STATE OF CONNECTICUT

DEPARTMENT OF PUBLIC HEALTH

February 13, 2015

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:

JONATHAN FOSTER MD

Was issued Connecticut:	Physician/Surgeon License
Date of Issuance:	05/27/1994
License Number:	33753
Expiration Date:	03/31/2016
Status of License:	APPROVED, PRINT LICENSE
Past or Pending Disciplinary History:	No

Sincerely,

Stephen B. Carragher

Stephen B. Carragher
Public Health Services Manager
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

STATE OF CONNECTICUT

DEPARTMENT OF PUBLIC HEALTH

STATE OF CONNECTICUT

DEPARTMENT OF PUBLIC HEALTH

CONSENT FOR RELEASE OF CONFIDENTIAL RECORDS

This is to certify that I hereby give my consent and authorize the Department of Public Health to confirm the existence of any pending petitions and to release any records of disciplinary action maintained by that department (with the exception of any documents identified below) to:

SEND VERIFICATION TO:
(Company Name and Address) _____

_____

_____

_____

I understand that these records are confidential pursuant to the provisions of Connecticut General Statutes 20-13e and may not be disclosed without my permission. This information will only be disclosed when this release is executed by me. I also understand that if I am a participant in a rehabilitation program sponsored by a county medical association or by the Connecticut State Medical Society that I have the right to contact the association or society prior to signing this release. Please honor a mechanically reproduced copy of this release.

Documents the department is not authorized to release include:

_____ _____

Signature Date

JONATHAN FOSTER MD Lic. No.:

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

Renewal - 1.033753

Name	JONATHAN FOSTER MD
Credential	1.033753

Fee Details

Renewal Application Fee	$570.00
	$570.00

Demographic Information-Renewal

1. First Name
   JONATHAN

2. Middle Initial

3. Last Name
   FOSTER

4. Maiden Name

5. Please provide your Date of Birth.
   03/08/1954

6. Gender
   Male

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

8. 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

9. What is your current work status in Medicine?
   Full Time - (30 hours or more per week)

Workforce Survey

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

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

12. 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.

60

13. 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.
1

14. 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

15. 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

16. 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.

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

Enter comments if "Other" is selected.
Physician Partmership

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.

18. Address 1
60 Westwood Ave

19. Address 2
Suite 100

20. City
Waterbury

21. State
CT

22. Zip Code
06708

Primary Source of Payment

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

23. Medicare
11 - 25%

24. Medicaid
26 - 50%

25. Self-Pay
less than 10%

26. Private Insurance

26 - 50%

27. Other
less than 10%

Connecticut Prescription Monitoring and Reporting System

All prescribing practitioners possessing a Connecticut controlled substance registration (CSP) issued by the Connecticut Department of Consumer Protection (DCP) must register with the Connecticut Prescription Monitoring and Reporting System (CPMRS) online at www.ctpmp.com.

After you have completed this transaction, please visit the DCP's website at www.ct.gov/dcp and select 'Programs & Services' then 'Prescription Monitoring Program' for information regarding registration.

28. I acknowledge that I have read the information regarding registration in the Connecticut Prescription Monitoring and Reporting System.
02/12/2015

Attestation

29. Within the last year, have you been convicted of a felony?
No

30. If yes, please provide details here

31. Within the last year, have you had any disciplinary action taken against you or any such actions pending by another State's licensing/certification authority?
No

32. If yes, please provide details here

33. **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.**
02/12/2015

34. 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.
02/12/2015

Important Note

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".**

PLEASE NOTE THAT WHEN ENTERING YOUR CREDIT CARD NUMBER, DO NOT ENTER SPACES OR DASHES AS IT WILL RESULT IN A FAILED TRANSACTION.

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.

Thank you for processing your renewal online.

