



STATE OF CONNECTICUT

DEPARTMENT OF PUBLIC HEALTH

July 27, 2010

TIMOTHY PATRICK SPURRELL, MD
1363 NARRAGANSETT BLVD
CRANSTON, RI 02905-5121

Dear Licensee:

I am pleased to inform you that you have met all requirements for licensure as a Physician/Surgeon in Connecticut. Your license number is 049042 and is effective as of 07/23/2010. Your formal license will be mailed to you during the third week of next month. Your name will appear on your license as shown above unless you notify us otherwise.

It is your responsibility to notify the Department of Public Health, Practitioner Licensing and Certification Unit of any changes of name, or address, either within or outside Connecticut. Please note that you may update your demographic information, renew your license and obtain other valuable information from our website at <https://www.elicense.ct.gov>.

Your user name and password are:

Online User ID: [REDACTED]
Online Password: [REDACTED]

Please note that your license must be renewed annually during your month of birth. Renewal will be required in the first birth month which immediately follows the issuance of licensure. Failure to renew your license within ninety (90) days of the due date will result in your license becoming void. In that event, re-licensure would require a new application to the department and a review of all credentials to determine whether you satisfy current licensing requirements.

Should you have any questions or concerns regarding the renewal of your license, please contact this office via e-mail at oplc.dph@ct.gov.

Respectfully,

A handwritten signature in cursive script that reads "Stephen B. Carragher".

Stephen B. Carragher
*Health Program Supervisor
Practitioner Licensing and Investigations Section*



Phone: (860) 509-7603
Telephone Device for the Deaf (860) 509-7191
410 Capitol Avenue - MS # 12 APP
P.O. Box 340308 Hartford, CT 06134
An Equal Opportunity Employer



**STATE OF CONNECTICUT
DEPARTMENT OF PUBLIC HEALTH**

PHYSICIAN APPLICATION

4-75

Initial licensure Reinstatement CT License No.: _____ Date Granted: _____

PLEASE INDICATE (X) THE EXAMINATION (S) YOU COMPLETED:

	National Board of Medical Examiners (NBME)	Federation Licensing Examination (FLEX)
	State Board Licensing Exam _____ (State) Year Taken: _____	Licentiate of the Medical Council of Canada (LMCC)
X	United States Medical Licensing Examination (USMLE)	Combination of Segments (please specify)
	National Board of Osteopathic Examiners (NBOME)	

Do you plan to use the Federation Credentials Verification Service (FCVS) to verify your credentials? Yes Packet ID# _____ No

Last Name: Spurrell First Name: Timothy MI: P Maiden Name: _____

Date of Birth: 02 / 16 / 1963 Social Security No. [REDACTED] Gender: Male

Name and Mailing Address: This will be how your name and address will appear on your official _____ address of record for all mailings from this office and releasable pursuant to Freedom of Information requests.

Name on License: Timothy Patrick Spurrell, MD

Address: 1363 Narragansett Blvd

City, State, Zip: Cranston, RI 02905

Daytime Phone Number: (401) 741-5850 E-mail: spurry@gmail.com

RACE/ETHNIC DATA: (This section is voluntary. Information gathered will be used solely for the purpose of examining the demographics of Connecticut licensees. This data will not be used for discriminatory purposes and will not be considered in the evaluation of your application.)

- AMERICAN INDIAN OR ALASKAN NATIVE: Persons having origins in any of the original peoples of North America, and who maintain cultural identification through tribal affiliation or community recognition.
- ASIAN OR PACIFIC ISLANDER: Persons having origins in any of the original peoples of the Far East, Southeast Asia the Indian Subcontinent of the Pacific Islands. This area includes, for example, China, Japan, Korea, the Philippine Islands, and Samoa.
- BLACK: Persons having origins in any of the black racial groups of Africa.
- HISPANIC: Persons of Mexican, Puerto Rican, Central or South American or other Spanish culture or origin, regardless of race.
- WHITE (not of Hispanic Origin): Persons having origins in any of the original peoples of Europe, North Africa, or the Middle East.

