New Mexico Medical Board
2055 S. Pacheco Street, Bldg. 400
Santa Fe, NM 87505
505-476-7220
Fax: 505-476-7237

April 23, 2010

I, Lynn S. Hart, Executive Director of the New Mexico Medical Board, as a custodian of this record, certify that it is a true and exact copy of all public records for license number MD2009-0759, accurately recorded, maintained and reproduced by this agency. The case involved:

Shelley Sella, M.D.
License #MD2009-0759
Public File

IN TESTIMONY WHEREOF, I have hereunto subscribed my name and caused the seal of the New Mexico Medical Board to be affixed, the day and year first above written.

SEAL

Lynn S. Hart
Executive Director
Records Custodian

THE NEW MEXICO MEDICAL SOCIETY

NMHHSA New Mexico Hospitals & Health Systems Association

1643 $434.00

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The New Mexico Statewide Application for Physician/Practitioner Appointment©

Physician (MD) Application

(USING FCVS)

Date of Application: 9/27/09

Application Fee: 400.00
Background Check Fee: 34.00
TOTAL COST: $ 434.00

Demographics

Name	ROBINSON (Last)	SUSAN (First)	CELINA. (Middle)
Other Names Used	N/A		

Will you be applying by endorsement Yes X No ___ exam
(See page 2 of the application instructions for requirements)

Gender M (F)	Place of Birth NEWYORK NY	Citizenship	USA
Immigration Status	N/A	INS Certification #	NA
*Social Security Number		Date of Birth	3/19/46
*NM Tax ID# (if applicable)	NA	Pending ☐	
*Fed. Tax ID# (if applicable)	NA	Pending ☐	
Current Practice Name	PLANNED PARENTHOOD MAR MONTE		
Practice Limited to: (Clinical Specialty)	OBGYN		
Street	(healthcenter) 650 N FULTON ST (CORPORATE) 518 GARDEN ST, Santa Barbara CA 93101		
City	FRESNO	State CA	Zip Code 93728.
Telephone Number	559-488-4900	Facsimile	(Phone/CORPORATE 805 963 2445)
*Office Manager or Contact Person:	healthcenter: Maryann GARCIA (CORPORATE Dr Virginia Siegfried		
Foreign Languages (spoken fluently by practitioner)			
Foreign Languages (spoken fluently at Practice)	Spanish		
* E-Mail Address (confidential)			
*Current Mailing Address (if different from above-confidential unless no practice address indicated)			
*Street			
*City		*State CA	*Zip Code ~~93446~~ 93446
Telephone Number		Facsimile	
What are your immediate or future Practice Plans in New Mexico?	WEEKEND WORK AS CONTRACTOR		
Home Address (Required)	*Telephone Number		
Street			
*City	*State CA	*Zip 93446	

*Information Confidential

Practice Associates in NM (If Applicable)	Call Coverage in NM (If Applicable)

Other Practice Locations (If Applicable)

Practice Name	PLANNED PARENTHOOD PPSBVSLO.				
Street	518 GARDEN ST				
City	SANTA BARBARA	State	CA	Zip Code	93101
Telephone Number	805 963 2445	Facsimile			
Answering Service		Effective Date			

Education (Please attach a separate sheet, if necessary.)

Undergraduate Education					
College or University	MONTEREY PENNSULA COLLEGE				
City	MONTEREY	State/Country	CA	Zip Code:	93940
Dates Attended	From: 1/1970 To: 6/1972	Degree	AA	Graduation Date	6/1972
College or University	UNIV. OF CALIFORNIA, SANTA CRUZ.				
City	SANTA CRUZ	State/Country	CA.	Zip Code:	95064
Dates Attended	From: 9/1972 To: 6/1974	Degree	BA	Graduation Date	6/1974
Professional / Medical Education					
College or University	UNIV OF CALIFORNIA, SAN DIEGO				
City	LA JOLLA	State/Country	CA	Zip Code:	92093
Dates Attended	From: 9/1974 To: 6/1978	Degree	MD	Graduation Date	6/18/1978
College or University					
City		State/Country		Zip Code:	
Dates Attended	From: To:	Degree		Graduation Date	
Graduate Education					
College or University					
City		State/Country		Zip Code:	
Dates Attended	From: To:	Degree		Graduation Date	
College or University					
City		State/Country		Zip Code:	
Dates Attended	From: To:	Degree		Graduation Date	

Internship/ Residency/ Fellowship					
Institution Name	U.C. San Diego Medical Center				
City	San Diego	State/Country	CA	Zip Code:	92103.
Dates Attended	From: 7/78 To: 6/79	Field	GENERAL SURGERY/UROLOGY		
Institution Name	TUFTS NEW ENGLAND MED. CENTER AFFILIATED HOSPITALS.				
City	BOSTON	State/County	MA.	Zip Code	02111
Dates Attended	From: 7/1979 To: 6/1982	Field	OB-GYN		
Institution Name	ST. MARGARETS HOSPITAL for Women.				
City	Boston.	State/Country	MA	Zip Code:	02125
Dates Attended	From: 7/1982 To: 6/1984	Field	MATERNAL FETAL MEDICINE		
Institution Name	N/A				
City		State/Country		Zip Code:	
Dates Attended	From: To:	Field			

Work History Please list all previous practice experience for the last 15 years, **including military or government service**, listing the most recent first. If military service, state type of discharge and rank achieved **and attach copy of discharge or separation documents.** Attach separate page, if necessary. Please provide written explanation for any gaps in work history of 6 months or more.

Location PLANNED PARENTHOOD MARMONTE	From 6/2008	To current	
Street 1605 the Alameda	Phone Number	408-297 9255 (3,6,3)	
City San Jose	State CA	Zip Code 93728	
Type of Practice contractor - gyn/abortion	Contact Person	Contracts & Credentialing	
Type of Discharge NA	Rank Achieved	NA	
Location PLANNED PARENTHOOD SBVSLO	From 5/2008	To current	
Street 518 GARDEN ST	Phone Number	805 .963.2445	
City Santa Barbara.	State CA	Zip Code 93101	
Type of Practice contractor - gyn/abortion	Contact Person	ROZ GILBERT (HR)	
Type of Discharge NA	Rank Achieved	NA	
Location CHOICE MEDICAL GRP.	From 9/07	To 1/09.	
Street 1834 Stone Ave #2B.	Phone Number	408 995 0102.	
City SAN JOSE	State CA	Zip Code 95125	
Type of Practice contractor, abortion care	Contact Person	LIZA TAPIA	
Type of Discharge N/A	Rank Achieved	NA.	
Location CONTINUED	From	To	
Street ON ATTACHED	Phone Number		
City SHEET	State	Zip Code	
Type of Practice	Contact Person		
Type of Discharge	Rank Achieved		

Hospital and Health Facility Affiliation History (other than postgraduate training) ☐ N/A

Please list hospital staff membership and/or healthcare organization affiliations in the past fifteen (15) years. If institution is no longer in existence, please provide an alternative source of verification. Use separate page, if nec **Providers who do NOT have admitting privileges, please explain your procedures or the arrangements you m instances when patients require admission to a hospital. If you are applying with a health plan, arrangements include admitting coverage by another provider, a signed letter from the covering pr including their primary admitting facility, is to be included with this application.**

(1) Current Primary Admitting Facility (Hospital Name)	no current admitting facility				
Street					
City		State		Zip Code	
Telephone Number		Facsimile			
Appointment Dates	**From:**	**To:**			
Type of Appointment					
Privileges Assigned					
(2) Facility Name	Sutter Lakeside Hospital				
Street	5176 Hill Road East				
City	Lakeport	State	CA	Zip Code	95453
Telephone Number	707 262 5000.	Facsimile	707 262 5119.		
Appointment Dates	**From:** 3/1999	**To:** 7/2001			
Type of Appointment					
Privileges Assigned	full OB-GYN privileges				
(3) Facility Name	Mendocino Coast District Hospital				
Street	700 River Rd.				
City	Fort Bragg	State	CA	Zip Code	95437.
Telephone Number	707 961 1234	Facsimile			
Appointment Dates	**From:** 9/1998	**To:** 5/2000.			
Type of Appointment					
Privileges Assigned	full OB-GYN				

