State of New Hampshire

BOARD OF REGISTRATION IN MEDICINE

HEALTH & WELFARE BUILDING — HAZEN DRIVE

CONCORD, NEW HAMPSHIRE 03301

TEL. (603) 271-4502

April 3, 1987

Cheryl A. Gibson, M.D.

[redacted]

Dear Dr. Gibson:

This is to certify that you have been granted licensure to practice medicine in the State of New Hampshire. Your license #7539 is dated April 1, 1987.

Licensure is issued under the provisions of RSA 329:16 which states in part, "...licenses issued under this section shall be conditioned upon the recipient taking up actual practice of medicine in the state within 18 months after issuance of the license and continuing such practice for at least one year..."

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

Sincerely,

William T. Wallace

William T. Wallace, Jr., M.D., M.P.H.
Executive Secretary

/tm

Enc.

The State of New Hampshire

Board of Registration in Medicine

P- Planned Parenthood
S-0866

Application No. 9269

I hereby apply* for license to practice Medicine in the State of New Hampshire as a Doctor of Medicine [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 enclose a certified check or postal or express money order for the regular fee of $150.00 (U. S. Funds) No Refunds.

1. **Personal Particulars**

Name in full Cheryl Ann Gibson
(Do not use initials) First Middle names in full

Present residence: No. [redacted] Street, [redacted]
(City or town) (County) (State) Zip Code

Post office address [redacted]

Date of birth [redacted] Birthplace [redacted]
(City town or county) (State or foreign country)

If foreign born, date and place of naturalization as a citizen of the United States: Date .....

.....1..... Place .....

Age at last birthday [redacted] Sex [redacted] Single, Married, Widowed, or Divorced (*write the word*) [redacted] Color or race [redacted]

2. **Academic Education:**

Name and Location of Institutions attended. Period of Study

.....University of Vermont, Burlington ..... 9/72-5/77.....

.....

Academic degree of .....BS....., received from ...UVM.....May..... 1 977.....

3. **Medical Education:**

Name and Location of All Institutions attended. Years attended with Date

.....University of Vermont College of Medicine ..... 9/81-5/85.....

.....

.....

.....

Degree of Doctor of Medicine [~~Osteopathy~~] received from ...University of Vermont.....
at .....Burlington, Vermont..... May..... 1 985.....

Period and places of practice ...Resident in Obstetrics and Gynecology.....6/85-present..

.....

Examined and licensed in the States of .....Vermont..... ✓
(Name all states in which examined or licensed)

4. **Certificate of Medical Education‡:**

It is hereby certified that ...Cheryl A. Gibson..... of .....Underhill, Vermont.....
matriculated in ..Univ. of Vt. College of Medt .....Burlington, Vermont.....
(Name of institution) (place)
on .....september 1981-May 19 85., attended .....4..... courses of lectures, and
on .....May..... 19 85 received a diploma from this institution conferring the degree of

***5. Certified Copy of State or National Board License or Certificate.**

(Give a verbatim copy of License or Certificate certified by the Secretary with seal.)

TO BE FORWARDED BY NATIONAL BOARD OF MEDICAL EXAMINERS

I hereby certify that the above is a true copy of certificate or license No. ..... issued ..... A. D. .....

[SEAL] .....
Secretary.

The seal of the board must be affixed

6. Affidavit of Secretary. NOT APPLICABLE

STATE OF .....

County of ..... ss.

.....of .....

being duly sworn, says that he is Secretary of .....

.....and that the original of the preceding certified copy of State or National Board License or Certificate No. ..... was issued to Dr. .....

.....

of ..... on ..... 1 .....

after a written examination by this Board in the following branches and upon obtaining a rating averaging ..... per cent .....

.....

.....

.....

.....

.....

.....

The subjects of examination and rating of each

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.**

Signature of Licensee (Signature Stamp Not Accepted) — Date: 4/14/11

7. **Affidavit of Internship.**

STATE OF Vermont [SEAL]

County of Chittenden ss.