MEDICAL EDUCATION:

List name and location of medical school(s) attended	Dates of Attendance
<u>University of Connecticut School of Medicine</u>	<u>08/92 - 05/96</u>

MD/DO DEGREE AWARDED BY: University of Connecticut School of Medicine DATE AWARDED: 05/23/96
(Name of School)

01

LICENSURE: List *all* states in which you have ever been licensed to practice medicine:

State	License/Permit Number	Expiration Date
Rhode Island	MD10395	06/30/12
Massachusetts	236470	12/31/10

SPECIALTY:

If certified by a specialty board approved by the American Board of Medical Specialties (ABMS), indicate name of Board:

American Board of: OB/GYN Date Certified: 2003

MEDICAL PRACTICE: Attach a CV or list *all* medical practice you have engaged in since graduation from medical school (identify internship and residency):

Hospitals Associated With	Location	Dates
Women and Infants Hospital of Rhode Island	Providence, RI	07/96 - 06/00
Planned Parenthood League of Southern NE	Providence, RI	08/00 - Present
Women's Care	Warwick, RI	08/00 - 07/01
Caring For Women	Warwick, RI	08/01 - Present
Planned Parenthood League of Massachusetts	Boston, MA	08/08 - Present

STATEMENT OF PROFESSIONAL HISTORY: Please answer the following questions referring to the instructions, if applicable.

- Have you ever been censured, disciplined, dismissed or expelled from, had admissions monitored or restricted, had privileges limited, suspended or terminated, been put on probation, or been requested to resign or withdraw from any of the following:
 -Any hospital, nursing home, clinic, or similar institution;
 -Any health maintenance organization, professional partnership, corporation, or similar health practice organization, either private or public;
 -Any professional school, clinical clerkship, internship, externship, preceptorship or postgraduate training program; -Any third party reimbursement program, whether governmental or private?

Yes No

If your answer is "yes", give full details, names, addresses, etc. on separate notarized statement.
- Have you ever had your membership in or certification by any professional society or association suspended or revoked for reasons related to professional practice?

Yes No

If your answer is "yes", give names of professional society or association, date and reasons your membership or certification was suspended or revoked on a separate notarized statement.
- Has any professional licensing or disciplinary body in any state, the District of Columbia, a United States possession or territory, or a foreign jurisdiction, limited, restricted, suspended or revoked any professional license, certificate, or registration granted to you, or imposed a fine or reprimand, or taken any other disciplinary action against you?

Yes No

If your answer is "yes", give full details, names, addresses, etc. on a separate notarized statement.
- Have you ever, in anticipation or during the pendency of an investigation or other disciplinary proceeding, voluntarily surrendered any professional license, certificate or registration issued to you by any state, the District of Columbia, a United States possession or territory, or a foreign jurisdiction?

Yes No

If your answer is "yes" give full details, names, addresses, etc. on a separate notarized statement.

5. Have you ever been subject to, or do you currently have pending, any complaint, investigation, charge, or disciplinary action by any professional licensing or disciplinary body in any state, the District of Columbia, a United States possession or territory, or a foreign jurisdiction or any disciplinary board/committee of any branch of the armed services? You need not report any complaints dismissed as without merit. Yes No
If your answer is "yes" give full details, names, addresses, etc. on a separate notarized statement.
6. Have you ever entered into, or do you currently have pending, a consent agreement of any kind, whether oral or written, with any professional licensing or disciplinary body in any state, the District of Columbia, a United States possession or territory, any branch of the armed services or a foreign jurisdiction? Yes No
If your answer is "yes" give full details on a separate notarized statement and submit notarized copy of agreement.
7. Have you ever been found guilty or convicted as a result of an act which constitutes a felony under the laws of this state, federal law or the laws of another jurisdiction and which, if committed within this state, would have a felony under the laws of this state? Yes No
If your answer is "yes" give full details on a separate notarized statement and furnish a Certified Court Copy (with court seal affixed) of the original complaint, the answer, the judgment, the settlement, and/or the disposition of the case.
8. Have you ever been denied or surrendered a state or federal controlled substance registration, had it revoked or restricted in any way, or been warned, reprimanded or fined by the responsible agency? Yes No
If your answer is "yes", give full details, dates, etc., on a separate notarized statement.

