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

TEMPORARY LICENSE
#T- 0279

Pursuant to the New Hampshire Code of Administrative Rules, Med 301.03(c), a Temporary License is issued to:

Alain L. Campbell, M.D.

The State of Massachusetts has provided the New Hampshire Board of Medicine proof that Dr. Campbell holds a full unrestricted medical license in that state.

This license is effective for the period stated below:

August 1, 2007 through February 1, 2008.

Penny Taylor

Penny Taylor, Administrator

(SEAL)

Date: August 1, 2007

New Hampshire Board of Medicine

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March 5, 2008

ALAIN CAMPBELL MD

Dear Dr. Campbell:

Congratulations, your application for licensure has been granted by the New Hampshire Board of Medicine. Your license, numbered 13850, is dated March 5, 2008, 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.

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NH BOARD

New Hampshire Board of Medicine

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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: ALAIN L CAMPBELL

Business Name: CONCORD FEMINIST HEALTH Center

[X] Address: 38 SOUTH MAIN ST

CONCORD NH 03301

Office telephone: 603-225-2739

Business Fax Number: 603-228-6255 Business E-Mail: _____

[ ] Home Address: _____

Home telephone: _____

Specialty: OB-GYN Board certified: 1986, 1996, 2006

Hospital affiliations: NORTH SHORE MEDICAL CENTER, SALEM AND LYNN, MA, PARTNERS HEALTH CARE

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

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JUL 19 2007
NH BOARD

Application for Physician Licensure

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

1. Full Name (use no initials)

Last Name CAMPBELL
First Name ALAIN
Middle Name LESTER
Suffix N/A
Maiden Name N/A
M.D. ☒ D.O. ☐

N/A
All other names used

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

Practice Address ATLANTICARE OB-GYN
☒ Public Access
☒ Mailing
Street 9 BOSTON ST SUITE 9
City LYNN State/Province MA ZIP Code 01904
Telephone 781-592-3000
Fax 781-592-9625
E-mail address N/A
Alternate Phone (e.g. pager or cell phone)

Home Address
☐ Public Access
☐ Mailing
Street
City State/Province ZIP Cod
Telephone
Fax
E-mail address
Alternate Phone (e.g. pager or cell phone)

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

3. Identification

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

M
Gender | Social Security Number | Are you a U.S. Citizen? ☐ Yes ☒ No

GREEN CARD A41476554

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

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

4. Medical School (attach additional pages if necessary)

1. School Name SCHOOL OF MEDICINE, McGILL UNIVERSITY
Address MC INTYRE BUILDING, 3655 PROMENADE SIR WILLIAM OSLER
City MONTREAL
State/Province QUEBEC
ZIP Code H3G 1Y6
Country CANADA
Attendance Dates (From – To) SEPT 1972 TO MAY 1976
Graduation Date MAY 27, 1976
Degree M.D., CM. - M.Sc STUDENT ID 7212065

2. School Name
Address
City
State/Province
ZIP Code
Country
Attendance Dates (From – To)
Graduation Date
Degree

USING FCVS

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

5. Fifth Pathway (if applicable)

Medical School Name N/A

Address

City

State/Province

ZIP Code

Country

Attendance Dates (From - To)

Graduation Date

Degree

Institution name where rotations performed

Address

City

State/Province

ZIP Code

Country

Attendance Dates (From - To)

Certification Date

Applicant Name: CAMPBELL, ALAIN C Date: JULY 14, 2007

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

6. Postgraduate Training (copy and attach additional pages if necessary)

Complete name and address of hospital where training was conducted (Do Not Abbreviate)

1.Hospital Name JEWISH GENERAL HOSPITAL, Teaching hospital of McGill University

Hospital Address 3755 COTE STE-CATHERINE ROAD

City MONTREAL

State/Province QUEBEC

ZIP Code H3T 1E2

Country CANADA

PGY: (e.g., 1, 2, 3, etc.) STRAIGHT ☒ Internship ☐ Residency ☐ Fellowship ☐ Research ☐ Other

Department/Specialty: OB-GYN, CREDITED AS RESIDENCY 1

From: 07 / 1976 To: 12 / 1976 Successfully Completed? Yes ☒ No ☐ In Progress ☐

Month Year Month Year

2.Hospital Name MONTREAL GENERAL HOSPITAL, Teaching hosp. McGill UN.

Hospital Address 1650 CEDAR AVE.