Daniel H. Riddick being duly sworn, says that he is

Chairman of OB/GYN of the Medical Center Hosp. of Vermont Hospital located

at Burlington, Vermont and that

Cheryl A. Gibson M. D. [D. O.], has been an intern at said hospital at least

12 months from June 23 19 85 to June 23 1986

Type of service (straight or rotating) straight
Division of service (medical, surgical, etc.) Obstetrics and Gynecology
If rotating, specify (in months) time devoted to:

Medicine	Dermatology	Pathology
Surgery	Oto-laryngo-rhinology	Neurology
Obstetrics	Ophthalmology	Clinical laboratory
Gynecology	Roentgenology	
Pediatrics	Psychiatry	

Daniel H. Riddick, M. D. [D. O.]
(Medical Director) (Chief of Staff)

Sworn to before me this 6th day of February 1987

Notary Public.

(affix seal above line)

8. **Affidavit of Internship Residency**

STATE OF Vermont

County of Chittenden ss.

Daniel H. Riddick being duly sworn, says that he is

Chairman of OB/GYN of the Medical Center Hosp. of Vermont Hospital located

at Burlington, Vermont and that

Cheryl A. Gibson M. D. [D. O.], has been an intern / resident at said hospital from

June 23 19 86 to present 19

Type of service (straight or rotating) straight
Division of service (medical, surgical, etc.) Obstetrics and Gynecology
If rotating, specify (in months) time devoted to:

Medicine	Dermatology	Pathology
Surgery	Oto-laryngo-rhinology	Neurology
Obstetrics	Ophthalmology	Clinical laboratory
Gynecology	Roentgenology	
Pediatrics	Psychiatry	

Daniel H. Riddick, M. D. [D. O.]
(Medical Director) (Chief of Staff)

Sworn to before me this 6th day of February 1987

9. Affidavit of Registrar BIRTH CERTIFICATE ENCLOSED

STATE OF .....

County of ..... ss.

..... being duly sworn says that he is the ..... of the Town (of the Village, City, County, Registration District, Province, State) of ..... and custodian of the records of birth thereof, and that an official record of birth bearing the name of ..... born on ....., 1....., at Number ..... Street in the Town / City of ..... County of..... State of ....., child of ..... and ..... is on file in the office of said official, and further that it appears that said official record of birth was filed on ....., 1.....

(title of official executing this affidavit)

(give name exactly as it appears on the record)

(month) (day)

(name of father exactly as it appears on the record)

(name of mother exactly as it appears on the record)

(month) (day)

(Signature) .....

Sworn to before me this ..... day of ..... 19.....

..... (SEAL)

Notary Public

10. Affidavit of Physician. Will be forwarded by physician

STATE OF .....

County of ..... ss.

I, ... M. D. [D. O.] of ..... being duly sworn do hereby certify: that I am acquainted with applicant and have known him (her) for ..... years; that I hold license No. ..... to practice medicine [osteopathy] in the State [Province] of .....; and that I know applicant personally to be a physician [osteopathic physician] of good moral character and in good professional standing.

..... M. D. [D. O.]

Sworn to before me this ..... day of ..... 19 .....

..... Notary Public. [SEAL]

11. Affidavit of Physician. Will be forwarded by physician

STATE OF .....

County of ..... ss.

I, ... M. D. [D. O.] of ..... being duly sworn do hereby certify: that I am acquainted with applicant and have known him (her) for ..... years; that I hold license No. ..... to practice medicine [osteopathy] in the State [Province] of .....; and that I know applicant personally to be a physician [osteopathic physician] of good moral character and in good professional standing.

..... M. D. [D. O.]

Sworn to before me this ..... day of ..... 19 .....

12. Affidavit of Officer of Medical [Osteopathic] Society: Will be forwarded by Vermont Medical Society

STATE OF .....

County of ..... ss.

..... M. D. [D. O.] of .....

being duly sworn, says that he is President or Secretary of the .....

Medical [Osteopathic] Society, and that ..... M. D. [D. O.] of

..... is at present a member in good standing of the said Medical [Osteopathic] Society and that he is an ethical practitioner of good moral character.

..... M. D. [D. O.]

Sworn to before me this ..... day of ..... 19.....

[SEAL] ..... Notary Public.

13. Affidavit of the Applicant:

STATE OF .....Vermont.....

County of .....[redacted]..... ss.

.....Cheryl A. Gibson..... of .....[redacted], Vermont.....

being duly sworn says that she is the person referred to in the above application for a license to practice medicine as a Doctor of Medicine [as a Doctor of Osteopathy] in the State of New Hampshire; that he is a citizen of the United States [of Canada in the province of .....

.....] as shown by the above Affidavit of Registrar, wherein ~~his~~ her name appears as

.....Cheryl Ann Gibson.....