Applicant Name Susan C. Robinson MD **Date** 9/27/09

(4) Facility Name	Miles Memorial Hospital				
Street	RR 2 PO Box 4500				
City	Damariscotta	State	ME	Zip Code	04543.
Telephone Number	207-563-4501		Facsimile		
Appointment Dates	**From:** 9/28/1998	**To:** 10/30/1998.			
Type of Appointment	Temporary.				
Privileges Assigned	OB-GYN				
(5) Facility Name	St. Joseph's Hospital				
Street	1915 Lake Ave				
City	Plymouth	State	IN	Zip Code	46563.
Telephone Number	219-935-3000		Facsimile		
Appointment Dates	**From:** 12/23/1997	**To:** 1/5/1998.			
Type of Appointment	Temporary				
Privileges Assigned	OB-GYN				
(6) Facility Name	Martha's Vineyard Hospital				
Street	Linton Lane				
City	Oak Bluffs.	State	MA	Zip Code	02557
Telephone Number	508-693-0410		Facsimile		
Appointment Dates	**From:** 11/23/97	**To:** 11/30/97			
Type of Appointment	Temporary				
Privileges Assigned	OB-GYN				
(7) Facility Name	NASHUA MEMORIAL Hosp (Southern NH Regional Med Ctr)				
Street	8 Prospect ST				
City	NASHUA	State	NH	ZIP Code	03060
Telephone Number	603 577-2000		Facsimile		
Appointment Dates	**From:** 1990	**To:** 1997			
Type of Appointment					
Privileges Assigned					
(8) Facility Name					
Street					
City		State		Zip Code	
Telephone Number			Facsimile		
Appointment Dates	**From:**	**To:**			
Type of Appointment					
Privileges Assigned					

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Professional References Please list three professional peers familiar with your professional performance in the past 5 years, (not including current or impending partners or associates in practice).

(1) Name and Title	Dick Fischer MD, Medical Director PP Mar Monte				
Address	1605 the Alameda				
City	San Jose	State	CA	Zip Code	95126
Telephone Number	408-297-9255		Facsimile		
(2) Name and Title	Shelley Sella MD.				
Address	427 62nd St				
City	Oakland	State	CA	Zip Code	94609
Telephone Number	510-655-1803		Facsimile		
(3) Name and Title	Michelle Wolfe MD.				
Address	121 Kinross Dr.				
City	San Rafael	State	CA	Zip Code	94901
Telephone Number	415-235-2185		Facsimile		

Applicant Name Susan C Robinson MD **Date** 9/27/09

Licensure-Registration-Certification Information

ECFMG Number (if applicable)	NA					
State Professional License/Certification Number						
State	CA	Issue Date	7/2/79	Expiration Date	3/31/2011	Pending ☐

All Other State License Numbers (regardless of status - attach separate list if necessary.)

State	Number	Issue Year	Expiration Date
See attached.			

***Federal Drug Enforcement Admin. (DEA) Registration**				N/A ☐
Number		Exp. Date	4/30/2011	Pending ☐
***State Controlled Substance Registration** (CSR)	See attached.			N/A ☐
Number	State MA	Exp. Date	12/91	Pending ☐
***Medicare Unique Physician Identification Number (UPIN)**				
Pending ☐				
***State Medicaid Provider Number**				
Pending ☐				
***National Provider Identification Number**				
Pending ☐				

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Specialty Board Certifications ☐N/A

Are you Board Certified? ☒Yes ☐No **Note:** If you are not Board certified by a Board recognized by the American Board of Medical Specialties, the American Osteopathic Association, the National Commission on Certification of Physician Assistants, the American Nurses' Credentialing Center, or the National Certification Commission, or accepted for examination in your specialty, please give a brief explanation on an attached sheet.

Certified/Recertified by the:				
1. American Board of OB-GYN. # 826775.				
Date Certified 11/7/86	Date Last Recertified 12/31/2008	Expiration Date 12/31/2009		
2. NA				
Date Certified	Date Last Recertified	Expiration Date		
3. NA				
Date Certified	Date Last Recertified	Expiration Date		
Accepted for Examination by the: NA				
Until (expiration date)	If not accepted, have you made application?	Yes No		
Certified/Recertified by the Subspecialty Board of NA				
1.				
Date Certified	Date Last Recertified	Expiration Date		
2.				
Date Certified	Date Last Recertified	Expiration Date		
Accepted for Examination by the Subspecialty Board of				

Professional Liability Insurance (confidential information)

Do you have current liability insurance? ☒ Yes ☐ No through Planned Parenthood					
Current Carrier	National Union Fire Insurance Co			Current ☒	Pending ☐
Address	1166 Ave of Americas NY, NY 10036				
Dates Insured	From 6/99	To current	Policy # · Coverage Limits	1 million / 3 million	

Applicant Name Susan C Robinson MD **Date** 9/27/09

Licensing Exam: Please check all that apply:

☐ State Board Exam (Prior to 1973) Which state? _____ Date(s) passed? _____

☐ FLEX ☐ LMCC ☒ National Board (NBME) ☐ USMLE

Part/Step 1 Date Passed 6/1976 Month/Year Part/Step 2 Date Passed 4/1978 Month/Year Part/Step 3 Date Passed 3/1979 Month/Year

Professional Practice Questions Please answer all of the following Yes or No questions. If you answer YES to any question, please give details including name, address, and telephone number of significant parties on a separate sheet of paper.

1. Has your professional liability coverage ever been terminated by action of the insurance company except as a result of the company ceasing to offer insurance to physicians?	Yes ☐	No ☒
2. Have you ever been denied professional liability insurance coverage?	Yes ☐	No ☒
3. Has your professional liability carrier ever excluded any specific procedures from your coverage?	Yes ☐	No ☒
4. Have you ever been denied membership or renewal thereof, or been subject to disciplinary action in any professional organization?	Yes ☐	No ☒
5. Have you ever been excluded from or sanctioned by Medicare and/or Medicaid?	Yes ☐	No ☒
6. Have you ever been arrested? If so explain the circumstance, regardless of the outcome (i.e. expunged, dismissed, sealed, vacated).	Yes ☐	No ☒
7. Have you ever been named as a defendant in any criminal proceedings?	Yes ☐	No ☒
8. Have you ever been subject to investigation by a governmental entity or Board that either could have resulted or did result in licensure sanction or other adverse actions, irrespective of the outcome?	Yes ☐	No ☒
9. Have you ever been named in any formal requests for corrective actions filed by any healthcare entity where you have had an appointment (a request which could result in either formal or informal proceedings).	Yes ☐	No ☒
10. a. Have your privileges at any healthcare entity ever been voluntarily or involuntarily suspended, restricted, diminished, revoked, surrendered, or not renewed, except for medical records delinquency?	Yes ☐	No ☒
b. Have you ever agreed not to exercise your clinical privileges while under investigation?	Yes ☐	No ☒
11. Have you ever resigned from a healthcare entity to avoid modification, suspension, or termination of privileges, or while under investigation?	Yes ☐	No ☒
12. a. Has your application for licensure or license to practice in any jurisdiction ever been investigated, voluntarily or involuntarily limited, suspended, revoked, surrendered or denied?	Yes ☐	No ☒
b. Are any currently held licenses pending investigation or being challenged?	Yes ☐	No ☒
13. Have you ever been notified to appear before any licensing agency for a hearing or complaint of any nature?	Yes ☐	No ☒
14. Has your federal or state narcotics registration certificate in any jurisdiction ever been voluntarily or involuntarily limited (stipulations), suspended, revoked, restricted, or are there currently challenges to any of these items?	Yes ☐	No ☒