City MONTREAL

State/Province QUEBEC

ZIP Code H3G 1A4

Country CANADA

PGY: (e.g., 1, 2, 3, etc.) STRAIGHT ☒ Internship ☐ Residency ☐ Fellowship ☐ Research ☐ Other

Department/Specialty: OB-GYN, CREDITED AS RESIDENCY 1

From: JAN / 1977 To: JUNE / 1977 Successfully Completed? Yes ☒ No ☐ In Progress ☐

Month Year Month Year

Applicant Name: CAMPBELL, ALAIN L Date: JULY 14, 2007

6. **Postgraduate Training (continued)**

3.Hospital Name HOTEL DIEU OF MONTREAL - UNIVERSITY OF MONTREAL
Hospital Address 3840 ST-URBAIN ST
City MONTREAL
State/Province QUEBEC
ZIP Code H2W 1T8
Country CANADA

PGY: (e.g., 1 (2) 3, etc.) ☐ Internship ☒ Residency ☐ Fellowship ☐ Research ☐ Other

Department/Specialty: GENERAL SURGERY

From: JULY 1977 To: DEC 1977 Successfully Completed? Yes ☒ No ☐ In Progress ☐
Month Year Month Year

4.Hospital Name HOTEL DIEU OF MONTREAL - UNIV. OF MONTREAL
Hospital Address 3840 ST-URBAIN ST
City MONTREAL
State/Province QUEBEC
ZIP Code H2W 1T8
Country CANADA

PGY: (e.g., 1 (2) 3, etc.) ☐ Internship ☒ Residency ☐ Fellowship ☐ Research ☐ Other

Department/Specialty: UROLOGY

From: JAN 1978 To: MARCH 1978 Successfully Completed? Yes ☒ No ☐ In Progress ☐
Month Year Month Year

Applicant Name: CAMPBELL, ALAIN C Date: JULY 14, 2007

6. Postgraduate Training (continued)

5.
3. Hospital Name STE - JUSTINE HOSPITAL, UNIVERSITY OF MONTREAL
Hospital Address 3175 COTE STE-CATHERINE ROAD
City MONTREAL
State/Province QUEBEC
ZIP Code H3T 1C5
Country CANADA

PGY: (e.g., 1 (2) 3, etc.) ☐ Internship ☒ Residency ☐ Fellowship ☐ Research ☐ Other

Department/Specialty: INTERNAL MEDICINE WITHIN OB-GYN

From: APRIL 1978 To: JUNE 1978 Successfully Completed? Yes ☒ No ☐ In Progress ☐
Month Year Month Year

6
4. Hospital Name STE JUSTINE HOSP., UNIVERSITY OF MONTREAL
Hospital Address 3175 COTE STE-CATHERINE ROAD
City MONTREAL
State/Province QUEBEC
ZIP Code H3T 1C5
Country CANADA

PGY: (e.g., 1, 2, (3) etc.) ☐ Internship ☒ Residency ☐ Fellowship ☐ Research ☐ Other

Department/Specialty: OB-GYN

From: JULY 1978 To: JUNE 1979 Successfully Completed? Yes ☒ No ☐ In Progress ☐
Month Year Month Year

6. Postgraduate Training (continued)

7a. Hospital Name STE. JUSTINE HOSP., UNIVERSITY OF MONTREAL
Hospital Address 3175 COTE STE. CATHERINE ROAD
City MONTREAL
State/Province QUEBEC
ZIP Code H3T 1C5
Country CANADA

PGY: (e.g., 1, 2, 3, etc.) (4) ☐ Internship ☒ Residency ☐ Fellowship ☐ Research ☐ Other

Department/Specialty: OB-GYN - PERINATOLOGY

From: JULY 1979 To: DEC 1979 Successfully Completed? Yes ☒ No ☐ In Progress ☐
Month Year Month Year

8a. Hospital Name HOTEL DIEU HOSP., UNIVERSITY OF MONTREAL
Hospital Address 3840 ST. URBAIN ST
City MONTREAL
State/Province QUEBEC
ZIP Code H2W 1T8
Country CANADA

PGY: (e.g., 1, 2, 3, etc.) (4) ☐ Internship ☒ Residency ☐ Fellowship ☐ Research ☐ Other

Department/Specialty: OB-GYN ONCOLOGY

From: ~~JAN~~ 1980 To: MARCH 1980 Successfully Completed? Yes ☒ No ☐ In Progress ☐
Month Year Month Year

6. Postgraduate Training (continued)

9
3. Hospital Name NOTRE-DAME HOSP., UNIVERSITY OF MONTREAL
Hospital Address 1560 SHERBROOKE ST EAST
City MONTREAL
State/Province QUEBEC
ZIP Code H2L 4M1
Country CANADA

(4)
PGY: (e.g., 1, 2, 3, etc.) ☐ Internship ☒ Residency ☐ Fellowship ☐ Research ☐ Other

