STATE OF CONNECTICUT

DEPARTMENT OF PUBLIC HEALTH

December 31, 2014

TO WHOM IT MAY CONCERN:

LICENSURE VERIFICATION

Please be advised that Connecticut General Statutes, certain matters involving the investigation and rehabilitation of Physician/Surgeon remain confidential. Therefore, in response to your inquiry regarding the status of the Physician/Surgeon identified below, at this time we are providing only publically disclosable information. In order for this office to confirm or deny whether there is any confidential information relevant to your inquiry, a release form from such Physician/Surgeon must be provided.

IF YOU WISH TO ESTABLISH WHETHER CONFIDENTIAL INFORMATION EXISTS CONCERNING THIS Physician/Surgeon, PLEASE HAVE HIM/HER SIGN THE REVERSE SIDE OF THIS FORM, WHICH CONSTITUTES A RELEASE FOR SUCH INFORMATION, AND RETURN IT TO THIS OFFICE. PLEASE NOTE THAT ONLY THIS DEPARTMENT'S RELEASE FORM WILL BE ACCEPTED.

This is to certify that the records of the Connecticut Department of Public Health indicate that:

DONNA D RANDALL

Was issued Connecticut:	Physician/Surgeon License
Date of Issuance:	01/14/2003
License Number:	41081
Expiration Date:	04/30/2005
Status of License:	INACTIVE, LAPSED DUE TO NON-RENEWAL
Past or Pending Disciplinary History:	No

Sincerely,

Stephen B. Carragher

Stephen B. Carragher
Health Program Supervisor
Office of Practitioner Licensing and Investigation

Printed by: Meghan Bennett

Phone: (860) 509-7603
Telephone Device for the Deaf (860) 509-7191
410 Capitol Avenue - MS # 12 APP
P.O. Box 340308 Hartford, CT 06134
An Equal Opportunity Employer

Practitioner Profile for DONNA D RANDALL, 1.041081 [view pub]

Practitioner Profile Status

Prepublication Status	None
Publication Status	Published
Pending Updates	NO

1. Physician Information [update]

License Number	41081
Effective Date	01/14/2003
Expiration Date	04/30/2005
Currently practicing medicine in CT	NO
Actively involved in patient care	NO

Practice Locations [add]

	Practice	Address	Languages	Primary?
[update]	Aspen Medical Group	1020 Bandana Blvd., West St. Paul, MN 55108	Spanish	YES

Staff Privileges [add]

Facility	Address	Start Date	End Date

2. Medical School [update]

Medical School	School of Medicine, University of Connecticut
Year of Graduation	1995

3. Post Graduate Training [add]

	Start	End	Type	Level	Hospital	Address
[update]	07/01/1996	06/30/1999	OB/GYN	Resident	Regions Hospital	St. Paul, MN UNITED STATES
[update]	07/01/1995	06/30/1996	Family Medicine	Intern	Montefiore Medical Center	Bronx, NY UNITED STATES

4. Specialty Area and Board Certification [add]

	Specialty/Subspecialty	Board Cert Date	Speciality End Date	Certifying Board
[update]	Obstetrics and Gynecology [add sub]	01/11/2002		American Board of Obstetrics and Gynecology

5. CT Medical Education Responsibility [update]

Member of faculty of a CT medical school	NO
Medical School	
Current Responsibility for graduate medical education	NO

6. Publications, Professional Services, Activities, Awards [add]

Publisher/Issuer	Title/Award Name	Date

7. Hospital Discipline [add]

Hospital	Address	Date	Discipline

8. Medical Malpractice Payments [add] [dispute]

Payment Date	Payment Category	Amount Paid	Related Practice Specialty

9. Felony Convictions [add] [dispute]

Date of Conviction	Conviction

10. CT Licensure Disciplinary Actions [dispute]

Date of Action	Action	License Status

Physician Profile Survey
Please Print or Type and Provide All Information Requested in Each Section

1. Biographical and Current Practice Information

CT License Number: 041081 Social Security No.: [redacted] - [redacted] - [redacted]

