NEW HAMPSHIRE BOARD OF MEDICINE

May 1, 1996

JENNIFER M DONOFRIO MD
[redacted]

Dear Dr. Donofrio:

This is to certify that you have been granted licensure to practice medicine in the State of New Hampshire. Your license number 9693 is dated May 1, 1996.

As soon as your engrossed certificate is received in this office, which should take approximately one year, it will be forwarded to you. Until such time, this letter is your full authorization for the privilege of practicing medicine in the this state.

Please keep this office informed of any change in home or office address.

Sincerely,

Karen laCroix
Administrator

KL/se
Encl.

2 INDUSTRIAL PARK DRIVE SUITE 8 CONCORD, NH 03301-8520 TDD Access: Relay NH 1-800-735-2964 TEL. (603) 271-1203 FAX (603) 271-[illegible]

SPEC: OBG

NEW HAMPSHIRE BOARD OF MEDICINE

Application No. 10614

I hereby apply for a license to practice medicine in the State of New Hampshire as a Doctor of Medicine or as a Doctor of Osteopathy and submit the following proofs, as required by the rules and regulations, formulated in accordance with the laws of the State of New Hampshire, and enclosed a certified check or postal or express money order for the application fee of $250.00, check made payable to the "Treasurer, State of New Hampshire" - U.S. Funds only. Application fees are **non-refundable.**

1. PERSONAL INFORMATION:

Name: JENNIFER Michelle DONOFRIO
(please print) FIRST MIDDLE LAST MAIDEN

Home Address: [redacted]

Office Address: MANCHESTER OBSTETRICAL ASSOCIATES
150 TARRYTOWN Road Manchester NH

Date of Birth [redacted] Place of Birth [redacted]

Social Security Number [redacted]

2. ACADEMIC EDUCATION:

Name and Location of Institutions	Dates Attended	Degree Awarded
College of William and Mary Williamsburg VA	8/84 - 5/88	B.S
MEDICAL COLLEGE OF Virginia Richmond VA	8/88 - 5/92	M.D.

3. **MEDICAL EDUCATION:**

Name and Location of Institutions	Dates Attended	Degree Awarded
MEDICAL COLLEGE OF VIRGINIA Richmond VA	8/88 - 5/92	M.D.

5. **FOREIGN MEDICAL GRADUATES.**

(a) Foreign graduates must submit a transcript of grades and proof of graduation from medical school. Certified copies of these documents with certified English translation is required.

(b) Foreign medical graduates must also submit original verification directly from ECFMG documenting that the applicant currently holds standard certification by ECFMG. Please indicate ECFMG #:_____

6. **POST GRADUATE EDUCATION.**

Internship and/or Residency

Program	Location	Dates
CARILION HEALTH SYSTEMS		
COMMUNITY HOSPITAL of Roanoke Valley	ROANOKE, VA	7/92 - 6/96

NH Requires at least 2 years of post graduate training in the United States or Canada. An official, original letter from the residency program verifying internship and/or residency is required.

7. **EXAMINATION.**

Name of Examination	Date of Completion	Score
NATIONAL Board	3/93	PASS

A National Board or FLEX score report form is enclosed. Please have an official transcript of your scores sent directly to the Board. If examination is by USMLE, LMCC or state examination, you must contact these organizations and have an official transcript of your scores sent directly to the Board.

8. **LICENSURE.**

Please list all states where you hold or have ever held a physician's license.

* Temporary License for Intern-Resident Lic# 0116-004653		
	Virginia	

You must obtain a verification from all states where you hold, or have ever held a license. Verifications must be received directly from the licensing authority. A form is enclosed for your convenience. Please make copies as necessary.

9. Are you certified by an American Specialty Board? ____YES__✓__NO
If yes, please provide a notarized photocopy of such certification.

