Renewal - 1.049781

Name	NANCY L STANWOOD MD
Credential	1.049781

Fee Details

Renewal Application Fee	$570.00
	$570.00

Demographic Information

1. First Name
   NANCY

2. Middle Initial

3. Last Name
   STANWOOD

4. Maiden Name

5. Please provide your Date of Birth.
   05/04/1968

6. Gender
   Female

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.

32

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.
20

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.
6

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.
2

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.
0

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

Enter comments if "Other" is selected.

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
800 Howard Avenue

19. Address 2
Third Floor, OBGYN

20. City
New Haven

21. State
CT

22. Zip Code
06519

Primary Source of Payment

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

23. Medicare
less than 10%

24. Medicaid
51 - 75%

25. Self-Pay
less than 10%

26. Private Insurance

26 - 50%

27. Other
None

Attestation

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

29. If yes, please provide details here

30. 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

31. 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.

32. 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.
03/13/2014

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 - 1.049781

Name	NANCY L STANWOOD MD
Credential	1.049781

Fee Details

Renewal Application Fee	$565.00
	$565.00

Demographic Information

1. Please provide your Date of Birth.
   05/04/1968

Workforce Survey Introduction

Dear Licensee:

Thank you for renewing your license online. It IS NOT necessary that you mail your hardcopy renewal application to the Department after you have renewed 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

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

Workforce Survey

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

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

5. 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.
38

6. 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.
15

7. 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

8. 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.
2

9. 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.

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

Enter comments if "Other" is selected.
Hospital - Out patient

11. Gender
Female

12. Race: Choose all that apply:
White

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

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.

14. Address 1
789 Howard Avenue

15. Address 2

16. City
New Haven

17. State
CT

18. Zip Code
06510

Primary Source of Payment

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

19. Medicare
None

20. Medicaid
51 - 75%

21. Self-Pay
less than 10%

22. Private Insurance
26 - 50%

23. Other
None

Attestation

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

25. 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

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.

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. DO NOT submit the hardcopy renewal application with an additional fee.

To continue processing your renewal, please click "Next" below.

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

On the top right of the invoice screen, you will be given the option to **"Pay Invoice"** or **"Print Invoice."** When you are ready to pay the renewal fee, choose **"Pay Invoice"** to process your credit card payment.

Thank you for processing your renewal online.

Review

Credential Profile - 1.049781

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 NANCY L STANWOOD MD
Credential 1.049781

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
Dept of Obstetrics, Gynecology and Reproductive Services	333 Cedar Street	PO Box 208063		New Haven	Connecticut	06520	Yes	

Connecticut Staff Privileges

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

Facility Name	City	State
Yale-New Haven Hospital	New Haven	Connecticut

Medical School

5. Medical School
   University of Pennsylvania School of Medicine

6. Enter the Year of Graduation from Medical School
   1995

Post Graduate Training

7. List your postgraduate training:

Site Name	City	State	Country	Start Date	End Date	Level	Type
University of Michigan	Ann Arbor	Michigan	UNITED STATES	07/01/1995	06/30/1999	Resident	OB/GYN

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	01/17/2003

Medical Education Responsibilities

9. Are you a member of the faculty of a Connecticut medical school?
Yes

10. Select the state medical schools at which you are a member of the faculty.
Yale University Medical School

11. Do you have current responsibility for graduate medical education?
Yes

Publications, Professional Services, Activities, and Awards

12. Publications, Professional Services, Activities, and Awards

Publisher/Issuer	Title/Award Name	Date
J Adolesc Health. 2010; 47(2):160-7	How Are Restrictive Abortion Statutes Associated With Unintended Teen Birth?	
Contraception, 2008; 78:284-289	Contraceptive nonuse among US women at risk for unplanned pregnancy.	
Cell Stem Cell, 2008), doi:10.1016/j.stem.2008.03.020	Neonatal Chimerization with Human Glial Progenitor Cells Can Both Remyelinate and Rescue the Otherwise Lethally Hypomyelinated Shiverer Mouse.	

