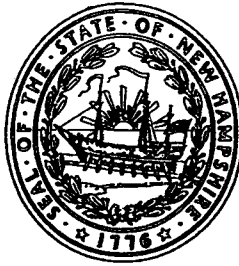


MARK SULLIVAN, P.A.
President

JOHN H. WHEELER, D.O.
Vice President of the Board

KATHRYN M. BRADLEY
Executive Director

PENNY TAYLOR
Administrator



LOUIS E. ROSENTHALL, M.D.
Vice President of the Medical Review Subcommittee
AMY FEITELSON, M.D.
ROBERT J. ANDELMAN, M.D.
ROBERT M. VIDAVER, M.D.
MICHAEL BARR, M.D.
GAIL A. BARBA, PUBLIC MEMBER
DANIEL MORRISSEY, O.P., PUBLIC MEMBER
EDMUND J. WATERS, JR., PUBLIC MEMBER

New Hampshire Board of Medicine

2 INDUSTRIAL PARK DRIVE, SUITE 8, CONCORD, NH 03301-8520

Tel. (603) 271-1203 Fax (603) 271-6702

TDD Access: Relay NH 1-800-735-2964

WEB SITE: www.nh.gov/medicine

August 7, 2013

DONNA L BURKETT MD

Dear Dr. Burkett:

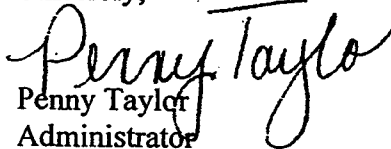
Congratulations, the New Hampshire Board of Medicine has granted your application for licensure. Your license, numbered 16261 is dated August 7, 2013 and expires June 30, 2015. Please be advised that your wallet card will be mailed to you as soon as it is available.

You are required to renew your license on a biennial basis and forms for that purpose will be forwarded to you at the address on file with the Board in April of the year in which your renewal is set to occur. For this reason, a form is enclosed which should be returned to us if and when you change your home or business address. Please be aware that you are required to inform the Board of any change of address within 30 days of that change.

An engrossed certificate of licensure will be provided to you within the next six months. This certificate is for display purposes only and does not constitute a legal document which verifies current licensure. The enclosed pocket size card should be used for that purpose.

Please feel free to contact this office if you have any questions.

Sincerely,


Penny Taylor
Administrator

Encl.

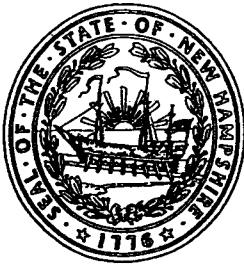
MARK SULLIVAN, P.A.
President

JOHN H. WHEELER, D.O.
Vice President of the Board

KATHRYN M. BRADLEY
Executive Director

PENNY TAYLOR
Administrator

*File
17543*



LOUIS E. ROSENTHALL, M.D.
Vice President of the Medical Review Subcommittee
AMY FEITELSON, M.D.
ROBERT J. ANDELMAN, M.D.
ROBERT P. CERVENKA, M.D.
ROBERT M. VIDAVER, M.D.
MICHAEL BARR, M.D.
GAIL A. BARBA, PUBLIC MEMBER
DANIEL MORRISSEY, O.P., PUBLIC MEMBER
EDMUND J. WATERS, M.D., PUBLIC MEMBER

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AUG 30 2013

NH BOARD

New Hampshire Board of Medicine

2 INDUSTRIAL PARK DRIVE, SUITE 8, CONCORD, NH 03301-8520

Tel. (603) 271-1203 Fax (603) 271-6702

TDD Access: Relay NH 1-800-735-2964

WEB SITE: www.nh.gov/medicine

**PLEASE COMPLETE AND RETURN TO THE BOARD OF MEDICINE
AS SOON AS POSSIBLE. PLEASE PRINT.**

*****NOTE.....Please mark the box next to the address you would prefer to list as your mailing address.**

Physician Name: Donna L Burkett MD

N.H. License Number: 16261

Business Name: Planned Parenthood Northern New England

Address: 128 Lakeside Ave Suite 301

Burlington, VT 05401

Office telephone: 802-448-9717

Business Fax Number: _____ Business E-Mail: _____

Home Address: _____

Home telephone: _____

Specialty: Family Medicine Board certified: Yes

Hospital affiliations: Fletcher Allen

In what other states do you hold a current license: Vermont, Maine, West Virginia,
Virginia, North Carolina and South Carolina

Uniform Application for Physician Licensure

UA Username dburkett

Date Submitted 7/5/2013

FCVS Status Applicant has an FCVS Packet

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

7/8/13

1. Full Name (use no initials)

Last Name Burkett

First Name Donna

Middle Name Lynn

Suffix

Maiden Name

M.D.

