13177

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.state.nh.us/medicine

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.**

Name: Kym Boyman, MD.

☐ Office name and address: Vermont Women's Choice
23 Mansfield Ave, Burlington, VT 05401

Office telephone: 802/863-9001

☒ Home Address: [redacted]

Home telephone: [redacted]

Specialty: Ob/Gyn Board certified: No - Board eligible

Hospital affiliations: Fletcher Allen Health Care, Burlington, VT

In what other states do you hold a current license: Vermont, Maine

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.state.nh.us/medicine

November 5, 2003

KYM M BOYMAN MD

Dear Dr. Boyman:

Congratulations, your application for licensure has been granted by the New Hampshire Board of Medicine. Your license, numbered 12128, is dated November 5, 2003, 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

Penny Taylor
Administrator

Encl.

RECEIVED BY PHYSICIAN 11/20/03

RECEIVED
AUG 0 8 2003
NH BOARD

New Hampshire Board of Medicine

Application for Licensure by Endorsement

Staple your application fee to the upper left–hand corner of this page.

Name (as it will appear on your medical license):

Boyman — M.D
Last Name (include Maiden Name, if applicable) — Gen. Suffix

Kym — Margaret
First Name — Middle Name

Office Name: Planned Parenthood

Office Address: 89 so. main street
Number and Street — Apartment Number

West Lebanon — NH — 03784
City — State — Zip (or postal) Code

Home Address (where all Board correspondence will be sent):

Number and Street — Apartment Number

City — State — Zip (or postal) Code

Telephone Numbers

Business: (603) 298-7966 — Home: ( ) _____

Other: ( ) N/A — Fax: ( ) N/A

Identifying Information

Date of Birth: _____ Month _____ Day _____ Year

Place of Birth _____ City _____ State

Social Security Number: _____

For Board Use Only:

Application Received: 8/8, 20 03 — Fee Paid: 400.00 — Check#: 2001

License Number: 12128 — Date of Issue: 11-5-03

Application for Licensure by Endorsement (continued)

List all states where you hold or have ever held a license to practice medicine. **Please continue list on back of this page if needed.**

Vermont # 042-0010597

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).		✓
2. Have you ever, for any reason, lost American Specialty Board Certification?		✓
3. Have you been denied required recertification by any specialty boards? (If yes, list each boards and dates denied).		✓
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).		✓
5. Have you ever applied for licensure or to sit for an examination, or taken an examination, under a different name?		✓
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?		✓
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.)		✓
8. Have you ever failed a foreign licensing or certification examination?		✓
9. Have you ever been denied a medical license, whether full, limited or temporary, for any reason?		✓
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?		✓

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)?

	✓ 6/7/02

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?

	✓

13. Have you ever been a defendant in a criminal proceeding including driving while under the influence or driving while suspended, but not including traffic offenses not classified as misdemeanors or felonies?

✓	(See explanation on reverse)

14. 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?

	✓

15. Have you ever had any physical, emotional or mental illness which has impaired or would be likely to impair your ability to practice medicine?

	✓

16. Are you now, or have you, during the past 5 years, been dependent upon alcohol or habituating drugs or undergone treatment for such?

	✓

Anticipated Practice Location(s) (if known):

Planned Parenthood
89 So. main St.
West Lebanon, NH. 03784

I, Kym Margaret Bayman
(type/print your complete name)

hereby apply for a license to practice medicine in the State of New Hampshire as a Doctor of Medicine or as a Doctor of Osteopathy and submit the following proofs, as required by the rules and regulations, formulated in accordance with the laws of the State of New Hampshire, and enclosed a check or postal or express money order for the application fee of $250.00, check made payable to the "Treasurer, State of New Hampshire" - U.S. Funds only. In doing so, I hereby release, discharge, and hold harmless the State of New Hampshire, the Board of Medicine, its agents or representatives and any person furnishing information, records, or documents of any and all liability.