Review

Renewal - 1.033753

Name	JONATHAN FOSTER MD
Credential	1.033753

Fee Details

Renewal Application Fee	$570.00
	$570.00

Demographic Information

1. First Name
   JONATHAN

2. Middle Initial
   T

3. Last Name
   FOSTER

4. Personal Suffix
   MD

5. Maiden Name

6. Please provide your Date of Birth.
   03/08/1954

7. Gender
   Male

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

9. Race
   White

Workforce Survey Introduction

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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?
    Full Time - (30 hours or more per week)

Workforce Survey

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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.
60

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.
2

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.
Group Practice-Owner/Operator

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
60 Westwood Ave

20. Address 2
Suite 100

21. City
Wetwerbury

22. State
CT

23. Zip Code
06708

Primary Source of Payment

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

24. Medicare
less than 10%

25. Medicaid
26 - 50%

26. Self-Pay

less than 10%

27. Private Insurance
26 - 50%

28. Other
less than 10%

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.
02/12/2014

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

Credential Profile - 1.033753

This profile contains information that may be used as a starting point in evaluating a health care provider. This profile should not, however, be the sole basis for selecting a health care provider. Please direct questions and comments about this profile to: Connecticut Department of Public Health, Physician Profiles, 410 Capitol Ave., M.S. 12 APP, P.O. Box 340308, Hartford, CT 06134-0308, oplc.dph@ct.gov.

Name JONATHAN FOSTER MD
Credential 1.033753

Current Practice Locations

1. Are you currently practicing medicine in Connecticut?
   Yes

2. Are you actively involved in Patient Care?
   Yes

3. Enter your practice locations

Practice Name	Address 1	Address 2	Address 3	City	State	Zip Code	Primary Practice	Languages Spoken at this Location
Center For Women's Health	1389 W. Main St., Suite 320			Waterbury	Connecticut	06708	Yes	Spanish

Connecticut Staff Privileges

4. Indicate the Connecticut Hospitals or Nursing Homes for which you have Staff privileges.

Facility Name	City	State
WATERBURY HOSPITAL		
SAINT MARY'S HOSPITAL, INC.		

Medical School

5. Medical School
   Yale University School Of Medicine

6. Enter the Year of Graduation from Medical School
   1990

Post Graduate Training

7. List your postgraduate training:

Site Name	City	State	Country	Start Date	End Date	Level	Type
Brigham and Women's Hospital	Boston	Massachusetts	UNITED STATES	07/01/1991	06/30/1994	Resident	
Brigham and Women's Hospital	Boston	Massachusetts	UNITED STATES	07/01/1990	06/30/1991	Intern	

Specialty Area/American Board Certification

This physician has reported the Certification information below. For more information regarding Board Certification please contact:

- *The American Board of Medical Specialties at www.abms.org, or*
- *The American Osteopathic Association at www.am-osteo-assn.org.*

8. Please indicate practice specialties, subspecialties and the date you were certified by ABMS or ABOMS.

Specialty	Subspecialty		Certifying Board	Certification Date
Obstetrics and Gynecology	Subspecialty	Certification Date	American Board of Obstetrics and Gynecology	11/07/1997

Medical Education Responsibilities

9. Are you a member of the faculty of a Connecticut medical school?
No

10. Select the state medical schools at which you are a member of the faculty.

11. Do you have current responsibility for graduate medical education?
No

Publications, Professional Services, Activities, and Awards

12. Publications, Professional Services, Activities, and Awards

Publisher/Issuer	Title/Award Name	Date

Medical Malpractice Information

13. Indicate your malpractice insurance carrier:

14. Indicate the Medical Malpractice Payments you have made within the past ten years.
Some studies have shown that there is no significant correlation between malpractice history and a physician's competence. At the same time, consumers should have access to malpractice information. This profile contains information about the malpractice payment history of the physician. Payment amounts have been placed into three statistical categories: below average, average and above average. To make the best health care decisions, you should view this information in perspective. You could miss an opportunity for high quality care by selecting a doctor based solely on malpractice history.

When considering malpractice data, please keep in mind:

- *Malpractice histories tend to vary by specialty. Some specialties are more likely than others to be the subject of litigation. This report compares physicians only to the members of their specialty, not all physicians, in order to make an individual physician's history more meaningful.*
- *This malpractice information reflects data for the last 10 years of the physician's practice. For physicians practicing less than 10 years, the data covers their total years of practice. You should take into account how long the doctor has been in practice when considering malpractice averages.*
- *The incident causing the malpractice claim may have happened years before payment is finally made. Sometimes it takes a long time for a malpractice lawsuit to move through the legal system.*
- *Some physicians work primarily with high-risk patients. These physicians may have malpractice histories that are higher than average because they specialize in cases or patients who are at very high risk of problems.*
- *Settlement of a claim may occur for a variety of reasons that do not necessarily reflect negatively on the professional competence or conduct of the physician. A payment in settlement of a medical malpractice action or claim should not be construed as creating a presumption that medical malpractice has occurred. For example, an insurer may choose to settle a case even if the physician opposes such settlement.*

You may wish to discuss the information provided in this report, and malpractice generally, with your physician.