D.O.

All other names used

First

Middle

Last

Suffix

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

2. Address/Phone

Business

Public Access

Street

Mailing

City

State/Province

Zip Code

Country USA

Telephone

Fax

Email

Alternate Phone

Home

Public Access

Street

Mailing

City

State/Province

Zip Code

Country USA

Telephone

Fax

Email

Alternate Phone

DONNA BURKETT

Applicant Name: Donna Burkett
Submission Type: FCVS

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

3. Identification

Date of Birth (mm/dd/yyyy)	Birth City	Birth State/Province	Birth Country
Gender	Social Security Number	NPI	Are you a U.S. Citizen? <input type="checkbox"/> Yes <input type="checkbox"/> No

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

The National Provider Identifier (NPI) is a Health Insurance Portability and Accountability Act (HIPAA) Administrative Simplification Standard. For more information on the NPI, please go to <http://www.cms.hhs.gov/NationalProviderStand/>.

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

4. Medical School

1	School Name	University of North Carolina at Chapel Hill School of Medicine		
	Address	Office of Student Affairs/Guy Winstead Campus Box #7000 121 MacMider Boulevard		
	City	Chapel Hill		
	State/Province	NC		
	ZIP Code	27599-7000		
	Country	USA		
	Attendance Dates	From (mm/yyyy)	08/1991	To (mm/yyyy) 05/1995
	Graduation Date	5/14/1995		
	Degree	MD		

Applicant Name: Donna Burkett
Submission Type: FCVS

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

5. Fifth Pathway (if applicable)

Medical School Name
Address

City
State/Province
ZIP Code
Country

Attendance Dates	From (mm/yyyy)	To (mm/yyyy)	In Progress
Graduation Date			
Degree			

Institution name where rotations performed
Address

City
State/Province
ZIP Code
Country

Rotation Dates	From (mm/yyyy)	To (mm/yyyy)	In Progress
Certification Date			

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

6. Postgraduate Training															
1	Hospital Name		Oregon Health Sciences University												
	Hospital Address		3181 SW Sam Jackson Park Road												
	City		Portland												
	State/Province		Oregon												
	ZIP Code		97201-3098												
	Country		USA												
	PGY: (e.g., 1, 2, 3, etc.)	<input type="checkbox"/>	Internship	<input checked="" type="checkbox"/>	Residency	<input type="checkbox"/>	Fellowship	<input type="checkbox"/>	Research	<input type="checkbox"/>	Other				
	Department/Specialty		Family Practice												
	From:	07	/	1995	To:	06	/	1998	Successfully Completed?	<input checked="" type="checkbox"/>	Yes	<input type="checkbox"/>	No	In Progress	<input type="checkbox"/>
		Month		Year		Month		Year							

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

7. Examination History

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

Examination	State	Most Recent Date taken(Month/Year)	Passed (P) or Failed (F)		Number of attempts
USMLE Step 1		06/1997	<input type="checkbox"/> P	<input type="checkbox"/> F	1
USMLE Step 2			<input type="checkbox"/> P	<input type="checkbox"/> F	1
USMLE Step 3			<input type="checkbox"/> P	<input type="checkbox"/> F	1

Applicant Name: Donna Burkett
Submission Type: FCVS

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

8. ECFMG (if applicable)

Certificate Number	Issue Date	Valid Through Date
--------------------	------------	--------------------

