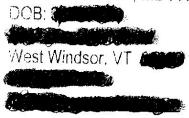
Renee J. Novello, MD FACOG (nee Johannensen)



Curriculum Vitae

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1/86-5/90 Rutgers University – Newark
BA, Biology
Elected Phi Beta Kappa
Magna Cum Laude
College Honors Program
Elected Beta Beta Beta - Biological Honor Society

Residency

)7/99-6/03 Monmouth Medical Center

300 2nd Avenue, Long Branch, NJ 07740 Resident: Obstetrics and Gynecology

Chief Resident: 7/02-6/03

Awards: Dr. Robert M. Mackensie Award (to the resident who contributed most to overall teaching program and patient care in field of OB/GYN) 2001, 2003

Highest In-service score - all four years

Highest in-service score for Level - all four years

OB/GYN Resident Physician Research Award - 2000, 2001, 2002

Licensure

State of New Jersey - 2001 State of New Hampshire - 2006 State of Vermont - 2006

Board Certification

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Medical Employment

5/1/2010 - Present

Planned Parenthood of Northern New England 39 Main Street West Lebanon, NH

General gynecology with focus on family planning.

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Practice consists of hospital based obstetrics (laborist) and coverage of Emergency Department derived gynecology. Resident and medical student training and education.

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Role of progesterone on regulation of LH secretion and the regulation of the menstrual cycle. This research came out of the work I did earlier with HMG-CoA reductase inhibitors & studying pooled progesterone measurements.

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Senior thesis was derived from work performed in the Physical Biochemistry Laboratory. We isolated and studied the physical and biochemical properties of Phodopsin and other membrane proteins.

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Provide free general gynecology services to the uninsured

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6/84-12/89
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Syndicate Associate – Syndication Department
Registered Representative Series 7 & 63
Distribution of initial public offerings and other new public security issues.
(Held this job full time throughout college)
New York, NY

Personal: Married, 4 children ages 9-21. Strong interests in farming, knitting, snowboarding and equestrian pursuits.

Medicine Form 1

The University of the State of New York THE STATE EDUCATION DEPARTMENT Office of the Professions Division of Professional Licensing Services 39 Washington Avenue Albany, NY 12234-1000 www op.nysed gov

Department Use Only

Application for Licensure

and First Registration \$735 ER Applicants Must Complete All Six Pages Of This Application In Ink NYS License Number Social Security Number Date Issued (Leave this blank if you do not have a U.S. Social Security Number) initials Birth Date Print Name Exactly As You Wish It To Appear On Your License Telephone/E-Mail Address OVEL **Daytime Phone** First NEE Middle Area Code Phone Number Mailing Address (You must notify the Department promptly of any address or name changes.) E-Mail Address (Please print clearly) Street State Zip Code Province/Country If not U.S. ŝ Name as it appears on degree or other credentials (if different from above): 7 Citizenship: ✓ United States Alien lawfully admitted for a permanent residence in the United States ☐ Other Immigration Citizen of Attach a photocopy of the front and back of your Alien Registration Card 8 I wish to become licensed on the basis of: Acceptable examination scores (see page 3 of this form) Endorsement of another license (See "Applicants Licensed in Another State" section of instructions.) Lam using FCVS to collect my credentials: Have you previously applied for a New York State License or a limited permit to practice medicine? YES **⊠** NO 10 Have you ever been found guilty after trial, or pleaded guilty, no contest, or nolo contendere to a crime (felony or misdemeanor) in any court? 11 Are criminal charges pending against you in any court? Has any licensing or disciplinary authority refused to issue you a license or ever revoked, annualed, cancelled, accepted surrender of, suspended, placed on probation, refused to renew a professional license or certificate held by you now or previously, or ever fined, censured, reprimanded or otherwise disciplined you? Are charges pending against you in any jurisdiction for any sort of professional misconduct? 13 Has any hospital or licensed facility restricted or terminated your professional training, employment, or privileges or have you ever voluntarily or involuntarily resigned or withdrawn from such association to avoid imposition NOTE: If you answer "Yes" to any questions numbered 10-14, submit a letter giving complete explanation. Include copies of any

court records, and if you possess one, a copy of the "Certificate of Relief from Disabilities" or your "Certificate of Good Conduct."

