7798

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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

RECEIVED
AUG 31 2010
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: Kathleen M. Toivanen

Business Name: Kathleen M. Toivanen, M.D.

☐ Address: 875 Greenland Rd, B11
Orchard Park
Portsmouth NH 03801 Office telephone: 603-436-2667

Business Fax Number: Business E-Mail:

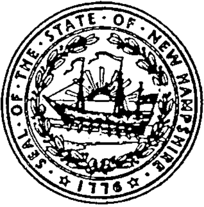
☒ Home Address:

Home telephone:

Specialty: Gynecology Board certified: yes ABOG

Hospital affiliations: Portsmouth Regional Hospital

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



State of New Hampshire

BOARD OF REGISTRATION IN MEDICINE

HEALTH & WELFARE BUILDING — HAZEN DRIVE
CONCORD, NEW HAMPSHIRE 03301

TEL. (603) 271-4502

BOARD MEMBERS
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JANE WALTER, RPT, M. Ed.
WILLIAM T. WALLACE, Jr., M.D.
EXECUTIVE SECRETARY

May 2, 1985

Kathleen Marie Toivanen, M.D.

This is to certify that you have been granted licensure to practice medicine in the state of New Hampshire. Your license #7106 is dated May 2, 1985.

Licensure is issued under the provisions of 329:16 which states in part, "...licenses issued under this section shall be conditioned upon the recipient taking up actual practice of medicine in the state within 18 months after issuance of the license and continuing such practice for at least one year..."

As soon as your engrossed certificate is received in this office, it will be forwarded to you. Until such time, this letter is your full authorization for the privilege of practicing medicine in this state.

William T. Wallace, M.D., M.P.H.

William T. Wallace, Jr., M.D., M.P.H.
Executive Secretary

Encs.

/tm

FAX 3 pages To: Sharon

[illegible] May 15, [illegible] Tina @NHMS

7798

May 15, 1998

Tina Paquette, Membership Secretary
NH Medical Society
7 North State Street
Concord, NH 03301-4018

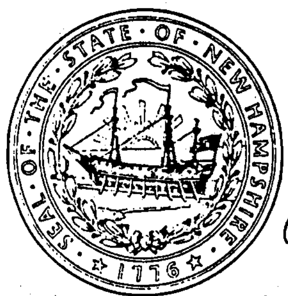
To Whom it May Concern:

This is to inform you that I will be practicing gynecology only as a sole proprietorship as of July 1, 1998. My new practice location will be 1245 Washington Road, P.O. Box 677, Rye, NH 03870 (phone 603-964-6918). Please address any communications to me at my new address and phone or preferably at my home after June 30, 1998. Thank you for your assistance.

Sincerely,

Kathleen M. Toivanen, M.D.

7-10 days to be allowed for notification of Board action following meeting.



The State of New Hampshire

Board of Registration in Medicine

Spec - OB-Gyn
Resid to 6/85
Plans - Ports c David Eldredge

Application No. 7798

I hereby apply* for license to practice Medicine in the State of New Hampshire as a Doctor of Medicine [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 enclose a certified check or postal or express money order for the regular fee of $150.00 (U. S. Funds) No Refunds.

1. **Personal Particulars**

Name in full KATHLEEN MARIE TOIVANEN
(Do not use initials) First Middle names in full Last

Present residence: No. Street, (City or town) (County) (State) Zip Code

Post office address Same

Date of birth , Birthplace (City town or county) (State or foreign country)

If foreign born, date and place of naturalization as a citizen of the United States: Date 1 Place

Age at last birthday Sex FEMALE Single, Married, Widowed, or Divorced (*write the word*) Color or race

2. **Academic Education:**

Name and Location of Institutions attended.	Period of Study
Cornell University, Ithaca, N.Y.	9/1965 - 6/1969
University of Pennsylvania, Phila, Pa.	9/1969 - 5/1970
University of Minnesota, Minneapolis, Minn	9/1973 - 12/1975

Academic degree of B.A, received from CORNELL UNIVERSITY 1969
M.A " " UNIV. OF PENNSYLVANIA 1970
B.S " " UNIV. OF MINNESOTA 1975

3. **Medical Education:**

Name and Location of All Institutions attended.	Years attended with Date
Boston University School of Medicine Boston Massachusetts	9/77 - 6/81

***5. Certified Copy of State or National Board License or Certificate.**

(Give a verbatim copy of License or Certificate certified by the Secretary with seal.)

See National Board of Medical Examiners Endorsement of Certification

I hereby certify that the above is a true copy of certificate or license No. .... issued .... A. D. ....

[SEAL] ....

Secretary.

The seal of the board must be affixed

6. Affidavit of Secretary.

STATE OF ....

County of .... ss.

....of ....

7. Affidavit of Internship.

STATE OF ....MASSACHUSETTS.......................... [SEAL]

County of .....SUFFOLK.................................. ss.

.... being duly sworn, says that he is

.... of the ....BRIGHAM and WOMEN'S....... Hospital located

at ....75 FRANCIS ST., BOSTON, MA............................... and that ....KATHLEEN...........

....MARIE TOIVANEN.................... M. D. [D. O.], has been an intern at said hospital at least

12 months from ....JULY 1................. 19.81.. to ....JUNE 30................................ 19.82

Type of service (straight or rotating)
Division of service (medical, surgical, etc.)
If rotating, specify (in months) time devoted to:

Medicine - 6	Dermatology	Pathology
Surgery - 3	Oto-laryngo-rhinology	Neurology
Obstetrics - 3	Ophthalmology	Clinical laboratory
Gynecology	Roentgenology	
Pediatrics	Psychiatry	

......................................[signature]......................................, M. D. [D. O.]
(Medical Director) (Chief of Staff)

Sworn to before me this .... day of .... 19 ....

.... Notary Public.

(affix seal above)

8. Affidavit of
Internship
Residency

STATE OF ....MASSACHUSETTS.........................

County of .....SUFFOLK.................................. ss.

..................Kenneth J. Ryan MD.............. being duly sw n, says that he is

Prof. of OB-Gyn.............. of the ....BRIGHAM and WOME ospital located

at ....75 FRANCIS ST., BOSTON, MA................................ an EN.............