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

9. State Licensure

1	State/Province NC ✓	Practitioner Type (MD, DO, etc.)	MD	Type of License (Full, Temporary, etc.)	Full License
	License Number 200100124	Status	Active	Issue Date	2/1/2001
2	State/Province VA	Practitioner Type (MD, DO, etc.)	MD	Type of License (Full, Temporary, etc.)	Full License
	License Number 0101241288	Status	Active	Issue Date	2/1/2007
3	State/Province SC	Practitioner Type (MD, DO, etc.)	MD	Type of License (Full, Temporary, etc.)	Full License
	License Number 29999	Status	Active	Issue Date	9/1/2007
4	State/Province WV ✓	Practitioner Type (MD, DO, etc.)	MD	Type of License (Full, Temporary, etc.)	Full License
	License Number 22710	Status	Active	Issue Date	5/1/2007
5	State/Province OR ✓	Practitioner Type (MD, DO, etc.)	MD	Type of License (Full, Temporary, etc.)	Full License
	License Number MD20096	Status	Expired	Issue Date	10/18/1996

Applicant Name: Donna Burkett
 Submission Type: FCVS

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

10. Chronology of Activities

Dates: From/To	Practice/Employment
<p>1</p> <p>From:</p> <p>Month: 07</p> <p>Year: 1995</p> <p>To:</p> <p>Month: 06</p> <p>Year: 1998</p> <p>In Progress <input type="checkbox"/></p>	<p>Practice/Employment Name Oregon Health Sciences University (or list non-working time as indicated above)</p> <p>Practice/Employment Address 3181 SW Sam Jackson Park Rd</p> <p>City Portland</p> <p>State/Province Oregon</p> <p>ZIP Code 97239 Country USA</p> <p>Position and Department Resident-Family Medicine</p> <p>Percent Clinical: 99% Percent Administrative: 1%</p> <p>Employment <input type="checkbox"/> Staff Privileges <input type="checkbox"/> Affiliation <input type="checkbox"/> Other training</p>

Dates: From/To	Practice/Employment
<p>2</p> <p>From:</p> <p>Month: 07</p> <p>Year: 1998</p> <p>To:</p> <p>Month: 08</p> <p>Year: 1998</p> <p>In Progress <input type="checkbox"/></p>	<p>Practice/Employment Name travel between jobs (or list non-working time as indicated above)</p> <p>Practice/Employment Address 3522 SE Brooklyn</p> <p>City Portland</p> <p>State/Province Oregon</p> <p>ZIP Code 97202 Country USA</p> <p>Position and Department</p> <p>Percent Clinical: 0% Percent Administrative: 0%</p> <p>Employment <input type="checkbox"/> Staff Privileges <input type="checkbox"/> Affiliation <input type="checkbox"/> Other</p>

Dates: From/To	Practice/Employment
<p>3</p> <p>From:</p> <p>Month: 08</p> <p>Year: 1998</p> <p>To:</p> <p>Month: 12</p> <p>Year: 1999</p> <p>In Progress <input type="checkbox"/></p>	<p>Practice/Employment Name Providence Health Systems, North Portland (or list non-working time as indicated above)</p> <p>Practice/Employment Address North Portland Family Medicine Clinic</p> <p>City Portland</p> <p>State/Province Oregon</p> <p>ZIP Code 97217 Country USA</p> <p>Position and Department Physician-Family Medicine</p> <p>Percent Clinical: 95% Percent Administrative: 5%</p> <p>Employment <input checked="" type="checkbox"/> Staff Privileges <input type="checkbox"/> Affiliation <input type="checkbox"/> Other</p>