[or proof of citizenship ..... hereto attached]; that he has studied the treatment of human ailments not less than four school years prior to receiving the degree of Doctor of Medicine [Osteopathy]; that all the statements herein contained respecting age, citizenship, residence, academic and medical education, internship, state or national board examination and license, good professional standing, and any other statements made on said application or attached hereto are each and all true in every respect, and that no disciplinary action has been brought against him by any State, county or local medical society.

He further says that he has never been an inmate in an institution for treatment for insanity, drug addiction, or inebriety, except as follows: .....; and that he has never been convicted, nor fined, nor imprisoned, nor placed on probation, nor has he ever forfeited collateral for breach or violation of any law or police regulation or ordinance whatsoever except as follows: .....

.....

.....

THE STATE OF NEW HAMPSHIRE
BOARD OF REGISTRATION IN MEDICINE

(the following is to be filled out by the board)

Application received ..... 19.....

Application examined ..... 19.....

Candidate interviewed 3/27 19 87

by ..... Jane Walters

Fee paid 2/20 19 87

~~No Fee~~

Form of fee	P.O. order	Check	Cash	Express Order	Other

Application approved [denied] ..... 19.....

Examination ..... 19.....

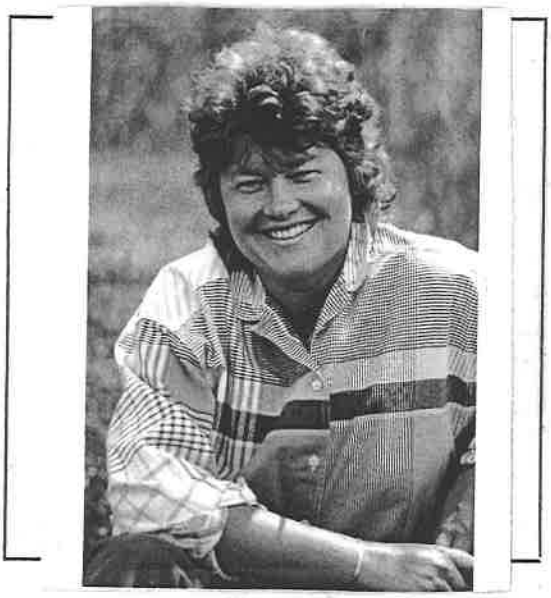
Accepted without examination ..... 19.....

License granted .....

Date 4/1/87

License No. 7539

Remarks: .....



Applicant Please do not write above this line.

The affixed photograph is of

.....
(Signature of Applicant)

Curriculum Vitae

Cheryl A. Gibson

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

Home Address:
[redacted]

Undergraduate Education:
High School: Bristol Eastern High School, Bristol, Connecticut
Honors: National Honor Society-Junior Year
College: University of Vermont, Burlington, Vermont- graduated 1977, B.S. Professional Nursing
Honors: Dean's List, 3 semesters

Postgraduate Education:
New Jersey College of Medicine and Dentistry/ Planned Parenthood-World Population
Certificate-Family Planning Nurse Practitioner, 1978

Professional Certification:
NAACOG certification as Outpatient OB-GYN Nurse Practitioner, 1980

Medical Education:
University of Vermont College of Medicine, Burlington, Vermont- graduation May 1985
Honors: Alpha Omega Alpha-Junior Year
Coursework Honors: Human Sexuality, Fall 1982
Surgery, Clinical Clerkship, Spring 1983
Medicine, Clinical Clerkship, Spring 1983
Pediatrics, Clinical Clerkship, Summer 1983
Epidemiology, Spring 1984
Community OB-GYN, Senior Major Program, Spring 1984
Reproductive Endocrinology, Acting Internship, Spring 1984
Activities: Student Council- Treasurer 1981-1982
Vice President 1982-1983
President 1983-1984
Instructor- Pelvic Exam for Basic Clerkship for sophomore medical students, 1981-1983
Certification: National Boards- Part I, September 1983-Pass
Part II, June 1984- Pass Part III, 1985-pas
Residency Training-OB/GYN, Med. Ctr. Hosp. of Vermont, June 1985-preser

Employment Experience:
OB-GYN Nurse Practitioner and Clinical Supervisor, Planned Parenthood of Vermont, Burlington, Vermont, 1978-present
Veterinary Office and Surgical Assistant, Green Mountain Animal Hospital, Burlington, Vermont, 1974-1978