Medical Malpractice Information

13. Indicate your malpractice insurance carrier:
MCIC Vermont, Inc.

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

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
Michigan	No
North Carolina	No
New York	No

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

STATE OF CONNECTICUT
DEPARTMENT OF PUBLIC HEALTH

475

PHYSICIAN APPLICATION

☒ Initial licensure ☐ Reinstatement 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)		Combination of Segments (please specify)
	National Board of Osteopathic Examiners (NBOME)		

Do you plan to use the Federation Credentials Verification Service (FCVS) to verify your credentials? Yes ☐ Packet ID# _____ No ☐

First Name: Nancy **MI:** L **Last Name:** Stanwood **Maiden Name:** —

Social Security No.: [redacted] **E-mail:** [redacted]

Name and Mailing Address: This will be how your name and address will appear on your official license, your address of record for all mailings from this office and releasable pursuant to Freedom of Information requests.

Name on License: Nancy L. Stanwood

Address: [redacted]

City, State, Zip: [redacted]

Phone Number: ([redacted] **Date of Birth:** 05 / 04 / 1968 (Month / Day / Year) **Gender:** F

RACE/ETHNIC DATA: (This section is voluntary. Information gathered will be used solely for the purpose of examining the demographics of Connecticut licensees. This data will not be used for discriminatory purposes and will not be considered in the evaluation of your application.)

☐ AMERICAN INDIAN OR ALASKAN NATIVE: Persons having origins in any of the original peoples of North America, and who maintain cultural identification through tribal affiliation or community recognition.

☐ ASIAN OR PACIFIC ISLANDER: Persons having origins in any of the original peoples of the Far East, Southeast Asia the Indian Subcontinent of the Pacific Islands. This area includes, for example, China, Japan, Korea, the Philippine Islands, and Samoa.

☐ BLACK: Persons having origins in any of the black racial groups of Africa.

☐ HISPANIC: Persons of Mexican, Puerto Rican, Central or South American or other Spanish culture or origin, regardless of race.

☒ WHITE (not of Hispanic Origin): Persons having origins in any of the original peoples of Europe, North Africa, or the Middle East.

LICENSURE: List *all* states in which you have ever been licensed to practice medicine (attach additional sheets as necessary):

State	Lic. #			
MI	4301065697			
NC	9900687			
NY	221265			

Upon issuance of your license, will you practice medicine in Connecticut? ☒ Yes ☐ No

Will you be actively involved in patient care? ☒ Yes ☐ No

01

Please indicate the name of your malpractice insurance carrier: MCIC

Please indicate the name and location of the primary location where you will be practicing medicine in Connecticut:

Practice Name: Dept. of Obstetrics, Gynecology & Reproductive Sciences

Address: 333 Cedar St. PO Box 208063

City: New Haven State: CT Zip Code: 06520-8063

Please list the languages, other than English, that are spoken at this location:

Practice Name: _____

Address: _____

City: _____ State: _____ Zip Code: _____

Please list the languages, other than English, that are spoken at this location:

Please list the Connecticut Hospitals or Nursing Homes where you will have admitting privileges:

Yale New Haven Hospital	

MEDICAL EDUCATION

Please list the medical school you graduated from and the year the MD/DO degree was awarded:

Medical School Name and Location	Year of Graduation
University of Pennsylvania School of Medicine	1995

POST-GRADUATE EDUCATION

Please list the following information regarding all of your post-graduate training (attach additional sheets if necessary):

Site, City and State	Date Start	Date End	Level (Intern, Resident, Fellow)	Training Type (Pediatrics, OB/GYN, etc)
Univ. of Michigan Ann Arbor, MI	6/1995	6/1999	Res 1→4	Obgyn.

SPECIALTY/AMERICAN BOARD CERTIFICATION

Please indicate your practice specialty area:

Practice Specialty: ob-gyn (ABOG) Practice Sub-Specialty: _____

Practice Specialty: _____ Practice Sub-Specialty: _____

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

American Board of: obstetrics & gynecology Date Certified: 1/17/03

American Board of: _____ Date Certified: ___/___/___

PUBLICATIONS, PROFESSIONAL SERVICES, ACTIVITIES/ AWARDS **(THIS SECTION IS VOLUNTARY)** ***Please include a maximum of ten (10) entries in this section. For publications, please attach a CV or typed list.***

Publication/Entity Issuing Award	Title of Article/Award	Date Published/Awarded

MEDICAL EDUCATIONAL RESPONSIBILITIES

Are you/will you be 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/will you have current responsibility for graduate medical education in Connecticut? ☒ Yes ☐ No

HOSPITAL DISCIPLINE – None.

