New Hampshire Board of Medicine

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

August 3, 2011

REBECCA JONES MD

Dear Dr. Jones:

Congratulations, your application for licensure has been granted by the New Hampshire Board of Medicine. Your license, numbered 15350, is dated August 3, 2011, and is enclosed with this letter.

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

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

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

Sincerely,

Penny Taylor

Penny Taylor
Administrator

Encl.

08/15/11 (BC)

sent 8/8/11 6/21/11

Uniform Application for Physician Licensure

UA Username pineytop
FCVS Status Applicant has an FCVS Packet

Date Submitted 6/20/2011

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

1. Full Name (use no initials)

Last Name	Jones
First Name	Rebecca Keene
Middle Name	
Suffix	
Maiden Name	

M.D. [X] **D.O.** [ ]

All other names used

First	Middle	Last	Suffix

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

2. Address/Phone

Business

[ ] **Public Access**
[X] **Mailing**

Street
City **State/Province** **Zip Code**
Country
Telephone
Fax
Email
Alternate Phone

Home

[X] **Public Access**
[ ] **Mailing**

Street 204 Maple Grove Road
City Mohnton **State/Province** PA **Zip Code** 19540
Country
Telephone
Fax
Email
Alternate Phone

*

JONES KEENE

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

3. Identification

Date of Birth (mm/dd/yyyy)	Birth City	Birth State/Province	Birth Country

Gender _____ Social Security Number _____ NPI _____ Are you a U.S. Citizen? ☐ Yes ☐ No

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

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

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

4. Medical School

1 **School Name** University of Pennsylvania School of Medicine
Address 36th and Hamilton Walk
City Philadelphia
State/Province PA
ZIP Code 19104-6055
Country USA
Attendance Dates **From (mm/yyyy)** 09/1986 **To (mm/yyyy)** 05/1991
Graduation Date 5/21/1991
Degree MD

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

5. Fifth Pathway (if applicable)

Medical School Name			
Address			
City			
State/Province			
ZIP Code			
Country			
Attendance Dates	**From (mm/yyyy)**	**To (mm/yyyy)**	**In Progress**
Graduation Date			
Degree			
Institution name where rotations performed			
Address			
City			
State/Province			
ZIP Code			
Country			
Rotation Dates	**From (mm/yyyy)**	**To (mm/yyyy)**	**In Progress**
Certification Date			

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

6. Postgraduate Training

1 **Hospital Name** Reading Hospital and Medical Center
Hospital Address Box 16052

City Reading
State/Province Pennsylvania
ZIP Code 19611
Country USA

PGY: (e.g., 1, 2, 3, etc.) [X] **Internship** [ ] **Residency** [ ] **Fellowship** [ ] **Research** [ ] **Other**

Department/Specialty Obstetrics and Gynecology

From: 06 /1991 **To:** 06 /1992 **Successfully Completed?** [X] **Yes** [ ] **No** **In Progress** [ ]
Month Year Month Year

2 **Hospital Name** Reading Hospital and Medical Center
Hospital Address Box 16052

City Reading
State/Province Pennsylvania
ZIP Code 19611
Country USA

PGY: (e.g., 1, 2, 3, etc.) [ ] **Internship** [X] **Residency** [ ] **Fellowship** [ ] **Research** [ ] **Other**

Department/Specialty Obstetrics and Gynecology

From: 06 /1992 **To:** 06 /1994 **Successfully Completed?** [X] **Yes** [ ] **No** **In Progress** [ ]
Month Year Month Year

3 **Hospital Name** Reading Hospital and Medical Center
Hospital Address Box 16052

City Reading
State/Province Pennsylvania
ZIP Code 19611
Country USA

PGY: (e.g., 1, 2, 3, etc.) [ ] **Internship** [ ] **Residency** [ ] **Fellowship** [ ] **Research** [X] **Other**

Department/Specialty Obstetrics and Gynecology

From: 06 /1994 **To:** 06 /1995 **Successfully Completed?** [X] **Yes** [ ] **No** **In Progress** [ ]
Month Year Month Year

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

7. Examination History

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

Examination	State	Most Recent Date taken(Month/Year)	Passed (P) or Failed (F)		Number of attempts
NBME Part I		09/1988	[X] P	[ ] F	1
NBME Part II		04/1991	[X] P	[ ] F	1
NBME Part III		03/1992	[X] P	[ ] F	1

