16551

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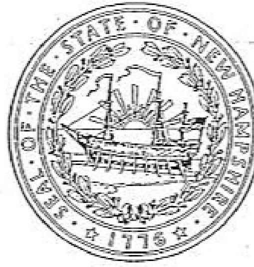

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New Hampshire Board of Medicine

2 INDUSTRIAL PARK DRIVE, SUITE 8, CONCORD, NH 03301-8520
Tel. (603) 271-1203 Fax (603) 271-6702
TDD Access: Relay NH 1-800-735-2964
WEB SITE: www.nh.gov/medicine

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NH BOARD

PLEASE COMPLETE AND RETURN TO THE BOARD OF MEDICINE AS SOON AS POSSIBLE. PLEASE PRINT.

*****NOTE……Please mark the box next to the address you would prefer to list as your mailing address.**

Physician Name: Regan Theiler

Business Name: Planned Parenthood Northern New England

[X] Address: 183 Talcott Rd
Williston VT 05495

Office telephone: 802/288-8409

Business Fax Number: Business E-Mail:

[ ] Home Address:

Home telephone:

Specialty: Ob/Gyn Board certified: Yes

Hospital affiliations: Fletcher-Allen

In what other states do you hold a current license: TX, ME, VT

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President

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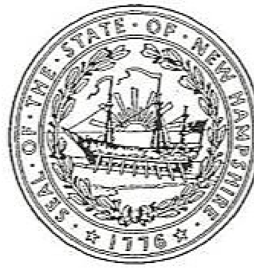

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New Hampshire Board of Medicine

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Tel. (603) 271-1203 Fax (603) 271-6702
TDD Access: Relay NH 1-800-735-2964
WEB SITE: www.nh.gov/medicine

August 3, 2011

REGAN THEILER MD

Dear Dr. Theiler:

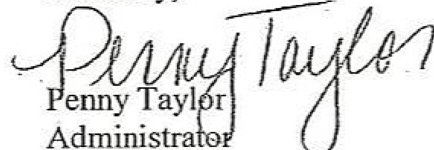
Congratulations, your application for licensure has been granted by the New Hampshire Board of Medicine. Your license, numbered 15363, is dated August 3, 2011, and is enclosed with this letter.

Please make note of the expiration date. You are required to renew your license on a biennial basis and forms for that purpose will be forwarded to you at the address on file with the Board in April of the year in which your renewal is set to occur. For this reason, a form is enclosed which should be returned to us if and when you change your home or business address. Please be aware that you are required to inform the board of any change of address within 30 days of that change.

An engrossed certificate of licensure will be provided to you within the next six months. This certificate is for display purposes only and does not constitute a legal document which verifies current licensure. The enclosed pocket size card should be used for that purpose.

Please feel free to contact this office if you have any questions.

Sincerely,



Penny Taylor
Administrator

Encl.

Uniform Application for Physician Licensure

UA Username rtheiler | Date Submitted 6/10/2011

FCVS Status Applicant has an FCVS Packet

1. Name: Indicate your full legal name. If your name has changed at any time during your life and you are not using FCVS, you must submit a copy of the legal document (marriage certificate, divorce decree, etc.) supporting your name change.

1. Full Name (use no initials)

Last Name	Theiler
First Name	Regan Nell
Middle Name	
Suffix	
Maiden Name	

M.D. [X] **D.O.** [ ]

All other names used

First	Middle	Last	Suffix

2. Address/Phone: Please complete all sections and indicate which address you wish to be used for public access and which is to be used for mailings from the medical board. Each state's law determines whether each address or phone number is a public record in the state in which you are applying. You may wish to contact the licensing authority for that state for further information. Many boards publish the "Public Access" address on their website, therefore you should consider what your preferred address is for these purposes.

2. Address/Phone

Business

[X] **Public Access**

[X] **Mailing**

Street Planned Parenthood Northern New England
183 Talcott Rd

City Williston **State/Province** VT **Zip Code** 05495

Country USA

Telephone 4093709644

Fax

Email

Alternate Phone 4093709644

Home

[ ] **Public Access**

[X] **Mailing**

Street

City **State/Province** **Zip Code**

Country USA

Telephone

Fax

Email

Alternate Phone

sent gg.✓ 6/14/11

THEILER, REGAN

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3. Identification: If you are not using FCVS, you must submit either a notarized copy of your birth certificate or a notarized copy of your current, valid passport.