....MARIE TOIVANEN....................... M. D. [D. O.], h l from

...................JULY 1.................................. 19.82... to 85

Type of service (straight or rotating)
Division of service (medical, surgical, etc
If rotating, specify (in months) tim

Medicine
Surgery
Obstetrics 18
Gynecology 18
Pediatrics

9. **Affidavit of Registrar** See Notarized Copy of Birth Certificate

STATE OF ....

County of .... ss.

.... being

duly sworn says that he is the .... of the Town (of the Village,
(title of official executing this affidavit)

City, County, Registration District, Province, State) of ....

and custodian of the records of birth thereof, and that an official record of birth bearing the name of

.... born
(give name exactly as it appears on the record)

on ...., 1........, at Number .... Street in
(month) (day)

the Town / City of .... County of.........................., State of ....,

child of ....
(name of father exactly as it appears on the record)

and .... is on file in the office of said official, and further that it
(name of mother exactly as it appears on the record)

appears that said official record of birth was filed on ...., 1........
(month) (day)

(Signature) ....

Sworn to before me this .... day of .... 19........

.... (SEAL)

Notary Public

10. **Affidavit of Physician.**

STATE OF. MASSACHUSETTS ....

County of MIDDLESEX .... ss.

I, VANESSA BARSS .... M. D. [D. O.] of BOSTON, MASSACHUSETTS

being duly sworn do hereby certify: that I am acquainted with applicant and have known him (her) for TWO years; that I hold license No. 47537 to practice medicine [osteopathy] in the State [Province] of MASSACHUSETTS; and that I know applicant personally to be a physician [osteopathic physician] of good moral character ~ good professional standing.

[signature] D. [D. O.]

Sworn to before me this 27th day of . 19 85

[signature] [SEAL]

11. **Affidavit of Physician.**

STATE OF MASSACHUSETTS ....

County of MIDDLESEX ....

I, JOAN BENGTSON ...

being duly sworn do here'

(her) for .... FOUR

[osteopathy] in t'

sonally to b'

standir

12. Affidavit of Officer of Medical [Osteopathic] Society:

STATE OF ....

County of .... ss.

.... M. D. [D. O.] of ....

being duly sworn, says that he is President or Secretary of the ....

Medical [Osteopathic] Society, and that .... M. D. [D. O.] of

.... is at present a member in good standing of the

said Medical [Osteopathic] Society and that he is an ethical practitioner of good moral character.

.... M. D. [D. O.]

Sworn to before me this .... day of .... 19......

[SEAL] .... Notary Public.

13. Affidavit of the Applicant:

STATE OF ...MASSACHUSETTS....................

County of ...SUFFOLK.. ss.

KATHLEEN MARIE TOIVANEN .... of ...BROOKLINE, MASSACHUSETTS

being duly sworn says that she is the person referred to in the above application for a license to practice medicine as a Doctor of Medicine [as a Doctor of Osteopathy] in the State of New Hampshire; that she is a citizen of the United States [of Canada in the province of ....

....] as shown by the above Affidavit of Registrar, wherein her name appears as

.................................KATHLEEN MARIE TOIVANEN...

[or proof of citizenship .... hereto attached]: that

THE STATE OF NEW HAMPSHIRE
BOARD OF REGISTRATION IN MEDICINE

(the following is to be filled out by the board)

Application received 3/11 1985

Application approved [denied] .... 19......

Examination .... 19......

Application examined .... 19......

Accepted without examination .... 19......

Candidate interviewed 4/10 1985

License granted .... End N.B Cert ....

by .... S Tzianabos MD, ...

Date 5/2 1985

Fee paid .... TK 3/11 1985

License No. .... 7106 ....

Form of fee	P.O. order	Check	Cash	Express Order	Other
		150-			

Remarks: Satisfactory Interview

Name:	Kathleen Marie Toivanen
Address:	
Phone:	617-732-6987 (work)
Date of Birth:	
Place of Birth:	
Occupation:	Chief Resident, Obstetrics and Gynecology, Brigham and Women's Hospital, Boston, Ma.
Marital Status:	
Spouse's Name:	
Spouse's Occupation:	Retina Fellow, Massachusetts Eye and Ear Hospital, Boston, Ma.
Number of Children:	
Education:	
1969 A.B.	Cornell University, Ithaca, N.Y., magna cum laude, Psychology and English
1970 M.A.	University of Pennsylvania, Philadelphia, Pa., Experimental Psychology
1975 B.S.	University of Minnesota, Minneapolis, Minn with high honors, Nursing
1981 M.D.	Boston University School of Medicine, Boston, Ma., cum laude
Work Experience:	
1967-1969	Teaching Fellow, Introductory Psychology, Cornell University, Ithaca, N.Y.
1969-1970	Research Fellow, Department of Psychology University of Pennsylvania, Philadelphia,
1970-1972	Assistant Editor, College Division, Hough Mifflin Publishing Company, Boston, Ma.
1972-1973	Clerk, Rustler Lodge, Alta, Ut.
1973-1975	Research Assistant, Department of Oto-laryngology, University of Minnesota, Minneapolis, Minn.
1976-1979	Registered Nurse, General Medical and Medical ICU, Beth Israel Hospital, Boston, Ma.

Postdoctoral Training:

Internship and Residencies:

1981-1985	Obstetrics and Gynecology, Brigham and Women's Hospital, Boston, Ma.

Licensure and Certification:

1984	Massachusetts License Registration No. 53813

Awards and Honors:

1968	Psi Chi (Psychology Honorary), Cornell University, Ithaca, N.Y.
1980	Alpha Omega Alpha, Boston University School of Medicine, Boston, Ma.
1981	Benjamin Tenney Award in Obstetrics and Gynecology, Boston University School of Medicine, Boston, Ma.

Memberships, Offices and Committee Assignments in Professional Societies:

1982-	Junior Fellow, American College of Obstetricians and Gynecologists

References:

Dr. Frederick Frigoletto, Department of Obstetrics and Gynecology, Brigham and Women's Hospital, 75 Francis St., Boston, Ma.

Dr. Robert Knapp, Department of Obstetrics and Gynecology, Brigham and Women's Hospital, 75 Francis St., Boston, Ma.

