Taylor, Patricia

From: Shumway, Allegra
Sent: Monday, December 16, 2013 2:02 PM
To: Taylor, Patricia
Subject: Change of physician address

Dear Ms Taylor:

I have recently changed my primary work address. My new address is:

Planned Parenthood of Northern New England
501 Portland St.
St. Johnsbury, VT 05819

Phone: 802-751-7821

My home address remains unchanged.

My preference would be for all mail to go to my work address in St Johnsbury.

Thank you very much.

Allegra Shumway, MD

1383

Mooney, Nichole

From: Shumway, Allegra
Sent: Tuesday, August 07, 2012 1:40 PM
To: Mooney, Nichole
Subject: Change of Work Address

Dear Nichole:

I am changing my work address to :

Allegra Shumway
PPNNE
90 Washington St
Barre, VT 05641

This does not actually represent a change in work location, as I work at several different PPNNE offices. However I will now be using the Barre address as my main work address.

My home address continues to be:

Correspondence from the Board of Medicine should be sent to me at my home address.

Please let me know if you need any additional information.

Allegra Shumway, MD

NEWPORT HEALTH CENTER
79 Coventry Street, Newport, VT 05855
Phone 802-334-5822 ■ Fax 802-334-5312

April 18, 2011

Dear New Hampshire Board of medicine:

My current work address is:

Planned Parenthood of Northern New England
Newport Health Center
79 Coventry St Suite 3
PO Box 932
Newport VT 05040
Phone 802-334-5822

My home address continues to be:

Phone:

Email:

I apologize for any confusion.

Sincerely,

Allegra Shumway, MD

New Hampshire Board of Medicine

2 INDUSTRIAL PARK DRIVE, SUITE 8, CONCORD, NH 03301-8520
Tel. (603) 271-1203 Fax (603) 271-6702
TDD Access: Relay NH 1-800-735-2964
WEB SITE: www.state.nh.us/medicine

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

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

Physician Name: Allegra Shumway, MD

Business Name: Planned Parenthood of Northern New England

[X] Address: 357 Western Ave. Suite 101

ST Johnsbury VT 05819

Office telephone: 802-748-8194

Business Fax Number: _____ Business E-Mail: _____

[ ] Home Address: _____

_____ Home telephone: _____

Specialty: Family Medicine Board certified: ✓

Hospital affiliations: None

In what other states do you hold a current license: VT

New Hampshire Board of Medicine

2 INDUSTRIAL PARK DRIVE, SUITE 8, CONCORD, NH 03301-8520
Tel. (603) 271-1203 Fax (603) 271-6702
TDD Access: Relay NH 1-800-735-2964
WEB SITE: www.nh.gov/medicine

April 1, 2009

ALLEGRA SHUMWAY MD

Dear Dr. Shumway:

Congratulations, your application for licensure has been granted by the New Hampshire Board of Medicine. Your license, numbered 14395, is dated April 1, 2009, and is enclosed with this letter.

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

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

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

Sincerely,

Penny Taylor

Penny Taylor
Administrator

Encl.

Common Licensure Application - Self-Reported

TAP Username:allegrashumway Submitted on: 11/29/2008 10:49 AM

1. Name

Name	Allegra Lucille Shumway MD
Maiden Name	
Alternate Name(s)	

2. Address/Phone

PLANNED PARENTHOOD

(Practice)	357 Western Ave. Suite 101
	St. Johnsbury, VT 05819
	USA
	Public Access: Public Mailing: N
(Home)	
	USA
	Public Access: None Mailing: Y
Phone	
Business	802-748-8194
Business Fax	
Home	
Home Fax	
Email	
Primary	
Secondary	

3. Identification

Sent 8.5.11 12/1/08

SHUMWAY, ALLEGRA

Birth Date	
Location:	
	USA
SSN	
National Provider ID	
U.S. Citizen	
Gender	

4. Medical Education

School	University of Vermont College of Medicine
Address	E109 Given Building Burlington, VT 05405 USA
Attendance Dates	09/1984 to 05/1988
Grad Date	5/21/1988
Degree	MD

5. Fifth Pathway

No information reported.

6. Postgraduate Medical Education

Fletcher Allen Health Care

Hospital	Fletcher Allen Health Care
	111 Colchester Avenue
	Burlington, VT 05401
	USA
PGY	

Year(s):1	Internship: **Complete?**: Completed
	Family Practice
	Dates: 07/1988 to 07/1989
Year(s):2-3	Residency: **Complete?**: Completed
	Family Practice
	Dates: 07/1989 to 07/1991

7. Examination History

Exam	NBME1
Date	
Attempts	1
Pass/Fail	P

Exam	NBME2
Date	
Attempts	1
Pass/Fail	P

Exam	NBME3
Date	
Attempts	1
Pass/Fail	P

8. ECFMG

ECFMG ID:	
Cert Date:	

9. State or Professional Licensure

State	VT
License Number	042-0008297
Type	MD : Doctor of Medicine
Status	ACT

Issue Date	11/27/2006

10. Chronology of Activities

Dates	07/1988 to 06/1991
Practice/Employment Name	Medical Center Hospital of VErmont
Address	111 colchester Ave.
	Burlington, VT 05401
Position	Intern/resident
Department	Family Practice
% Clinical / % Adm	100% / 0%
Employment	Y
Staff Priviledges	N
Affiliation	N
Other	N