	YES	NO
10. Have you ever, for any reason, lost American Specialty Board Certification?	___	✓
11. Have you been denied required recertification by any specialty boards? If yes, list each such boards and dates denied._____ _____	___	✓
12. Has any medical malpractice claim been made against you in the last ten years (whether or not a lawsuit was filed in relation to the claim)? If so, how many?_____	___	✓
13. Have you ever applied for licensure or to sit for an examination, or taken an examination, under a different name?	___	✓
14. 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?	___	✓
15. Have you ever failed any of the following examinations: the USMLE, the FLEX examination, any state board examination or have you ever failed to gain certification from the National Board of Medical Examiners?	[redacted]	___
16. Have you ever failed a foreign licensing or certification examination?	___	✓
17. Have you ever been denied a medical license, whether full, limited or temporary, for any reason?	___	✓
18. 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?	___	✓
19. Is any investigation or disciplinary action pending, or has any investigation or disciplinary action been taken against you in the last ten years by any governmental authority, by any hospital or health care facility, or by any professional medical association (international, national, state or local)?	___	✓

	YES	NO
20. 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?	___	✓
21. Have you ever withdrawn an application for medical licensure, hospital privileges or appointment, for any reason?	___	✓
22. Have you ever been a defendant in a criminal proceeding including driving while under the influence or driving while suspended, but not including traffic offenses not classified as misdemeanors?	___	✓
23. 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?	___	✓
24. Have you ever had any emotional disturbance or mental illness which has impaired or would be likely to impair your ability to practice medicine?	___	✓
25. Are you now, or have you, during the past 5 years, been dependent upon alcohol or habituating drugs?	___	✓

NOTE ON QUESTIONS 23-25: The harm that befalls physicians and patients alike when impairment goes undetected and untreated by the medical profession is devastating. The Board wants impaired physicians treated in the early stages of impairment before irreparable harm to the physician or patient occurs.

If you have answered "yes" to any of the above, please explain on the reverse side. Attach additional 8 1/2" x 11" sheets if necessary.

26. A current curriculum vitae is required.

27. An official certified copy of your birth certificate is required.

28. A total of 4 reference letters are required. Letters of reference shall be provided by the following individuals:

Dr MARK ARNER — Dr LARRY DENNIS

Dr Carey Winkler — Dr Ellwood Cobey

29. **AFFIDAVIT OF THE APPLICANT:**

STATE OF Virginia
City ~~COUNTY~~ OF [redacted]

I, Jennifer M Donofrio of Roanoke, VA

being duly sworn say that I am the person referred to in the above application for a license to practice medicine as a Doctor of Medicine or Doctor of Osteopathy in the State of New Hampshire; that I have studied the treatment of human ailments not less than four school years, received a degree of Doctor of Medicine or Doctor of Osteopathy; and that all the statements herein respecting age, academic and medical education, internship, state or national board examination and license, good professional standing, and all other statements made on said application are true in every respect, and that no investigation or disciplinary action is pending or has been brought against me by any state, county or local medical society, hospital or health care facility or professional medical association, except as disclosed on this application.

Jennifer M Donofrio, M.D., D.O.

Sworn to before me this 18th day of March, 1996

(SEAL) Kristie M. Gillian Notary Public

My Commission Expires April 30, 1999

****

Jennifer M Donofrio
Signature of Applicant

PLEASE DO NOT WRITE BELOW THIS LINE - FOR BOARD USE ONLY:

Application received 3/27, 1996

Fee Paid 250.00 3/25, 1996 Check Number [redacted]

License Number: 9693 **Date of Issue:** 5/1/96

JENNIFER M. DONOFRIO, M.D.

ADDRESS: [redacted]

DOB: [redacted]
MARITAL STATUS:
HOMETOWN:

OFFICE: Carilion Health Systems/
Community Hospital of Roanoke Valley
102 Highland Avenue, SE
Suite 435
Roanoke, VA 24013
(703) 985-9977

EDUCATION:

RESIDENCY: 1992-1996	Obstetrics and Gynecology, Carilion Health Systems/Community Hospital of Roanoke Valley, Roanoke, Virginia; graduation June 30, 1996.
MEDICAL SCHOOL: 1988-1992	Medical College of Virginia/Virginia Commonwealth University, Richmond, Virginia
UNDERGRADUATE: 1984-1988	College of William and Mary, Williamsburg, Virginia

RESEARCH:

ONGOING:

"Premature Rupture of Membranes: Home vs. Hospital Management", supervised by Carey Winkler, M.D., Director of Perinatology, CHRV.

"The Occurrence of Lymphoma in Cardiac Transplant Patients at the Medical College of Virginia", supervised by Andrea Hastillo, M.D., Department of Cardiology, MCV. 1991-1992.