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	Complete this section only if you are a graduate of a program not registered by New York State or LCME or AOA accredited. Have you completed all portions of the examination requirements for ECFMG certification?								
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	Are you applying for licensure on the basis of a Fifth Pathway program? If Yes, list name and location of medical school or hospital and the inclusive dates of attendance.								
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	GENDER AND ETHNICITY: (This item is optional.)					
iii	Information on gender and ethnicity is sought solely to allow the Education Department to collect and analyze data concerning diversity in the licensed professions. The ethnic and gender data you provide will be used only for statistical, research, and program evaluation purposes. It will not be released to the public. This information has absolutely no bearing on your qualification for licensure.					
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لت	STUDENT LOAN DISCLOSURE:					
	The State Education Department is required* to ask these questions about any student loans made or guaranteed by the New York State Higher Education Services Corporation, and to forward any "yes" responses to the New York State Higher Education Services Corporation. Your license application is not complete without this information.					
	(a) Do you have any outstanding loans made or guaranteed by the New York State Higher Education Services Corporation? Yes No					
	(b) If you have such a loan(s), is any part in default?					
	'New York State Education Law, section 6501-a					
	Everyone applying for a professional license, permit, or registration, or any renewal thereof, must file a written statement that, as of the date of the filing, she or he is, or is not, under an obligation to pay child support. Individuals who are four months or more in arrears in child support or who have failed to comply with a summons, subject to suspension of their business, professional, drivers and or warrant relating to a paternity or child support proceeding may be faise written statements for the purpose of frustrating or defecting the leavest to successional discusses and permits. The intentional submission of					
	false written statements for the purpose of frustrating or defeating the lawful enforcement of sup-port obligations is punishable under section 175.35 of the Penal Law.					
	You must complete this section before we can issue the credential for which you have applied. Individuals who are not in compliance with their obligation to pay child support can be issued a credential for no more than six months in order to comply with their child support obligations.					
	Check only A or B below. If you check B, you must check one of the five statements listed below it.					
	A 🔀 Lam not under an obligation to pay child support:					
	OR .					
	B					
	am current and am not four months or more in arrears in the payment of child support; or,					
	I am making payments by income execution or by court agreed payment plan or by a plan agreed to by the parties; or,					
	The child support obligation is the subject of a pending court proceeding; or,					
	am receiving public assistance or supplemental security income; or.					
	None of the above four statements apply.					
	*New York State General Obligations Law. section 3-503					
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	Medicine Form 1, Page 5 of 6, Rev. 4/11					

Post Medical School Activity Record Form

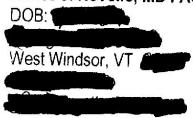
The University of the State of New York
THE STATE EDUCATION DEPARTMENT
Office of the Professions
Edvision of Professional Licensing Services
39 Washington Avenue
Albany, NY 12234-1006
www.op.nysed.gov



Post Medical School Activity Record

INSTRUCTIONS: Please complete this form, have it notarized by a Notary Public and return it to the Office of the Professions at the address at the rest of this form.
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APPLICANT I being a by sworn declare and affirm that the statements made in this application including accompanying documents are true, improve and correct. I Enderstand that any false or misleading information in, or in connection with a publication may be cause for denial or ldss of ficensure and source in criminal prosecution. Signature of the applicant.
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On the 27th Jay of 0013 BER in the year 2011 before me, the undersigned personally
independed Active 1001-cco rersonally known to me or proved to me on the basis of satisfactory evidence
to be the individual whose name is subscribed to this application and acknowledged to me that he/she executed the application and swore that the statements made by him/her in the application and all supporting materials are made.
complete and correct.
Notary Public signature
Notary ID number ル/ キ
Sociation state 02 10 12015 DENEL MCINTIRE Votary Public - State of Vermont My Comm. Expires: Feb. 10, 2015
Post Medical School Activity Record Form, Page 1 of 2, July 2004

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Medicine Form 1

The University of the Islate of New York
THE ISLATE EDUCATION DEPARTMENT

Fifting of the Professions
System of Professional Ucensing Services
9 Washington Average
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Application for Licensure and First Registration

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Post Medical School | Activity Record Form

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Post Medical School Activity Record

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