Dates	07/1991 to 12/1998
Practice/Employment Name	Northern Counties Health Care Inc.
Address	165 Sherman Drive
	St Johnsbury, VT 05819
Position	Family Physician
Department	Hardwick Area Health Center
% Clinical / % Adm	100% / 0%
Employment	Y
Staff Priviledges	Y
Affiliation	N
Other	N

Dates	10/1998 to 11/1999
Practice/Employment Name	Planned Parenthood of Northern New England
Address	183 Talcott Rd. Suite 101
	Williston, VT 05495
Position	Float Coverage (per Diem)

Department	Northern Vt
% Clinical / % Adm	100% / 0%
Employment	Y
Staff Priviledges	N
Affiliation	N
Other	N

Dates	11/1999 to 06/2008
Practice/Employment Name	Planned Parenthood of Northern New England
Address	183 Talcott Rd. Suite 101
	Williston, VT 05495
Position	Site Manager
Department	Newport Health Center
% Clinical / % Adm	84% / 16%
Employment	Y
Staff Priviledges	N
Affiliation	N
Other	N

Dates	07/2004 to /2005
Practice/Employment Name	Stowe Immediate Care
Address	394 Mountain Rd.
	Stowe, VT 05672
Position	Physician
Department	
% Clinical / % Adm	100% / 0%
Employment	Y
Staff Priviledges	N
Affiliation	N
Other	N

Dates	06/2008 to In Progress
Practice/Employment Name	Planned Parenthood of Northern New England
Address	183 Talcott Rd. Suite 101
	Williston, VT 05495
Position	Health Care Provider
Department	St Johnsbury Health Center
% Clinical / % Adm	100% / 0%

Employment	Y
Staff Priviledges	N
Affiliation	N
Other	N

11. Malpractice Liability Claims Information

No information reported.

TAP Username: Submission tracking ID: **Self-Reported**
ver 200611113

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.

JAN 12 2009

BN BOARD

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 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 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 licensure or permit to practice medicine.

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

Shumway

Applicant's Printed Last Name

Allegra Lucille

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

11/26/08

Date of Signature

Dated 11/26/08 Signed Paula E. Shea NOTARY

State of Vermont County of Orange

SUBSCRIBED AND SWORN TO before me this 26th day of, Nov 2008.

My commission expires: 2/10/11 (NOTARY PUBLIC SIGNATURE & SEAL)

ADDENDUM TO APPLICATION

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

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

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

Anticipated Practice Location(s) (if known):

Planned Parenthood of Northern New England
West Lebanon Health Center

Applicant's Signature

Shumway, Allegra Lucille
Applicant's Printed Last Name

12/5/08
Date of Signature

For Board Use Only:

Application Received: 1-12-, 2009 Fee Paid: $250.00 Check#: _____

License Number: _____ Date of Issue: _____

Allegra Shumway, MD

Phone: (W) 802-748-8194
email:

Certified Family Physician providing gynecological, health maintenance, and family planning clinical services and related community services. Currently employed by Planned Parenthood of Northern New England in Vermont, and seeking New Hampshire license in order to provide float or part time coverage for patient care in the West Lebanon Planned Parenthood Health Center, as well as other New Hampshire Planned Parenthood sites.

Education:

University of Vermont College of Medicine and Fletcher Allen Health Center, Burlington, Vermont: Internship and Residency, Department of Family Practice, June 1988 through completion of Residency June 1991

University of Vermont College of Medicine, 1984-1988. Received MD degree May 1988

Kirkland College, Clinton NY, 1974-78 Double major in Biology and Philosophy. Received BA degree May, 1978

Tompkins Cortland Community College, Ithaca, NY, 1982-83. 14 credit hour, Spanish, computer science, chemistry

Licensure and Certification:

State of Vermont Physician's License with Ionizing Radiation Privileges renewed 10/29/2008. First obtained Vermont Physician's license in 1988, have maintained a current license without lapse since that time.

Certified as a Diplomate of the American Board of Family Practice 1991, recertified 1998 and 2005.
Current Valid Controlled Substances Registration Certificate; have maintained current certificate without lapse since 1988

Experience:

Planned Parenthood of Northern New England, St Johnsbury Health Center, St Johnsbury, Vt. June 2008- present
Provide direct patient care consisting of outpatient gynecology, health care maintenance, cancer screening, extensive family planning services, and STI screening, diagnosis, and treatment for both men and women, as well as presentations to school and other community groups regarding STI's and family planning. Also provide coverage for other Northern Vermont Planned Parenthood Health Centers.

Planned Parenthood of Northern New England, Newport Health Center, Newport, VT. Nov 1999-June 2008.
Provided clinical and community services as above; in addition oversaw Health Center budget operations and personnel.

Stowe Immediate Care, Stowe Vermont. Jan 2003-July 2004.
Provided part time physician coverage for a walk-in clinic seeing all manner of acute problems.