3. Identification

Date of Birth (mm/dd/yyyy)	Birth City	Birth State/Province	Birth Country
			USA

Gender	Social Security Number	NPI	Are you a U.S. Citizen?
F			[X] Yes [ ] No

Your social security number is required to facilitate reporting to the federal Healthcare Integrity & Protection Data Bank (42 U.S.C. Sections 1320a-7e(b), 5 U.S.C. Section 552a, and 45 C.F.R. pt. 61) and for accurate identification under the federal and state child support enforcement law (42 U.S.C. Section 666 and applicable state law). It may also be used for reporting to the National Practitioner Data Bank (42 U.S.C. Section 11101 and 45 C.F.R. pt. 60) and for other investigative/enforcement purposes in compliance with state laws governing physician discipline or as otherwise required by state or federal law.

The National Provider Identifier (NPI) is a Health Insurance Portability and Accountability Act (HIPAA) Administrative Simplification Standard. For more information on the NPI, please go to http://www.cms.hhs.gov/NationalProvidentStand/.

4. Medical School: List all medical schools you have attended, even those from which you did not graduate, in chronological order. Attach an additional sheet if necessary. If you are not using FCVS, you must complete the attached "Medical Education Verification" form and send it to all medical schools you have attended. You must include a copy of your diploma to which the medical school must attach their seal prior to forwarding it to this Board. Additionally, the medical school must provide this Board with an official copy of your transcripts. The medical school must forward all documentation directly to this Board.

4. Medical School

1 **School Name** University of Wisconsin Medical School
Address 750 Highland Drive
Room 2141G HLSC

City Madison
State/Province WI
ZIP Code 53705
Country USA
Attendance Dates **From (mm/yyyy)** 08/1996 **To (mm/yyyy)** 05/2003
Graduation Date 5/15/2003
Degree MD

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5. Fifth Pathway: If you attended a Fifth Pathway program and are not using FCVS, you must complete the attached "Fifth Pathway Verification" form and send it to your medical school and to the institution where you completed your rotations. You must include a copy of your diploma. The medical school and institution must forward all documentation directly to this Board.

5. Fifth Pathway (if applicable)

Medical School Name			
Address			
City			
State/Province			
ZIP Code			
Country			
Attendance Dates	**From (mm/yyyy)**	**To (mm/yyyy)**	**In Progress**
Graduation Date			
Degree			

Institution name where rotations performed			
Address			
City			
State/Province			
ZIP Code			
Country			
Rotation Dates	**From (mm/yyyy)**	**To (mm/yyyy)**	**In Progress**
Certification Date			

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6. Postgraduate Training: List **all** postgraduate programs you have attended, even those you did not complete. Attach an additional sheet if necessary. If you are not using FCVS, you must complete the attached "Postgraduate Training Verification" form and send it to **all** postgraduate training programs you have attended. You must submit a copy of your certificate of program completion to this Board. The postgraduate program must forward all documentation directly to this Board.

6. Postgraduate Training

1

Hospital Name Emory University School of Medicine
Hospital Address 69 Jesse Hill Jr Drive

City Atlanta
State/Province Georgia
ZIP Code 30303
Country USA

PGY: (e.g., 1, 2, 3, etc.) [ ] Internship [X] Residency [ ] Fellowship [ ] Research [ ] Other

Department/Specialty Obstetrics and Gynecology

From: 07 /2005 **To:** 06 /2006 (Month Year Month Year) **Successfully Completed?** [X] Yes [ ] No **In Progress** [ ]

2

Hospital Name Emory University School of Medicine
Hospital Address 69 Jesse Hill Jr Drive

City Atlanta
State/Province Georgia
ZIP Code 30303
Country USA

PGY: (e.g., 1, 2, 3, etc.) [ ] Internship [ ] Residency [ ] Fellowship [ ] Research [X] Other