Department/Specialty: OB-GYN : INFERTILITY

From: APRIL 1980 To: JUNE 1 1980 Successfully Completed? Yes ☒ No ☐ In Progress ☐
Month Year Month Year

4. Hospital Name STE-JUSTINE HOSP. - HOTEL-DIEU HOSP
Hospital Address 3175 COTE STE-CATHERINE ROAD → 3840 ST URBAIN ST
City MONTREAL H3T 1C5 H2W 1T8
State/Province QUEBEC
ZIP Code
Country CANADA

(5)
PGY: (e.g., 1, 2, 3, etc.) ☐ Internship ☒ Residency ☐ Fellowship ☐ Research ☐ Other

Department/Specialty: CHIEF RESIDENT IN OB-GYN, TERTIARY CENTER

From: JULY 1 1979 To: JUNE 1 1980 Successfully Completed? Yes ☒ No ☐ In Progress ☐
Month Year Month Year

USING FCVS

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

7. Examination History

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

Examination	Most Recent Date taken(Month/Year)	Passed (P) or Failed (F)	Number of attempts
State Board Exam	QC McGill, 1976	☒ P ☐ F	1
State	N/A: NOT MANDATORY FOR SPECIALISTS IN QUEBEC IN 1976		
FLEX Pre-1985		☐ P ☐ F	
FLEX Component 1		☐ P ☐ F	
FLEX Component 2		☐ P ☐ F	
LMCC – Single		☐ P ☐ F	
LMCC – Part I		☐ P ☐ F	
LMCC – Part II		☐ P ☐ F	
NBME Part I		☐ P ☐ F	
NBME Part II		☐ P ☐ F	
NBME Part III		☐ P ☐ F	
SPEX		☐ P ☐ F	
NBOME Part I		☐ P ☐ F	
NBOME Part II		☐ P ☐ F	
NBOME Part III		☐ P ☐ F	
COMLEX Level 1		☐ P ☐ F	
COMLEX Level 2		☐ P ☐ F	
COMLEX Level 3		☐ P ☐ F	
COMVEX		☐ P ☐ F	
USMLE Step I		☐ P ☐ F	
USMLE Step II		☐ P ☐ F	
USMLE Step III		☐ P ☐ F	

Applicant Name: CAMPBELL, ALAIN L Date: JULY 14, 2007

USING FCVS

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

8. ECFMG (if applicable) N/A

Certificate Number _____ Issue Date _____ Valid Through Date _____

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

9. State Licensure – MD or DO only – attach additional pages if necessary

1. State/Province MA Type M.D (MD, DO, etc) License Number 60491 Status ACTIVE Issue Date OCT 19, 1988
2. State/Province QUEBEC Type MD (MD, DO, etc) License Number 77.182 Status INACTIVE Issue Date 06/17/1977, 1988 LEFT QUEBEC
3. State/Province _____ Type _____ (MD, DO, etc) License Number _____ Status _____ Issue Date _____
4. State/Province _____ Type _____ (MD, DO, etc) License Number _____ Status _____ Issue Date _____
5. State/Province _____ Type _____ (MD, DO, etc) License Number _____ Status _____ Issue Date _____
6. State/Province _____ Type _____ (MD, DO, etc) License Number _____ Status _____ Issue Date _____
7. State/Province _____ Type _____ (MD, DO, etc) License Number _____ Status _____ Issue Date _____
8. State/Province _____ Type _____ (MD, DO, etc) License Number _____ Status _____ Issue Date _____
9. State/Province _____ Type _____ (MD, DO, etc) License Number _____ Status _____ Issue Date _____
10. State/Province _____ Type _____ (MD, DO, etc) License Number _____ Status _____ Issue Date _____

Applicant Name: CAMPBELL, ALAIN C Date: JULY 14, 2007

All Other Health Care Licensure/Certification (e.g., RN, PA, etc.) - attach additional pages if necessary.

N/A

1. State/Province _____ Type _____ License Number _____ Status _____ Issue Date _____
2. State/Province _____ Type _____ License Number _____ Status _____ Issue Date _____
3. State/Province _____ Type _____ License Number _____ Status _____ Issue Date _____
4. State/Province _____ Type _____ License Number _____ Status _____ Issue Date _____
5. State/Province _____ Type _____ License Number _____ Status _____ Issue Date _____