Planned Parenthood of Northern New England, Oct 1998- Nov. 1999
Provided coverage for vacations and other absences for health care providers in Planned Parenthood Health Centers throughout Northern Vermont

Northern Counties Health Care Inc., Hardwick Area Health Center, Hardwick, VT. July1991-Jan 1999
Provided full range of Family Medicine services to children and adults in the greater Hardwick Area. Admitting privileges in Medicine and ICU at Copley Hospital, Morrisville, VT.

American Board of Family Medicine, Inc.

Founded 1969

December 30, 2008

To Whom It May Concern:

This letter verifies Allegra L. Shumway, M.D. is currently certified with the American Board of Family Medicine (ABFM).

Family Medicine Certification History:

Jul 12, 1991 - Jul 09, 1998
Jul 10, 1998 - Jul 22, 2005
Jul 23, 2005 - Dec 31, 2012

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

Current Status: Participating and Current

Certification in Family Medicine is for a period of seven years. A Certificate of Added Qualifications (Geriatrics, Sports Medicine, etc.) has a length of 10 years. From 1970 through 2002, certification was renewed by completion of requirements for Recertification. Each physician (Diplomate) fulfilled the obligation of maintaining a full and unrestricted medical license, earning 300 hours of continuing medical education (CME), and successfully completing the recertification examination.

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

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

Sincerely,

Kathy Baker

Kathy Baker
Verification Coordinator

2228 Young Drive
Lexington, KY
40505-4294

Tel: (888) 995-5700
(859) 269-5626
Fax: (859) 335-7501
(859) 335-7509
www.theabfm.org

A Member Board of the American Board of Medical Specialties

Allegra Shumway, MD

Phone: (W) 802 748-8194
E-mail:

New Hampshire Board of Medicine
2 Industrial Park Drive
Concord, NH 03301

Jan 6, 2009

Dear People:

Enclosed please find the following materials for my application for a New Hampshire Medical License:

1) Addendum to Application
2) Affadavit and Authorization for Release of Information
3) Resume
4) Notarized Copy of DEA Certificate
5) Letter from American Board of Family Medicine, Inc. verifying my current certification status. I have requested that an additional letter be sent to you directly from the Board office.
6) My inked fingerprints.
7) Authorization for release of my criminal record convictions, if any
8) Reference letter from Dr. Cheryl Gibson. Additional reference letters will be sent
9) Check payable to the Treasurer, State of New Hampshire, for $250
10) Check payable to State of NH—Criminal Records for $42.25

Please let me know if there are additional materials that are needed in order to process my application.

Thank you for your assistance.

Sincerely,

Allegra Shumway, MD

STATE OF NEW HAMPSHIRE

Telephone #: 603-271-6934

BOARD OF MEDICINE
2 Industrial Park Drive, Suite 8
Concord, NH 03301-8520

RENEWAL APPLICATION

Renewal Fee $300.00

For expiration on: 06/30/2013

For Office Use Only:
Date Pd: 5-13-11 Check #

If you **DO NOT** wish to renew your license, check here. ☐

If you choose not to renew, your license will be placed on inactive status. To reactivate the license, you will be required to file a reinstatement application.

The following information represents the information on file for you with the Board of Medicine. **Please make any necessary changes. Please note that pursuant to RSA 329:16-f, all licensees must inform the Board of any change in address within 30 days of the change.**

Specialty: FP

Currently Board Certified? (Y/N) Y

Please list ABMS Board Specialty: FP

Currently licensed in the states of: (2 letter state abbrev.) VT

You must provide both home and business street address. PO Boxes are not acceptable.
Please mark the box next to the address you would prefer to list as your mailing address.

License # 14395 File # 15483

☐ Work Address

ALLEGRA L SHUMWAY, MD
PLANNED PARENTHOOD
[redacted] WESTERN AVE STE 101
ST JOHNSBURY VT 05819

79 Country St Suite 3
Newport VT 05855

Phone: 802-748-8141 802-334-5862

Business Tax Number: [redacted]

Business Email Address: [redacted]

☒ Home Address

[redacted]

Phone: [redacted]

Hospital Affiliations ***Please list city and state where hospital is located. Check off type of privileges you hold for each Hospital

Hospital	Privilege	Full	Courtesy	Consult
None				

None

(RENEWAL APPLICATION CONTINUED ON REVERSE SIDE)

STATE OF NEW HAMPSHIRE

Telephone #: (603) 271-1203

BOARD OF MEDICINE
2 Industrial Park Drive, Suite 6
Concord, NH 03301-8520

RENEWAL APPLICATION

For expiration on: 6/30/2015

Renewal Fee: $350.00

For Office Use Only
Date Pd: 6/8/15 Check #:

If you DO NOT wish to renew your license, check here. ☐

If you choose not to renew, your license will be placed on inactive status. To reactivate the license, you will be required to file a reinstatement application.

The following information represents the information on file for you with the Board of Medicine. Please make any necessary changes. Please note that pursuant to RSA 329:16-f, all licensees must inform the Board of any change in address within 30 days of the change.

Specialty: FP

Currently Board Certified? (Y/N) Y

(If yes, provide proof of board certification)

Please list ABMS Board Specialty: FP

Currently licensed in the states of: (2 letter state abbrev.) VT

You must provide both home and business street address. PO Boxes are not acceptable.
Please mark the box next to the address you would prefer to list as your mailing address.