Payments made by or on behalf of this healthcare provider:

Resolved Date	Payment Category	Specialty
09/09/2011	Average	Obstetrics and Gynecology
09/06/2005	Average	Obstetrics and Gynecology

Connecticut Hospital Discipline

This section contains categories disciplinary actions taken by hospitals during the past ten years which are specifically required by law to be released in the physician's profile.

16. Hospital Discipline

Hospital Name	City	State	Country	Discipline Date	Disciplinary Action

Other State License

18. Indicate States outside of CT where licenses are held.

State	Disciplinary Action

Connecticut Licensure Disciplinary Actions

19. The following lists any past disciplinary actions taken against this licensee. If there is no data present, there have been no disciplinary action taken.

Date of Action	Action	License Status

Felony Convictions

20. Felony Convictions within the previous ten years.

Conviction Date	Conviction

Profile 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 revocation of my license to practice medicine in Connecticut.

21. Enter the date.

Review

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

1K

1. Biographical and Current Practice Information

CT License Number: 033753 Social Security No.: [redacted]

Last Name: Foster First Name: Jonathan MI: T

Telephone No. (Where you may be reached, 8:30 a.m.-4:30 p.m. (203) 754 - 5129

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

Primary Practice Location-Name of Practice: Center for Women's Health

Address: Suite 320
1889 W. Main St.
Waterbury CT

City, State Zip: ~~064~~ 06708

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

Spanish	

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
Waterbury Hospital / Waterbury CT	
St Mary's Hospital / Waterbury CT	

2. Medical School

Medical School: Yale University School of Medicine Year of Graduation 1990

****

: received.

Practice Specialty Related To Payment

Gynecology

ate **Disciplinary Action**

Conviction

****

ITION

ed in this profile is true and accurate and understand that providing
ision or revocation of my license to practice medicine in Connecticut.

2/1/00
Date

narked date of this survey. You may send it via facsimile to
d, addressed envelope) to:

ublic Health
Profiles
, MS # 12 APP
40308
T 06134

Training (Please list your postgraduate training)

d/ Brigham + Women's Hospital City: Boston MA Country: USA

From: 6/25/90 To: 6/25/91 ☒ Intern ☐ Resident ☐ Fellowship (Please check one)

(i.e. Pediatrics, Internal Medicine): OB/GYN/SURGERY/INT MED/PEDS

****

d/ Brigham + Women's Hospital City: Boston MA Country: USA

From: 6/26/91 To: 6/25/94 ☐ Intern ☒ Resident ☐ Fellowship (Please check one)

(i.e. Pediatrics, Internal Medicine): OB/GYN

****

__________ City: __________ Country: __________

From: ___/___/___ To: ___/___/___ ☐ Intern ☐ Resident ☐ Fellowship (Please check one)

(i.e. Pediatrics, Internal Medicine): __________

****

__________ City: __________ Country: __________

From: ___/___/___ To: ___/___/___ ☐ Intern ☐ Resident ☐ Fellowship (Please check one)

(i.e. Pediatrics, Internal Medicine): __________

****

__________ City: __________ Country: __________

From: ___/___/___ To: ___/___/___ ☐ Intern ☐ Resident ☐ Fellowship (Please check one)

(i.e. Pediatrics, Internal Medicine): __________

****

__________ City: __________ Country: __________

From: ___/___/___ To: ___/___/___ ☐ Intern ☐ Resident ☐ Fellowship (Please check one)

(i.e. Pediatrics, Internal Medicine): __________

****

a/American Board Certification

y: __________ Practice Sub-Specialty: __________

le of specialties and sub-specialties for a list of acceptable specialties)

ty: __________ Practice Sub-Specialty: __________

le of specialties and sub-specialties for a list of acceptable specialties)

nt certifications held by the American Board of Medical Specialties or the American Board of Osteopathic Medical Specialties

d of: Obstetrics + Gynecology Date Certified: 11 / 7 / 97

d of: __________ Date Certified: ___/___/___

d of: __________ Date Certified: ___/___/___

****

ucational Responsibilities (This Section is Voluntary)

ber of the faculty of a Connecticut medical school? ☐ Yes ☒ No

ndicate which one.