Applicant Name: Donna Burkett
Submission Type: FCVS

Dates: From/To		Practice/Employment	
4		Practice/Employment Name	Family Leave/pregnancy and childbirth/seeking employment/moving (or list non-working time as indicated above)
From:		Practice/Employment Address	105 Sunset Dr.
Month: 01		City	Asheville
Year: 2000		State/Province	North Carolina
To:		ZIP Code	28804
Month: 04		Country	USA
Year: 2001		Position and Department	
In Progress	<input type="checkbox"/>	Percent Clinical:	0%
		Percent Administrative:	0%
		Employment	<input type="checkbox"/>
		Staff Privileges	<input type="checkbox"/>
		Affiliation	<input type="checkbox"/>
		Other	
Dates: From/To		Practice/Employment	
5		Practice/Employment Name	WNC OB-Gyn and Family Practice (or list non-working time as indicated above)
From:		Practice/Employment Address	17 McDowell St.
Month: 04		City	Asheville
Year: 2001		State/Province	North Carolina
To:		ZIP Code	28801
Month: 02		Country	USA
Year: 2005		Position and Department	Physician-n/a
In Progress	<input type="checkbox"/>	Percent Clinical:	95%
		Percent Administrative:	5%
		Employment	<input checked="" type="checkbox"/>
		Staff Privileges	<input type="checkbox"/>
		Affiliation	<input type="checkbox"/>
		Other	Partner
Dates: From/To		Practice/Employment	
6		Practice/Employment Name	looking for parttime work and being stay-at-home parent (or list non-working time as indicated above)
From:		Practice/Employment Address	17 Panola St.
Month: 02		City	Asheville
Year: 2005		State/Province	North Carolina
To:		ZIP Code	28801
Month: 06		Country	USA
Year: 2005		Position and Department	
In Progress	<input type="checkbox"/>	Percent Clinical:	0%
		Percent Administrative:	0%
		Employment	<input type="checkbox"/>
		Staff Privileges	<input type="checkbox"/>
		Affiliation	<input type="checkbox"/>
		Other	

Applicant Name: Donna Burkett
 Submission Type: FCVS

Dates: From/To		Practice/Employment	
7		Practice/Employment Name MAHEC (or list non-working time as indicated above)	
From:		Practice/Employment Address 118 WT Weaver Blvd	
Month: 07			
Year: 2005			
To:		City Asheville	
		State/Province North Carolina	
Month: 05		ZIP Code 28804 Country USA	
Year: 2013		Position and Department Faculty Physician-Family Medicine	
In Progress <input type="checkbox"/>		Percent Clinical: 100%	Percent Administrative: 0%
		Employment <input type="checkbox"/>	Staff Privileges <input checked="" type="checkbox"/> Affiliation <input type="checkbox"/> Other part-time faculty

Dates: From/To		Practice/Employment	
8		Practice/Employment Name Planned Parenthood Health Systems, Inc (or list non-working time as indicated above)	
From:		Practice/Employment Address 603 Biltmore Avenue	
Month: 07			
Year: 2006			
To:		City Asheville	
		State/Province North Carolina	
Month:		ZIP Code 28801 Country USA	
Year:		Position and Department Affiliate Medical Director-Medical Services	
In Progress <input checked="" type="checkbox"/>		Percent Clinical: 5%	Percent Administrative: 95%
		Employment <input checked="" type="checkbox"/>	Staff Privileges <input type="checkbox"/> Affiliation <input type="checkbox"/> Other

Applicant Name: Donna Burkett
 Submission Type: FCVS

UA

UNIFORM APPLICATION FOR PHYSICIAN STATE LICENSURE

Affidavit and Authorization for Release of Information

JUL 15 2013 NH BOARD

This form should be sent to the state board you are applying to, NOT to FSMB.

Applicant:

Securely tape or glue a recent (less than 6 month old) front-view 2" x 2" passport-type color photo of yourself in the square below.

Sign this form with attached photo in the presence of a notary public.

Send the notarized form to the board you are applying to for licensure.

DO NOT SEND THIS FORM TO FSMB.

Doing so will cause a delay with your state board application.

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

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

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

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

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

I understand my failure to answer questions contained in this application truthfully and completely may lead to denial, revocation, or other disciplinary sanction of my license or permit to practice medicine.



Donna L. Burkett

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

Burkett

Applicant's printed last name

Donna L.

Applicant's printed first name, middle initial, and suffix (e.g., Jr.)

6/28/2013

Date of signature (must correspond to date of notarization)

Notary

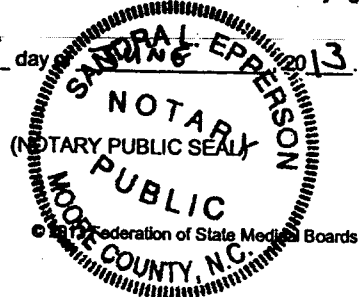
State of NORTH CAROLINA County of _____

I certify that on the date set forth below, the individual named above did appear personally before me and that I did identify this applicant by: (a) comparing his/her physical appearance with the photograph on the identifying document presented by the applicant and with the photograph affixed hereto, and (b) comparing the applicant's signature made in my presence on this form with the signature on his/her identifying document.

