR USE OR MISUSE OF ANY CHEMICAL SUBSTANCE?	4. ___ YES X NO
5.	HAVE YOU HAD ANY EMOTIONAL DISTURBANCE OR MENTAL ILLNESS WHICH HAS IMPAIRED YOUR ABILITY TO PRACTICE MEDICINE?	5. ___ YES X NO
6.	HAVE YOU BEEN FOUND GUILTY OR ENTERED A PLEA OF NO CONTEST TO ANY FELONY, OR TO A MISDEMEANOR?	6. ___ YES X NO
7.	HAVE YOU BEEN REPORTED TO THE NATIONAL PRACTITIONER DATA BANK? IF YES, PLEASE SUBMIT A COPY OF THE REPORT	7. ___ YES X NO
8.	HAVE YOU BEEN THE SUBJECT OF AN INVESTIGATION OR DISCIPLINARY PROCEEDING?	8. ___ YES X 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 X NO
10.	HAVE ANY MEDICAL MALPRACTICE CLAIMS BEEN MADE AGAINST YOU? SEE ATTACHED REPORTING FORM	10. ___ YES X 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.

Virginia McGlad — Signature of Licensee (Signature Stamp Not Accepted)

4-12-96 — Date

HAVE YOU BEEN CONTINUOUSLY ENGAGED IN THE ACTIVE PRACTICE OF MEDICINE? YES X NO ___ IF NO, PLEASE EXPLAIN

SPECIALTY OB/GYN BOARD CERTIFIED? YES 1985 / Renewed 1996

RENEWAL FEE: $100.00

___ I DO NOT INTEND TO RENEW MY LICENSE - PLEASE PLACE MY LICENSE ON INACTIVE STATUS. ~No

LIST ALL HOSPITAL AFFILIATIONS: Exeter Hospital

IN WHAT OTHER STATES DO YOU HOLD LICENSE: Mass, Calif.

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 X 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. X 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.

Virginia McGlad — Signature of Licensee (Signature Stamp Not Accepted)

5-30-97 — Date

JUN 09 1998

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, you will be required to file a reinstatement application.

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

Specialty: OBG

Board Certified: (Y/N) Y

Please list ABMS Board Specialty: OB

Licensed in the states of: (2 letter state abbrev.)

CA,MA

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

License #: 9388

File #: 10256

☑ Work Address:

☐ Home Address:

VIRGINIA A SIEGFRIED, MD
~~EXETER HAMPTON OB-GYN~~
PARTNERS FOR WOMENS HEALTH P.A.
3 ALUMNI DR 302
EXETER, NH 03833-

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

EXETER HOSPITAL, EXETER 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.

Virginia Medford

Signature of Licensee (Signature Stamp Not Accepted)

5-8-98

Date

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: 6/30/2000

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, you will be required to file a reinstatement application.

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

Specialty: OBG

Board Certified: (Y/N) Y

Please list ABMS Board Specialty: OBG

Licensed in the states of: (2 letter state abbrev.)

CA,MA

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

License #: 9388

File #: 10256

☒

☐

VIRGINIA A SIEGFRIED, MD
PARTNERS FOR WOMENS HEALT
3 ALUMNI DR 302
EXETER, NH 03833-
Phone: 603*778-0557

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

EXETER HOSPITAL, EXETER 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?	___	X
2. Have you been denied or have you surrendered a license in any state other than for relocation or retirement?	___	X
3. Have you been subject to any denial, restriction, suspension or loss/revocation of your DEA certificate?	___	X
4. Have you been treated for use or misuse of any chemical substance?	___	X
5. Have you had any emotional disturbance or mental or physical illness which has impaired your ability to practice medicine?	___	X
6. Have you been found guilty or entered a plea of no contest to any felony or misdemeanor?	___	X
7. Have you been reported to the National Practitioner's Data Bank? If yes, please submit a copy of the report.	___	X
8. Have you been the subject of an investigation or disciplinary proceeding?	___	X
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?	___	X
10. Have any medical malpractice claims been made against you? See attached reporting form.	___	X

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

Signature of Licensee (Signature Stamp Not Accepted)

4-16-99
Date

MAY 0 1 2000

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: 6/30/2001

Renewal Fee: $100.00

If you do not wish to renew your license, check here. ☐

If you choose not to renew, your license will be placed on inactive status. To reactivate the license, you will be required to file a reinstatement application.