On this 21 day of June, 2010 (month/year) TIMOTHY SPURLOCK (applicant's name) personally appeared before me, who being duly sworn says that she/he is the person referred to in the foregoing application and that the photograph attached hereto is a true picture of self and that the statements made herein are true in every respect.

All of the above statements contained herein are true and correct to the best of my knowledge and belief.



 SIGNATURE OF APPLICANT

Sworn to me this 21st day of JUNE (month/year) 2010.
 Notary Public Signature Cara Lynn G. Jettan My Commission Expires 2-10-2014.

Please return this application, the fee for \$565.00 (certified bank check or money order) and a separate certified bank check or money order for \$4.75 made payable to, "Treasurer, State of Connecticut" to:

Department of Public Health
 Physician Licensure-Remittance Unit
 410 Capitol Ave., MS# 12MQA
 P.O. Box 340308
 Hartford, CT 06134-0308

IMPORTANT: Please do not send this form and fee unless you have read and understood the licensing policies and requirements. No fees are refundable should you not be eligible for licensure.

Timothy Spurrell, MD
1363 Narragansett Blvd
Cranston, RI 02905

June 10, 2010

Connecticut Medical Examining Board
410 Capitol Avenue, MS #12 APP
Hartford, CT 06134

Dear Connecticut Medical Examining Board:

Enclosed is my application for licensure to practice medicine. All supporting documents have been requested. A certified check or money order in the amount of \$565.00 is included.

I have engaged the services of Amy Groover with Healthcare Licensing Services to assist with this process. Please forward any letters of deficiency to the address below:

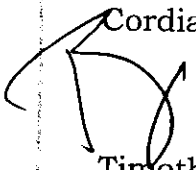
Healthcare Licensing Services, Inc.

Attn: Amy Groover
3 West Garden Street
7th Floor, Suite 700
Pensacola, FL 32502
Tel: (850) 444-9814

I have personally reviewed my application for accuracy and completeness.

Thank you for your consideration.

Cordially,


Timothy Spurrell, MD

Healthcare Licensing Services, Inc.

...Experts in Medical Licensing

Amy Groover

Licensing Consultant

The Blount Building
3 West Garden Street, Suite 700
Pensacola, FL 32502

Office 850-444-9814 ext. 110

Fax 904-339-9075

STATE OF CONNECTICUT
DEPARTMENT OF PUBLIC HEALTH

VERIFICATION OF RESIDENCY TRAINING FORM

APPLICANT: Enter your full name and birth date on this form and forward it to the Chief of Staff or program director at the facility in which you completed your residency training. This form must be completed by the facility and returned directly to this office.

Applicant's Name: Timothy Spurrell, MD Date of Birth: 02/16/1963

Chief of Staff/Program Director: Please provide the following verification of residency training for the above named Connecticut physician licensure applicant.

Name of facility where residency training was completed: Women & Infants Hospital / Brown University

Dates of Residency: From 6.23.1996 To 6.24.2000
(month/day/year) (month/day/year)

In what specialty was the residency training completed: OB/GYN

At what level(s) was this residency completed (PGY1, PGY2, etc.)? PG1, PG2, PG3 & PG4

At the time of the applicant's training, was the residency training program in this specialty area accredited by the Accreditation Council for Graduate Medical Education (ACGME), American Osteopathic Association (AOA) or The Royal College of Physicians and Surgeons of Canada (RCPSC)? yes (YES or NO)

Did the applicant satisfactorily complete this period of residency training? yes (YES or NO)

Do you have any derogatory information regarding the competency or conduct of this applicant? NO (YES or NO)
If yes, please attach any disclosable documents you may have on file regarding such information.

