FOR OFFICE USE ONLY: DATE REC'D 4/21/94
TS# 94-181

STATE OF CONNECTICUT
DEPARTMENT OF PUBLIC HEALTH AND ADDICTION SERVICES
BUREAU OF HEALTH SYSTEM REGULATION

04/21/94 TR # 111313
OPER MLB TS # 94-181
M D AP 4001-3517
RCVD $450.00 CHK

PHYSICIAN'S APPLICATION FOR LICENSURE WITHOUT EXAMINATION
FEE: $450.00

I hereby apply to the Department of Public Health and Addiction Services for licensure without examination to practice medicine in the State of Connecticut by: (Please check one

A. [X] Endorsement of my certificate issued by the National Board of Medical Examiners. Certificate #: _____ Date: _____

B. [ ] Endorsement of my certificate issued by the Federation of State Medical Boards of the United States. STATE: _____ DATE: _____

C. [ ] Endorsement of my license issued after written examination by the licensing authority named below: STATE: _____ DATE: _____

D. [ ] Endorsement of my license issued after written examination by the Medical Council of Canada. DATE: _____

* *

1. FULL NAME: Jonathan Irving Todd Foster
(first) (middle) (maiden) (last)

PRESENT ADDRESS: 50 Irving Street Newton Ctr. MA 02159
(street) (town) (state) (zip)

TELEPHONE NO.: (Where you can be reached 8:30 - 4:30, Monday - Friday) 617 ~~203~~ 732 6987

PLACE OF BIRTH: New Haven CT (town, state or country) DATE OF BIRTH: 3/8/54 month/day/year

SOCIAL SECURITY NUMBER: [redacted]

2. PREMEDICAL EDUCATION:

LIST NAMES AND LOCATIONS OF ALL INSTITUTIONS ATTENDED	DATE ENTER (Mo. Yr.)	DATE DEPART (Mo. Yr.)
Cornell College Mt. Vernon IA	9/72	1/75
Pace University Pleasantville NY	9/82	5/85

OFFICE USE ONLY:
License Number: 033753 Effective Date: 5/27/94

9857V/4 10/93

3. MEDICAL EDUCATION:

LIST NAMES AND LOCATIONS OF ALL INSTITUTIONS ATTENDED | DATE ENTER (Mo. Yr.) | DATE DEPART (Mo. Yr.)

Yale Univ. School of Medicine New Haven CT | 8/86 | 5/90

Doctor of Medicine Degree Awarded by: Yale Univ (Name of School) Date Awarded: May '90 (Month/Yr.)

4. MEDICAL LICENSURE:

LIST ALL STATES IN WHICH YOU HAVE EVER BEEN LICENSED TO PRACTICE MEDICINE:

STATE	LIC. NUMBER	DATE LICENSED ISSUED	LICENSED BY: Exam	Endorsement
Massachusetts	75815	4/92		X

5. MEDICAL PRACTICE:

LIST ALL MEDICAL PRACTICE YOU HAVE ENGAGED IN SINCE GRADUATION FROM MEDICAL SCHOOL (IDENTIFY INTERNSHIP AND RESIDENCY):

HOSPITALS ASSOCIATED WITH	LOCATION (ADDRESS)	DATE ENTERED (Mo. Yr.)	DATE DEPART (Mo. Yr.)
Internship Brigham + Women's (BWH) Hospital	75 Francis St Boston	6/90	6/91
Residency BWH, Boston	Francis St Boston	6/91	6/94
Mass General Hospital	Fruit St Boston		
Preterm Health Services	842 Beacon St Boston	6/92	6/94
Women's Health Services	1852 Boylston St Boston	9/93	6/94

6. SPECIALTY:

IF CERTIFIED BY A SPECIALTY BOARD APPROVED BY THE AMERICAN BOARD OF MEDICAL SPECIALTIES, INDICATE NAME OF AMERICAN BOARD:

AMERICAN BOARD	DATE CERTIFIED
	(94)

7. Answer ONLY if applying for endorsement of Medical Council of Canada license. Have you requested a "Certificate of Standing" with scores from the Medical Council of Canada? _____

STATEMENT OF PROFESSIONAL HISTORY

Please answer each question below. If you answer yes to any question, please refer to attached instructions.