Dr. Ruth Tuomala, Department of Obstetrics and Gynecology, Brigham and Women's Hospital, 75 Francis St., Boston, Ma.

UNIVERSITATIS BOSTONIENSIS

IN REPUBLICA MASSACHUSETTENSI
SENATUS ET CURATORES
OMNIBUS AD QUOS HAE LITERAE PERVENERINT SALUTEM.

Cum Kathleen Marie Toivanen, A.B., B.S., A.M.
ingenio bono praeditum moribusque probis ornatum se studiis in Schola hujus Universitatis Medica requisitis addixisset, et, interrogationibus rigidis a professoribus singulis propositis, se in arte medicinae et in scientiis ei inservientibus bene eruditum esse praebuisset; idcirco nobis placuit professoribus scholae antedictae consentientibus eum gradu

MEDICINAE DOCTORIS

Cum Laude

adornare, et ei omnia insignia, jura, honores et privilegia ad eum gradum hic aut uspiam spectantia concedere.

In cujus rei testimonium literis hisce Universitatis sigillo munitis Die XVII Mensis Maii anno salutis nostrae MCMLXXXI Reiquepublicae CCV Nos pro auctoritate nobis commissa nomina subscripsimus. 1981

DECANUS

SCRIBA FACULTATIS

PRAESES

SCRIBA CURATORUM

March 6, 1985

Board of Registration in Medicine
The State of New Hampshire
Health and Welfare Building
Hazen Drive
Concord, N.H. 03301

To Whom It May Concern:

I am planning on practicing Obstetrics and Gynecology in Portsmouth, N.H. after completing my residency June 30, 1985. I will be associated with Dave Eldredge, who has sent you notification of my employment.

Also included is the formal application, a notarized photocopy of my medical school diploma, endorsement of certification from the National Board of Medical Examiners, a notarized copy of my birth certificate, and a money order for $150. Clearance forms have been submitted to the State of Massachusetts, where I hold a current license. I hold no staff privileges at any hospital, and therefore have requested Dr. Kenneth Ryan and Dr. Frederick Frigoletto, Chief of Ob-Gyn and Coordinator of Residency Program, to submit letters of reference directly to you. I submitted a curriculum vitae with my request for application for licensure.

I understand that a personal interview is required and will be requesting a date as soon as my application is complete.

Sincerely,
Kathleen Towson
TOIVANEN

February 4, 1985

RECEIVED

FEB 8 1985

Office of the Director
Division of
Public Health Services

Board of Registration in Medicine
Health and Welfare Building
Hazen Drive
Concord, N.H. 03301

Dear Sir:

I am completing my residency training in obstetrics and gynecology in June, 1985 and am moving to , N.H. where I will enter practice with Dr. David Eldredge as of July, 1985. I therefore am applying for a medical license in New Hampshire. I have completed four years of post-graduate training in the U.S. as required by the Board. I am enclosing a curriculum vitae as requested. Please send me the necessary forms and information for application.

Sincerely,

Kay Toivanen

TOIVANEN

WOMEN'S HEALTH ASSOCIATES of PORTSMOUTH, P.A.
Obstetrics & Gynecology

KATHLEEN M. TOIVANEN, M.D. SUSAN P. TREDWELL, M.D. WENDY A. McLAUGHLIN, M.D.

Orchard Park Bldg. A
875 Greenland Road
Portsmouth, NH 03801
(603) 436-1128

RECEIVED
APR 0 3 1991
NH BOARD OF
REGISTRATION IN MEDICINE

March 28, 1991

NH State Board of Registration
in Medicine
6 Hazen Dr.
Concord, NH 03301

ATTN: Records Department

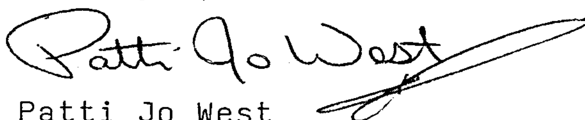
I would like to notify you of a change of address for the following physicians:

Kathleen M. Toivanen #7106

Our old address was: 278 Lafayette Rd.
Portsmouth, NH 03801

The new address is listed on this letterhead.

Thank you,



Patti Jo West
Office Manager

American Board of Obstetrics and Gynecology

COMPOSED OF MEMBERS NOMINATED BY THE
AMERICAN GYNECOLOGICAL AND OBSTETRICAL SOCIETY
AMERICAN MEDICAL ASSOCIATION
AMERICAN COLLEGE OF OBSTETRICIANS AND GYNECOLOGISTS
ASSOCIATION OF PROFESSORS OF GYNECOLOGY-OBSTETRICS

CERTIFIES THAT

KATHLEEN M. TOIVANEN

HAVING PURSUED AN ACCEPTED COURSE OF GRADUATE STUDY AND CLINICAL WORK, HAS MET THE STANDARDS AND QUALIFICATIONS AND PASSED THE EXAMINATIONS REQUIRED BY THE AMERICAN BOARD OF OBSTETRICS AND GYNECOLOGY, INC. SHE HAS THEREBY DEMONSTRATED TO THE SATISFACTION OF THIS BOARD THAT SHE IS POSSESSED OF SPECIAL KNOWLEDGE, AND BY THE AWARD OF THIS DIPLOMA HER PROFICIENCY IN THE SPECIALTY OF OBSTETRICS AND GYNECOLOGY IS RECOGNIZED, AND SHE IS AN ACKNOWLEDGED DIPLOMATE OF THIS BOARD FROM DECEMBER 1987 THROUGH DECEMBER 1997.