☐ Yale University Medical School ☐ University of Connecticut School of Medicine

urrent responsibility for graduate medical education? ☐ Yes ☒ No

****

s in Peer Reviewed Journals/Professional Services Offered/Activities and Awards (This Section is Voluntary, but provides unity to highlight accomplishments, ABMS Board Eligible status or special interests.)

publications or awards, please use the following format: "Journal of Gynecologic Surgery" "Abdominal Hysterectomy and

Electronic file

MAL-

Please fill in the following information:

Publications in peer-reviewed journals (name of journal, title of article and date published)
Professional Awards (name of entity issuing award, title of award, date received)

1. Journal of Gynecologic Surgery Vol 11, No 1 (1995)
2. "Abdominal Hysterectomy and Abdominal
3. Myomectomy: A Comparison of Preoperative
4. Demographics and Postoperative Morbidity"
5.
6.
7.
8.
9.
10.

MEDICAL MALPRACTICE HISTORY

Date Resolved	Amount Paid	Date Resolved	Amount Paid

HOSPITAL DISCIPLINE WITHIN LAST 10 YRS (in any state)

Hospital, City, State, Country	Date	Disciplinary Action

FELONY CONVICTIONS WITHIN LAST TEN YEARS (In any state)

Date of Conviction	Conviction

.....

ATTESTATION

I have reviewed the information provided in my PWH/WHC credentialing file, and attest to its accuracy. 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

Jonathan T. Foster MD

2/28/00

date

33753

STATE OF CONNECTICUT

DEPARTMENT OF PUBLIC HEALTH AND ADDICTION SERVICES

BUREAU OF HEALTH SYSTEM REGULATION

MAY 27, 1994

JONATHAN T FOSTER, MD
50 IRVING STREET
NEWTON CTR MA, 02159

Dear Doctor Foster:

On behalf of the Department of Public Health and Addiction Services, I want to congratulate you upon the successful completion of all requirements for licensure as a Medical Doctor in the State of Connecticut.

Connecticut medical license 033753 has been issued to you, effective the date of this letter. You are eligible to begin the practice of medicine as of this date.

You will receive your license certificate in about eight (8) weeks, by certified mail, at the address shown above. Full instructions regarding future renewal will also be enclosed.

It is your responsibility to notify the Department of Public Health and Addiction Services, Licensure and Registration Section, in writing of any future changes of name and/or address, as well as the establishment of professional locations, either within or outside Connecticut. Such notification to the Department of Public Health and Addiction Services is required by law, and failure to provide same will jeopardize the status of your license.

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. In order to avoid such a process, be sure that you renew your license in a timely manner each year in the month of your birth.

Connecticut General Statutes, Chapter 370, Section 20-13d, effective October 1, 1990, requires that a physician report to the Department any disciplinary action taken against him/her by a duly authorized professional disciplinary agency of any other state, the District of Columbia, a United States possession or territory, or a foreign jurisdiction, within thirty days of such action. Failure to so report may constitute a ground for disciplinary action againist the Connecticut license under section 20-13c.

I wish you success in your medical career.

Respectfully,

Joseph J. Gillen, Ph.D
Section Chief
Applications, Examinations and Licensure

JJG:cas
0683V

Phone: *TDD: 203-566-1279*
150 Washington Street — Hartford, CT 06106
An Equal Opportunity Employer

STATE OF CONNECTICUT

DEPARTMENT OF REVENUE SERVICES

ALLAN A. CRYSTAL
COMMISSIONER

October 1993

Dear Licensee:

As part of the process of assuring the fair and equitable sharing of the state tax burden, the 1993 General Assembly passed An Act Concerning the Disclosure of Information Maintained by Public Agencies to the Commissioner of Revenue Services and the Discouragement of Tax Evasion by Nonresident Construction Contractors Working at Connecticut Construction Sites (Public Act 93-228).

This bill requires all state agencies who issue licenses and permits to collect the licensee's federal employer identification number or social security number, and provide the Department of Revenue Services with this information. The Department will utilize this information in the administration and collection of state taxes.

Thank you for your cooperation in this matter.