License #: 14395

File #: 15483

☒ Home Address

ALLEGRA L SHUMWAY, MD

☐ Work Address

PLANNED PARENTHOOD OF NOR
90 WASHINGTON ST
BARRE, VT 05641

Please provide current Email, Fax and Phone Numbers below:

Phone:

Phone: 802-334-5822
Business Fax Number:
Business Email Address:

Hospital Affiliations: ***Please list city and state where hospital is located. Check off type of privileges you hold for each Hospital**

Hospital	Privilege	Full	Courtesy	Consult
NONE		☑	☐	☐
		☑	☐	☐
		✓	☐	☐
		☑	☐	☐
		✓		
		✓		
		✓		

(RENEWAL APPLICATION CONTINUED ON REVERSE SIDE)

File # 15483

American Board of Family Medicine

RECEIVED

JUN 26 2013

NH BOARD

Verification

The certification history below verifies **Allegra Lucille Shumway, M.D.** is currently certified with the American Board of Family Medicine (ABFM).

Certification by the American Board of Family Medicine is time-limited for a period of seven years and is renewed through successful completion of the Maintenance of Certification for Family Physicians (MC-FP) process. The MC-FP process became effective for physicians certified or recertified on or after July 11, 2003. Physicians whose certification has expired may renew their certification at such time as they fulfill all the requirements in effect at that time.

The ABFM website serves as primary source verification.

Certification	Certification Status	Certification History	Current MC-FP Status
Family Medicine	Certified	Jul 12, 1991 - Jul 09, 1998 Jul 10, 1998 - Jul 22, 2005 Jul 23, 2005 - Dec 31, 2015	Meeting Requirements

*Note: The ABFM began assigning certification numbers in 2011 for the Family Medicine Certification. Those physicians last certified/recertified prior to 2011 will not have a certification number.

Comment(s) are available.

As an ABFM Diplomate, certification status only changes at the beginning of a calendar year, unless revoked for specific reasons such as disciplinary actions, conducting ANNUAL primary source verification **on or after February 15 of each year** will ensure you have accurate certification status for ABFM Diplomates.

MC-FP Status is based on participation in the Maintenance of Certification for Family Physicians (MC-FP) process. Please see the descriptions below for each status:

- *Meeting Requirements*—Physician has met all current requirements.
- *Not Certified*—Physician is currently not certified therefore does not have an MC-FP Status.

The ABFM recommends the use of the online verification letter for verifying the physician's status with the ABFM, however identical information can be provided in a written verification of a physician's status from the ABFM at no charge.

▶ View/Print Verification Letter Online

▶ Request hard copy from the ABFM

The American Board of Family Medicine, Inc. | 1648 McGrathiana Parkway Suite 550, Lexington KY. 40511-1247
Phone: 859-269-5626 or 888-995-5700 | Fax: 859-335-7501 or 859-335-7509 | Email: help@theabfm.org
The ABFM is a member of the American Board of Medical Specialties

Social Security Number:

Please answer each of the following questions. If your answer [illegible] provide a complete written explanation of the circumstances including any [illegible] NEW INFORMATION REPORTED ON A PRIOR RENEWAL APPLICATION.

In the past 24 months OR since you last reported to the Board of Medicine if greater than 24 months:

	YES	NO
1. With regard to any and all Boards or licensing bodies with which you hold or have held a license to practice medicine, have you been subject to any disciplinary action, limitation or restriction on your license, or entered into any agreement with a licensing body for any reason, including but not limited to rehabilitation?	___	X
2. Have you been denied, or have you surrendered or allowed to lapse, a license to practice medicine in any state other than New Hampshire?	___	X
3. Have you been subject to any investigation or to a denial, restriction, suspension, loss or revocation of your DEA certificate?	___	X
4. Have you been treated, other than through the Physician Health Program, for abuse or misuse of any chemical substance, including alcohol?	___	X
5. Have you had any emotional disturbance or mental or physical illness which has impaired your ability to practice medicine?	___	X
6. Have you been found guilty or entered a plea of no contest to any felony, misdemeanor or alcohol or drug related offense that has not been annulled by a court?	___	X
7. Have you been reported to the National Practitioner's Data Bank? If yes, please submit a copy of the report.	___	X
8. Have you been the subject of an investigation or disciplinary proceeding regarding the practice of medicine? Please exclude investigations and disciplinary proceedings conducted by the New Hampshire Board of Medicine.	___	X
9. Have any hospital privileges been suspended, limited or denied other than for medical records violations, or have you been placed on administrative or medical leave?	___	X
10. Have any medical malpractice claims been made against you? See attached reporting form.	___	X

**Pursuant to RSA 125:25-c, I, please attach a list of ALL diagnostic and therapeutic services in which you have an ownership interest.

I HEREBY CERTIFY UNDER PENALTY OF PERJURY THAT ALL INFORMATION ON THIS FORM IS APPARENTLY ACCURATE. I acknowledge that I am governed by the Medical Practice Act (RSA 329), the New Hampshire Code of Administrative Rules (Med 100-500), and the American Medical Association's Code of Medical Ethics. I have familiarized myself with these documents and acknowledge that deviation from the standards set therein may subject me to disciplinary action by the New Hampshire Board of Medicine.

