PERMANENT

LIC #: MD19175

ISSUED:

DATE APP REC'D: 01/30/2012 APP FEE PD: $700 REC'D: 01/30/2012

EXPIRES:

NAME: PAUL,MAUREEN E. SS#: [redacted]

PLACE OF BIRTH: WORCESTER ,MA DOB: [redacted]

MEDICAL SCHOOL: TUFTS UNIVERSITY SCHOOL OF MEDICINE

LOCATION: BOSTON, MA YEAR GRAD: 1979

SPECIALTY: OB/GYN, OCCUPATIONAL MEDICINE AM BD CERT (Y) N

LICENSE EXAM:	BASED ON	ON FILE	NUMBER/PLACE
☐ NBME	I, II, III	☐	3-210-413-5
☑ WRITTEN EXAM	3/9/12	☑	96.7%

MALPRACTICE #13 OTHER PERSONAL DATA N/R ☑ NPDB 01/30/2012

☑ FCVS 2-14-12 ☑ LICENSES ~~AR, CA, WA, CT,~~ NY ☐ REFERENCES

COMMENTS: _____

_____

APPROVAL

D. SPRAGUE DS DATE: 3/22/12

MAROULLA GLEATON, M.D. E-MAIL DATE: _____ APPROVAL DATE: _____

LIST A ✓ LIST B _____ LIC COM _____

COMMENTS: _____

_____

BOARD APPROVED - YES ☐ NO ☐ APPROVAL DATE _____

6575

CN 2000 692-1

Affidavit and Authorization for Release of Information: You must attach a recent (less than 6 months old) passport quality, color photograph of yourself to this form. Take the form to a notary public and sign the form in the presence of the notary public. The notarized form then must be sent directly to this Board.

RECEIVED
VISA
JAN 30 2012
$700
BOARD OF LICENSURE IN MEDICINE

Affidavit
And
Authorization For Release of Information

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 Application for Physician 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.

Maureen Paul
Applicant's Signature (must be signed in the presence of a notary)

PAUL
Applicant's Printed Last Name

MAUREEN E.
Applicant's Printed First Name, Middle Initial, and Suffix (e.g., Jr.)

01/26/2012
Date of Signature

NOTARY

Dated 1/26/12 Signed Sharon Edwards

State of New York County of Manhattan

SUBSCRIBED AND SWORN TO before me this 26th day of, January 20 12.

My commission expires: 10-14-12 (NOTARY PUBLIC SIGNATURE & SEAL)

SHARON EDWARDS
Notary Public - State of New York
NO. 01ED6194887
Qualified in Bronx County
My Commission Expires 10-14-12

Date

ADDENDUM 1

1. SPECIALTY

Please list any specialties or subspecialties, and if you are ABMS board certified in any specialty, check the box.

Primary Specialty: Obstetrics + Gynecology ☑ Specialty2: Preventive Medicine (Occupational Medicine) ☐

Specialty3: _____ ☐ Specialty4: _____ ☐

2. MEDICAL LICENSURE

List **all** countries, states and provinces where you have held, now hold, or have applied for a medical license.

Country	Cert. #	Status	Date Expires
USA/Washington	18747	Expired	09/19/81
USA/Connecticut	035618	Expired	09/30/99
USA/Arkansas	E-3126	Expired	09/30/04
USA/California	G86493	Expired	09/30/11
USA/Massachusetts	48979	Active	09/19/12
USA/New York	236603	Active	08/31/12

3. LIABILITY INSURANCE DATA

Information you supply here is required for the Maine Rural Health Access Program {24-A MRSA, Ch. 75, §6304, (3)}. The information will be reported to the Maine Superintendent of Insurance for administration of this program as provided in that law. Maintenance of professional liability insurance is not a requirement to maintain a Maine medical license in force. Please select 'Self Insured' if you have no professional liability insurance, or if you only pay a portion of the premium.

Please check the appropriate box to indicate the method you employ to secure professional medical malpractice liability insurance.

☐ Self Insured ☐ Physician Paid ☑ Employer Paid

If you checked off "Employer Paid", please enter the name of the employer who or which paid your premiums here: Planned Parenthood of New York City

Insurance Company (Name/Address): Policy #: [redacted]

National Union Fire Insurance Co. of Pittsburgh PA.
2595 Interstate Drive, Suite 103
Harrisburg, PA. 17110
Administrative offices: 175 Water St, NY, NY 10038

4. ADDITIONAL INFORMATION

Will you practice in Maine within the next year? ☑ Yes ☐ No If yes, in what community? Portland

5. HOSPITAL AFFILIATIONS

List **in chronological order** all hospitals where you have held or now hold privileges. Include all periods of time (Month and Year) from the date of completion of residency to the present. Be certain to report **COMPLETE ADDRESSES.** Failure to do so will delay the application process. You may photocopy this page, if necessary.

From Mo./Yr.	To Mo./Yr.	Name of Hospital, Institution, or Practice	Complete Address (Street, City, State, Zip)	Nature of Experience	Office Use Only S	Office Use Only R
08/84	12/86	Tufts Medical Center	800 Washington St. Boston, MA. 02111	Active staff		
01/88	06/02	UMASS Memorial Health Care	Medical Staff Services Dept. 11 Shattuck St - Suite 101 Worcester, MA. 01605	Active 01/88-06/01 courtesy 07/01-06/02		
12/01	06/02	Beth Israel - Deaconness Medical Center	330 Brookline Av. Boston, MA. 02215 FAX (617) 667-1950	Active		
12/02	01/04	San Francisco General Hospital	Medical Staff Services 1001 Potrero Av. Building 20, 3rd floor, Room 2300 San Francisco, CA. 94110 FAX (415) 206-2360	Courtesy	1/31	3/2
11/04	07/05	UCSF Medical center at Mt. Zion	Medical Staff Office 1600 Divisadero St. - Room C136 San Francisco, CA. 94143-1639 FAX (415) 885-7611	Active	1/31	2/1
01/06	Present	Beth Israel Medical Center	Office of Credentialing Services 1st Av at 16th St - 2 Gilman Hall NY, NY 10003 FAX (212) 420-4682	Active 01/06-12/11 Courtesy 01/12-present	1/31	3/22

Please note that, in some cases, the main hospital address differed from the Medical staff office address. I called the Maine Medical Board and was advised to provide the addresses for the medical staff offices. Thank you.
Maureen Paul

ADDENDUM 2

PERSONAL DATA

Check off (X) each appropriate response. Every 'YES' response must be fully explained by written statement on a separate 8.5" x 11" sheet of white paper. Each such explanation must be cross-referenced with the question number, and must be signed, dated, and submitted to the Board.

YES NO

☐ ☒ 1. Have you EVER had ANY licensing authority (INCLUDING MAINE) deny your application for any type of license, or take any disciplinary action against the license issued to you in that jurisdiction, including but not limited to warning, reprimand, fine, suspension, revocation, restrictions in permitted practice, probation with or without monitoring?

☐ ☒ 2. Have you EVER been notified of the existence of allegations involving you, filed with or by ANY licensing authority (INCLUDING MAINE), which allegations remain open as of the date of this application?

☐ ☒ 3. Have you EVER left a medical licensing jurisdiction (INCLUDING MAINE) while a complaint or allegation was pending?

☐ ☒ 4. Have you EVER been denied registration, or had your ability to prescribe or dispense controlled substances modified, restricted, suspended, revoked, or voluntarily suspended by, or surrendered to

☐ ☒ a) The U. S. Drug Enforcement Administration (US DEA)?

☐ ☒ b) Any state/territory of the U. S., INCLUDING MAINE?

☐ ☒ 5. Have you EVER received a sanction from Medicare or from any state Medicaid program?

6. The purpose of the following questions is to determine the current fitness of the applicant to practice medicine. The following inquiries concern medical, mental health, and addiction issues. This information is treated confidentially by the Board. The mere fact of treatment for medical, mental health or addiction(s) is not, in itself, a basis on which an applicant is ordinarily denied licensure when he/she has demonstrated personal responsibility and maturity in dealing with these issues. The Board encourages applicants who may benefit from such treatment to seek it. The Board may deny a license to applicants whose ability to function in the practice of medicine or whose behavior, judgment, and understanding is impaired by a medical, mental health or addictive condition.

☐ ☒ a. Since becoming a medical student, have you been diagnosed with or treated for a medical, mental health, or addictive condition which in any way currently limits or impairs your ability to practice medicine or to function as a physician?

☐ ☒ b. Within the last five (5) years have you been diagnosed with or treated for any medical, mental health, or addictive disorder that impaired your behavior, judgment, understanding, or ability to function in school, work or other important life activities?

☐ ☒ c. Are you now, or have you during the past five (5) years been dependent upon alcohol or habituating drugs or undergone treatment for such?

Yes No N/A

☐ ☐ ☒ d. If any of your answers to questions 6(a-c) is "Yes," are the limitations or impairments caused by your medical, mental health, or addictive condition reduced or improved because you receive ongoing professional treatment (with or without medication) or because you participate in a professional monitoring program?

☐ ☒ e. Within the last five (5) years have you ever raised the issue of consumption of drugs or alcohol or the issue of a medical, mental health or addictive disorder as a defense or in mitigation of, or as an explanation for your actions in the course of any administrative or judicial proceeding or investigation; any inquiry or other proceeding; or any proposed termination action (educational, employer, government agency, professional organization, or licensing authority?

☐ ☒ f. Are you currently engaged in the illegal use of drugs or misuse of any drugs?

☐ ☒ g. Have you ever been diagnosed with or treated for any type of sexual behavior disorder?

☐ ☒ 7. Have you EVER been charged, summonsed, indicted, arrested, or convicted of any criminal offense, including when those events have been deferred, set aside, dismissed, expunged or issued a stay of execution? Please include motor vehicle offenses but not minor traffic or parking violations.

YES NO

☐ ☒ 8. Have you EVER applied for hospital, HMO or other health care entity privileges which were denied?

☐ ☒ 9. Have you EVER had your staff privileges or employment at any hospital, nursing home, HMO, or other health care entity terminated, revoked, reduced, restricted in any way, suspended, made subject to probation, limited in any way, or withdrawn involuntarily?

☐ ☒ 10. Have you EVER voluntarily surrendered privileges or resigned from staff membership during peer review or investigation or to avoid peer review or investigation?

☐ ☒ 11. Have you EVER been deselected from a managed care organization physician panel?

☐ ☒ 12. Have you EVER been disciplined by a professional society or resigned while accusation was pending?

☒ ☐ 13. Have you EVER been named as a party or a defendant, or as an employee of a party or a defendant, in a medical malpractice liability claim or lawsuit, including nuisance suits settled, adjudicated by a court in favor of the other party, or settled by your insurance company/representatives without your express consent? PLEASE SEE ADDENDUM 3

☐ ☒ 14. Do you have any open malpractice claims?

☐ ☒ 15. Do you intend to practice medicine within the State of Maine without active medical staff privileges at a Maine hospital?

ADDENDUM 3

Maine Board of Licensure in Medicine

Professional (Malpractice) Liability Claims Experience

Duplicate For Multiple Claims

My Name:
MAUREEN ELIZABETH PAUL

Identity of Case:
[redacted] v. MAUREEN PAUL MD;
SUFFOLK SUPERIOR COURT, DOCKET #86-13

Date and Place of Original Occurrence:
NEW ENGLAND MEDICAL CENTER, BOSTON, MA. 03/19/1985
(NOW TUFTS MEDICAL CENTER)

Malpractice Alleged By Claimant:
NEGLIGENT TREATMENT OF CHORIOAMNIONITIS

Summary of My Defense:
PLAINTIFF WAS TREATED FOR CHORIOAMNIONITIS WITH IV ANTIBIOTICS DURING AND AFTER HER VAGINAL DELIVERY AT NEW ENGLAND MEDICAL CENTER. I WAS THE ATTENDING PHYSICIAN ON THE OB SERVICE AT THE TIME. PATIENT DEVELOPED CHRONIC PAIN AND ALLEGED INADEQUATE TREATMENT OF CHORIOAMNIONITIS, EVEN THOUGH SHE RECEIVED IV ANTIBIOTICS UNTIL SHE WAS AFEBRILE FOR SEVERAL DAYS. SUBSEQUENT DIAGNOSTIC LAPAROSCOPY BY ANOTHER PHYSICIAN SHOWED NO PELVIC PATHOLOGY.