The statements on this document are subscribed and sworn to before me by the applicant on this 28th day of June 2013.

Notary Public Signature: Sandra L. Epperson

My Notary Commission Expires: 12-7-2013



ADDENDUM TO APPLICATION

RECEIVED

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

JUL 15, 2013
NH BOARD

	YES	NO
1. Have you been actively engaged in the practice of clinical medicine within the past 12 months?	✓	
2. Are you certified by an American Specialty Board? (If yes, provide a notarized copy of all certificates).	✓	
3. Have you ever, for any reason, lost American Specialty Board Certification?		✓
4. Have you been denied required recertification by any specialty boards? (If yes, list each boards and dates denied).		✓
5. Has any medical malpractice suit been brought against you or has any claim been settled on your behalf in the last ten years? (If so, indicate how many).		✓
6. Have you ever applied for licensure or to sit for an examination, or taken an examination, under a different name?		✓
7. Have you ever been denied the privilege of taking or finishing an examination or been accused of cheating or improper conduct during an examination since you graduated from high school?		✓
8. Have you ever failed any national medical licensure examination, or any part of that examination, state board examination or failed to gain certification from the National Board of Medical Examiners? You must report all exam failures, even if you later passed the examination. (This does not include specialty board certification examinations.)		✓
9. Have you ever failed a foreign licensing or certification examination?		✓
10. Have you ever been denied a medical license, whether full, limited or temporary, for any reason?		✓
11. Have you ever had staff privileges, employment or appointment in a hospital or other health care institution denied, limited, suspended or revoked, or have you ever resigned from a medical staff in lieu of disciplinary action?		✓
12. Is any investigation or disciplinary action pending, or has any investigation or disciplinary action been taken against you in the last ten years by any governmental authority, by any hospital or health care facility, or by any professional medical association (international, national, state or local)?		✓

- | | YES | NO |
|--|-------|---------|
| 13. Have you ever voluntarily surrendered a license to practice medicine or any healing art or allowed such a license to lapse in lieu of facing disciplinary investigation or action? | _____ | _____ ✓ |
| 14. Have you ever withdrawn an application for licensure, hospital privileges or appointment for any reason? | _____ | _____ ✓ |
| 15. Have you ever been a defendant in a criminal proceeding including driving while under the influence or driving while suspended, which has not been annulled by a court, but not including traffic offenses not classified as misdemeanors or felonies? | _____ | _____ ✓ |
| 16. Has your privilege to possess, dispense or prescribe controlled substances ever been suspended, revoked, denied, restricted or surrendered, or have you ever been charged, investigated or warned by a state or federal agency based on controlled substance issues? | _____ | _____ ✓ |
| 17. Have you ever had any physical, emotional or mental illness which has impaired or would be likely to impair your ability to practice medicine? | _____ | _____ ✓ |
| 18. Are you now, or have you, during the past 5 years, been dependent upon alcohol or habituating drugs or undergone treatment for such? | _____ | _____ ✓ |

Anticipated Practice Location(s) (if known):
See attached

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

SOCIAL SECURITY NUMBER: _____

Norman Burkett Burkett 7/11/2013
 Applicant's Signature Applicant's Printed Last Name Date of Signature

For Board Use Only:

Application Received: July 15, 2013, 2013 Fee Paid: 300 Check#: _____

License Number: _____ Date of Issue: _____

PPNNE Health Center Address & Contact Information

Claremont	136 Pleasant St, Claremont, NH 03743	Same	T. 542-4568 F.
Derry	4 Birch St, Derry, NH 03038	Same	T. 434-1354 F.
Exeter	108 High St, Exeter, NH 03833	Same	T. 772-9315 F.
Keene	8 Middle St, Keene, NH 03431	Same	T. 352-6898 F.
Manchester	24 Pennacook St, Manchester, NH 03104	Same	T. 669-7321 F.
West Lebanon	89 South Main St, W. Lebanon, NH 03784	Same	T. 298-7766 F.

RECEIVED
JUL 15 2013
NH BOARD



American Board of Family Medicine, Inc.