Very truly yours,

A. A. Crystal

Allan A. Crystal
Commissioner of Revenue Services

Taxpayer Information; 1-800-321-7829 or 566-8520

DEAR LICENSURE APPLICANT:

PLEASE RECORD, IN THE APPROPRIATE SPACES, YOUR SOCIAL SECURITY NUMBER (SS#) AND/OR YOUR FEDERAL EMPLOYER IDENTIFICATION NUMBER (FEIN).

SS# [redacted]

FEIN _ _ _ _ _ _ _ _ _

IF YOU DO NOT PROVIDE AT LEAST ONE OF THE ABOVE NUMBERS, PLEASE INDICATE THE REASON FOR NOT REPORTING BY PLACING A CHECK MARK IN THE APPROPRIATE SPACE BELOW:

1. ___ **SS/FEIN APPLICATION PENDING**
2. ___ **RESIDENT ALIEN**
3. ___ **NON-U.S. RESIDENT**
4. ___ **OTHER (EXPLAIN)** _____

_____

_____

FOR OFFICE USE ONLY: DATE REC'D 4/21/94
TS# 94-181

STATE OF ~~CONNECTICUT~~
DEPARTMENT OF PUBLIC HEALTH AND ADDICTION SERVICES
BUREAU OF HEALTH SYSTEM REGULATION

04/21/94 TR # 111313
OPER MLB TS # 94-181
M D AP 4001-3517
RCVD $450.00 CHK

PHYSICIAN'S APPLICATION FOR LICENSURE WITHOUT EXAMINATION
FEE: $450.00

I hereby apply to the Department of Public Health and Addiction Services for licensure without examination to practice medicine in the State of Connecticut by: (Please check one

A. [X] Endorsement of my certificate issued by the National Board of Medical Examiners
Certificate #: _____ Date: _____

B. [ ] Endorsement of my certificate issued by the Federation of State Medical Boards of the United States. STATE: _____ DATE: _____

C. [ ] Endorsement of my license issued after written examination by the licensing authority named below: STATE: _____ DATE: _____

D. [ ] Endorsement of my license issued after written examination by the Medical Council of Canada. DATE: _____

* *

1. FULL NAME: Jonathan Todd Irving Foster
(first) (middle) (maiden) (last)

PRESENT ADDRESS: 50 Irving Street Newton Ctr. MA 02159
(street) (town) (state) (zip)

TELEPHONE NO.: (Where you can be reached 8:30 - 4:30, Monday - Friday) 617 ~~965~~ 732 6987

PLACE OF BIRTH: New Haven CT (town, state or country) DATE OF BIRTH: 3/8/54 month/day/year

SOCIAL SECURITY NUMBER: [redacted]

2. PREMEDICAL EDUCATION:

LIST NAMES AND LOCATIONS OF ALL INSTITUTIONS ATTENDED	DATE ENTER (Mo. Yr.)	DATE DEPART (Mo Yr.)
Cornell College Mt. Vernon IA	9/72	11/75
Pace University Pleasantville NY	9/82	5/85

OFFICE USE ONLY:
License Number: 033753 Effective Date: 5/27/94

9852V44 10/93

3. MEDICAL EDUCATION:
LIST NAMES AND LOCATIONS OF ALL INSTITUTIONS ATTENDED | DATE ENTER (Mo. Yr.) | DATE DEPART (Mo. Yr.)

Yale Univ. School of Medicine New Haven CT 8/86 — 5/90

Doctor of Medicine Degree Awarded by: Yale Univ (Name of School) Date Awarded: May '90 (Month/Yr.)

4. MEDICAL LICENSURE:
LIST ALL STATES IN WHICH YOU HAVE EVER BEEN LICENSED TO PRACTICE MEDICINE:

STATE	LIC. NUMBER	DATE LICENSED ISSUED	LICENSED BY: Exam	Endorsement
Massachusetts	75815	4/92		X

5. MEDICAL PRACTICE:
LIST ALL MEDICAL PRACTICE YOU HAVE ENGAGED IN SINCE GRADUATION FROM MEDICAL SCHOOL (IDENTIFY INTERNSHIP AND RESIDENCY):