Current Status of Case (Include payment amounts):
MA. MEDICAL TRIBUNAL FOUND IN MY FAVOR 06/10/88, BUT PLAINTIFF FILED A BOND TO PURSUE THE ACTION. TRIAL 08/09/91 - 08/14/91 ENDED IN A DIRECTED VERDICT IN MY FAVOR.
NO PAYMENTS

Name and Address of Insurance Company and/or Attorney Defending the Case:
TUFTS MEDICAL CENTER INDEMNITY COMPANY
800 WASHINGTON ST. - BOX 55
BOSTON, MA. 02111
PHONE: (617) 636-6363; FAX (617) 636-8277

ADDENDUM 3

Maine Board of Licensure in Medicine

Professional (Malpractice) Liability Claims Experience

Duplicate For Multiple Claims

RECEIVED
JAN 30 2012
BOARD OF LICENSURE IN MEDICINE

My Name:
MAUREEN ELIZABETH PAUL

Identity of Case:
[redacted] v. PLANNED PARENTHOOD LEAGUE OF MASSACHUSETTS; SUFFOLK SUPERIOR COURT, case # SUCV2001-05610-E.

Date and Place of Original Occurrence:
05/1996, PLANNED PARENTHOOD LEAGUE OF MASSACHUSETTS (PPLM)

Malpractice Alleged By Claimant:
FAILURE TO DIAGNOSE CERVICAL CANCER

Summary of My Defense:
PLAINTIFF RECEIVED ROUTINE GYN CARE AT THE PLANNED PARENTHOOD LEAGUE OF MASSACHUSETTS DURING THE MID 1990's, DURING WHICH TIME SHE HAD TWO NORMAL PAP SMEARS. SHE WAS REFERRED FOR COLPOSCOPY WHEN A CLINICIAN NOTED A CERVICAL LESION ON ANNUAL EXAM, BUT THE PATIENT DID NOT RETURN FOR CARE. AS PART OF MY EMPLOYMENT AT THE UNIV. OF MA. MEDICAL CENTER, I SOMETIMES PROVIDED SERVICES AT PLANNED PARENTHOOD ON A CONTRACT BASIS. MY NAME APPEARS IN THE CHART BECAUSE I CO-SIGNED A CLINICIAN'S NOTE AS PART OF A CHART REVIEW. I WAS ERRONEOUSLY NAMED AS MEDICAL DIRECTOR IN THIS SUIT, AND I NEVER SAW THIS PATIENT.

Current Status of Case (Include payment amounts):
PLAINTIFF VOLUNTARILY DISMISSED LITIGATION BEFORE ANY DEPOSITIONS BY DEFENDANTS. THE CASE WAS DISMISSED WITH PREJUDICE IN DECEMBER 2004. NO PAYMENTS.

Name and Address of Insurance Company and/or Attorney Defending the Case:
KENNETH FOX, ESQ.
McALOON & FRIEDMAN, PC
123 WILLIAMS ST.
NY, NY 10038

Name: MAUREEN ELIZABETH PAUL

ADDENDUM 3

Maine Board of Licensure in Medicine

Professional (Malpractice) Liability Claims Experience

Duplicate For Multiple Claims

My Name:
MAUREEN ELIZABETH PAUL

Identity of Case:
[redacted] v. PLANNED PARENTHOOD OF NYC, BETH ISRAEL MEDICAL CENTER, GERALD ZUPNICK MD, MAUREEN PAUL MD, ZOE RODRIGUEZ MD, AND JACQUELINE BROWN MD; NY SUPREME COURT, case # 116033/07

Date and Place of Original Occurrence:
02/03/2007, PLANNED PARENTHOOD OF NYC (PPNYC)

Malpractice Alleged By Claimant:
AGAINST PPNYC: IMPROPER PERFORMANCE OF AN ABORTION, LACK OF INFORMED CONSENT
AGAINST BETH ISRAEL MEDICAL CENTER: FAILURE TO PROPERLY TREAT HEMORRHAGE

Summary of My Defense:
AS A STAFF PHYSICIAN AT PPNYC, I PLACED LAMINARIA FOR CERVICAL PREPARATION BEFORE THIS PATIENT'S ELECTIVE TERMINATION OF PREGNANCY AT 18 WEEKS' GESTATION. WHEN MY COLLEAGUE REMOVED THE LAMINARIA THE NEXT DAY, THE PATIENT BLED PROFUSELY. MY COLLEAGUE COMPLETED THE D+E AND TRANSFERRED THE PATIENT TO THE HOSPITAL WHERE SHE WAS TREATED FOR HEMORRHAGE AND DIC. LAPAROSCOPY REVEALED NO EVIDENCE OF ANY INJURY, INCLUDING PERFORATION, FROM THE LAMINARIA INSERTION. THE PATIENT UNDERWENT UTERINE ARTERY EMBOLIZATION AND WAS DISCHARGED HOME STABLE IN 2 DAYS.

Current Status of Case (Include payment amounts):
THE MATTER WAS DISCONTINUED AS TO ME ON 02/02/2011 WITH PREJUDICE + WITH NO PAYMENTS ON MY BEHALF. THE CASE WAS SETTLED BY THE REMAINING DEFENDANTS AND DISCONTINUED ON 03/01/2011. SETTLEMENT AMOUNTS: PLANNED PARENTHOOD $195,000; HOSPITAL (BETH ISRAEL) $75,000.

Name and Address of Insurance Company and/or Attorney Defending the Case:
KENNETH FOX, ESQ.
McALOON & FRIEDMAN, PC
123 WILLIAMS ST.
NY, NY 10038

Name: MAUREEN ELIZABETH PAUL

BethIsrael University Hospital and Manhattan Campus for the Albert Einstein College of Medicine

Continuum Health Partners, Inc.

Beth Israel Medical Center
Medical Staff Services
Milton and Carroll Petrie Division
First Avenue at 16th Street
New York, NY 10003
Tel: 212 420 2835 Fax: 212 420 4682

March 21, 2012

To Whom it May Concern:

Re: Maureen E. Paul, MD

Beth Israel Medical Center has received your request for information regarding the above referenced physician. Please note that due to the large volume of requests received, this response form is used for routine responses in lieu of completing each query individually.

Please see check mark next to each applicable response:

☑ We can verify affiliation with Beth Israel Medical Center as follows:

Current Status:	**Active**
Department:	**Obstetrics/Gynecology**
Specialty:	
Position:	**Adj Asst Attending**
Admitting Privileges:	**No**
Affiliation Dates:	**BI-Petrie: 01/11/2006 - 09/30/2013**

☐ In response to your query and in accordance with the New York State Public Health Law 2805, Beth Israel has no knowledge of any pending medical malpractice actions, judgments or settlements; pending or finalized professional misconduct investigations; limitation of privileges or information required to be reported concerning disciplinary actions on record for this physician.

☐ In response to your query and in accordance with the New York State Public Health Law 2805, our records indicate the following information regarding malpractice or professional misconduct. Please see attached.

☐ Based on the information provided, we were unable to locate a record for the above referenced physician.

☐ Based on the information provided, we were unable to complete an affiliation request at this time.

Please realize that we are unable to answer any questions regarding privileges, clinical competence, and/or professional performance. Please direct them to the chairman of the department. If you require further details regarding malpractice/professional liability history for physicians insured by Hospitals Insurance Company (HIC), please contact the Risk Management department at (212) 420-4672.

Sincerely,

Diane Duany

Diane Duany
Administrative Assistant
Ph: (212)420-2203

City and County of San Francisco
Department of Public Health
San Francisco General Hospital and Trauma Center

February 24, 2012

State of Maine
Board of Licensure in Medicine
137 State House Station
Augusta, MA 04333-0137

Dear Sir or Madam:

RE: **Maureen E. Paul, MD.**

We have received your inquiry regarding the above named practitioner. A review of our records indicates the following:

Date of Medical Staff Appointment:	**December 17, 2002**
Department:	**Obstetrics & Gynecology/**
Current Staff Category or Status:	**Resignation as of January 20, 2004**

Information regarding clinical issues may be addressed to:

Rebecca Jackson, MD
Service Chief, Obstetrics & Gynecology
San Francisco General Hospital
1001 Potrero Avenue, NH 6D14
San Francisco, CA 94110

Sincerely,
Rachel Morales
Rachel Morales
Medical Staff Services Assistant
SFGH Medical Staff Services

UCSF Medical Center

Medical Staff Services
1600 Divisadero St
1st Fl. Hellman Bldg.
Rm. C-136, Box 1639
San Francisco, CA
94115-1639

P: (415) 885-7268
F: (415) 885-7445

January 31, 2012

TRACY MORRISON
LICENSING SPECIALIST
MBOLIM
161 CAPITOL STREET
AUGUSTA, ME 04333

RE: Maureen E. Paul, MD

Due to the volume UCSF Medical Center receives for hospital affiliation requests, we are able to provide the following information:

Department: Ob/Gyn & Reproductive Sci
Specialty: Obstetrics & Gynecology,
Record Status: Inactive
Status Category: Attending
Affiliation Date: 11/25/2003 to 06/30/2005

The above-mentioned practitioner is/was a member in good standing on the UCSF Medical Staff. This letter does not reference any communications from the National Practitioner Databank or the Medical Board of California, as all healthcare entities receive such reports directly. For information concerning this practitioner's clinical competence, please contact the practitioner's respective clinical department. This letter only reflects the provider's most recent and/or current affiliation. For any discrepancies or questions, please contact the UCSF Medical Staff Services Department at 415.885.7268.

Sincerely,

D. W. Eisele

David Eisele, MD
President, UCSF Medical Staff

STATE OF WASHINGTON
DEPARTMENT OF HEALTH
MEDICAL QUALITY ASSURANCE COMMISSION
PO Box 47866, Olympia, WA 98504-7866

February 06, 2012

RECEIVED
FEB 13 2012
BOARD OF LICENSURE IN MEDICINE

STATE OF MAINE
137 STATE HOUSE STATION
AUGUSTA ME 04333

Subject: Credential Verification

To Whom It May Concern:

This verifies the status of the Physician And Surgeon License for MAUREEN ELIZABETH PAUL.

You may see blank sections because we do not have the information in our database or it is not applicable for this credential type. This information is valid from the date of this letter.

Year of Birth:	[redacted]
Credential Number:	MD.MD.00018747
Credential Type:	Physician And Surgeon License
Current Credential Status:	EXPIRED
First Credential Date:	09/26/1980
Current Expiration Date:	09/19/1981
Last Renewal Date:	09/19/1981
Disciplinary Action:	No

If you have questions, please call (360) 236-2766 for physicians and (360) 236-2771 for physician assistants, or visit our Online Provider Credential Search at www.doh.wa.gov.

Betty Elliott

Betty Elliott, Licensing Manager

MEDICAL BOARD OF CALIFORNIA
Licensing Program

January 31, 2012

MAINE BOARD OF LICENSURE IN MEDICINE
137 STATE HOUSE STATION
2 BANGOR ST 2ND FL
AUGUSTA ME 04333

To Whom It May Concern:

This is to certify that on the date of this letter the records of the Medical Board of California (Board) indicate the following information:

Physician:	Maureen Elizabeth Paul
License Number:	G 86493
Issued Date:	May 3, 2002
Exam Type:	A written examination
Expiration Date:	September 30, 2011
License Status:	License Canceled
Board Discipline:	No

If Board Discipline is indicated, you may contact the Board's Enforcement Program, Central File Room by email at fileroom@mbc.ca.gov, by fax at (916) 263-2420 or by mail at 2005 Evergreen Street, Suite 1200, Sacramento, CA 95815, to obtain information concerning the action.

Further public records pertaining to the above licensee, as well as information related to license status may be available from the Board's Web site at http://www.mbc.ca.gov.