	YES	NO
1. Have you ever been censured, disciplined, dismissed or expelled from, had admissions monitored or restricted, had privileges limited, suspended or terminated, been put on probation, or been requested to resign or withdraw from any of the following: -Any hospital, nursing home, clinic, or similar institution; -Any health maintenance organization, professional partnership, corporation, or similar health practice organization, either private or public; -Any professional school, clinical clerkship, internship, externship, preceptorship, or postgraduate training program; -Any third party reimbursement program, whether governmental or private?	___	X
2. Have you ever had your membership in or certification by any professional society or association suspended or revoked for reasons related to professional practice?	___	X
3. Has any professional licensing or disciplinary body in any state, the District of Columbia, a United States possession or territory, or a foreign jurisdiction, limited, restricted, suspended, or revoked any professional license, certificate, or registration granted to you, or imposed a fine or reprimand, or taken any other disciplinary action against you?	___	X
4. Have you ever, in anticipation or during the pendency of an investigation or other disciplinary proceeding, voluntarily surrendered any professional license, certificate, or registration issued to you by any state, the District of Columbia, a United States possession or territory, or a foreign jurisdiction?	___	X
5. Have you ever been subject to, or do you currently have pending, any complaint, investigation, charge, or disciplinary action by any professional licensing or disciplinary body in any state, the District of Columbia, a United States possession or territory, or a foreign jurisdiction or any disciplinary board/committee of any branch of the armed services? You need not report any complaints dismissed as without merit.	___	X
6. Have you ever entered into, or do you currently have pending, a consent agreement of any kind, whether oral or written, with any professional licensing or disciplinary body in any state, the District of Columbia, a United States possession or territory, any branch of the armed services or a foreign jurisdiction?	___	X
7. Have you ever been found guilty or convicted as a result of an act which constitutes a felony under the laws of this state, federal law or the laws of another jurisdiction and which, if committed within this state, would have constituted a felony under the laws of this state?	___	X
8. Have you ever been denied or surrendered a state or federal controlled substance registration, had it revoked or restricted in any way, or been warned, reprimanded, or fined by the responsible agency?	___	X

STATE OF CONNECTICUT

DEPARTMENT OF PUBLIC HEALTH AND ADDICTION SERVICES

BUREAU OF HEALTH SYSTEM REGULATION

MAY 27, 1994

JONATHAN T FOSTER, MD
50 IRVING STREET
NEWTON CTR MA, 02159

Dear Doctor Foster:

On behalf of the Department of Public Health and Addiction Services, I want to congratulate you upon the successful completion of all requirements for licensure as a Medical Doctor in the State of Connecticut.

Connecticut medical license 033753 has been issued to you, effective the date of this letter. You are eligible to begin the practice of medicine as of this date.

You will receive your license certificate in about eight (8) weeks, by certified mail, at the address shown above. Full instructions regarding future renewal will also be enclosed.

It is your responsibility to notify the Department of Public Health and Addiction Services, Licensure and Registration Section, in writing of any future changes of name and/or address, as well as the establishment of professional locations, either within or outside Connecticut. Such notification to the Department of Public Health and Addiction Services is required by law, and failure to provide same will jeopardize the status of your license.

Failure to renew your license within ninety (90) days of the due date will result in your license becoming void. In that event, re-licensure would require a new application to the Department and a review of all credentials to determine whether you satisfy current licensing requirements. In order to avoid such a process, be sure that you renew your license in a timely manner each year in the month of your birth.

Connecticut General Statutes, Chapter 370, Section 20-13d, effective October 1, 1990, requires that a physician report to the Department any disciplinary action taken against him/her by a duly authorized professional disciplinary agency of any other state, the District of Columbia, a United States possession or territory, or a foreign jurisdiction, within thirty days of such action. Failure to so report may constitute a ground for disciplinary action againist the Connecticut license under section 20-13c.

I wish you success in your medical career.

Respectfully,

Joseph J Gillen, Ph.D
Section Chief
Applications, Examinations and Licensure

JJG:cas
0683V

Phone: *TDD: 203-566-1279*
150 Washington Street — Hartford, CT 06106
An Equal Opportunity Employer

Pursuant to Public Law 100-93, the Federal Government requires all states to report disciplinary actions to the Inspector General for Health and Human Services or risk losing Federal medicaid contributions. Although the disclosure of your social security number on this application is voluntary, Public Law 100-93 also requires the Department of Public Health and Addiction Services to request the disclosure of your number as data that would then be available to the National Practitioner Data Bank in the event that disciplinary action should be taken against your Connecticut license. You are not required by any law to disclose your social security number, but should you decide to do so, it will be used for identification purposes only, including verifying and retrieving

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All of the above statements containe herein are true and correct to the best of my knowledge and belief

here.
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graph.)