ACTIVITIES/MEMBERSHIPS:

American College of Obstetrics and Gynecology, Junior Fellow, 1992-present
Roanoke OB/GYN Society, 1992-present
Southern Medical Society, 1992-1993
American Medical Association, 1988-1992
American Medical Student Association, 1988-1992

CERTIFICATION:

Basic Life Support, 1992
Advanced Cardiac Life Support, 1992
Neonatal Advanced Life Support, 1993
National Board of Medical Examiners, 1993

VOLUNTEER WORK:

Indian Health Service, Gallup, NM, November 1994
Bradley Free Clinic, 1993-present
Rural Medicine in Nassawadox, VA, October 1991
AIDS education program for students, 1988-1989

COMMITTEES:

Committee for Improvement of the Carilion OB/GYN Clinic
Residency Revision Committee
Patient Education Committee

HOBBIES:

Hiking, moutain biking, camping, running, weight lifting, pottery, gardening

THIS MUST BE SENT TO THE SCHOOL FROM WHICH YOU GRADUATED

4. CERTIFICATE OF MEDICAL EDUCATION:

It is hereby certified that Jennifer M. DeNotrio matriculated
(Your Name)

in Medical College of Virginia/VCU at Richmond, Virginia on
(Name of Institution) (Location of Institution)

August 22, 1988 and received a diploma from this institution conferring

the degree of Doctor of Medicine or Doctor of Osteopathy.

Louise C. Mitchell
~~President, Secretary or Dean~~
Registrar, School of Medicine

(SCHOOL SEAL)
REQUIRED

****

After completing, please return this form to the following address:

BOARD OF MEDICINE
2 INDUSTRIAL PARK DRIVE, SUITE 8
CONCORD, NEW HAMPSHIRE 03301-8520

3 yrs req

CARILION
Health System

March 26, 1996

Department of Medical Education
At Community Hospital of Roanoke Valley

RECEIVED
APR 01 1996
NH Board of
Registration & Medicine

National Board of Medicine
2 Industrial Park Drive
Suite 8
Concord, NH 03301-8520

TO WHOM IT MAY CONCERN:

This letter is to confirm that Jennifer M. Donofrio, M.D. began her residency here at Carilion Health System's OB/GYN Residency Program on July 1, 1992. Her anticipated date of completion is June 30, 1996.

Should have any further questions concerning Dr. Donofrio, please do not hesitate in contacting me.

Thank you.

Sincerely,

Larry G. Dennis, M.D.
Director of OB/GYN Education
Carilion Health System
Associate Professor of OB/GYN
University of Virginia - Roanoke Program

LGD/kmg

Carilion Health System
Department of Medical Education at Community Hospital of Roanoke Valley Post Office Box 12946 Roanoke, Virginia 24029-2946
Telephone 703-985-9977 Telefax 703-985-9817

MAY 19 1997

STATE OF NEW HAMPSHIRE

[redacted]

Board of Medicine

EXPIRES: 6/30/98

Please check appropriate mailing address.

Name in full Jennifer M. Donofrio MD

X Place of employment 150 Tarrytown Road
Manchester NH 03103

Business Tel: 603-622-3162

Home Address [redacted]

Home Tel: [redacted]

JENNIFER M DONOFRIO, MD
MANCHESTER OB ASSOC
150 TARRYTOWN RD
MANCHESTER NH 03103-

JUN 0 3 1998

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: 6/30/1999

Renewal Fee: $100.00

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: OBG

Board Certified: (Y/N) Y

Please list ABMS Board Specialty: eligible

Licensed in the states of: (2 letter state abbrev.)