[illegible] Licensee's Signature Stamp Not Accepted

Please answer each of the following questions. If your answer to any question is "Yes", you must provide a complete written explanation of the circumstances including any required documents. DO NOT RESUBMIT INFORMATION REPORTED ON A PRIOR RENEWAL APPLICATION.

In the past 24 months:

	YES	NO
1. With regard to any and all Boards or licensing bodies with which you hold or have held a license to practice medicine, have you been subject to any disciplinary action, limitation or restriction on your license, or entered into any agreement with a licensing body for any reason, including but not limited to rehabilitation?		X
2. Have you been denied, or have you surrendered or allowed to lapse, a license to practice medicine in any state other than New Hampshire?		X
3. Have you been subject to any investigation or to a denial, restriction, suspension, loss or revocation of your DEA certificate?		X
4. Have you been treated, other than through the Physician Health Program, for abuse or misuse of any chemical substance, including alcohol?		X
5. Have you had any emotional disturbance or mental or physical illness which has impaired your ability to practice medicine?		X
6. Have you been found guilty or entered a plea of no contest to any felony, misdemeanor or alcohol or drug related offense that has not been annulled by a court?		X
7. Have you been reported to the National Practitioner's Data Bank? If yes, please submit a copy of the report.		X
8. Have you been the subject of an investigation or disciplinary proceeding regarding the practice of medicine? Please exclude investigations and disciplinary proceedings conducted by the New Hampshire Board of Medicine.		X
9. Have any hospital privileges been suspended, limited or denied other than for medical records violations, or have you been placed on administrative or medical leave?		X
10. Have any medical malpractice claims been made against you? See attached reporting form.		X

****Pursuant to RSA 125:25-c, I, please attach a list of ALL diagnostic and therapeutic services in which you have an ownership interest.**

I HEREBY CERTIFY UNDER PENALTY OF PERJURY THAT ALL INFORMATION ON THIS FORM IS CURRENTLY ACCURATE. **I acknowledge that I am governed by the Medical Practice Act (RSA 329), the New Hampshire Code of Administrative Rules (Med 100-500), and the American Medical Association's Code of Medical Ethics. I have familiarized myself with these documents and acknowledge that deviation from the standards set therein may subject me to disciplinary action by the New Hampshire Board of Medicine.**

Signature of Licensee (Signature Stamp Not Accepted)

4/20/2011
Date

STATE OF NEW HAMPSHIRE

Telephone #: 603-271-6934

BOARD OF MEDICINE
2 Industrial Park Drive, Suite 8
Concord, NH 03301-8520

RENEWAL APPLICATION

For expiration on: 06/30/2013

Renewal Fee: $300.00

For Office Use Only:
Date Pd: 5-13-11 Check #

If you **DO NOT** wish to renew your license, check here. ☐

If you choose not to renew, your license will be placed on inactive status. To reactivate the license, you will be required to file a reinstatement application.

The following information represents the information on file for you with the Board of Medicine. **Please make any necessary changes. Please note that pursuant to RSA 329:16-f, all licensees must inform the Board of any change in address within 30 days of the change.**

Specialty: FP

Currently Board Certified? (Y/N) Y

Please list ABMS Board Specialty: FP

Currently licensed in the states of: (2 letter state abbrev.) VT

You must provide both home and business street address. PO Boxes are not acceptable.
Please mark the box next to the address you would prefer to list as your mailing address.

License #: 14395 File #: 15483

☐ Work Address

ALLEGRA L SHUMWAY, MD
PLANNED PARENTHOOD
~~357 WESTERN AVE STE 101~~ 79 Coventry ST Suite 3
~~ST JOHNSBURY, VT 05819~~ Newport, VT 05855
Phone: ~~802-748-8194~~ 802-334-5822
Business Fax Number:
Business Email Address:

☒ Home Address

[redacted]

Phone: [redacted]

Hospital Affiliations: ***Please list city and state where hospital is located. Check off type of privileges you hold for each Hospital

Hospital	Privilege	Full	Courtesy	Consult
None				
	None			

(RENEWAL APPLICATION CONTINUED ON REVERSE SIDE)

RENEWAL APPLICATION

If you DO NOT wish to renew your license, check here: ☐

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Specialty: FP

Currently Board Certified? (Y/N) Y

(If yes, provide proof of board certification)

Please list ABMS Board Specialty: FP

Currently licensed in the states of: (2 letter state abbrev.) VT

You must provide both home and business street address. PO Boxes are not acceptable.

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

License #: 14395

File #: 15483

☒ Home Address

ALLEGRA L SHUMWAY, MD

☐ Work Address

PLANNED PARENTHOOD OF NOR
90 WASHINGTON ST
BARRE, VT 05641

Please provide current Email, Fax and Phone Numbers below:

Phone:

Phone: 802-334-5822
Business Fax Number:
Business Email Address:

Hospital Affiliations: ***Please list city and state where hospital is located. Check off type of privileges you hold for each Hospital

Hospital	Privilege	Full	Courtesy	Consult
NONE		☑	☐	☐
		☑	☐	☐
		✓		
		✓		
		✓		
		✓		
		✓		

(RENEWAL APPLICATION CONTINUED ON REVERSE SIDE)

mandatory. Social Security Number:

**Please answer each of the following questions. If your answer to one of the questions is "yes", you must provide a complete written explanation of the circumstances including any required documentation. DO NOT RESUBMIT INFORMATION REPORTED ON A PRIOR RENEWAL APPLICATION.

