STATE OF CONNECTICUT

DEPARTMENT OF PUBLIC HEALTH

OCTOBER 4, 1996

MAUREEN E PAUL, MD
21 BURROUGHS
JAMAICA PLAIN, MA 02130

Dear Doctor Paul:

On behalf of the Department of Public Health, 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 035618 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, 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 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,

Debra L. Johnson

Debra L. Johnson
Health Program Associate
Applications and Examinations

DLJ:cas
0683V

Phone:
Telephone Device for the Deaf (860) 509-7191
410 Capitol Avenue - MS # ______
P.O. Box 340308 Hartford, CT 06134
An Equal Opportunity Employer

FOR OFFICE USE ONLY: DATE REC'D 8/27/96 TS# 97-035

no fee

LICENSE NUMBER: 035618
EFFECTIVE DATE: 10-4-96

STATE OF CONNECTICUT
DEPARTMENT OF PUBLIC HEALTH

2nd rec'd 9/25/96

PHYSICIAN'S APPLICATION FOR LICENSURE
FEE: $450.00

done 9/26/96

I hereby apply to the Department of Public Health for licensure to practice medicine/surgery in Connecticut based on my successful completion of the following examination: (Please check one)

✓ National Board of Medical Examiners (NBME)

____ Federation Licensing Examination (FLEX)

____ State Board Licensing Examination ____________ (STATE)

____ Examination to become registered as a Licentiate of the Medical Council of Canada (LMCC)

____ United States Medical Licensing Examination (USMLE). Was Step 3 taken in Connecticut? ____ (YES or NO)

____ Combination of examination segments. Please specify ________________ If you took USMLE Step 3, was this segment taken in Connecticut.____ **(YES or NO)**

****

FULL NAME: Maureen (FIRST) Elizabeth (MIDDLE) ____ (MAIDEN) Paul (LAST)

PRESENT ADDRESS: 21Burroughs, (STREET) Jamaica Plain, (TOWN) MA (STATE) 02130 (ZIP)

Please indicate below how you would like your name and address to appear on your official license.

NAME: Maureen Paul
ADRESS: 21 Burroughs St.
Jamaica Plain, MA 02130

TELEPHONE NO.: (WHERE YOU MAY BE REACHED 8:30-4:30, MONDAY - FRIDAY) (508) 792-8463

DATE OF BIRTH 09/19/49

SOCIAL SECURITY NUMBER: [redacted]

PREMEDICAL EDUCATION:

LIST NAMES AND LOCATIONS OF ALL INSTITUTIONS ATTENDED

	DATE ENTER (MO./YR.)	DATE DEPART (MO./YR)
University of Washington, Seattle, WA.	09/73	05/75
Michigan State University, E. Lansing, MI	09/67	1971

MEDICAL EDUCATION:

LIST NAMES AND LOCATIONS OF ALL INSTITUTIONS ATTENDED

	DATE ENTER (MO./YR.)	DATE DEPART (MO./YR.)
~~Tufts University School of Medicine, Boston, MA~~	~~09/75~~	~~05/79~~
Boston Univ. School of Public Health, Boston, Ma	1986	1988

DOCTOR OF MEDICINE DEGREE AWARDED BY: Tufts University (NAME OF SCHOOL) **DATE AWARDED:** 05/79 (MONTH/YEAR)

MEDICAL LICENSURE:

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

STATE	LIC. NUMBER	DATE ISSUED	LICENSED BY:	
			EXAM	ENDORSEMENT
Washington	18747	1980	✓	
MA	48979	1981	✓	

MEDICAL PRACTICE:

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

HOSPITALS ASSOC. WITH	LOCATION (ADDRESS)	DATE ENTERED (MO./YR.)	DATE DEPART (MO./YR)
OB/GYN Residency Univ. of Wash. School of Med.	Seattle, WA.	07/79	06/81
OB/GYN Residency Tufts Univ. School of Med.	Boston, MA	07/81	06/84
New Eng. Med. Ctr.	Boston, MA	09/84	12/86
Univ. of MA (Occupational Health Residency) →	Worcester, MA	01/87	12/87
UMASS →	"	01/88	Present

SPECIALTY:

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

AMERICAN BOARD:	DATE CERTIFIED
~ Obstetrics & Gynecology	1986-recert 1996
~ Preventative Medicine (Occupational Medicine)	1989

ANSWER ONLY IF APPLYING FOR ENDORSEMENT OF THE MEDICAL COUNCIL OF CANADA LICENSE. HAVE YOU REQUESTED A "CERTIFICATE OF GOOD STANDING" WITH SCORES FROM THE MEDICAL COUNCIL OF CANADA?____(YES OR NO)

IF YOU ARE A FOREIGN MEDICAL GRADUATE, DO YOU HOLD CURRENT ECFMG CERTIFICATION OR HAVE COMPLETED A FIFTH PATHWAY PROGRAM?____(YES OR NO)

STATEMENT OF PROFESSIONAL HISTORY

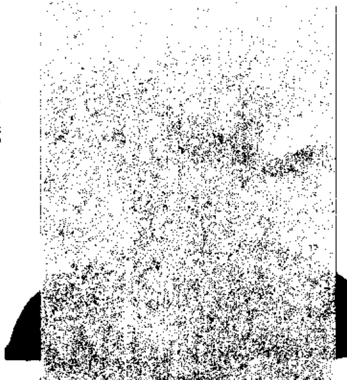
Please answer each question below. If you answer yes to any question, please refer to attached instructions.