Curtis J. Worden
Chief of Licensing

SECTION 162 OF THE BUSINESS AND PROFESSIONS CODE:
The certificate of the officer in charge of the records of any board in the department that any person was or was not on a specified date, or during a specified period of time, licensed, certified or registered under the provisions of law administered by the Board, or that the license, certificate or registration of any person was revoked or under suspension, shall be admitted in any court as prima facie evidence of the facts therein recited.

ARKANSAS STATE MEDICAL BOARD

1401 West Capitol, Suite 340, Little Rock, Arkansas 72201 (501) 296-1802 FAX: (501) 603-3555
www.armedicalboard.org

Detailed License Verification

Queried on: Monday, January 30, 2012 at: 4:53 PM

General Information

Name: Maureen Elizabeth Paul, M.D.
Specialty: Obstetrics & Gynecology

Address Information

Mailing Address: [redacted]
City/State/Zip: [redacted]
Phone: [redacted]
Fax: [redacted]

License Information

License Number: E-3126
Original Issue Date: 12/7/2001
Expiration Date: 9/30/2004
Basis: Exam
License Status: Inactive
License Category: Expired

No Information Found for: License Board History

ARKANSAS STATE MEDICAL BOARD

1401 West Capitol, Suite 340, Little Rock, Arkansas 72201 • (501) 296-1802 • FAX (501) 603-3555
www.armedicalboard.org

February 1, 2012

Maureen Elizabeth Paul, M.D.

CERTIFICATION

I, Peggy Pryor Cryer, Executive Secretary of the Arkansas State Medical Board, do hereby certify that the enclosed certification of the above referenced practitioner is true and correct as same appears on file in this office.

Witness my hand and official seal of the Board, this 1st day of February 2012.

ARKANSAS STATE MEDICAL BOARD

BY: _____
Peggy Pryor Cryer
Executive Secretary

THE UNIVERSITY OF THE STATE OF NEW YORK
THE STATE EDUCATION DEPARTMENT
DIVISION OF PROFESSIONAL LICENSING SERVICES
89 WASHINGTON AVENUE
ALBANY, NEW YORK 12234

ME

This is to certify that according to the records of the Division of Professional Licensing Services, New York State Education Department Albany, New York, PAUL MAUREEN ELIZABETH
was issued license/certificate number 236603 for the practice of MEDICINE on 06/20/05.

Our records also indicate the following information:
Date of birth: 09/19/49
School attended: TUFTS UNIVERSITY
Date of graduation: 05/20/79
Degree earned: MD

Program was acceptable in accordance with the NYS Regulations of the Commissioner of Education. Requirements met at the time of licensure.

Basis of licensure:

DATE	FLEX1	NBME1	USML1	NBME2	FLEX2	USML2	NBME3	USML3	OTHER
03/80							0000P		
09/78				0000P					
06/77		0000P							

NP 330610,332503,335051
NP 360466,360484,360223,304825,304731,304828,304833
NP 420701,420608,420760,420547,420020,420014,420546,420736,
NP 420686,420880,420878,420877,420948,420949,421019,421054
EXMS TAKEN=03

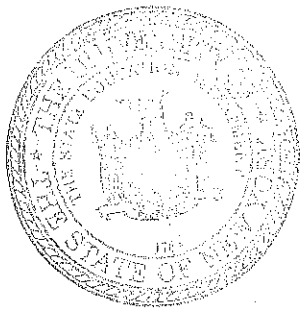
A license is valid during the life of the holder unless revoked, annulled or suspended by the Board of Regents. A licensee must register periodically with this Department to practice in this state.

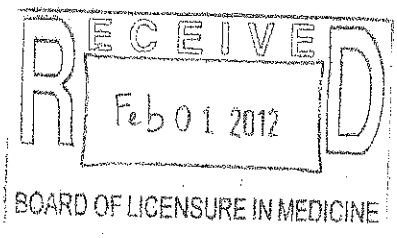
Currently Registered: YES Reg period ends: 08/31/12
Address: PLANNED PARENTHOOD NYC
26 BLEECKER ST NEW YORK NY 10012-0000
Disciplinary information: No charges have been preferred against this licensee
Comments:

I, Martin Carmody, Principal Clerk, Division of Professional Licensing Services of the New York State Education Department, do hereby state that as Principal Clerk of said Division, I have legal custody of the official records of the Division of Professional Licensing Services and to the best of my knowledge, the aforesaid information is true and correct.

SEAL

Martin Carmody 01/27/12
Principal Clerk





Commonwealth of Massachusetts
Board of Registration in Medicine
200 Harvard Mill Square, Suite 330
Wakefield, Massachusetts 01880
(781) 876-8200

DEVAL L. PATRICK
GOVERNOR

TIMOTHY P. MURRAY
LIEUTENANT GOVERNOR

Enforcement Division Fax: (781) 876-8381
Legal Division Fax: (781) 876-8380
Licensing Division Fax: (781) 876-8383

STANCEL M. RILEY, JR. MD.
EXECUTIVE DIRECTOR

1/27/2012

To Whom It May Concern:

This certifies that Maureen E Paul, M.D., a 1979 graduate of Tufts University School of Medicine, has been duly registered by this board as provided by the laws of the Commonwealth.

Certificate Number 48979 was issued to Dr. Paul on 03/02/1982. The license status is: Active. The expiration date is 9/19/2012.

Listed below is certain complaint and disciplinary information on this physician. Please note that the Board can neither confirm nor deny the existence of open complaints.

Closed Complaint Information

Our files contain 0 closed complaint(s) on this physician.

Final Board Disciplinary Action

Our files contain 0 disciplinary action(s) taken against this physician by the Board.

This information is derived from Board files from January 1, 1987 to the present. It does not include all the information contained in a license application.

As a service to the public and to designated agencies, the Massachusetts Board of Registration in Medicine offers an online profile of all physicians with full licenses who are licensed in the Commonwealth. This profile is updated daily and may include public information that is not otherwise contained in this certification letter. You may access this information at the Board's website:

www.mass.gov/massmedboard

Finally, the Board tallies closed complaints separately from disciplinary actions. If the same underlying incident gives rise to both a complaint and a disciplinary action, the Board counts this as two separate actions. In the same way, multiple disciplinary actions are tallied separately, even if they arise from a single set of circumstances.

Francee K. Arsenault

SEAL

Staff Member, Board of Registration in Medicine

Francee Arsenault

STATE OF CONNECTICUT

DEPARTMENT OF PUBLIC HEALTH

February 03, 2012

Maine Board of Licensure in Medicine
137 State House Station
161 Capitol Street
Augusta, ME 04333-0137

TO WHOM IT MAY CONCERN:

VERIFICATION OF LICENSURE

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

MAUREEN E. PAUL, MD

Was issued Connecticut:	Physician/Surgeon License
Date of Issuance:	10/04/1996
License Number:	35618
Expiration Date:	09/30/1999
Status of License:	INACTIVE, LAPSED DUE TO NON-RENEWAL
Past or Pending Disciplinary History:	No

Disciplinary History

Past or pending public Disciplinary action:

There has been no public disciplinary action	X
Public action taken, see attached	_____

Past or pending confidential action taken:

There has been no confidential disciplinary action	X
Complaint under investigation, see attached	_____
Confidential action taken, see attached	_____
Other, see attached	_____

Sincerely,

Stephen B. Carragher

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

Printed by: lf

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

ABMS MOC® Certification Matters™

Inaccessible between 8 AM and 8:30 AM Central Time.

Search Now

You are logged in as: TRACY.A.MORRISON@MAINE.GOV Change Profile Sign out

Enter the doctor's information below or you can search by location and specialty. If you are unsure of any of the fields, leave it blank.

Last Name	PAUL	First Name	
City		State/Prov	[Select]
Zip Code		Specialty	[Select]

SEARCH CLEAR

View Search FAQs

Back To Results

Physician Certification

Name
Maureen Elizabeth Paul

Education
MD
MPH

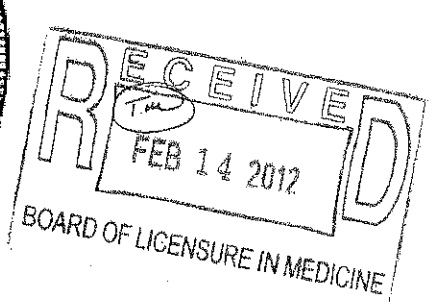
Location (First city and state listed is the last known location)
New York, NY (United States)
San Francisco, CA (United States)

Certification (For a definition of a specialty or subspecialty click here)
American Board of Obstetrics & Gynecology
Obstetrics & Gynecology - General (General indicates Primary Certificate)

American Board of Preventive Medicine

The Federation of State Medical Boards of the United States, Inc
Federation Credentials Verification Service
400 Fuller Wiser Road, Suite 300
Euless, Texas 76039
Telephone: (817) 868-5000
Fax: (817) 868-5099

Physician Information Profile



This report is compiled exclusively for:

Name: Maureen Elizabeth Paul
SSN: [redacted]
DOB: [redacted]
Packet ID: 50433
Recipient: Maine Board of Licensure in Medicine

NOTICE:

The Federation Credentials Verification Service (FCVS) was retained by the above referenced physician to verify his/her medical credentials for submission to your agency/organization. Unless noted otherwise, all documents contained in this report were received directly from the issuing institution per written request made by FCVS.

NOTICE: All documents bearing an original Official FCVS seal are certified to be an exact reproduction of the original. Where required, original documents are provided according to the agreements with the Institution issuing such document. FCVS maintains all original documents (excluding third-party examination transcripts) in the physician's source file.

This FCVS Physician Information Profile ("Profile") is compiled and provided by the Federation of State Medical Boards of the United States, Inc. (Federation) as a reference source for, and only for, its member boards and other entities authorized by the Federation. The Profile embodies and contains confidential business information because the information, and the format and presentation of that information, comprise trade secrets of the Federation and because the Profile's disclosure would harm the Federation by providing others with an unfair business advantage in competing with the Federation's FCVS services. Further, the form of the Profile and the contents of this Profile, including the compilation of information in this Profile, are the Federation's copyrighted works and proprietary, confidential information and are subject to the protections of United States laws governing copyright, trademark and trade secrets, as well as various state laws protecting the Federation's trade secrets and other intellectual property rights. This Profile and its contents may not be (1) copied, reformatted, modified, published or displayed publicly or (2) used, disclosed, distributed, shared or sold, in whole or part, for any purpose, including use to establish any database or files as a compendium or otherwise, all of which is strictly prohibited without the express written consent of the Federation's CEO.