In the past 24 months OR since you last reported to the Board of Medicine if greater than 24 months:

	YES	NO
1. With regard to any and all Boards or licensing bodies with which you hold or have held a license to practice medicine, have you been subject to any disciplinary action, limitation or restriction on your license, or entered into any agreement with a licensing body for any reason, including but not limited to rehabilitation?	___	X
2. Have you been denied, or have you surrendered or allowed to lapse, a license to practice medicine in any state other than New Hampshire?	___	X
3. Have you been subject to any investigation or to a denial, restriction, suspension, loss or revocation of your DEA certificate?	___	X
4. Have you been treated, other than through the Physician Health Program, for abuse or misuse of any chemical substance, including alcohol?	___	X
5. Have you had any emotional disturbance or mental or physical illness which has impaired your ability to practice medicine?	___	X
6. Have you been found guilty or entered a plea of no contest to any felony, misdemeanor or alcohol or drug related offense that has not been annulled by a court?	___	X
7. Have you been reported to the National Practitioner's Data Bank? If yes, please submit a copy of the report.	___	X
8. Have you been the subject of an investigation or disciplinary proceeding regarding the practice of medicine? Please exclude investigations and disciplinary proceedings conducted by the New Hampshire Board of Medicine.	___	X
9. Have any hospital privileges been suspended, limited or denied other than for medical records violations, or have you been placed on administrative or medical leave?	___	X
10. Have any medical malpractice claims been made against you? See attached reporting form.	___	X

**Pursuant to RSA 125:25-c, I, please attach a list of ALL diagnostic and therapeutic services in which you have an ownership interest.

I HEREBY CERTIFY UNDER PENALTY OF PERJURY THAT ALL INFORMATION ON THIS FORM IS CURRENTLY ACCURATE. I acknowledge that I am governed by the Medical Practice Act (RSA 329), the New Hampshire Code of Administrative Rules (Med 100-500), and the American Medical Association's Code of Medical Ethics. I have familiarized myself with these documents and acknowledge that deviation from the standards set therein may subject me to disciplinary action by the New Hampshire Board of Medicine.

Signature of Licensee (Signature Stamp Not Accepted)

Date 6/14/2013

Please answer each of the following questions. If your answer to any question is "Yes", you must provide a complete written explanation of the circumstances including any required documents. DO NOT RESUBMIT INFORMATION REPORTED ON A PRIOR RENEWAL APPLICATION.

In the past 24 months:

	YES	NO
1. With regard to any and all Boards or licensing bodies with which you hold or have held a license to practice medicine, have you been subject to any disciplinary action, limitation or restriction on your license, or entered into any agreement with a licensing body for any reason, including but not limited to rehabilitation?		X
2. Have you been denied, or have you surrendered or allowed to lapse, a license to practice medicine in any state other than New Hampshire?		X
3. Have you been subject to any investigation or to a denial, restriction, suspension, loss or revocation of your DEA certificate?		X
4. Have you been treated, other than through the Physician Health Program, for abuse or misuse of any chemical substance, including alcohol?		X
5. Have you had any emotional disturbance or mental or physical illness which has impaired your ability to practice medicine?		X
6. Have you been found guilty or entered a plea of no contest to any felony, misdemeanor or alcohol or drug related offense that has not been annulled by a court?		X
7. Have you been reported to the National Practitioner's Data Bank? If yes, please submit a copy of the report.		X
8. Have you been the subject of an investigation or disciplinary proceeding regarding the practice of medicine? Please exclude investigations and disciplinary proceedings conducted by the New Hampshire Board of Medicine.		X
9. Have any hospital privileges been suspended, limited or denied other than for medical records violations, or have you been placed on administrative or medical leave?		X
10. Have any medical malpractice claims been made against you? See attached reporting form.		X

**Pursuant to RSA 125-25 c II, please attach a list of ALL diagnostic and therapeutic services in which you have an ownership interest.

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Signature of Licensee (Signature Stamp Not Accepted)

4/20/2011
Date

STATE OF NEW HAMPSHIRE

Telephone #: 603-271-6934

BOARD OF MEDICINE
2 Industrial Park Drive, Suite 8
Concord, NH 03301-8520

RENEWAL APPLICATION

For expiration on: 06/30/2013

Renewal Fee $300.00

For Office Use Only:
Date Pd: 5-13-11 Check #

If you **DO NOT** wish to renew your license, check here. ☐

If you choose not to renew, your license will be placed on inactive status. To reactivate the license, you will be required to file a reinstatement application.

The following information represents the information on file for you with the Board of Medicine. **Please make any necessary changes. Please note that pursuant to RSA 329:16-f, all licensees must inform the Board of any change in address within 30 days of the change.**

Specialty: FP

Currently Board Certified? (Y/N) Y

Please list ABMS Board Specialty: FP

Currently licensed in the states of: (2 letter state abbrev.) VT

You must provide both home and business street address. PO Boxes are not acceptable.
Please mark the box next to the address you would prefer to list as your mailing address.