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

8. ECFMG (if applicable)

Certificate Number	Issue Date	Valid Through Date

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

9. State Licensure

1	State/Province	ME	Practitioner Type (MD, DO, etc.)	MD	Type of License (Full, Temporary, etc.)	Full License	
	License Number	018312	Status	Active	Issue Date	9/28/2009	
2	State/Province	NH	Practitioner Type (MD, DO, etc.)	MD	Type of License (Full, Temporary, etc.)	Temporary License	
	License Number	LT-2993	Status	Active	Issue Date	1/31/2011	
3	State/Province	MA	Practitioner Type (MD, DO, etc.)	MD	Type of License (Full, Temporary, etc.)	Full License	
	License Number	227062	Status	Active	Issue Date	1/4/2006	
4	State/Province	NM	Practitioner Type (MD, DO, etc.)	MD	Type of License (Full, Temporary, etc.)	Full License	
	License Number	MD20050829	Status	Active	Issue Date	12/8/2005	
5	State/Province	PA	Practitioner Type (MD, DO, etc.)	MD	Type of License (Full, Temporary, etc.)	Full License	
	License Number	MD051312L	Status	Active	Issue Date		
6	State/Province	VT	Practitioner Type (MD, DO, etc.)	MD	Type of License (Full, Temporary, etc.)	Full License	
	License Number	0420011506	Status	Active	Issue Date	1/2/2008	
7	State/Province	WA	Practitioner Type (MD, DO, etc.)	MD	Type of License (Full, Temporary, etc.)	Full License	
	License Number	00045964	Status	Inactive	Issue Date	11/1/2006	
8	State/Province	WV	Practitioner Type (MD, DO, etc.)	MD	Type of License (Full, Temporary, etc.)	Full License	
	License Number	222000	Status	Inactive	Issue Date	1/9/2006	

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

10. Chronology of Activities

Dates: From/To	Practice/Employment
1 From: Month: 06 Year: 1995 To: Month: 09 Year: 2005 In Progress ☐	**Practice/Employment Name** Reading Obstetrics & Gynecology (or list non-working time as indicated above) **Practice/Employment Address** 3701 Perkiomenville Ave **City** Reading **State/Province** Pennsylvania **ZIP Code** 19696 **Country** USA **Position and Department** physician-Ob/Gyn **% Clinical** 85 **% Administrative** 15 **Employment** ☐ **Staff Privileges** ☐ **Affiliation** ☐ **Other**
2 From: Month: 10 Year: 2005 To: Month: 10 Year: 2005 In Progress ☐	**Practice/Employment Name** Brandywine Hospital (or list non-working time as indicated above) **Practice/Employment Address** 201 Reeceville Rd **City** Coatesville **State/Province** Pennsylvania **ZIP Code** 19320 **Country** USA **Position and Department** locum physician-Ob/Gyn **% Clinical** 100 **% Administrative** 0 **Employment** ☐ **Staff Privileges** ☐ **Affiliation** ☐ **Other**
3 From: Month: 11 Year: 2005 To: Month: 01 Year: 2006 In Progress ☐	**Practice/Employment Name** Planned Parenthood of Northeast Pennsylvania (or list non-working time as indicated above) **Practice/Employment Address** Box 813 **City** Trexlertown **State/Province** Washington **ZIP Code** 18087 **Country** USA **Position and Department** locum physician-family planning **% Clinical** 100 **% Administrative** 0 **Employment** ☐ **Staff Privileges** ☐ **Affiliation** ☐ **Other**

Dates: From/To	Practice/Employment
4 From: Month: 01 Year: 2006 To: Month: 09 Year: 2006 In Progress ☐	**Practice/Employment Name** Caritas Norwood Hospital (or list non-working time as indicated above) **Practice/Employment Address** 800 Washington St **City** Norwood **State/Province** Massachusetts **ZIP Code** 02062 **Country** USA **Position and Department** locum physician-Ob/Gyn **% Clinical** 100 **% Administrative** 0 **Employment** ☐ **Staff Privileges** ☐ **Affiliation** ☐ **Other**

Dates: From/To	Practice/Employment
5 From: Month: 05 Year: 2006 To: Month: 07 Year: 2006 In Progress ☐	**Practice/Employment Name** Weirton Medical Center (or list non-working time as indicated above) **Practice/Employment Address** 651 Colliers Way **City** Weirton **State/Province** West Virginia **ZIP Code** 26062 **Country** USA **Position and Department** locum physician-Ob/Gyn **% Clinical** 100 **% Administrative** 0 **Employment** ☐ **Staff Privileges** ☐ **Affiliation** ☐ **Other**