Applicant Name Susan C Robinson MD Date 9/27/09

15. Have you ever been involved in a settlement, medical malpractice claim or suit, or have you ever received written notice of intent to file such a suit? **If yes, please provide the following information on the attached Malpractice History form for each case:** • Name, age, sex of patient/claimant. • Date(s) and type of treatment and/or surgery, which led to the allegations against you. • Nature of allegations in claims/suits. Specify whether a suit was ever filed. • Names of other practitioners and hospital, if any, involved in claims or suit. • Disposition or current status of claim or suit (be specific). • Name of insurance carrier defending you. • Name of defense attorney. attached	Yes ☒	No ☐
16. Have you ever been reported to the National Practitioner Data Bank?	Yes ☐	No ☒
17. Are you now, or were you in the past, addicted to, abusive of, or in treatment for abuse of any controlled substances, habit-forming drugs, illegal drugs, prescription medication or alcohol?	Yes ☐	No ☒
18. In the five (5) years prior to this application, have you had any physical injury or disease, or mental illness or impairment, which you are currently under treatment for or could reasonably be expected to affect your on-going ability to practice medicine safely and competently? **If yes, please have your treating physician send the NM Medical Board a letter regarding your diagnosis and treatment.**	Yes ☐	No ☒
19. Have you ever, for any reason:		
a) Resigned from a medical school or postgraduate training (PGT) program?	Yes ☐	No ☒
b) Withdrawn from a medical school or postgraduate training program?	Yes ☐	No ☒
c) Been suspended, dismissed, or expelled from a medical school or PGT program?	Yes ☐	No ☒
d) Been placed on probation or remediation, including academic probation or remediation, by a medical school or PGT program?	Yes ☐	No ☒
e) Taken a leave of absence or break from, or had any interruptions or extensions in, a medical school or PGT program for any personal or professional reason (including illness or disability, pregnancy or maternity, any academic issue, etc)?	Yes ☐	No ☒

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If you answer YES to any question, please give details including name, address, and telephone number of significant parties on a separate sheet of paper.

New Mexico Medical Board
2055 S. Pacheco St. Bldg. 400
Santa Fe, NM 87505 (505) 476-7220

APPLICANT'S OATH

I, Susan C Robinson MD, **hereby certify that I am the person pictured below and named in this application for a license to practice as a Physician in the State of New Mexico; that all statements I have made herein are true; that I am the original and lawful possessor and person named in the various forms and credentials furnished to the New Mexico Medical Board (Board) with my application.**

I acknowledge and state that I have read the Information and Instructions that accompanied this application and I have answered all questions truthfully. I understand that the fee I submitted is not refundable.

I authorize and request every person, hospital, clinic, community, governmental agency, court, association, institution or other organization having 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 their 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, and their agents or representatives, and any person furnishing information, from any and all liability of every nature and kind arising out of the furnishing or inspection of such documents, records, other information, or the investigation made by the Board. I authorize the Board to release information, material, documents, orders, or the like relating to me or to this application to any other agency of the State of New Mexico or the appropriate licensing agency of any other state or Territory of the United States or any agency of the United States government.

Susan C Robinson MD 9/27/09
Applicant Signature Date

*Passport-quality color photograph taken within six months prior to filing the application, approximate size 2 x 2 inches, head and shoulders only, full face, front view, plain white or off-white background, standard photo stock paper, scanned or computer-generated photographs should have no visible pixels or dots.

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-OBSTETRICS

CERTIFIES THAT

SUSAN C. ROBINSON

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. SHE HAS THEREBY DEMONSTRATED TO THE SATISFACTION OF THIS BOARD THAT SHE IS POSSESSED OF SPECIAL KNOWLEDGE, AND BY THE AWARD OF THIS DIPLOMA HER PROFICIENCY IN THE SPECIALTY OF OBSTETRICS AND GYNECOLOGY IS RECOGNIZED, AND SHE IS AN ACKNOWLEDGED DIPLOMATE OF THIS BOARD FROM NOVEMBER 1986 THROUGH DECEMBER 1996.

NOVEMBER 7, 1986

Charles B Hammond MD
C D Christian
John H Masaca, MD

PRESIDENT
Robert C Cefalo
William Droegemueller
Leo J Stirm
Clarence Edwards MD
N B Gant M D

EXECUTIVE DIRECTOR
Arthur L Herbst
James M. Ingram, M.D.
Roy Lee Pitman
Ruth W. Lidenthal
William N Spellacy

American Board of Obstetrics and Gynecology

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AMERICAN MEDICAL ASSOCIATION
AMERICAN COLLEGE OF OBSTETRICIANS AND GYNECOLOGISTS
ASSOCIATION OF PROFESSORS OF GYNECOLOGY AND OBSTETRICS

Obstetrics and Gynecology

SUSAN CELINA ROBINSON, 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 JUNE, 1995 THROUGH DECEMBER, 2006
JUNE 26, 1995

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NM MEDICAL BOARD

President

Executive Director

DIPLOMATE NO. 22976

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Logged in as:
Susan Celina Robinson, M.D.

Personal Home Page

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Statuses and Applications
FAQs

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Important Dates
FAQ
Physician Support
About Us

Personal Home Page

Susan Celina Robinson, M.D.
ABOG ID Number:

Welcome to your Personalized Member Page

Credit Card payment is accepted for all online transactions.

For questions about the Recertification process, please send a message to: Recertification Department

For questions about the General Certification process, please send an email to: General Certification Department

If you should experience any problems navigating this site, please send an email to: Webmaster

CURRENT MOC STATUS

MOC Phase II - ABC (Year: 1)
(Click for further detail)

2009	2010	2011	2012	2013	2014
Not Applied	future	future	future	future	future

MOC Phase IV - Modules (Year: 1)
(Click for further detail)

Attention	Attention	Attention	Attention	Attention	Attention	Attention	Attention	Attention	Attention

OB/GYN Certification

Original Certification Date:	11/7/1986
Current Certification Expiration:	12/31/2009
Date of Last Recertification:	12/31/2008

June 2009,
address changed to
351 Pleasant ST #332
Northampton MA 01060.

STATE OF CALIFORNIA
dca
DEPARTMENT OF CONSUMER AFFAIRS

The Medical Board of California
2005 Evergreen Street, Suite 1200
Sacramento, CA 95815

PHYSICIAN AND SURGEON

CERTIFICATE NO G39852 EXPIRATION 03/31/2011

SUSAN CELINA ROBINSON
WOMENS HEALTH CARE SERVICES
5107 EAST KELLOGG
WICHITA KS 67218

ORIGINAL ISSUANCE DATE
07/02/1979

RECEIPT NO
01600126

DEA REGISTRATION NUMBER	THIS REGISTRATION EXPIRES	FEE PAID
	04-30-2011	FEE PAID

SCHEDULES	BUSINESS ACTIVITY	ISSUE DATE
2,2N, 3,3N,4,5,	PRACTITIONER	03-11-2008

ROBINSON, SUSAN C. (MD)
PLANNED PARENTHOOD MAR MONTE
650 N. FULTON STREET
FRESNO, CA 93728-0000

CONTROLLED SUBSTANCE REGISTRATION CERTIFICATE
UNITED STATES DEPARTMENT OF JUSTICE
DRUG ENFORCEMENT ADMINISTRATION
WASHINGTON D.C. 20537

Sections 304 and 1008 (21 USC 824 and 958) of the Controlled Substances Act of 1970, as amended, provide that the Attorney General may revoke or suspend a registration to manufacture, distribute, dispense, import or export a controlled substance.

THIS CERTIFICATE IS NOT TRANSFERABLE ON CHANGE OF OWNERSHIP, CONTROL, LOCATION, OR BUSINESS ACTIVITY, AND IT IS NOT VALID AFTER THE EXPIRATION DATE.

CONTROLLED SUBSTANCE REGISTRATION CERTIFICATE
UNITED STATES DEPARTMENT OF JUSTICE
DRUG ENFORCEMENT ADMINISTRATION
WASHINGTON D.C. 20537

DEA REGISTRATION NUMBER	THIS REGISTRATION EXPIRES	FEE PAID
	04-30-2011	FEE PAID

SCHEDULES	BUSINESS ACTIVITY	ISSUE DATE
2,2N, 3,3N,4,5,	PRACTITIONER	03-11-2008

ROBINSON, SUSAN C. (MD)
PLANNED PARENTHOOD MAR MONTE
650 N. FULTON STREET
FRESNO, CA 93728-0000

Sections 304 and 1008 (21 USC 824 and 958) of the Controlled Substances Act of 1970, as amended, provide that the Attorney General may revoke or suspend a registration to manufacture, distribute, dispense, import or export a controlled substance.

THIS CERTIFICATE IS NOT TRANSFERABLE ON CHANGE OF OWNERSHIP, CONTROL, LOCATION, OR BUSINESS ACTIVITY, AND IT IS NOT VALID AFTER THE EXPIRATION DATE.