Professional Memberships:
Vermont State Nurses Association, 1977-present
Vice President, District I, 1980
American Nurses Association, 1977-present
Physicians for Social Responsibility, 1981-present
Vermont State Medical Society, 1985- present

Bibliography:
"From Policy to Preventive Services: A Successful Teenage Contraceptive Program", 1980 Papers, Planned Parenthood National Executive Council, Denver, Colorado, September, 30, 1980

Presentations:
Above paper presented at The Fifth International Conference on Venereal Disease, Family Planning and Human Sexuality, Honolulu, Hawaii, June, 1980

Outside Interests:
Gardening
Racquetball
Medical Antiques

References:
Mark Gibson, MD
Dept. OB-GYN
Medical Center Hosp. of Vermont- UVM College of Medicine
Burlington, Vermont

Judith Tyson, MD
Dept. OB-GYN
Mary Hitchcock Hosp.- Dartmouth Medical School
Hanover, New Hampshire

Marga Sproul, MD
Dept. of Family Practice
Medical Center Hosp. of Vermont- UVM College of Medicine
Burlington, Vermont

Alan Rubin, MD
Dept. of Medicine
Medical Center Hosp. of Vermont-UVM College of Medicine
Burlington, Vermont

MAY 1 1 1992

Practice? Private _____ Other (Specify) Affiliated with Planned Parenthood Retired? _____

ARE YOU CERTIFIED BY THE AMERICAN BOARD OF MEDICAL SPECIALTIES?

X YES _____ NO IF YES, DESIGNATE SPECIALTY OB-GYN

SOCIAL SECURITY NUMBER [redacted]

_____ I do not intend to renew by license - please place my license on inactive.

$75.00 DUE AND PAYABLE PRIOR TO JUNE 30, 1992.

$75.00 RENEWAL FEE + $75.00 LATE FEE FOR ALL RENEWAL CARDS RECEIVED AFTER JULY 1, 1992.

MAKE CHECK PAYABLE TO: **TREASURER, STATE OF NH**

CHERYL A GIBSON M
UNIVERSITY HEALTH CENTER
1 SOUTH PROSPECT STREET
BURLINGTON VT 05401

* office
CHANGE OF ADDRESS

Womens Choice Gyn
Assoyates
23 Mansfield Ave
BURLINGTON VT
05401

DURING THE LAST REGISTRATION PERIOD:

1. HAS ANY ACTION, INCLUDING ANY DISCIPLINARY ACTION OR LIMITATION OR RESTRICTION, OR ANY AGREEMENT FOR ANY REASON INCLUDING REHABILITATION BEEN TAKEN OR ENTERED BY A LICENSING BOARD? ___ YES X NO
2. HAS THERE BEEN ANY DENIAL, RESTRICTION, SUSPENSION OR LOSS/ REVOCATION OF YOUR DEA? ___ YES X NO
3. HAVE YOU BEEN TREATED FOR USE OR MISUSE OF ANY CHEMICAL SUBSTANCE? ___ YES X NO
4. HAVE YOU FAILED A WRITTEN (INCLUDING SPEX) OR ORAL EXAMINATION FOR LICENSURE OR COMPETENCY DETERMINATION? ___ YES X NO
5. HAVE YOU BEEN HOSPITALIZED OR TREATED WITH MEDICATION FOR ANY PSYCHIATRIC, NEUROLOGICAL, OR COMMUNICABLE ILLNESS FOR A PERIOD EXCEEDING THIRTY DAYS? ___ YES X NO
6. HAVE YOU BEEN FOUND GUILTY OR ENTERED A PLEA OF NO CONTEST TO ANY FELONY, OR TO A MISDEMEANOR INVOLVING MORAL TURPITUDE? ___ YES X NO
7. HAVE YOU EVER BEEN REPORTED TO THE NATIONAL PRACTITIONER DATA BANK? ___ YES X NO
8. ARE YOU OR HAVE YOU BEEN THE SUBJECT OF AN INVESTIGATION OR DISCIPLINARY PROCEEDING, BY ANY HOSPITAL, PROFESSIONAL SOCIETY, OR OTHER HEALTH CARE FACILITY? ___ YES X NO
9. HAVE ANY HOSPITAL PRIVILEGES BEEN SUSPENDED, LIMITED OTHER THAN FOR MEDICAL RECORDS VIOLATIONS; OR DENIED. ___ YES X NO

IF THE ANSWER IS YES, PLEASE FILE A WRITTEN EXPLANATION.

