Shannon Carr, MD

Licensed Physician #MD2012-0010

Issue Date	Expiration Date
01/06/2012	07/01/2012

Signature of Holder

The bearer is prohibited by law from using this identification card to give the impression that they are in any way connected with a governmental agency.

New Mexico Medical Board

Triennial Renewal Certificate

This is to certify that

Shannon Carr, MD

License Number: MD2012-0010

Having complied with the provisions of the Medical Practice Act is hereby granted a license to practice in the State of New Mexico as a Physician.

Issue Date: 01/06/2012 Date Expires: 07/01/2012*

**A New Mexico medical license that has not been renewed by July 1 of the renewal year will remain temporarily active with respect to medical practice until September 30 of the renewal year at which time, the status will be changed to lapsed. A lapsed license is not valid for practice in New Mexico.*

This License Must Be Conspicuously Posted In Each Practice Location

New Mexico Medical Board
2055 S. Pacheco Street
Building 400
Santa Fe, NM 87505
505-476-7220 505-476-7233 fax

RECEIVED
NOV 14 2011
NM MEDICAL BOARD

Susana Martinez
Governor

Steven Weiner, M.D.
Chair

Authorization to Release Information

I, SHANNON L. CARR, MD have contracted with
Name of Applicant
FEDERAL CREDENTIALING VERIFICATION SERVICE to assist with the New
Name of Service
Mexico Medical Board's licensure process. The following employees of
UNM FACULTY RECRUITMENT & CREDENTIALING shall be designated
Name of Service
to obtain information regarding the licensure status of my application:

THERESA EVERLING, COORDINATOR

I certify that I have thoroughly read and understand the application instructions and Guidelines for Applicants and Representatives.

SHANNON L. CARR MD
Printed Name

Signature

NOVEMBER 7, 2011
Date

THE NEW MEXICO MEDICAL SOCIETY

New Mexico Hospital Association

The New Mexico Statewide Application for Physician/Practitioner Appointment©

Physician (MD) Application

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Shannon Carr MD

Other Names Used:

☐ Will you be applying by endorsement? Applying using: FCVS endorsement

Are you requesting to be credentialed as a PCP if Family Practice, Internal Medicine, or Pediatrics? ☐ Yes

Gender: F Citizenship: USA Place of Birth: [redacted]

Immigration Status: Certification #:

Social Security Number: [redacted] Date of Birth: [redacted]1966

State Tax ID#: ☐ Pending Fed. Tax ID#: ☐ Pending

Medicare #: ☐ Pending Medicaid #: ☐ Pending

Unique Physician Identification Number (UPIN): ☐ Pending

National Provider Identifier Number (NPI): 1023016789 ☐ Applied

What are your immediate or future Practice Plans in New Mexico?

I will start a fellowship in the department of Obstetrics & Gynecology at the University of New Mexico in July 2012

Current Mailing Address

[redacted]

United States

Telephone Number: [redacted] Faxsimile:

Home address

[redacted]

United States

Cell Phone: Telephone: [redacted] Pager:

Other Practice Locations

Practice Name: Women's Health Associates

330 Sabattus Street

St Mary's Regional Medical Center

Lewiston ME 04240

United States

Telephone Number: 207-777-4300 Facsimile: 207-755-3021

scarrgo2666@yahoo.com

Answering Service: Effective Date: 09/12/2011

Office Manager or Contact Person: Jayme White

Manager's Phone Number:

Practice Limited to: (Clinical Specialty): Obstetrics & Gynecology

Billing Address:

330 Sabattus Street

St Mary's Regional Medical Center ME 04240

United States

Telephone Number: 207-777-4300 Facsimile:

Contact Person:

Practice Associates:

Robert Tardif, DO	Call Coverage:
Carla Burkley, MD	Call Coverage:
Melissa Collard, MD	Call Coverage:

What are the office hours for your Practice or Group Practice? (Provide days/hours):

Monday - Friday/ 8:00AM - 5:00PM

What provisions have been made for after hours?:

providers cover service

EDUCATION

Undergraduate Eductation

College or University: University of ME - Farmington

Department: Degree: Bachelor of Arts

Address: 86 MAIN ST

City: FARMINGTON State/Province: ME Zip Code: 04938-1911

Telephone Number: 207-778-7050 Facsimile: Country: United States

Contact Person: Title:

Email Address: Specialty:

Dates Attended From: 06/92 To: 05/94 Graduation Date: 1994

College or University: University of Illinois, Urbana-Champaign

Department: Degree: Not Completed

Address: 601 E John St.

City: Champaign State/Province: IL Zip Code: 61820-

Telephone Number: 217 244-4637 Facsimile: Country: United States

Contact Person: Title:

Email Address: Specialty:

Dates Attended From: 09/84 To: 12/86 Graduation Date:

College or University: Southwestern Illinois College (Belleville Area Coll.)

Department: 2500 Carlyle Avenue Degree: N/A

Address:

City: Belleville State/Province: IL Zip Code: 62221

Telephone Number: 618-235-2700 Facsimile: Country: United States

Contact Person: Title:

Email Address: Specialty:

Dates Attended From: 01/86 To: 05/86 Graduation Date:

Graduate Education

College or University: University of VT College of Medicine

Department: Office of Student Affairs Degree: Doctor of Medicine

Address: Given E-215 89 Beaumont Ave

City: Burlington State/Province: VT Zip Code: 05405

Telephone Number: 802 656-2045 Facsimile: 802 656-8230 Country: United States

Contact Person: Title:

Email Address: Specialty:

Dates Attended From: 08/94 To: 05/00 Graduation Date:

Residency/Fellowship

College or University: Maine Medical Center

Department: Degree: Obstetrics/Gynecology

Address: 22 Bramhall St.

City: Portland State/Province: ME Zip Code: 04102

Telephone Number: 207-662-2749 Facsimile: Country: United States

Contact Person: Cindy Croteau Title:

Email Address: crotec@mmc.org Specialty: Obstetrics/Gynecology

Dates Attended From: 06/00 To: 06/04 Graduation Date: 2004

WORK HISTORY

Please list all previous practice experience for the previous 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. Please provide written explanation for any gaps in work history of 6 months or more.

Location: St Mary's Regional Medical Center Lewiston From: 09/01/2011 To:

Department: Medical Staffing Dept

Street: 95 Campus Ave | Phone Number: 207 777-8590

City: Lewiston | State/Province: ME | Zip Code: 04240

Contact Person: | Country: United States

Explanation of gap:

Location: Weatherby Locums | From: 10/01/2011 | To: 10/01/2011

Department: 6451 North Federal Hwy, Suite 800

Street: | Phone Number: 800-586-5022 x2312

City: Fort Lauderdale | State/Province: FL | Zip Code: 33308

Contact Person: | Country: United States

Explanation of gap: I was employed through Weatherby Locums for one day of coverage, 10/31/11, at my former place of employment, Miles Memorial Hospital.

Location: All About Women | From: 04/01/2006 | To: 12/01/2006

Department: 195 Fore River Parkway, Suite 440

Street: | Phone Number: 207-553-6920

City: Portland | State/Province: ME | Zip Code: 04102

Contact Person: | Country: United States

Explanation of gap: I covered for this practice for two weekends in the calendar year noted. They employed me directly. This practice was bought by Mercy Hospital Portland, Maine since that time.