Table of Contents

I. FCVS / FSMB Reports

A. Physician Information Report
B. Credentials Analysis Report
C. Board Action Data Bank Search Results
D. ABMS Specialty Certification(s)

II. Identity

A. Affidavit and Release
B. Certified Birth Certificate or Photocopy of Original Passport

III. Medical Education

A. Verification of Medical Education Form(s)
B. Official Medical Education Transcripts(s)
C. Certified Photocopy of Medical School Diploma
D. Verification of Fifth Pathway Form(s)
E. Photocopy of Fifth Pathway Certificate of Completion
F. Confirmation of ECFMG Certification
G. Photocopy of ECFMG Certificate

IV. Graduate Medical Education

A. Verification of Graduate Medical Education Form(s)

V. Examination History / Score Transcripts **(State Licensing Authorities Only)**

A. USMLE Transcript
B. FLEX Transcript
C. NBME Record of Scores
D. NBME Endorsement of Certification
E. NBOME Transcript
F. LMCC Transcript
G. State Board Exam Transcript

Section I

FCVS Reports

FEDERATION CREDENTIALS VERIFICATION SERVICE

Physician Information Report

Identity:

Name:	**Maureen Elizabeth Paul**	
Other Name Used:	**Maureen Elizabeth Groening**	
Gender:	**Female**	
Date of Birth:	[redacted]	
Place of Birth:	**Worcester, MA USA**	
SSN:	[redacted]	
Current Address:	**Planned Parenthood NYC** **26 Bleecker Street** **New York, NY 10012**	
Permanent Address:	**Same**	
Telephone Numbers:	Bus:	N/A
	Fax:	N/A
	Home:	[redacted]
	Other:	**917-208-9521**
Physical Description:	Height:	**5' 04"**
	Weight:	**126 lbs**
	Eye Color:	**Blue**
	Hair Color:	**Blond**
Physical Marks:	Description:	**N/A**
	Location:	**N/A**

Premedical Education (Reported by physician. Not verified by FCVS):

Institution:	**Michigan State University, East Lansing, MI 48824**
Dates of Attendance:	**09/1967 - 04/1970**
Degree Conferred/Issued:	**None**
Institution:	**University of Washington, Seattle, WA 98195-5850**
Dates of Attendance:	**06/1973 - 06/1975**
Degree Conferred/Issued:	**Bachelor of Science**

Medical Education:

Medical School:	**Tufts University School of Medicine** **145 Harrison Avenue** **Boston, MA 02111**

Dates of Attendance:	09/08/1975 - 03/24/1979
Date Degree Conferred/Issued:	05/20/1979
Degree Conferred/Issued:	**Doctor of Medicine**
Unusual Circumstance:	None

Graduate Medical Education:

Institution:	**University of Washington School of Medicine** **Department of Obstetrics/Gynecology** **1959 NE Pacific Street, Box 356460** **Health Sciences Building, BB667** **Seattle, WA 98195**
Training Level:	1
Program Type:	**Internship**
Specialty/Subspecialty:	**Obstetrics and Gynecology**
Dates of Attendance:	**07/01/1979 - 06/30/1980**
Completion:	**Yes**
Accreditation:	**ACGME**

Training Level:	2
Program Type:	**Residency**
Specialty/Subspecialty:	**Obstetrics and Gynecology**
Dates of Attendance:	**07/01/1980 - 06/30/1981**
Completion:	**Yes**
Accreditation:	**ACGME**
Unusual Circumstance:	None

Institution:	**Tufts Medical Center** **Department of Obstetrics and Gynecology** **750 Washington Street** **NEMC Box 022** **Boston, MA 02111**
Training Level:	2-4
Program Type:	**Residency**
Specialty/Subspecialty:	**Obstetrics and Gynecology**
Dates of Attendance:	**07/01/1981 - 06/30/1984**
Completion:	**Yes**
Accreditation:	**ACGME**
Unusual Circumstance:	None

Institution:	**University of Massachusetts Medical School** **Department of Preventive Medicine** **55 Lake Avenue North** **Worcester, MA 01655**

Training Level:	5
Program Type:	**Residency**
Specialty/Subspecialty:	**Occupational Medicine**
Dates of Attendance:	**01/01/1987 - 12/31/1987**
Completion:	**Yes**
Accreditation:	**ACGME**
Unusual Circumstance:	**None**

Fifth Pathway:

N/A

Examination History:

Licensure Examinations:	**NBME Part I** **NBME Part II** **NBME Part III**

Board Action:

A Report of the results from a search of the Board Action Data Bank is enclosed.

Credentials Analysis Report

The Credentials Analysis Report is a comparative report of a physician's credentials as reported to FCVS by the physician applicant and the primary source (Medical School, PGT program, etc.). It will also list particular missing documentation, if any, as outlined in the FCVS Policies and Procedures.

Physician Identification:

Name:	Maureen Elizabeth Paul
DOB:	[redacted]
SSN:	[redacted]
Packet ID:	50433
Request ID:	24770096

OMISSIONS

There are none identified.

DISCREPANCIES

Discrepancy 1:

Section of Profile:	**Medical Education**
Discrepancy:	The applicant reports the degree/diploma was issued/conferred/awarded by Tufts Univ Sch Med on 06/13/1979. The institution reports 05/20/1979.
Follow-Up:	FCVS has defined "graduation date" as the date the diploma was issued to the applicant by the medical school.

Discrepancy 2:

Section of Profile:	**Medical Education**
Discrepancy:	The applicant reports attendance at Tufts Univ Sch Med from 09/00/1975 to 06/00/1979. The institution reports attendance from 09/08/1975 to 03/24/1979.
Follow-Up:	FCVS does not follow up with the applicant or the institution for resolution of discrepant attendance dates less than one year.

MISCELLANEOUS INFORMATION

Miscellaneous 1:

VACATION

Section of Profile:	**Continuity of Education**
Issue:	Time periods of 6 months or more in which the physician did not participate in activities verified as part of the Physician Information Profile were identified during medical education between:

Verified postgraduate programs

Follow-Up: Included immediately after the Credentials Analysis Report is one of the following documents which were obtained from the applicant to explain the interruption:

Explanation of Activities During Medical Education Form ✓
Curriculum Vitae
FCVS Application page(s)
Written Explanation from the Applicant

End of report for Maureen Elizabeth Paul

Packet Id: 50433 Request Id: 24770096 Report Created By: RDG

DS

MAUREEN ELIZABETH PAUL M.D DOCKET ID 50433

EXPLANATION OF GAPS IN MEDICAL EDUCATION

Please provide a complete, specific explanation regarding any other training or breaks between the beginning of your medical education and the final year of your postgraduate training. Dates should be reported in mm/yyyy format.

From Date: 07/1981 (MM/YYYY)
To Date: 06/1984 (MM/YYYY)
Activity: Completed residency in Obstetrics + Gynecology, Tufts New England Medical Center, Boston, MA.

From Date: 07/1984 (MM/YYYY)
To Date: 07/1984 (MM/YYYY)
Activity: Vacation – travelled to Central America for month of July 1984

From Date: 08/1984 (MM/YYYY)
To Date: 12/1986 (MM/YYYY)
Activity: Employed as faculty physician in Dept. Obstetrics + Gynecology, Tufts New England Medical Center, Boston

From Date: 01/1987 (MM/YYYY)
To Date: 12/1987 (MM/YYYY)
Activity: Completed residency in Occupational Medicine at Univ. of Massachusetts Medical Center, Worcester, MA. (residency program now closed)

From Date:
To Date:
Activity:

From Date:
To Date:
Activity:

Maureen Paul MD 05/04/2005

The Federation of State Medical Boards
of the United States, Inc
PO Box 619850
Dallas, Texas 75261-9850
Telephone: (817)868-4000
FAX (817)868-4099

BOARD ACTION CLEARANCE REPORT

February 10, 2012

Attn: Tracy Bevers
FCVS
Tracy Bevers
400 Fuller Wiser Rd., #209
Euless, TX 76039

Re: Board Action Query Dated: February 10, 2012
Your Reference Number: fcvs-rdg
FSMB Batch Number: BQ2027998

The following is a final report of the search results from the Board Action Data Bank as of February 10, 2012 for practitioners the above-referenced batch for which NO board actions were identified.

Practitioners Cleared with No Actions as of February 10, 2012

Name	DOB	School	Yr/Grad
Paul, Maureen Elizabeth	[redacted]	022040	1979

LICENSE HISTORY
State Board
ARKANSAS
CALIFORNIA
MASSACHUSETTS
NEW YORK
WASHINGTON

PLEASE NOTE: The licensure history information contained in these reports is not considered licensure verification but rather an indicator of known states of historical licensure for these individuals. Use of this information should be limited to cross-reference purposes.

AMERICAN BOARD OF MEDICAL SPECIALTIES
VERIFICATION OF CERTIFICATION

As of: 2/10/2012

State Queried For:	Maine Board of Licensure in Medicine
Physician Name:	Maureen Elizabeth Paul
Date of Birth:	[redacted]
Year of Graduation:	1979 (Doctor of Medicine)
Social Security Number:	[redacted]
ABMSU ID:	199930

Certification:

Board:	Obstetrics and Gynecology
Specialty:	Obstetrics and Gynecology
Status:	ACTIVE
Initial Certification:	11/07/1986

Board:	Preventive Medicine
Specialty:	Occupational Medicine
Status:	ACTIVE
Initial Certification:	01/30/1990

All information on the ABMS report is based on a search of data shared with the FSMB by the American Board of Medical Specialties. For some physicians the biographic data in the ABMS database is incomplete and is not included in the shared data. FCVS is unable to verify specialty certification on these physicians. FCVS does not follow up with the applicant or ABMS on any missing or discrepant information.

Section II

Identity

AFFIDAVIT AND RELEASE

I, the undersigned, hereby certify under oath that I am the person named in this application, that all statements I have or shall make with respect thereto are true, that I am the original and lawful possessor 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 "INSTRUCTIONS FOR COMPLETING THE FCVS APPLICATION" 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 Federation Credentials Verification Service 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 Federation Credentials Verification Service 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 Federation Credentials Verification Service, its agents or representatives and any person furnishing information, of any and all liability of every nature and kind arising out of investigation made by the Federation Credentials Verification Service. I authorize the Federation Credentials Verification Service to release information, material, documents, orders or the like relating to me or this application to any entity at my request.

Maureen E. Paul

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

PAUL

Applicant's Printed Last Name

MAUREEN E.

Applicant's Printed First Name, Middle Initial, and Suffix (e.g., Jr.)

03/10/2005

Date of Signature (must correspond to date of notarization)

State of CALIFORNIA County of SAN FRANCISCO

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 10TH day of MARCH, 2005.

Notary Public signature:

My commission expires: MAY 5, 2005

PUNAM C. PATEL
Comm. # 1301158
NOTARY PUBLIC-CALIFORNIA
Alameda County
My Comm. Expires May 5, 2005

Notary:
The physician has been instructed to sign the front of the photograph. Your seal (or stamp) must be partly upon the photo and partly upon the signature of the applicant.

Section III

Medical Education

FEDERATION CREDENTIALS VERIFICATION SERVICE (FCVS)

VERIFICATION OF MEDICAL EDUCATION

(This form must be completed by the medical school)

INSTRUCTIONS TO THE DEAN

The individual identified on the attached Authorization For Release of Information, Documents and Records form has authorized your medical school to provide to the Federation Credentials Verification Service (FCVS) any and all information pertaining to their education at your institution. **Please complete this form and forward it to FCVS in the enclosed postage-paid, self-addressed envelope.**

Please note: If your institution processes transcript requests through another office, FCVS has likely made such a request under separate cover. **If your office also processes transcript requests, please attach the individual's official transcript (which indicates courses taken, dates and hours of attendance, and scores, grades, or evaluation).**

VERIFICATION OF MEDICAL EDUCATION

Name of Institution: Tufts University School of Medicine

Complete Address:

Street Address: 145 HARRISON AVE.

City: BOSTON **State:** MA **ZIP Code (Postal Code):** 02111

If name of institution was different when this individual attended, please note this name below:

Premedical Education:

Years of education required for admission to your medical school: 3

Credential/degree presented by the applicant for admission to your medical school: B.S.

Enrollment and Participation: Our records indicate that PAUL, MAUREEN ELIZABETH
(type/print individual's name: Last, First, Middle, Suffix)

attended our medical school for total of 138 weeks of medical education on the following dates (mm/dd/yy):

From 09 / 08 / 75 (Month / Date / Year) **To** 03 / 24 / 79 (Month / Date / Year)

This individual (check one):

☑ was awarded the degree of DOCTOR OF MEDICINE on 05 / 20 / 79 (Month / Date / Year)

☐ was NOT awarded a degree (please attach an explanation)

Certification: By my signature, I, CAROL A. DUFFEY (type/print name), certify that the above information is an accurate account of the above named individual's official records maintained in this and is true and correct to my knowledge.

Affix Institutional Seal Here. If no seal is available, this form must be notarized.

SEAL VERIFIED

Signature: Carol A Duffey

Title: REGISTRAR

Date of Signature: 4/6/05

Phone: (617) 636-6528 **Fax:** (617) 636-0432

Email: carol.duffey@tufts.edu

VERIFICATION OF MEDICAL EDUCATION

Unusual Circumstances: The following questions apply to unusual circumstances that occurred during any part of the individual's medical education. Please check the appropriate response and provide dates and requested information. "Yes" responses to any of these questions require a copy of explanatory records or a written explanation (attach additional pages as necessary).