Dates: From/To	Practice/Employment
6 From: Month: 09 Year: 2006 To: Month: 01 Year: 2008 In Progress ☐	**Practice/Employment Name** Yakima Valley Farm Workers' Clinic (or list non-working time as indicated above) **Practice/Employment Address** Yakima Memorial Hospital 2811 Tieton Drive **City** Yakima **State/Province** Washington **ZIP Code** 98902 **Country** USA **Position and Department** locum physician-Ob/Gyn **% Clinical** 100 **% Administrative** 0 **Employment** ☐ **Staff Privileges** ☐ **Affiliation** ☐ **Other**

Dates: From/To	Practice/Employment
7 From: Month: 01 Year: 2008 To: Month: 09 Year: 2010 In Progress ☐	Practice/Employment Name: Gifford Medical Center (or list non-working time as indicated above) Practice/Employment Address: 44 S. Main St City: Randolph State/Province: Vermont ZIP Code: 05060 Country: USA Position and Department: locum physician-Ob/Gyn % Clinical: 100 % Administrative: 0 Employment ☐ Staff Privileges ☐ Affiliation ☐ Other

Dates: From/To	Practice/Employment
8 From: Month: 02 Year: 2008 To: Month: 06 Year: 2008 In Progress ☐	Practice/Employment Name: Reading Hospital and Medical Center (or list non-working time as indicated above) Practice/Employment Address: 6th and Spruce City: Reading State/Province: Pennsylvania ZIP Code: 19611 Country: USA Position and Department: Supervised residents-Ob/Gyn % Clinical: 85 % Administrative: 15 Employment ☐ Staff Privileges ☐ Affiliation ☐ Other

Dates: From/To	Practice/Employment
9 From: Month: 06 Year: 2008 To: Month: 09 Year: 2008 In Progress ☐	Practice/Employment Name: Jordan Hospital (or list non-working time as indicated above) Practice/Employment Address: 275 Sandwich St City: Plymouth State/Province: Massachusetts ZIP Code: 02360 Country: USA Position and Department: locum physician-Ob/Gyn % Clinical: 100 % Administrative: 0 Employment ☐ Staff Privileges ☐ Affiliation ☐ Other

Dates: From/To	Practice/Employment
10 From: Month: 09 Year: 2008 To: Month: 09 Year: 2010 In Progress ☐	**Practice/Employment Name** Western Mass OB/GYN (or list non-working time as indicated above) **Practice/Employment Address** Holyoke Medical Center 575 Beech St **City** Holyoke **State/Province** Massachusetts **ZIP Code** 01040 **Country** USA **Position and Department** locum physician-Ob/Gyn **% Clinical** 100 **% Administrative** 0 **Employment** ☐ **Staff Privileges** ☐ **Affiliation** ☐ **Other**

Dates: From/To	Practice/Employment
11 From: Month: 09 Year: 2009 To: Month: 06 Year: 2010 In Progress ☐	**Practice/Employment Name** Coastal OB/GYN (or list non-working time as indicated above) **Practice/Employment Address** York Hospital 15 Hospital Drive **City** York **State/Province** Maine **ZIP Code** 03909 **Country** USA **Position and Department** locum physician-Ob/Gyn **% Clinical** 100 **% Administrative** 0 **Employment** ☐ **Staff Privileges** ☐ **Affiliation** ☐ **Other**

Dates: From/To	Practice/Employment
12 From: Month: 10 Year: 2010 To: Month: 03 Year: 2011 In Progress ☐	**Practice/Employment Name** Tairawhiti District Health (or list non-working time as indicated above) **Practice/Employment Address** Private Bag 7001 Gisborne Hospital **City** Gisborne **State/Province** **ZIP Code** **Country** New Zealand **Position and Department** locum consultant-Ob/Gyn **% Clinical** 100 **% Administrative** 0 **Employment** ☐ **Staff Privileges** ☐ **Affiliation** ☐ **Other**

Dates: From/To	Practice/Employment
13 From: Month: 04 Year: 2011 To: Month: Year: In Progress [X]	**Practice/Employment Name** Garrison Women's Health (or list non-working time as indicated above) **Practice/Employment Address** 770 Central Ave **City** Dover **State/Province** New Hampshire **ZIP Code** 03820 **Country** USA **Position and Department** locums physician-Ob/Gyn **% Clinical** 100 **% Administrative** 0 **Employment** [X] **Staff Privileges** [ ] **Affiliation** [ ] **Other**

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

JUN 27 2011

NH BOARD

Affidavit
And
Authorization For Release of Information

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

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

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

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

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

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

Rebecca Jones

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

Jones

Applicant's Printed Last Name

Rebecca J K.