Location: Maine Medical Center | From: 06/01/2000 | To: 06/01/2004

Department:

Street: 22 Bramhall St. | Phone Number: 207-662-2749

City: Portland | State/Province: ME | Zip Code: 04102

Contact Person: Cindy Croteau | Country: United States

Explanation of gap:

Location: University of VT College of Medicine | From: 01/01/1997 | To: 12/01/1997

Department: Department of Pathology

Street: E203 Given Bldg, 89 Beaumont Drive | Phone Number: 802-656-0359

City: Burlington | State/Province: VT | Zip Code: 05405

Contact Person: | Country: United States

Explanation of gap:

HOSPITAL AND HEALTHCARE AFFILIATIONS

☐ Are you a PCP? ☑ Do you deliver babies? ☑ Are you an MD, DO, or DPM?

If you answered yes to any question above, you must:

(a) Have admitting privileges at a hospital (list the affiliation in this section) OR
(b) Provide a written explanation as to the arrangements you have made with a physician to admit your patients along with a signed letter from that physician confirming the arrangements, and the name of the facility which your patients will be admitted.

Please list all hospital staff membership and/or healthcare organization affiliations in the past (5) years, and the status (active, courtesy, consulting, etc.). If an institution is no longer in existence, please provide an alternative source of verification. Use a separate page if necessary.

Current Primary Admitting Facility

Name: St Mary's Regional Medical Center Lewiston

Department: Medical Staffing Dept

Street: 95 Campus Ave

City: Lewiston State: ME Zip Code: 04240

Province: Country: United States

Phone Number: 207 777-8590 Facsimile: 207 777-8595

Appointment Dates From: 09/11 To: Present

Type of Appointment: Active

☐ Check here if you have restrictions at this facility, and provide a written explanation below:

Privileges Assigned:

Obstetrics and Gynecology

Check all that apply:

☐ If you have courtesy or consulting privileges at this facility.

☐ If these courtesy or consulting privileges allow you to admit patients.

If your courtesy or consulting privileges do not allow you to admit patients, please provide a written explanation as to the arrangements you have made with a physician to admit your patients, along with a signed letter from that physician confirming the arrangements, and the name of the facility where your patients will be admitted. The signed letter should be forwarded to HSC along with your signature pages and other accompanying documents.

Facility Name

Name: Miles Memorial Hospital

Department: Medical Staff Office

Street: PO Box 4500 35 Miles St

City: Damariscotta State: ME Zip Code: 04543

Province: Country: United States

Phone Number: 207 563-1234 Facsimile:

Appointment Dates From: 09/04 To: 09/11

Type of Appointment: Active

☐ Check here if you have restrictions at this facility, and provide a written explanation below:

Privileges Assigned:

Obstetrics & Gynecology. As I am presently working at St. Mary's Regional Medical Center as my primary admitting facility, I have been made "Consulting" staff at Miles Memorial Hospital.

Check all that apply:

☐ If you have courtesy or consulting privileges at this facility.

☐ If these courtesy or consulting privileges allow you to admit patients.

If your courtesy or consulting privileges do not allow you to admit patients, please provide a written explanation as to the arrangements you have made with a physician to admit your patients, along with a signed letter from that physician confirming

the arrangements, and the name of the facility where your patients will be admitted. The signed letter should be forwarded to HSC along with your signature pages and other accompanying documents.

Name: St Andrew's Hospital-Boothbay Harbor

Department:

Street: PO Box 417

City: Boothbay Harbor State: ME Zip Code: 04538-0417

Province: Country: United States

Phone Number: 207 633-2121 Facsimile:

Appointment Dates From: 09/04 To: 09/11

Type of Appointment: Active

☐ Check here if you have restrictions at this facility, and provide a written explanation below:

Privileges Assigned:

This hospital is a critical access hospital affiliated with Miles Memorial Hospital and I was automatically granted privileges as a result of being active staff at Miles Memorial Hospital. However, 100% of my practice was at Miles Memorial Hospital.

Check all that apply:

☐ If you have courtesy or consulting privileges at this facility.

☐ If these courtesy or consulting privileges allow you to admit patients.

If your courtesy or consulting privileges do not allow you to admit patients, please provide a written explanation as to the arrangements you have made with a physician to admit your patients, along with a signed letter from that physician confirming the arrangements, and the name of the facility where your patients will be admitted. The signed letter should be forwarded to HSC along with your signature pages and other accompanying documents.

Name: Maine Medical Center

Department:

Street: 22 Bramhall St

City: Portland State: ME Zip Code: 04102-3175

Province: Country: United States

Phone Number: 207 871-0111 Facsimile:

Appointment Dates From: 04/06 To: Present

Type of Appointment: Active

☐ Check here if you have restrictions at this facility, and provide a written explanation below:

Privileges Assigned:

Check all that apply:

☐ If you have courtesy or consulting privileges at this facility.

☐ If these courtesy or consulting privileges allow you to admit patients.

If your courtesy or consulting privileges do not allow you to admit patients, please provide a written explanation as to the arrangements you have made with a physician to admit your patients, along with a signed letter from that physician confirming the arrangements, and the name of the facility where your patients will be admitted. The signed letter should be forwarded to HSC along with your signature pages and other accompanying documents.

Name: Mercy Hospital-Portland (web)

Department:

Street: 1445 State St

City: Portland State: ME Zip Code: 04101-3795

Province: Country: United States

Phone Number: 207 879-3000 Facsimile: 879 366-6207

Appointment Dates From: 04/06 To: Present

Type of Appointment: Courtesy

☐ Check here if you have restrictions at this facility, and provide a written explanation below:

Privileges Assigned:

Check all that apply:

☑ If you have courtesy or consulting privileges at this facility.

☐ If these courtesy or consulting privileges allow you to admit patients.

If your courtesy or consulting privileges do not allow you to admit patients, please provide a written explanation as to the arrangements you have made with a physician to admit your patients, along with a signed letter from that physician confirming the arrangements, and the name of the facility where your patients will be admitted. The signed letter should be forwarded to HSC along with your signature pages and other accompanying documents.

PROFESSIONAL REFERENCES

Please list three (3) professional peers familiar with your professional performance in the past five (5) years, (not including current or impending partners or associates in practice).