Last Name: Randall First Name: Donna MI: D

Telephone No. (Where you may be reached, 8:30 a.m.-4:30 p.m. ([redacted]) [redacted] - [redacted]

Are you currently practicing medicine in Connecticut? ☐ YES ☒ NO

Primary Practice Location-Name of Practice: Aspen Medical Group

Address: 1020 Bandana Blvd W
St. +

City, State Zip: St. Paul MN 55108

List of languages, other than English, spoken at practice location:

Spanish	

Other Practice Location(s)-Name of Practice: None

Address:

City, State Zip:

List of Languages, other than English, spoken at practice location:

Please list the Connecticut hospitals/nursing homes at which you have staff privileges:

Name/City, State	Name/City, State
None	

2. Medical School

Medical School: University of Connecticut Year of Graduation 1995

****

3. Post Graduate Training (Please list your postgraduate training)

Site: Montefiore Medical Center City: Bronx NY Country: US

Inclusive Dates: From: 7/1/95 To: 6/30/96 [X] Intern [ ] Resident [ ] Fellowship (Please check one)

Type of Training (i.e. Pediatrics, Internal Medicine): Family Practice

****

Site: Regions Hospital City: St. Paul MN Country: US

Inclusive Dates: From: 7/1/96 To: 6/30/99 [ ] Intern [X] Resident [ ] Fellowship (Please check one)

Type of Training (i.e. Pediatrics, Internal Medicine): OB/Gyn

****

Site: ______ City: ______ Country: ______

Inclusive Dates: From: __/__/__ To: __/__/__ [ ] Intern [ ] Resident [ ] Fellowship (Please check one)

Type of Training (i.e. Pediatrics, Internal Medicine): ______

****

Site: ______ City: ______ Country: ______

Inclusive Dates: From: __/__/__ To: __/__/__ [ ] Intern [ ] Resident [ ] Fellowship (Please check one)

Type of Training (i.e. Pediatrics, Internal Medicine): ______

****

Site: ______ City: ______ Country: ______

Inclusive Dates: From: __/__/__ To: __/__/__ [ ] Intern [ ] Resident [ ] Fellowship (Please check one)

Type of Training (i.e. Pediatrics, Internal Medicine): ______

****

Site: ______ City: ______ Country: ______

Inclusive Dates: From: __/__/__ To: __/__/__ [ ] Intern [ ] Resident [ ] Fellowship (Please check one)

Type of Training (i.e. Pediatrics, Internal Medicine): ______

****

4. Specialty Area/American Board Certification

Practice Specialty: OB/GyN Practice Sub-Specialty: None

(Please use the attached table of specialties and sub-specialties for a list of acceptable specialties)

Practice Specialty: ______ Practice Sub-Specialty: ______

(Please use the attached table of specialties and sub-specialties for a list of acceptable specialties)

Please list current certifications held by the American Board of Medical Specialties or the American Board of Osteopathic Medical Specialties

American Board of: OB/GyN Date Certified: 1/11/2002

American Board of: ______ Date Certified: __/__/__

American Board of: ______ Date Certified: __/__/__

****

5. Medical Educational Responsibilities (This Section is Voluntary)

Are you a member of the faculty of a Connecticut medical school? [ ] Yes [X] No

If Yes, Please indicate which one.

[ ] Yale University Medical School [ ] University of Connecticut School of Medicine

Do you have current responsibility for graduate medical education? [ ] Yes [X] No

****

6. Publications in Peer Reviewed Journals/Professional Services Offered/Activities and Awards (This Section is Voluntary, but provides you an opportunity to highlight accomplishments, ABMS Board Eligible status or special interests.) None

If you include publications or awards, please use the following format:

For publications: Include name of journal, title of article and date published.

For awards: Include name of entity issuing award, title of award, and date received.