Please list any revocation or restriction of hospital privileges for reasons related to competence or quality of patient care that has been taken by the hospital's governing body or any other official of the hospital after procedural due process has been afforded. Also include the resignation from or the non-renewal of medical staff privileges or the restriction of privileges at a hospital during the course of an investigation. Please list only those that have occurred within the most recent ten (10) years. If you require additional space please provide details on a separate sheet of paper indicating the section for which you are providing additional information.

Hospital, City and State	Date	Disciplinary Action

MEDICAL MALPRACTICE PAYMENTS — None.

Please list medical malpractice court judgments and all medical malpractice arbitration awards in which a payment was awarded to a complaining party in the last ten (10) years in any state that you have held an active license. Also list all settlements of malpractice claims in which a payment was made to a complaining third party in the last ten years in any state in which you have held an active license. Please see the attached sample profile. If you require additional space please provide details on a separate sheet of paper indicating the section for which you are providing additional information.

Date Resolved	Amount Paid	Practice Specialty Related To Payment

FELONY CONVICTIONS — None.

Please list any felony convictions in any state within the last ten (10) years. For the purpose of this section a person shall be deemed to be convicted of a crime if the licensee plead guilty or was found or adjudged guilty by a court of competent jurisdiction or has been convicted of a felony by the entry of a plea of nolo contendere in any state. If you require additional space please provide details on a separate sheet of paper indicating the section for which you are providing additional information.

Date of Conviction	Conviction

STATEMENT OF PROFESSIONAL HISTORY: Please answer the following questions referring to the instructions, if applicable.

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?
   If your answer is "yes", give full details, names, addresses, etc. on separate notarized statement.
   Yes ☐ No ☒

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?
   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.
   Yes ☐ No ☒

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?
   If your answer is "yes", give full details, names, addresses, etc. on a separate notarized statement.
   Yes ☐ No ☒

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?
   If your answer is "yes" give full details, names, addresses, etc. on a separate notarized statement.
   Yes ☐ No ☒

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.
   If your answer is "yes" give full details, names, addresses, etc. on a separate notarized statement.
   Yes ☐ No ☒

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

Yes ☐ No ☒

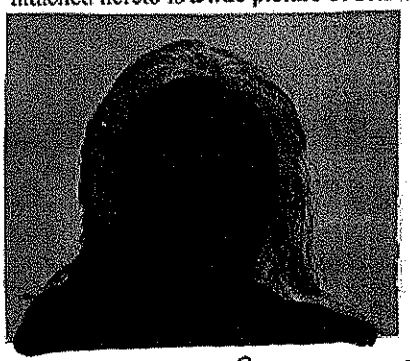
7. Have you ever been found guilty or convicted as a result of an act which constitutes a felony under the laws of this state, federal law or the laws of another jurisdiction and which, if committed within this state, would have a felony under the laws of this state?
If your answer is "yes" give full 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.

Yes ☐ No ☒

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

Yes ☐ No ☒

On this 8 day of February (*month/ year*) 2011 (*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 8 day of February (month/year) 2011.