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

10. Chronology of Activities (copy and attach additional pages if necessary)

Dates: From/To	Practice/Employment
1. From: Month: JULY Year: 1980 To: Month: DEC Year: 1988	Practice/Employment Name STE-JUSTINE UNIVERSITY HOSPITAL (or list non-working time as indicated above) Practice/Employment Address 3175 COTE STE-CATHERINE ROAD City MONTREAL State/Province QUEBEC ZIP Code H3T 1C5 Country CANADA Position and Department STAFF-OB-GYN % Clinical 100 % Administrative _____ Employment ☐ Staff Privileges ☒ Affiliation ☐ Other _____
2. From: Month: JULY Year: 1980 To: Month: DEC Year: 1988	Practice/Employment Name FACULTY OF MEDICINE - UNIVERSITY OF MONTREAL (or list non-working time as indicated above) Practice/Employment Address 2900 EDOUARD MONTPETIT BLVD City MONTREAL State/Province QUEBEC ZIP Code H3T 1J4 Country CANADA Position and Department OB-GYN % Clinical 100 % Administrative _____ Employment ☐ Staff Privileges ☐ Affiliation ☒ Other _____ ASSISTANT PROFESSOR CLINICAL OB-GYN

Applicant Name: CAMPBELL, ALAIN C Date: JULY 14, 2007

Dates: From/To	Practice/Employment
3. From: Month: JULY Year: 1980 To: Month: DEC Year: 1988	Practice/Employment Name: ST ALTERNATIVE MEDICAL CLINIC (or list non-working time as indicated above) Practice/Employment Address: 2034 ST HUBERT ST City: MONTREAL State/Province: QUEBEC ZIP Code: H2L 3Z5 Country: CANADA Position and Department: OB-GYN % Clinical: 90 % Administrative: 10 Employment ☐ Staff Privileges ☐ Affiliation ☐ Other: PRIVATE OFFICE
4. From: Month: DEC Year: 1988 To: Month: ACTUAL Year:	Practice/Employment Name: NORTH SHORE MEDICAL CENTER-UNION HOSP. (or list non-working time as indicated above) Practice/Employment Address: 500 LYNNFIELD ST City: LYNN State/Province: MA ZIP Code: 01904 Country: USA Position and Department: OB-GYN % Clinical: 100 % Administrative: Employment ☐ Staff Privileges ☒ Affiliation ☐ Other:
5. From: Month: SEPT Year: 1989 To: Month: ACTUAL Year:	Practice/Employment Name: NORTH SHORE MEDICAL CENTER-SALEM HOSP. (or list non-working time as indicated above) Practice/Employment Address: 81 HIGHLAND AVE City: SALEM State/Province: MA ZIP Code: 01970 Country: USA Position and Department: OB-GYN % Clinical: % Administrative: Employment ☐ Staff Privileges ☒ Affiliation ☐ Other:
6. From: Month: DEC Year: 1988 To: Month: ACTUAL Year:	Practice/Employment Name: ATLANTICARE OB-GYN (or list non-working time as indicated above) Practice/Employment Address: 9 BOSTON ST #9 City: LYNN State/Province: MA ZIP Code: 01904 Country: USA Position and Department: OB-GYN % Clinical: 90 % Administrative: 10% Employment ☐ Staff Privileges ☐ Affiliation ☐ Other: PRIVATE PRACTICE

Applicant Name: CAMPBELL, ALAIN L Date: JULY 14, 2007

VARIA

Dates: From/To	Practice/Employment
8.7 From: Month: Year: 1992 To: Month: Year: 1996	Practice/Employment Name ASSOCIATED PHYSICIANS-REPRO (or list non-working time as indicated above) Practice/Employment Address BEACON ST City BROOKLINE State/Province MA ZIP Code _____ Country USA Position and Department GYNECOLOGY % Clinical 100 % Administrative _____ Employment ☒ Staff Privileges ☐ Affiliation ☐ Other _____ REPRO WENT OUT OF BUSINESS IN 2005
8.8 From: Month: Year: 1992 To: Month: Year: 1993	Practice/Employment Name LYNN COMMUNITY HEALTH CENTER (or list non-working time as indicated above) Practice/Employment Address 269 UNION ST City LYNN State/Province MA ZIP Code 01901 Country USA Position and Department GYNECOLOGY % Clinical 100 % Administrative _____ Employment ☒ Staff Privileges ☐ Affiliation ☐ Other _____
8.9 From: Month: Year: 1998 To: Month: Year:	LOCUM TENANS Practice/Employment Name MARTHA'S VINEYARD HOSPITAL (or list non-working time as indicated above) Practice/Employment Address 1 HOSPITAL ROAD City OAK BLUFFS - MARTHAS VINEYARD State/Province MA ZIP Code 02557 Country USA Position and Department OB-GYN % Clinical 100 % Administrative _____ Employment ☒ Staff Privileges ☐ Affiliation ☐ Other _____
6. From: Month: Year: To: Month: Year:	Practice/Employment Name _____ (or list non-working time as indicated above) Practice/Employment Address _____ City _____ State/Province _____ ZIP Code _____ Country _____ Position and Department _____ % Clinical _____ % Administrative _____ Employment ☐ Staff Privileges ☐ Affiliation ☐ Other _____