Name: Carrie Bolander DO Specialty: Ob-Gyn

Address1:

Address2: [redacted]

City: State/Province: [redacted] Zip Code: [redacted]

Email: Country: United States

Phone Number: [redacted] Facsimile:

Name: Mary Brandes MD Specialty: Ob-Gyn

Address1:

Address2: [redacted]

City: State/Province: [redacted]

Email: Country: United States

Phone Number: [redacted]

Name: Amy Etzweiler MD Specialty: Internal Medicine

Address1:

Address2: [redacted]

City: [redacted] State/Province: [redacted]

Email: Country: United States

Phone Num[redacted] Facsimile: [redacted]

Military Service

Branch: ☒ Current

Dates: From: To:

Rank: Type of Discharge:

Immigration

Status: Certification Number:

CLIA

Number (if applicable): Approval Level: Expiration Date:

Certifications

ACLS Certified? No Expires:

ATLS Certified? No Expires:

PALS Certified? No Expires:

ECFMG (Educational Commission for Foreign Medical Graduates)

Number (if applicable): Date Issued:

STATE PROFESSIONAL LICENSE/CERTIFICATION NUMBERS

State: ME Number: 016521 Issue Date: 05/11/2010 Expiration Date: 06/30/2012 ☐ Pending

FEDERAL DRUG ENFORCEMENT ADMINISTRATION (DEA) REGISTRATION

Number: BC8796128 Expiration: 08/31/2013 ☐ Pending

STATE CONTROLLED SUBSTANCE REGISTRATION (CSR)

Number: State: Expiration: ☐ Pending

BOARD/SUBSPECIALTY BOARD CERTIFICATIONS

Are you Board Certified? ☐ Yes ☐ No ☐ N/A

Certified/Recertified by the Board/Subspecialty Board of: Obstetrics and Gynecology

Date Certified: 12/08/2006 Date Last Recertified: Expiration Date: 12/31/2012

Certification Number: 9008732

☑ Accepted for Examination?

☑ If not accepted, have you made application?

If no, provide an explanation:

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. Explain any

gaps or delays in achieving Board certification by the recognized Board in your specialty area.

PROFESSIONAL MEDICAL MALPRACTICE INSURANCE

☐ Do you have current medical malpractice insurance?

(Please list medical malpractice insurance carriers for the past 5 years.)

Current Carrier

Name: [redacted]

Department: [redacted]

Street:

City: [redacted]

Province: Country: United States

Policy #: [redacted]

Dates Insured From: [redacted]

Carrier

Name: [redacted]

Departm

Street:

City:

Province

Policy #: 00

Dates In

LICENSING EXAM: Please check all that apply:

☐ State Board Exam Which State? Date(s) passed?

☐ FLEX	☐ National Board (NMBE)	☑ USMLE
Date Passed: /	Part/Step 1 Date Passed	Part/Step 1 Date Passed 10/97
	Part/Step 2 Date Passed	Part/Step 2 Date Passed 03/99
☐ LMCC	Part/Step 3 Date Passed	Part/Step 3 Date Passed 07/03
Date Passed:		

PROFESSIONAL PRACTICE QUESTIONS

Please answer the following Yes or No questions. If you answer Yes to any question, you must give details including name, address, and telephone number of significant parties. You must respond to each question.

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? No
2. Have you ever been denied professional liability insurance coverage? If yes, explain below. No
3. Has your professional liability carrier ever excluded any specific procedures from your coverage? If yes, explain below. No
4. Have you ever been denied membership or renewal thereof, or been subject to disciplinary action in any professional organization? If yes, explain below. No

5.	Have you ever had any sanctions imposed by Medicare and/or Medicaid?	No
6.	Have you ever been arrested? If so, explain the circumstance, regardless of the outcome (i.e. expunged, dismissed, sealed, vacated).	Yes
7.	Have you ever been named as a defendant in any criminal proceedings?	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?	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)? If yes, explain below.	No
10.	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?	No
	b.) Have you ever agreed not to exercise your clinical privileges while under investigation?	No
11.	Have you ever resigned from a healthcare entity to avoid modification, suspension, or termination of privileges, or while under investigation?	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?	No
	b.) Are any currently held licenses pending investigation or being challenged?	No
13.	Have you ever been notified to appear before any licensing agency for a hearing or complaint of any nature? If yes, explain below.	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?	No
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 for each claim or suit. • Name, age, sex of patient/claimant. • Date(s) and type of treatment and/or surgery that 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.	No
16.	Have you ever been reported to the National Practitioner Data Bank?	No
17.	Are you now, or were you in the past, addicted to, abusive of, or in treatments for abuse of any controlled substances, habit-forming drugs, illegal drugs, prescription medication or alcohol?	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 either has affected 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.	No
19.	Have you ever, for any reason:	
	a) Resigned from a medical school or postgraduate training (PGT) program?	No
	b) Withdrawn from a medical school or postgraduate training program?	No
	c) Been suspended, dismissed, or expelled from a medical school or PGT program?	No
	d) Been placed on probation or remediation, including academic probation or remediation, by a medical school or PGT program?	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 reason, personal or professional (include illness, pregnancy, academic, etc)?	Yes

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

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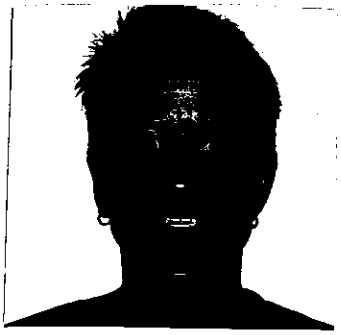
APPLICANT'S OATH

I, Shannon L. Carr **, 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.



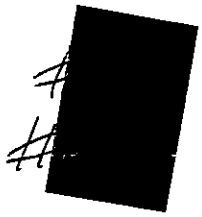
Shannon Carr — November 14, 2011
Applicant Signature — Date

*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.

Applicant Name Shannon Carr — **Date** November 14, 2011
SHANNON L. CARR

Explanations:

6. On April 19, 1990 I was travelling back from Honduras, where I was visiting a friend, into the United States. I was arrested in Houston, Texas for possession of less than 2 ounces of marijuana. I appeared in court in Houston on May 11, 1990 and entered a plea of guilty to the misdmeanor offense of possession of marijuana. I was placed on probation for 6 months which I completed. On November 21, 1990 the Judge of County Criminal Court at Law No. 7 dismissed the charges. Harris County Criminal Court Cause No. 9015388.My Attorney:John E. Ackerman4515 Yoakum BlvdHouston, TX 77006713-237-910019.e. January-December 1997 - I participated in a one year medical student pathology fellowship which I completed at the University of Vermont College of Medicine. May-October 1998 - I was granted half time status during this period of my medical education to travel to Nepal to work in an internship capacity at Tribhuvan University Teaching Hospital, Kathmandu. I also volunteered with two non-governmental organizations; John Snow Institute & JHPIEGO.



American Board of Obstetrics and Gynecology

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

bstetrics and ynecology

Shannon Louise Carr, 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 DECEMBER, 2006 THROUGH DECEMBER 31, 2012
DECEMBER 8, 2006

President — Executive Director

ABOG
First in Women's Health

DIPLOMATE NO. 9008732

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AMA AMERICAN MEDICAL ASSOCIATION

AMA Physician Profile

Name and Mailing Address:

SHANNON LOUISE CARR MD
[redacted]

Primary Office Address:

WOMEN'S HEALTH ASSOCIATES
330 SABATTUS ST
LEWISTON ME 04240-5553

Phone: [redacted]

Birthdate: [redacted]1966

Physician's Major Professional Activity: OFFICE BASED PRACTICE

Practice Specialties Self Designated by the Physician*:

Primary Specialty: OBSTETRICS & GYNECOLOGY

Secondary Specialty: UNSPECIFIED

**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 VT COLL OF MED, BURLINGTON VT 05405

Degree Awarded: Yes

Degree Year: 2000

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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):

Beginning with the 2010 cycle of the National GME Census, post-graduate training segments will include the name of the program attended in addition to the sponsoring institution. Program-level information prior to 2010 will not be available for reporting. Future training dates, as reported by the program, should be interpreted as "in progress" or "current" with the projected date of completion.