Bayman	Kym	Margaret
Typed/Printed Last Name	First Name	Middle Name

KMBayman 7/14/03

Applicant's Signature

Date of Signature

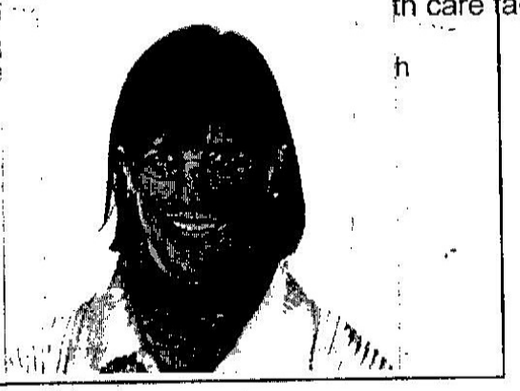
AFFIDAVIT OF THE APPLICANT

STATE OF Vermont
(where applicant resides)

COUNTY OF Addison
(where applicant resides)

I, Kym Margaret Boyman of _____
(Applicant's Name) (City and State where Applicant Resides)

being duly sworn say that I am the person referred to in the above application for a license to practice ~~medicine as a Doctor of Medicine or Doctor~~ of Osteopathy in the State of New Hampshire; that I have studied the treatment of human ailments not less than four school years, received a degree of Doctor of Medicine or Doctor of Osteopathy; and that all the statements herein respecting age, academic and medical education, internship, state or national board examination and license, good professional standing, and all other statements made on said application are true in every respect, and that no investigation or disciplinary action is pending or has been brought against me by any state, county or local me th care facility or professional medical association, except as disclos h
Pa



X _____
Applicant's Signature

Boyman Kym margaret
Last Name First Name Middle Name

7/17/03
Date of Signature

Sworn to before me this 17 day of July, 2003

CURRICULUM VITAE

KYM M. BOYMAN, M.D.

EDUCATION

Residency	Obstetrics and Gynecology: University of Vermont / Fletcher Allen Health Care ("FAHC"), Burlington, VT, 1999-2003
Medical School	MD: University of Vermont College of Medicine ("UVM COM"), Burlington, VT, 1995-1999
Undergraduate	AB, History: Stanford University, Stanford, CA, 1985-1989
	Premedical studies: University of Vermont, Burlington, VT; Middlebury College, Middlebury, VT; and Montgomery College, Rockville, MD, 1992-1996

LICENSES & CERTIFICATIONS

- State of Vermont Physician's License
- United States Medical Licensing Examination, Steps 1-3 (Passed)
- Board-eligible, Obstetrics and Gynecology

PROFESSIONAL EXPERIENCE

Ob/Gyn Teaching Chief Resident and Clinical Instructor in Obstetrics and Gynecology
University of Vermont / Fletcher Allen Health Care, Burlington, VT (2002-2003)
Provided clinical instruction to medical students and residents, helped coordinate resident lecture series and journal clubs, and presented teaching conferences in a busy academic Ob/Gyn department.

Coordinator, Employee Wellness Program
Saint Michael's College, Colchester, VT (1994-1995)
Planned, designed, and implemented health promotion programs for college personnel.

Counselor
The Lund Family Center, Burlington, VT (1994-1995)
Counseled pregnant and parenting teens in a residential parent/child center.

Instructor, Undergraduate Studies
Stanford University, Stanford, CA (1989)
Developed and taught seminar, "Medical Models: Wellness and Healing in Cultural Perspective."

COMMITTEES & ACTIVITIES

Member, Education Committee, FAHC Ob/Gyn Department (2002-2003)
Member, Quality Assurance Committee, FAHC Ob/Gyn Department (2002-2003)
ACOG Vermont Section Junior Fellow Vice-Chair (2000-2001) and Chair (2001-2002)
Representative, Committee for Medical Student Well-being, UVM COM (1995-1999)
Co-founder, Women's Mentoring Project, UVM COM (1996-1999)
Co-founder, University of Vermont chapter of Medical Students for Choice (1996-1999)
Volunteer, Students Teaching AIDS to Students (1995-1996)
Interviewer, UVM College of Medicine Admissions Committee (1997-1999)
Interviewer, FAHC Psychiatric Consultation Service Search Committee (1998)
Hotline Counselor, Women's Rape Crisis Center (1994-1995)
Emergency Care Attendant, Vergennes Area Rescue Squad (1994-1995)

RESEARCH

Comparison of complication rates in first trimester abortions performed by physicians and mid-level providers (2000-2003)