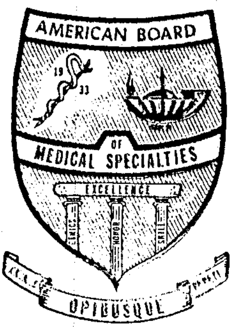
DECEMBER 11, 1987

My Commission Expires May 14, 1990

PRESIDENT

EXECUTIVE DIRECTOR

CHAIRMAN



Nº 24509

F-7798

American Board of Obstetrics and Gynecology

COMPOSED OF MEMBERS NOMINATED BY THE
AMERICAN GYNECOLOGICAL AND OBSTETRICAL SOCIETY
AMERICAN MEDICAL ASSOCIATION
AMERICAN COLLEGE OF OBSTETRICIANS AND GYNECOLOGISTS
ASSOCIATION OF PROFESSORS OF GYNECOLOGY-OBSTETRICS

CERTIFIES THAT

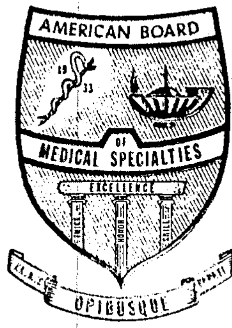
KATHLEEN M. TOIVANEN

HAVING PURSUED AN ACCEPTED COURSE OF GRADUATE STUDY AND CLINICAL WORK, HAS MET THE STANDARDS AND QUALIFICATIONS AND PASSED THE EXAMINATIONS REQUIRED BY THE AMERICAN BOARD OF OBSTETRICS AND GYNECOLOGY, INC. SHE HAS THEREBY DEMONSTRATED TO THE SATISFACTION OF THIS BOARD THAT SHE IS POSSESSED OF SPECIAL KNOWLEDGE, AND BY THE AWARD OF THIS DIPLOMA HER PROFICIENCY IN THE SPECIALTY OF OBSTETRICS AND GYNECOLOGY IS RECOGNIZED, AND SHE IS AN ACKNOWLEDGED DIPLOMATE OF THIS BOARD FROM DECEMBER 1987 THROUGH DECEMBER 1997.

DECEMBER 11, 1987

My Commission Expires May 14, 1990

3rd may 1988



Nº 24509

PRESIDENT

EXECUTIVE DIRECTOR

CHAIRMAN

JUN 16 1992

6K

Practice? Private X Other (Specify) ______ Retired? ______

ARE YOU CERTIFIED BY THE AMERICAN BOARD OF MEDICAL SPECIALTIES?

X YES ____ NO IF YES, DESIGNATE SPECIALTY 036

SOCIAL SECURITY NUMBER ____

________ I do not intend to renew by license - please place my license on inactive.

$75.00 DUE AND PAYABLE PRIOR TO JUNE 30, 1992.

$75.00 RENEWAL FEE + $75.00 LATE FEE FOR ALL RENEWAL CARDS RECEIVED AFTER JULY 1, 1992.

MAKE CHECK PAYABLE TO: **TREASURER, STATE OF NH**

CHANGE OF ADDRESS

KATHLEEN M TOIVANEN MD
ORCHARD PARK BUILDING A
875 GREENLAND ROAD
PORTSMOUTH NH 03801

DURING THE LAST REGISTRATION PERIOD:

1. HAS ANY ACTION, INCLUDING ANY DISCIPLINARY ACTION OR LIMITATION OR RESTRICTION, OR ANY AGREEMENT FOR ANY REASON INCLUDING REHABILITATION BEEN TAKEN OR ENTERED BY A LICENSING BOARD? ____ YES X NO
2. HAS THERE BEEN ANY DENIAL, RESTRICTION, SUSPENSION OR LOSS/ REVOCATION OF YOUR DEA? ____ YES X NO
3. HAVE YOU BEEN TREATED FOR USE OR MISUSE OF ANY CHEMICAL SUBSTANCE? ____ YES X NO
4. HAVE YOU FAILED A WRITTEN (INCLUDING SPEX) OR ORAL EXAMINATION FOR LICENSURE OR COMPETENCY DETERMINATION? X YES X NO
5. HAVE YOU BEEN HOSPITALIZED OR TREATED WITH MEDICATION FOR ANY PSYCHIATRIC, NEUROLOGICAL, OR COMMUNICABLE ILLNESS FOR A PERIOD EXCEEDING THIRTY DAYS? ____ YES X NO
6. HAVE YOU BEEN FOUND GUILTY OR ENTERED A PLEA OF NO CONTEST TO ANY FELONY, OR TO A MISDEMEANOR INVOLVING MORAL TURPITUDE? ____ YES X NO
7. HAVE YOU EVER BEEN REPORTED TO THE NATIONAL PRACTITIONER DATA BANK? ____ YES X NO
8. ARE YOU OR HAVE YOU BEEN THE SUBJECT OF AN INVESTIGATION OR DISCIPLINARY PROCEEDING, BY ANY HOSPITAL, PROFESSIONAL SOCIETY, OR OTHER HEALTH CARE FACILITY? ____ YES X NO
9. HAVE ANY HOSPITAL PRIVILEGES BEEN SUSPENDED, LIMITED OTHER THAN FOR MEDICAL RECORDS VIOLATIONS, OR DENIED. ____ YES X NO

IF THE ANSWER IS YES, PLEASE FILE A WRITTEN EXPLANATION.

______

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

K Toivanen MD ______ 6/8/92
Signature of Licensee (Signature Stamp Not Accepted) Date

LIST ALL HOSPITAL AFFILIATIONS: ______

JUN 14 1993

STATE OF NEW HAMPSHIRE

Board of Registration in Medicine

EXPIRES: 06/30/1994

Please check appropriate mailing address.

✓ Name in full: Kathleen Toivanen
Place of employment: 875 Greenland Rd
Portsmouth NH 03
Business Tel.: 603-436-1128
Home Address:

Home Tel.:

KATHLEEN M TOIVANEN MD
ORCHARD PARK BUILDING A
875 GREENLAND RD
PORTSMOUTH NH 03801-4164

Practice? Private ✓ Other (Specify) ______ Retired? ______
Specialty OB-GYN Board Certified? YES If yes, designate specialty OB-GYN
Social Security # ___

______ I DO NOT intend to renew my license - please place my license on inactive status.
List all hospital affiliations: Portsmouth Regional Hospital
In what other states do you hold license: ______