Post-graduate training performed at accredited osteopathic institutions or in Canada are updated on the AMA Physician Masterfile only upon verification by the program. US licensing authorities accept graduate medical education from both entities as equivalent to training performed in a US program accredited by ACGME.

Sponsoring Institution: MAINE MED CTR
Sponsoring State: MAINE
Specialty: OBSTETRICS & GYNECOLOGY
Dates: 07/2000 - 06/2004 (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.**

Current and/or Historical Medical Licensure:

Jurisdiction	MD/ DO	Date Granted	Expiration Date	Status	License Type	Last Reported
MAINE	MD	05/12/2004	06/30/2012	ACTIVE	UNLIMITED	10/06/2011
MAINE	MD	07/01/2003	06/30/2004	UNKNOWN	TEMPORARY	06/14/2004
MAINE	MD	07/01/2002	06/30/2003	UNKNOWN	TEMPORARY	08/27/2003
MAINE	MD	07/01/2001	06/30/2002	UNKNOWN	TEMPORARY	08/27/2003
MAINE	MD	07/01/2000	06/30/2001	UNKNOWN	TEMPORARY	08/27/2003

Current and/or Historical NPI Information:

NPI Number	Enumeration Date	Deactivation Date	Reactivation Date	Replacement Number	Last Reported Date
1023016789	07/07/2005	NOT RPTD	NOT RPTD	NOT RPTD	10/28/2011

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AMA AMERICAN MEDICAL ASSOCIATION

AMA Physician Profile

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
XXXXXX128	22N 33N 4 5	08/31/2013	11/07/2011

Address: Women's Center/Mmg, 24 Miles Center Way, Damariscotta, ME 04543-4067

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.

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	Reverification	Occurrence	Last Reported
TIME LIMITED	12/31/2011	12/31/2012		RE-CERT	11/03/2011
TIME LIMITED	12/31/2010	12/31/2012		RE-CERT	11/03/2011
TIME LIMITED	12/31/2009	12/31/2012		RE-CERT	11/03/2011

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.

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AMA
AMERICAN
MEDICAL
ASSOCIATION

AMA Physician Profile

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.

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 60654
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.

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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

November 15, 2011

Attn: Lynn S. Hart
New Mexico Medical Board
Lynn S. Hart
2055 S. Pacheco St, Ste 400
Santa Fe, NM 87505-0503

Re: Board Action Query Dated: November 15, 2011
Your Reference Number:
FSMB Batch Number: BQ1991989

The following is a report of the search results from the Board Action Data Bank as of November 15, 2011 for practitioners submitted as part of the above-referenced batch for which NO board actions were identified.

Practitioners Cleared with No Actions as of November 15, 2011

Item	Name	DOB	School	Yr/Grad	Request ID
2	Carr, Shannon	[redacted]1966	046010	2000	24438890

LICENSE HISTORY
State Board
MAINE

[redacted]

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.

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

RECEIVED
DEC 19 2011
NM MEDICAL BOARD

PROFESSIONAL RECOMMENDATION

The New Mexico Medical Board requires the completion of this Professional Recommendation by a physician or a Chief of Staff or a Department Chief with whom I have worked and who has personal knowledge of my character and competence to practice medicine. This form is required as part of my application for licensure. ***All*** elements in the section below ***must*** be completed. The lower half of the form may be used for narrative comment. This is my authorization to release all information in your files, favorable or otherwise, DIRECTLY to the NMMB, 2055 S. Pacheco St., Bldg. 400, Santa Fe, NM 87505.

Applicant's Name: Shannon L. CARR Date of Birth [redacted] 66

Applicant' Signature: Shannon Carr Date: 12/13/2011

Address: [redacted]

ALL ELEMENTS IN THIS SECTION MUST BE COMPLETED BY THE RECOMMENDING PHYSICIAN
The information on this form is NOT a public document.

1. Date and type of service: This individual served with me as a colleague
from 7/2002 (Month/Year) to 10/2011 (Month/Year) at Maine Medical and Miles Memorial (Location)

2. Please evaluate:

	(Please indicate with check mark)			
	Poor	Fair	Good	Superior
Professional knowledge				✓
Clinical judgment				✓
Relationship with patients				✓
Ethical/professional conduct				✓
Ability to communicate				✓
Clinical skills				✓

3. Recommendation: (please indicate with a check mark)
1. Recommend highly and without reservation ✓
2. Recommend as qualified and competent
3. Recommend with some reservation (explain)
4. Concerns (explain)

4. Of particular value in evaluating the candidate is information regarding any notable strengths and weaknesses (including personal demeanor). We would appreciate your comments.
Universally liked and Respected by patients and co-workers

5. The above report is based on: (please indicate with check mark)
1. Close personal observation ✓
2. General impression
3. A composite of evaluations
4. Other

Name (Please Print): ANDREW RUSS Title: MD Phone: [redacted]

Signature: [signature] Date: 12/15/11

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

RECEIVED
DEC 23 2011
NM MEDICAL BOARD

PROFESSIONAL RECOMMENDATION

The New Mexico Medical Board requires the completion of this Professional Recommendation by a physician or a Chief of Staff or a Department Chief with whom I have worked and who has personal knowledge of my character and competence to practice medicine. This form is required as part of my application for licensure. ***All*** elements in the section below ***must*** be completed. The lower half of the form may be used for narrative comment. This is my authorization to release all information in your files, favorable or otherwise, DIRECTLY to the NMMB, 2055 S. Pacheco St., Bldg. 400, Santa Fe, NM 87505.

Applicant's Name: Shannon L. Carr Date of Birth [redacted] 66

Applicant' Signature: Shannon Carr Date: 12/13/2011

Address: [redacted]

ALL ELEMENTS IN THIS SECTION MUST BE COMPLETED BY THE RECOMMENDING PHYSICIAN
The information on this form is NOT a public document.

1. Date and type of service: This individual served with me as Chief Resident 2004-2005 / Locums for our Office All Ass Women 2005-2006 - Locums

from 08/04 (08/05) Month/Year to 06/05 (08/06) Month/Year at Maine Medical Center (All Assoc Women Portsmouth) Location

2. Please evaluate:

(Please indicate with check mark)

	Poor	Fair	Good	Superior
Professional knowledge				X
Clinical judgment				X
Relationship with patients				X
Ethical/professional conduct				X
Ability to communicate				X
Clinical skills				X

3. Recommendation: (please indicate with a check mark)

1. Recommend highly and without reservation — X
2. Recommend as qualified and competent
3. Recommend with some reservation (explain)
4. Concerns (explain)

4. Of particular value in evaluating the candidate is information regarding any notable strengths and weaknesses (including personal demeanor). We would appreciate your comments.