AWARDS & HONORS

American Medical Women's Association Clinical Gender Equity Award (2003)
Appointed Teaching Chief Resident, UVM Department of Ob/Gyn (2002-2003)
The Gold Foundation Humanism and Excellence in Teaching Award (2002)
University of Vermont College of Medicine Humanism in Medicine Award (1999)
The Carbee Award for Excellence in Obstetrics and Gynecology (1999)
Medical School Honors: Ob/Gyn; Family Practice; Psychiatry; Acting Internship in General Obstetrics; Reproductive Endocrinology; Ob/Gyn Externship; Urology; Women's Initiative; Emergency Medicine; Infectious Diseases (1997-1999)

PROFESSIONAL AFFILIATIONS

American College of Obstetrics and Gynecology; American Medical Women's Association; Physicians for Human Rights; Physicians for Social Responsibility; Physicians for Reproductive Choice and Health; Vermont Medical Society

OTHER

- Administrative work for national nonprofit organization, 1990-1993
- Photography editor and free-lance photographer, 1985-1989
- Personal interests:

References available upon request.

RECEIVED BY PHYSICIAN

RECEIVED
AUG 0 8 2003
NH BOARD

State of Vermont
Board of Medical Practice

THIS IS TO CERTIFY

that Kym Boyman, M.D.

a graduate of the University of Vermont, 1999

having successfully qualified as a practitioner of medicine before this Board has been registered as provided by the Laws of the State.

Chair: Elizabeth A. Turner, M.D., J.D.

Secretary: Hilton H. Dier, Jr.

License Number 42-0010597

Burlington

Date: June 4, 2003
Received and duly recorded.
Vermont Department of Health

STATE OF NEW HAMPSHIRE

Telephone #: 603-271-6934

APR 05 2007

BOARD OF MEDICINE
2 Industrial Park Drive, Suite 8
Concord, NH 03301-8520

RENEWAL APPLICATION

#88329
06/600.00

For expiration on: 06/30/07

Renewal Fee: $300.00

If you **DO NOT** wish to renew your license, check here. ☐

If you choose not to renew, your license will be place on inactive status. To reactivate the license, you will be required to file a reinstatement application.

The following information represents the information on file for you with the Board of Medicine. **Please make any necessary changes. Please note that pursuant to RSA 329:16-f, all licensees must inform the Board of any change in address within 30 days of the change.**

Specialty: OBG

Board Certified: (Y/N) N
Please list ABMS Board Specialty: _____

Licensed in the states of: (2 letter state abbrev.)
VT & ME

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

License #: 12128

File #: 13177

☒ Work Address

KYM M BOYMAN, MD
VERMONT WOMENS CHOICE
23 MANSFIELD AVE
BURLINGTON, VT 05401

Phone: 802-863-9001
Business Fax Number: [redacted]
Business Email Address: [redacted]

☐ Home Address

[redacted]

Phone: [redacted]

Hospital Affiliations: *** **Please list city and state where hospital is located. Check off type of privileges you hold for each Hospital**

Hospital			Privilege	Full	Courtesy	Consult
FLETCHER ~~ALAN~~ Allen HEALT	BURLINGTON	VT		☑	☐	☐
				☑	☐	☐
				☑	☐	☐
				☒	☒	☒
				☒	☒	☒
				☒	☒	☒
				☒	☒	☒

(RENEWAL APPLICATION CONTINUED ON REVERSE SIDE)

Please answer each of the following questions. If your answer to any question is "Yes", you must provide a complete written explanation of the circumstances including any required documents. DO NOT RESUBMIT INFORMATION REPORTED ON A PRIOR RENEWAL APPLICATION.

