### 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 against the Connecticut license under section 20-13c.

I wish you success in your medical career.

Respectfully,

Debra L. Johnson

Health Program Associate

Applications and Examinations Phone:

DLJ:cas 0683V

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 121/14 TSS	FOR OFFICE USE ONLY:	DATE REC'D 8/27/96			no Le
DEPARTMENT OF PUBLIC HEALTH  PHYSICIAN'S APPLICATION FOR LICENSURE FEE: \$450.00  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 Flizabeth (MADEN) (AAST)  STREET, (TOOCH) (STATE) (ADD)  PRESENT ADDRESS: 218urroughs Jamaica Riain (MADEN) (STATE) (ADD)  PRESENT ADDRESS: 218urroughs St. Jamaica Plain, MA 02130 (STATE) (ADD)  TELEPHONE NO: (WHERE YOU MAY BE REACHED 8:30-4:30, MONDAY - FRIDAY) (50.8) 792-8463  DATE OF BIRTH 09/19/49  SOCIAL SECURITY NUMBER:  PREMEDICAL EDUCATION:  Michigan State Holmore the language of the language of the part of the Michigan State Holmore is the language of the langua	<i>y</i> = <b>4.121.</b>			LICENSE NUMBER: EFFECTIVE DATE:	1556/8
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HOSPITALS ASSOC. WITH OB/GYN Residency Univ. of Wash. School of Med.	LOCATION (ADDRESS) Seattle, WA.	DATE ENTERED ( MO./YR.)07/79	DATE DEPART (MO./YR) 06/81
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New Eng. Med. Ctr.	Boston, MA	09/84	12/86
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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)

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### 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? 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? 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?

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- If your answer is "yes", give full details, names, addresses, etc. on separate notarized statement. 1. 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.
- If your answer is "yes", give full details, names, addresses, etc. on a separate notarized statement. 3. 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.
- If your answer is "yes", give full details, dates, etc., on a separate notarized statement. 8.

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.

On this 14 day of 110 19 19 19 19 (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.

Sworn to me this 14 day of Wuqu

My Commission Expires Oct. 27, 2000

My Commision expires

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

app8md.doc

## 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.

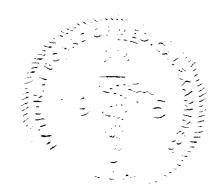
Diplomate Name: Maureen Elizabeth Paul, MD

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.

		Test	Total	Min.	Pass/							Beh
Exam		Date	Test	Pass	Fail	Anat	Phys	Bioc	Path	Micr	Phar	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
						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

PAGE: 1 of 1

# 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 Di Please provide the following verif licensure applicant.	rector		•
Name of Facility where residency training	g was completed:	Mass Med Ct	·
Dates of residency: From	/0//87 h/day/year	(month/day/ye	187
In what specialty was the residency traini	ng completed: Occo	p. Med	
At what level(s) was this residency complete	eted (PGY1, PGY2 etc	=)?_ PG94-5	
At the time of the applicant's training, wa Council for Graduate Medical Education?	s the residency training <u>YUL</u> (YES or NO)	program in this specialty as	rea accredited by the Accreditation
Did the applicant satisfactorily complete the	nis period of residency	training?	
Do you have any derogatory information	regarding the compete	ency or conduct of this app	licant? NO
I, Glenn Fransky, being duly	sworn, do depose and	certify that I am the Chief of	of Staff/Program Director at
NAME OF FACILITY	<u>×</u>		- Small rogidin Director at.
or Modelli		AD	DRESS
Worcester MA 01655	<del></del>		
CITY and that the information provided by		STATE	<del></del>
and that the information provided herein is		best of my knowledge and b	pelief.
Signature of Chief of Staff/Program Dire			
Subscribed and sworn to me this 16 day	V		Sawbedein Notary Public
	(My commi	ssion expires)	
Please return this form directly to:	Department of Put 410 Capitol Ave., N Physician Licensur P.O. Box 340308	IS#12 APP	
app12md.doc	Hartford, CT 0613	4.	

## 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: MAUREE	EN ELIZABETH PAULDate of Birth: 09-19-49
Dear Chief of Staff/Program D	Nimanta
Please provide the following <b>ver</b> licensure applicant.	ification of residency training for the above-named Connecticut physician
Name of Facility where residency train	ing was completed. Tufts Univ./St. Margaret's Hospital For Women
Dates of residency: From 7/1/81	nth/day/year (month/day/year)
In what specialty was the residency train	ning completed: Obstetrics/Gyencology
At what level(s) was this residency com	
At the time of the applicant's training, we Council for Graduate Medical Education	vas the residency training program in this specialty area accredited by the Accreditation
Did the applicant satisfactorily complete	this period of residency training? Yes
X.Do you have any derogatory informatio	on regarding the competency or conduct of this applicant?
I, Robert D. Kennison, Meiby du Tufts Uviv. New England Med	ly sworn, do depose and certify that I am the Chief of Staff/Program Director at:
NAME OF FACILITY	BOX 22
Boston	ADDRESS
CITY	Massachusetts
and that the information provided herein i	STATE s true and correct to the best of my knowledge and belief.
Signature of Chief of Stany Program Dir	V 12
Subscribed and sworn to me this 15th da	Notary Public Notary Public
	My Commission Expires February 21, 2003
	(My commission expires)
Please return this form directly to:	Department of Public Health
	410 Capitol Ave., MS # 12 APP Physician Licensure
app12md.doc	P.O. Box 340308 Hartford, CT 06134



#### 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)



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

## 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

RAFIK ATTIA, M.D. CHAIRMAN

BRUCE A. SINGAL, J.D.
VICE-CHAIRMAN

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CARL M. SAPERS, J.D. BOARD MEMBER

MARY ANNA SULLIVAN, M.D.

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

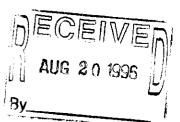
Nishan J. Kechejian, M.D., Secretary

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:

Paul LAST NAME	Maureen FIRST NAM	ИЕ	Elizabeth MIDDLE	M.D. M.P DEGREE
Z1_Burroughs_S ADDRESS	t			
Jamaica_Plain, CITY 49/09/19		A STATE		02130 ZIP
DATE OF BIRTH	(YEAR/MO	ONTH/DATE)		
SOCIAL SECURITY NUME	BER			
Tufts Universit MEDICAL SCHOOL OF GR (Include complete name and I	LY School of ADUATION branch location)	Medicine		
1979 DATE OF GRADUATION			J.S.A. Y OF MEDICAL SCHOO	L
ECFMG NUMBER (if foreign AUGULANT SIGNATURE	n medical graduate)	D.		
Please mail the response	directly to:	Department Physician Li	of Public Health	

app10md.doc



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

P.O. Box 340308

Hartford, CT 06134

410 Capitol Ave., MS# 12 APP

WE HAVE NO UNFAVORABLE INFORMATION REGARDING THE ABOVE NAMED PHYSICIAN

AUG 2 7 1996

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