Notary Public Signature Sharon E. Starzyk My Commission Expires

SHARON E STARZYK
No. 01ST5061654
Notary Public, State of New York
Qualified in Monroe County
My Commission Expires 6-30-14

Please return this application, the fee for $565.00 (certified bank check or money order) *and* a separate certified bank check or money order for $4.75 made payable to, "Treasurer, State of Connecticut" to:

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

***IMPORTANT:* Please do not send this form and fee unless you have read and understood the licensing policies and requirements. All fees are non-refundable.**

Curriculum Vitae
Nancy Love Stanwood, MD, MPH

Department of Obstetrics and Gynecology
[redacted]

Education

1986-1990	Brown University, Providence, RI; AB in Biochemistry Magna Cum Laude
1990-1995	University of Pennsylvania School of Medicine, Philadelphia, PA; MD
1995-1999	University of Michigan, Ann Arbor, MI - Department of Obstetrics & Gynecology, Residency
1999-2001	University of North Carolina School of Public Health, Chapel Hill, NC; MPH
1999-2001	University of North Carolina at Chapel Hill; Robert Wood Johnson Foundation's Clinical Scholars Program

Academic Appointments

1999-2001	Clinical Instructor, University of North Carolina at Chapel Hill, Department of Obstetrics & Gynecology
2001-2008	Assistant Professor, University of Rochester School of Medicine & Dentistry, Department of Obstetrics & Gynecology
2008-Present	Associate Professor, University of Rochester School of Medicine & Dentistry, Department of Obstetrics & Gynecology

Employment

1998-1999	Clinician, Planned Parenthood of Mid-Michigan, Ann Arbor, MI
2000-2001	Clinician volunteer, Planned Parenthood of Orange & Durham Counties, Chapel Hill, NC
2001-2003	Clinician, Planned Parenthood of Rochester/Syracuse Region, Rochester, NY
2010-Present,	Clinician, Planned Parenthood of Rochester/Syracuse Region, Rochester, NY

Peer-Review Publications

- Grimes D, Schulz K, Stanwood N. Immediate post-abortal insertion of intrauterine devices. Cochrane Database Systematic Reviews. 2000; Issue 2.
- Grimes D, Schulz K, van Vliet H, Stanwood N. Immediate post-partum insertion of intrauterine devices. Cochrane Database Systematic Reviews. 2001; Issue 2.
- Stanwood NL, Grimes DA, and Schulz KF. Insertion of an intrauterine contraceptive device after induced or spontaneous abortion: a review of the evidence. BJOG, 2001. 108(11): 1168-73.
- Stanwood NL, Garrett JM, Konrad TR. Obstetrician-gynecologists and the intrauterine device: a survey of attitudes and practice. Obstetrics & Gynecology. Feb. 2002;99(2): 275-280.
- Grimes D, Schulz K, van Vliet H, Stanwood N. Immediate post-partum insertion of intrauterine devices: a Cochrane review. Human Reproduction. 2002;17(3): 549-54.

- Godfrey EM, Mawson JT, Stanwood NL, Fielding SL, Schaff EA. Low-dose mifepristone for contraception: A weekly vs planned post-coital randomized pilot study. Contraception. July. 2004; 70(1): 41-46.
- Stanwood NL, Eastwood K, Carletta A. Self-injection of monthly combined hormonal contraceptive. Contraception, 2006. 73 (1): 53-55.
- Bakhru A, Stanwood NL. Performance of Contraceptive Patch Compared With Oral Contraceptive Pill in a High-Risk Population. Obstetrics & Gynecology 2006 108: 378-386.
- Stanwood NL, Bradley KA. Young Pregnant Women's Knowledge of Modern Intrauterine Devices. Obstetrics & Gynecology, 2006. 108 (6): 1417-1422.
- Stanwood NL, Cohn SE, Heiser JR, Pugliese M. Contraception and fertility plans in a cohort of HIV-positive women in care. Contraception, 2007, 75: 294-298.
- Windrem MS. Schanz SJ. Guo M. Tian GF. Washco V. Stanwood N. Rasband M. Roy NS. Nedergaard M. Havton LA. Wang S. Goldman SA, Neonatal Chimerization with Human Glial Progenitor Cells Can Both Remyelinate and Rescue the Otherwise Lethally Hypomyelinated Shiverer Mouse. Cell Stem Cell, 2008), doi:10.1016/j.stem.2008.03.020
- Wu J, Meldrum S, Dozier A, Stanwood N, Fiscella K. Contraceptive nonuse among US women at risk for unplanned pregnancy. Contraception, 2008, 78: 284-289.
- Coles MS, Makino KK, Stanwood NL, et al. How Are Restrictive Abortion Statutes Associated With Unintended Teen Birth? J Adolesc Health. 2010;47(2):160-7.