HOSPITALS ASSOCIATED WITH	LOCATION (ADDRESS)	DATE ENTERED (Mo. Yr.)	DATE DEPART (Mo. Yr.)
Internship Brigham + Women's (BWH) Hospital	75 Francis St Boston	6/90	6/91
Residency BWH, Boston	Francis St Boston	6/91	6/94
Mass General Hospital	Fruit St Boston		
Preterm Health Services	842 Beacon St Boston	6/92 —	6/94
Women's Health Services	1852 Boylston St Boston	9/93 -	6/94

6. SPECIALTY:
IF CERTIFIED BY A SPECIALTY BOARD APPROVED BY THE AMERICAN BOARD OF MEDICAL SPECIALTIES, INDICATE NAME OF AMERICAN BOARD:

AMERICAN BOARD	DATE CERTIFIED
	(99)

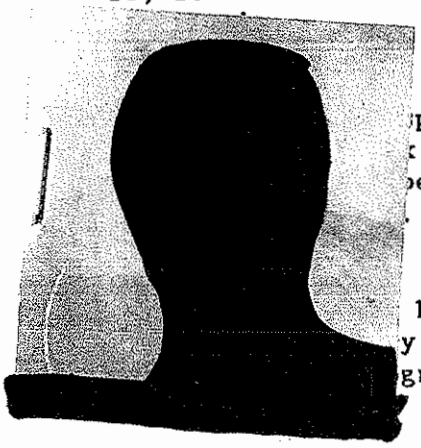
7. Answer ONLY if applying for endorsement of Medical Council of Canada license.
Have you requested a "Certificate of Standing" with scores from the Medical Council of Canada? _____

STATEMENT OF PROFESSIONAL HISTORY

Please answer each question below. If you answer yes to any question, please refer to attached instructions.

	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
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
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
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
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
6. Have you ever entered into, or do you currently have pending, a consent agreement of any kind, 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
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 constituted a felony under the laws of this state?		X
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

Pursuant to Public Law 100-93, the Federal Government requires all states to report disciplinary actions to the Inspector General for Health and Human Services or risk losing Federal medicaid contributions. Although the disclosure of your social security number on this application is voluntary, Public Law 100-93 also requires the Department of Public Health and Addiction Services to request the disclosure of your number as data that would then be available to the National Practitioner Data Bank in the event that disciplinary action should be taken against your Connecticut license. You are not required by any law to disclose your social security number, but should you decide to do so, it will be used for identification purposes only, including verifying and retrieving



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

Signature of Applicant Date 4/4/94

State of Connecticut)
County New Haven)ss

On this 18 day of April 1994, Jonathan Foster (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.

Signature of Applicant

Sworn to before me this 18 day of April 1994.

Signature of Notary Public

My Commission expires 6-30-98.

1. If your answer is "yes", give full details, names, addresses, etc. on separate notarized statement.
2. 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. If your answer is "yes", give full details, names, addresses, etc. on a separate notarized statement.
4. If your answer is "yes" give full details, names, addresses, etc. on a separate notarized statement.
5. If your answer is "yes" give full details, names, addresses, etc. on a separate notarized statement.
6. If your answer is "yes" give full details on a separate notarized statement and submit notarized copy of agreement.
7. 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 judgement, the settlement, and/or the disposition of the case.
8. If your answer is "yes", give full details, dates, etc. on a separate notarized statement.

Yale University

SCHOOL OF MEDICINE
Office of the Dean
333 Cedar Street
P. O. Box 3333
New Haven, Connecticut 06510

To Whom It May Concern:

It is not the policy of this School to grade its students, and numerical standings are not determined. The performance of our students is carefully evaluated and reported by the faculty. All students must also pass the Part I and Part II examinations of the National Board of Medical Examiners as a threshold requirement for graduation.

Gerard N. Burrow, M.D.
Dean

Yale University

Office of the Registrar
School of Medicine
Edward S. Harkness Hall
P.O. Box 3333
New Haven, Connecticut 06510-8046

Campus address:
Edward S. Harkness Hall
367 Cedar Street
Telephone: 203 785-2644

OFFICIAL TRANSCRIPT

April 22, 1994

This is an official transcript to certify that **Jonathan T. Foster,** B.S. Pace University 1985 matriculated in the Yale University School of Medicine on September 4, 1986. He satisfactorily completed the following preclinical courses:

Human Anatomy and Development
Cell Biology
Clinical Correlations
History of Medicine
Behavioral Science/Adult & Child Study
Physiology
Molecular Biophysics & Biochemistry
Professional Responsibility
Biostatistics
Immunobiology
Human Genetics
Neuroscience
Pathology
Microbiology
Pharmacology
Epidemiology and Public Health
Introduction to Clinical Medicine

Doctor Foster passed the required comprehensive examinations, Part I and II of the National Board of Medical Examiners. He satisfactorily completed the following clinical clerkships.