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

License #: 9682

File #: 10614

☑ Work Address:

[redacted] DONORRIO, MD
MANCHESTER OB ASSOC
150 TARRYTOWN RD
[redacted]

☐ Home Address:

[redacted]

Hospital Affiliations: **(If not a NH hospital, please list city and state where hospital is located.)**

ELLIOT HOSPITAL

(RENEWAL APPLICATION CONTINUED ON REVERSE SIDE)

APR 2 9 1999

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: 6/30/2000

Renewal Fee: $100.00

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: OBG

Board Certified: (Y/N) N

Please list ABMS Board Specialty: OBG

Licensed in the states of: (2 letter state abbrev.) NH

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

License #: 9693

File #: 10614

☒

☐

JENNIFER M DONOFRIO, MD
MANCHESTER OB ASSOC
150 TARRYTOWN RD
MANCHESTER, NH 03103-
Phone: 603*622-3162

[redacted]

[redacted]

Phone: [redacted]

Hospital Affiliations: **(If not a NH hospital, please list city and state where hospital is located.)**

ELLIOT HOSPITAL

(RENEWAL APPLICATION CONTINUED ON REVERSE SIDE)

APR 1 3 2000

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: 6/30/2001

Renewal Fee: $100.00

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: OBG

Board Certified: (Y/N) Y

Please list ABMS Board Specialty: OBG

Licensed in the states of: (2 letter state abbrev.)

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

License #: 9693

File #: 10614

☑

☐

JENNIFER M DONOFRIO, MD
MANCHESTER OB ASSOC
150 TARRYTOWN RD
MANCHESTER, NH 03102
Phone: [redacted]

Hospital Affiliations: **(If not a NH hospital, please list city and state where hospital is located.)**

ELLIOT HOSPITAL- MANCHESTER, NH

(RENEWAL APPLICATION CONTINUED ON REVERSE SIDE)

APR 1 3 2001

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: (date) 6/30/2002

Renewal Fee: $150.00

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: OBG

Board Certified: (Y/N) Y

Please list ABMS Board Specialty: OBG

Licensed in the states of: (2 letter state abbrev.)

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

License #: 9693 [redacted] File #: 10614

☒ Work Address

JENNIFER M DONOFRIO, MD
MANCHESTER OB ASSOC
[redacted] HOWARD
[redacted] 03103
Phone: [redacted]

☐ Home Address

[redacted]

Phone: [redacted]

Hospital Affiliations: (If not a NH hospital, please list city and state where hospital is located.)

ELLIOT HOSPITAL- MANCHESTER, NH

Catholic Medical Center

(RENEWAL APPLICATION CONTINUED ON REVERSE SIDE)

MAR 1 3 2002

#17599

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: 6/30/2003

Renewal Fee: $150.00

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: OBG

Board Certified: (Y/N) Y

Please list ABMS Board Specialty: OBG

Licensed in the states of: (2 letter state abbrev.)

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

License #: 9693 File #: 10614

☒ **Work Address**

JENNIFER M DONOFRIO, MD
MANCHESTER OB ASSOC
150 TARRYTOWN RD
MANCHESTER, NH 03103

Phone: 603*622-3162

Hospital Affiliations: (If not a NH hospital, please list city and state where hospital is located.)

ELLIOT HOSPITAL- MANCHESTER, NH
CATHOLIC MED CTR - MANCHESTER, NH

(RENEWAL APPLICATION CONTINUED ON REVERSE SIDE)

MAR 19 2003

STATE OF NEW HAMPSHIRE

Telephone #: 603-271-6934

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

19145

RENEWAL APPLICATION

For expiration on: 06/30/04

Renewal Fee: $150.00 $900.00

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: OBG

Board Certified: (Y/N) Y

Please list ABMS Board Specialty: OBG

Licensed in the states of: (2 letter state abbrev.) NH

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

License #: 9693 File #: 10614

☑ Work Address ☐ Home Address

JENNIFER M DONOFRIO, MD
MANCHESTER OB ASSOC
150 TARRYTOWN RD
MANCHESTER, NH 03103-

Phone: 603*622-3162 Phone: [redacted]

Hospital Affiliations: (If not a NH hospital, please list city and state where hospital is located.)

ELLIOT HOSPITAL, MANCHESTER, NH ~~CATHOLIC MEDICAL~~ Voluntary decision to limit practice to the Elliot Hospital
MANCHESTER, NH

(RENEWAL APPLICATION CONTINUED ON REVERSE SIDE)

MAR 15 2004

STATE OF NEW HAMPSHIRE

Telephone #: 603-271-6934

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

RENEWAL APPLICATION

#20645

For expiration on: 6/30/06

Renewal Fee: $300.00 of 900.00

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: OBG

Board Certified: (Y/N) Y

Please list ABMS Board Specialty: OBG

Licensed in the states of: (2 letter state abbrev.)

