

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

 IK

1. Biographical and Current Practice Information

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

Last Name: Foster 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

1389 W. Main St.

City, State Zip: Waterbury CT  
06406 06708

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

<u>Spanish</u>	

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
<u>Waterbury Hospital / Waterbury CT</u>	
<u>St Mary's Hospital / Waterbury CT</u>	

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/PEOS

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

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): \_\_\_\_\_

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: \_\_\_\_\_ 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: \_\_\_\_/\_\_\_\_/\_\_\_\_

5. Medical Educational Responsibilities (This Section is Voluntary)

Are you a member of the faculty of a Connecticut medical school?  Yes  No  
If Yes, Please indicate which one.  
 Yale University Medical School  University of Connecticut School of Medicine  
Do you have current responsibility for graduate medical education?  Yes  No

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

If you include publications or awards, please use the following format:  
**For publications:** Include name of journal, title of article and date published. Journal of Gynecologic Surgery  
Abdominal Hysterectomy and Abdominal Myomectomy: A Comparison

**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**

<u>Date Resolved</u>	<u>Amount Paid</u>	<u>Practice Specialty Related To Payment</u>
8/98	NA	Gynecology
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____

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

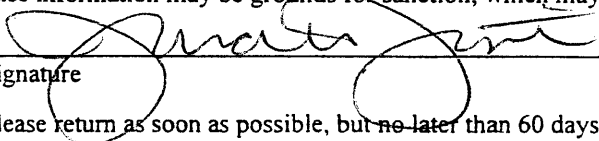
<u>Hospital, City, State, Country</u>	<u>Date</u>	<u>Disciplinary Action</u>
_____	_____	_____
_____	_____	_____
_____	_____	_____

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

<u>Date of Conviction</u>	<u>Conviction</u>
_____	_____
_____	_____
_____	_____

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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

2/1/00  
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.

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 Myosarcoma and Abdominal
3. Myosarcoma: A Comparative Prospective
4. Demographics and Postoperative Morbidity"
5. \_\_\_\_\_
6. \_\_\_\_\_
7. \_\_\_\_\_
8. \_\_\_\_\_
9. \_\_\_\_\_
10. \_\_\_\_\_

**MEDICAL MALPRACTICE HISTORY**

<u>Date Resolved</u>	<u>Amount Paid</u>	<u>Date Resolved</u>	<u>Amount Paid</u>
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____

**HOSPITAL DISCIPLINE WITHIN LAST 10 YRS (in any state)**

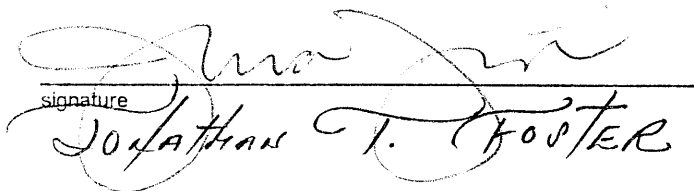
<u>Hospital, City, State, Country</u>	<u>Date</u>	<u>Disciplinary Action</u>
_____	_____	_____
_____	_____	_____
_____	_____	_____

**FELONY CONVICTIONS WITHIN LAST TEN YEARS (In any state)**

<u>Date of Conviction</u>	<u>Conviction</u>
_____	_____
_____	_____
_____	_____

**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. Footer MD

2/22/00  
 date

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