Applicant Name: CAMPBELL, ALAIN C Date: JULY 14, 2007

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

Affidavit
And
Authorization For Release of Information

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

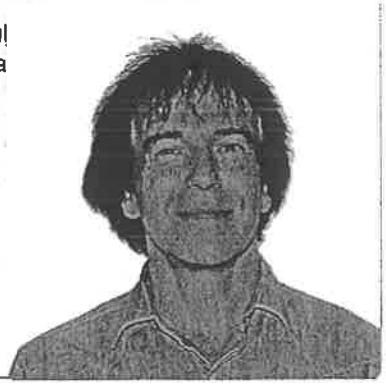
I acknowledge that I have read and understand the Application for Physician Licensure and have answered all questions contained in the application truthfully and completely. I further acknowledge that failure on my part to answer questions truthfully and completely may lead to my being prosecuted under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

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

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

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

I understand my failure to answer questions contained in this application truthful denial, revocation, or other disciplinary sanction of my licensure or permit to pra



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

CAMPBELL
Applicant's Printed Last Name

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

July 16, 2007
Date of Signature

NOTARY

Dated July 16 2007 Signed Amy Walsh

State of Massachusetts County of Middlesex

SUBSCRIBED AND SWORN TO before me this 16 day of July 2007

My commission expires: 2.20.2009 Amy Walsh (NOTARY PUBLIC SIGNATURE & SEAL)

AMY WALSH
Notary Public
Commonwealth of Massachusetts
My Commission Expires
February 20, 2009

ADDENDUM TO APPLICATION

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

	YES	NO
1. Are you certified by an American Specialty Board? (If yes, provide a notarized copy of all certificates).	✓	
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).	✓2	
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)?		✓

	YES	NO
12. Have you ever voluntarily surrendered a license to practice medicine or any healing art or allowed such a license to lapse in lieu of facing disciplinary investigation or action?		✓
13. Have you ever been a defendant in a criminal proceeding including driving while under the influence or driving while suspended, which has not been annulled by a court, but not including traffic offenses not classified as misdemeanors or felonies?		✓
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):

CONCORD FEMINIST HEALTH CENTER, CONCORD, NH
I ALREADY HAVE A LOCUM TENENS LICENSE FROM YOUR STATE

M Campbell
Applicant's Signature

CAMPBELL
Applicant's Printed Last Name

July 14, 2007
Date of Signature

For Board Use Only:

Application Received: 7/19, 2007 Fee Paid: $250- Check#: 4633

License Number: _____ Date of Issue: _____

Alain L. Campbell, M.D.

30 July 2007

NH Board of Medicine
2 Industrial Park Drive, Suite 8
Concord, NH 03301

Dear Honorable Members of the NH Board of Medicine:

On May 2, 2007 I was granted a locum tenens license, which is due to expire on August 11, 2007. Since that time I have been providing gynecological services approximately one day per week at the Concord Feminist Health Center with the intent of applying for a New Hampshire medical license. It has been through the application process for both a temporary and permanent license that I was informed that the examination requirement that New Hampshire necessitates is problematic in my situation.

I specifically did not take any national exam, which is apparently a requirement in New Hampshire as I am a Canadian resident. Please understand that when I graduated from the McGill University School of Medicine in 1976, I was not required to take the LMCC or any other US national exam since I was sure I would practice in Quebec and this was not a requirement for specialists in Quebec. I took the McGill University exams necessary to graduate with an MD degree. I received my MD license to practice in Quebec in 1977 without having taken the national exam(s), covering more general medicine than specialty medicine, at least this is the way it was seen in Quebec in those days.

As documented in the attached application, my Canadian MD license remained in active status until 1988. I left Quebec and in 1988 obtained my MD license in the State of Massachusetts (license number 60491) that remains active and in effect to this day. In November 2006, I again successfully passed the Annual Board Certification examination for the American Board of Obstetrics and Gynecology (certified previously for 10 years in 1986 and 1996) . Finally, in addition to my private practice in Obstetrics and Gynecology, I have staff privileges at the North Shore Medical Center Salem Hospital in Salem and Lynn Massachusetts.

My responsibilities at the Concord Feminist Health Center (Health Center) have been limited to gynecological care and more specifically termination procedures. I am pursuing a New Hampshire license because I would like to continue to provide this gynecological service at the Health Center and do not have any plans to extend my practice to any other medical facility in the state.

