2012 Renewal

BOX 1

SOC. SEC. NO xxx
IF SOC. SEC. NO. IS [illegible] RENT THAN ABOVE
PL[illegible] [illegible]ELOW

TYPE 01

IF YOU DO NOT HAVE A S.S.N., INDICATE REASON

____ APP. FOR NO. PENDING

____ NOT U.S. CITIZEN ____ OTHER ____

BOX 2 Make Any Changes or Corrections in Box 4

0000259 FP **PRSRT T3 0 1563 06001
JANICE L. LEE, MD
29 RIVER MEAD
AVON CT 06001

Check appropriate address box: ☐ Office ☐ Residence

STATE OF CONNECTICUT
DEPARTMENT OF PUBLIC HEALTH
POST OFFICE BOX 1080 HARTFORD, CT 06143-1080

BOX 3 YOU MUST RENEW YOUR LICENSE/CERTIFICATE BY THE DUE DATE INDICATED.

RENEWAL FEE: $565.00 DUE DATE 01/31/13

LICENSE/CERTIFICATE NUMBER 020580

Profession PHYSICIAN/SURGEON

BOX 4 Print or Type Changes in Space Provided At The Right.

LAST NAME (101)

FIRST NAME (102) MI (103)

ADD 1 (111)

ADD 2 (112)

ADD 3 (113)

CITY (114) ST (115)

ZIP (116) COUNTRY

44020580015650001312013000691465 26

INSTRUCTIONS: Answer each question, read the statements that follow as they relate to your license, and sign and date below.

1. Within the last year have you been convicted of a felony or have you had any disciplinary action taken against you or have any such actions pending by another state's licensing authority? NO ✓ YES ____
2. Are you presently working in your licensed/certified profession in Connecticut? NO ____ YES ✓ Hours of Practice Per Week: 20
   Are you actively involved in direct patient/client care? NO ____ YES ✓
3. What is the address of your primary place of employment? Provide Name: Hartford Gyn Center
   Street: 1 Main St City: Hartford State: CT Zip: 06001
   Type of Agency: Clinic Phone: 860-525-1900
4. What is the address of your residence? Street: 29 River mead
   City: Avon State: CT Zip: 06001 Phone: 860-678-7058 Email: Janice51d@comcast.net

↓ DO NOT WRITE IN THIS AREA ↓

020005 0014 0027 01 020580 0056500 112612 S

5. If an optometrist, are you qualified to hold yourself out as authorized to practice advanced optometric care? NO ____ YES ____
6. If certified in a lead or asbestos discipline, verification of annual refresher training should be submitted to the department by the course instructor or your certificate will not be renewed.
7. Continuing education is mandatory for many professions. As a licensee/certificate holder, you are responsible for familiarizing yourself with the current laws and regulations regarding your profession. You may access this information online at www.ct.gov/dph/license. Advanced Practice RNs and PAs must maintain certification from the national certifying body that qualified them for initial licensure in order to renew such license. By signing this application, you are attesting that you are in compliance with current continuing education requirements, mandatory certification requirements, if applicable and that you are familiar with the laws and regulations governing your profession.
8. Many practice acts require that a licensee/certificate holder providing direct patient care services must maintain professional liability insurance or other indemnity against liability for professional malpractice, in accordance with CT General Statutes. You may find information regarding your profession online at www.ct.gov/dph/license. By signing this application, you are attesting that you are in compliance with mandatory malpractice insurance coverage requirements appropriate to your profession.

I have reviewed the information provided and requested on this form. I verify that it is accurate and that I satisfy the requirements as they apply to my license/certificate.

Janice L. Lee MD
Signature

11/23/12
Date

Renewal - 1.020580

Name	JANICE L LEE
Credential	1.020580

Fee Details

Fee Increase Effective 7/12/13	$5.00
Renewal Application Fee	$565.00
	$570.00

Demographic Information

1. First Name
   JANICE

2. Middle Initial

3. Last Name
   LEE

4. Personal Suffix

5. Maiden Name

6. Please provide your Date of Birth.
   01/11/1951

7. Gender
   Female

8. Ethnicity: Please choose one:
   Not Hispanic or Latino

9. Race
   White

Workforce Survey Introduction

Dear Licensee:

Thank you for renewing your license online.

The purpose of the next several questions is to allow the Department of Public Health to collect valuable workforce data that is currently unavailable but critical in identifying and addressing healthcare workforce shortage issues.

Thank you for assisting the Department in this important initiative.

Current Workforce Status in Medicine

10. What is your current work status in Medicine?
    Part-time (less than 30 hours per week)

Workforce Survey

11. In the next 12 months, do you plan to (please mark all that apply):

12. If you are **NOT** working in your licensed profession, please indicate your plans for returning to work in your licensed field.

13. Please provide the number of hours per week that you provide DIRECT PATIENT CARE in your primary professional position.

If you do not provide hours in this category, please indicate 0.
15

14. Please provide the number of hours per week that you work as an ADMINISTRATOR/MANAGER in your primary professional position.