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

[signature] 4/28/92

Signature of Licensee (Signature Stamp Not Accepted) Date

LIST ALL HOSPITAL AFFILIATIONS: Medical Center Hospital of VT, Fanny Allen Hosp

STATE OF NEW HAMPSHIRE

Board of Registration in Medicine

MAY 10 1993

EXPIRES: 06/30/1994

CHERYL A GIBSON MD
WOMENS CHOICE GYN ASSOCIATES
23 MANSFIELD AVE
BURLINGTON VT 05401-3456

Please check appropriate mailing address.

Name in full Cheryl A Gibson MD

X Place of employment WomesChoice gyn Assoc

23 Mansfield Ave Burlington VT 05401

Business Tel: 802-863 9001

____ Home Address [redacted]

Home Tel: _____

Practice? Private _____ (Other) (Specify) _____ Retired? _____

Specialty OB-gyn Board Certified? Yes If yes, designate specialty OB-gyn

Social Security # [redacted]

_____ I DO NOT intend to renew my license - please place my license on inactive status.

List all hospital affiliations: Medical Center Hospital of Vermont, Fanny Allen Hospital

In what other states do you hold license: Vermont, Maine

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	X NO
2. HAVE YOU EV[redacted]ED A LICENSE IN ANY OTHER STATE?	2. ___ YES	X NO
3. HAS THERE BEEN [redacted] RESTRICTION, SUSPENSION OR LOSS/REVOCATION OR YOUR DEA?	3. ___ YES	X NO
4. [redacted] BEEN TREATED FOR USE OR MISUSE OF ANY CHEMICAL SUBSTANCE?	4. ___ YES	X NO
5. [redacted] LICENSURE OR COMPETENCY DETERMINATION?	5. ___ YES	X NO
6. HAVE YOU EVER HAD ANY EMOTIONAL DISTURBANCE OR MENTAL ILLNESS WHICH HAS IMPAIRED YOUR ABILITY TO PRACTICE MEDICINE?	6. ___ YES	X NO
7. HAVE YOU BEEN FOUND GUILTY OR ENTERED A PLEA OF NO CONTEST TO ANY FELONY, OR TO A MISDEMEANOR?	7. ___ YES	X NO
8. HAVE YOU EVER BEEN REPORTED TO THE NATIONAL PRACTITIONER DATA BANK?	8. ___ YES	X NO
9. ARE YOU NOW OR HAVE YOU EVER BEEN THE SUBJECT OF AN INVESTIGATION OR DISCIPLINARY PROCEEDING?	9. ___ YES	X NO
10. HAVE ANY HOSPITAL PRIVILEGES BEEN SUSPENDED OR LIMITED OTHER THAN FOR MEDICAL RECORDS VIOLATIONS, OR HAVE ANY PRIVILEGES BEEN DENIED OR SURRENDERED?	10. ___ YES	X NO
11. HAVE ANY MEDICAL MALPRACTICE CLAIMS EVER BEEN MADE AGAINST YOU?	11. ___ YES	X 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] MD — 4/30/93

Signature of Licensee (Signature Stamp Not Accepted) — Date

MAY 0 2 1994

EXPIRES: 06/30/1995

STATE OF NEW HAMPSHIRE

Board of Registration in Medicine

CHERYL A GIBSON MD
WOMENS CHOICE GYN ASSOCIATES
23 MANSFIELD AVE
BURLINGTON VT 05401-3456

Please check appropriate mailing address.

Name in full Cheryl A Gibson MD

X Place of employment Womens Choice Gyn Assoc
23 Mansfield Ave, Burlington VT 05401

Business Tel: 802-863-9001

____ Home Address _____

_____

Home Tel: _____

HAVE YOU BEEN CONTINUOUSLY ENGAGED IN THE ACTIVE PRACTICE OF MEDICINE? YES X NO ___ IF NO, PLEASE EXPLAIN

RENEWAL FEE $100.00

SPECIALTY OB-gyn BOARD CERTIFIED? yes

___ I DO NOT INTEND TO RENEW MY LICENSE - PLEASE PLACE MY LICENSE ON INACTIVE STATUS.

LIST ALL HOSPITAL AFFILIATIONS: Med Ctr Hospital of Vermont, Fanny Allen Hospital