Quality Healthcare, Public Trust . . . Setting the Standards in Family Medicine

RECEIVED

July 24, 2013

JUL 29 2013

To Whom It May Concern:

NIH BOARD

This letter verifies Donna Lynn Burkett, M.D. (NPI: _____) is currently certified with the American Board of Family Medicine (ABFM).

Family Medicine Certification History:

Jul 10, 1998 - Jul 22, 2005
Jul 23, 2005 - Dec 31, 2015*

* Three Year extension of certification earned by completion of MC-FP requirements.

Maintenance of Certification for Family Physicians (MC-FP):

Current Status:  Meeting Requirements

Beginning in 2004 with the family physicians who performed successfully on the Certification and Recertification examinations in 2003, the ABFM began a gradual transition from Recertification to Maintenance of Certification for Family Physicians (MC-FP). MC-FP was designed to transition all Diplomates into the program by 2010, enrolling all physicians who certified or recertified as they successfully passed the examination.

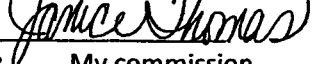
The MC-FP program is divided into separate three-year stages. By completing Stage 1 and Stage 2 by specified deadlines, the life of a certificate will be extended from seven to ten years. Diplomates who are unable to complete these requirements will retain their original seven-year certificate. Regardless of whether a Diplomate is on a 10-year or 7-year cycle, MC-FP requirements must be completed prior to applying for the next MC-FP examination. The prior requirements for licensure and CME are incorporated into the requirements of MC-FP.

The ABFM website serves as primary source verification. Details of the MC-FP process are available online at www.theabfm.org.

Sincerely,

Mary McIntosh
Verification Coordinator and Candidate Assistant

4/2/17

Subscribed and sworn before me this 24 day of July, 2013 Signature 
_____, Notary Public Printed Name: Janice Thomas My commission
expires: April 2, 2017



American Board of Family Medicine, Inc.

Quality Healthcare, Public Trust . . . Setting the Standards in Family Medicine

RECEIVED

July 15, 2013

JUL 18 2013

To Whom It May Concern:

NH BOARD

This letter verifies Donna Lynn Burkett, M.D. (NPI: _____) is currently certified with the American Board of Family Medicine (ABFM).

Family Medicine Certification History:

Jul 10, 1998 - Jul 22, 2005
Jul 23, 2005 - Dec 31, 2015*

* Three Year extension of certification earned by completion of MC-FP requirements.

Maintenance of Certification for Family Physicians (MC-FP):

Current Status:  Meeting Requirements

Beginning in 2004 with the family physicians who performed successfully on the Certification and Recertification examinations in 2003, the ABFM began a gradual transition from Recertification to Maintenance of Certification for Family Physicians (MC-FP). MC-FP was designed to transition all Diplomates into the program by 2010, enrolling all physicians who certified or recertified as they successfully passed the examination.

The MC-FP program is divided into separate three-year stages. By completing Stage 1 and Stage 2 by specified deadlines, the life of a certificate will be extended from seven to ten years. Diplomates who are unable to complete these requirements will retain their original seven-year certificate. Regardless of whether a Diplomate is on a 10-year or 7-year cycle, MC-FP requirements must be completed prior to applying for the next MC-FP examination. The prior requirements for licensure and CME are incorporated into the requirements of MC-FP.

The ABFM website serves as primary source verification. Details of the MC-FP process are available online at www.theabfm.org.

Sincerely,

Mary McIntosh
Verification Coordinator and Candidate Assistant

DONNA L. BURKETT, MD

Curriculum Vitae

Affiliate Medical Director

Planned Parenthood Health Systems, Inc.