1. Do this individual's official records reflect (an) interruption(s) or extension(s) in his/her medical education?
   Response YES ☐ NO ☑

   If YES, please select the reason(s) for, indicate the dates of the interruption(s) or extension(s) and check whether the interruption/extension was approved or unapproved.

	From Mo/Yr	To Mo/Yr	Approved	Unapproved
Personal/Family			☐	☐
Academic remediation			☐	☐
Health			☐	☐
Financial			☐	☐
Participation in joint degree Program (e.g., MD/PhD)			☐	☐
Participation in non-research special study (e.g., fellowship, international experience)			☐	☐
Participation in non-degree research			☐	☐
Other			☐	☐

   Please Specify: _____

2. Do this individual's official records reflect that he/she was ever placed on academic or disciplinary probation during his/her medical education?
   Response YES ☐ NO ☑

   If YES, please select the reason(s) for the probation, indicate the date(s) of placement on and removal from probation and attach additional documentation to this report.

	From Mo/Yr	To Mo/Yr
Academic Probation		
Probation for unprofessional conduct/behavioral		
Probation for other reason		

   Please specify reason: _____

3. Do this individual's official records reflect that he/she was ever disciplined for unprofessional conduct/behavioral reasons by the medical school or parent university?
   Response YES ☐ NO ☑

   If YES, please provide detailed documentation/information about the circumstances and outcome(s):

4. Do this individual's official records reflect that he/she was ever the subject of negative reports or an investigation by the medical school or parent university?
   Response YES ☐ NO ☑

   If YES, please provide detailed documentation/information about the circumstances and outcome(s):

5. Do this individual's official records reflect that there were any limitations or special requirements imposed on the individual because of questions of academic incompetence, disciplinary problems, or any other reason?
   Response YES ☐ NO ☑

   If YES, please provide detailed documentation/information about the nature of the limitations or special requirements.

PROVIDED BY
APPLICANT

Medical Education:

Medical School:	022040 - Tufts University School of Medicine 145 Harrison Avenue Boston, MA 02111
Date of Attendance:	09/1975 - 06/1979
Graduated?:	Y
Graduation Date:	06/13/1979
Degree Awarded:	Doctor of Medicine
Clinical Training Dates:	Not Reported
FedEx # (Foreign):	
Return via FedEx:	

Unusual Circumstances:

Leave:	N
Probation:	N
Discipline:	N
Negative Reports:	N
Limitations:	N

TUFTS UNIVERSITY
School of Medicine

Office of the Registrar

April 6, 2005

To Whom It May Concern:

The official transcript of Tufts University School of Medicine documents the student's name, undergraduate school, degree earned, date of graduation from medical school (when applicable), and the date of registration for each of the four years of the medical school program. The official transcript does not include courses or grades. The transcript is validated by the signature of the Registrar and the application of the raised school seal.

The performance record card is the document of record at Tufts University School of Medicine of the courses completed by the student and the official grades received. The performance record card also includes the student's matriculation date. Since the performance record card is not the school's official transcript, it does not bear the Registrar's signature or the school seal. You will see a notation to that effect.

Please call me with any questions.

Sincerely yours,

Carol A. Duffey
Registrar

145 Harrison Avenue
Boston, Massachusetts 02111
(617) 636-6568
Fax: (617) 636-0432

Universitas Cuttensis

in Republica Massachusettensi

Omnibus ad quos hae litterae pervenerint salutem plurimam dicit

Praeses Universitatis Cuttensis

honorandis ac reverendis Curatoribus iubentibus
doctis ac eruditis Professoribus probantibus
Scholae eius quae scientiam medicinae colit,

Maureen Elizabeth Paul

ad gradum **Medicinae Doctoris** *admisit eique fruenda dedit et concessit omnia iura, honores, insignia, privilegia ad hunc gradum pertinentia. In cuius rei testimonium, litteris hisce Sigillo Academico munitis*

ante diem XIII *Kal. Jun.* MCMLXXIX

nos Praeses Universitatis et Decanus Scholae
auctoritate nobis commissa nomina subscripsimus.

SEAL VERIFIED

Decanus

Praeses

TUFTS UNIVERSITY

School of Medicine

Office of Student Affairs

THE ACADEMIC SENATE OF TUFTS UNIVERSITY
IN THE COMMONWEALTH OF MASSACHUSETTS

To all those to whom this document may come, greeting

THE PRESIDENT OF TUFTS UNIVERSITY

On the nomination of the Faculty and authorized by the honorable and respected Trustees has admitted

MAUREEN ELIZABETH PAUL

to the degree of **Doctor of Medicine** and has granted and conceded to him/her to enjoy all the rights, honors, distinctions, and privileges to the degree appertaining. In testimony whereof, with this document secured by the Academic Seal,

MAY 20, 1979

we, the President of the University and the Dean of the College by the authority entrusted to us, have signed our names below.

Lauro F. Cavazos
Dean

Jean Mayer
President

Certified as a true copy

Amy B. Kuhlik M.D.
Dean for Student Affairs

JUN - 3 2005
Date

145 Harrison Avenue
Boston, Massachusetts 02111
617 636-6534
Fax: 617 636-0432

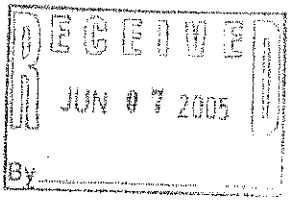
SEAL VERIFIED

30433

This is to certify that this is a true copy of the original document.

Carol A. Duffey, Registrar

June 3, 2005
Date



Section IV

Graduate Medical Education Training

Federation Credentials Verification Service (FCVS)

Federation Place, P.O. Box 619850, Dallas, TX 75261-9850
Tel: (817) 868-5000. Fax: (817) 868-5098

Verification of Postgraduate Medical Education

RECEIVED MAY 13 2005 By

Institution: **University of Washington School of Medicine**
Address: Department of Obstetrics/Gynecology, Seattle, WA 98195-6460
Attention: Program Director
Affiliated University:

Verification For:
Name: **Paul, Maureen Elizabeth**
SSN: [redacted]
DOB: [redacted]
Individual's Name on Record (If different from above):

RECEIVED APR 27 2005

Program Participation:
Important:
Report incomplete postgraduate years (PGY) separate from those that were successfully completed.

If the postgraduate year is currently in progress report the expected completion date in the "To" field.

Report Internships, Residencies and Fellowships separately.

Use one section per Department/Specialty. If the Department/Specialty is rotating or transitional, please provide a schedule of rotations.

PGY: 1
✓ Internship ___ Residency ___ Chief Residency ___ Fellowship ___ Research
Specialty/Subspecialty: OB-Gyn
From: 7, 1, 1979 To: 6, 30, 1980
Successfully Completed?: X Yes ___ No ___ In Progress
Accredited by: X ACGME __ AOA __ LCGME __ RSC __ CFPC __ RCPSC __ APPAP __ None of these

PGY: 2
✓ Internship ___ Residency ___ Chief Residency ___ Fellowship ___ Research
Specialty/Subspecialty: OB-Gyn
From: 7, 1, 1980 To: 6, 30, 1981
Successfully Completed?: X Yes ___ No ___ In Progress
Accredited by: X ACGME __ AOA __ LCGME __ RSC __ CFPC __ RCPSC __ APPAP __ None of these

PGY: ___ Internship ___ Residency ___ Chief Residency ___ Fellowship ___ Research
Specialty/Subspecialty:
From: / / To: / /
Successfully Completed?: ___ Yes ___ No ___ In Progress
Accredited by: __ ACGME __ AOA __ LCGME __ RSC __ CFPC __ RCPSC __ APPAP __ None of these

Unusual Circumstances:
Circle the correct response. Omitted responses require written explanation.

If necessary, you may continue your explanation on a separate sheet of paper.

Did this individual ever take a leave of absence or break from his/her training? Yes (No)
Was this individual ever placed on probation? Yes (No)
Was this individual ever disciplined or placed under investigation? Yes (No)
Were any negative reports ever filed by instructors? Yes (No)
Were any limitations or special requirements placed upon this individual because of questions of academic incompetence, disciplinary problems or any other reason? Yes (No)

Please explain any "Yes" response from above:

SEAL VERIFIED

ELIZABETH A. JARRETT NOTARY PUBLIC STATE OF WASHINGTON

Affix your official seal in this space. If no seal is available, you must have this signature notarized.

Completion of the following is certification that the information above is an accurate account of this individual's records and is true and correct. This section MUST be signed by the Program Director (M.D./D.O. only).

Name: ZANE A. Brown, MD Signature:
Title: Professor & Residency Director Date of Signature: 4/19/05
Tel: 206-543-3714 Fax: 206-616-9479 E-Mail: zbrown@u.washington.edu

Rev. 07/02/02 Packet ID: 50433 Request ID: 15353368 EAD [13656]

Elizabeth A Jarrett Notary 4/19/05

PROVIDED BY APPLICANT

Post Graduate Education:

Hospital:	University of Washington Medical Center
Affiliated Medical School:	Univ. of Washington Medical School 1959 NE Pacific Seattle, WA 98195
Post Graduate Year:	1-2
Program Type:	Residency
Department:	Obstetrics and Gynecology
Dates of Attendance:	07/1979 - 06/1981
Complete:	Y
Unusual Circumstances:	
Leave:	N
Probation:	N
Discipline:	N
Negative Reports:	N
Limitations:	N

Federation Credentials Verification Service (FCVS)

Federation Place, P.O. Box 619850, Dallas, TX 75261-9850
Tel: (817) 868-5000 Fax: (817) 868-5099

Verification of Postgraduate Medical Education

Institution: **New England Medical Center**
Address: Department of Obstetrics and Gynecology, Boston, MA 02111
Attention: Program Director
Affiliated University: Tufts Univ. - New England Medical Center

Verification For:
Name: **Paul, Maureen Elizabeth**
SSN: [redacted]
DOB: [redacted]
Individual's Name on Record (If different from above):

RECEIVED MAY 09 2005 By

Program Participation:
Important: Report incomplete postgraduate years (PGY) separate from those that were successfully completed.

If the postgraduate year is currently in progress report the expected completion date in the "To" field.

Report Internships, Residencies and Fellowships separately.

Use one section per Department/Specialty. If the Department/Specialty is rotating or transitional, please provide a schedule of rotations.

PGY: 2-4
___ Internship
✓ Residency
___ Chief Residency
___ Fellowship
___ Research
Specialty/Subspecialty: Obstetrics & Gynecology
From: 7 / 1 / 81 To: 6 / 30 / 84
Successfully Completed?: ✓ Yes ___ No ___ In Progress
Accredited by: ✓ ACGME __AOA __LCGME __RSC __CFPC __RCPSC __APPAP __None of these

PGY: _____
___ Internship
___ Residency
___ Chief Residency
___ Fellowship
___ Research
Specialty/Subspecialty: _____
From: ___/___/_____ To: ___/___/_____
Successfully Completed?: ___Yes ___No ___In Progress
Accredited by: __ACGME __AOA __LCGME __RSC __CFPC __RCPSC __APPAP __None of these

PGY: _____
___ Internship
___ Residency
___ Chief Residency
___ Fellowship
___ Research
Specialty/Subspecialty: _____
From: ___/___/_____ To: ___/___/_____
Successfully Completed?: ___Yes ___No ___In Progress
Accredited by: __ACGME __AOA __LCGME __RSC __CFPC __RCPSC __APPAP __None of these

Unusual Circumstances:
Circle the correct response. Omitted responses require written explanation.

If necessary, you may continue your explanation on a separate sheet of paper.

Did this individual ever take a leave of absence or break from his/her training? Yes (No)
Was this individual ever placed on probation? Yes (No)
Was this individual ever disciplined or placed under investigation? Yes (No)
Were any negative reports ever filed by instructors? Yes (No)
Were any limitations or special requirements placed upon this individual because of questions of academic incompetence, disciplinary problems or any other reason? Yes (No)

Please explain any "Yes" response from above:

Certification:
Affix your institutional seal in this space. If you must have this form notarized.

SEAL VERIFIED

Completion of the following is certification that the information above is an accurate account of this individual's records and is true and correct. This section MUST be signed by the Program Director (M.D./D.O. only).