Excellent w/ Patients
Team leader / Respectful to Staff

5. The above report is based on: (please indicate with check mark)

1. Close personal observation — X
2. General impression
3. A composite of evaluations
4. Other

Name (Please Print): Lisa Persons Title: DO Phone: [redacted]

Signature: [signature] Date: 12/18/11

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

Paul R. LePage
GOVERNOR

SHERIDAN R. OLDHAM, M.D.
CHAIRMAN

RANDAL C. MANNING, M.B.A
EXECUTIVE DIRECTOR

November 21, 2011

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:	SHANNON L CARR, M.D.
License Number:	MD16521
Issue Date:	05/12/2004
Expiration Date:	06/30/2012
Current Status:	A
Disciplinary Action:	No

Examination Information:

Exam Date	Exam State	Exam Type	Exam Status	Exam Score	Exam Details
		USMLE 1 USMLE 2 USMLE 3			
	ME	WRITTEN EXAM	PASSED		

This license information was last updated on: 11/18/2011

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

Sincerely,

Randal C. Manning
Executive Director

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

RECEIVED
DEC 19 2011
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.**

Shannon L. Carr
Applicant Name

[redacted]

Applicant Signature

09/11 - PRESENT
*Dates of Privilege/Employment mm/yy to mm/yy (must be provided)

[redacted]
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.

JAYME WHITE
Type or Print Name of person completing this form

PRACTICE MANAGER
Title

WOMEN'S HEALTH ASSOCIATES - ST. MARY'S MEDICAL CENTER
Name of Institution

330 Sabattus St.
Address

LEWISTON, ME 04243
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.

JAYME L. WHITE — 12/16/11
Printed name of person completing this form — Signature — Date

Please affix hospital or notary seal here

Rebecca S. Cyr — 12/16/11
Signature of Notary (if applicable) — Date

My commission expires: 01/27/2013

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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NOV 21 2011
NM MEDICAL BOARD

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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.**

RECEIVED
NOV 21 2011

Shannon L. Carr
Applicant Name
[redacted]
Address
City

Applicant Signature
09/11 - present
*Dates of Privilege/Employment mm/yy to mm/yy (must be provided)
Telephone [redacted]

Letters of Recommendation are ***NOT*** accepted in lieu of this form.

Lori Lachance
Type or Print Name of person completing this form
Privileging Specialist
Title
St. Mary's Regional Medical Center
Name of Institution
100 Campus Ave
Address
Lewiston ME 04240
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.

Lori B. Lachance — Printed name of person completing this form
Lori — Signature
11/17/11 — Date

Please affix hospital or notary seal here

Monique R. Menier — Signature of Notary (if applicable)
11/17/11 — Date

My commission expires: 02/02/2012

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

Weatherby HEALTHCARE™

RECEIVED
DEC 14 2011
NM MEDICAL BOARD

Work History Report

1 record(s) found

Shannon L. Carr, MD

OB/GYN

Generated on 12/12/2011 @ 12:05:40

Assignment Dates	Facility	Worksite
10/31/2011 - 11/01/2011	MILES HEALTH CARE	MILES HEALTH CARE BRISTOL ROAD, RR 2, BOX 4500 DAMARISCOTTA, ME 04543 207-563-4205

[redacted]

Weatherby HEALTHCARE™

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DEC 14 2011
NM MEDICAL BOARD

December 12, 2011

New Mexico Board of Medicine
2055 S. Pacheco Street
Building 400
Sante Fe, NM 87505

RE: Shannon Carr, MD – Request for Information

Dear Sir or Madam,

This is in response to your request for information concerning the above-referenced physician.

Please be advised that this physician worked on a locum tenens basis as an independent contractor for Weatherby Locums (a subsidiary of CHG Healthcare Services, Inc., of "CHG"). CHG is a medical staffing company. Enclosed with this letter please find a list of dates and locations that Dr. Shannon Carr worked through CHG. It is the policy of CHG to only provide dates and locations of independent contractor locum tenens services. CHG encourages you to contact the locations of work directly for further information related to this physician's practice of medicine and personal attributes.

Sincerely,

Eve Mordetsky

Eve Mordetsky
Medical Staff Services, Weatherby Locums
CHG Healthcare Services, Inc.
(800) 586-5022 Ext-3038

Lynn Cheryl Hannon

NOTARY PUBLIC STATE OF FLORIDA
LYNN CHERYL HANNON
MY COMMISSION # DD 866361
EXPIRES: May 25, 2013
Bonded Thru Budget Notary Services

Encl.: *Work History (if any)*

6451 North Federal Highway Suite 800 Fort Lauderdale, FL 33308
office 800.586.5022
fax 866.588.0085
www.weatherbyhealthcare.com

RED RIBBON SERVICE

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

RECEIVED
DEC 19 2011
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.**

Shannon Carr
Applicant Name

[redacted]
Address

[redacted]
City/State

Applicant Signature

09/04 - PRESENT
*Dates of Privilege/Employment mm/yy to mm/yy (must be provided)

[redacted]
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.

Anne Russell
Type or Print Name of person completing this form

Executive Administrative Assistant
Title

Mibes Memorial Hospital
Name of Institution

35 Mibes ST.
Address

Damariscotta, ME, 04543
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 08/2004 (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.

Anne Russell — Anne Russell — 12/13/11
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
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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DEC 19 2011
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.**

Shannon Cahn
Applicant Name

[redacted]
Address

[redacted]
City

Applicant Signature

09/04 - PRESENT
*Dates of Privilege/Employment mm/yy to mm/yy (must be provided)

[redacted]
Telephone

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.

Anne Nusseas
Type or Print Name of person completing this form

Executive Administrative Asst.
Title

St. Andrews Hospital
Name of Institution

PO Box 417
Address

Bath/Boothbay Harbor ME. 04538
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 04/2008 (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.

Anne Nusseas — Anne Nusseas — 12/13/11
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
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

RECEIVED
DEC 19 2011
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.**

SHANNON L-CARR
Applicant Name

[redacted]
Address

City/State/Zip

Applicant Signature

06/00 - 06/04 SEE PRESENT
*Dates of Privilege/Employment mm/yy to mm/yy (must be provided)

[redacted]
Telephone Number

Attending Staff

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.

Hector M TARRAZA M.D.
Type or Print Name of person completing this form

Dept Chair, OB/GYN
Title

Maine Medical Center
Name of Institution

22 Bramhall Street
Address

Portland, ME 04102
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

Hector M. Tarraza H.M. TARRAZA 12/14/11
Printed name of person completing this form Signature Date

Cynthia L Cutter 12/14/11
Signature of Notary (if applicable) Date

My commission expires: 09-20-2012

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

RECEIVED
DEC 16 2011
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.**

Stannard Cove
Applicant Name [redacted]

Applicant Signature

Addre [redacted]

*Dates 04/06 - PRESENT ust be provided)

City/S [redacted]

Telepho [redacted]

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.

Janet E. Cole
Type or Print Name of person completing this form

Medical Staff Support Specialist
Title

Mercy Hospital
Name of Institution

144 State St
Address

Portland, ME 04101
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 4/06 (Month/Year) Ending Present (Month/Year) Per Janet Cole @ Mercy Hosp. 1/4/12 BK

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.