NONE

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

License #: 9693

File #: 10614

☒ **Work Address**

JENNIFER M DONOFRIO, MD
MANCHESTER OB ASSOC
150 TARRYTOWN RD
MANCHESTER, NH 03103-

Phone: (603) 622-3162

☐ **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
~~CATHOLIC MED CTR MANCHESTER NH~~ WRONG →		☑	☐	☐
		☐	☐	☐
Elliot Hospital Manchester NH		☒	☐	☐
		☐	☐	☐
Catholic Med Ctr Manchester NH		☐	☒	☐
		☐	☐	☐
		☐	☐	☐

(RENEWAL APPLICATION CONTINUED ON REVERSE SIDE)

APR 18 2006

RECEIVED
APR 11 2006
NH BOARD

RECEI
MAR 2 8
NH BO

STATE OF NEW HAMPSHIRE

Telephone #: 603-271-6934

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

#23884

RENEWAL APPLICATION

For expiration on: 6/30/08

Renewal Fee: $300.00

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

If you choose not to renew, your license will be place 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-I, all licensees must inform the Board of any change in address within 30 days of the change.**

Specialty: OBG

Board Certified: (Y/N) Y

Please list ABMS Board Specialty: OBG

Licensed in the states of: (2 letter state abbrev.)
NONE

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

License #: 9693

File #: 10614

☒ Work Address

JENNIFER M DONOFRIO, MD
MANCHESTER OB ASSOC
150 TARRYTOWN RD
MANCHESTER, NH 03103-

Phone: 603*622-3162
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
CATHOLIC MED CTR	MANCHESTER	NH	☐	☑	☐
ELLIOT HOSPITAL	MANCHESTER	NH	☑	☐	☐
			☐	☐	☐
			☐	☐	☐
			☐	☐	☐
			☐	☐	☐
			☐	☐	☐

(RENEWAL APPLICATION CONTINUED ON REVERSE SIDE)

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. Have you been subject to any disciplinary action, limitation, restriction, or agreement for any reason, including rehabilitation by a licensing board?		✓
2. Have you been denied, or have you surrendered, a license in any state other than for relocation or retirement?		✓
3. Have you been subject to any denial, restriction, suspension or loss/revocation of your DEA certificate?		✓
4. Have you been treated, other than through the Physician Health Program, for abuse or misuse of any chemical substance, including alcohol?		✓
5. Have you had any emotional disturbance or mental or physical illness which has impaired your ability to practice medicine?		✓
6. Have you been found guilty or entered a plea of no contest to any felony or misdemeanor that has not been annulled by a court?		✓
7. Have you been reported to the National Practitioner's Data Bank? If yes, please submit a copy of the report.		✓
8. Have you been the subject of an investigation or disciplinary proceeding?		✓
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?		✓
10. Have any medical malpractice claims been made against you? See attached reporting form.		✓

I HEREBY CERTIFY UNDER PENALTY OF PERJURY, THAT ALL INFORMATION ON THIS FORM IS CURRENTLY ACCURATE.

Signature of Licensee (Signature Stamp Not Accepted)

Date 3-20-06

MAR 19 2008 RECEIVED

STATE OF NEW HAMPSHIRE MAR 17 2008

Telephone #: 603-271-6934 NH BOARD

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

RENEWAL APPLICATION

For expiration on: 06/30/2010

Renewal Fee: $300.00 H 57 1 off 600

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: OBG

Currently Board Certified? (Y/N) Y

Please list ABMS Board Specialty: OBG

Currently licensed in the states of: (2 letter state abbrev.) NONE

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

License #: 9693

File #: 10614

☑ Work Address

JENNIFER M DONOHRIO, MD
MANCHESTER OB ASSOC
150 TARRYTOWN RD
MANCHESTER, NH 03103

Phone: 603*622-3162
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
CATHOLIC MED CTR	MANCHESTER	NH		☐	☑	☐
ELLIOT HOSPITAL	MANCHESTER	NH		☑	☐	☐
				☐	☐	☐
				☐	☐	☐
				☐	☐	☐
				☐	☐	☐
				☐	☐	☐

(RENEWAL APPLICATION CONTINUED ON REVERSE SIDE)