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

6/24/11

Date of Signature

NOTARY

Dated 6/24/11 Signed Irene E McCann

State of New Hampshire County of Strafford

SUBSCRIBED AND SWORN TO before me this 24 day of, June 20 11.

My commission as Notary Public Irene E McCann (NOTARY PUBLIC SIGNATURE & SEAL)

IRENE E. McCANN, Notary Public
My Commission Expires October 20, 2015

ADDENDUM TO APPLICATION

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

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

Rebecca Jones

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

Anticipated Practice Location(s) (if known):

Garrison Women's Health Clinic
770 Central Ave
Dover, NH 03820

Applicant's Signature | Jones — Applicant's Printed Last Name | 6/23/11 — Date of Signature

For Board Use Only:

Application Received: 6/27, 2011 Fee Paid: $250 — Check#: _____

License Number: _____ Date of Issue: _____

Rebecca Jones

Rebecca K. Jones, M.D, Ph.D, F.A.C.O.G.

Home:
Cell:

Email:

Following ten years of private practice in general obstetrics and gynecology, for the past six years I have worked full-time as a locum tenens provider. I enjoy traveling to different locations and serving, learning from, and teaching the women and clinicians I work with. I am a flexible, resourceful, productive, and skilled physician. I am open to both short and long-term assignments and am eager to live and work in different geographic locations.

Education

1991-1995	Reading Hospital Reading, PA	Intern and Resident Obstetrics & Gynecology
1986-1991	University of Pennsylvania Philadelphia, PA (studies extended one year for independent study)	M.D.
1979-1982	Institute of Child Development University of Minnesota	Ph.D. Child Development
1977-1979	University of Edinburgh Edinburgh, Scotland, UK	M.Phil. Experimental Psychology
1973-1977	Boston University Boston, MA	B.A., *summa cum laude* Psychology & Philosophy

Employment

2005-present	Locum Tenens	
1995-2005	Reading OB/GYN, PC Reading, PA	Physician
1988-1989	School of Medicine University of Pennsylvania	Instructor, Seminar on Child Development
1983-1984	Eastern Women's Center New York, NY	Counselor
1982-1983	Department of Psychology Villanova University, PA	Lecturer

Locum Tenens Assignments

04/11-present	Garrison Women's Health Dover, NH	General OB/GYN
10/10-03/11	Gisborne Hospital Gisborne, New Zealand	Obstetrics & Gynecology Consultant
07/10-08/10	Holyoke Medical Center Holyoke, MA	General OB/GYN
09/09-06/10	York Hospital York, ME	General OB/GYN
06/09-08/09	Jordan Hospital Plymouth, MA	Weekend hospital call General OB/GYN
09/08-05/09	Holyoke Medical Center Holyoke, MA	General OB/GYN
01/08-08/08	Gifford Medical Center Randolph, VT	General OB/GYN
07/07-12/07	Yakima Valley Farm Workers Yakima, WA	General OB/GYN
02/07-05/07	Reading Hospital Reading, PA	Supervised OB/GYN residents
09/06-01/07	Yakima Valley Farm Workers Yakima, WA	General OB/GYN
05/06-06/06	Weirton Medical Center Weirton, WV	General OB/GYN
02/06-04/06	Caritas Norwood Hospital Norwood, MA	General OB/GYN
11/05-01/06	Planned Parenthood of Northeastern Pennsylvania	General GYN
10/05	Brandywine Hospital Coatesville, PA	General OB/GYN

Honors and Awards

Elected member *Phi Beta Kappa*, 1977
National Science Foundation Graduate Fellowship, 1977-1980
Janet M. Glasgow Award, American Medical Women's Association, 1989

Professional Organizations

Fellow, American College of Obstetricians and Gynecologists
Diplomate, American Board of Obstetrics and Gynecology
(Original certification 1997; Annual voluntary recertification through 2011)

State Licenses

PA MD 051312L	exp. 12/31/2012
NM MD 2005-0829	exp. 07/01/2011
MA 227062	exp. 11/17/2012
WV 22200	exp. 06/30/2012
WA 00045964	exp. 11/17/2012
VT 042-0011506	exp. 11/30/2012
ME 018312	exp. 11/30/2011