Janet E. Cole — Printed name of person completing this form
JE Cole — Signature
12/13/11 — Date

Please affix hospital or notary seal here

Signature of Notary (if applicable)
12/13/11 — Date

My commission expires: 5/1/15

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

FREDERICA JACKSON
Notary Public, Maine
My Commission Expires May 1, 2015

The Federation of State Medical Boards of the United States, Inc.
Federation Credentials Verification Service
400 Fuller Wiser Road, Suite 300
Euless, Texas 76039
Telephone: (817) 868-5000
Fax: (817) 868-5099

RECEIVED
JAN 11 2012
NM MEDICAL BOARD

Physician Information Profile

This report is compiled exclusively for:

Name:	**Shannon Louise Carr**
SSN:	[redacted]
DOB:	[redacted]1966
Packet ID:	**39936**
Recipient:	**New Mexico Medical Board**

NOTICE:

The Federation Credentials Verification Service (FCVS) was retained by the above referenced physician to verify his/her medical credentials for submission to your agency/organization. Unless noted otherwise, all documents contained in this report were received directly from the issuing institution per written request made by FCVS.

NOTICE: All documents bearing an original Official FCVS seal are certified to be an exact reproduction of the original. Where required, original documents are provided according to the agreements with the Institution issuing such document. FCVS maintains all original documents (excluding third-party examination transcripts) in the physician's source file.

This FCVS Physician Information Profile ("Profile") is compiled and provided by the Federation of State Medical Boards of the United States, Inc. (Federation) as a reference source for, and only for, its member boards and other entities authorized by the Federation. The Profile embodies and contains confidential business information because the information, and the format and presentation of that information, comprise trade secrets of the Federation and because the Profile's disclosure would harm the Federation by providing others with an unfair business advantage in competing with the Federation's FCVS services. Further, the form of the Profile and the contents of this Profile, including the compilation of information in this Profile, are the Federation's copyrighted works and proprietary, confidential information and are subject to the protections of United States laws governing copyright, trademark and trade secrets, as well as various state laws protecting the Federation's trade secrets and other intellectual property rights. This Profile and its contents may not be (1) copied, reformatted, modified, published or displayed publicly or (2) used, disclosed, distributed, shared or sold, in whole or part, for any purpose, including use to establish any database or files as a compendium or otherwise, all of which is strictly prohibited without the express written consent of the Federation's CEO.

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Table of Contents

Section I

FCVS Reports

FEDERATION CREDENTIALS VERIFICATION SERVICE

Physician Information Report

Identity:

Name:	**Shannon Louise Carr**
Other Name Used:	**Shannon Carr**
Gender:	**Female**
Date of Birth:	[redacted]1966
Place of Birth:	[redacted]
SSN:	[redacted]
Current Address:	[redacted]
Permanent Address:	**Same**
Telephone Numbers:	Bus: [redacted] Fax: Home: Other:
Physical Description:	Height: **5' 03"** Weight: **120 lbs** Eye Color: **Brown** Hair Color: **Brown**
Physical Marks:	Description: **N/A** Location: **N/A**

Premedical Education (Reported by physician. Not verified by FCVS):

Institution:	**University of Illinois - Champaign/Urbana, Urbana, IL 61801**
Dates of Attendance:	**09/1984 - 12/1986**
Degree Conferred/Issued:	**None**
Institution:	**University of Maine Garmington, Farmington, VT 04938**
Dates of Attendance:	**06/1992 - 05/1994**
Degree Conferred/Issued:	**Bachelor of Arts**

Medical Education:

Medical School:	**University of Vermont College of Medicine** **360 Waterman** **85 South Prospect Street** **Burlington, VT 05405**
Dates of Attendance:	**08/16/1994 - 04/30/2000**
Date Degree Conferred/Issued:	**05/21/2000**
Degree Conferred/Issued:	**Doctor of Medicine**
Unusual Circumstance:	**Leave** **See Form**

Graduate Medical Education:

Institution:	**Maine Medical Center** **Department of Obstetrics and Gynecology** **22 Bramhall Street** **Portland, ME 04102**
Training Level:	**1**
Program Type:	**Internship**
Specialty/Subspecialty:	**Obstetrics and Gynecology**
Dates of Attendance:	**07/01/2000 - 06/30/2001**
Completion:	**Yes**
Accreditation:	**ACGME**
Training Level:	**2-3**
Program Type:	**Residency**
Specialty/Subspecialty:	**Obstetrics and Gynecology**
Dates of Attendance:	**07/01/2001 - 06/30/2003**
Completion:	**Yes**
Accreditation:	**ACGME**
Training Level:	**4**
Program Type:	**Chief Resident**
Specialty/Subspecialty:	**Obstetrics and Gynecology**
Dates of Attendance:	**07/01/2003 - 06/30/2004**
Completion:	**Yes**
Accreditation:	**ACGME**
Unusual Circumstance:	**None**

Fifth Pathway:

N/A

Examination History:

Licensure Examinations:	**USMLE Step 1** **USMLE Step 2** **USMLE Step 3**

Board Action:

A Report of the results from a search of the Board Action Data Bank is enclosed.

Credentials Analysis Report

The Credentials Analysis Report is a comparative report of a physician's credentials as reported to FCVS by the physician applicant and the primary source (Medical School, PGT program, etc.). It will also list particular missing documentation, if any, as outlined in the FCVS Policies and Procedures.

Physician Identification:

Name:	Shannon Louise Carr
DOB:	[redacted]1966
SSN:	[redacted]
Packet ID:	39936
Request ID:	24416949

OMISSIONS

There are none identified.

DISCREPANCIES

Disrepancy 1:

Section of Profile: **Medical Education**

Omission: The applicant responded No to all of the questions in the Unusual Circumstances Section of the application for attendance at Univ Vermont Col Of Med. The institution responded Yes to the Leave question in the Unusual Circumstances Section of the Verification of Medical Education form.

Follow-Up: FCVS does not follow up with the applicant or the institution with discrepant information on Unusual Circumstances questions. Any supporting information provided by the applicant and/or institution is included in the Physician Information Profile.

MISCELLANEOUS INFORMATION

Miscellaneous 1:

Section of Profile: **Identity**

Issue: The applicant did not provide a photocopy of a birth certificate, passport, court order, baptismal certificate, naturalization certificate, marriage certificate or divorce decree to support alternate names, as requested by FCVS.

Follow-Up: FCVS has made several unsuccessful attempts to obtain documentation to support the alternate name from the applicant; the applicant was unable to provide one. In lieu of the document, FCVS obtained an explanation from the physician. See the Name Explanation Form included.

End of report for Shannon Louise Carr

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

January 10, 2012

Attn: Tracy Bevers
FCVS
Tracy Bevers
400 Fuller Wiser Rd., #209
Euless, TX 76039

Re: Board Action Query Dated: January 10, 2012
Your Reference Number:
FSMB Batch Number: BQ2012922

The following is a final report of the search results from the Board Action Data Bank as of January 10, 2012 for practitioners submitted as part of the above-referenced batch for which NO board actions were identified.

Practitioners Cleared with No Actions as of January 10, 2012

Item	Name	DOB	School	Yr/Grad	Request ID
11	Carr, Shannan Louise	[redacted]966	046010	2000	24722191

LICENSE HISTORY
State Board
MAINE

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.