Department/Specialty Obstetrics and Gynecology

From: 07 /2006 **To:** 06 /2007 (Month Year Month Year) **Successfully Completed?** [X] Yes [ ] No **In Progress** [ ]

3

Hospital Name Emory University School of Medicine
Hospital Address 69 Jesse Hill Jr Drive

City Atlanta
State/Province Georgia
ZIP Code 30303
Country USA

PGY: (e.g., 1, 2, 3, etc.) [X] Internship [ ] Residency [ ] Fellowship [ ] Research [ ] Other

Department/Specialty Obstetrics and Gynecology

From: 07 /2003 **To:** 06 /2004 (Month Year Month Year) **Successfully Completed?** [X] Yes [ ] No **In Progress** [ ]

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4 **Hospital Name** Emory University School of Medicine
Hospital Address 69 Jesse Hill Jr Drive

City Atlanta
State/Province Georgia
ZIP Code 30303
Country USA

PGY: (e.g., 1, 2, 3, etc.) [ ] **Internship** [X] **Residency** [ ] **Fellowship** [ ] **Research** [ ] **Other**

Department/Specialty Obstetrics and Gynecology

From: 07 /2004 **To:** 06 /2005 **Successfully Completed?** [X] **Yes** [ ] **No** **In Progress** [ ]

Month Year Month Year

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7. Examination History: If you are not using FCVS, you are responsible for contacting the appropriate examination entity and having a certified transcript of your scores sent directly to this Board.

7. Examination History

List each licensure examination, U.S. or international, you have taken (USMLE, NBME, NBOME, LMCC, Etc.).If additional space is necessary, please enclose a separate sheet with your application and include all the information below

Examination	State	Most Recent Date taken(Month/Year)	Passed (P) or Failed (F)		Number of attempts
USMLE Step 1		10/1998	☐ P	☐ F	1
USMLE Step 2		04/2003	☐ P	☐ F	1
USMLE Step 3		10/2004	☐ P	☐ F	1

Applicant Name: Regan Nell Theiler
Submission Type: FCVS

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8. ECFMG: If ECFMG is applicable and you are not using FCVS, you are responsible for contacting ECFMG and having a certified "Status Report" forwarded directly to this Board. There is a separate fee for this report. Reports can be obtained through the ECFMG web site at www.ecfmg.org.

8. ECFMG (if applicable)		
Certificate Number	Issue Date	Valid Through Date

9. State or Professional Licensure: List all state and Canadian provinces where you currently hold or have ever held any type of medical/osteopathic license. You must also complete the attached "Licensure Verification" form (Form #1) and forward it to all states in which you have held any health care license or certification. The verifying entity must forward all documentation directly to this Board. Some state boards charge a fee for this information. Contact the state board where you hold or held a license to determine their requirements.

9. State Licensure

1	**State/Province** GA ✓	**Practitioner Type** (MD, DO, etc.)	MD	**Type of License** (Full, Temporary, etc.)	Training License	
	License Number 000305	**Status**	Inactive	**Issue Date**	7/1/2003	
2	**State/Province** TX ✓	**Practitioner Type** (MD, DO, etc.)	MD	**Type of License** (Full, Temporary, etc.)	Full License	
	License Number M6911	**Status**	Active	**Issue Date**	7/25/2007	

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10. Chronology of Activities: List ALL activities (medical, non-medical, and postgraduate training) in chronological order beginning with medical school graduation to the PRESENT date, using **MONTH** and **YEAR**. *For any non-working time, you MUST state on the form exactly what your activities were, such as "vacation" or "seeking employment," as well as your permanent address.* If you worked for a physician-staffing group or did locum tenens, you must list all facilities where you worked and include complete dates and addresses. **DO NOT SUBSTITUTE ANY OTHER RESUME FOR THIS FORM.** Be sure to indicate the percentage of working time spent in clinical administrative duties.