1. ______
2. ______
3. ______
4. ______
5. ______
6. ______
7. ______
8. ______
9. ______
10. ______

7. Medical Malpractice History None

Date Resolved	Amount Paid	Practice Specialty Related To Payment

8. Hospital Discipline Within Last Ten (10) Years - In Any State None

Hospital, City, State, Country	Date	Disciplinary Action

9. Felony Convictions Within Last Ten (10) Years - In Any State None

Date of Conviction	Conviction

****

ATTESTATION

I hereby certify that to the best of my knowledge, the information contained in this profile is true and accurate and understand that providing false information may be grounds for sanction, which may include suspension or revocation of my license to practice medicine in Connecticut.

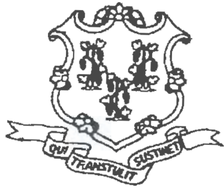
Signature

2/5/03
Date

Please return as soon as possible, but no later than 60 days from the postmarked date of this survey. You may send it via facsimile to "Physician Profiles" at (860) 509-8457 or by mail (please use the enclosed, addressed envelope) to:

Department of Public Health
Physician Profiles
410 Capitol Ave., MS # 12 APP
PO Box 340308
Hartford, CT 06134-0308

If you have questions, please contact this office at (860) 509-7557.



STATE OF CONNECTICUT

DEPARTMENT OF PUBLIC HEALTH

January 14, 2003

Donna Denise Randall MD

Dear Licensee:

I am pleased to inform you that you have met all requirements for licensure as **a Physician/Surgeon** in Connecticut. Your license number is **041081** and is effective as of the date of this letter. Your formal license will be mailed to you in the near future. Your name will appear on your license as shown above unless you notify us otherwise.

It is your responsibility to notify the Department of Public Health, Division of Health Systems Regulation, in writing, of any changes of name, residence address or business address, either within or outside Connecticut. Such notification to the Department of Public Health is required by law; failure to provide same may jeopardize the status of your license.

Please note that your license must be renewed annually during your month of birth. Renewal will be required in the first birth month which immediately follows the issuance of licensure. Failure to renew your license within ninety (90) days of the due date will result in your license becoming void. In that event, re-licensure would require a new application to the department and a review of all credentials to determine whether you satisfy current licensing requirements.

Should you have any questions or concerns regarding the renewal of your license, please contact the renewal staff at (860) 509-7603.

Respectfully,

Stephen B. Carragher

Stephen B. Carragher
Health Program Supervisor
Office of Practitioner Licensing and Certification

SC:MM

Phone: (860) 509-7603
Telephone Device for the Deaf (860) 509-7191
410 Capitol Avenue - MS # 12MQA
P.O. Box 340308 Hartford, CT 06134
An Equal Opportunity Employer
Website for licensure verification http://www.ct-clic.com

STATE OF CONNECTICUT
DEPARTMENT OF PUBLIC HEALTH

$ No 5.00

PHYSICIAN APPLICATION FOR:

✓ Initial licensure ($450)

_____ Reinstatement (Fee $450) CT License No.: __________ Date Granted: __________

PLEASE INDICATE (X) THE EXAMINATION(S) YOU COMPLETED:

	National Board of Medical Examiners (NBME)		Federation Licensing Examination (FLEX)
	State Board Licensing Exam (State) (Year Taken)		Licentiate of the Medical Council of Canada (LMCC)
X	United States Medical Licensing Examination (USMLE) Was Step 3 taken in CT? N If yes, what date		Combination of Segments (please specify)
	National Board of Osteopathic Examiners (NBOME)		

NAME: Randall (Last) Donna (First) Denisè (Middle) — (Maiden)

ADDRESS: [redacted] (Street) [redacted] (Town) [redacted] (State) [redacted] (Zip)

Please indicate below how you would like your name and address to appear on your official license. This will become your address of record for all future mailings.