AMERICAN BOARD OF MEDICAL SPECIALTIES
VERIFICATION OF CERTIFICATION

As of: 1/10/2012

State Queried For:	New Mexico Medical Board
Physician Name:	Shannon Louise Carr
Date of Birth:	[redacted]1966
Year of Graduation:	(Doctor of Medicine)
Social Security Number:	[redacted]
ABMSU ID:	853880

Certification:

Board:	Obstetrics and Gynecology
Specialty:	Obstetrics and Gynecology
Status:	ACTIVE
Initial Certification:	12/08/2006

All information on the ABMS report is based on a search of data shared with the FSMB by the American Board of Medical Specialties. For some physicians the biographic data in the ABMS database is incomplete and is not included in the shared data. FCVS is unable to verify specialty certification on these physicians. FCVS does not follow up with the applicant or ABMS on any missing or discrepant information.

Section II

Identity

AFFIDAVIT AND RELEASE

I, the undersigned, hereby certify under oath that I am the person named in this application, that all statements I have or shall make with respect thereto are true, that I am the original and lawful possessor 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 "INSTRUCTIONS FOR COMPLETING THE FCVS APPLICATION" 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 Federation Credentials Verification Service 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 Federation Credentials Verification Service 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 Federation Credentials Verification Service, its agents or representatives and any person furnishing information, of any and all liability of every nature and kind arising out of investigation made by the Federation Credentials Verification Service. I authorize the Federation Credentials Verification Service to release information, material, documents, orders or the like relating to me or this application to any entity at my request.

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

CARR

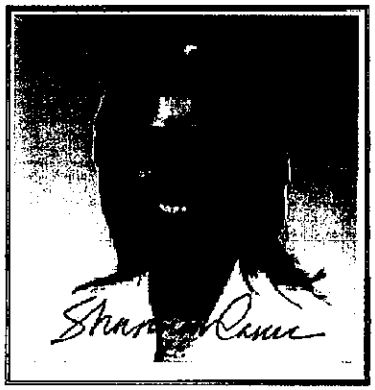
Applicant's **Printed** Last Name

SHANNON, L.

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

March 9, 2004

Date of Signature (must correspond to date of notarization)



State of Maine, County of Cumberland,
I certify that on the date set forth below the individual named above did appear personally before me and that I did identify this applicant by: (a) comparing his/her physical appearance with the photograph on the identifying document presented by the applicant and with the photograph affixed hereto, and (b) comparing the applicant's signature made in my presence on this form with the signature on his/her identifying document. The statements on this document are subscribed and sworn to before me by the applicant on this 9th day of March 9, 2004.

Notary Public signature: Cynthia A Croteau

CYNTHIA A. CROTEAU
Notary Public, Maine
My Commission Expires September 11, 2005

My commission expires: 9-11-2005

Notary:
The Physician has been instructed to sign the front of the photograph. Your seal (or stamp) must be partly upon the photo and partly upon the signature of the applicant.

Federation Credentials Verification Service

EXPLANATION OF ALTERNATE NAME FORM

Use this form to explain the use of any name(s) not supported by the identity document(s) submitted with your application. Do not write on the back of this form. If additional space is required, please make a photocopy(ies). Be certain to sign the form in the space provided at the bottom of the page.

Documented Name
The name reported here must be the name on your identity document

Last Name (Surname) and Generational Suffix: Carr
First and Middle Name(s): Shandon

Last Name (Surname) and Generational Suffix: Carr
First and Middle Name(s): Shandon Louise

Explanation of Use of Name:
I was born on my great grandmother's birthday - her given name was Louise. I have used Louise as my middle name since childhood. My passport and social security card document this name. Documentation has been forwarded

Last Name (Surname) and Generational Suffix:
First and Middle Name(s):
Explanation of Use of Name:

Last Name (Surname) and Generational Suffix:
First and Middle Name(s):
Explanation of Use of Name:

Signature (Required)
Signature: [signature]
Date: 4/21/04

Federation Credentials Verification Service

The Secretary of State
of the United States of America
hereby requests all whom it may concern to permit the citizen/national of the United States named herein to pass without delay or hindrance and in case of need to give all lawful aid and protection.

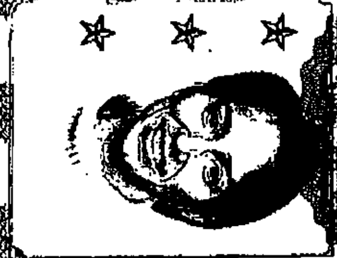
Le Secrétaire d'Etat
des Etats-Unis d'Amérique
prie par les présentes toutes autorités compétentes de laisser passer le citoyen ou ressortissant des Etats-Unis titulaire du présent passeport, sans délai ni difficulté et, en cas de besoin, de lui accorder toute aide et protection légitimes.

SIGNATURE OF BEARER/SIGNATURE DU TITULAIRE

NOT VALID UNTIL SIGNED

UNITED STATES OF AMERICA

PASSPORT
PASSEPORT



Type/Catégorie: P
Code of Issuing State/Code du pays émetteur: USA
PASSPORT NO./NO. DU PASSEPORT: 102813014

Surname / Nom
CARR
Given names / Prénoms
SHANNON LOUISE
Nationality / Nationalité
UNITED STATES OF AMERICA
[redacted]
Sex / Sexe: F
Place of birth / Lieu de naissance: NEW YORK, U.S.A.
Date of issue / Date de délivrance: 04 MAR/MAR 98
Date of expiration / Date d'expiration: 03 [illegible]/MAR [illegible]
Authority / Autorité
PASSPORT AGENCY
BOSTON
Amendments/Modifications
SEE PAGE 24

P<USACARR<<SHANNON<LOUISE<<<<<<<<<<<<<<<<<<<<
[illegible]28130[illegible]8USA6606264F0803038<<<<[illegible]<<<<[illegible]8

YOUR SOCIAL SECURITY CARD

Detach the card below and sign it in ink immediately.
Keep your card in a safe place to prevent loss or theft.
Do not laminate your card.

[illegible] this stub with your personal records. The other side contains important [illegible]mation.

SOCIAL SECURITY

[redacted]

THIS [redacted]

SHANNON LOUISE CARR

SIGNATURE

SHANNON LOUISE CARR
[redacted]

Section III

Medical Education

DERATION CREDENTIALS VERIFICATION SER[illegible] (FCVS)

VERIFICATION OF MEDICAL EDUCATION

(This form must be completed by the medical school)

INSTRUCTIONS TO THE DEAN

The individual identified on the attached Authorization For Release of Information, Documents and Records form has authorized your medical school to provide to the Federation Credentials Verification Service (FCVS) any and all information pertaining to their education at your institution. **Please complete this form and forward it to FCVS in the enclosed postage-paid, self-addressed envelope.**

Please note: If your institution processes transcript requests through another office, FCVS has likely made such a request under separate cover. **If your office also processes transcript requests, please attach the individual's official transcript (which indicates courses taken, dates and hours of attendance, and scores, grades, or evaluation).**

VERIFICATION OF MEDICAL EDUCATION

Name of Institution: University of Vermont College of Medicine

Complete Address: Student Affairs, Given E-215

Street Address: 89 Beaumont Ave

City: Burlington **State:** VT **ZIP Code (Postal Code):** 05405

If name of institution was different when this individual attended, please note this name below:

Premedical Education:

Years of education required for admission to your medical school: three years college level

Credential/degree presented by the applicant for admission to your medical school: BA

Enrollment and Participation: Our records indicate that Carr, Shannon Loiuse
(type/print individual's name: Last, First, Middle, Suffix)

attended our medical school for total of 164 weeks of medical education on the following dates (mm/dd/yy):

From 8 / 16 / 1994 (Month / Date / Year) **To** 4 / 30 / 2000 (Month / Date / Year)

This individual (check one):

[x] was awarded the degree of Doctor of Medicine on 5 / 21 / 2000 (Month / Date / Year)

[ ] was NOT awarded a degree (please attach an explanation)

Certification: By my signature, I, Marga Susan Sproul, M.D. (type/print name) certify that the above information is an accurate account of the above named individual's official records maintained in this and is true and correct to my knowledge.