Form DEA-223 (4/07)

Malpractice History

Provider Name: Susan C Robinson MD

Please DUPLICATE this form and complete for EACH case.

1. **Patient Name:** ∪
2. **Diagnosis:**
   BRAIN DAMAGE
3. **Your involvement in the case, i.e... Attending, Consulting, Etc.:**
   ATTENDING
4. **Allegation(s):**
   CARELESS & NEGLIGENT CARE
5. **Clinical Case Summary:**
   OB patient came to L+D with abruptio, emergency C-section done. Baby had brain damage.
6. **Patient Outcome:** poor.
7. **Other pertinent details:**
   see attached.
8. **Date of incident:** 7/4/88 **Date filed:** 9/10/91
   Date closed: 6/30/92
9. **Resolution of case, i.e. Dismissed, Settled Out of Court, Litigated, Pending, Other:**
   DISMISSED
10. **Settlement amount paid on your behalf (if any):** ∅
11. **Professional liability insurer involved:**
    a. **Name of Insurer:** PROMUTUAL. 101 ARCH ST 4th FL.
    b. **Address of Insurer:** BOSTON MA 02110
12. **Defense attorney:** WILLIAM DAVENPORT

Susan C Robinson MD
Signature

9/27/09
Date

SUMMARY OF MALPRACTICE ALLEGATION

- Plaintiffs

- Defandants

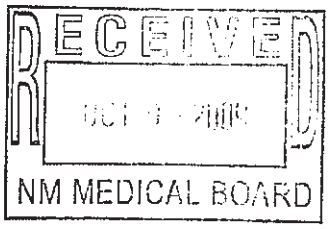
  City of Quincy, Yvonne Swistack, CNM, Cynthia Davis, MD, Susan Alex, Susan Robinson MD, and Center for Women's Health

- Court

  Norfolk Superior

- Summons

  #91-01900



- Event date

  7/4/88

- Claim date

  9/10/91

- Tribunal date

  3/20/92

- Dismissal date

  6/30/92

- Plaintiff counsel

  Michael Gillis, Gillis, Gillis and Bikofsky PC, 1340 Centre St., Newton Centre, MA 02159, 617-244-4300

- Defendant counsel

  William Davenport, Bloom and Buell PC, 1340 Soldier's Field Rd., Boston, MA, 02135, 617-254-7610 (fax) 617-254-4400 (phone)

- Insurer

  Joint Underwriting Association (now called "Promutual") 101 Arch Street, 4th Floor, Boston, MA 02110 **Phone**: 617-330-1755 **Fax**: 617-330-1748

- Claim representative

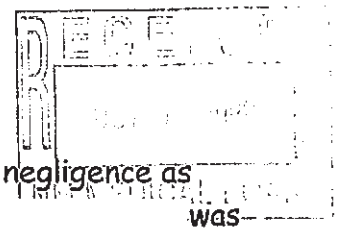
  Mary Lou Sawatzky, RN (ext 327)

- File number

  #2892

- Policy number

- Allegation



As a result of the defendants' carelessness and negligence as described in the plaintiff's complaint, . was caused to sustain severe and permanent personal injuries, including permanent brain injuries

- Description

  The patient's prenatal course was complicated by an abnormal 1 hour glucose tolerance test (with normal 3 hour glucose tolerance test) and by heavy cigarette smoking. She was at 41 ½ weeks gestation and was being followed with biweekly nonstress tests which were reactive. A biophysical profile done 5 days prior to admission was normal. The patient ceased noting fetal movement 7/3/88 at about 1400. 7/4/88 at about 1500 she had the onset of back and abdominal pain. She presented to labor and delivery on 7/4/88 at 2340. The fetal heart could not be heard with electronic fetal monitor but was visualized using bedside ultrasound on 7/5/88 at 0005. The rate was abnormally slow at 80 beats per minute. An emergency cesarean section was done and a baby girl with APGAR scores of 1, 5 and 7 was delivered. The baby was resuscitated by the anesthesiologist and transferred to Boston Floating Hospital for Children. A retroplacental clot of 200 ccs was noted at surgery. The final diagnosis was placental abruption.

- Disposition

  The medical tribunal's report entered a finding (re: all defendants) that this was an unfortunate medical result, that is, that there was no medical negligence involved. The plaintiffs did not post the medical tribunal bond and were unable to find any physician or expert willing to write a letter stating that something that was done was below the standard of care. The plaintiffs sought no other relief or appeal. The court dismissed the case 6/30/92. No money was paid on behalf of or by any of the defendants.

AMA
AMERICAN
MEDICAL
ASSOCIATION

AMA Physician Profile

Name and Mailing Address:

SUSAN CELINA ROBINSON MD

Primary Office Address:

SAME AS MAILING ADDRESS

Phone: UNKNOWN

Birthdate: 03/19/1946
Birthplace: NEW YORK, NY UNITED STATES OF AMERICA

Physician's Major Professional Activity: OFFICE BASED PRACTICE

Practice Specialties Self Designated by the Physician*:

Primary Specialty: OBSTETRICS & GYNECOLOGY
Secondary Specialty: GENERAL SURGERY

**Self-Designated Practice Specialties/Areas of Practice (SDPS) listed on the AMA Physician Profile do not imply "recognition" or "endorsement" of any field of medical practice by the Association, nor does it imply, certification by a Member Medical Specialty Board of the American Board of Medical Specialties, or that the physician has been trained or has special competence to practice the SDPS.*

AMA membership: NON MEMBER

All Information from this Point Forward is Provided by the Primary Source

Current and/or Historical Medical School:

UNIV OF CA, SAN DIEGO, SCH OF MED, LA JOLLA CA 92093
Degree Awarded: Yes
Degree Year: 1978

AMA AMERICAN MEDICAL ASSOCIATION

AMA Physician Profile

Current and/or Historical Post Graduate Medical Training Programs Accredited by the Accreditation Council for Graduate Medical Education (ACGME):

Future training dates, as reported by the program, should be interpreted as "in progress" or "current" with projected date of completion. If the training program indicates that training for a physician in a particular specialty was not completed at their institution, the training segment will be identified as "INCOMPLETE TRAINING".

Institution: UNIV CA SAN DIEGO MED CTR — **State:** CALIFORNIA
Specialty : GENERAL SURGERY — 07/1978 - 06/1979 (VERIFIED)

Institution: TUFTS UNIV AFFIL HOSPS — **State:** MASSACHUSETTS
Specialty : OBSTETRICS & GYNECOLOGY — 07/1979 - 06/1980 (VERIFIED)

Institution: TUFTS UNIV AFFIL HOSPS — **State:** MASSACHUSETTS
Specialty : OBSTETRICS & GYNECOLOGY — 07/1980 - 06/1982 (VERIFIED)

Note: If you have discrepant information, please submit a Request for Investigation to the AMA so that we may verify the information with the primary source(s). See the last page of this Profile for instructions on how to report a data discrepancy.

NATIONAL BOARD OF MEDICAL EXAMINERS (NBME) CERTIFICATION YEAR: MD: 1979

Current and/or Historical Medical Licensure:

Jurisdiction	MD/ DO	Date Granted	Expiration Date	Status	License Type	Last Reported
ARKANSAS	MD	04/02/2004	03/31/2006	UNKNOWN	UNLIMITED	07/25/2008
KANSAS	MD	10/18/2003	06/30/2010	ACTIVE	UNLIMITED	09/01/2009
MAINE	MD	09/24/1998	04/01/1999	INACTIVE	TEMPORARY	09/01/2009
ARIZONA	MD	04/03/1998	05/01/1999	INACTIVE	UNLIMITED	09/02/2009
INDIANA	MD	01/23/1998	06/30/1999	INACTIVE	UNLIMITED	02/22/2007
NEW HAMPSHIRE	MD	06/06/1990	06/30/1999	INACTIVE	UNLIMITED	01/23/2007
MASSACHUSETTS	MD	10/02/1980	03/19/1999	INACTIVE	UNLIMITED	08/25/2003

AMA
AMERICAN
MEDICAL
ASSOCIATION

AMA Physician Profile

Current and/or Historical Medical Licensure:

Jurisdiction	MD/ DO	Date Granted	Expiration Date	Status	License Type	Last Reported
CALIFORNIA	MD	07/02/1979	03/31/2011	ACTIVE	UNLIMITED	09/16/2009

Note: When the specific month and day are unknown, the date will display the default value of "01." Not all licensing boards maintain or provide full date values. Please contact the appropriate licensing board directly for this information.