Given the uniqueness of my situation, I respectfully request that the Board waive the national exam requirement for both my temporary and permanent New Hampshire medical license as I am Board certified in my specialty and have unrestricted license in Massachusetts for 19 years; my practice is strictly limited to Ob/Gyn. If that is not feasible, will the Board please consider issuing either a Special or Restricted medical license to Ob/Gyn? If the Board is unable to make a determination at your August 1st board meeting, could a Courtesy license be extended until this situation is resolved? I understand that with the present rules, I could apply for a locum tenens license next year and be granted one, as I was this year, as I have an active license in Massachusetts. I have been practicing medicine since 1977 as a specialist in Ob/Gyn.

Please do not hesitate to contact me if you have any questions. I thank you for your time and consideration to my request.

Very Truly Yours,

Alain L. Campbell, M.D.

ABO+G

American Board of Obstetrics + Gynecology

First in Women's Health

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President

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Galveston, TX

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Chicago, IL

George D. Wendel, Jr., M.D.
Dallas, TX

Norman F. Gant, M.D.
Executive Director

Alvin L. Brekken, M.D.
Assistant to the Executive Director

The Vineyard Centre
2915 Vine Street
Dallas, TX 75204
Phone (214) 871-1619
Fax (214) 871-1943

November 1, 2006

RECEIVED FROM THE FORUM

RECEIVED
JUL 19 2007
NH BOARD

Alain L. Campbell, M.D.

Dear Dr. Campbell:

Congratulations! I am pleased to inform you that you have satisfactorily passed the Annual Board Certification examination. You have earned 25 CME credits which will be awarded by the American College of Obstetricians and Gynecologists (ACOG). If you paid for the additional CME credits, and you answered enough of the questions, your additional CME credits are included in the above total. Your recertification in Obstetrics and Gynecology will be valid through 12/31/2007. Documentation of passing the annual board certificate renewal process will be furnished to the engraving company. If you have not been contacted by them within six (6) months from the date of this letter, please notify the Board office in writing or by fax (214) 871-1943.

The answers for all the questions will be published by the ACOG in the January/February 2007 Clinical Review.

The American Board of Obstetrics and Gynecology, Inc. will notify the American Journal of Obstetrics and Gynecology, Obstetrics and Gynecology, the American Board of Medical Specialties, and ACOG of your passing the Annual Board Certification examination.

We have included information to apply for the 2007 Annual Board Certification, allowing you to continue this process. We hope you will maintain an active interest in the specialty, and you will continue to provide excellent care of women.

Your ID and Password for the 2007 Annual Board Certification is listed below. Go to www.abog.org then select ABC Registration from the right side and follow the prompts. If you prefer a paper application please fax a written request to (214) 871-1943. *Your application and fee must be received by January 12, 2007 to avoid a late fee being applied.*

ID #: -

Password:

Sincerely yours,

Norman F. Gant, M.D.
Executive Director
NFG:mjm

Amy Walsh

AMY WALSH
Notary Public
Commonwealth of Massachusetts
My Commission Expires
February 20, 2009

RECEIVED

JUL 19 2007

RECEIVED FROM PHYSICIAN

NH BOARD

Amy Walsh

AMY WALSH
Notary Public
Commonwealth of Massachusetts
My Commission Expires
February 20, 2009

DEA REGISTRATION NUMBER	THIS REGISTRATION EXPIRES	FEE PAID
BC1705625	08-31-2009	Paid

SCHEDULES	BUSINESS ACTIVITY	DATE ISSUED
2,2N,3 3N,4,5	PRACTITIONER	08-21-2006

CAMPBELL, ALAIN L MDM SC
DEPT OB/GYN
ATLANTICARE MEDICAL CENTER
9 BOSTON STREET, STE 9
LYNN, MA 01904

CONTROLLED SUBSTANCE REGISTRATION CERTIFICATE
UNITED STATES DEPARTMENT OF JUSTICE
DRUG ENFORCEMENT ADMINISTRATION
WASHINGTON, D.C, 20537

Sections 304 and 1008 (21 U.S.C. 824 and 958) of the Controlled Substances Act of 1970, as amended, provide that the Attorney General may revoke or suspend a registration to manufacturer, distribute, dispense, import or export a controlled substance.

THIS CERTIFICATE IS NOT TRANSFERABLE ON CHANGE OF OWNERSHIP, CONTROL, LOCATION, OR BUSINESS ACTIVITY, AND IS NOT VALID AFTER THE EXPIRATION DATE.