NAME: Donna Denisè Randall, MD

ADDRESS: [redacted]

CITY/STATE/ZIP CODE: [redacted]

TELEPHONE NO.: (Where you may be reached 8:30-4:30, M-F) [redacted]

SOCIAL SECURITY NUMBER: [redacted] **DATE OF BIRTH:** 4/ 14/ 55

MEDICAL EDUCATION:

List name and location of medical school(s) attended — Dates of Attendance

University of Connecticut — 1987-88, 1991-95

M.D. DEGREE AWARDED BY: University of Connecticut (Name of school) **DATE AWARDED:** May 1995

MEDICAL LICENSURE:
List all states in which you have ever been licensed to practice medicine:

STATE	LIC. NUMBER	DATE ISSUED	LICENSED BY:	
			EXAM	ENDORSEMENT
MN	39856			X
SD	4679			X

SPECIALTY:

If certified by a specialty board approved by the American Board of Medical Specialties (ABMS), indicate name of American Board:

AMERICAN BOARD OF: OB/Gyn Date Certified January 2002

MEDICAL PRACTICE:

List all medical practice you have engaged in since graduation from medical school (identify internship and residency):

Hospitals Associated With	Location	Dates
Montefiore Medical Center (intern)	Bronx, NY	7/95 - 6/96
Regions Hospital (residency)	St. Paul, MN	7/96 - 6/99
Aspen Medical Group	St. Paul, MN	7/99 - present

Answer only if applying for endorsement of the Medical Council of Canada license. Have you requested a "certificate of good standing" with scores from the Medical Council of Canada? ________ **(Yes or No)**

If you are a foreign medical graduate, do you hold current Educational Commission for Foreign Medical Graduates (ECFMG) certification or have you completed a Fifth Pathway Program? _______ (Yes or No)

STATEMENT OF PROFESSIONAL HISTORY

Please answer the following questions referring to the instructions, if applicable.

YES (NO)

1. Have you ever been censured, disciplined, dismissed or expelled from, had admissions monitored or restricted, had privileges limited, suspended or terminated, been put on probation, or been requested to resign or withdraw from any of the following:
-Any hospital, nursing home, clinic, or similar institution;
-Any health maintenance organization, professional partnership, corporation, or similar health practice organization, either private or public;
-Any professional school, clinical clerkship, internship, externship, preceptorship or postgraduate training program;-Any third party reimbursement program, whether governmental or private? ___ X

If your answer is "yes", give full details, names, addresses, etc. on separate notarized statement.

2. Have you ever had your membership in or certification by any professional society or association suspended or revoked for reasons related to professional practice? ___ X

If your answer is "yes", give names of professional society or association, date and reasons your membership or certification was suspended or revoked on a separate notarized statement.

3. Has any professional licensing or disciplinary body in any state, the District of Columbia, a United States possession or territory, or a foreign jurisdiction, limited, restricted, suspended or revoked any professional license, certificate, or registration granted to you, or imposed a fine or reprimand, or taken any other disciplinary action against you? ___ X

If your answer is "yes", give full details, names, addresses, etc. on a separate notarized statement.

4. Have you ever, in anticipation or during the pendency of an investigation or other disciplinary proceeding, voluntarily surrendered any professional license, certificate or registration issued to you by any state, the District of Columbia, a United States possession or territory, or a foreign jurisdiction? ___ X

If your answer is "yes" give full details, names, addresses, etc. on a separate notarized statement.

5. Have you ever been subject to, or do you currently have pending, any complaint, investigation, charge, or disciplinary action by any professional licensing or disciplinary body in any state, the District of Columbia, a United States possession or territory, or a foreign jurisdiction or any disciplinary board/committee of any branch of the armed services? You need not report any complaints dismissed as without merit. ___ X

If your answer is "yes" give full details, names, addresses, etc. on a separate notarized statement.

6. Have you ever entered into, or do you currently have pending, a consent agreement of any whether oral or written, with any professional licensing or disciplinary body in any state, the District of Columbia, a United States possession or territory, any branch of the armed services or a foreign jurisdiction? ___ X

If your answer is "yes" give full details on a separate notarized statement and submit notarized copy of agreement.