ECFMG Certfication:

Applicant Number:

Note: The Educational Commission for Foreign Medical Graduates (ECFMG) applicant identification number does not imply current ECFMG certification status. To verify ECFMG status, contact the ECFMG Certification Verification Service in writing at P.O. Box 13679, Philadelphia, PA 19101.

Federal Drug Enforcement Administration:

* *Only the last three characters of active DEA number(s) are displayed.*

DEA Number *	Schedule	Expiration Date	Last Reported
		04/30/2011	09/10/2009

Address:

Note: Many states require their own controlled substances registration/license. Please check with your state licensing authority for requirement information as the AMA does not maintain this information.

AMA AMERICAN MEDICAL ASSOCIATION

AMA Physician Profile

Specialty Board Certification(s)*:

Specialty Board Certification(s) by one or more of the 24 boards recognized by the American Board of Medical Specialties (ABMS) and the American Medical Association (AMA) through the Liaison Committee on Specialty Boards, as reported by the ABMS:

The AMA Physician Profile has been designated by the ABMS as an Official ABMS Display Agent of Member Board Certification data. Therefore, the ABMS Board Certification information on the AMA Physician Profile is considered a designated equivalent source in regard to credentialing standards set forth by accrediting bodies such as the Joint Commission and National Committee for Quality Assurance (NCQA).

Certifying Board: AMERICAN BOARD OF OBSTETRICS AND GYNECOLOGY
Certificate: OBSTETRICS & GYNECOLOGY
Certificate Type: GENERAL

Duration	Effective	Expiration	Occurrence	Last Reported
TIME LIMITED	12/31/2008	12/31/2009	RE-CERT	09/10/2009
TIME LIMITED	12/31/2007	12/31/2009	RE-CERT	09/10/2009
TIME LIMITED	12/31/2006	12/31/2008	RE-CERT(**)	09/10/2009
TIME LIMITED	12/31/2005	04/30/2008	RE-CERT(**)	09/10/2009
TIME LIMITED	12/31/2004	04/30/2008	RE-CERT(**)	09/10/2009
TIME LIMITED	12/31/1999	12/31/2006	RE-CERT(**)	09/10/2009
TIME LIMITED	06/26/1995	12/31/2006	RE-CERT(**)	09/10/2009
TIME LIMITED	11/07/1986	12/31/1996	INITIAL(**)	09/10/2009

Note: **For certification dates, a default value of "01" appears in the day or month field if data were not provided to AMA. Please contact the appropriate specialty board directly for this information. (**) Indicates an expired certificate.**

Medicare/Medicaid Sanction(s):

TO DATE, THERE HAVE BEEN NO SUCH SANCTIONS REPORTED TO THE AMA BY THE DEPARTMENT OF HEALTH AND HUMAN SERVICES.

Other Federal Sanction(s):

TO DATE, THERE HAVE BEEN NO FEDERAL SANCTIONS REPORTED TO THE AMA BY ANY BRANCH OF THE US MILITARY, THE VETERAN'S ADMINSTRATION OR THE US PUBLIC HEALTH SERVICE.

AMA
AMERICAN
MEDICAL
ASSOCIATION

AMA Physician Profile

Additional Information:

TO DATE, THERE IS NO ADDITIONAL INFORMATION FOR THIS PHYSICIAN ON FILE.

The content of the AMA Physician Profile is intended to assist with credentialing. Appropriate use of the AMA Physician Masterfile data contained on this Profile by an organization would meet the primary source verification requirements of the Joint Commission and the American Accreditation HealthCare Commission/URAC. The Physician Masterfile meets the National Committee for Quality Assurance (NCQA) standards for verification of medical education, post graduate medical training, board certification, DEA status, and Medicare/Medicaid sanctions.

If you note any discrepancies, please log onto our web site (http://www.ama-assn.org/go/amaprofiles) and go to the order detail page, select the D following the physician's name and enter the data in question. Or you can mark the issues on a copy of the profile and mail or fax to:

Division of Database Products and Licensing
Attn: Credentialing Products
515 N. State Street
Chicago, IL 60610
800- 665-2882
312 464-5900 (fax)

If you have questions or need additional information, please call the AMA Profile Service customer support line at 800-665-2882.

The Federation of State Medical Boards
of the United States, Inc
PO Box 619850
Dallas, Texas 75261-9850
Telephone: (817)868-4000
FAX (817)868-4099

BOARD ACTION CLEARANCE REPORT

October 02, 2009

Attn: Lynn S. Hart, Executive Dir.
New Mexico Medical Board
2055 S. Pacheco, Bldg.400
Santa Fe, NM 87505

Re: Board Action Query Dated: October 02, 2009
Your Reference Number:
FSMB Batch Number: BQ1676483

The following is a report of the search results from the Board Action Data Bank as of October 02, 2009 for practitioners submitted as part of the above-referenced batch for which NO board actions were identified.

Practitioners Cleared with No Actions as of October 02, 2009

Item	Name	DOB	School	Yr/Grad	Request ID
3	robinson, susan	03/19/1946	005040	0678	21427044

LICENSE HISTORY
State Board
ARIZONA
ARKANSAS
CALIFORNIA
KANSAS
MAINE
MASSACHUSETTS
NEW HAMPSHIRE

PLEASE NOTE: The licensure history information contained in these reports is not considered licensure verification but rather an indicator of known states of historical licensure for these individuals. Use of this information should be limited to cross-reference purposes.

STATE AND CONSUMER SERVICES AGENCY

ARNOLD SCHWARZENEGGER, Governor

State of California Department of Consumer Affairs

MEDICAL BOARD OF CALIFORNIA
LICENSING PROGRAM
2005 EVERGREEN ST SUITE 1200
SACRAMENTO CA 95815-3831
TELEPHONE: (800) 633-2322
FAX: (916) 263-2944

www.mbc.ca.gov

October 7, 2009

NEW MEXICO MEDICAL BOARD
2055 SOUTH PACHECO BUILDING 400
SANTA FE NM 87505

To Whom It May Concern:

This is to certify that on the date of this letter the records of the Medical Board of California (Board) indicate the following information:

Physician:	SUSAN CELINA ROBINSON
License No.:	G 39852
Issued:	July 2, 1979
Exam Type:	A written examination
Expiration Date:	March 31, 2011
Status:	Renewed/current
Board Discipline:	NO

Further public records pertaining to the above licensee may be available from the Board's Web site at www.mbc.ca.gov.

Deborah Pellegrini

Deborah Pellegrini
Chief of Licensing

SEAL

KANSAS

MARK PARKINSON
GOVERNOR

STATE BOARD OF HEALING ARTS

JACK CONFER
EXECUTIVE DIRECTOR

September 22, 2009

New Mexico Medical Board
2055 S Pacheco St Bldg 400
Santa Fe, NM 87505

This is to certify that: Susan C Robinson, MD has been licensed to practice in Kansas in the following profession: Medical Doctor (MD)

License Number:	04-30388
Date of Birth:	03/19/1946
Profession:	Medical Doctor (MD)
License Designation:	MD Inactive License
License Status:	Current
Original License Date:	10/18/2003
Expiration Date:	06/30/2010
Disciplinary Action:	None
Pending Complaints:	None

Unless otherwise indicated, this licensee has not been subject to disciplinary proceeding by the Kansas Board of Healing Arts.

Verified by:

Theresa Massey

Theresa Massey
Senior Administrative Assistant

235 SW TOPEKA BLVD., TOPEKA, KS 66603
Voice: 785-296-7413 Toll Free: 888-886-7205 Fax: 785-296-0852 Website: www.ksbha.org
Hearing Impaired Callers Dial 711 or 800-766-3777/voice/TTY

MARK PARKINSON
GOVERNOR

STATE BOARD OF HEALING ARTS

JACK CONFER
EXECUTIVE DIRECTOR

September 22, 2009

New Mexico Medical Board
2055 S Pacheco St Bldg 400
Santa Fe, NM 87505

This is to certify that: Susan C Robinson, MD has been licensed to practice in Kansas in the following profession: Medical Doctor (MD)

License Number:	0425106
Date of Birth:	03/19/1946
Profession:	Medical Doctor (MD)
License Designation:	MD Temporary Permit
License Status:	Cancelled – Permanent Number Assigned
Original License Date:	08/19/2003
Expiration Date:	02/15/2004
Disciplinary Action:	None
Pending Complaints:	None

Unless otherwise indicated, this licensee has not been subject to disciplinary proceeding by the Kansas Board of Healing Arts.