Internal Medicine	12 weeks
Surgery and the Surgical Subspecialities	12 weeks
Pediatrics	9 weeks
Obstetrics and Gynecology	6 weeks
Psychiatry	6 weeks
Ambulatory Care Requirement	6 weeks

Doctor Foster was awarded the degree of **Doctor of Medicine** from Yale University on May 28, 1990.

Cynthia Andrien
Cynthia Andrien,
Registrar

STATE OF CONNECTICUT

DEPARTMENT OF PUBLIC HEALTH AND ADDICTION SERVICES

BUREAU OF HEALTH SYSTEM REGULATION

RECEIVED APR 21 1994

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

DISCIPLINARY INQUIRIES

Federation of State Medical Boards
6000 Western Place, Suite 707
Fort Worth, TX 76107

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

Foster Jonathan Todd MD
NAME (last, first, middle) (Degree)

50 Irving Street
ADDRESS

Newton Ctr., MA 02159
CITY, STATE AND ZIP CODE

03/08/54
DATE OF BIRTH yy/mm/dd

[redacted]
SOCIAL SECURITY NUMBER

Yale University School of Medicine
MEDICAL SCHOOL OF GRADUATION
(Include complete name and branch location)

5/90 USA
DATE OF GRADUATION COUNTRY OF MEDICAL SCHOOL

ECFMG NUMBER (if foreign medical graduate)

Please mail the response to the following address:

Department of Public Health and Addiction Services
Physician Licensure
150 Washington Street
Hartford, CT 06106
ATTENTION: Jackie Leduc

WE HAVE NO UNFAVORABLE INFORMATION REGARDING THE ABOVE NAMED PHYSICIAN

APR 26 1994

James A. Winn, M.D.
JAMES A. WINN, M.D.
EXECUTIVE VICE-PRESIDENT

APPLICANT SIGNATURE

9223V/11
02/94

Phone (203)566-1035 *TDD: 203-566-1279*
150 Washington Street — Hartford, CT 06106
An Equal Opportunity Employer

HARVARD MEDICAL SCHOOL

BRIGHAM AND WOMEN'S HOSPITAL

ROBERT L. BARBIERI, M.D.

Kate Macy Ladd Professor of Obstetrics, Gynecology and Reproductive Biology

CHAIRMAN, DEPARTMENT OF OBSTETRICS AND GYNECOLOGY

Brigham and Women's Hospital
75 Francis Street, ASB1-3-073
Boston, Massachusetts 02115
Administrative Office: (617) 732-5444
FAX: (617) 277-1440

May 19, 1994

Ms. Jackie Ledue
Physician Licensure
Dept. of Public Health &
Addiction Services
150 Washington St.
Hartford, CT 06106

Dear Ms. Ledue:

Following is the information you requested on **Jonathan T. Foster, M.D.**:

Name:	Jonathan Todd Foster, M.D.
Date of Birth:	03/08/54
Residency Facility:	Brigham and Women's Hospital, Boston, MA OK
Specialty:	Obstetrics and Gynecology
Levels:	PGY1-PGY4
Training Period:	07/01/90-06/30/94 2+
Program Accreditation:	Yes, by ACGMB
Satisfactory Completion:	Is expected to satisfactorily complete 06/30/94
Any derogatory statement as to competency or conduct of resident:	No

If you have any questions, please do not hesitate to contact me.

Sincerely,

Robert Barbieri

Robert L. Barbieri, M.D.

RLB:pmn

Marcella Williams
Notary Public
My Comm. Exp.
6.9.2000

Commonwealth of Massachusetts
Board of Registration in Medicine

Ten West Street
Boston, Massachusetts 02111

(617) 727-3086

PAUL G. GITLIN, J.D.
CHAIRMAN
ALEXANDER F. FLEMING
EXECUTIVE DIRECTOR

An Agency within the Executive Office of Consumer Affairs and Business Regulation

April 20, 1994

To Whom It May Concern:

This is to certify that JONATHAN TODD FOSTER

a graduate of YALE UNIVERSITY SCHOOL OF MEDICINE in the year 1990

has been duly registered by this board as provided by the laws of the Commonwealth.