License # 14395 File # 16483

☐ Work Address

ALLEGRA L SHUMWAY MD
PLANNED PARENTHOOD
~~85 WESTERN AVE STE 101~~ 79 Coventry ST Suite 3
ST JOHNSBURY VT 05819 Newport, VT 05855

Phone ~~802-748-3721~~ 802-334-5802
Business Fax Number [redacted]
Business Email Address [redacted]

☒ Home Address

[redacted]

Phone [redacted]

Hospital Affiliations *** Please list city and state where hospital is located. Check off type of privileges you hold for each Hospital

Hospital	Privilege	Full	Courtesy	Consult
None				
		None		

(RENEWAL APPLICATION CONTINUED ON REVERSE SIDE)

STATE OF NEW HAMPSHIRE

Telephone #: 603-271-1203

BOARD OF MEDICINE
2 Industrial Park Drive, Suite 7
Concord, NH 03301-8520

RENEWAL APPLICATION

For expiration on: 6/30/2015

Renewal Fee: $350.00

For Office Use Only
Date Pd: 6/9/15 Check #:

If you DO NOT wish to renew your license, check here. ☐

If you choose not to renew, your license will be placed on inactive status. To reactivate the license, you will be required to file a reinstatement application.

The following information represents the information on file for you with the Board of Medicine. Please make any necessary changes. Please note that pursuant to RSA 329:16-f, all licensees must inform the Board of any change in address within 30 days of the change.

Specialty: FP

Currently Board Certified? (Y/N) Y

(If yes, provide proof of board certification)

Please list ABMS Board Specialty: FP

Currently licensed in the states of: (2 letter state abbrev.) VT

You must provide both home and business street address. PO Boxes are not acceptable.
Please mark the box next to the address you would prefer to list as your mailing address.

License #: 14395

File #: 15483

☒ Home Address

ALLEGRA L SHUMWAY, MD

☐ Work Address

PLANNED PARENTHOOD OF NOR
90 WASHINGTON ST
BARRE, VT 05641

Please provide current Email, Fax and Phone Numbers below:

Phone:

Phone: 802-334-5822
Business Fax Number:
Business Email Address:

Hospital Affiliations: ***Please list city and state where hospital is located. Check off type of privileges you hold for each Hospital

Hospital	Privilege	Full	Courtesy	Consult
NONE		☑	☐	☐
		☑	☐	☐
		✓	☐	☐
		✓	☐	☐
		✓		
		✓		
		✓		

(RENEWAL APPLICATION CONTINUED ON REVERSE SIDE)

The Board is required to obtain your Social Security Number. If you refuse to submit your social security number, your professional license will not be issued. Your SSN will not be made available to the public. The Board is required to obtain your SSN for purposes of child support enforcement and in compliance with IRS regulations. Submission of your SSN is mandatory. Social Security Number:

**Please answer each of the following questions. If your answer to any question is "yes", you must provide a complete written explanation of the circumstances including any required documents. DO NOT RESUBMIT INFORMATION REPORTED ON A PRIOR RENEWAL APPLICATION.

In the past 24 months OR since you last reported to the Board of Medicine if greater than 24 months:

	YES	NO
1. With regard to any and all Boards or licensing bodies with which you hold or have held a license to practice medicine, have you been subject to any disciplinary action, limitation or restriction on your license, or entered into any agreement with a licensing body for any reason, including but not limited to rehabilitation?	___	X
2. Have you been denied, or have you surrendered or allowed to lapse, a license to practice medicine in any state other than New Hampshire?	___	X
3. Have you been subject to any investigation or to a denial, restriction, suspension, loss or revocation of your DEA certificate?	___	X
4. Have you been treated, other than through the Physician Health Program, for abuse or misuse of any chemical substance, including alcohol?	___	X
5. Have you had any emotional disturbance or mental or physical illness which has impaired your ability to practice medicine?	___	X
6. Have you been found guilty or entered a plea of no contest to any felony, misdemeanor or alcohol or drug related offense that has not been annulled by a court?	___	X
7. Have you been reported to the National Practitioner's Data Bank? If yes, please submit a copy of the report.	___	X
8. Have you been the subject of an investigation or disciplinary proceeding regarding the practice of medicine? Please exclude investigations and disciplinary proceedings conducted by the New Hampshire Board of Medicine.	___	X
9. Have any hospital privileges been suspended, limited or denied other than for medical records violations, or have you been placed on administrative or medical leave?	___	X
10. Have any medical malpractice claims been made against you? See attached reporting form.	___	X

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Signature of Licensee (Signature Stamp Not Accepted)

6/16/2013
Date

STATE OF NEW HAMPSHIRE

Telephone #: 603-271-1934

BOARD OF MEDICINE
2 Industrial Park Drive, Suite 8
Concord, NH 03301-8520

RENEWAL APPLICATION

For expiration on: 6/30/2015

Renewal Fee: $350.00

For Office Use Only:
Date Pd: 6/24/15 Check #

If you DO NOT wish to renew your license, check here. ☐

If you choose not to renew, your license will be placed on inactive status. To reactivate the license, you will be required to file a reinstatement application.