APR 12 2010

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: 06/30/2012

Renewal Fee: $300.00

For Office Use Only: Date Pd: 4-9-10 Check #: 3654

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: OBG

Currently Board Certified? (Y/N) Y

Please list ABMS Board Specialty: OBG

Currently licensed in the states of: (2 letter state abbrev.) NONE

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 #: 9693

File #: 10614

☒ Work Address

JENNIFER M DONOFRIO, MD
MANCHESTER OB ASSOC
150 TARRYTOWN RD
MANCHESTER, NH 03103-

Phone: 603-622-3162
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
CATHOLIC MED CTR	MANCHESTER	NH	☐	☑	☐
ELLIOT HOSPITAL	MANCHESTER	NH	☑	☐	☐
			☐	☐	☐
			☐	☐	☐
			☐	☐	☐
			☐	☐	☐
			☐	☐	☐

(RENEWAL APPLICATION CONTINUED ON REVERSE SIDE)

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?		✓
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?		✓
3. Have you been subject to any investigation or to a denial, restriction, suspension, loss or revocation of your DEA certificate?		✓
4. Have you been treated, other than through the Physician Health Program, for abuse or misuse of any chemical substance, including alcohol?		✓
5. Have you had any emotional disturbance or mental or physical illness which has impaired your ability to practice medicine?		✓
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?		✓
7. Have you been reported to the National Practitioner's Data Bank? If yes, please submit a copy of the report.		✓
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.		✓
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?		✓
10. Have any medical malpractice claims been made against you? See attached reporting form.		✓

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.**

[redacted] 4-6-10

Signature of Licensee (Signature Stamp Not Accepted) Date

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 12 months:

	YES	NO
1. Have you been subject to any disciplinary action, limitation, restriction, or agreement for any reason, including rehabilitation by a licensing board?		✓
2. Have you been denied or have you surrendered a license in any state other than for relocation or retirement?		✓
3. Have you been subject to any denial, restriction, suspension or loss/revocation of your DEA certificate?		✓
4. Have you been treated for use or misuse of any chemical substance?		✓
5. Have you had any emotional disturbance or mental or physical illness which has impaired your ability to practice medicine?		✓
6. Have you been found guilty or entered a plea of no contest to any felony or misdemeanor?		✓
7. Have you been reported to the National Practitioner's Data Bank? If yes, please submit a copy of the report.	✓	
8. Have you been the subject of an investigation or disciplinary proceeding?		✓
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?		✓
10. Have any medical malpractice claims been made against you? See attached reporting form.		✓

I HEREBY CERTIFY UNDER PENALTY OF PERJURY, THAT ALL INFORMATION ON THIS FORM IS CURRENTLY ACCURATE.

Signature of Licensee (Signature Stamp Not Accepted)

4-29-98
Date

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 12 months:	YES	NO
1. Have you been subject to any disciplinary action, limitation, restriction or agreement for any reason, including rehabilitation, by a licensing board?		✓
2. Have you been denied, or have you surrendered, a license in any state other than for relocation or retirement?		✓
3. Have you been subject to any denial, restriction, suspension or loss/revocation of your DEA certificate?		✓
4. Have you been treated, other than through the Physician Health Program, for abuse or misuse of any chemical substance, including alcohol?		✓
5. Have you had any emotional disturbance or mental or physical illness which has impaired your ability to practice medicine?		✓
6. Have you been found guilty or entered a plea of no contest to any felony or misdemeanor?		✓
7. Have you been reported to the National Practitioner's Data Bank? If yes, please submit a copy of the report.		✓
8. Have you been the subject of an investigation or disciplinary proceeding?		✓
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?		✓
10. Have any medical [redacted]laims been made against you? See attached reporting form.		✓

I HEREBY CERTIFY UNDER PENALTY OF PERJURY THAT ALL INFORMATION ON THIS FORM IS CURRENTLY ACCURATE.