In the past 24 months:	YES	NO
1. Have you been subject to any disciplinary action, limitation, restriction, or agreement for any reason, including rehabilitation by a licensing board?	___	✓
2. Have you been denied, or have you surrendered, a license in any state other than for relocation or retirement?	___	✓
3. Have you been subject to any denial, restriction, suspension or loss/revocation of your DEA certificate?	___	✓
4. Have you been treated, other than through the Physician Health Program, for abuse or misuse of any chemical substance, including alcohol?	___	✓
5. Have you had any emotional disturbance or mental or physical illness which has impaired your ability to practice medicine?	___	✓
6. Have you been found guilty or entered a plea of no contest to any felony or misdemeanor that has not been annulled by a court?	___	✓
7. Have you been reported to the National Practitioner's Data Bank? If yes, please submit a copy of the report.	___	✓
8. Have you been the subject of an investigation or disciplinary proceeding?	___	✓
9. Have any hospital privileges been suspended, limited or denied other than for medical records violations, or have you been placed on administrative or medical leave?	___	✓
10. Have any medical malpractice claims been made against you? See attached reporting form.	___	✓

I HEREBY CERTIFY UNDER PENALTY OF PERJURY, THAT ALL INFORMATION ON THIS FORM IS CURRENTLY ACCURATE.

[signature]

Signature of Licensee (Signature Stamp Not Accepted)

3/16/05

Date

RECEIV

MAR 26 2

STATE OF NEW HAMPSHIRE

MAR 28 2007

BOARD OF MEDICINE
2 Industrial Park Drive, Suite 8 NH BOAR
Concord, NH 03301-8520

Telephone #: 603-271-6934

RENEWAL APPLICATION

1-103591

For expiration on: 06/30/2009

Renewal Fee: $300.00

If you **DO NOT** wish to renew your license, check here. ☐

If you choose not to renew, your license will be placed on inactive status. To reactivate the license, you will be required to file a reinstatement application.

The following information represents the information on file for you with the Board of Medicine. **Please make any necessary changes. Please note that pursuant to RSA 329:16-f, all licensees must inform the Board of any change in address within 30 days of the change.**

Specialty: OBG

Board Certified: (Y/N) Yes

Please list ABMS Board Specialty: ABOG

Licensed in the states of: (2 letter state abbrev.) VT ME NH

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

License #: 12128

File #: 13177

☒ Work Address

KYM M BOYMAN, MD
VERMONT WOMENS CHOICE
23 MANSFIELD AVE
BURLINGTON, VT 05401

Phone: 802-863-9001
Business Fax Number: [redacted]
Business Email Address: [redacted]

☐ Home Address

[redacted]

Phone: [redacted]

Hospital Affiliations: ***Please list city and state where hospital is located. Check off type of privileges you hold for each Hospital**

Hospital			Privilege	Full	Courtesy	Consult
FLETCHER ALLEN HEAL	BURLINGTON	VT		☑	☐	☐
				☑	☐	☐
				☑	☐	☐
				☐	☐	☐
				☐	☐	☐
				☐	☐	☐
				☐	☐	☐

(RENEWAL APPLICATION CONTINUED ON REVERSE SIDE)

Please answer each of the following questions. If your answer to any question is "Yes", you must provide a complete written explanation of the circumstances including any required documents. DO NOT RESUBMIT INFORMATION REPORTED ON A PRIOR RENEWAL APPLICATION.

In the past 24 months:	YES	NO
1. Have you been subject to any disciplinary action, limitation, restriction or agreement for any reason, including rehabilitation, by a licensing board?	___	✓
2. Have you been denied, or have you surrendered, a license in any state other than for relocation or retirement?	___	✓
3. Have you been subject to any denial, restriction, suspension or loss/revocation of your DEA certificate?	___	✓
4. Have you been treated, other than through the Physician Health Program, for abuse or misuse of any chemical substance, including alcohol?	___	✓
5. Have you had any emotional disturbance or mental or physical illness which has impaired your ability to practice medicine?	___	✓
6. Have you been found guilty or entered a plea of no contest to any felony or misdemeanor that has not been annulled by a court?	___	✓
7. Have you been reported to the National Practitioner's Data Bank? If yes, please submit a copy of the report.	___	✓
8. Have you been the subject of an investigation or disciplinary proceeding? Please exclude investigations and disciplinary proceedings conducted by the New Hampshire Board of Medicine.	___	✓
9. Have any hospital privileges been suspended, limited or denied other than for medical records violations, or have you been placed on administrative or medical leave?	___	✓
10. Have any medical malpractice claims been made against you? See attached reporting form.	___	✓

****Pursuant to RSA 125:25-c, I, please attach a list of ALL diagnostic and therapeutic services in which you have an ownership interest.** → There are none. 3/7/07

I HEREBY CERTIFY UNDER PENALTY OF PERJURY THAT ALL INFORMATION ON THIS FORM IS CURRENTLY ACCURATE.