Posters, Oral Presentations

- Oral Presentation, November 2000 The Robert Wood Johnson Clinical Scholars Program Annual National Meeting. "The American College of Obstetricians and Gynecologists and Abortion Policy, 1965-1975" Stanwood
- Poster, February 2005 Conference on Retrovirals and Opportunistic Infections. "Fertility and Contraception among HIV-positive Women." Stanwood, Heiser, Pugliese, Cohn
- Poster, May 2005 American College of Obstetricians & Gynecologist, Annual Clinical Meeting. "Lunelle for Self-Injection at Home: A Pre-Post Design Study." Stanwood, Eastwood, Carletta.
- Poster, September 2005 Associate of Reproductive Health Professionals, Annual Meeting. "Young Pregnant Women's Knowledge about Intrauterine Devices." Stanwood, Bradley.
- Oral Presentation, June 4, 2006 Annual WRHR Meeting, Detroit. "A Pilot RCT of DMPA vs. LNG-IUD for Young Postpartum Women." Stanwood, Guzick, Carletta, Cooper, Nasso.
- Poster, September 2006 Association of Reproductive Health Professions. "A Pilot RCT of LNG-IUD versus DMPA for Young Postpartum Women." Stanwood, Cooper, Nasso, Guzick.
- Poster, May 2007 American College of Obstetricians & Gynecologist, Annual Clinical Meeting. "Contraceptive History of Women having Abortions within One Year of Delivery." Stanwood, Slattery.

Grants

- Women's Reproductive Health Research Career Development Grant, Scholar at University of Rochester site, 2001-2006.
- Kenneth J. Ryan Training Program in Abortion and Family Planning for residents in Obstetrics and Gynecology, 2002-2003, renewed 2003-2004, renewed 2010-2011.

- Research funding for an investigator-initiated study, Lunelle™ for Self-injection at Home: A Prospective Pre-Post Design Trial, from Pharmacia/Pfizer, 2002.
- Berlex Scholar Award in Clinical Research, Berlex Foundation. Postpartum contraception for young mothers: A pilot randomized trial of the levonorgestrel-IUD versus depo-medroxy-progesterone acetate. 2004.
- NIH/NICHD 1 R03 HD47238-01, Postpartum contraception for mothers age 14 to 25: a pilot RCT of the LNG-IUD vs. DMPA, 2004-2007.
- AAMC/CDC OB/GYN Population Health Education Committee Grant, 1/1/2008-1/1/2009. Committee member.

Awards & Honors

1994 Stolley Fellowship in Clinical Epidemiology, University of Pennsylvania Department of Epidemiology.
2003 American College of Obstetricians and Gynecologists, Council on Resident Education in Obstetrics and Gynecology National Faculty Award

Professional Societies

Fellow, American College of Obstetricians and Gynecologists, as of Sept. 30, 2003, F#0411960
Board of Directors, Physicians for Reproductive Choice and Health, 2007-present; 2008-Present Executive Committee Secretary
Member, Association of Reproductive Health Professionals
Fellow, Society of Family Planning
Member, National Abortion Federation
Member, ACOG District II Legislative Committee, 2006-2007

Certification & Licensure

Diplomat of the American Board of Obstetric and Gynecology, Board Certified January 17, 2003 through December 31, 2011 (Diplomat #9001932).
Current Physician License State of New York, #221265 (Exp. 04/30/12)
Physician License State of North Carolina, #9900687
Physician License State of Michigan, #4301065697

Academic Teaching

2001-Present	Director, University of Rochester Department of Obstetrics & Gynecology, Family Planning Training Program
2001-2005	Lecturing Faculty, Family Medicine Reproductive Health Program, University of Rochester
2002-2007	Director, University of Rochester Department of Obstetrics & Gynecology, Resident Research Curriculum
2002-Present	Lecturing Faculty, Sexual Assault Examiner Program, University of Rochester Department of Obstetrics & Gynecology.
2005-2007	Interim Fellowship Director, Reproductive Health Program, Department of Family Medicine, University of Rochester