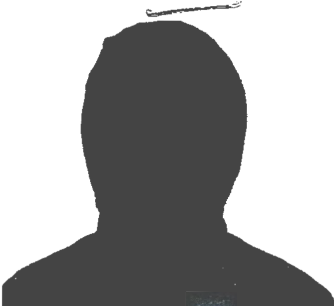
7. Have you ever been found guilty or convicted as a result of an act which constitutes a felony under the laws of this state , federal law or the laws of another jurisdiction and which, if committed within this state, would have a felony under the laws of this state? ___ X

If your answer is "yes" give full details on a separate notarized statement and furnish a Certified Court Copy (with court seal affixed) of the original complaint, the answer, the judgment, the settlement, and/or the disposition of the case.

8. Have you ever been denied or surrendered a state or federal controlled substance registration, had it revoked or restricted in any way, or been warned, reprimanded or fined by the responsible agency? ___ X

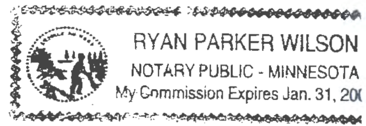
If your answer is "yes", give full details, dates, etc., on a separate notarized statement.

On this 31 day of July (month/ year) 2002 (applicant's name) personally appeared before me, who being duly sworn says that she/he is the person referred to in the foregoing application and that the photograph attached hereto is a true picture of self and that the statements made herein are true in every respect.



All of the above statements contained herein are true and correct to the best of my knowledge and belief.

SIGNATURE OF APPLICANT



Sworn to me this 31 day of July (month/ year) 2002

Mail Boxes Etc. #2105
1360 F. University Ave. V
St. Paul, MN 55104

SIGNATURE OF NOTARY PUBLIC

My Commission expires 31 Jan 05

PLEASE RETURN THIS APPLICATION AND THE FEE FOR $450 (CERTIFIED CHECK OR MONEY ORDER) MADE PAYABLE TO, **"TREASURER, STATE OF CONNECTICUT"** TO:

DEPARTMENT OF PUBLIC HEALTH
PHYSICIAN LICENSURE
410 CAPITOL AVE., MS# 12MQA
P.O. BOX 340308
HARTFORD, CT 06134-0308

IMPORTANT: The application packet for this profession consists of 10 pages, including instructions and eligibility requirements. Do not send this form and fee unless you have read and understood all pertinent information. No fees are refundable should you not be eligible for licensure.

STATE OF CONNECTICUT
DEPARTMENT OF PUBLIC HEALTH
VERIFICATION OF RESIDENCY TRAINING

APPLICANT: Enter your full name and birthdate on this form and forward it to the Chief of Staff or program director at the facility in which you completed your residency training. This form must be completed by the facility and returned directly to this office.

Applicant's name: Donna Denise Randall Date of Birth: 4-14-55

Dear Chief of Staff/Program Director:
Please provide the following verification of residency training for the above-named Connecticut physician licensure applicant.

Name of facility where residency training was completed: Regions Hospital

Dates of residency: From 7/1/96 (month/day/year) To 6/30/99 (month/day/year)

In what specialty was the residency training completed: Obstetrics and Gynecology

At what level(s) was this residency completed (PGY1, PGY2 etc.)? PGY 2, 3, 4

At the time of the applicant's training, was the residency training program in this specialty area accredited by the Accreditation Council for Graduate Medical Education? yes (YES or NO)

Did the applicant satisfactorily complete this period of residency training? yes

Do you have any derogatory information regarding the competency or conduct of this applicant? see attached If yes, please attach any disclosable documents you may have on file regarding such information.

I, Carol E. Ball, MD, being duly sworn, do depose and certify that I am the Chief of Staff/Program Director at:

Name of Facility: Regions Hospital

Address: 640 Jackson Street
St. Paul, MN 55101

Telephone Number: 651-254-1025

and that the information provided herein is true and correct to the best of my knowledge and belief.