Signature of Licensee (Signature Stamp Not Accepted)

3/7/07
Date

JUN 24 2009

RECEIVED

JUN 23 2009

NH BOARD

STATE OF NEW HAMPSHIRE

Telephone #: 603-271-6934

BOARD OF MEDICINE
2 Industrial Park Drive, Suite 8
Concord, NH 03301-8520

#11961

RENEWAL APPLICATION

For expiration on: 06/30/2011

Renewal Fee: $300.00

If you **DO NOT** wish to renew your license, check here. ☐

If you choose not to renew, your license will be placed on inactive status. To reactivate the license, you will be required to file a reinstatement application.

The following information represents the information on file for you with the Board of Medicine. **Please make any necessary changes. Please note that pursuant to RSA 329:16-f, all licensees must inform the Board of any change in address within 30 days of the change.**

Specialty: OBG

Currently Board Certified? (Y/N) Y

Please list ABMS Board Specialty: OBG

Currently licensed in the states of: (2 letter state abbrev.) VT ME

You must provide both home and business street address. PO Boxes are not acceptable.
Please mark the box next to the address you would prefer to list as your mailing address.

License #: 12128

File #: 13177

☐ Home Address

KYM M BOYMAN, MD
[redacted]

Phone: [redacted]

☒ Work Address

VERMONT WOMENS CHOICE
23 MANSFIELD AVE
BURLINGTON, VT 05401

Phone: 802-863-9001
Business Fax Number: [redacted]
Business Email Address: [redacted]

Hospital Affiliations: ***Please list city and state where hospital is located. Check off type of privileges you hold for each Hospital

Hospital			Privilege Full	Courtesy	Consult
FLETCHER ALLEN HEAL	BURLINGTON	VT	☑	☐	☐
			☑	☐	☐
			☑	☐	☐
			☐	☐	☐
			☐	☐	☐
			☐	☐	☐
			☐	☐	☐
			☐	☐	☐

(RENEWAL APPLICATION CONTINUED ON REVERSE SIDE)

Please answer each of the following questions. If your answer to any question is "Yes", you must provide a complete written explanation of the circumstances including any required documents. DO NOT RESUBMIT INFORMATION REPORTED ON A PRIOR RENEWAL APPLICATION.

In the past 24 months:

	YES	NO
1. With regard to any and all Boards or licensing bodies with which you hold or have held a license to practice medicine, have you been subject to any disciplinary action, limitation or restriction on your license, or entered into any agreement with a licensing body for any reason, including but not limited to rehabilitation?		✓
2. Have you been denied, or have you surrendered or allowed to lapse, a license to practice medicine in any state other than New Hampshire?		✓
3. Have you been subject to any investigation or to a denial, restriction, suspension, loss or revocation of your DEA certificate?		✓
4. Have you been treated, other than through the Physician Health Program, for abuse or misuse of any chemical substance, including alcohol?		✓
5. Have you had any emotional disturbance or mental or physical illness which has impaired your ability to practice medicine?		✓
6. Have you been found guilty or entered a plea of no contest to any felony, misdemeanor or alcohol or drug related offense that has not been annulled by a court?		✓
7. Have you been reported to the National Practitioner's Data Bank? If yes, please submit a copy of the report.		✓
8. Have you been the subject of an investigation or disciplinary proceeding regarding the practice of medicine? Please exclude investigations and disciplinary proceedings conducted by the New Hampshire Board of Medicine.		✓
9. Have any hospital privileges been suspended, limited or denied other than for medical records violations, or have you been placed on administrative or medical leave?		✓
10. Have any medical malpractice claims been made against you? See attached reporting form.		✓

****Pursuant to RSA 125:25-c, I, please attach a list of ALL diagnostic and therapeutic services in which you have an ownership interest.**

I HEREBY CERTIFY UNDER PENALTY OF PERJURY THAT ALL INFORMATION ON THIS FORM IS CURRENTLY ACCURATE.

[signature] 6/13/09

Signature of Licensee (Signature Stamp Not Accepted) Date