I, Gary Frishman, being duly sworn, do depose and certify that I am the Chief of Staff/Program Director at:

Name of Facility: Women & Infants Hospital

Address: 101 Dudley Street
Providence, RI 02905

Telephone Number: (401) 274-1122 EXT 1440

Email: G.Frishman@WIHRI.org

and that the information provided herein is true and correct to the best of my knowledge and belief.

Gary Frishman
Signature of Chief of Staff/Program Director

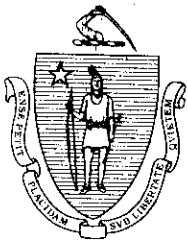
Subscribed and sworn to me this 6 day of 28 (month/year) 2010

Gunda Gurecki
Notary Public's Signature

7/31/2010
My Commission Expires

Please return this form directly to:

Connecticut Department of Public Health
Physician Licensure
410 Capitol Ave., MS # 12 APP
P.O. Box 340308
Hartford, CT 06134-0308



Commonwealth of Massachusetts Board of Registration in Medicine

200 Harvard Mill Square, Suite 330
Wakefield, Massachusetts 01880
(781) 876-8200

DEVAL L. PATRICK
GOVERNOR

TIMOTHY P. MURRAY
LIEUTENANT GOVERNOR

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

STANCEL M. RILEY, JR. MD.
EXECUTIVE DIRECTOR

To Whom It May Concern:

7/9/2010

This certifies that Timothy P Spurrell M.D., a 1996 graduate of University of Connecticut School of Medicine, has been duly registered by this board as provided by the laws of the Commonwealth.

Certificate Number 236470 was issued to Dr. Spurrell on 08/20/2008. This license is Current. The expiration date is 02/16/2011.

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

Closed Complaint Information

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

Final Board Disciplinary Action

Our files contain 0 Board Discipline(s) on this physician.

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

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

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

SEAL


Staff Member, Board of Registration in Medicine
Carrie Doyle



AIM

Association of State Medical Board Executive Directors

**Rhode Island Department of Health
Board of Medical Licensure and Discipline
Search Results**

Licensee Name	TIMOTHY PATRICK SPURRELL
License Status	ACTIVE
License Number	MD10395
License Type	MD
Business Address	CARING FOR WOMEN
Business Address	166 TOLLGATE ROAD
City State Zip	WARWICK RI 02886
Business Phone	(401)-739-2000
Birthdate	1963
Gender	Male
Primary Specialty	OBSTETRICS & GYNECOLOGY
Year Board Certified	2003
License issue date	08/03/2000
License expire date	06/30/2012
License last renewed	2010
Medical School	UNIVERSITY OF CONNECTICUT SCHOOL OF MEDICINE
Medical School Location	FARMINGTON CT UNITED STATES
Medical School Graduation Year	1996
Examination Code	USMLE III
Hospital Privileges	Yes
Hospital Privileges at:	Kenty County Hospital
Hospital Privileges at:	Rhode Island Hospital
Hospital Privileges at:	Women's AND Infants'
Disciplinary Action in RI?	NO

This physician's record was last updated on 10/10/2011

**Direct questions and comments about these results to
Rhode Island Department of Health**

Board of Medical Licensure and Discipline

This Board's data has been searched 2401555 times since 12/11/1997

Please read the AIM Disclaimer

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**RHODE ISLAND
BOARD OF MEDICAL LICENSURE AND DISCIPLINE**

FULL LICENSE VERIFICATION

PHYSICIAN:	TIMOTHY PATRICK SPURRELL,
DATE OF BIRTH:	02/16/1963
LICENSE NUMBER:	LMD18677
DATE ISSUED:	06/24/1999
LICENSE STATUS:	Expired
EXPIRATION DATE:	06/23/2000
MEDICAL SCHOOL:	University of Connecticut School of Medicine
GRADUATION YEAR:	1996
EXAM:	USMLE - USMLE III
PHYSICIAN:	TIMOTHY PATRICK SPURRELL,
DATE OF BIRTH:	02/16/1963
LICENSE NUMBER:	LMD16524
DATE ISSUED:	06/24/1996
LICENSE STATUS:	Expired
EXPIRATION DATE:	06/23/1997
MEDICAL SCHOOL:	University of Connecticut School of Medicine
GRADUATION YEAR:	1996
EXAM:	USMLE - USMLE II