Invited Presentations

Jan. 21, 1999	Grand Rounds, University of Michigan Department of Obstetrics & Gynecology, "Emergency contraception: Preventing Unintended Pregnancies"
May 5, 1999	Resident Paper Day, University of Michigan Department of Obstetrics & Gynecology, "Contraceptive coverage and unplanned pregnancies"
Nov. 9, 2000	The Robert Wood Johnson Clinical Scholars Program Annual National Meeting, "The American College of Obstetricians and Gynecologists and Abortion Policy, 1965-1975"
Jan. 4, 2001	Research Seminar, University of Rochester Department of Obstetrics and Gynecology, "Post-abortal IUD Insertion: A Systematic Review"
Feb. 14, 2001	Grand Rounds, University of North Carolina at Chapel Hill Department of Obstetrics and Gynecology, "The American College of Obstetricians and Gynecologists & Abortion Policy, A Decade of Change: 1965-1975"
April 18, 2001	Seminar, University of North Carolina at Chapel Hill Department of Pharmacy, "Emergency Contraception with Plan B"
Sept. 15, 2001	Gynecology 2001: University of Rochester Annual Meeting. "Levonorgestrel Intrauterine System: Contraception and More."
Oct. 11, 2001	Grand Rounds, University of Rochester Department of Obstetrics and Gynecology, "Emergency Contraception: Preventing Unintended Pregnancies."
Oct. 22, 2001	American Public Health Association Annual Meeting, Atlanta, GA, "Obstetrician-gynecologists and the intrauterine device: A survey of attitudes and practice."
Nov. 10, 2001	Robert Wood Johnson Clinical Scholars Program Annual Meeting, Ft. Lauderdale, FL, "Obstetrician-gynecologists and the intrauterine device: A survey of attitudes and practice."
Oct. 19, 2002	Gynecology 2001: University of Rochester Annual Meeting. "New Contraceptive Methods: Rings, Patches and More."
May 15, 2003.	Grand Rounds, University of Rochester School of Medicine, Department of Obstetrics and Gynecology, "The American College of Obstetricians and Gynecologists & Abortion Policy, A Decade of Change: 1965-1975"
Oct. 25, 2003	Gynecology 2002: University of Rochester Annual Meeting. "No Need to Bleed: And other new evidence in hormonal contraception."
April 18, 2004	National Abortion Federation Annual Meeting, New Orleans. "Immediate Postabortal IUD Insertion"
April 18, 2004	National Abortion Federation Annual Meeting, New Orleans. "Antibiotic Prophylaxis for Surgical Induced Abortion"
Nov. 6, 2004	Gynecology 2004: University of Rochester Annual Meeting. "Improving Contraceptive Care"
Dec. 10, 2005	Gynecology 2005: University of Rochester Annual Meeting. "Contraceptive Update"
May 19, 2007	University of Rochester Medical Center's 17th Annual HIV/AIDS Clinical Conference, "Contraception to Conception: Reproduction Choices for HIV Positive Women."

STATE OF CONNECTICUT
DEPARTMENT OF PUBLIC HEALTH

VERIFICATION OF RESIDENCY TRAINING FORM

APPLICANT: Enter your full name and birth date 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: Nancy Shorwood Date of Birth: 05/04/1968

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: Univ of Michigan

Dates of Residency: From June 1995 (month/day/year) To June 1999 (month/day/year)

In what specialty was the residency training completed: Obgyn

At what level(s) was this residency completed (PGY1, PGY2, etc.)? PGY1 - PGY4

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 (ACGME), American Osteopathic Association (AOA) or The Royal College of Physicians and Surgeons of Canada (RCPSC)? yes (YES or NO)

Did the applicant satisfactorily complete this period of residency training? Yes (YES or NO)

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

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

Name of Facility: University of Michigan Health System

Address: Dept. of Obgyn
1500 E. Medical Center Drive Ann Arbor, MI 48109

Telephone Number: 734-764-8323

Email: dianacur@med.umich.edu

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

Diana Curran MD
Signature of Chief of Staff/Program Director

Subscribed and sworn to me this 10 day of February (month/ year) 2011.