IN WHAT OTHER STATES DO YOU HOLD LICENSE: Maine, Vermont

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?	___ YES X NO
2.	HAVE YOU BEEN DENIED OR HAVE YOU SURRENDERED A LICENSE IN ANY STATE OTHER THAN FOR RELOCATION OR RETIREMENT?	___ YES X NO
3.	HAS THERE BEEN ANY DENIAL, RESTRICTION, SUSPENSION OR LOSS/REVOCATION OF YOUR DEA?	___ YES X NO
4.	HAVE YOU BEEN TREATED FOR USE OR MISUSE OF ANY CHEMICAL SUBSTANCE?	___ YES X NO
5.	HAVE YOU HAD ANY EMOTIONAL DISTURBANCE OR MENTAL ILLNESS WHICH HAS IMPAIRED YOUR ABILITY TO PRACTICE MEDICINE?	___ YES X NO
6.	HAVE YOU BEEN FOUND GUILTY OR ENTERED A PLEA OF NO CONTEST TO ANY FELONY, OR TO A MISDEMEANOR?	___ YES X NO
7.	HAVE YOU BEEN REPORTED TO THE NATIONAL PRACTITIONER DATA BANK? IF YES, PLEASE SUBMIT A COPY OF THE REPORT	___ YES X NO
8.	HAVE YOU BEEN THE SUBJECT OF AN INVESTIGATION OR DISCIPLINARY PROCEEDING?	___ YES X 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?	___ YES X NO
10.	HAVE ANY MEDICAL MALPRACTICE CLAIMS BEEN MADE AGAINST YOU? SEE ATTACHED REPORTING FORM	___ YES X 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.

[signature]
Signature of Licensee (Signature Stamp Not Accepted)

4/26/94
Date

MAY 17 1995

STATE OF NEW HAMPSHIRE

Board of Registration in Medicine

06/30/1996
EXPIRES: 7539

CHERYL A GIBSON MD
WOMENS CHOICE GYN ASSOCIATES
23 MANSFIELD AVE
BURLINGTON VT 05401-3456

Please check appropriate mailing address.

Name in full Cheryl A Gibson MD

X Place of employment Womens Choice Gyn
23 Mansfield Ave Burlington

Business Tel: 802-8639001

____ Home Address _____

_____

Home Tel: _____

3EEN CONTINUOUSLY ENGAGED IN THE ACTIVE PRACTICE OF MEDICINE? YES X NO ___ IF NO, PLEASE EXPLAIN

OB-GYN BOARD CERTIFIED? YES

RENEWAL FEE: $100.00

___ I DO NOT INTEND TO RENEW MY LICENSE - PLEASE PLACE MY LICENSE ON INACTIVE STATUS.

SPITAL AFFILIATIONS: Fletcher Allen Health Care, Burlington VT

HER STATES DO YOU HOLD LICENSE: Vermont, Maine

12 MONTHS:

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

ER IS YES TO ANY OF THESE QUESTIONS, PLEASE FILE A WRITTEN EXPLANATION.

ITIFY UNDER PENALTY OF PERJURY, THAT ALL INFORMATION ON THIS FORM IS CURRENTLY ACCURATE.

[signature] MD
e of Licensee (Signature Stamp Not Accepted)

4/26/95
Date

MAY 07 1996

STATE OF NEW HAMPSHIRE

Board of Medicine

8269

EXPIRES: 06/30/1997

Please check appropriate mailing address.

X Name in full Cheryl A Gibson

Place of employment Womens Choice

23 Mansfield Ave Burl

Business Tel: 802-8639001

____ Home Address [redacted]

Home Tel: [redacted]

CHERYL A GIBSON MD
WOMENS CHOICE GYN ASSOCIATES
23 MANSFIELD AVE
BURLINGTON VT 05401-3456

[redacted]

I CONTINUOUSLY ENGAGED IN THE ACTIVE PRACTICE OF MEDICINE? YES X NO ___ IF NO, PLEASE EXPLAIN

RENEWAL FEE: $100.00

OB-gyn BOARD CERTIFIED? Yes

___ I DO NOT INTEND TO RENEW MY LICENSE - PLEASE PLACE MY LICENSE ON INACTIVE STATUS

AL AFFILIATIONS: Fletcher Allen Health Care

STATES DO YOU HOLD LICENSE: Vermont, Maine

MONTHS:

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

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

F), UNDER PENALTY OF PERJURY, THAT ALL INFORMATION ON THIS FORM IS CURRENTLY ACCURATE.