Name: Robert Kennison, MD Signature: [signature]
Title: Program Director & Professor Date of Signature: MAY 3, 2005
Tel: 617-636-0665 Fax: (617)636-8315 E-Mail: RKennison@tufts-nemc.org

EAD

Rev. 07/02/02 Packet ID: 50433 Request ID: 15353368 [17969]

PROVIDED BY APPLICANT

Post Graduate Education:

Hospital:	New England Medical Center
Affiliated Medical School:	Tufts University School of Medicine 750 Washington Street Boston, MA 02111
Post Graduate Year:	2-4
Program Type:	Residency
Department:	Obstetrics and Gynecology
Dates of Attendance:	07/1981 - 06/1984
Complete:	Y

Unusual Circumstances:

Leave:	N
Probation:	N
Discipline:	N
Negative Reports:	N
Limitations:	N

Federation Credentials Verification Service (FCVS)

Federation Place, P.O. Box 619850, Dallas, TX 75261-9850
Tel: (817) 868-5000 Fax: (817) 868-5099

Verification of Postgraduate Medical Education

Institution: **University of Massachusetts Medical School**
Address: Department of Preventive Medicine
Worcester, MA 01655

Attention: Program Director
Affiliated University:

Verification For:
Name: **Paul, Maureen Elizabeth**
SSN: [redacted]
DOB: [redacted]
Individual's Name on Record (If different from above):

RECEIVED
APR 25 2005
By

Program Participation:
Important:
Report incomplete postgraduate years (PGY) separate from those that were successfully completed.

If the postgraduate year is currently in progress report the expected completion date in the "To" field.

Report Internships, Residencies and Fellowships separately.

Use one section per Department/Specialty. If the Department/Specialty is rotating or transitional, please provide a schedule of rotations.

PGY: 5
___ Internship
✓ Residency
___ Chief Residency
___ Fellowship
___ Research
Specialty/Subspecialty: Occupational Medicine
From: 01 / 01 / 1987 To: 12 / 31 / 1987
Successfully Completed?: ✓ Yes ___ No ___ In Progress
Accredited by: ✓ ACGME __ AOA __ LCGME __ RSC __ CFPC __ RCPSC __ APPAP __ None of these

PGY: _____
___ Internship
___ Residency
___ Chief Residency
___ Fellowship
___ Research
Specialty/Subspecialty: _____
From: ___/___/_____ To: ___/___/_____
Successfully Completed?: ___ Yes ___ No ___ In Progress
Accredited by: __ ACGME __ AOA __ LCGME __ RSC __ CFPC __ RCPSC __ APPAP __ None of these

PGY: _____
___ Internship
___ Residency
___ Chief Residency
___ Fellowship
___ Research
Specialty/Subspecialty: _____
From: ___/___/_____ To: ___/___/_____
Successfully Completed?: ___ Yes ___ No ___ In Progress
Accredited by: __ ACGME __ AOA __ LCGME __ RSC __ CFPC __ RCPSC __ APPAP __ None of these

Unusual Circumstances:
Circle the correct response. Omitted responses require written explanation.

If necessary, you may continue your explanation on a separate sheet of paper.

Did this individual ever take a leave of absence or break from his/her training?	Yes (No)
Was this individual ever placed on probation?	Yes (No)
Was this individual ever disciplined or placed under investigation?	Yes (No)
Were any negative reports ever filed by instructors?	Yes (No)
Were any limitations or special requirements placed upon this individual because of questions of academic incompetence, disciplinary problems or any other reason?	Yes (No)

Please explain any "Yes" response from above:
NA

SEAL VERIFIED

Lucy Goodridge Comp Dep 9-15-11

Certification:
Affix your institutional seal in this space. If no seal is available, you must have this form notarized.

Completion of the following is certification that the information above is an accurate account of this individual's records and is true and correct. This section MUST be signed by the Program Director (M.D./D.O. only).

Name: Jacalyn Coghlin-Strom, MD Signature: Jacalyn Coghlin-Strom, MD
Title: Program Director Date of Signature: 4-14-05
Tel: (508) 856-5615 Fax: (508) 856-1212 E-Mail: Jacki.coghlin-strom@umassmed.edu

CMM

PROVIDED BY APPLICANT

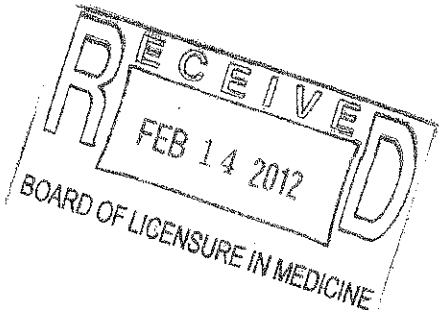
Post Graduate Education:

Hospital:	Univ. of Massachusetts Medical Center
Affiliated Medical School:	Univ. of Massachusetts Medical School 55 Lake Avenue North Worcester, MA 01655
Post Graduate Year:	1
Program Type:	Residency
Department:	Preventive Medicine
Dates of Attendance:	01/1987 - 12/1987
Complete:	Y

Unusual Circumstances:

Leave:	N
Probation:	N
Discipline:	N
Negative Reports:	N
Limitations:	N

Please note that this residency program has closed.



Examination History:

Exam Type:	NBME Part I
Most Recent Attempt:	06/1977
Nbr Of Attempts:	1

Examination History:

Exam Type:	NBME Part II
Most Recent Attempt:	09/1978
Nbr Of Attempts:	1

Examination History:

Exam Type:	NBME Part III
Most Recent Attempt:	03/1980
Nbr Of Attempts:	1

Recipient Designation:

State Board Name:	New York State Board for Medicine

Section V

Examination History/Score Transcripts

NATIONAL BOARD OF MEDICAL EXAMINERS® (NBME®)
Record of Score

This document was prepared by
National Board of Medical Examiners® (NBME®)
3750 Market Street, Philadelphia, PA 19104-3190 · Telephone (215) 590-9700

Recipient: To Whom It May Concern **Date:** 01/26/2012

Examinee: Paul, Maureen E **Examinee ID:** [redacted]
Date of Birth: [redacted]

This record shows a complete Part history for this examinee:

NBME PART I

Test Date	Pass/Fail	Score Scale	Total Score	(Min.Pass)	Individual Subject Scores Anat	Phys	Bioc	Path	Micr	Phar	Beh Sci
06/14/1977	Pass	Three-Digit	505	(380)	495	510	600	490	545	440	410
		Two-Digit	81	(75)	80	81	87	80	83	77	75

NBME PART II

Test Date	Pass/Fail	Score Scale	Total Score	(Min.Pass)	Individual Subject Scores Med	Surg	ObGyn	Prev	Peds	Psych
09/26/1978	Pass	Three-Digit	500	(290)	490	535	550	405	540	475
		Two-Digit	82	(75)	82	84	85	77	84	81

NBME PART III

Test Date	Pass/Fail	Score Scale	Total Score	(Min.Pass)
03/05/1980	Pass	Three-Digit	450	(290)
		Two-Digit	80.3	(75)

RECEIVED
FEB 14 2012
BOARD OF LICENSURE IN MEDICINE

50433

TouchSafe®

SEE REVERSE SIDE FOR EXPLANATION OF INFORMATION REPORTED ABOVE

Uniform Application for Physician Licensure

UA Username: mpaulsf **Date Submitted:** 01/21/2012
FCVS Status: **Applicant has an FCVS Packet**

1. Full Name (use no initials)

Last Name Paul
First Name Maureen Elizabeth
Middle Name
Suffix
Maiden Name
M.D. Yes **D.O.** No

All other names used

First	Middle	Last	Suffix
Maureen Elizabeth		Groening	

2. Address/Phone

Business
Public Access **Street** Planned Parenthood NYC
Mailing 26 Bleecker Street
City New York **State/Province** NY **Zip Code** 10012
Country USA
Telephone 212-274-7266
Email maureen.paul@ppnyc.org

Home
[redacted]
Zip Code [redacted]
Country [redacted]
Telephone [redacted]
Email [redacted]

3. Identification

[redacted]	Worcester	Massachusetts	USA
Date of Birth (mm/dd/yyyy)	**Birth City**	**Birth State/Province**	**Birth Country**

F	[redacted]	[redacted]		
Gender	**Social Security Number**	**NPI**	**Are you a U.S. Citizen?**	Yes

4. Medical School

School Name Tufts University School of Medicine
Address 136 Harrison Avenue
City Boston
State/Province MA

ZIP Code 02111
Country USA
Attendance Dates From 09/1975 (mm/yyyy) **To** 06/1979 (mm/yyyy)
Graduation Date 06/13/1979
Degree MD

6. Postgraduate Training

Hospital Name University of Washington School of Medicine
Hospital Address 1959 NE Pacific Street, Box 356460
Health Sciences Building, BB667
City Seattle
State/Province Washington
ZIP Code 98195
Country USA

PGY: (e.g., 1, 2, 3, etc.) Residency
Department/Specialty Obstetrics and Gynecology

From Month	From Year	To: Month	To: Year	Successfully Completed?	In Progress
07	1979	06	1981	Completed	N

Hospital Name Tufts Medical Center
Hospital Address 750 Washington Street
NEMC Box 022
City Boston
State/Province Massachusetts
ZIP Code 02111
Country USA

PGY: (e.g., 1, 2, 3, etc.) Residency
Department/Specialty Obstetrics and Gynecology

From Month	From Year	To: Month	To: Year	Successfully Completed?	In Progress
07	1981	06	1984	Completed	N

Hospital Name University of Massachusetts Medical School
Hospital Address 55 Lake Avenue North
City Worcester
State/Province Massachusetts
ZIP Code 01655
Country USA

PGY: (e.g., 1, 2, 3, etc.) Residency

Department/Specialty Preventive Medicine

From	Month	Year	To:	Month	Year	Successfully Completed?	In Progress
	01	1987		12	1987	Completed	N

7. Examination History

Examination	State	Most Recent Date taken(Month/Year)	Passed (P) or Failed (F)	Number of attempts
NBME Part I		06/1977	U	1
NBME Part II		09/1978	U	1
NBME Part III		03/1980	U	1

9. State Licensure

State/Province	WA	**Practitioner Type (MD,DO, etc.)**	MD	**Type of License (Full, Temporary, etc.)**		Full License
License Number	18747	**Status**	Inactive	**Issue Date**		09/26/1980
State/Province	MA	**Practitioner Type (MD,DO, etc.)**	MD	**Type of License (Full, Temporary, etc.)**		Full License
License Number	48979	**Status**	Active	**Issue Date**		07/19/2005
State/Province	MA	**Practitioner Type (MD,DO, etc.)**	MD	**Type of License (Full, Temporary, etc.)**		Full License
License Number	48979	**Status**	Inactive	**Issue Date**		03/02/1982
State/Province	CT	**Practitioner Type (MD,DO, etc.)**	MD	**Type of License (Full, Temporary, etc.)**		Full License
License Number	035618	**Status**	Inactive	**Issue Date**		09/30/1997
State/Province	AR	**Practitioner Type (MD,DO, etc.)**	MD	**Type of License (Full, Temporary, etc.)**		Full License
License Number	E3126	**Status**	Inactive	**Issue Date**		12/07/2001
State/Province	CA	**Practitioner Type (MD,DO, etc.)**	MD	**Type of License (Full, Temporary, etc.)**		Full License
License Number	G86493	**Status**	Active	**Issue Date**		05/03/2002
State/Province	CA	**Practitioner Type (MD,DO, etc.)**	MD	**Type of License (Full, Temporary, etc.)**		Full License
License Number	G86493	**Status**	Inactive	**Issue Date**		09/30/2007
State/Province	NY	**Practitioner Type (MD,DO, etc.)**	MD	**Type of License (Full, Temporary, etc.)**		Full License
License Number	236603	**Status**	Active	**Issue Date**		06/20/2005

10. Chronology of Activities

Dates: From/To	Practice/Employment	
From: **Month:** 05 **Year:** 1979	**Practice/Employment Name** (or list non-working time as indicated above)	Moved from Boston, Massachusetts to Seattle, Washington