Signature of Licensee (Signature Stamp Not Accepted)

3-8-04
Date

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 12 months:

	YES	NO
1. Have you been subject to any disciplinary action, limitation, restriction, or agreement for any reason, including rehabilitation by a licensing board?		✓
2. Have you been denied, or have you surrendered, a license in any state other than for relocation or retirement?		✓
3. Have you been subject to any denial, restriction, suspension or loss/revocation of your DEA certificate?		✓
4. Have you been treated, other than through the Physician Health Program, for abuse or misuse of any chemical substance, including alcohol?		✓
5. Have you had any emotional disturbance or mental or physical illness which has impaired your ability to practice medicine?		✓
6. Have you been found guilty or entered a plea of no contest to any felony or misdemeanor?		✓
7. Have you been reported to the National Practitioner's Data Bank? If yes, please submit a copy of the report. [redacted]		✓
8. Have you been the subject of an investigation or disciplinary proceeding?		✓
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? [redacted]		✓
10. Have any medical malpractice claims been made against you? See attached reporting form.		✓

I HEREBY CERTIFY UNDER PENALTY OF PERJURY, THAT ALL INFORMATION ON THIS FORM IS CURRENTLY ACCURATE.

Jennifer Madsen Koo

Signature of Licensee (Signature Stamp Not Accepted)

3/2/03

Date

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 12 months:

	YES	NO
1. Have you been subject to any disciplinary action, limitation, restriction, or agreement for any reason, including rehabilitation by a licensing board?		✓
2. Have you been denied or have you surrendered a license in any state other than for relocation or retirement?		✓
3. Have you been subject to any denial, restriction, suspension or loss/revocation of your DEA certificate?		✓
4. Have you been treated for use or misuse of any chemical substance?		✓
5. Have you had any emotional disturbance or mental or physical illness which has impaired your ability to practice medicine?		✓
[redacted]		
[redacted]		
[redacted]		
[redacted]		
[redacted]		

[redacted] INFORMATION ON THIS FORM IS [redacted]

Signature of Licensee (Signature Stamp Not Accepted)

3-4-02
Date

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 12 months:	YES	NO
1. Have you been subject to any disciplinary action, limitation, restriction, or agreement for any reason, including rehabilitation by a licensing board?	___	X
2. Have you been denied or have you surrendered a license in any state other than for relocation or retirement?	___	X
3. Have you been subject to any denial, restriction, suspension or loss/revocation of your DEA certificate?	___	X
4. Have you been treated for use or misuse of any chemical substance?	___	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 or misdemeanor?	___	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?	___	X
9. Have any hospital [redacted] 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

I HEREBY CERTIFY UNDER PENALTY OF PERJURY, THAT ALL INFORMATION ON THIS FORM IS CURRENTLY ACCURATE.

Signature of Licensee (Signature Stamp Not Accepted)

4-30-1
Date

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 12 months:

	YES	NO
1. Have you been subject to any disciplinary action, limitation, restriction, or agreement for any reason, including rehabilitation by a licensing board?	___	✓
2. Have you been denied or have you surrendered a license in any state other than for relocation or retirement?	___	✓
3. Have you been subject to any denial, restriction, suspension or loss/revocation of your DEA certificate?	___	✓
4. Have you been treated for use or misuse of any chemical substance?	___	✓
5. Have you had any emotional disturbance or mental or physical illness which has impaired your ability to practice medicine?	___	✓
6. Have you been found guilty or entered a plea of no contest to any felony or misdemeanor?	___	✓
7. [redacted]	___	✓
8. Have you been [redacted] or disciplinary proceeding?	___	✓
9. [redacted]	___	✓
10. Have any medical malpractice claims been made against you? See attached reporting form.	___	✓

I HEREBY CERTIFY UNDER PENALTY OF PERJURY, THAT ALL INFORMATION ON THIS FORM IS CURRENTLY ACCURATE.

Signature of Licensee (Signature Stamp Not Accepted)

4-4-06
Date

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 12 months:

	YES	NO
1. Have you been subject to any disciplinary action, limitation, restriction, or agreement for any reason, including rehabilitation by a licensing board?	___	✓
2. [redacted] or retirement?	___	✓
3. Have you been subject to any [redacted] suspension or loss/revocation of your DEA certificate?	___	✓
4. Have you been treated for [redacted] substance?	___	✓
5. Have you had any emotional [redacted] or mental or physical illness which has impaired your ability to [redacted]	___	✓
6. [redacted]	___	✓
[redacted]	___	✓
[redacted]	___	✓
[redacted]	___	✓

[redacted] IS

Signature of Licensee (Signature Stamp Not Accepted)