Verified by:

Theresa Massey

Theresa Massey
Senior Administrative Assistant

235 SW TOPEKA BLVD., TOPEKA, KS 66603
Voice: 785-296-7413 Toll Free: 888-886-7205 Fax: 785-296-0852 Website: www.ksbha.org
Hearing Impaired Callers Dial 711 or 800-766-3777/voice/TTY

STATE OF MAINE
BOARD OF LICENSURE IN MEDICINE
137 STATE HOUSE STATION
AUGUSTA, MAINE
04333-0137

JOHN ELIAS BALDACCI
GOVERNOR

SHERIDAN R. OLDHAM, M.D.
CHAIRMAN

RANDAL C. MANNING
EXECUTIVE DIRECTOR

September 19, 2009

To Whom It May Concern:

This is to certify that the records of the Maine Board of Licensure in Medicine indicate the following with regard to the licensee named below:

Licensee:	Susan C Robinson, M.D.
License Number:	TD-98-87
Issue Date:	09/24/1998
Expiration Date:	04/01/1999
Current Status:	Expired
Disciplinary Action:	No

Examination Information:

Exam Date	Exam State	Exam Type	Exam Status	Exam Score	Exam Details
		NBME I + NBME II + NBME III	Pass		3-196-982-7

This license information was last updated on: 09/19/2009

If we can be of further assistance, please do not hesitate to contact the Board office.

Sincerely,

Randal C. Manning
Executive Director

ARKANSAS STATE MEDICAL BOARD

2100 Riverfront Drive, Little Rock, Arkansas 72202-1435 (501) 296-1802 FAX: (501) 603-3555
www.armedicalboard.org

Detailed License Verification

Queried on: Monday, September 28, 2009 at: 8:09 AM

General Information

Name: Susan Celina Robinson, M.D.
Specialty: Obstetrics & Gynecology

Address Information

Mailing Address: 759 South State Street
Address 2: PMB 72
City/State/Zip: Ukiah, CA 95482
Phone:
Fax:

License Information

License Number: E-4038
Original Issue Date: 4/2/2004
Expiration Date: 3/31/2006
Basis: Exam
License Status: Inactive
License Category: Expired

No Information Found for: License Board History

ARKANSAS STATE MEDICAL BOARD

2100 Riverfront Drive, Little Rock, Arkansas 72202-1435 (501) 296-1802 FAX: (501) 603-3555
www.armedicalboard.org

September 28, 2009

Susan Celina Robinson, M.D.

CERTIFICATION

I, Peggy Pryor Cryer, Executive Secretary of the Arkansas State Medical Board, do hereby certify that the enclosed certification of the above referenced practitioner is true and correct as same appears on file in this office.

Witness my hand and official seal of the Board, this the 28th day of September 2009.

ARKANSAS STATE MEDICAL BOARD

BY: _____
Peggy Pryor Cryer
Executive Secretary

Indiana
Online Licensing

New Search
Litigation Documents
Digital Certification
Medical Board

Person Information

Susan Celina Robinson

Address Information

NASHUA NH 03063

License Information

License No:	01048096A
Profession:	Medical Licensing Board
License Type:	Physician
Obtained By Method:	Endorsement
Issue Date:	1/23/1998
Expiration Date:	6/30/1999
License Status:	Expired Non-Renewable

Specialty Information as Reported by Physician

No Specialty Information

Previous Action

Previous Action - None

Related Licenses

License No: 01048096B Name: Robinson, Susan Celina
License Type: CSR-Physician Status: Expired Relationship: Same Person

Printed on 09/24/09 @ 10:57

General Information

Susan C. Robinson MD	License Number: 26306 License Status: Expired License Issued: 04/03/1998 License Reissued: 04/03/1998 Due to Renew By: 01/01/1999 If not Renewed, License Expires: 05/01/1999

Education and Training (a)

	Medical School: Graduation Date:	UNIV OF CA, SAN DIEGO, SCH OF MED La Jolla, California 06/18/1978
	Fellowship:	07/01/1982 - 06/13/1984 ST MARGARET'S HOSPITAL-WOMEN BOSTON , MA
	Internship:	06/24/1978 - 06/27/1979 U CA SAN DIEGO MEDICAL CENTER SAN DIEGO , CA
	Residency:	07/01/1979 - 06/30/1982 (Obstetrics & Gynecology) TUFTS UNIVERSITY/NEW ENGLAND MEDICAL CENTER BOSTON , MA
(b)	Area of Interest	Obstetrics & Gynecology (ABMS Board Certified)

Board Actions (c)

None

Amanda Schnabe Public Records Coordinator 9-24-09

The Arizona Medical Board presents this information as a service to the public. The Board relies upon information provided by licensees to be true and correct, as required by statute. It is an act of unprofessional

conduct for a licensee to provide erroneous information to the Board. The Board makes no warranty or guarantee concerning the accuracy or reliability of the content of this website or the content of any other website to which it may link. Assessing accuracy and reliability of the information obtained from this website is solely the responsibility of the user. The Board is not liable for errors or for any damages resulting from the use of the information contained herein.

Please note that some Board Actions may not appear until a few weeks after they are taken, due to appeals, effective dates and other administrative processes.

Board actions taken against physicians in the past 24 months are also available in a chronological list .

Credentials Verification professionals, please click here for information on use of this website

(a) Information up to the date of initial licensure is verified by the Board. Information provided by the physician after this date is not verified by the Board.

(b) The Board does not verify current specialties. For more information please see the American Board of Medical Specialties website at http://www.abms.org to determine if the physician has earned a specialty certification from this private agency

(c) Advisory Letters and Physician Responses to the Advisory Letters are only available on-line for a 5 year period from date of issuance by the Board.

(d) The settlement of a medical malpractice action may occur for a variety of reasons that do not necessarily reflect negatively on the professional competence or conduct of the doctor. A payment in settlement of a medical malpractice action does not create a presumption that medical malpractice occurred.

(e) Prior to 1999, "Advisory Letters" were known as "Letters of Concern"

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

10/2/2009

To Whom It May Concern:

This certifies that Susan C Robinson M.D., a 1978 graduate of University of California, San Diego School of Med, has been duly registered by this board as provided by the laws of the Commonwealth.

Certificate Number 46659 was issued to Dr. Robinson on 10/02/1980. This license is not Current. The expiration date is 03/19/1999.

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) to 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

State of New Hampshire
Board of Medicine
2 Industrial Park Drive, Suite 8

Concord, NH 03301-8520

(603) 271-6936

Verification Report

This is to certify that the records of the New Hampshire Board indicate the following information:

Licensee: SUSAN C ROBINSON, MD

Specialty: OB OBSTETRICS & GYNECOLOGY

License Number: 8361

Issue Date: 6/6/1990

Expiration Date: 6/30/1999

Disciplinary Action: None

To expedite the certification of licensure process, the above is the standard format for all professionals regulated by this Board.

Nichole Taylor
License Clerk

SEAL

9-28-09
Date

New Mexico Medical Board
2055 S. Pacheco St.
Building 400
Santa Fe, NM 87505
(505) 476-7220

RECEIVED
SEP 21 2009
NM MEDICAL BOARD

WORK EXPERIENCE VERIFICATION

I am applying for a medical license in the State of New Mexico. The New Mexico Medical Board requires this form to be completed by the Chief of Staff or facility's administrative staff. I hereby authorize release of all information in your files, favorable or otherwise, DIRECTLY to the **NMMB, 2055 S. Pacheco St., Bldg. 400, Santa Fe, NM 87505.**

Applicant Name

Address: ~~Susan Robinson M.D~~

City/State/Zip: P

Susan Robinson MD
Applicant Signature

05/2008 – current
*Dates of Privilege/Employment mm/yy to mm/yy (must be provided)

Telephone Number

The section below should be completed by the chief of staff or facility's administrative staff.
Letters of Recommendation are ***NOT*** accepted in lieu of this form.