Signature of Applicant Date 4/4/94

State of Connecticut)
County New Haven)ss

On this 18 day of April 1994, Jonathan Foster (applicant's name) personally appeared before me, who being duly sworn says that she/he is the person referred to in the foregoing application and that the photograph attached hereto is a true picture of self and that the statements made herein are true in every respect.

Signature of Applicant

Sworn to before me this 18 day of April 1994.

Signature of Notary Public

My Commission expires 6-30-98.

1. If your answer is "yes", give full details, names, addresses, etc. on separate notarized statement.
2. If your answer is "yes", give names of professional society or association, date and reasons your membership or certification was suspended or revoked on a separate notarized statement.
3. If your answer is "yes", give full details, names, addresses, etc. on a separate notarized statement.
4. If your answer is "yes" give full details, names, addresses, etc. on a separate notarized statement.
5. If your answer is "yes" give full details, names, addresses, etc. on a separate notarized statement.
6. If your answer is "yes" give full details on a separate notarized statement and submit notarized copy of agreement.
7. If your answer is "yes" give full details on a separate notarized statement and furnish a Certified Court Copy (with court seal affixed) of the original complaint, the answer, the judgement, the settlement, and/or the disposition of the case.
8. If your answer is "yes", give full details, dates, etc. on a separate notarized statement.

NATIONAL BOARD OF MEDICAL EXAMINERS®

ENDORSEMENT OF CERTIFICATION

Note: The embossed seal of the National Board of Medical Examiners (NBME®) in the lower left corner certifies the authenticity of this document.

Diplomate Name: Jonathan Todd Foster, MD

Date of Birth: 03/08/1954

Certification Date: 07/01/1991 **Certificate #:** 388119

It is certified that the physician named above has successfully completed the examination, education, and training requirements for certification by the NBME as of the certification date shown above.

Exam	Test Date	Total Test	Min. Pass	Pass/ Fail	Anat	Phys	Bioc	Path	Micr	Phar	Beh Sci
NBME	Jun	410	380		530	440	445	390	420	370	370
PART I	1988	75	75	PASS	82	77	77	75	75	72	72

Exam	Test Date	Total Test	Min. Pass	Pass/ Fail	Med	Surg	Ob/Gyn	PM/PH	Ped	Psych
NBME	Apr	375	290		315	370	420	535	420	340
PART II	1990	77	75	PASS	74	76	78	83	78	75

Exam	Test Date	Total Test	Min. Pass	Pass/ Fail
NBME	May	395	290	
PART III	1991	78	75	PASS

DATE: 04/26/1994

SEE OTHER SIDE FOR SCORE INFORMATION

CT0239

STATE OF CONNECTICUT

DEPARTMENT OF PUBLIC HEALTH AND ADDICTION SERVICES

BUREAU OF HEALTH SYSTEM REGULATION

RECEIVED APR 21 1994

APPLICANT: Please complete and sign this inquiry form and forward it to the Federation of State Medical Boards, at the address shown below.

DISCIPLINARY INQUIRIES

Federation of State Medical Boards
6000 Western Place, Suite 707
Fort Worth, TX 76107

The Connecticut Department of Public Health and Addiction Services requests a disciplinary search concerning the following individual:

Foster Jonathan Todd MD

NAME (last, first, middle) (Degree)

50 Irving Street

ADDRESS

Newton Ctr., MA 02159

CITY, STATE AND ZIP CODE

03/08/54

DATE OF BIRTH yy/mm/dd

SOCIAL SECURITY NUMBER

Yale University School of Medicine

MEDICAL SCHOOL OF GRADUATION
(Include complete name and branch location)

5/90 USA

DATE OF GRADUATION COUNTRY OF MEDICAL SCHOOL

ECFMG NUMBER (if foreign medical graduate)

Please mail the response to the following address:

Department of Public Health and Addiction Services
Physician Licensure
150 Washington Street
Hartford, CT 06106
ATTENTION: Jackie Leduc

WE HAVE NO UNFAVORABLE INFORMATION REGARDING THE ABOVE NAMED PHYSICIAN

APR 26 1994

James R. Winn, M.D.
JAMES R. WINN, M.D.
EXECUTIVE VICE-PRESIDENT

APPLICANT SIGNATURE

9223V/11
02/94

Phone (203)566-1035 TDD: 203-566-1279
150 Washington Street — Hartford, CT 06106
An Equal Opportunity Employer

HARVARD MEDICAL SCHOOL

BRIGHAM AND WOMEN'S HOSPITAL

ROBERT L. BARBIERI, M.D.