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

Specialty: OBG

Board Certified: (Y/N) Y

Please list ABMS Board Specialty: OBG

Licensed in the states of: (2 letter state abbrev.)

CA,MA

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

License #: 9388

File #: 10256

☑ Work Address

VIRGINIA A SIEGFRIED, MD
PARTNERS FOR WOMENS HEALT
3 ALUMNI DR 302
EXETER, NH 03833-
Phone: 603*778-0557

☐ Home Address

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

EXETER HOSPITAL, EXETER 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.

Virginia Mayfield — 4-20-00

Signature of Licensee (Signature Stamp Not Accepted) — Date

APR 2 0 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, you will be required to file a reinstatement application.

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

Specialty: OBG

Board Certified: (Y/N) Y

Please list ABMS Board Specialty: OBG

Licensed in the states of: (2 letter state abbrev.)
CA,MA

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

License #: 9388

File #: 10256

☑ Work Address

☐ Home Address

VIRGINIA A SIEGFRIED, MD
~~PARTNERS FOR WOMENS HEALT~~
~~3 ALUMNI DR 302~~
~~EXETER, NH 03833~~

over Professional Center
uite 201
5 Old Rollinsford Rd 749-4963
over, NH 03820

Phone: 603*~~778-0557~~

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

EXETER HOSPITAL- EXETER, NH

Wentworth-Douglass Hospital - Dover, NH

(RENEWAL APPLICATION CONTINUED ON REVERSE SIDE)

APR 2 0 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, you will be required to file a reinstatement application.

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

Specialty: OBG

Board Certified: (Y/N) Y

Please list ABMS Board Specialty: OBG

Licensed in the states of: (2 letter state abbrev.)

CA,MA

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

License #: 9388

File #: 10256

☑ Work Address

☐ Home Address

VIRGINIA A SIEGFRIED, MD
~~PARTNERS FOR WOMENS HEALT~~
~~3 ALUMNI DR 302~~
~~EXETER, NH 03833~~

Dover Professional Center
Suite 201
5 Old Rollinsford Rd
Dover, NH 03820

Phone: 603*~~778-0557~~ 749-4963

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

EXETER HOSPITAL- EXETER, NH

Wentworth-Douglass Hospital - Dover, NH

(RENEWAL APPLICATION CONTINUED ON REVERSE SIDE)

#11843

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: 6/30/2003

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, you will be required to file a reinstatement application.

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Specialty: OBG

Board Certified: (Y/N) Y

Please list ABMS Board Specialty: ~~OBG~~

Licensed in the states of: (2 letter state abbrev.)

CA,MA

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

License #: 9388

File #: 10256

☒ Work Address

☐ Home Address

VIRGINIA A SIEGFRIED, MD
DOVER PROFFESSIONAL CTR
15 OLD ROLLINSFORD RD STE 201
DOVER, NH 03820

Phone: 603*749-4963

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

EXETER HOSPITAL- EXETER, NH WENTWORTH-DOUGLAS ~~HOSP-DOVER,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.	✓	

? 2000 or 2001 – not sure if reported last yr

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

Virginia [signature]

Signature of Licensee (Signature Stamp Not Accepted)

3-1-02

Date

MAR 24 2003

STATE OF NEW HAMPSHIRE

Telephone #: 603-271-6934

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

RENEWAL APPLICATION

#13288
of 600 ck

For expiration on: 06/30/05

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 reactive the license, you will be required to file a reinstatement application.

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

Specialty: OBG

Board Certified: (Y/N) Y

Please list ABMS Board Specialty: OBG

Licensed in the states of: (2 letter state abbrev.)

CA,MA

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

License #: 9388

File #: 10256

☒ Work Address

☐ Home Address

VIRGINIA A SIEGFRIED, MD
DOVER PROFFESSIONAL CTR
15 OLD ROLLINSFORD RD STE 201
DOVER, NH 03820

Phone: 603*749-4963

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

EXETER HOSPITAL- EXETER, NH WENTWORTH-DOUGLAS HOSP-DOVER,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.	✓	___

pending claim settled

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

Virginia Moffitt

Signature of Licensee (Signature Stamp Not Accepted)

3-12-03

Date

MAR 2 3 2007

STATE OF NEW HAMPSHIRE

Telephone #: 603-271-6934

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

15952

RENEWAL APPLICATION

For expiration on: 06/30/07

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, you will be required to file a reinstatement application.

