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

1K

1. Biographical and Current Practice Information

CT License Number: 033753 Social Security No.: [redacted]

Last Name: Fostev First Name: Jonathan MI: T

Telephone No. (Where you may be reached, 8:30 a.m.-4:30 p.m. (203) 754 - 5129

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

Primary Practice Location-Name of Practice: Center for Women's Health

Address: Suite 320
889 W. Main St.

City, State Zip: Waterbury CT ~~064~~ 06708

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

Spanish	

Other Practice Location(s)-Name of Practice:

Address:

City, State Zip:

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

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

Name/City, State	Name/City, State
Waterbury Hospital / Waterbury CT	
St Mary's Hospital / Waterbury CT	

2. Medical School

Medical School: Yale University School of Medicine Year of Graduation 1990

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

Site: Harvard/ Brigham + Women's Hospital City: Boston MA Country: USA

Inclusive Dates: From: 6/25/90 To: 6/25/91 ☒ Intern ☐ Resident ☐ Fellowship (Please check one)

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

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Site: Harvard/ Brigham + Women's Hospital City: Boston MA Country: USA

Inclusive Dates: From: 6/26/91 To: 6/25/94 ☐ Intern ☒ Resident ☐ Fellowship (Please check one)

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

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Site: ______ City: ______ Country: ______

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

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

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Site: ______ City: ______ Country: ______

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

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

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Site: ______ City: ______ Country: ______

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

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

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Site: ______ City: ______ Country: ______

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

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

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4. Specialty Area/American Board Certification

Practice Specialty: ______ 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: 11/7/97

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

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

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5. Medical Educational Responsibilities (This Section is Voluntary)

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

If Yes, Please indicate which one.

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

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

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

If you include publications or awards, please use the following format: "Journal of Gynecologic Surge[ry]"

For publications: Include name of journal, title of article and date published. "Abdominal Hysterectomy and Abdominal Myomectomy: A Comparis[on] [illegible]

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

1. _____
2. _____
3. _____
4. _____
5. _____
6. _____
7. _____
8. _____
9. _____
10. _____

7. Medical Malpractice History

Date Resolved	Amount Paid	Practice Specialty Related To Payment
8/98	NA	Gynecology

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

Hospital, City, State, Country	Date	Disciplinary Action

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

Date of Conviction	Conviction

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ATTESTATION

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

Signature _____ Date 2/1/00

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

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

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

Electronic file

MAL

Please fill in the following information:

Publications in peer-reviewed journals (name of journal, title of article and date published)
Professional Awards (name of entity issuing award, title of award, date received)

1. Journal of Gynecologic Surgery Vol 11, No 1 (1995
2. "Abdominal Hysterectomy and Abdominal
3. Myomectomy: A Comparison of Preoperative
4. Demographics and Postoperative Morbidity"
5.
6.
7.
8.
9.
10.

MEDICAL MALPRACTICE HISTORY

Date Resolved	Amount Paid	Date Resolved	Amount Paid

HOSPITAL DISCIPLINE WITHIN LAST 10 YRS (in any state)

Hospital, City, State, Country	Date	Disciplinary Action

FELONY CONVICTIONS WITHIN LAST TEN YEARS (In any state)

Date of Conviction	Conviction

ATTESTATION

I have reviewed the information provided in my PWH/WHC credentialing file, and attest to its accuracy. 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

Jonathan T. Foster MD

date 2/22/00

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