[redacted] MD

I Licensee (Signature Stamp Not Accepted)

4/10/94

Date

JUN 2 0 1997

STATE OF NEW HAMPSHIRE

Board of Medicine

82

EXPIRES: 6/30/98

Please check appropriate mailing address.

Name in full Cheryl A Gibson M

X Place of employment Womens Choice
23 Mansfield Ave Bur

Business Tel: 802 863 9001

CHERYL A GIBSON, MD
WOMENS CHOICE GYN ASSOCIATES
23 MANSFIELD AVE
BURLINGTON VT 05401-3456

____ Home Address same

Home Tel: same

:ONTINUOUSLY ENGAGED IN THE ACTIVE PRACTICE OF MEDICINE? YES X NO ___ IF NO, PLEASE EXPLAIN

RENEWAL FEE: $100.00

OB/gyn BOARD CERTIFIED? yes

___ I DO NOT INTEND TO RENEW MY LICENSE - PLEASE PLACE MY LICENSE ON INACTIVE STATUS.

AFFILIATIONS: Fletcher Allen Health Care

TATES DO YOU HOLD LICENSE: Vermont, Maine

)NTHS:

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

YES TO ANY OF THESE QUESTIONS, PLEASE FILE A WRITTEN EXPLANATION.

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

[signature]
icensee (Signature Stamp Not Accepted)

4/23/97
Date

MAY 2 8 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: OB

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

VT ME

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

License #: 7539

File #: 8269

☐ Work Address:

CHERYL A GIBSON, MD
WOMENS CHOICE GYN ASSOCIA
23 MANSFIELD AVE
BURLINGTON, VT 05401-3456

☐ Home Address:

23 MANSFIELD AVE

BURLINGTON, VT 05401

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

FLETCHER ALLEN HEALTH CARE-BURLINGTON, VT

(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 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 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

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

Signature of Licensee (Signature Stamp Not Accepted)

5/6/08
Date

MAY 13 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.

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Specialty: OBG

Board Certified: (Y/N) Y

Please list ABMS Board Specialty: OBG

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

VT ME

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

License #: 7539

File #: 8269

☒

CHERYL A GIBSON, MD
WOMENS CHOICE GYN ASSOCIA
23 MANSFIELD AVE
BURLINGTON, VT 05401-3456
Phone: 802*863-9001

☐

23 MANSFIELD AVE
BURLINGTON, VT 05401
Phone: 802*863-9001

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

FLETCHER ALLEN HEALTH CARE-BURLINGTON, VT

(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 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 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

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

Signature of Licensee (Signature Stamp Not Accepted)

4/27/99
Date

APR 1 8 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.)

VT ME

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

License #: 7539

File #: 8269

☐ Work Address

CHERYL A GIBSON, MD
WOMENS CHOICE GYN ASSOCIA
23 MANSFIELD AVE
BURLINGTON, VT 05401-3456
Phone: 802*863-9001

☐ Home Address

23 MANSFIELD AVE
BURLINGTON, VT 05401
Phone: 802*863-9001

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

FLETCHER ALLEN HEALTH CARE-BURLINGTON, VT

(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 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]

Signature of Licensee (Signature Stamp Not Accepted)

4/3/2020

Date

JUN 1 1 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.)
VT ME

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

License #: 7539

File #: 8269

☒

☐

Work Address

CHERYL A GIBSON, MD
WOMENS CHOICE GYN ASSOCIA
23 MANSFIELD AVE
BURLINGTON, VT 05401-3456
Phone: 802*863-9001

Home Address

~~23 MANSFIELD AVE~~ 23 Mansfield Ave Burlington VT 05401
~~BURLINGTON, VT 05401~~
Phone: ~~802*863-9001~~ 802-863-9001

Private

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

FLETCHER ALLEN HEALTH CARE-BURLINGTON, VT

(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 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 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

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

[signature] MD

Signature of Licensee (Signature Stamp Not Accepted)

3/30/01

Date

JUN 2 0 2002

#63523

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) 06/30/2003

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.)