If you do not provide hours in this category, please indicate 0.
0

15. Please provide the number of hours per week that you work as an EDUCATOR/FACULTY in your primary professional position. If you do not provide hours in this category, please indicate 0.
0

16. Please provide the number of hours per week that you work as a RESEARCHER in your primary professional position. If you do not provide hours in this category, please indicate 0.
0

17. If your primary profesional position is in a category other than those above, please provide that category in the box below and indicate the number of hours per week.

If you do not provide hours in this category, please indicate 0.
0

18. Please indicate the setting of your primary professional employment.

Enter comments if "Other" is selected.
Outpatient Clinic

Practice Location

If you are providing direct patient care, please identify the location of the primary site where you spend the most time providing direct patient care.

19. Address 1
1 Main St., Suite N1

20. Address 2

21. City
Hartford

22. State
Connecticut

23. Zip Code
06106

Primary Source of Payment

What percent of your patients have the following source of Payment?

24. Medicare
less than 10%

25. Medicaid
76 - 100%

26. Self-Pay
    11 - 25%

27. Private Insurance
    11 - 25%

28. Other
    None

Attestation

29. Have you been convicted of a felony since your last application?
    No

30. If yes, please provide details here

31. Have you had any disciplinary action taken against you or any such actions pending by another State's licensing/certification authority since your last application?
    No

32. If yes, please provide details here

By completing this renewal online, I verify that all the information I have provided is accurate and that I satisfy the renewal requirements that apply to my license.

33. I attest that on this date I completed this renewal application online and that all of the statements made by me on this renewal are accurate.
    12/10/2013

Important Note

Please note that you will receive your new licensing documents (2 wallet-sized cards and 1 suitable for posting) during the third week of next month.

To continue processing your renewal, please click "Next" below (read the rest of this information first).

On the review screen, click **"Add to Invoice."**

On the top right of the invoice screen, select **"Pay Invoice".**

Thank you for processing your renewal online.

Review

Practitioner Profile for JANICE L LEE, 1.020580 [view pub]

Practitioner Profile Status

Prepublication Status	None
Publication Status	Published
Pending Updates	NO

1. Physician Information [update]

License Number	20580
Effective Date	08/01/1978
Expiration Date	01/31/2015
Currently practicing medicine in CT	YES
Actively involved in patient care	YES

Practice Locations [add]

	Practice	Address	Languages	Primary?
[update]	HARTFORD GYN CENTER	1 MAIN STREET HARTFORD, CT 06070		YES

Staff Privileges [add]

	Facility	Address	Start Date	End Date
[update]	HARTFORD HOSPITAL			
[update]	SAINT FRANCIS HOSPITAL AND MEDICAL CENTER			

2. Medical School [update]

Medical School	ALBANY MEDICAL COLLEGE
Year of Graduation	1974

3. Post Graduate Training [add]

	Start	End	Type	Level	Hospital	Address
[update]	07/01/1985	06/30/1987	OB/GYN	Fellowship	MT SINAI HOSPITAL	HARTFORD, CT UNITED STATES
[update]	07/01/1975	06/30/1978	OB/GYN	Resident	HARTFORD HOSPITAL	HARTFORD, CT UNITED STATES
[update]	07/01/1974	06/30/1975	Internal Medicine	Intern	BERKSHIRE MEDICAL CENTER	PITTSFIELD, MA 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]**	12/01/1984		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]

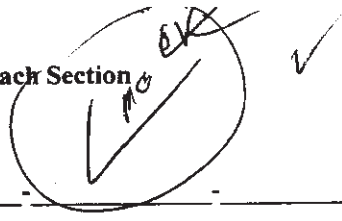
Payment Date	Payment Category	Amount Paid	Related Practice Specialty

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

. *Biographical and Current Practice Information*

CT License Number: 020580 Social Security No.: ______-______-______

Last Name: Lee ~~Janice~~ First Name: Janice MI: L

Telephone No. (Where you may be reached, 8:30 a.m.-4:30 p.m. (860) 525-1900

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

Primary Practice Location-Name of Practice: Hartford Gyn Center

Address: 1 Main St.
Hartford, CT 06070

City, State Zip: Hart ford, CT 06070

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

Other Practice Location(s)-Name of Practice:

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
Hartford Hospital	
St. Francis Hospital	

2. Medical School

Medical School: Albany Medical College Year of Graduation 1974

****

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

Site: Berkshire Medical Center City: Pittsfield, Mass Country: USA

Inclusive Dates: From: 7/1/74 To: 6/31/75 ☑ Intern ☐ Resident ☐ Fellowship (Please check one)

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

****

Site: Hartford Hospital City: Hartford, CT Country: USA

Inclusive Dates: From: 7/1/7~~8~~5 To: 6/31/78 ☐ Intern ☑ Resident ☐ Fellowship (Please check one)

Type of Training (i.e. Pediatrics, Internal Medicine): Obstetrics- gynecology

****

Site: ______ City: ______ Country: ______

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

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

****

Site: Mt. Sinai Hospital City: Hartford, CT Country: USA

Inclusive Dates: From: 7/1/85 To: 6/31/87 ☐ Intern ☐ Resident ☑ Fellowship (Please check one)

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

****

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: Obstetrics & Gynecology Practice Sub-Specialty: ______

(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: Obstetrics & Gynecology Date Certified: Dec/1/1984

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 ☐ 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 ☐ 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.)

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.

Janice Lee MD 2/21/00

Signature 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

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