Kate Macy Ladd Professor of Obstetrics, Gynecology and Reproductive Biology

CHAIRMAN, DEPARTMENT OF OBSTETRICS AND GYNECOLOGY

Brigham and Women's Hospital
75 Francis Street, ASB1-3-073
Boston, Massachusetts 02115
Administrative Office: (617) 732-5444
FAX: (617) 277-1440

May 19, 1994

Ms. Jackie Ledue
Physician Licensure
Dept. of Public Health &
Addiction Services
150 Washington St.
Hartford, CT 06106

Dear Ms. Ledue:

Following is the information you requested on **Jonathan T. Foster, M.D.**:

Name:	Jonathan Todd Foster, M.D.
Date of Birth:	03/08/54
Residency Facility:	Brigham and Women's Hospital, Boston, MA OK
Specialty:	Obstetrics and Gynecology
Levels:	PGY1-PGY4
Training Period:	07/01/90-06/30/94 2+
Program Accreditation:	Yes, by ACGMB
Satisfactory Completion:	Is expected to satisfactorily complete 06/30/94
Any derogatory statement as to competency or conduct of resident:	No

If you have any questions, please do not hesitate to contact me.

Sincerely,

Robert Barbieri

Robert L. Barbieri, M.D.

RLB:pmn

Marsha Williams
Notary Public
My Comm. Exp.
6.9.2000

Commonwealth of Massachusetts
Board of Registration in Medicine
Ten West Street
Boston, Massachusetts 02111

(617) 727-3086

PAUL G. GITLIN, J.D.
CHAIRMAN
ALEXANDER F. FLEMING
EXECUTIVE DIRECTOR

An Agency within the Executive Office of Consumer Affairs and Business Regulation

April 20, 1994

To Whom It May Concern:

This is to certify that JONATHAN TODD FOSTER

a graduate of YALE UNIVERSITY SCHOOL OF MEDICINE in the year 1990

has been duly registered by this board as provided by the laws of the Commonwealth.

Certificate Number 75815 was issued to Dr. JONATHAN TODD FOSTER

on 05/13/92. THIS LICENSE IS CURRENT.

Expiration date: 03/08/95

Our files contain NO OPEN or CLOSED complaints, and NO formal disciplinary action regarding this physician.

Rafik Attia, M.D.,
Secretary

SEAL

Please be advised that the above information is based entirely on examination of our open and closed complaint file. It is not based on a review of the application for licensure, renewal of licensure or any reports that the Board is required to receive by statute (from Courts, Insurers, Hospitals, etc.).

STATE OF CONNECTICUT

DEPARTMENT OF HEALTH SERVICES
DIVISION OF MEDICAL QUALITY ASSURANCE

APR 20

APPLICANT - Complete the top portion of this form and send it to all of the state(s) in which you are/were licensed. The Medical Examining Board of the state should complete the lower portion and return it to this office.

Name: Jonathan Todd Foster (First Middle Last) Date of Birth: 03/08/54 (mo day year)

Current Address: 50 Irving St Newton Ctr MA 02159 Place of Birth: New Haven Connecticut

License Number: 75815

PLEASE BE ADVISED, THAT SOME STATES REQUIRE A FEE. CONTACT STATES BEFORE SENDING THEM THIS FORM.

STATE MEDICAL EXAMINING BOARD - The above named individual has made application for licensure as a physician in Connecticut. Would you kindly complete this portion of this form and return it to the address noted below. Your assistance is appreciated.

On what date was a license issued to this applicant? _____

Is the license presently current and valid? _____

Have there been any investigations or formal charges brought against this applicant? _____

Is this applicant presently the subject of a pending complaint or unresolved disciplinary action? _____

What was the basis for licensure in your state, i.e., FLEX, National Boards, State Examination? If a State Examination was given, please list the subject areas and the score received in each.

_____

_____

Completed By: _____, Title: _____

for State Medical Examining Board of: _____
State

(Board Seal)

Upon completion, please return this form to: Jackie Leduc
PHYSICIANS LICENSURE
Division of Medical Quality Assurance
Department of Health Services
150 Washington Street
Hartford, Connecticut 06106

(203) 566-1035

9223V