RHODE ISLAND
BOARD OF MEDICAL LICENSURE AND DISCIPLINE

FULL LICENSE VERIFICATION

PHYSICIAN: TIMOTHY PATRICK SPURRELL, MD
DATE OF BIRTH: 02/16/1963
LICENSE NUMBER: MD10395
DATE ISSUED: 08/03/2000
LICENSE STATUS: Active
EXPIRATION DATE: 06/30/2012
MEDICAL SCHOOL: University of Connecticut School of Medicine
GRADUATION YEAR: 1996
EXAM: USMLE - USMLE III
PHYSICIAN: TIMOTHY PATRICK SPURPELL, MD
DATE OF BIRTH: 02/16/1963
LICENSE NUMBER: LMD17690
DATE ISSUED: 07/21/1997
LICENSE STATUS: Expired
EXPIRATION DATE: 07/20/1998
MEDICAL SCHOOL: University of Connecticut School of Medicine
GRADUATION YEAR: 1996
EXAM: USMLE - USMLE III

**RHODE ISLAND
BOARD OF MEDICAL LICENSURE AND DISCIPLINE**

FULL LICENSE VERIFICATION

PHYSICIAN:	TIMOTHY PATRICK SPURRELL,
DATE OF BIRTH:	02/16/1963
LICENSE NUMBER:	LMD17465
DATE ISSUED:	06/24/1997
LICENSE STATUS:	Expired
EXPIRATION DATE:	06/23/1998
MEDICAL SCHOOL:	University of Connecticut School of Medicine
GRADUATION YEAR:	1996
EXAM:	USMLE - USMLE III
PHYSICIAN:	TIMOTHY PATRICK SPURRELL,
DATE OF BIRTH:	02/16/1963
LICENSE NUMBER:	LMD17864
DATE ISSUED:	06/24/1998
LICENSE STATUS:	Expired
EXPIRATION DATE:	06/23/1999
MEDICAL SCHOOL:	University of Connecticut School of Medicine
GRADUATION YEAR:	1996
EXAM:	USMLE - USMLE III

**RHODE ISLAND
BOARD OF MEDICAL LICENSURE AND DISCIPLINE**

FULL LICENSE VERIFICATION

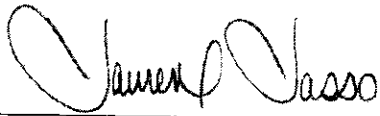
PHYSICIAN:	TIMOTHY PATRICK SPURRELL, MD
DATE OF BIRTH:	02/16/1963
LICENSE NUMBER:	LMD19339
DATE ISSUED:	08/13/1999
LICENSE STATUS:	Expired
EXPIRATION DATE:	08/12/2000
MEDICAL SCHOOL:	University of Connecticut School of Medicine
GRADUATION YEAR:	1996
EXAM:	USMLE - USMLE III
PHYSICIAN:	TIMOTHY PATRICK SPURRELL, MD
DATE OF BIRTH:	02/16/1963
LICENSE NUMBER:	LMD18520
DATE ISSUED:	07/30/1998
LICENSE STATUS:	Expired
EXPIRATION DATE:	07/29/1999
MEDICAL SCHOOL:	University of Connecticut School of Medicine
GRADUATION YEAR:	1996
EXAM:	USMLE - USMLE III

This license information was last updated on: 06/25/2010

**RHODE ISLAND
BOARD OF MEDICAL LICENSURE AND DISCIPLINE**

FULL LICENSE VERIFICATION

This is to certify that the above-named physician is licensed to practice medicine in the State of Rhode Island. There have been no disciplinary actions taken against this physician's license.



**Lauren Lasso
Medical License Coordinator
Board of Medical Licensure & Discipline**

June 25, 2010