Languages:

DIPLOMATE

6/24/11 True and attest copy Irene E McCain

IRENE E. McCAIN, Notary Public
My Commission Expires October 20, 2015

American Board of Obstetrics and Gynecology

COMPOSED OF MEMBERS NOMINATED BY THE
AMERICAN GYNECOLOGICAL AND OBSTETRICAL SOCIETY
AMERICAN MEDICAL ASSOCIATION
AMERICAN COLLEGE OF OBSTETRICIANS AND GYNECOLOGISTS
ASSOCIATION OF PROFESSORS OF GYNECOLOGY AND OBSTETRICS

RECEIVED
JUN 27 2011
NH BOARD

Obstetrics and Gynecology

Rebecca Keene Jones, M.D.

HAVING PURSUED AN ACCEPTED COURSE OF GRADUATE STUDY AND CLINICAL WORK, HAS MET THE STANDARDS AND QUALIFICATIONS, AND PASSED THE EXAMINATIONS REQUIRED BY THE AMERICAN BOARD OF OBSTETRICS AND GYNECOLOGY, INC., AND IS AN ACKNOWLEDGED DIPLOMATE OF THE BOARD FROM NOVEMBER, 1997 THROUGH DECEMBER, 2007
NOVEMBER 7, 1997

American Board of Obstetrics & Gynecology

President

Executive Director

DIPLOMATE NO. 951172

AMERICAN BOARD OF MEDICAL SPECIALTIES

Larry C. Gilstrap, III, M.D.
Executive Director

Alvin L. Brekken, M.D.
Assistant to the Executive Director

Kenneth L. Noller M.D.
Director of Evaluation

The Vineyard Centre
2915 Vine Street
Dallas, TX 75204
Phone (214) 871-1619
Fax (214) 871-1943

October 5, 2010

Rebecca Keene Jones, M.D.

Dear Doctor:

Congratulations! I am pleased to inform you that you have satisfactorily passed the first year of the Maintenance of Certification (MOC), Part II-ABC examination. You have earned 25 credits which will be awarded by the American College of Obstetricians and Gynecologists (ACOG).

Documentation of passing the MOC/ABC process will be furnished to the engraving company. If you have not been contacted by them within six (6) months from the date of this letter, please notify the Board office in writing or by fax (214) 871-1943.

The answers to the questions will be published by the ACOG in the July 2011 Clinical Review.

Your certification status on October 5, 2010 in Obstetrics and Gynecology is current through 12/31/2011, provided that you participate fully in the MOC process.

As a reminder you must complete the required MOC Phase IV Modules to maintain your active certification status.

Please use this letter to provide to your hospitals. **Pass letters are <u>ONLY</u> available through your Statuses and Application page.**

The American Board of Obstetrics and Gynecology, Inc. will notify the American Journal of Obstetrics and Gynecology, Obstetrics and Gynecology, the American Board of Medical Specialties, and ACOG of your passing the MOC/ABC examination.

Please remember to access your ABOG Member Login in October to check for next year's MOC Application availability.

We hope you will maintain an active interest in the specialty, and you will continue to provide excellent care of women.

Sincerely yours,

Larry C. Gilstrap III, MD

Larry C. Gilstrap, M.D.
Executive Director

True and attest copy
Irene E McCain

IRENE E. McCAIN, Notary Public
My Commission Expires October 20, 2015
6/24/15

ABOG ID: 951172

195575

MAY 0 1 2013

RECEIVED

STATE OF NEW HAMPSHIRE

Telephone #: 603-271-6934

BOARD OF MEDICINE APR 1 0 2013
2 Industrial Park Drive, Suite 8
Concord, NH 03301-8520 NH BOARD

RENEWAL APPLICATION

Renewal Fee: $350.00

For expiration on: 6/30/2015

For Office Use Only: Date Pd: 4/10/13 Check # 4692

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

(If yes, provide proof of board certification.)