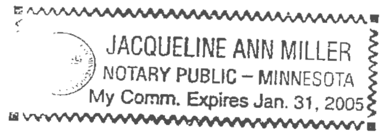
Carol E. Ball, MD
Signature of Chief of Staff/Program Director

Subscribed and sworn to me this 23 day of August (month/ year) 2002

Jacqueline Ann Miller
Notary Public's Signature

1-31-05
(My Commission Expires)

Please return this form directly to: Department of Public Health
410 Capitol Ave., MS # 12 APP
Physician Licensure
P.O. Box 340308
Hartford, CT 06134-0308



Department of Obstetrics and Gynecology
640 Jackson Street
St. Paul, MN 55101-2595
(651) 254-1025
(651) 254-1024 Fax

August 26, 2002

Department of Public Health
410 Capital Ave., MS #12 APP
Physician Licensure
P.O. Box 340308
Hartford, CT 06134-0308

To Whom It May Concern:

Donna Denise Randall, MD was a resident in the OB/Gyn training program at Regions Hospital for three years beginning in July 1996. Dr. Randall's clinical performance was outstanding and she graduated in good standing on June 30, 1999. Dr. Randall was briefly on non-academic, intradepartmental probation due anger management issues. She complied with the conditions of her probation, her behavior improved, and she was subsequently removed form probationary status. I recommend her to you as a highly knowledgeable, skilled, and compassionate physician.

Sincerely,

Carol E. Ball, MD

Carol E. Ball, M.D.
Associate Residency Program Director
University of Minnesota Twin Cities Integrated Residency
In Obstetrics, Gynecology and Women's Health

STATE OF CONNECTICUT
DEPARTMENT OF PUBLIC HEALTH
VERIFICATION OF RESIDENCY TRAINING

APPLICANT: Enter your full name and birthdate on this form and forward it to the Chief of Staff or program director at the facility in which you completed your residency training. This form must be completed by the facility and returned directly to this office.

Applicant's name: Donna Denise Randall Date of Birth: 4-14-55

Dear Chief of Staff/Program Director:
Please provide the following verification of residency training for the above-named Connecticut physician licensure applicant.

Name of facility where residency training was completed: Montefiore Medical Center

Dates of residency: From 7/1/95 (month/day/year) To 6/30/96 (month/day/year)

In what specialty was the residency training completed: Family Practice

At what level(s) was this residency completed (PGY1, PGY2 etc.)? PGY-1

At the time of the applicant's training, was the residency training program in this specialty area accredited by the Accreditation Council for Graduate Medical Education? Yes (YES or NO)

Did the applicant satisfactorily complete this period of residency training? Yes

Do you have any derogatory information regarding the competency or conduct of this applicant? No If yes, please attach any disclosable documents you may have on file regarding such information.

I, VICTORIA GORSKI, MD., being duly sworn, do depose and certify that I am the Chief of Staff/Program Director at:

Name of Facility: Montefiore Med. Cntr. - Dept. of Family Medicine + Community Health

Address: 3544 Jerome Ave.
Bronx, N.Y. 10467

Telephone Number: 718-920-5521

and that the information provided herein is true and correct to the best of my knowledge and belief.

Victoria Gorski, MD
Signature of Chief of Staff/Program Director

Subscribed and sworn to me this 7th day of August (month/year) 02

[signature]
Notary Public's Signature

ELBA IRIS CARPIO
Notary Public, State of New York
No. [illegible]
Qualified in Bronx County
Commission Expires Feb. 25, 2006
(My Commission Expires)

Please return this form directly to: Department of Public Health
410 Capitol Ave., MS # 12 APP
Physician Licensure
P.O. Box 340308
Hartford, CT 06134-0308

MINNESOTA BOARD OF MEDICAL PRACTICE

University Park Plaza 2829 University Avenue SE Suite 400 Minneapolis, MN 55414-3246
**Telephone (612) 617-2130 *Fax 612) 617-2166 *www.bmp.state.mn.us*
MN Relay Service for Hearing Impaired (800) 627-3529

August 6, 2002

Dept. of Public Health
Physician Licensure
410 Capitol Ave. MS#12APP
PO Box 340308
Hartford, CT 06134-0308

This is to certify that a standard search of the available records of the Minnesota Board of Medical Practice indicates the following:

PHYSICIAN: Donna D Randall
DATE OF BIRTH: 14-APR-1955
WAS ISSUED LICENSE NUMBER: 39856
ON: 12-JUL-1997
EXPIRATION DATE IS: 30-APR-2003
STATUS: ACTIVE
ISSUED ON THE BASIS OF: USMLE
CORRECTIVE ACTION: NONE
DISCIPLINARY ACTION: NONE

The above format is the standard format prepared for all physicians regulated by this board.