Question	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?	___	✓
2. Have you ever had your membership in or certification by any professional society or association suspended or revoked for reasons related to profess-ional practice?	___	✓
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?	___	✓
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?	___	✓
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.	___	✓
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?	___	✓
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 a felony under the laws of this state?	___	✓
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?	___	✓

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.

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 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 f nly, including verifying and retrieving information.

Affix a recent photograph he



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

Maureen Paul
SIGNATURE OF APPLICANT

On this 14 day of Aug 1996 (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.

Maureen Paul
SIGNATURE OF APPLICANT

Sworn to me this 14 day of August 19 96

Julie A. Sealey
Signature of Notary Public

My Commision expires My Commission Expires Oct. 27, 2000

PLEASE RETURN THIS APPLICATION AND THE FEE FOR $450.00 MADE PAYABLE TO, "TREASURER, STATE OF CONNECTICUT" TO:

DEPARTMENT OF PUBLIC HEALTH
PHYSICIAN LICENSURE
410 CAPITOL AVE., **MS# 12MQA**
P.O. BOX 340308
HARTFORD, CT 06134

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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: Maureen Elizabeth Paul, MD

Date of Birth: 09/19/1949

Certification Date: 07/01/1980

Certificate #: 210413

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 PART I	Jun 1977	505 81	380 75	PASS	495 80	510 81	600 87	490 80	545 83	440 77	410 75

Exam	Test Date	Total Test	Min. Pass	Pass/ Fail	Med	Surg	Ob/Gyn	PM/PH	Ped	Psych
NBME PART II	Sep 1978	500 82	290 75	PASS	490 82	535 84	550 85	405 77	540 84	475 81
NBME PART III	Mar 1980	450 80.3	290 75	PASS						

DATE: 08/13/1996

SEE OTHER SIDE FOR SCORE INFORMATION

STATE OF CONNECTICUT
DEPARTMENT OF PUBLIC HEALTH
VERIFICATION OF RESIDENCY TRAINING

APPLICANT: Enter your full name and birthdate on this form and forward it to the Chief of Staff or program director at the facility in which you completed your residency training. This form must be completed by the facility and returned directly to this office.

Applicant's name: MAUREEN ELIZABETH PAUL Date of Birth: 09-19-49

Dear Chief of Staff/Program Director:
Please provide the following **verification of residency training** for the above-named Connecticut physician licensure applicant.

Name of Facility where residency training was completed: UMass Med Ctr

Dates of residency: From 01/01/87 **month/day/year** To 12/31/87 **(month/day/year)**

In what specialty was the residency training completed: Occup. Med

At what level(s) was this residency completed **(PGY1, PGY2 etc.)**? PGY 4-5

At the time of the applicant's training, was the residency training program in this specialty area accredited by the Accreditation Council for Graduate Medical Education? Yes **(YES or NO)**

Did the applicant satisfactorily complete this period of residency training? Yes

Do you have **any derogatory** information **regarding** the competency or conduct of **this applicant**? NO

I, Glenn Pransky, being duly sworn, do depose and certify that I am the Chief of Staff/Program Director at:

Univ. of Mass. Medical Center
NAME OF FACILITY

ADDRESS

Worcester MA 01655
CITY

STATE

and that the information provided herein is true and correct to the best of my knowledge and belief.

[signature]
Signature of Chief of Staff/Program Director

Subscribed and sworn to me this 16th day of Aug 1996

Lucy Garabedian
Notary Public

10-24-97
(My commission expires)

Please return this form directly to:

Department of Public Health
410 Capitol Ave., MS # 12 APP
Physician Licensure
P.O. Box 340308
Hartford, CT 06134

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STATE OF CONNECTICUT
DEPARTMENT OF PUBLIC HEALTH
VERIFICATION OF RESIDENCY TRAINING

APPLICANT: Enter your full name and birthdate on this form and forward it to the Chief of Staff or program director at the facility in which you completed your residency training. This form must be completed by the facility and returned directly to this office.

Applicant's name: MAUREEN ELIZABETH PAUL Date of Birth: 09-19-49

Dear Chief of Staff/Program Director:
Please provide the following **verification of residency training** for the above-named Connecticut physician licensure applicant.

Name of Facility where residency training was completed: Tufts Univ./St. Margaret's Hospital For Women (No longer operating)

Dates of residency: From 7/1/81 (**month/day/year**) To 6/30/84 (**(month/day/year)**)

In what specialty was the residency training completed: Obstetrics/Gyencology

At what level(s) was this residency completed (**PGY1, PGY2 etc.**)? PGY4

At the time of the applicant's training, was the residency training program in this specialty area accredited by the Accreditation Council for Graduate Medical Education? Yes (**YES or NO**)

Did the applicant satisfactorily complete this period of residency training? Yes

X Do you have **any derogatory** information **regarding** the competency or conduct of **this applicant?** No

I, Robert D. Kennison, M.D., being duly sworn, do depose and certify that I am the Chief of Staff/Program Director at:

Tufts Univ./New England Medical Center
NAME OF FACILITY

750 Washington Street, Box 22
ADDRESS

Boston
CITY

Massachusetts
STATE

and that the information provided herein is true and correct to the best of my knowledge and belief.