10. Chronology of Activities

Dates: From/To	Practice/Employment
1 From: Month: 07 Year: 2007 To: Month: Year: In Progress [X]	**Practice/Employment Name** University of Texas Medical Branch (or list non-working time as indicated above) **Practice/Employment Address** 301 University Blvd **City** Galveston **State/Province** Texas **ZIP Code** 77555 **Country** USA **Position and Department** Assistant Professor-Obstetrics and Gynecology **% Clinical** 25 **% Administrative** 75 **Employment** [X] **Staff Privileges** [ ] **Affiliation** [ ] **Other**

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11. Malpractice: List of all claims or suits for medical malpractice made against you. A claim is any formal or informal demand for payment to any person or organization. If you do not have any such claims or suits, this section will be blank. Please have your information available before reviewing this section and contact the state board or FCVS to make changes.

11. Malpractice Liability Claims Information

Name of patient involved:

In which state did the action take place?

Case number (if applicable)

Which court?
(If private compromise or settled before initiation of civil action, state here)

Current status of claim:

☐ Open (pending) ☐ Closed (settled or judgment) ☐ Dismissed (no money paid out) ☐ Other

Amount of judgement or settlement $

Amount paid on your behalf $

Month and year of event precipitating claim:

Month and year of lawsuit:

Insurance carrier at time:

What is/or was your status? ☐ Primary defendant ☐ Co-defendant ☐ Other

Please provide specifics in reference to the adverse event including the allegations and your role in the event:

Applicant Name: Regan Nell Theiler
Submission Type: FCVS

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Affidavit and Authorization for Release of Information: You must attach a recent (less than 6 months old) passport quality, color photograph of yourself to this form. Take the form to a notary public and sign the form in the presence of the notary public. The notarized form then must be sent directly to this Board.

Affidavit
And
Authorization For Release of Information

I, the undersigned, being duly sworn, hereby certify under oath that I am the person named in this application, that all statements I have made or shall make with respect thereto are true, that I am the original and lawful possessor of and person named in the various forms and credentials furnished or to be furnished with respect to my application and that all documents, forms or copies thereof furnished or to be furnished with respect to my application are strictly true in every aspect.

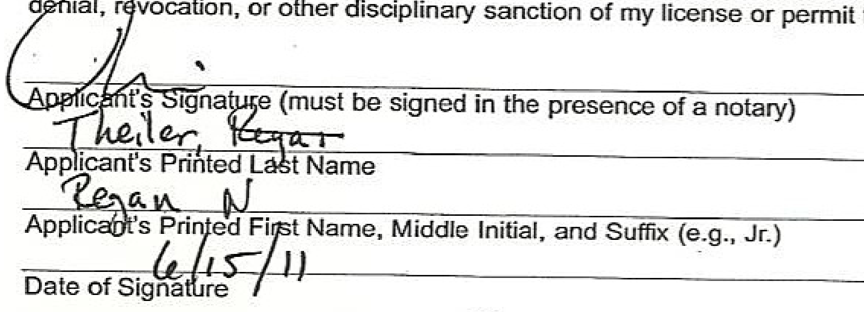
I acknowledge that I have read and understand the Application for Physician Licensure and have answered all questions contained in the application truthfully and completely. I further acknowledge that failure on my part to answer questions truthfully and completely may lead to my being prosecuted under appropriate federal and state laws.

I authorize and request every person, hospital, clinic, government agency (local, state, federal or foreign), court, association, institution or law enforcement agency having custody or control of any documents, records and other information pertaining to me to furnish to the Board any such information, including documents, records regarding charges or complaints filed against me, formal or informal, pending or closed, or any other pertinent data and to permit the Board or any of its agents or representatives to inspect and make copies of such documents, records, and other information in connection with this application.

I hereby release, discharge and exonerate the Board, its agents or representatives and any person, hospital, clinic, government agency (local, state, federal or foreign), court, association, institution or law enforcement agency having custody or control of any documents, records and other information pertaining to me of any and all liability of every nature and kind arising out of investigation made by the Board.

I will immediately notify the board in writing of any changes to the answers to any of the questions contained in this application if such a change occurs at any time prior to a license to practice medicine being granted to me by the board.

I understand my failure to answer questions contained in this application truthfully and completely may lead to denial, revocation, or other disciplinary sanction of my license or permit to practice medicine.