1. HAS ANY ACTION, INCLUDING ANY DISCIPLINARY ACTION, LIMITATION, RESTRICTION, OR AN AGREEMENT FOR ANY REASON INCLUDING REHABILITATION BEEN TAKEN OR ENTERED BY A LICENSING BOARD?
2. HAVE YOU EVER BEEN DENIED OR YOU HAVE SURRENDERED A LICENSE IN ANY OTHER STATE?
3. HAS THERE BEEN ANY DENIAL, RESTRICTION, SUSPENSION OR LOSS/REVOCATION OR YOUR DEA?
4. HAVE YOU BEEN TREATED FOR USE OR MISUSE OF ANY CHEMICAL SUBSTANCE?
5. HAVE YOU FAILED A WRITTEN (INCLUDING SPEX) OR ORAL EXAMINATION OR LICENSURE OR COMPETENCY DETERMINATION?
6. HAVE YOU EVER HAD ANY EMOTIONAL DISTURBANCE OR MENTAL ILLNESS WHICH HAS IMPAIRED YOUR ABILITY TO PRACTICE MEDICINE?
7. HAVE YOU BEEN FOUND GUILTY OR ENTERED A PLEA OF NO CONTEST TO ANY FELONY, OR TO A MISDEMEANOR?
8. HAVE YOU EVER BEEN REPORTED TO THE NATIONAL PRACTITIONER DATA BANK?
9. ARE YOU NOW OR HAVE YOU EVER BEEN THE SUBJECT OF AN INVESTIGATION OR DISCIPLINARY PROCEEDING?
10. HAVE ANY HOSPITAL PRIVILEGES BEEN SUSPENDED OR LIMITED OTHER THAN FOR MEDICAL RECORDS VIOLATIONS, OR HAVE ANY PRIVILEGES BEEN DENIED OR SURRENDERED?
11. HAVE ANY MEDICAL MALPRACTICE CLAIMS EVER BEEN MADE AGAINST YOU?

	YES	NO
1.		✓
2.		✓
3.		✓
4.		✓
5.	✓	
6.		✓
7.		✓
8.		✓
9.		✓
10.		✓
11.	✓	

IF THE ANSWER IS YES TO ANY OF THESE QUESTIONS, PLEASE FILE A WRITTEN EXPLANATION

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

K Toivanen
Signature of Licensee (Signature Stamp Not Accepted)

5/10/93
Date

✓

MAY 0 9 1994
06/30/1995

EXPIRES:

STATE OF NEW HAMPSHIRE

Board of Registration in Medicine

Please check appropriate mailing address.

Name in full Kathleen M. Toivanen

____ Place of employment ____

Business Tel: ____

____ Home Address ____

Home Tel: ____

KATHLEEN M TOIVANEN MD
ORCHARD PARK BUILDING A
875 GREENLAND RD
PORTSMOUTH NH 03801-4164

HAVE YOU BEEN CONTINUOUSLY ENGAGED IN THE ACTIVE PRACTICE OF MEDICINE? YES ✓ NO ___ IF NO, PLEASE EXPLAIN

SPECIALTY OBGYN BOARD CERTIFIED? Yes

RENEWAL FEE: $100.00

___ I DO NOT INTEND TO RENEW MY LICENSE - PLEASE PLACE MY LICENSE ON INACTIVE STATUS.

LIST ALL HOSPITAL AFFILIATIONS: Portsmouth Regional Hospital

IN WHAT OTHER STATES DO YOU HOLD LICENSE: Ø active

IN THE PAST 12 MONTHS:

1. HAS ANY ACTION, INCLUDING ANY DISCIPLINARY ACTION, LIMITATION, RESTRICTION, OR AN AGREEMENT FOR ANY REASON INCLUDING REHABILITATION BEEN TAKEN OR ENTERED 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. HAS THERE BEEN ANY DENIAL, RESTRICTION, SUSPENSION OR LOSS/REVOCATION OF YOUR DEA?
4. HAVE YOU BEEN TREATED FOR USE OR MISUSE OF ANY CHEMICAL SUBSTANCE?
5. HAVE YOU HAD ANY EMOTIONAL DISTURBANCE OR MENTAL 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 TO A MISDEMEANOR?
7. HAVE YOU BEEN REPORTED TO THE NATIONAL PRACTITIONER 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 LEAVE?
10. HAVE ANY MEDICAL MALPRACTICE CLAIMS BEEN MADE AGAINST YOU? SEE ATTACHED REPORTING FORM

	YES	NO
1.		✓
2.		✓
3.		✓
4.		✓
5.		✓
6.		✓
7.		✓
8.		✓
9.		✓
10.	✓	

Ø during last 12 mos.

IF THE ANSWER IS YES TO ANY OF THESE QUESTIONS, PLEASE FILE A WRITTEN EXPLANATION.

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

K Toivanen
Signature of Licensee (Signature Stamp Not Accepted)

4/21/94
Date

MAY 24 1995
EXPIRES: 06/30/1996
7106

STATE OF NEW HAMPSHIRE

Board of Registration in Medicine

Please check appropriate mailing address.

Name in full ______

______ Place of employment Women's Health Associates

Business Tel: 603-436-1128

✓ Home Address ______

Home Tel: ______

KATHLEEN M TOIVANEN MD
ORCHARD PARK BUILDING A
875 GREENLAND RD
PORTSMOUTH NH 03801-4164

HAVE YOU BEEN CONTINUOUSLY ENGAGED IN THE ACTIVE PRACTICE OF MEDICINE? YES ✓ NO ___ IF NO, PLEASE EXPLAIN

RENEWAL FEE: $100.00

SPECIALTY OB-GYN BOARD CERTIFIED? Yes

______ I DO NOT INTEND TO RENEW MY LICENSE - PLEASE PLACE MY LICENSE ON INACTIVE STATUS.

LIST ALL HOSPITAL AFFILIATIONS: Portsmouth Regional Hospital

IN WHAT OTHER STATES DO YOU HOLD LICENSE: None active

IN THE PAST 12 MONTHS:

1. HAS ANY ACTION, INCLUDING ANY DISCIPLINARY ACTION, LIMITATION, RESTRICTION, OR AN AGREEMENT FOR ANY REASON INCLUDING REHABILITATION BEEN TAKEN OR ENTERED BY A LICENSING BOARD? — 1. ___ YES ✓ NO
2. HAVE YOU BEEN DENIED OR HAVE YOU SURRENDERED A LICENSE IN ANY STATE OTHER THAN FOR RELOCATION OR RETIREMENT? — 2. ___ YES ✓ NO
3. HAS THERE BEEN ANY DENIAL, RESTRICTION, SUSPENSION OR LOSS/REVOCATION OF YOUR DEA? — 3. ___ YES ✓ NO
4. HAVE YOU BEEN TREATED FOR USE OR MISUSE OF ANY CHEMICAL SUBSTANCE? — 4. ___ YES ✓ NO
5. HAVE YOU HAD ANY EMOTIONAL DISTURBANCE OR MENTAL ILLNESS WHICH HAS IMPAIRED YOUR ABILITY TO PRACTICE MEDICINE? — 5. ___ YES ✓ NO
6. HAVE YOU BEEN FOUND GUILTY OR ENTERED A PLEA OF NO CONTEST TO ANY FELONY, OR TO A MISDEMEANOR? — 6. ___ YES ✓ NO
7. HAVE YOU BEEN REPORTED TO THE NATIONAL PRACTITIONER DATA BANK? IF YES, PLEASE SUBMIT A COPY OF THE REPORT — 7. ___ YES ✓ NO
8. HAVE YOU BEEN THE SUBJECT OF AN INVESTIGATION OR DISCIPLINARY PROCEEDING? — 8. ___ YES ✓ NO
9. HAVE ANY HOSPITAL PRIVILEGES BEEN SUSPENDED, LIMITED, OR DENIED OTHER THAN FOR MEDICAL RECORDS VIOLATIONS, OR HAVE YOU BEEN PLACED ON ADMINISTRATIVE LEAVE? — 9. ___ YES ✓ NO
10. HAVE ANY MEDICAL MALPRACTICE CLAIMS BEEN MADE AGAINST YOU? SEE ATTACHED REPORTING FORM — 10. ___ YES ✓ NO

IF THE ANSWER IS YES TO ANY OF THESE QUESTIONS, PLEASE FILE A WRITTEN EXPLANATION.

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

K Toivanen — Signature of Licensee (Signature Stamp Not Accepted)

5/9/95 — Date

MAY 20 1996

STATE OF NEW HAMPSHIRE

Board of Medicine

772

EXPIRES: 06/30/1997

Please check appropriate mailing address.

Name in full Kathleen M. Toivanen

____ Place of employment Women's Health Associates, P.A. Portsmouth

Business Tel: 603-436-1128

✓ Home Address

Home Tel:

KATHLEEN M TOIVANEN MD

HAVE YOU BEEN CONTINUOUSLY ENGAGED IN THE ACTIVE PRACTICE OF MEDICINE? YES ✓ NO ___ IF NO, PLEASE EXPLAIN

SPECIALTY OB-Gyn BOARD CERTIFIED? Yes

RENEWAL FEE: $100.00

___ I DO NOT INTEND TO RENEW MY LICENSE - PLEASE PLACE MY LICENSE ON INACTIVE STATUS.

LIST ALL HOSPITAL AFFILIATIONS: Portsmouth Regional Hospital

IN WHAT OTHER STATES DO YOU HOLD LICENSE: Ø active

IN THE PAST 12 MONTHS:

1. HAS ANY ACTION, INCLUDING ANY DISCIPLINARY ACTION, LIMITATION, RESTRICTION, OR AN AGREEMENT FOR ANY REASON INCLUDING REHABILITATION BEEN TAKEN OR ENTERED 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. HAS THERE BEEN ANY DENIAL, RESTRICTION, SUSPENSION OR LOSS/REVOCATION OF YOUR DEA?
4. HAVE YOU BEEN TREATED FOR USE OR MISUSE OF ANY CHEMICAL SUBSTANCE?
5. HAVE YOU HAD ANY EMOTIONAL DISTURBANCE OR MENTAL 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 TO A MISDEMEANOR?
7. HAVE YOU BEEN REPORTED TO THE NATIONAL PRACTITIONER 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 LEAVE?
10. HAVE ANY MEDICAL MALPRACTICE CLAIMS BEEN MADE AGAINST YOU? SEE ATTACHED REPORTING FORM

	YES	NO
1.		✓
2.		✓
3.		✓
4.		✓
5.		✓
6.		✓
7.		✓
8.		✓
9.		✓
10.	✓	

IF THE ANSWER IS YES TO ANY OF THESE QUESTIONS, PLEASE FILE A WRITTEN EXPLANATION.

Kathleen M. Toivanen

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

KToivanen
Signature of Licensee (Signature Stamp Not Accepted)

4/18/96
Date

MAY 19 1997

7798

STATE OF NEW HAMPSHIRE

Board of Medicine

EXPIRES: 6/30/98

Please check appropriate mailing address.

Name in full Kathleen M. Toivanen

____ Place of employment 875 Greenland Rd
Portsmouth, NH 03801

Business Tel: 603-436-1128

KATHLEEN M TOIVANEN, MD

✓ Home Address

Home Tel:

HAVE YOU BEEN CONTINUOUSLY ENGAGED IN THE ACTIVE PRACTICE OF MEDICINE? YES ✓ NO ___ IF NO, PLEASE EXPLAIN

SPECIALTY OBGyn BOARD CERTIFIED? yes

RENEWAL FEE: $100.00

______ I DO NOT INTEND TO RENEW MY LICENSE - PLEASE PLACE MY LICENSE ON INACTIVE STATUS.

LIST ALL HOSPITAL AFFILIATIONS: Portsmouth Regional Hospital (Columbia)

IN WHAT OTHER STATES DO YOU HOLD LICENSE: —

IN THE PAST 12 MONTHS:

1. HAS ANY ACTION, INCLUDING ANY DISCIPLINARY ACTION, LIMITATION, RESTRICTION, OR AN AGREEMENT FOR ANY REASON INCLUDING REHABILITATION BEEN TAKEN OR ENTERED BY A LICENSING BOARD? — 1. __ YES ✓ NO
2. HAVE YOU BEEN DENIED OR HAVE YOU SURRENDERED A LICENSE IN ANY STATE OTHER THAN FOR RELOCATION OR RETIREMENT? — 2. __ YES ✓ NO
3. HAS THERE BEEN ANY DENIAL, RESTRICTION, SUSPENSION OR LOSS/REVOCATION OF YOUR DEA? — 3. __ YES ✓ NO
4. HAVE YOU BEEN TREATED FOR USE OR MISUSE OF ANY CHEMICAL SUBSTANCE? — 4. __ YES ✓ NO
5. HAVE YOU HAD ANY EMOTIONAL DISTURBANCE OR MENTAL ILLNESS WHICH HAS IMPAIRED YOUR ABILITY TO PRACTICE MEDICINE? — 5. __ YES ✓ NO
6. HAVE YOU BEEN FOUND GUILTY OR ENTERED A PLEA OF NO CONTEST TO ANY FELONY, OR TO A MISDEMEANOR? — 6. __ YES ✓ NO
7. HAVE YOU BEEN REPORTED TO THE NATIONAL PRACTITIONER DATA BANK? IF YES, PLEASE SUBMIT A COPY OF THE REPORT — 7. __ YES ✓ NO
8. HAVE YOU BEEN THE SUBJECT OF AN INVESTIGATION OR DISCIPLINARY PROCEEDING? — 8. __ YES ✓ NO
9. HAVE ANY HOSPITAL PRIVILEGES BEEN SUSPENDED, LIMITED, OR DENIED OTHER THAN FOR MEDICAL RECORDS VIOLATIONS, OR HAVE YOU BEEN PLACED ON ADMINISTRATIVE LEAVE? — 9. __ YES ✓ NO
10. HAVE ANY MEDICAL MALPRACTICE CLAIMS BEEN MADE AGAINST YOU? SEE ATTACHED REPORTING FORM — 10. ✓ YES __ NO

IF THE ANSWER IS YES TO ANY OF THESE QUESTIONS, PLEASE FILE A WRITTEN EXPLANATION.

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

K Toivanen
Signature of Licensee (Signature Stamp Not Accepted)

5/2/97
Date

MAY 2 7 1998

STATE OF NEW HAMPSHIRE

Telephone #: 603-271-6934

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

RENEWAL APPLICATION

For expiration on: 6/30/1999 Renewal Fee: $100.00

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) Y

Please list ABMS Board Specialty: OBG

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

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

License #: 7106 File #: 7798

☐ Work Address: ☒ Home Address:

KATHLEEN M TOIVANEN, MD
1245 Washington Road
P.O. Box 677
NH
Rye 03870

Hospital Affiliations: **(If not a NH hospital, please list city and state where hospital is located.)**

PORTSMOUTH REGIONAL HOSPITAL - PORTSMOUTH, NH

(RENEWAL APPLICATION CONTINUED ON REVERSE SIDE)

Kathleen M. Toivanen

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 12 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 for use or misuse of any chemical substance?		✓
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?		✓
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.

Kathleen M. Toivanen
Signature of Licensee (Signature Stamp Not Accepted)

5/7/98
Date

May 15, 1998

Karen Lamoureux
NH Board of Medicine
2 Industrial Park Drive - Ste 8
Concord, NH 03301-8520

To Whom It May Concern:

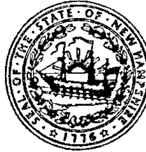
This is to inform you that I will be practicing gynecology only as a sole proprietorship as of July 1, 1998. My new practice location will be 1245 Washington Road, P.O. Box 677, Rye, NH 03870 (phone 603-964-6918). Please address any communications to me at my new address and phone after June 30, 1998. Thank you for your assistance.

Sincerely,

Kathleen M. Toivanen MD

Kathleen M. Toivanen, M.D.

MAY 1 9 1999



STATE OF NEW HAMPSHIRE

Telephone #: 603-271-6934

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

RENEWAL APPLICATION

For expiration on: 6/30/2000

Renewal Fee: $100.00

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) Y

Please list ABMS Board Specialty: OBG

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

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

License #: 7106

File #: 7798

☒ Home

KATHLEEN M TOIVANEN, MD

Phone:

☐ Work

1245 WASHINGTON RD
PO BOX 677
RYE, NH 03870
Phone: 603*964-6918

Hospital Affiliations: **(If not a NH hospital, please list city and state where hospital is located.)**

PORTSMOUTH REGIONAL HOSPITAL - PORTSMOUTH, NH

(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 12 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 for use or misuse of any chemical substance?		✓
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?		✓
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.		✓

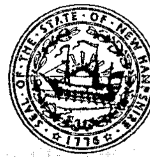
I HEREBY CERTIFY UNDER PENALTY OF PERJURY THAT ALL INFORMATION ON THIS FORM IS CURRENTLY ACCURATE.

Kathleen M. Tawanen MD — Signature of Licensee (Signature Stamp Not Accepted)

5/11/99 — Date

MAR 3 1 2000

STATE OF NEW HAMPSHIRE



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

Telephone #: 603-271-6934

RENEWAL APPLICATION

For expiration on: 6/30/2001

Renewal Fee: $100.00

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) Y

Please list ABMS Board Specialty: OBG

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

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

License #: 7106

File #: 7798

☒ Home Address

KATHLEEN M TOIVANEN, MD

Phone:

☐ Work Address

1245 WASHINGTON RD
PO BOX 677
RYE, NH 03870
Phone: (603)964-6918

Hospital Affiliations: **(If not a NH hospital, please list city and state where hospital is located.)**

PORTSMOUTH REGIONAL HOSPITAL - PORTSMOUTH, NH

(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 12 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 for use or misuse of any chemical substance?		✓
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?		✓
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.

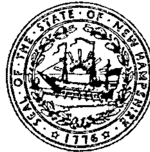
Kathleen M. Taivanen — 3/25/00

Signature of Licensee (Signature Stamp Not Accepted) Date

APR 10 2001

STATE OF NEW HAMPSHIRE

Telephone #: 603-271-6934



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

RENEWAL APPLICATION

For expiration on: (date) 6/30/2002

Renewal Fee: $150.00

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) Y

Please list ABMS Board Specialty: OBG

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

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

License #: 7106

File #: 7798

☑ Home Address

KATHLEEN M TOIVANEN, MD

Phone:

☐ Work Address

1245 WASHINGTON RD
PO BOX 677
RYE, NH 03870

Phone: 603*964-6918

Hospital Affiliations: **(If not a NH hospital, please list city and state where hospital is located.)**

PORTSMOUTH REGIONAL HOSPITAL - PORTSMOUTH, NH

(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 12 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 for use or misuse of any chemical substance?		✓
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?		✓
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.