Marlene Ann Woodard
(Notary Public Signature)

4/12/2012
My Commission Expires

Please return this form directly to:

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

Marlene Ann Woodard, Notary Public
State of Michigan, County of Wayne
My Commission Expires 4/12/2012
Acting in the County of

JENNIFER M. GRANHOLM
Governor

STATE OF MICHIGAN
DEPARTMENT OF COMMUNITY HEALTH
LANSING

JANET OLSZEWSKI
Director

VERIFICATION OF LICENSURE
MICHIGAN BOARD OF MEDICINE
VERIFICATION OF LICENSURE AS OF 02/04/2011

NAME: Nancy Love Stanwood

BIRTHDATE: 05/04/1968

ADDRESS: Univ Of Rochester Med CTR
Box 666
Rochester NY 146428668

TYPE: Medical Doctor

ORIGINAL DATE: 03/02/1998

LICENSE NUMBER: 4301065697 **STATUS:** Active

EXPIRATION DATE: 01/31/2011

OBTAINED BY: Examination

EXAM DATE	EXAM TYPE	EXAM SCORE OR RESULT
12/01/1997	USMLE	PASS

DISCIPLINARY ACTION NONE

OPEN FORMAL COMPLAINTS NONE

This license information was last updated on: 02/04/2011

REC'D FEB 16 2011

Connecticut Medical Examining Board
Physician Licensure
P. O. Box 340308
Hartford, CT 06134-0308

LICENSE VERIFICATION FORM

DATE: **February 07, 2011**

TO WHOM IT MAY CONCERN:

This is to verify that the practitioner noted below was issued a North Carolina License. A review of the files indicate the following information:

Name: Nancy Love Stanwood
Address: Dept of OB/GYN
University of Rochester Medical Center
601 Elmwood Ave, Box 668
Rochester, NY 14642-8668

Annual Renewal Date: May 4, 2007
Public Action: No

License Number	License Type	Issue Date	Current Status	Expire Date
9900687	MD	05/22/1999	Active	
9900687	MD	05/22/1999	Inactive	
9900687	MD	05/22/1999	Inactive	07/28/2008

Sincerely,

R. David Henderson

R. David Henderson
Executive Director

R. David Henderson
Executive Director

1203 Front Street
Raleigh, North Carolina 27609-7533

Mailing:
P.O. Box 20007
Raleigh, North Carolina 27619-0007

Telephone: (919) 326-1100
Fax: (919) 326-1131
Email: info@ncmedboard.org
Web: www.ncmedboard.org

NORTH CAROLINA MEDICAL BOARD
Primum Non Nocere
April 15, 1859

Second mailing 3/6/11 Marlene Woodard

STATE OF CONNECTICUT
DEPARTMENT OF PUBLIC HEALTH

VERIFICATION OF RESIDENCY TRAINING FORM

APPLICANT: Enter your full name and birth date 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: Nancy Stanwood Date of Birth: 05/04/1968

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: Univ of Michigan

Dates of Residency: From June 1995 (month/day/year) To June 1999 (month/day/year)

In what specialty was the residency training completed: Obgyn

At what level(s) was this residency completed (PGY1, PGY2, etc.)? PGY1 - PGY4

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 (ACGME), American Osteopathic Association (AOA) or The Royal College of Physicians and Surgeons of Canada (RCPSC)? Yes (YES or NO)

Did the applicant satisfactorily complete this period of residency training? Yes (YES or NO)

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

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

Name of Facility: University of Michigan Health System

Address: Dept. of obgyn
1500 E. Medical Center Drive Ann Arbor, MI 48109

Telephone Number: 734-764-8123

Email: dianacur@med.umich.edu

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

Diana C MD
Signature of Chief of Staff/Program Director

Subscribed and sworn to me this 10 day of February (month/ year) 2011.

Marlene Ann Woodard
Notary Public's Signature

4/12/2012
My Commission Expires

Please return this form directly to:

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

Marlene Ann Woodard, Notary Public
State of Michigan, County of Wayne
My Commission Expires 4/12/2012
Acting in the County of Wayne