Certificate Number 75815 was issued to Dr. JONATHAN TODD FOSTER

on 05/13/92. THIS LICENSE IS CURRENT.

Expiration date: 03/08/95

Our files contain NO OPEN or CLOSED complaints, and NO formal disciplinary action regarding this physician.

Rafik Attia, M.D.,
Secretary

SEAL

Please be advised that the above information is based entirely on examination of our open and closed complaint file. It is not based on a review of the application for licensure, renewal of licensure or any reports that the Board is required to receive by statute (from Courts, Insurers, Hospitals, etc.).

STATE OF CONNECTICUT

DEPARTMENT OF HEALTH SERVICES
DIVISION OF MEDICAL QUALITY ASSURANCE

APR 20

APPLICANT - Complete the top portion of this form and send it to all of the state(s) in which you are/were licensed. The Medical Examining Board of the state should complete the lower portion and return it to this office.

Name: Jonathan Todd Foster (First Middle Last) Date of Birth: 03/08/54 (mo day year)

Current Address: 30 Irving St Newton Ctr MA 02159 Place of Birth: New Haven Connecticut

License Number: 75815

PLEASE BE ADVISED, THAT SOME STATES REQUIRE A FEE. CONTACT STATES BEFORE SENDING THEM THIS FORM.

STATE MEDICAL EXAMINING BOARD - The above named individual has made application for licensure as a physician in Connecticut. Would you kindly complete this portion of this form and return it to the address noted below. Your assistance is appreciated.

On what date was a license issued to this applicant? _____

Is the license presently current and valid? _____

Have there been any investigations or formal charges brought against this applicant? _____

Is this applicant presently the subject of a pending complaint or unresolved disciplinary action? _____

What was the basis for licensure in your state, i.e., FLEX, National Boards, State Examination? If a State Examination was given, please list the subject areas and the score received in each.

_____

_____

Completed By: _____, Title: _____

for State Medical Examining Board of: _____
State

(Board Seal)

Upon completion, please return this form to: Jackie Leduc
PHYSICIANS LICENSURE
Division of Medical Quality Assurance
Department of Health Services
150 Washington Street
Hartford, Connecticut 06106

(203) 566-1035

9223V

DOCUMENT CONTROL NO.: 3119941191152001 RESPONSE TO INFORMATION DISCLOSURE REQUEST PROCESS DATE: 05/02/94
OATA BANK ID: [redacted] PAGE 1
THE FOLLOWING INFORMATION IS RELEASED UNDER THE PROVISIONS OF TITLE IV OF PUBLIC LAW 99-660, AS AMENDED. FOR FURTHER INFORMATION REGARDING THE ACTION(S) LISTED, IF ANY, CONTACT THE ENTITY WHICH REPORTED THE INFORMATION.

PRACTITIONER IOENTIFIEO IN INFORMATION REQUEST — TYPE OF QUERY: STATE LICENSING BOARD

	(LAST, FIRST, MIDDLE, SUFFIX)		
NAME:	FOSTER, JONATHAN TOOO		
OTHER NAME USEO:	,		
ORGANIZATION NAME:	WATERBURY MED CTR		
WORK ADDRESS:	1389 WEST MAIN ST	WORK COUNTRY:	
CITY, STATE, ZIP CODE:	WATERBURY CT 06708		
HOME ADDRESS:	50 IRVING STREET	HOME COUNTRY:	
CITY, STATE, ZIP COOE:	NEWTON CTR MA 02159		
LICENSE NO.:	758S	STATE OF LICENSURE: MA	FIELD OF LICENSURE: 010
DATE OF BIRTH:	03/08/54	SOCIAL SECURITY NO.:	[redacted]
FEDERAL DEA NO.:	BR3197743-	FEDERAL DEA NO.:	[redacted]
PROFESSIONAL SCHOOL:	YALE UNIVERSITY SCHOOL OF MEO	YEAR OF GRADUATION:	1990

NO INFORMATION ON FILE FOR IDENTIFIED PRACTITIONER