Applicant's Signature (must be signed in the presence of a notary)

Theiler, Regan

Applicant's Printed Last Name

Regan N

Applicant's Printed First Name, Middle Initial, and Suffix (e.g., Jr.)

6/15/11

Date of Signature

NOTARY

Dated 6/15/11 Signed Pamela A. Simmons

State of Texas County of Galveston

SUBSCRIBED AND SWORN TO before me this 15th day of, June 2011.

My commission expires: 1-25-2013 (NOTARY PUBLIC SIGNATURE & SEAL)

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ADDENDUM TO APPLICATION

Please answer the following questions. **If you answer "yes" to any of these questions, please explain on the reverse side of this sheet, or attach an additional 8 1/2" x 11" sheet(s) if necessary.**

	YES	NO
1. Are you certified by an American Specialty Board? (If yes, provide a notarized copy of all certificates).	X	
2. Have you ever, for any reason, lost American Specialty Board Certification?		X
3. Have you been denied required recertification by any specialty boards? (If yes, list each boards and dates denied).		X
4. Has any medical malpractice suit been brought against you or has any claim been settled on your behalf in the last ten years? (If so, indicate how many).		X
5. Have you ever applied for licensure or to sit for an examination, or taken an examination, under a different name?		X
6. Have you ever been denied the privilege of taking or finishing an examination or been accused of cheating or improper conduct during an examination since you graduated from high school?		X
7. Have you ever failed any national medical licensure examination, or any part of that examination, state board examination or failed to gain certification from the National Board of Medical Examiners? **You must report all exam failures, even if you later passed the examination.** (This does not include specialty board certification examinations.)		X
8. Have you ever failed a foreign licensing or certification examination?		X
9. Have you ever been denied a medical license, whether full, limited or temporary, for any reason?		X
10. Have you ever had staff privileges, employment or appointment in a hospital or other health care institution denied, limited, suspended or revoked, or have you ever resigned from a medical staff in lieu of disciplinary action?		X
11. Is any investigation or disciplinary action pending, or has any investigation or disciplinary action been taken against you in the last ten years by any governmental authority, by any hospital or health care facility, or by any professional medical association (international, national, state or local)?		X

	YES	NO
12. Have you ever voluntarily surrendered a license to practice medicine or any healing art or allowed such a license to lapse in lieu of facing disciplinary investigation or action?	____	X
13. Have you ever withdrawn an application for licensure, hospital privileges or appointment for any reason?	____	X
14. Have you ever been a defendant in a criminal proceeding including driving while under the influence or driving while suspended, which has not been annulled by a court, but not including traffic offenses not classified as misdemeanors or felonies?	____	X
15. Has your privilege to possess, dispense or prescribe controlled substances ever been suspended, revoked, denied, restricted or surrendered, or have you ever been charged, investigated or warned by a state or federal agency based on controlled substance issues?	____	X
16. Have you ever had any physical, emotional or mental illness which has impaired or would be likely to impair your ability to practice medicine?	____	X
17. Are you now, or have you, during the past 5 years, been dependent upon alcohol or habituating drugs or undergone treatment for such?	____	X

Anticipated Practice Location(s) (if known):

Planned Parenthood clinics throughout New Hampshire.

[signature] — Applicant's Signature

Theiler — Applicant's Printed Last Name

6/13/11 — Date of Signature

For Board Use Only:

Application Received: 6/16, 2011 Fee Paid: $250 - Check#: ______

License Number: ______ Date of Issue: ______

REGAN N. THEILER, MD, PHD, FACOG

PRESENT POSITION AND ADDRESS:

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2007-Present Assistant Professor
Division of Gynecology
Department of Obstetrics and Gynecology
University of Texas Medical Branch
Galveston, Texas 77555-0587

BIOGRAPHICAL:

Sex: Female
Date of Birth:
Place of Birth:
Citizenship: U.S.A.