4-22-99
Date

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 12 months:	YES	NO
1. Have you been subject to any disciplinary action, limitation, restriction, or agreement for any reason, including rehabilitation by a licensing board?		✓
2. Have you been denied or have you surrendered a license in any state other than for relocation or retirement?		✓
3. Have you been subject to any denial, restriction, suspension or loss/revocation of your DEA certificate?		✓
4. Have you been treated for use or misuse of any chemical substance?		✓
5. Have you had any emotional disturbance or mental or physical illness which has impaired your ability to practice medicine?		✓
6. Have you been found guilty or entered a plea of no contest to any felony or misdemeanor?		✓
7. Have you been reported to the National Practitioner's Data Bank? If yes, please submit a copy of the report.	✓	
8. Have you been the subject of an investigation or disciplinary proceeding?		✓
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?		✓
10. Have any medical malpractice claims been made against you? See attached reporting form.		✓

I HEREBY CERTIFY UNDER PENALTY OF PERJURY, THAT ALL INFORMATION ON THIS FORM IS CURRENTLY ACCURATE.

Signature of Licensee (Signature Stamp Not Accepted)

4-29-98
Date

[redacted]

[redacted] EDICINE? YES ✓ NO ___ IF NO, PLEASE EXPLAIN

RENEWAL FEE: $100.00

SPECIALTY ___ eligible

___ I DO NOT INT[redacted] PLACE MY LICENSE ON INACTIVE STATUS.

LIST ALL HOSPITAL AFFILIATIONS: Eli[redacted]

IN WHAT OTHER STATES DO YOU HOLD LICENSE: None

IN THE PAST 12 MONTHS:

1.	HAS ANY ACTION, INCLUDING ANY DISCIPLINARY ACTION, LIMITATION, RESTRICTION, OR AN AGREEMENT FOR ANY REASON INCLUDING REHABILITATION BEEN TAKEN OR ENTERED BY A LICENSING BOARD?	1. ___ YES ✓ NO
2.	HAVE YOU BEEN DENIED OR HAVE YOU SURRENDERED A LICENSE IN ANY STATE OTHER THAN FOR RELOCATION OR RETIREMENT?	2. ___ YES ✓ NO
3.	HAS THERE BEEN ANY DENIAL, RESTRICTION, SUSPENSION OR LOSS/REVOCATION OF YOUR DEA?	3. ___ YES ✓ NO
4.	HAVE YOU BEEN TREATED FOR USE OR MISUSE OF ANY CHEMICAL SUBSTANCE?	4. ___ YES ✓ NO
5.	HAVE YOU HAD ANY EMOTIONAL DISTURBANCE OR MENTAL ILLNESS WHICH HAS IMPAIRED YOUR ABILITY TO PRACTICE MEDICINE?	5. ___ YES ✓ NO
6.	HAVE YOU BEEN FOUND GUILTY OR ENTERED A PLEA OF NO CONTEST TO ANY FELONY, OR TO A MISDEMEANOR?	6. ___ YES ✓ NO
7.	HAVE YOU BEEN REPORTED TO THE NATIONAL PRACTITIONER DATA BANK? IF YES, PLEASE SUBMIT A COPY OF THE REPORT	7. ___ YES ✓ NO
8.	HAVE YOU BEEN THE SUBJECT OF AN INVESTIGATION OR DISCIPLINARY PROCEEDING?	8. ___ YES ✓ NO
9.	HAVE ANY HOSPITAL PRIVILEGES BEEN SUSPENDED, LIMITED, OR DENIED OTHER THAN FOR MEDICAL RECORDS VIOLATIONS, OR HAVE YOU BEEN PLACED ON ADMINISTRATIVE LEAVE?	9. ___ YES ✓ NO
10.	HAVE ANY MEDICAL MALPRACTICE CLAIMS BEEN MADE AGAINST YOU? SEE ATTACHED REPORTING FORM	10. ___ YES ___ NO

IF THE ANSWER IS YES TO ANY OF THESE QUESTIONS, PLEASE FILE A WRITTEN EXPLANATION.

I HEREBY CERTIFY, UNDER PENALTY OF PERJURY, THAT ALL INFORMATION ON THIS FORM IS CURRENTLY ACCURATE.

[redacted]

Signature of Licensee (Signature Stamp Not Accepted)

4-23-97

Date