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

Specialty: OBG

Board Certified: (Y/N) Y

Please list ABMS Board Specialty: OBG

Licensed in the states of: (2 letter state abbrev.)

CA,MA

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

License #: 9388

File #: 10256

☒ Work Address

☐ Home Address

VIRGINIA A SIEGFRIED, MD
DOVER PROFESSIONAL CTR
16 OLD ROLLINSFORD RD STE 20
DOVER, NH 03820

Phone: 603*749-4963
Business Fax Number:

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
EXETER HOSPITAL	EXETER	NH	☒	☒	☐
WENTWORTH-DOUGLAS	DOVER	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. 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.

Virginia Mayfield
Signature of Licensee (Signature Stamp Not Accepted)

3-14-05
Date

RECEIVED
APR 23 2007
NH BOARD

STATE OF NEW HAMPSHIRE

Telephone #: 603-271-6934 APR 24 2007

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

RENEWAL APPLICATION

For expiration on: 06/30/2009

#2735
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, you will be required to file a reinstatement application.

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

Specialty: OBG

Board Certified: (Y/N) Y
Please list ABMS Board Specialty: OBG

Licensed in the states of: (2 letter state abbrev.) CA,MA, ME

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

License #: 9388

File #: 10256

☐ Work Address

☒ Home Address

VIRGINIA A SIEGFRIED, MD
~~DOVER PROFFESSIONAL CTR~~
~~15 OLD ROLLINSFORD RD STE 20~~
~~DOVER, NH 03820~~

Planned Parenthood
970 Forest Ave
Portland, ME
04104

207 797-8881
Phone: ~~603*749-4963~~
Business Fax Number: 207 797-5093

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
~~EXETER HOSPITAL~~	EXETER	NH		☐	☑	☐
~~WENTWORTH~~-DOUGLAS	DOVER	NH		☑	☐	☐
				☐	☐	☐
				☐	☐	☐
				☐	☐	☐
				☐	☐	☐
				☐	☐	☐

No current hospital privileges

(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?	___	X
2. Have you been denied, or have you surrendered, a license in any state other than for relocation or retirement?	___	X
3. Have you been subject to any denial, restriction, suspension or loss/revocation of your DEA certificate?	___	X
4. Have you been treated, other than through the Physician Health Program, for abuse or misuse of any chemical substance, including alcohol?	___	X
5. Have you had any emotional disturbance or mental or physical illness which has impaired your ability to practice medicine?	___	X
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?	___	X
7. Have you been reported to the National Practitioner's Data Bank? If yes, please submit a copy of the report.	___	X
8. Have you been the subject of an investigation or disciplinary proceeding? Please exclude investigations and disciplinary proceedings conducted by the New Hampshire Board of Medicine.	___	X
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?	___	X
10. Have any medical malpractice claims been made against you? See attached reporting form.	X	___

****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.

Virginia Negrucci

Signature of Licensee (Signature Stamp Not Accepted)

4-16-07

Date

RECEIVED
APR 23 2007
NH BOARD

STATE OF NEW HAMPSHIRE

Telephone #: 603-271-6934 APR 24 2007

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

RENEWAL APPLICATION

For expiration on: 06/30/2009

#2735
Renewal Fee: $300.00

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Specialty: OBG

Board Certified: (Y/N) Y
Please list ABMS Board Specialty: OBG

Licensed in the states of: (2 letter state abbrev.) CA,MA, ME

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

License #: 9388

File #: 10256

☐ Work Address

☒ Home Address

VIRGINIA A SIEGFRIED, MD
~~DOVER PROFFESSIONAL CTR~~
~~15 OLD ROLLINSFORD RD STE 20~~
~~DOVER, NH 03820~~

Planned Parenthood
970 Forest Ave
Portland, ME
04104

207 797-8881
Phone: ~~603*749-4963~~
Business Fax Number: 207 797-5093

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
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~~WENTWORTH~~-DOUGLAS	DOVER	NH		☑	☐	☐
				☐	☐	☐
				☐	☐	☐
				☐	☐	☐
				☐	☐	☐
				☐	☐	☐

No current hospital privileges

(RENEWAL APPLICATION CONTINUED ON REVERSE SIDE)