VT ME

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

License #: 7539

File #: 8269

☒ Work Address

CHERYL A GIBSON, MD
WOMENS CHOICE GYN ASSOCIA
23 MANSFIELD AVE
BURLINGTON, VT 05401-3456

Phone: 802*863-9001

☐ Home Address

23 MANSFIELD AVE

BURLINGTON, VT 05401

Phone: 802*863-9001

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

FLETCHER ALLEN HEALTH CARE-BURLINGTON, VT

(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 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] MD

Signature of Licensee (Signature Stamp Not Accepted)

6/10/02

Date

MAR 24 2003

STATE OF NEW HAMPSHIRE

Telephone #: 603-271-6934

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

RENEWAL APPLICATION

#70408

For expiration on: 06/30/05

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 reactive 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.)

VT ME

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

License #: 7539

File #: 8269

☒ Work Address

CHERYL A GIBSON, MD
WOMENS CHOICE GYN ASSOCIA
23 MANSFIELD AVE
BURLINGTON, VT 05401-3456

Phone: 802*863-9001

☐ Home Address

23 MANSFIELD AVE

BURLINGTON, VT 05401

Phone: 802*863-9001

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

FLETCHER ALLEN HEALTH CARE-BURLINGTON, VT

(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 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 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] MD

Signature of Licensee (Signature Stamp Not Accepted)

3/4/03

Date

STATE OF NEW HAMPSHIRE

Telephone #: 603-271-6934

APR 18 2005

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

#88329
of 600 00

RENEWAL APPLICATION

For expiration on: 06/30/07

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-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.)

VT ME

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

License #: 7539

File #: 8269

☒ Work Address

CHERYL A GIBSON, MD
WOMENS CHOICE GYN ASSOCIA
23 MANSFIELD AVE
BURLINGTON, VT 05401-3456

Phone: 802*863-9001
Business Fax Number: [redacted]
Business Email Address:

☐ Home Address

23 MANSFIELD AVE

BURLINGTON, VT 05401

Phone: 802*863-9001

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
FLETCHER ALLEN HEAL	BURLINGTON	VT	☑	☐	☐
			☐	☐	☐
			☐	☐	☐
			☐	☐	☐
			☐	☐	☐
			☐	☐	☐
			☐	☐	☐

(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?		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, 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 or misdemeanor 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?		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

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

[redacted] 3/17/05

Signature of Licensee (Signature Stamp Not Accepted) Date

RECEI

STATE OF NEW HAMPSHIRE

Telephone #: 603-271-6934 MAR 28 2007

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

MAR 28 2
NH BOA

#03590

RENEWAL APPLICATION

For expiration on: 06/30/2009

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 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.) VT ME

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

License #: 7539

File #: 8269

☒ Work Address

CHERYL A GIBSON, MD
WOMENS CHOICE GYN ASSOCIA
23 MANSFIELD AVE
BURLINGTON, VT 05401-3456

Phone: 802*863-9001
Business Fax Number: [redacted]
Business Email Address: [redacted]

☐ Home Address

23 MANSFIELD AVE

BURLINGTON, VT 05401

Phone: 802*863-9001

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
FLETCHER ALLEN HEAL	BURLINGTON	VT		☑	☐	☐
				☐	☐	☐
				☐	☐	☐
				☐	☐	☐
				☐	☐	☐
				☐	☐	☐
				☐	☐	☐

(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?		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, 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 or misdemeanor 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? 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.

Signature of Licensee (Signature Stamp Not Accepted)

3/9/07
Date

RECEIVED

APR 13 2009

NH BOARD

STATE OF NEW HAMPSHIRE

Telephone #: 603-271-6934

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

1783

RENEWAL APPLICATION

For expiration on: 06/30/2011

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 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.) VT ME NH

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 #: 7539

File #: 8269

☑ Work Address

CHERYL A GIBSON, MD
WOMENS CHOICE GYN ASSOCIA
23 MANSFIELD AVE
BURLINGTON, VT 05401-3456

Phone: 802*863-9001
Business Fax Number: [redacted]
Business Email Address: [redacted]

☐ Home Address

23 MANSFIELD AVE

BURLINGTON, VT 05401

Phone: 802*863-9001

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
FLETCHER ALLEN HEAL	BURLINGTON	VT	☑	☐	☐
			☐	☐	☐
			☐	☐	☐
			☐	☐	☐
			☐	☐	☐
			☐	☐	☐
			☐	☐	☐

(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?	___	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. [redacted]	___	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.

[signature] 3/30/09

Signature of Licensee (Signature Stamp Not Accepted) Date