Please list ABMS Board Specialty: OBG

Currently licensed in the states of: (2 letter state abbrev.) MA,ME,NM,WV,PA,WA,VT

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

License #: 15350

File #: 16569

☐ Home Address

REBECCA K JONES, MD

☒ Work Address

272 GRUBB RD

POTTSTOWN, PA 19465

Please provide current Email, Fax and Phone Numbers below:

Phone:

Phone: 610-495-7216
Business Fax Number
Business Email Address:

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

Hospital	Privilege	Full	Courtesy	Consult
St Joseph's, Buckhannon, WV		☑	☐	☐
Morton Hospital, Taunton, MA		☑	☐	☐
		☑	☐	☐
		☑	☐	☐
		☑	☐	☐
		☑	☐	☐
		☑	☐	☐

(RENEWAL APPLICATION CONTINUED ON REVERSE SIDE)

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

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

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

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

****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] 4/6/2013

Signature of Licensee (Signature Stamp Not Accepted) Date

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Important Dates
FAQ
Diplomate Verification
Physician Support
About Us
Value of MOC

Diplomate Verification Search

MEMBER LOGIN

Rebecca Keene Jones, M.D.

Status as of 4/12/2013

Below are all certifications held by this physician with ABOG.

ABOG ID: 951172
Pottstown, PA

Obstetrics and Gynecology Certification		
Original Certification Date	Certification Status	Meeting Requirements of Maintenance of Certification
11/7/1997	Valid through: 12/31/2013	YES

SEARCH

Search Again

To purchase a copy of this status information sent from ABOG

Purchase Status Letter

The letter will contain the information above and be sent directly to an address of your choosing

MAY 22 2015

RECEIVED
APR 16 2015
NH BOARD

STATE OF NEW HAMPSHIRE

Telephone #: 603-271-6934

RECEIVED
MAY 20 2015
NH BOARD

BOARD OF MEDICINE
121 South Fruit Street, Suite 301
Concord, NH 03301-2412

RENEWAL APPLICATION

For expiration on: 6/30/2017

Renewal Fee: $350.00

For Office Use Only: Date Pd: 4/16/15 Check # 4857

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 business or home address within 30 days of the change.**

Specialty: OBG

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

Currently licensed in the states of: (2 letter state abbrev.) MA,ME,NM,WV,PA,~~VA~~,VT

You must provide both home and business street address. P.O. Boxes are not acceptable without a street address provided. ***Please mark the box next to the address you would prefer to list as your mailing address.***

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☐ Work Address
REBECCA K JONES, MD
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POTTSTOWN, PA 19465

☐ Home Address

Please provide current Email, Fax and Phone Numbers below:

Phone: 610-495-7216
Business Fax Number:
Business Email Address:

Phone:

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

Hospital Privileges			Full	Courtesy	Consult	Other
ST JOSEPHS	BUCKHANNON	WV	☑	☐	☐	☐
MORTON HOSPITAL	TAUNTON	MA	☑	☐	☐	☐
			☐	☐	☐	☐
			☐	☐	☐	☐
			☐	☐	☐	☐
			☐	☐	☐	☐
			☐	☐	☐	☐

(RENEWAL APPLICATION CONTINUED ON REVERSE SIDE)

XXX

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

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

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

	YES	NO
1. With regard to any and all Boards or licensing bodies with which you hold or have held a license to practice medicine, have you been subject to any disciplinary action, limitation or restriction on your license, or entered into any agreement with a licensing body for any reason, including but not limited to rehabilitation?	___	X
2. Have you been denied a license to practice medicine, or have you surrendered a license due to an investigation or disciplinary action, 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 N.H. Professionals Health Program, for abuse or misuse of any chemical substance, including alcohol?	___	X
5. Have you had any emotional disturbance or mental or physical illness which has impaired your ability to practice medicine?	___	X
6. Have you been found guilty or entered a plea of no contest to any felony, misdemeanor or alcohol or drug related offense that has not been annulled by a court?	___	X
7. Have you been reported to the National Practitioner's Data Bank? If yes, please submit a copy of the report.	___	X
8. Have you been the subject of an investigation or disciplinary proceeding regarding the practice of medicine? Please exclude investigations and disciplinary proceedings conducted by the New Hampshire Board of Medicine.	___	X
9. Have any hospital privileges been suspended, limited or denied other than for medical records violations, or have you been placed on administrative or medical leave?	___	X
10. Have any medical malpractice claims been made against you? See attached reporting form.	___	X
11. Are you practicing in any other location other than the principal business address listed on the front of this renewal? If so, please attach a list with all additional business address(es) and business phone number(s).	___	X
12. Have you registered with the Controlled Drug Health and Safety Program (also known as the N.H. Prescription Drug Monitoring Program)?	X	X
13. Have you completed the New Hampshire Department of Health and Human Services, Division of Public Health's Physician Licensure Survey?	X	___

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

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

Signature of Licensee (Signature Stamp Not Accepted)

Apr. 13, 2015
Date