PATRICIA FAJARDO
Type or Print Name of person completing this form

VP Clinical Services
Title

Planned Parenthood Santa Barbara, VTA + SLO
Name of Institution

518 Garden St
Address

Santa Barbara, CA 93101
City / State / Zip

1. This evaluation is based on: ___Observation of applicant ✓ Review of personnel file
2. In your estimation, is there any reason why this applicant should not be licensed to practice? ___Yes ✓ No
3. To your knowledge, is there any mental or physical reason why this applicant should not be licensed? ___Yes ✓ No
4. To your knowledge, is there any derogatory/disciplinary information regarding this applicant? ___Yes ✓ No
5. Are the dates of privilege/employment provided by the applicant on this form accurate?* ✓ Yes ___No

If not, please provide correct dates: Beginning 01-2008 (Month/Year) Ending present (Month/Year)

If you answered "YES" to questions 2, 3, and/or 4, please provide a written explanation and/or any supporting documentation that may be relevant.

Please affix hospital or notary seal here

Printed name of person completing this form — Signature — 9/15/09 Date

Victoria D. Dillingham — 9-16-09
Signature of Notary (if applicable) — Date

My commission expires: 2010

Please note on this form if there is no hospital or notary seal available.
Please return this form directly to the Medical Board.
Thank you for your cooperation.

VICTORIA DILLINGHAM
Notary Public - California
Santa Barbara County
My Comm. Expires Apr. 30, 2010

NRO1

Revised 8/08

ACKNOWLEDGMENT

State of California
County of Santa Barbara

On 9-16-09 before me, PATRICIA FASARDO
(insert name and title of the officer)

personally appeared _____,
who proved to me on the basis of satisfactory evidence to be the person(s) whose name(s) is/are subscribed to the within instrument and acknowledged to me that he/she/they executed the same in his/her/their authorized capacity(ies), and that by his/her/their signature(s) on the instrument the person(s), or the entity upon behalf of which the person(s) acted, executed the instrument.

I certify under PENALTY OF PERJURY under the laws of the State of California that the foregoing paragraph is true and correct.

WITNESS my hand and official seal.

Signature _____ (Seal)

NRO1 VICTORIA DILLINGHAM
COMM. #1662327
Notary Public - California
Santa Barbara County
My Comm. Expires Apr. 30, 2010 NRO1

State of California
County of Santa Barbara

Subscribed and sworn to (or affirmed) before me on this 16 day of Sept, 2009, by PATRICIA FARRELL proved to me on the basis of satisfactory evidence to be the person(s) who appeared before me.

(Seal)

Signature Victoria Dillingham

New Mexico Medical Board
2055 S. Pacheco St.
Building 400
Santa Fe, NM 87505
(505) 476-7220

WORK EXPERIENCE VERIFICATION

I am applying for a medical license in the State of New Mexico. The New Mexico Medical Board requires this form to be completed by the Chief of Staff or facility's administrative staff. I hereby authorize release of all information in your files, favorable or otherwise, DIRECTLY to the **NMMB, 2055 S. Pacheco St., Bldg. 400, Santa Fe, NM 87505.**

Applicant Name: Susan Robinson

Address: P

City/State/Zip:

Applicant Signature: Susan Robinson MD

June 2008 – present
*Dates of Privilege/Employment (mm/yy to mm/yy (must be provided)

Telephone Number:

The section below should be completed by the chief of staff or facility's administrative staff.
Letters of Recommendation are ***NOT*** accepted in lieu of this form.

RICHARD L. FISCHER, MD
Type or Print Name of person completing this form

ASSOCIATE MEDICAL DIRECTOR
Title

PLANNED PARENTHOOD MAR MONTE
Name of Institution

1691 THE ALAMEDA
Address

SAN JOSE, CA 95126
City / State / Zip

1. This evaluation is based on: ✓ Observation of applicant ___ Review of personnel file
2. In your estimation, is there any reason why this applicant should not be licensed to practice? ___ Yes ✓ No
3. To your knowledge, is there any mental or physical reason why this applicant should not be licensed? ___ Yes ✓ No
4. To your knowledge, is there any derogatory/disciplinary information regarding this applicant? ___ Yes ✓ No
5. Are the dates of privilege/employment provided by the applicant on this form accurate?* ___ Yes ✓ No

If not, please provide correct dates: Beginning _____ (Month/Year) Ending _____ (Month/Year)

If you answered "YES" to questions 2, 3, and/or 4, please provide a written explanation and/or any supporting documentation that may be relevant.

RICHARD L. FISCHER MD — Printed name of person completing this form
Signature
9/15/09 — Date

Please affix hospital or notary seal here

NOT AVAILABLE

Signature of Notary (if applicable) — Date

My commission expires: _____

Please note on this form if there is no hospital or notary seal available.

Please return this form directly to the address above
Thank you for your cooperation.

Revised 8/08

New Mexico Medical Board
2055 S. Pacheco St.
Building 400
Santa Fe, NM 87505
(505) 476-7220

WORK EXPERIENCE VERIFICATION

I am applying for a medical license in the State of New Mexico. The New Mexico Medical Board requires this form to be completed by the Chief of Staff or facility's administrative staff. I hereby authorize release of all information in your files, favorable or otherwise, DIRECTLY to the NMMB, 2055 S. Pacheco St., Bldg. 400, Santa Fe, NM 87505.

Applicant Name: Susan Robinson

Address:

City/State/Zip:

Applicant Signature: Susan Robinson MD

*Dates of Privilege/Employment (mm/yy to mm/yy (must be provided): June 2008 – Present

Telephone Number:

The section below should be completed by the chief of staff or facility's administrative staff.
Letters of Recommendation are *NOT* accepted in lieu of this form.

Type or Print Name of person completing this form: RICHARD L. FISCHER, MD

Title: ASSOCIATE MEDICAL DIRECTOR

Name of Institution: PLANNED PARENTHOOD MAR MONTE

Address: 1691 THE ALAMEDA

City / State / Zip: SAN JOSE, CA 95126

1. This evaluation is based on: ✓ Observation of applicant ___ Review of personnel file
2. In your estimation, is there any reason why this applicant should not be licensed to practice? ___ Yes ✓ No
3. To your knowledge, is there any mental or physical reason why this applicant should not be licensed? ___ Yes ✓ No
4. To your knowledge, is there any derogatory/disciplinary information regarding this applicant? ___ Yes ✓ No
5. Are the dates of privilege/employment provided by the applicant on this form accurate?* ___ Yes ✓ No

*If not, please provide correct dates: Beginning 6/08 (Month/Year) Ending PRESENT (Month/Year)

If you answered "YES" to questions 2, 3, and/or 4, please provide a written explanation and/or any supporting documentation that may be relevant.

Richard L. Fischer MD — Signature — 9/15/09
Printed name of person completing this form — Date

Please affix hospital or notary seal here: NOT AVAILABLE

Signature of Notary (if applicable) — Date

My commission expires:

Please note on this form if there is no hospital or notary seal available.

Please return this form directly to the address above
Thank you for your cooperation.

Revised 8/08

New Mexico Medical Board
2055 S. Pacheco St.
Building 400
Santa Fe, NM 87505
(505) 476-7220

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SEP 25 2009
NM MEDICAL BOARD

WORK EXPERIENCE VERIFICATION

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Applicant Name: Susan Robinson MD

Address:

City/State/Zip:

Applicant Signature: Susan C Robinson MD

*Dates of Privilege/Employment mm/yy to mm/yy (must be provided): 5/1999 – 10/2006

Telephone Number:

Rohnert Park, San Rafael, Eddy ST, MacArthur Oakland, Hayward, San Mateo

The section below should be completed by the chief of staff or facility's administrative staff.
Letters of Recommendation are ***NOT*** accepted in lieu of this form.