To:	Practice/Employment Address
Month: 06 Year: 1979 In Progress: N	City State/Province Zip Code Country Position and Department % Clinical % Administrative

Dates: From/To	Practice/Employment
From: Month: 07 Year: 1979 To: Month: 06 Year: 1981 In Progress: N	Practice/Employment Name University of Washington Medical Center (or list non-working time as indicated above) Practice/Employment Address 1959 NE Pacific City Seattle State/Province Washington Zip Code 98195 Country USA Position and Department Resident physician - Obstetrics & Gynecology % Clinical 100 % Administrative

Dates: From/To	Practice/Employment
From: Month: 07 Year: 1981 To: Month: 06 Year: 1984 In Progress: N	Practice/Employment Name Tufts New England Medical Center (or list non-working time as indicated above) Practice/Employment Address 750 Washington Street City Boston State/Province Massachusetts Zip Code 02111 Country USA Position and Department Resident physician - Obstetrics & Gynecology % Clinical 100 % Administrative

Dates: From/To	Practice/Employment
From: Month: 07 Year: 1984 To: Month: 07 Year: 1984 In Progress: N	Practice/Employment Name vacationed in Central America (or list non-working time as indicated above) Practice/Employment Address City State/Province Zip Code Country Position and Department % Clinical % Administrative

Dates: From/To	Practice/Employment
From: **Month:** 08 **Year:** 1984 **To:** **Month:** 12 **Year:** 1986 **In Progress:** N	**Practice/Employment Name** Tufts New England Medical Center (or list non-working time as indicated above) **Practice/Employment Address** 750 Washington Street **City** Boston **State/Province** Massachusetts **Zip Code** 02111 **Country** USA **Position and Department** Faculty/staff physician - Obstetrics & Gynecology **% Clinical** 80 **% Administrative**

Dates: From/To	Practice/Employment
From: **Month:** 01 **Year:** 1987 **To:** **Month:** 12 **Year:** 1987 **In Progress:** N	**Practice/Employment Name** University of Massachusetts Medical Center (or list non-working time as indicated above) **Practice/Employment Address** 55 Lake Avenue North **City** Worcester **State/Province** Massachusetts **Zip Code** 01655 **Country** USA **Position and Department** resident physician - Occupational Medicine **% Clinical** 100 **% Administrative**

Dates: From/To	Practice/Employment
From: **Month:** 01 **Year:** 1988 **To:** **Month:** 06 **Year:** 1998 **In Progress:** N	**Practice/Employment Name** UMass Memorial Medical Center (or list non-working time as indicated above) **Practice/Employment Address** 119 Belmont Street **City** Worcester **State/Province** Massachusetts **Zip Code** 01605 **Country** USA **Position and Department** Faculty/staff physician - Obstetrics & Gynecology **% Clinical** 75 **% Administrative**

Dates: From/To	Practice/Employment
From: **Month:** 07 **Year:** 1998 **To:** **Month:** 05 **Year:** 2002 **In Progress:** N	**Practice/Employment Name** Planned Parenthood League of Massachusetts (or list non-working time as indicated above) **Practice/Employment Address** 1055 Commonwealth Avenue **City** Boston **State/Province** Massachusetts **Zip Code** 02215 **Country** USA

	Position and Department Physician/Medical Director - N/A **% Clinical** 50 **% Administrative**

Dates: From/To	Practice/Employment
From: **Month:** 06 **Year:** 2002 **To:** **Month:** 06 **Year:** 2002 **In Progress:** N	**Practice/Employment Name** Moved from Boston, Massachusetts to San Francisco, California (or list non-working time as indicated above) **Practice/Employment Address** **City** **State/Province** **Zip Code** **Country** **Position and Department** **% Clinical** **% Administrative**

Dates: From/To	Practice/Employment
From: **Month:** 07 **Year:** 2002 **To:** **Month:** 05 **Year:** 2005 **In Progress:** N	**Practice/Employment Name** Planned Parenthood Golden Gate (or list non-working time as indicated above) **Practice/Employment Address** 815 Eddy Street **City** San Francisco **State/Province** California **Zip Code** 94109 **Country** USA **Position and Department** Physician/Chief Medical Officer - N/A **% Clinical** 50 **% Administrative**

Dates: From/To	Practice/Employment
From: **Month:** 06 **Year:** 2005 **To:** **Month:** 06 **Year:** 2005 **In Progress:** N	**Practice/Employment Name** Moved from San Francisco, California to New York City (or list non-working time as indicated above) **Practice/Employment Address** **City** **State/Province** **Zip Code** **Country** **Position and Department** **% Clinical** **% Administrative**

Dates: From/To	Practice/Employment
From:	**Practice/Employment Name** Planned Parenthood of New York City (or list non-working time as indicated above)

Month: 07 **Year:** 2005 **To:** **Month:** **Year:** **In Progress:** Y	**Practice/Employment Address** 26 Bleecker Street **City** New York **State/Province** New York **Zip Code** 10012 **Country** USA **Position and Department** Physician/Chief Medical Officer - N/A **% Clinical** 50 **% Administrative**

Dates: From/To	Practice/Employment
From: **Month:** 06 **Year:** 2006 **To:** **Month:** **Year:** **In Progress:** Y	**Practice/Employment Name** Planned Parenthood League of Massachusetts (or list non-working time as indicated above) **Practice/Employment Address** 1055 Commonwealth Avenue **City** Boston **State/Province** Massachusetts **Zip Code** 02215 **Country** USA **Position and Department** per diem physician - N/A **% Clinical** 100 **% Administrative**

11. Malpractice Liability Claims Information

Name of Patient involved: Marie Wicks

In which state did the action take place? MA **Case number (if applicable)** 86-13

Which court? Suffolk Superior Court

(If private compromise or settled before initiation of civil action, state here)

Current status of claim: Dismissed (no money paid out)

Amount of judgement or settlement $ 0 **Amount paid on your behalf $** 0

Month and year of event precipitating claim: 01 / 1985

Month and year of lawsuit: 11 / 1987

Insurance carrier at time: New England Medical Center

What is/or was your status? PRIMARY DEFENDANT

Please provide specifics in reference to the adverse event including the allegations and your role in the event:

Plaintiff alleged negligent treatment of chorioamnionitis during my role as an OB-Gyn attending physician at New England Medical Center in Boston, Massachusetts. Medical tribunal on 06/10/1988 found in my favor, but plaintiff filed a bond to pursue the action. Trial in Suffolk Superior Court commenced on 08/09/1991 and ended on 08/14/1991 with a directed verdict in my favor.

Name of Patient involved: [redacted]

In which state did the action take place? NY **Case number (if** 116033/07

applicable)

Which court? Supreme Court
(If private compromise or settled before initiation of civil action, state here)

Current status of claim: Dismissed (no money paid out)

Amount of judgement or settlement $ 0 **Amount paid on your behalf $** 0

Month and year of event precipitating claim: 02 / 2007

Month and year of lawsuit: 12 / 2007

Insurance carrier at time: National Union Fire Insurance Company

What is/or was your status? CO-DEFENDANT

Please provide specifics in reference to the adverse event including the allegations and your role in the event:

32 yo plaintiff presented to Planned Parenthood of New York City at 18 weeks' gestation for elective termination of pregnancy. I inserted laminaria for cervical preparation, and the patient returned the following day. Upon removal of the laminaria by my colleague, the patient bled profusely. My colleague completed the dilation and evacuation procedure and transferred the patient to the hospital where she underwent treatment for hemorrhage and DIC, including laparoscopic repair of a small cervical laceration, dilation and curettage, and uterine artery embolization. The plaintiff alleged improper performance of an abortion and lack of informed consent against Planned Parenthood. She also sued the hospital for failure to properly treat hemorrhage. The matter was discontinued with prejudice as to me on 02/02/2011.

Name of Patient involved: [redacted]

In which state did the action take place? MA **Case number (if applicable)** SUCV2001-05610-E

Which court? Suffolk Superior
(If private compromise or settled before initiation of civil action, state here)

Current status of claim: Dismissed (no money paid out)

Amount of judgement or settlement $ 0 **Amount paid on your behalf $** 0

Month and year of event precipitating claim: 05 / 1996

Month and year of lawsuit: 01 / 2002

Insurance carrier at time: National Union Fire Insurance Company

What is/or was your status? OTHER

Please provide specifics in reference to the adverse event including the allegations and your role in the event:

32 year old plaintiff filed a claim against Planned Parenthood League of Massachusetts alleging failure to diagnose cervical cancer. She had two normal pap tests at Planned Parenthood. A cervical lesion noted on annual exam prompted a referral for colposcopy, but the patient did not return to Planned Parenthood for care. I was erroneously named as Medical Director in the suit. I never saw this patient. The plaintiff voluntarily dismissed litigation before any depositions by defendants. The case was dismissed with prejudice in December 2004.

-1 (=12) 96.7%

Maine Board of Licensure in Medicine
State Licensure Examination
Revised 1/23/2008

Applicant: MAUREEN ELIZABETH PAUL (please PRINT full name)

Question #1. True or False - Sexual contact between a licensee and a patient is not misconduct if the patient suggests it.

☐ True ☑ False

Question #2. True or False – A patient is never entitled to a copy of his or her own medical record.

☐ True ☑ False

Question #3. True or False - Habitual rudeness to patients and or colleagues is potential grounds for Board investigation and /or disciplinary action.

☑ True ☐ False

Question #4. True or False – Even if the Licensee (physician or physician assistant) does not belong to the American Medical Association, the AMA code of ethics will be applied to that licensee's behavior.

☑ True ☐ False

Question #5. Which of the following statements about Maine's Letters of Guidance from the Board of Medicine to a licensee is true?

A. Letters of Guidance are reported to the National Data Bank.
B. Letters of Guidance are a type of disciplinary action by the Board of Medicine.
C. Letters of Guidance are a mechanism for the Board to deal with problem licensee behavior that is not serious enough to warrant formal discipline.
D. Letters of Guidance are absolutely confidential.

☐ A ☐ B ☑ C ☐ D

Question #6. True or False - Outbursts of anger from licensees caused by stress or lack of rest will be excused as long as the licensee is otherwise competent.

☐ True ☑ False

Question #7. True or False - Sexual contact with a patient is not deemed misconduct if it occurred outside the office.

☐ True ☑ False

Question #8. True or False -There is little a licensee can do to prevent the diversion of opioids to drug abusers.

☐ True ☑ False

Question #9. True or False - If a patient has not paid a bill, the licensee has no obligation to forward records upon request until the bill is paid.

☐ True ☑ False

Question #10. True or False - If deemed pertinent to the investigation of a complaint, the Board of Medicine has the authority to insist that a licensee undergo a physical, mental, and/or substance abuse evaluation by an evaluator of the Board's choice.

☑ True ☐ False

Question #11. True or False - Licensees do not need to be concerned about rude behavior of their office staff such as the receptionist.

☐ True ☑ False

Question #12. True or False - The Board reports all disciplines and practice restrictions to the National Practitioner Data Bank and the Federation of State Medical Boards discipline databank.

☐ True ☑ False

Question #13. True or False - Licensees should not prescribe controlled substances for themselves or for family members except in emergency situations.

☑ True ☐ False

Question #14. True or False – The sale of goods from the licensee's office raises ethical questions.

☑ True ☐ False

Question #15. True or False – If a patient files a complaint and then withdraws it, the Board may still pursue the complaint.

☑ True ☐ False

Question #16. A 55-year-old man who recently moved to your area is keeping an appointment in your office during business hours to establish care. He says that he has been prescribed oxycontin and oxycodone for his chronic severe osteoarthritis for the last two years by a Boston Physical Medicine & Rehabilitation doctor. He indicates he has less than a one-day supply of pain medication. He also admits that he was jailed 7 years ago briefly for a "minor offense." He is requesting a prescription for a one-month supply of oxycontin and oxycodone.

The best approach here would be:

A. Prescribe a one-month supply and wait to see how it goes.
B. Insist on contact with the most recent prescriber before acceding to his request. Also check the Prescription Monitoring Program data base operated by Maine's Office of Substance Abuse.
C. Explain that osteoarthritis pain is not treated with opioids.
D. Presume addiction/diversion is occurring and refuse to prescribe any opioids.