Please be advised that the Board does not release information as to whether there has been a complaint filed or an investigation conducted on individual verifications. All physicians are considered in good standing unless noted otherwise.

If other information is needed, please contact the Minnesota Board of Medical Practice.

Sincerely

D Lorsung

Denise Lorsung
Licensure Specialist

AN EQUAL OPPORYUNITY EMPLOYER
PRINTED ON RECYCLED PAPER

STATE OF CONNECTICUT
DEPARTMENT OF PUBLIC HEALTH
VERIFICATION OF LICENSURE

JUL 31 2002

Applicant- Complete the top portion of this form and forward it to each state where you have been licensed as a physician (make copies as necessary). The Medical Examining Board should complete and return the entire form to this office.

Name: Randall Donna D
Last First MI Maiden

Address [redacted]
No. & Street City State Zip Code

Original License number 4679 Date Issued ? 2000, expired 2/28/02
(in the state to which the form is being forwarded)

I hereby authorize the SD State Board of Med Ex. to furnish the Connecticut Department of Public Health the information requested below.

Signature [signature] Date 7/29/02

DO NOT WRITE BELOW THIS LINE--FOR LICENSING AGENCY USE ONLY

This is to certify that the above named individual was issued license number 4679 to practice as a physician effective

Current Status: Active ____ Inactive ____ Lapsed X

Date license expires: 3/11/02

What was the basis of licensure in your state, i.e. FLEX, NBME or a State Board Examination? USMLE Endorsement If a State Board Examination was given, please attach a listing of the subjects areas and the score received in each.

Has this individual ever been subject to disciplinary action of any type or is this individual currently the subject of a pending disciplinary action or unresolved complaint? YES ___ NO X. If yes, please forward all publicly disclosable information regarding the individual's status and the basis for same. Please advise this office if you require a consent for release of this information from the applicant.

SEAL Signed: [signature] Title Admnt Assnt
State: South Dakota Date 8/9/02
Telephone Number: 6053348343

PLEASE RETURN FORM TO: DEPARTMENT OF PUBLIC HEALTH
PHYSICIAN LICENSURE
410 CAPITOL AVE., MS# 12APP
P.O. BOX 340308
HARTFORD, CT 06134-0308

STATE OF CONNECTICUT
DEPARTMENT OF PUBLIC HEALTH
DISCIPLINARY INQUIRY

APPLICANT: Please complete and sign this inquiry form and forward it to the Federation of State Medical Boards, at the address shown below.

Federation of State Medical Boards
400 Fuller Wiser Road
Euless, TX 76039

The Connecticut Department of Public Health requests a disciplinary search concerning the following individual:

Randall — Donna — D. — MD
LAST NAME — FIRST NAME — MI — DEGREE

[redacted]
STREET ADDRESS

[redacted] — [redacted] — [redacted]
CITY — STATE — ZIP

4-14-55 — 1955/April/14
DATE OF BIRTH — (YEAR/MONTH/DAY)

[redacted]
SOCIAL SECURITY NUMBER

University of Connecticut
MEDICAL SCHOOL OF GRADUATION (include complete name and branch location)

May 1995 — U.S.
DATE OF GRADUATION — COUNTRY OF MEDICAL SCHOOL

ECFMG NUMBER (if foreign medical graduate)

[signature]
APPLICANT SIGNATURE

Please mail the response directly to:

Department of Public Health
Physician Licensure
410 Capitol Ave., MS# 12 APP
P.O. Box 340308
Hartford, CT 06134-0308

WE HAVE NO UNFAVORABLE INFORMATION REGARDING THE ABOVE NAMED PHYSICIAN

AUG - 6 2002

[signature]
DALE L. AUSTIN
DEPUTY EXECUTIVE VICE PRESIDENT AND CHIEF OPERATING OFFICER