Box # 13751

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RT 788

This is to certify that **Savita Ginde, M.D.** has been granted a TRAINING LICENSE to practice as a Medical Resident at the Dartmouth Hitchcock Medical Center, Lebanon or off-site, under faculty supervision, as determined by the facility, as part of their training program.

Service begins 6/28/99 and ends 6/28/02.

Allen Hall
Administrator

(Seal)

This certificate does not entitle holder to practice after the specified date.

2 INDUSTRIAL PARK DRIVE SUITE 8 CONCORD, NH 03301-8520 TDD Access: Relay NH 1-800-735-2964 TEL. (603) 271-1203 FAX (603) 271-670

RT-788

STATE OF NEW HAMPSHIRE

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

RECEIVED
JUN 23 1999
NH BOARD OF MEDICINE

APPLICATION FOR TRAINING LICENSE RESIDENTS AND GRADUATE FELLOWS

****Please print legibly or type.**

NAME OF APPLICANT: Savita Ginde

CURRENT RESIDENCE ADDRESS: ______________________

____

TELEPHONE NUMBER: ______________________

BIRTH DATE ______ ______ ______ (Month Day Year) BIRTH PLACE ______ ______ ______ (City State Country)

MEDICAL SCHOOL(S) American University of the Caribbean

DATES ATTENDED ______________ YEAR M.D. RECEIVED 1997

CURRENT TRAINING HOSPITAL Concord Hospital

TRAINING PROGRAM NH Dartmouth Family Practice Resid

____

TRAINING BEGIN DATE 6 28 99 (Month Day Year) TRAINING FINISH DATE 6 28 02 (Month Day Year)

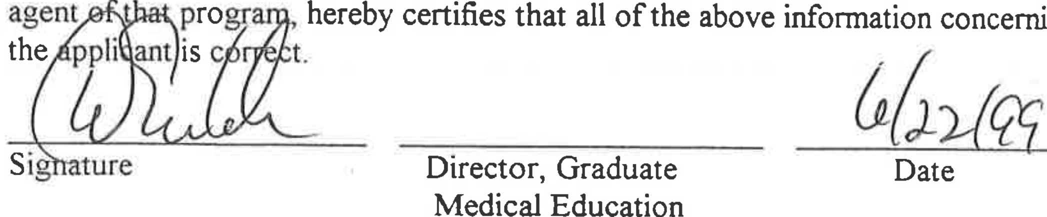
Standard ECFMG Certificate Number (if applicable) ______________________

FEE FOR TRAINING LICENSE IS $10.00. PLEASE MAKE CHECK PAYABLE TO TREASURER, STATE OF NEW HAMPSHIRE.

VERIFICATION BY ACCREDITED PROGRAM

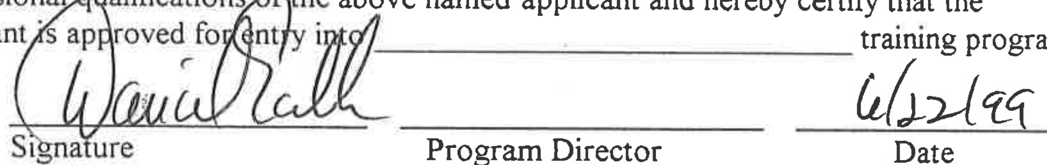
****

The above named applicant will be duly enrolled in the accredited residency or graduate fellowship program designated below, and the undersigned, an authorized agent of that program, hereby certifies that all of the above information concerning the applicant is correct.



Signature ________________ Director, Graduate Medical Education ________________ Date

I, ______________________________, have reviewed the personal and professional qualifications of the above named applicant and hereby certify that the applicant is approved for entry into ______________________________ training program.



Signature ________________ Program Director ________________ Date

SUPPLEMENT TO APPLICATION FOR TRAINING LICENSE AS RESIDENT/FELLOW

YOU ARE REQUIRED TO COMPLETE THE QUESTIONS BELOW:

	YES	NO
1. Have you ever resigned from a medical education program or medical practice position?	___	✓
2. Do you now or have you ever held a license in another state? If so, please list the states.________________ **Original verification of all prior permanent licenses is required.**	___	✓
3. Have you ever been reprimanded, sanctioned, restricted or disciplined in any activities involving medical education or practice?	___	✓
4. Have you ever been convicted of a felony?	___	✓
5. Are you now, or have you been in the past, dependent on alcohol or drugs?	___	✓

If you answered yes to any of the above questions, please provide a complete description on the reverse side. You may attach additional sheets as necessary.

I hereby certify, under penalty of perjury, that all of the information provided in this application is complete and accurate. I also hereby certify that I have read and understand the Medical Practice Act and the Rules of the New Hampshire Board of Registration in Medicine.

NAME (PLEASE PRINT) Savita Y. Ginde

SIGNATURE [signature] DATE 6/17/99