603 Biltmore Ave.

Asheville, NC 28801

Cell phone

Email

EDUCATION

- 1995-1998 Residency in Family Medicine, Oregon Health Sciences University (OHSU), Portland, OR. See below for detail.
- 1991-1995 Medical Degree, University of North Carolina School of Medicine, Chapel Hill, NC
- 1986-1990 B.S. Chemistry/B.A. French, Mars Hill College, Mars Hill, NC

EMPLOYMENT

- Anticipated Sept 2013 **Medical Director, Planned Parenthood of Northern New England**
- Feb 2011-present **Consultant, Planned Parenthood Federation of America, Medical Services Department, writing and editing Primary Care Standards and Guidelines**
- July 2006- Aug 2013 **Affiliate Medical Director, Planned Parenthood Health Systems, Inc, Regional Planned Parenthood in NC, SC, VA and WV. Duties include:**
- Oversight and evaluation of physician and clinical employees
 - Quality and risk management oversight for high-risk services in 12 health centers through 4 states
 - Protocol review and oversight
 - New clinical program innovation and implementation
- July 2005-May 2013 **Part-time faculty, MAHEC Family Health Center, Asheville, NC. Duties include:**
- Starting and running vasectomy clinic
 - Precepting residents in Family Practice clinic
 - Participating in Obstetrical call
 - Some didactic responsibilities for the reproductive health curriculum

BURKETT, DONNA

February 2005 – June 2005 Family leave/volunteer at ABCCM, local free clinic

2001-2005

Family Physician and Administrative Physician, WNC OB-Gyn and Family Practice, Asheville, NC. Activities included:

- Established FP side of practice and built a very busy practice over several years
- Scope of practice included care of men, women, and children, primary gynecological care, obstetrical care, vasectomy, circumcision, and minor dermatological care and procedures
- As a partner, took on the administration of a failing practice and brought it into improved fiscal conditions through hiring better qualified management staff, changing billing system to more up-to-date one and internalized billing, bringing the AR DSO from 90+ to 40-50 in 1-year period, developing standard practices for quality and efficiency in the practice
- Established a teaching vasectomy service
- Periodically provided abortions at a partner's private practice

Jan 2000 – April 2001

Family Leave/volunteer as Preceptor at OHSU Family Medicine Department prior to move to NC

1996 - 2000

All Women's Health Center, Portland and Eugene, OR. Part-time, contractual, abortion procedural work in a non-profit reproductive health organization.

1998 - 1999

Family Practitioner, North Portland Clinic, Providence Health System, Portland, OR. Full-time clinician in an underserved community clinic. Duties included:

- Active obstetrical practice
- Call, hospital management of patients
- Chair – End of Life Improvement committee
- Participant – several medical informatics endeavors

July and August 1998 Extended vacation, following residency

1995- 1998

Family Practice Resident, OHSU, Portland, OR. Full-time. In-patient, out-patient, surgical, rural and urgent care rotations. Extra duties:

- Chief Resident, 1997-1998 – scheduling, arranging conferences, teaching, and trouble-shooting
- Writing Abortion Curriculum for Ob/Gyn and Family Practice Residents in conjunction with Faculty Director

ADDITIONAL EDUCATIONAL EXPERIENCE

- 2004-2005 **Advanced Life Support in Obstetrics (ALSO) Instructor Course and Instructor Candidate** teaching completed, American Academy of Family Physicians (AAFP). Adult learning model utilized.
- 2003 **Fundamentals of Management Course, AAFP.** An intensive program designed to train FPs to become more effective managers and leaders.
- Spring 1988 **Semester Abroad, Institute d'Etude Francais, Avignon, FRANCE**

PROFESSIONAL MEMBERSHIPS

- 2011-present Member, WPATH (World Professional Association of Transgender Health)
- 1998-present Diplomate, American Board of Family Practice
- 1998-present Member, American Academy of Family Physicians
- 2006-present Member, Association of Reproductive Health Professionals
- 2001-present Member, NC Academy of Family Physicians
- 2001-5, 2012-present --Member, Western North Carolina Medical Society
- 1992-2002 Member, American Medical Women's Association

VOLUNTEER SERVICE

- 2010 -- present Member, Medical Advisory Board, AFAXYS
- 2012 -- present Member, Federation Patient Safety Committee, ARMS, Inc
- 2008 -- present Multiple short-term committees, PPFA
- 2005-2012 Board Member of children's school, serving preschool through 8th grade. Chair 2008-2011. Led the school through a director transition and through implementation of Policy Governance.
- 2003 -- present various volunteer activities, same school
- 2005 -- present Reproductive health educator, various schools and church

INTERESTS AND ACTIVITIES**REFERENCES**

Available upon request