CONTROLLED SUBSTANCE REGISTRATION CERTIFICATE
UNITED STATES DEPARTMENT OF JUSTICE
DRUG ENFORCEMENT ADMINISTRATION
WASHINGTON, D.C, 20537

DEA REGISTRATION NUMBER	THIS REGISTRATION EXPIRES	FEE PAID
BC1705625	08-31-2009	Paid

SCHEDULES	BUSINESS ACTIVITY	DATE ISSUED
2,2N,3 3N,4,5	PRACTITIONER	08-21-2006

CAMPBELL, ALAIN L MDM SC
DEPT OB/GYN
ATLANTICARE MEDICAL CENTER
9 BOSTON STREET, STE 9
LYNN, MA 01904

Sections 304 and 1008 (21 U.S.C. 824 and 958) of the Controlled Substances Act of 1970, as amended, provide that the Attorney General may revoke or suspend a registration to manufacturer, distribute, dispense, import or export a controlled substance.

Form DEA-223 (05/04)

THIS CERTIFICATE IS NOT TRANSFERABLE ON CHANGE OF OWNERSHIP, CONTROL, LOCATION, BUSINESS ACTIVITY, OR VALID AFTER THE EXPIRATION DATE.

AtlantiCare

AtlantiCare OB/GYN

RECEIVED
JUL 19 2007
NH BOARD

#4632
$50-

July 14, 2007

RECEIVED FROM PHYSICIAN

Board of Medicine
New Hampshire

To whom it may concern,

I ~~am applying for~~ both a regular medical license and ~~a temporary license~~. I have a locum tenens license now.

~~I have a full intent to complete the FCVS process, starting this month.~~

Thank you,

Alain Campbell

ALAIN CAMPBELL MD

RECEIVED
JUN 09 2010
NH BOARD

10 2010

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: 06/30/2012

Renewal Fee: $300.00

For Office Use Only: Date Pd: 6-9-10 Check # 4910

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.) MA

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 #: 13850

File #: 14843

☐ Home Address

ALAIN L CAMPBELL, MD
[redacted]

Phone: [redacted]

☑ Work Address

CONCORD FEMINIST HEALTH CT
38 SOUTH MAIN ST
CONCORD, NH 03301

Phone: 781-592-3000
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
		☑	☐	☐
		☑	☐	☐
		☑	☐	☐
		☑	☐	☐
		☑	☐	☐
		☑	☐	☐
		☑	☐	☐

(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.** NONE

I HEREBY CERTIFY UNDER PENALTY OF PERJURY THAT ALL INFORMATION ON THIS FORM IS CURRENTLY ACCURATE. **I acknowledge that I am governed by the Medical Practice Act (RSA 329), the New Hampshire Code of Administrative Rules (Med 100-500), and the American Medical Association's Code of Medical Ethics. I have familiarized myself with these documents and acknowledge that deviation from the standards set therein may subject me to disciplinary action by the New Hampshire Board of Medicine.**

[signature] 05/12/2010

Signature of Licensee (Signature Stamp Not Accepted) Date

JUL 0 6 2012

STATE OF NEW HAMPSHIRE

Telephone #: 603-271-6934

RECEIVED JUN 28 2012 NH BOARD

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

RENEWAL APPLICATION

For expiration on: 06/30/2014

Renewal Fee: $350.00

For Office Use Only:
Date Pd: 6-26-12 Check # 4745

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.) MA

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 #: 13850

File #: 14843

☑ Work Address

ALAIN L CAMPBELL, MD
CONCORD FEMINIST HEALTH CT
38 SOUTH MAIN ST
CONCORD, NH 03301

Phone: 781-592-3000
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
		☑	☐	☐
		☑	☐	☐
		☑	☐	☐
		☑	☐	☐
		☑	☐	☐
		☑	☐	☐
		☑	☐	☐

(RENEWAL APPLICATION CONTINUED ON REVERSE SIDE)

The Board will deny licensure if you refuse to submit your social security number (SSN). Your professional license will not display your SSN. Your SSN will not be made available to the public. The Board is required to obtain your SSN for the purpose of child support enforcement and in compliance with RSA 161-B:11. This collection of your SSN is mandatory.