X [signature]
Signature of Chief of Staff/Program Director

Subscribed and sworn to me this 15th day of August 1996

STARLA ENGELHARDT PATHAK
Notary Public
My Commission Expires February 21, 2003
(My commission expires)

[signature] **Notary Public**

Please return this form directly to:

Department of Public Health
410 Capitol Ave., MS # 12 APP
Physician Licensure
P.O. Box 340308
Hartford, CT 06134

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STATE OF WASHINGTON

DEPARTMENT OF HEALTH

1300 SE Quince St • P.O. Box 47866 • Olympia, WA 98504-7866

August 20, 1996

Connecticut Division of Medical
Quality Assurance
410 Capitol Ave MS# 12APP
PO. Box 340308
Hartford, CT 06134

I, Rob Darling Program Representative, do hereby certify that a standard search of the available records of the Medical Quality Assurance Commission indicates the following:

PHYSICIAN'S NAME	**Maureen E. Paul, MD**
LICENSE NUMBER:	**MD00018747**
ISSUE DATE:	**09-26-80**
EXPIRATION DATE:	**09-19-81**
DATE OF BIRTH:	**09-19-49**

ACCORDING TO OUR RECORDS, THIS LICENSE HAS NOT BEEN DISCIPLINED

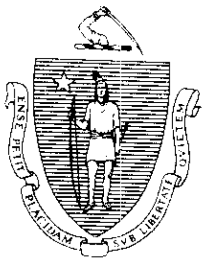
If our records above show that the license has been disciplined, photocopies from the public file are available upon written request. Send request to Medical Quality Assurance Commission, P.O. Box 47866, Olympia, WA 98504-7866.

The information above is the only certification information by the Commission. To expedite the certification process, the above format is the standard format prepared for all professions regulated by this Commission. If you have any questions, please contact me at (360)664-8689.

Sincerely,

Rob Darling
Program Representative

(SEAL)



Commonwealth of Massachusetts
Board of Registration in Medicine

10 West Street
Boston, Massachusetts 02111

(617) 727-3086
Fax: (617) 451-9568

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

ALEXANDER F. FLEMING, J.D.
EXECUTIVE DIRECTOR
PENELOPE WELLS, J.D.
GENERAL COUNSEL

RAFIK ATTIA, M.D.
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BOARD MEMBER
MARY ANNA SULLIVAN, M.D.
BOARD MEMBER

August 27, 1996

To Whom It May Concern:

This is to certify that MAUREEN E PAUL, a graduate of TUFTS UNIVERSITY SCHOOL OF MEDICINE in the year 1979, has been duly registered by this board as provided by the laws of the Commonwealth.

Certificate Number 48979 was issued to Dr. MAUREEN E PAUL on 03/02/82. THIS LICENSE IS CURRENT. The expiration date is 09/19/97. Our files contain NO OPEN or CLOSED complaints, and NO formal disciplinary action regarding this physician.

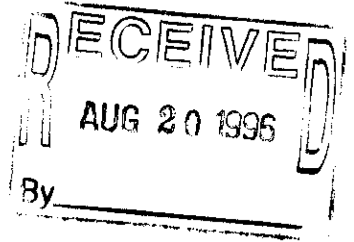
SEAL

Nishan J. Kechejian, M.D.,
Secretary

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 PUBLIC HEALTH



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

DISCIPLINARY INQUIRY

Federation of State Medical Boards
400 Fuller Wiser Road
Euless, TX 76039

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

LAST NAME	FIRST NAME	MIDDLE	DEGREE
Paul	Maureen	Elizabeth	M.D., M.P.H.

ADDRESS: 21 Burroughs St.

CITY	STATE	ZIP
Jamaica Plain,	MA	02130

DATE OF BIRTH (YEAR/MONTH/DATE): 49/09/19

SOCIAL SECURITY NUMBER: [redacted]

MEDICAL SCHOOL OF GRADUATION (Include complete name and branch location): Tufts University School of Medicine

DATE OF GRADUATION: 1979 COUNTRY OF MEDICAL SCHOOL: U.S.A.

ECFMG NUMBER (if foreign medical graduate):

APPLICANT SIGNATURE: Maureen Paul MD

Please mail the response directly to:

Department of Public Health
Physician Licensure
410 Capitol Ave., MS# 12 APP
P.O. Box 340308
Hartford, CT 06134

WE HAVE NO UNFAVORABLE INFORMATION REGARDING THE ABOVE NAMED PHYSICIAN

AUG 27 1996

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

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Phone:
Telephone Device for the Deaf (860) 509-7191
410 Capitol Avenue - MS # ________
P.O. Box 340308 Hartford, CT 06134
An Equal Opportunity Employer