☐A ☑B ☐C ☐D

Question #17. The most appropriate attitude about managing nonmalignant pain is:

A. The risk of opioid addiction in long-term pain management is not a concern.
B. Use of opioids in long-term pain management requires monitoring for opioid abuse and diversion.
C. Opioid treatment should be reserved for terminal situations.
D. Pain is not a life-threatening problem and therefore does not require urgent attention.

☐A ☑B ☐C ☐D

Question #18. If an addicted licensee seeks help by contacting the Maine Medical Association Physician Health Program:

A. The Board will view this as grounds for automatic discipline.
B. The Physician Health Program will immediately make a report to the Board, whether or not there is potential for patient harm.
C. Appropriate treatment will be offered and monitored confidentially.
D. The Physician Health Program will immediately make a report to the National Data Base

☐A ☐B ☑C ☐D

Question #19. If a Maine licensee is reasonably concerned that a licensed practicing colleague has a substance abuse problem:

A. The concerned licensee has a legal obligation to report the colleague either to the Board of Medicine or to the Maine Medical Association Physician Health Program.
B. The concerned licensee may report the addicted colleague to the Board of Medicine or the Maine Medical Association Physician Health Program, but has no obligation to do so.
C. There is no obligation to report unless the concerned licensee is aware of adverse patient outcomes as a result of the substance abuse.

☑A ☐B ☐C

Question #20. Which of the following situations warrant Board disciplinary action?

A. The licensee exhibits increased tolerance to a narcotic prescribed by his/her health care provider who is treating the licensee for a painful condition.
B. The licensee seeks treatment for depression.
C. The licensee uses a sedative hypnotic or an anxiolytic which is prescribed, documented, and monitored by the licensee's health care provider.
D. None of the above.

☐A ☐B ☐C ☑D

Question #21. If unsure how to answer a question on a licensure application, a prudent course would be to:

A. Answer the question putting yourself in the most favorable light.
B. Call the Board for advice and/or attach an addendum to the application explaining the situation/circumstances.
C. Skip the question
D. Guess

☐A ☑B ☐C ☐D

Question #22. Which of the following is true?

A. A high percentage of chemically dependent physicians and physician assistants respond successfully to treatment and return to full practice.
B. Heavy alcohol use, if restricted to times when the licensee is not practicing medicine, will have no impact on the licensee's fitness for practice.
C. Licensees are too intelligent and too informed about drugs and alcohol to get into trouble with them.
D. The Physician Health Program in Maine is of no assistance in keeping recovering licensees in practice.

☑A ☐B ☐C ☐D

Question #23. You have become concerned that a patient is addicted to, and/or diverting opioids you are prescribing for pain. You have learned that this patient is seeking opioid medication from multiple other providers. Which of the following is NOT true?

A. Opioid abuse /addiction is a potentially life-threatening medical condition.
B. Maine law supports communicating concern about the patient's opioid abuse and/or diversion to other providers and oversight agencies without the patient's consent.
C. Diversion of opioids threatens the health and safety of other Maine citizens.
D. You are obligated to continue prescribing opioids.

☐A ☐B ☐C ☑D

Question #24. Common issues underlying complaints against licensees to the Board of Licensure in Medicine include:

A. Office staff communication style.
B. Lack of communication regarding test results.
C. Poor communication among professionals.
D. Licensee rudeness.
E. All of the above.

☐A ☐B ☐C ☐D ☑E

Question #25. The major focus of the Maine Board of Licensure in Medicine is:

A. To protect the public health and welfare.
B. To provide education for licensees.
C. To provide a readily verifiable source of information for various credentialing bodies.
D. To provide rehabilitation for ill licensees.
E. To promote the public image of medicine.
F. To protect licensees from malpractice suits.

☑A ☐B ☐C ☐D ☐E ☐F

Question #26. If a licensee wishes to renew the license in active status and has failed to obtain adequate CME for license renewal, an acceptable course of action would be to:

A. Delay sending in the application for license renewal until the CME is completed.
B. Claim CME that is planned even if not yet completed.
C. Send in the application on time, including an accurate CME report, explain the circumstances around not having completed CME requirements, and request an extension.
D. Send in your renewal leaving CME information blank.

☐A ☐B ☑C ☐D

Question #27. Primary supervision of a Physician Assistant (PA) involves:

A. Accepting liability for the medical practice delegated to the physician assistant.
B. Developing, cosigning and implementing a detailed "plan of supervision" for each site at which the physician assistant is practicing.
C. Updating the plan of supervision at a minimum every two years with license renewal.
D. Knowledge of the specific competencies of the physician assistant.
E. All of the above.

☐A ☐B ☐C ☐D ☑E

Question #28. True or False – A Physician Assistant must obtain Board approval for schedule II prescribing authority in addition to DEA authority.

☑True ☐False

Question #29 True or False – A licensee whose license is in inactive status may practice medicine and surgery in Maine.

☐True ☑False

Question #30 True or False – The Board can assist licensees and/or complainants with medical malpractice issues.

☐True ☑False

I affirm that the foregoing answers are mine, and that I alone completed this examination.

Maureen Paul 03/07/2012

(Applicant signature) (Date)

The following are open comment questions to help us evaluate this exam.

Question #31. Through this experience did you learn anything that will be of value in your practice in Maine?

Absolutely! Particularly relevant sections included Board functions, mandatory reporting, and information about self/family prescribing. I thought the Informed Consent section was wonderful.

Question #32. If you have suggestions, questions, or other comments regarding the improvement of this examination, please make them here.

None regarding content. Most of the material was easy to read but the Mandatory Reporting Section was dense and "legalistic". Page numbers in Table of Contents would be helpful.

Question #33. Did you review the online Law/Rule/Policy review materials before taking this exam, or did you test your current level of knowledge?

__√__ **Read the materials first**

_____ **Did not read the materials first**

Online Licensing Request

Date: 08/26/2013
Regulator: BOARD OF LICENSURE IN MEDICINE
TXN Title: Renew as an Active Medical Doctor
License Prefix: MD
License Status: A
License: MAUREEN E. PAUL, MD (MD19175)

Application Information:

Address:

[redacted]

PLANNED PARENTHOOD OF NORTHERN NEW ENGLAND
443 CONGRESS ST
PORTLAND, ME 04101-3531
FIPS: 23005
Country: US
Addr Usages: BU

Email Address:

[redacted]

Email Usages: PR

Foreign Lic:

Delete
Type: MD
Number: G86493
Jurisdiction: CA
Issue Date: 05/03/2002

Change
Type: MD
Number: 48979
Jurisdiction: MA
Issue Date: 03/02/1982
Expiration Date: 09/19/2014

Add
Type: MD
Number: 236603
Jurisdiction: NY
Issue Date: 06/20/2005
Expiration Date: 08/31/2014

Licensee Board Data:

Legal State:

LICENSEE BOARD DATA ATTR - INDIVIDUALS
DEA Number: FP3329605
NPI Number: 1003822818

Phone:

+1 (212) 274-7218
Phone Usages: FAX
Cancel Date: 08/26/2013

+1 (212) 274-7266
Phone Usages: CA WO
Cancel Date: 08/26/2013

[redacted]
Phone Usages: CA OT

Questions:

Have you taken the Maine State Board of Medicine Written Exam within the four years previous to your current license expiration date and passed it?	Yes
1. Had ANY licensing authority (INCLUDING MAINE) deny your application for any type of license, or take any disciplinary action against the license issued to you in that jurisdiction, including but not limited to warning, reprimand, fine, suspension, revocation, restrictions in permitted practice, or probation with or without monitoring?	No
2. Been notified of the existence of allegations involving you, filed with or by ANY licensing authority (INCLUDING MAINE), which allegations remain open as of the date of this application?	No
1. Have you left a medical licensing jurisdiction (INCLUDING MAINE) while a complaint or allegation was pending?	No
2. Have you been denied registration or had your ability to prescribe or dispense controlled substances modified, restricted (except by administrative rule or statute in a jurisdiction), suspended, revoked, or voluntarily suspended by the U.S. Drug Enforcement Administration (DEA)?	No
3. Have you been denied registration or had your ability to prescribe or dispense controlled substances modified, restricted (except by administrative rule or statute in a jurisdiction), suspended, revoked, or voluntarily suspended by any state/territory of U.S. INCLUDING MAINE?	No
4. Have you received a sanction from Medicare or from any state Medicaid program?	No
5. Have you been diagnosed with or treated for a medical, mental	

health, or addictive condition which in any way currently limits or impairs your ability to practice medicine or to function as a health care provider?	No
6. Have you been diagnosed with or treated for any medical, mental health, or addictive disorder that impaired your behavior, judgment, understanding, or ability to function in school, work or other important life activities?	No
7. Are you now, or have you been dependent upon alcohol or habituating drugs or undergone treatment for such?	No
8. If any of your answers to questions 5-7 is *Yes*, are the limitations or impairments caused by your medical, mental health, or addictive condition reduced or improved because you receive ongoing professional treatment (with or without medication) or because you participate in a professional monitoring program?	No
9. Have you raised the issue of consumption of drugs or alcohol or the issue of a medical, mental health or addictive disorder as a defense or in mitigation of, or as an explanation for your actions in the course of any administrative or judicial proceeding or investigation; any inquiry or other proceeding; or any proposed termination action (educational, employer, government agency, professional organization, or licensing authority)?	No
10. Are you currently engaged in the illegal use of drugs or misuse of any drugs?	No
11. Have you been diagnosed with or treated for any type of sexual behavior disorder?	No
12. Have you been charged, summoned, indicted, arrested, or convicted of any criminal offense, including when those events have been deferred, set aside, dismissed, expunged or issued a stay of execution? Please include motor vehicle offenses but not minor traffic or parking violations.	No
13. Have you applied for hospital, HMO or other health care entity privileges which were denied?	No
14. Have you had your staff privileges or employment at any hospital, nursing home, HMO, or other health care entity terminated, revoked, reduced, restricted in any way, suspended, made subject to probation, limited in any way, or withdrawn involuntarily?	No
15. Have you voluntarily surrendered privileges or resigned from staff membership during peer review or investigation or to avoid peer review or investigation?	No
16. Have you been deselected from a managed care organization health care provider panel?	No
17. Have you been disciplined by a professional society or	

resigned while an accusation was pending?	No
18. Have you been named as a party or a defendant, or as an employee of a party or a defendant, in a medical malpractice liability claim or lawsuit, including a nuisance suit, which has been settled, adjudicated by a court in favor of the other party, or settled by your insurance company/representatives without your express consent?	No
19. Do you have any open malpractice claims?	No
20. Do you practice medicine within the State of Maine without active medical staff privileges at a Maine hospital?	Yes
Category I includes programs that have received accreditation by the AMA Council on Medical Education, the Accreditation Council for Continuing Medical Education (ACCME), or the Committee on CME of the Maine Medical Association. Category I CME's earned outside the U.S. or Canada must be approved by the Board; therefore such activities must be separately documented.	
Have you earned the 34 CME Category I credits required?	Yes
Category II includes programs with non-accredited sponsorship, i.e. Medical Teaching, Papers, Books, Publications, and Exhibits. Also included are non-supervised individual CME activities and other meritorious learning experiences. Note: Category I credits may be substituted in Category II.	
Have you earned the total of 85 CME Category I and Category II credits required?	Yes

Attachments:

Attachment ID: PRNOPRIV

My primary place of employment is Beth Israel Deaconess Medical Center (BIDMC)in Boston, where I serve as Director of the Family Planning Section in the Dept. of Obstetrics & Gynecology and have full active hospital privileges. As part of my job at BIDMC, I provide family planning services at Planned Parenthood of Northern New England in Portland, Maine, a few times per month. I do not have hospital privileges in Maine. In the rare event that a patient at Planned Parenthood requires hospital admission, the Medical Director or other attending physicians act as the referring physician of record.

Payments:

Amount:	$500.00
Method:	VISA - **** **** *** [redacted]
Expiration:	09/2014