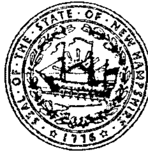
Kathleen M. Towanen
Signature of Licensee (Signature Stamp Not Accepted)

4/4/01
Date

MAR 1 2 2002

STATE OF NEW HAMPSHIRE

Telephone #: 603-271-6934



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

#596

RENEWAL APPLICATION

For expiration on: 6/30/2003

Renewal Fee: $150.00

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) Y

Please list ABMS Board Specialty: OBG

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

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

License #: 7106

File #: 7798

☑ Home Address

KATHLEEN M TOIVANEN, MD

Phone:

☐ Work Address

1245 WASHINGTON RD
PO BOX 677
RYE, NH 03870

Phone: 603*964-6918

Hospital Affiliations: **(If not a NH hospital, please list city and state where hospital is located.)**

PORTSMOUTH REGIONAL HOSPITAL - PORTSMOUTH, NH

(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 12 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 for use or misuse of any chemical substance?		✓
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?		✓
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.

Kathleen M. Tourzaner

Signature of Licensee (Signature Stamp Not Accepted)

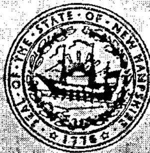
3/3/02

Date

MAR 24 2003

STATE OF NEW HAMPSHIRE

Telephone #: 603-271-6934



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

RENEWAL APPLICATION

For expiration on: 06/30/05

#853

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 reactive 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) Y

Please list ABMS Board Specialty: OBG

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

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

License #: 7106

File #: 7798

☐ Home Address

KATHLEEN M TOIVANEN, MD

Phone:

☐ Work Address

1245 WASHINGTON RD
PO BOX 677
RYE, NH 03870

Phone: 603*964-6918

Hospital Affiliations: **(If not a NH hospital, please list city and state where hospital is located)**

PORTSMOUTH REGIONAL HOSPITAL - PORTSMOUTH, NH

(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 12 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?	___	✓
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.

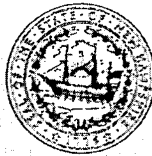
Kathleen M. Touranen
Signature of Licensee (Signature Stamp Not Accepted)

3/14/03
Date

MAR 23 2005

STATE OF NEW HAMPSHIRE

Telephone #: 603-271-6934



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

RENEWAL APPLICATION

For expiration on: 06/30/07

#1347 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) Y

Please list ABMS Board Specialty: OBG

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

NONE

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

License #: 7106

File #: 7798

☑ Home Address

KATHLEEN M TOIVANEN, MD

Phone:

☐ Work Address

1245 WASHINGTON RD
PO BOX 677
RYE, NH 03870

Phone: 603-964-6918
Business Fax Number:
Business Email Address:

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
PORTSMOUTH REGIONA PORTSMOUTH NH	☑	☐	☐
	☐	☐	☐
	☐	☐	☐
	☐	☐	☐
	☐	☐	☐
	☐	☐	☐
	☐	☐	☐

(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.

Kathleen M. Tourunen

Signature of Licensee (Signature Stamp Not Accepted)

3/14/05

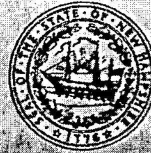
Date

MAR 15 2007

RECEI[illegible]
MAR 13 [illegible]
NH BOA[illegible]

STATE OF NEW HAMPSHIRE

Telephone #: 603-271-6934



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

RENEWAL APPLICATION

#1799

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) Y
Please list ABMS Board Specialty: OBG

Licensed in the states of: (2 letter state abbrev.) NONE

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

License #: 7106

File #: 7798

☒ Home Address

KATHLEEN M TOIVANEN, MD

Phone:

☐ Work Address

1245 WASHINGTON RD
PO BOX 677
RYE, NH 03870

Phone: 603 964-6918
Business Fax Number:
Business Email Address:

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
PORTSMOUTH REGIONA PORTSMOUTH NH		☑	☐	☐
		☐	☐	☐
		☐	☐	☐
		☐	☐	☐
		☐	☐	☐
		☐	☐	☐
		☐	☐	☐

(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.

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

Kathleen M. Tawanen

Signature of Licensee (Signature Stamp Not Accepted)

3/7/07

Date

MAR 3 1 2009

RECEIVED

MAR 3 0 2009

NH BOARD

STATE OF NEW HAMPSHIRE

Telephone #: 603-271-6934

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

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.) NONE

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 #: 7106

File #: 7798

☒ Home Address

KATHLEEN M TOIVANEN, MD

Phone:

☐ Work Address

1245 WASHINGTON RD
PO BOX 677
RYE, NH 03870

Phone: 603-964-6918
Business Fax Number:
Business Email Address:

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
PORTSMOUTH REGIONA	PORTSMOUTH	NH	☑	☐	☐
			☐	☐	☐
			☐	☐	☐
			☐	☐	☐
			☐	☐	☐
			☐	☐	☐
			☐	☐	☐

(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] 3/27/09

Signature of Licensee (Signature Stamp Not Accepted) Date

APR 14 2011

STATE OF NEW HAMPSHIRE RECEIVED

Telephone #: 603-271-6934 APR 11 2011

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

NH BOARD RENEWAL APPLICATION

For expiration on: 06/30/2013

Renewal Fee: $300.00

For Office Use Only
Date Pd: 4/11/11 Check # 2872

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.) ME NH VT

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 #: 7106

File #: 7798

☒ Home Address

KATHLEEN M TOIVANEN, MD

Phone:

☐ Work Address

875 GREENLAND RD B11
ORCHARD PARK
PORTSMOUTH, NH 03801

Phone: 603-436-2667
Business Fax Number:
Business Email Address: N/A

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
PORTSMOUTH REGIONA PORTSMOUTH NH	☑	☐	☐
	☐	☐	☐
	☐	☐	☐
	☐	☐	☐
	☐	☐	☐
	☐	☐	☐
	☐	☐	☐

(RENEWAL APPLICATION CONTINUED ON REVERSE SIDE)