EDUCATION:

2003-2007 Residency. Emory University, Atlanta Georgia
Department of Obstetrics and Gynecology

1996-2003 M.D. University of Wisconsin-Madison Medical School, Madison, Wisconsin
Medical Scientist Training Program

1998-2001 Ph.D. University of Wisconsin-Madison, Madison, Wisconsin
Microbiology Doctoral Training Program

1992-1996 B.S. DePaul University, Chicago, Illinois
Chemistry, with High Honor

CURRENT CLINICAL PRACTICE:

Clinical responsibilities include caring for private obstetric and gynecologic patients as part of a faculty group practice. Other clinical activities consist of supervising resident clinics, performing gynecologic surgeries, and managing high-risk labor and delivery.

General Obstetrics:

First and second trimester pregnancy complications
Management of high-risk pregnancy (Diabetes, hypertension, twins, thyroid disease, etc.)
Cesarean delivery
VBAC
Operative vaginal deliveries: vacuum, outlet forceps, low forceps
Limited obstetric ultrasound

General Gynecology:

Contraceptive management
Dysplasia, colposcopy, and LEEP
Total laparoscopic hysterectomy (TLH)
Laparoscopically-assisted vaginal hysterectomy (LAVH)
Vaginal hysterectomy
Mid-urethral slings
Anterior and posterior repair
Abdominal hysterectomy
Tubal ligation
Gynecologic ultrasound
Diagnostic and operative hysteroscopy

CERTIFICATION:

2009 — Diplomate, American Board of Obstetrics and Gynecology
Actively engaged in maintenance of certification.

2010 — Fellow, American Congress of Obstetricians and Gynecologists

LICENSURE:

Texas State Medical License – M6911

PROFESSIONAL AND TEACHING EXPERIENCE:

2007-Present — Assistant Professor and Women's Reproductive Health Research (WRHR) Scholar
Division of Gynecology, Department of Obstetrics and Gynecology, University of Texas Medical Branch, Galveston, Texas

2008-2011 — Staff Physician, Planned Parenthood Gulf Coast, Houston, Texas

2006-2007 — Administrative Chief Resident, Department of Gynecology and Obstetrics
Emory University, Atlanta, Georgia

2005-2007 — CDC Guest Researcher, Centers for Disease Control and Prevention
Atlanta, Georgia

2003-2006 — Resident, Department of Gynecology and Obstetrics
Emory University, Atlanta, Georgia

1995 — National Science Foundation Fellowship, Research Experience for Undergraduates
University of Utah Medical Center and Department of Chemistry
Bacterial Topoisomerases as Antimicrobial Targets

RESEARCH ACTIVITIES:

Interests include maternal/fetal infectious diseases, virology, and placental immunology.

2007-Present	Women's Reproductive Health Research Scholar National Institutes of Health K12 Mechanism Principle Investigator: Gary D. V. Hankins, MD Mentors: C. J. Peters, M.D. and Mahmoud Ahmed, PhD
2007-2011	National Institutes of Health Loan Repayment Program (LRP) for Clinical Researchers
2004-2005	Roche Diagnostics Grant: Cord Blood Screening for Cytomegalovirus Infection Using Quantitative PCR.

COMMITTEE ASSIGNMENTS:

2001-2003	Medical Scientist Training Program Admissions Committee, University of Wisconsin-Madison School of Medicine, Madison, Wisconsin
2005-2007	Residency Oversight Committee, Department of Gynecology and Obstetrics, Emory University School of Medicine, Atlanta, Georgia
2006-2007	Graduate Medical Education Resident Duty Hours Subcommittee, Emory University School of Medicine, Atlanta, Georgia
2006-2007	Graduate Medical Education Committee, Emory University School of Medicine, Atlanta, Georgia
2008-2009	Surgical Care Improvement Project Committee, John Sealy Hospital, University of Texas Medical Branch, Galveston, Texas
2008-Present	Pharmacy and Therapeutics Committee, John Sealy Hospital, UTMB, Galveston, Texas
2009-Present	Obstetrics and Gynecology Electronic Medical Records Committee.
2010-Present	Obstetrics and Gynecology Education Committee

TEACHING RESPONSIBILITIES:

2009-Present	Ob/Gyn Residents: Director of gynecology rotation for Ob/Gyn residents
2008-Present	Small Group Facilitator – Ob/Gyn Clerkship – 3rd Year Students
2008-Present	Practice of Medicine Course Facilitator and Lecturer
2009	Problem Based Learning Facilitator

MEMBERSHIP IN PROFESSIONAL AND SCIENTIFIC SOCIETIES:

2008-Present	Society for Gynecologic Investigation

2009-Present Infectious Disease Society of America

1996-Present American Medical Association

2007-Present American Society for Microbiology

HONORS:

1992-1996 Arthur J. Schmitt Scholar, DePaul University, Chicago, Illinois

1993 CRC Freshman Chemist of the Year Award, Department of Chemistry, DePaul University, Chicago, Illinois

1993, 94, 96 Dean's Award for Academic Excellence, DePaul University, Chicago, Illinois

1994-1996 Claire Booth Luce Scholarship for Women in Math and Science, DePaul University, Chicago, Illinois

1996 Merck Index Award, Department of Chemistry, DePaul University, Chicago, Illinois

1998-2000 National Research Service Award, Molecular Biosciences Training Grant T32 GM 07215, University of Wisconsin-Madison Graduate School, Madison, Wisconsin

2001-2003 Wisconsin Distinguished Rath Graduate Fellow in Medicine, University of Wisconsin-Madison School of Medicine, Madison, Wisconsin

2005 Carlos Moisa Research Recognition Award, Department of Gynecology and Obstetrics, Emory University, Atlanta, Georgia

2006 Second Place – Resident Research Day, Department of Gynecology and Obstetrics, Emory University, Atlanta, Georgia

2007 Golden Apple Award, Emory University Medical Student Teaching Award, Emory University, Atlanta, Georgia

2008 Charles C. Shepard Science Award Finalist – Laboratory and Methods Manuscript "Breast Milk CD4+ T Cells Express High Levels of Chemokine Receptor 5 and CXC Chemokine Receptor 4 and are Preserved in HIV-Infected Mothers Receiving Highly Active Antiretroviral Therapy". (Journal of Infectious Diseases 2007; 195:965-972) June 2008

2010 McGanity Lectureship, Texas Association of Obstetrics and Gynecology Annual Meeting

OTHER AFFILIATIONS:

2008-Present Member – UTMB Sealy Center for Vaccine Development

2009 Legislative Affairs Consultant to the University of Texas System

Ongoing Peer reviewer (*ad hoc*) for:

Infectious Diseases in Obstetrics and Gynecology
Journal of the American Medical Association (JAMA)
The American Journal of Obstetrics and Gynecology
The American Journal of Public Health
The Journal of Clinical Virology
The Journal of Travel Medicine

2010-Present Consultant to Bayer pharmaceuticals: Speakers bureau

2010-Present Consultant to Merck pharmaceuticals: Implanon faculty trainer

MENTORSHIP:

Undergraduate Students:
1. Kyle O'Boyle. Summer undergraduate research program, 2008.

Medical Students:
1. Emiko Petrosky. Senior research elective, 2009-10.
2. Holly Dunn. Senior research elective, 2009-10.

Graduate Students:
1. Janet Appleton. PhD student 2009-10.
2. Reagan Street. Masters of Medical Science, 2010.

Residents:
1. Sara Mucowski, M.D. Resident research project, 2008-2011.
2. Paula Doyle, M.D. Resident research project, 2008-2010.
3. Katie Gillaspy, M.D. Resident research project, 2008-2010.
4. Teresa Walsh, M.D. Resident research project, 2010-ongoing.
5. Katheryn Williams, M.D. Resident research project, 2010-ongoing.
6. Johanna Voutyras, M.D. Resident research project, 2011-ongoing.

Advisory Committee Memberships:
1. Nguyen V. Nguyen, medical student honors thesis
2. Dara Havemann, M.D. Masters of Medical Science

BIBLIOGRAPHY:

ARTICLES IN PEER-REVIEWED JOURNALS

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ABSTRACTS

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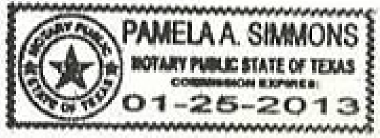

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