Abeba Woldemariam.
Type or Print Name of person completing this form

Credentialing Coordinator
Title

Planned Parenthood Golden Gate
Name of Institution

815 Eddy Street #100
Address

SF, CA 94109
City / State / Zip

1. This evaluation is based on: ___Observation of applicant __X__Review of personnel file
2. In your estimation, is there any reason why this applicant should not be licensed to practice? ___Yes __X__No
3. To your knowledge, is there any mental or physical reason why this applicant should not be licensed? ___Yes __X__No
4. To your knowledge, is there any derogatory/disciplinary information regarding this applicant? ___Yes __X__No
5. Are the dates of privilege/employment provided by the applicant on this form accurate?* ___Yes ___No

If not, please provide correct dates: Beginning 5/1999 (Month/Year) Ending 10/31/07 (Month/Year)

If you answered "YES" to questions 2, 3, and/or 4, please provide a written explanation and/or any supporting documentation that may be relevant.

See Attached

Printed name of person completing this form | Signature | Date

Please affix hospital or notary seal here

Signature of Notary (if applicable) | Date

My commission expires:

Please note on this form if there is no hospital or notary seal available.

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Revised 8/08

New Mexico Medical Board
2055 S. Pacheco St.
Building 400
Santa Fe, NM 87505
(505) 476-7220

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Applicant Name: Susan Robinson MD

Address:

City/State/Zip:

Applicant Signature: Susan C Robinson MD

Dates of Privilege/Employment: mm/yy to mm/yy (must be provided) 5/1999 – 10/2006

Telephone Number:

Rohnert Park, San Rafael, Eddy ST, MacArthur Oakland, Hayward, San Mateo

The section below should be completed by the chief of staff or facility's administrative staff.
Letters of Recommendation are ***NOT*** accepted in lieu of this form.

Abeba Woldemariam.
Type or Print Name of person completing this form

Credentialing Coordinator.
Title

Planned Parenthood Golden Gate.
Name of Institution

815 Eddy Street #100.
Address

SF, CA 94109
City/State/Zip

1. This evaluation is based on: ___Observation of applicant __X__Review of personnel file
2. In your estimation, is there any reason why this applicant should not be licensed to practice? ___Yes __X__No
3. To your knowledge, is there any mental or physical reason why this applicant should not be licensed? ___Yes __X__No
4. To your knowledge, is there any derogatory/disciplinary information regarding this applicant? ___Yes __X__No
5. Are the dates of privilege/employment provided by the applicant on this form accurate?* ___Yes ___No

**If not, please provide correct dates:* Beginning 5/1999 (Month/Year) Ending 10/31/07 (Month/Year)

If you answered "YES" to questions 2, 3, and/or 4, please provide a written explanation and/or any supporting documentation that may be relevant.

Abeba Woldemariam. 10/14/09
Printed name of person completing this form — Signature — Date

Please affix hospital or notary seal here

Signature of Notary (if applicable) 10/14/09
Date

My commission expires:

Please note on this form if there is no hospital or notary seal available.
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CMG.

New Mexico Medical Board
2055 S. Pacheco St.
Building 400
Santa Fe, NM 87505
(505) 476-7220

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NM MEDICAL BOARD

WORK EXPERIENCE VERIFICATION

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SUSAN C. ROBINSON MD
Applicant Name

Susan C Robinson MD
Applicant Signature

September 2007 – January 2009
*Dates of Privilage/Employment mm/yy to mm/yy (must be provided)

City/State/Zip

Telephone Number

The section below should be completed by the chief of staff or facility's administrative staff.
Letters of Recommendation are ***NOT*** accepted in lieu of this form.

LIZA TAPIA VAUGHAN
Type or Print Name of person completing this form

GENERAL MANAGER
Title

CHOICE MEDICAL GROUP
Name of Institution

1834 STONE AVE. #2B
Address

SAN JOSE, CA 95125
City / State / Zip

1. This evaluation is based on: ___Observation of applicant X Review of personnel file
2. In your estimation, is there any reason why this applicant should not be licensed to practice? ___Yes X No
3. To your knowledge, is there any mental or physical reason why this applicant should not be licensed? ___Yes X No
4. To your knowledge, is there any derogatory/disciplinary information regarding this applicant? ___Yes X No
5. Are the dates of privilege/employment provided by the applicant on this form accurate?* X Yes ___No

If not, please provide correct dates: Beginning _____ Ending _____
Month/Year Month/Year

If you answered "YES" to questions 2, 3, and/or 4, please provide a written explanation and/or any supporting documentation that may be relevant.

LIZA TAPIA VAUGHAN Liza Tapia Vaughan 9-15-09
Printed name of person completing this form Signature Date

Please affix hospital or notary seal here

Signature of Notary (if applicable) Date

My commission expires: _____

Please note on this form if there is no hospital or notary seal available.
Please return this form directly to the address above
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no notary or hospital seal.

New Mexico Medical Board
2055 S. Pacheco St.
Building 400
Santa Fe, NM 87505
(505) 476-7220

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Applicant Name ~~Susan Robinson MD~~

Applicant Signature [signature]

Address

Dates of Privilege/Employment mm/yy to mm/yy (must be provided) October 2005 - June 2009

City/State/Zip

Telephone Number

The section below should be completed by the chief of staff or facility's administrative staff.
Letters of Recommendation are ***NOT*** accepted in lieu of this form.

JOAN Armentrout
Type or Print Name of person completing this form

Administratve Director
Title

Women's Health Care Services
Name of Institution

5107 E. Kellogg
Address

Wichita KS 67218
City / State / Zip

1. This evaluation is based on: X Observation of applicant ___Review of personnel file
2. In your estimation, is there any reason why this applicant should not be licensed to practice? ___Yes X No
3. To your knowledge, is there any mental or physical reason why this applicant should not be licensed? ___Yes X No
4. To your knowledge, is there any derogatory/disciplinary information regarding this applicant? ___Yes X No
5. Are the dates of privilege/employment provided by the applicant on this form accurate?* X Yes ___No

***If not, please provide correct dates**: Beginning _____ (Month/Year) Ending _____ (Month/Year)

If you answered "YES" to questions 2, 3, and/or 4, please provide a written explanation and/or any supporting documentation that may be relevant.

JOAN Armentrout — Printed name of person completing this form
Joan Armentrout — Signature
9/30/09 — Date

Please affix hospital or notary seal here

Signature of Notary (if applicable) — Date

My commission expires: _____

Please note on this form if there is no hospital or notary seal available.

Please return this form directly to the address above
Thank you for your cooperation.

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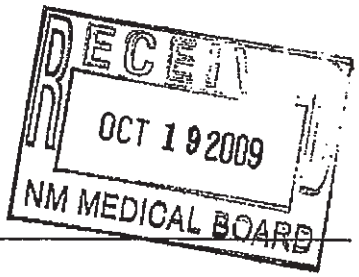
No Hospital or notary seal available

New Mexico Medical Board
2055 S. Pacheco St.
Building 400
Santa Fe, NM 87505
(505) 476-7220



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Susan C Robinson MD
Applicant Name

Susan C Robinson MD
Applicant Signature

10/2005 – 6/2009
*Dates of Privilege/Employment mm/yy to mm/yy (must be provided)

City/State/Zip

Telephone Number

The section below should be completed by the chief of staff or facility's administrative staff.
Letters of Recommendation are ***NOT*** accepted in lieu of this form.

Shellen Sella
Type or Print Name of person completing this form

Associate Physician
Title

Women's Health Care Services
Name of Institution

5107 E. Kellogg
Address

Wichita, KS 67218
City / State / Zip

1. This evaluation is based on: ✓ Observation of applicant ___ Review of personnel file
2. In your estimation, is there any reason why this applicant should not be licensed to practice? ___ Yes ✓ No
3. To your knowledge, is there any mental or physical reason why this applicant should not be licensed? ___ Yes ✓ No
4. To your knowledge, is there any derogatory/disciplinary information regarding this applicant? ___ Yes ✓ No
5. Are the dates of privilege/employment provided by the applicant on this form accurate?* ✓ Yes ___ No

***If not, please provide correct dates**: Beginning _____ Month/Year Ending _____ Month/Year

If you answered "YES" to questions 2, 3, and/or 4, please provide a written explanation and/or any supporting documentation that may be relevant.

Please affix hospital or notary seal here

Shellen Sella Shelle Sella 10/13/09
Printed name of person completing this form Signature Date

No hospital or notary seal available (ES)
Signature of Notary (if applicable) Date

My commission expires: _____

Please note on this form if there is no hospital or notary seal available.
Please return this form directly to the address above
Thank you for your cooperation.

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