Social Security Number: [redacted]

**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?	___	X
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?	___	X
3. Have you been subject to any investigation or to a denial, restriction, suspension, loss or revocation of your DEA certificate?	___	X
4. Have you been treated, other than through the Physician Health Program, for abuse or misuse of any chemical substance, including alcohol?	___	X
5. Have you had any emotional disturbance or mental or physical illness which has impaired your ability to practice medicine?	___	X
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?	___	X
7. Have you been reported to the National Practitioner's Data Bank? If yes, please submit a copy of the report.	___	X
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.	___	X
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?	___	X
10. Have any medical malpractice claims been made against you? See attached reporting form.	___	X

****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. **I acknowledge that I am governed by the Medical Practice Act (RSA 329), the New Hampshire Code of Administrative Rules (Med 100-500), and the American Medical Association's Code of Medical Ethics. I have familiarized myself with these documents and acknowledge that deviation from the standards set therein may subject me to disciplinary action by the New Hampshire Board of Medicine.**

[redacted] June 25th 2012

Signature of Licensee (Signature Stamp Not Accepted) Date

JUL 0 2 2014

STATE OF NEW HAMPSHIRE

Telephone #: 603-271-6934

BOARD OF MEDICINE
121 South Fruit Street, Suite 301
Concord, NH 03301-2412

RECEIVED
JUN 30 2014
NH BOARD

RENEWAL APPLICATION

For expiration on: 6/30/2016

Renewal Fee: $350.00

For Office Use Only: Date Pd: 6/30/14 Check # 5032

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

(If yes, provide proof of board certification.)

Please list ABMS Board Specialty: OBG

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

You must provide both home and business street address. P.O. Boxes are not acceptable without a street address provided. ***Please mark the box next to the address you would prefer to list as your mailing address.***

License #: 13850

File #: 14843

☐ Work Address

ALAIN L CAMPBELL, MD
CONCORD FEMINIST HEALTH CT
38 SOUTH MAIN ST
CONCORD, NH 03301

☐ Home Address

[redacted]

Please provide current Email, Fax and Phone Numbers below:

Phone: 781-592-3000

Business Fax Number: [redacted]

Business Email 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 Privileges	Full	Courtesy	Consult	Other
NORTH SHORE MEDICAL CENTER, SALEM, MA	☐	☐	☐	☑ LEAVE OF ABSENCE FOR SICKNESS
	☐	☐	☐	☐
	☐	☐	☐	☐
	☐	☐	☐	☐
	☐	☐	☐	☐
	☐	☐	☐	☐
	☐	☐	☐	☐

(RENEWAL APPLICATION CONTINUED ON REVERSE SIDE)

The Board will deny licensure if you refuse to submit your social security number (SSN). Your professional license will not display your SSN. Your SSN will not be made available to the public. The Board is required to obtain your SSN for the purpose of child support enforcement and in compliance with RSA 161-B:11. This collection of your SSN is mandatory. **Social Security Number:** [redacted]

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 OR since you last reported to the Board of Medicine if greater than 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?		NO
2. Have you been denied a license to practice medicine, or have you surrendered a license due to an investigation or disciplinary action, in any state other than New Hampshire?		NO
3. Have you been subject to any investigation or to a denial, restriction, suspension, loss or revocation of your DEA certificate?		NO
4. Have you been treated, other than through the Physician Health Program, for abuse or misuse of any chemical substance, including alcohol?		NO
5. Have you had any emotional disturbance or mental or physical illness which has impaired your ability to practice medicine?	YES	
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?		NO
7. Have you been reported to the National Practitioner's Data Bank? If yes, please submit a copy of the report.		NO
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.		NO
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?	YES	
10. Have any medical malpractice claims been made against you? See attached reporting form.		NO
11. Are you practicing in any other location other than the principal business address listed on the front of this renewal? If so, please attach a list with the secondary business address(es) and business phone number(s).	YES	

****Pursuant to RSA 125:25-c, I, please attach a list of ALL diagnostic and therapeutic services in which you have an ownership interest.** NONE

I HEREBY CERTIFY UNDER PENALTY OF PERJURY THAT ALL INFORMATION ON THIS FORM IS CURRENTLY ACCURATE. **I acknowledge that I am governed by the Medical Practice Act (RSA 329), the New Hampshire Code of Administrative Rules (Med 100-500), and the American Medical Association's Code of Medical Ethics. I have familiarized myself with these documents and acknowledge that deviation from the standards set therein may subject me to disciplinary action by the N.H. Board of Medicine.**

[redacted] June 30, 2014

Signature of Licensee (Signature Stamp Not Accepted) Date

Physician Certification

Name
Alain L. Campbell

Education
MD

Location (First city and state listed is the last known location)
Natick, MA (United States)

Certification (For a definition of a specialty or subspecialty **click here**
American Board of Obstetrics & Gynecology
Obstetrics & Gynecology - General (General indicates Primary Certif

Meeting Maintenance of Certification (MOC) Requirements
American Board of Obstetrics & Gynecology (**Learn more about Meeting Board's MOC Requi**
Obstetrics & Gynecology Yes

For some ABMS Member Boards, physicians who achieved Board Ce
Boards established their MOC programs are not required to participat
information regarding whether a specific physician is required to parti
contact the pertinent ABMS Member Board**http://www.CertificationMatt**
boards.aspx.