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(If yes, provide proof of board certification)

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License #: 14395

File #: 15483

☒ Home Address

ALLEGRA L SHUMWAY, MD

☐ Work Address

PLANNED PARENTHOOD OF NOR
90 WASHINGTON ST
BARRE, VT 05641

Please provide current Email, Fax and Phone Numbers below:

Phone:

Phone: 802-334-5822
Business Fax Number:
Business Email Address:

Hospital Affiliations: ***Please list city and state where hospital is located. Check off type of privileges you hold for each Hospital

Hospital	Privilege	Full	Courtesy	Consult
NONE		☑	☐	☐
		☑	☐	☐
		☑	☐	☐
		☑	☐	☐
		☑	☐	☐
		☑	☐	☐
		☑	☐	☐

(RENEWAL APPLICATION CONTINUED ON REVERSE SIDE)

mandatory. Social Security Number:

**Please answer each of the following questions. If your answer to any question is "YES", you must provide a complete written explanation of the circumstances including any required documents. DO NOT RESUBMIT INFORMATION REPORTED ON A PRIOR RENEWAL APPLICATION.

In the past 24 months OR since you last reported to the Board of Medicine if greater than 24 months:

	YES	NO
1. With regard to any and all Boards or licensing bodies with which you hold or have held a license to practice medicine, have you been subject to any disciplinary action, limitation or restriction on your license, or entered into any agreement with a licensing body for any reason, including but not limited to rehabilitation?	___	X
2. Have you been denied, or have you surrendered or allowed to lapse, a license to practice medicine in any state other than New Hampshire?	___	X
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4. Have you been treated, other than through the Physician Health Program, for abuse or misuse of any chemical substance, including alcohol?	___	X
5. Have you had any emotional disturbance or mental or physical illness which has impaired your ability to practice medicine?	___	X
6. Have you been found guilty or entered a plea of no contest to any felony, misdemeanor or alcohol or drug related offense that has not been annulled by a court?	___	X
7. Have you been reported to the National Practitioner's Data Bank? If yes, please submit a copy of the report.	___	X
8. Have you been the subject of an investigation or disciplinary proceeding regarding the practice of medicine? Please exclude investigations and disciplinary proceedings conducted by the New Hampshire Board of Medicine.	___	X
9. Have any hospital privileges been suspended, limited or denied other than for medical records violations, or have you been placed on administrative or medical leave?	___	X
10. Have any medical malpractice claims been made against you? See attached reporting form.	___	X

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Signature of Licensee (Signature Stamp Not Accepted)

6/16/2013
Date

STATE OF NEW HAMPSHIRE

Telephone #: (603) 271-1203

BOARD OF MEDICINE
2 Industrial Park Drive, Suite 6
Concord, NH 03301-8520

RENEWAL APPLICATION

For expiration on: 6/30/2015

Renewal Fee: $350.00

For Office Use Only:
Date Pd: 6/8/15 Ck #: [illegible]

If you DO NOT wish to renew your license, check here. ☐

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Specialty: FP

Currently Board Certified? (Y/N) Y
(If yes, provide proof of board certification)
Please list ABMS Board Specialty: FP

Currently licensed in the states of: (2 letter state abbrev.) VT

You must provide both home and business street address. PO Boxes are not acceptable.
Please mark the box next to the address you would prefer to list as your mailing address.

License #: 14395

File #: 15483

☒ Home Address

ALLEGRA L SHUMWAY, MD

☐ Work Address

PLANNED PARENTHOOD OF NOR
90 WASHINGTON ST
BARRE, VT 05641

Please provide current Email, Fax and Phone Numbers below:

Phone:

Phone: 802-334-5822
Business Fax Number:
Business Email Address:

Hospital Affiliations: ***Please list city and state where hospital is located. Check off type of privileges you hold for each Hospital**

Hospital	Privilege	Full	Courtesy	Consult
NONE		☑	☐	☐
		☑	☐	☐
		✓	☐	☐
		✓	☐	☐
		✓	☐	☐
		✓	☐	☐
		✓	☐	☐

(RENEWAL APPLICATION CONTINUED ON REVERSE SIDE)

Please be advised that the New Hampshire Board of Medicine has not issued any public discipline to Dr. Shumway. The Board has no suits on file for Dr. Shumway.

[redacted] copy of this application.

Sincerely,

Penny Taylor, Administrator
NH Board of Medicine
121 South Fruit Street, Suite 301
Concord, NH 03301-2412
(603) 271-1205
Penny.taylor@nh.gov

[redacted]

day of Nov 2005

day of, Nov 2013

UBLIC SIGNATURE & SEAL)

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.

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 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 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 licensure or permit to practice medicine.

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

Shumway

Applicant's Printed Last Name

Allegra Lucille

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

11/24/08

Date of Signature

NOTARY

Dated 11/24/08 Signed

State of Vermont County of Orange

SUBSCRIBED AND SWORN TO before me this 24th day of Nov 2008

My commission expires: 2/10/11

(NOTARY PUBLIC SIGNATURE & SEAL)