Affix Institutional Seal Here. If no seal is available, this form must be notarized.

SEAL VERIFIED

Signature: Marga Susan Sproul

Title: Associate Dean for Student Affairs

Date of Signature: 4/15/2004

Phone: (802) 656-2150 **Fax:** (802) 656-9377

Email:

VERIFICATION OF MEDICAL EDUCATION (continued)

Unusual Circumstances: The following questions apply to unusual circumstances that occurred during any part of the individual's medical education. Please check the appropriate response and provide dates and requested information. "Yes" responses to any of these questions require a copy of explanatory records or a written explanation (attach additional pages as necessary).

1. Do this individual's official records reflect (an) interruption(s) or extension(s) in his/her medical education?
   Response YES [X] NO [ ]

   If YES, please select the reason(s) for, indicate the dates of the interruption(s) or extension(s) and check whether the interruption/extension was approved or unapproved.

	From Mo/Yr	To Mo/Yr	Approved	Unapproved
Personal/Family			[ ]	[ ]
Academic remediation			[ ]	[ ]
Health			[ ]	[ ]
Financial			[ ]	[ ]
Participation in joint degree Program (e.g., MD/PhD)			[ ]	[ ]
Participation in non-research special study (e.g., fellowship, international experience)	Pathology Fellowship 1/97-12/97 International elective 4/99-11/99		[X]	[ ]
Participation in non-degree research			[ ]	[ ]
Other			[ ]	[ ]

Please Specify: _____

2. Do this individual's official records reflect that he/she was ever placed on academic or disciplinary probation during his/her medical education? Response YES [ ] NO [X]

   If YES, please select the reason(s) for the probation, indicate the date(s) of placement on and removal from probation and attach additional documentation to this report.

	From Mo/Yr	To Mo/Yr
Academic Probation		
Probation for unprofessional conduct/behavioral		
Probation for other reason		

Please specify reason: _____

3. Do this individual's official records reflect that he/she was ever disciplined for unprofessional conduct/behavioral reasons by the medical school or parent university? Response YES [ ] NO [X]

   If YES, please provide detailed documentation/information about the circumstances and outcome(s):

4. Do this individual's official records reflect that he/she was ever the subject of negative reports or an investigation by the medical school or parent university? Response YES [ ] NO [X]

   If YES, please provide detailed documentation/information about the circumstances and outcome(s):

5. Do this individual's official records reflect that there were any limitations or special requirements imposed on the individual because of questions of academic incompetence, disciplinary problems, or any other reason?
   Response YES [ ] NO [X]

   If YES, please provide detailed documentation/information about the nature of the limitations or special requirements.

RECEIVED APR 20 2004

Dean's Letter of Evaluation for Shannon Louise Carr, '00

INTRODUCTION

Shannon Carr grew up in Freeburg, Illinois and graduated from Freeburg Community High School in 1984. She subsequently enrolled at the University of Illinois at Urbana, Illinois, where she studied biomechanical engineering for two and a half years.

In 1987 Ms. Carr left college and moved to New York, New York. She worked as an audio engineer at a major recording studio and completed a one-year course of study at the Institute of Audio Research in New York. While in New York she volunteered at soup kitchens and shelters.

In 1992 Ms. Carr left her work in the music industry and relocated to Augusta, Maine. She enrolled as a full time student at the University of Maine at Farmington, Maine, where she completed a major in biology. She earned the B.A. degree *magna cum laude* in 1994.

While at the University of Maine she volunteered in the Veterans Administration Medical Center in Togus, Maine and was active in the Tri-Beta Biological Honor Society and the French Club. She worked part time as a laboratory assistant for biology courses and tutored anatomy, physiology, and biology.

BASIC SCIENCE CORE

Ms. Carr enrolled at the University of Vermont College of Medicine in August 1994. She completed the Basic Science Core and earned a grade of "honors" in General Pathology and Medical Microbiology. She earned a grade of "pass" in all her remaining courses.

Only twenty-three students in this class earned honors grades in two or more courses. This was a strong performance by Ms. Carr.

Ms. Carr's tutor in the first year of the Basic Clerkship said:

> Ms. Carr completed a thorough physical examination within an appropriate amount of time. She briefly and comfortably explained each step. She appears competent with the diagnostic instruments.

During the summer following her first year she took a clinical elective in family practice and pediatrics in Middlebury, Vermont. Her preceptor said:

Applicant: Print your complete last name: CARR

17. U.S./Canadian Medical Education

Complete this page only if you have attended a medical school located in the U.S. or Canada.

List all the medical schools you attended in chronological order.

You may photocopy this page to report more than two (2) institutions if necessary.

If your medical school is outside of the United States, and/or you participated in a Fifth Pathway program, proceed to the next page.

If necessary, you may continue your explanation of Unusual Circumstances on a separate 8.5" x 11" sheet of paper. Your response may not exceed 100 words per question.

DOCUMENTATION: You must include a complete, legible photocopy of your medical school diploma.

If a break of six (6) months or more occurred between medical schools attended or between graduation from medical school and your first year PGT, please provide a written explanation outlining your activities during this "gap" period on the enclosed Gap Explanation Form.

UNIVERSITY OF VERMONT

COLLEGE OF MEDICINE

Complete name of Institution #1 (Do not abbreviate)

BURLINGTON — City — VT — State

From: 08 (Month) 1994 (Year) To: 05 (Month) 2000 (Year) Degree ☐ None ☒ MD ☐ DO ☐ MD/PhD combined ☐ Did not graduate

Exact date of graduation: 05 (Month) 21 (Day) 2000 (Year)

Unusual Circumstances (circle yes or no):

Did you ever take a leave(s) of absence or break(s) from your medical education?	Yes (No)
Were you ever placed on probation?	Yes (No)
Were you ever disciplined or placed under investigation?	Yes (No)
Were any negative reports ever filed against you?	Yes (No)
Were any limitations or special requirements imposed on you because of academic, incompetence, disciplinary problems or for any other reason?	Yes (No)

Please explain any "Yes" responses from above:

Complete name of Institution #2 (Do not abbreviate)

City — State

From: Month Year To: Month Year Degree ☐ None ☐ MD ☐ DO ☐ MD/PhD combined ☐ Did not graduate

Exact date of graduation: Month Day Year

Unusual Circumstances (circle yes or no):

Did you ever take a leave(s) of absence or break(s) from your medical education?	Yes No
Were you ever placed on probation?	Yes No
Were you ever disciplined or placed under investigation?	Yes No
Were any negative reports ever filed against you?	Yes No
Were any limitations or special requirements imposed on you because of academic, incompetence, disciplinary problems or for any other reason?	Yes No

Please explain any "Yes" responses from above:

Shannon was very pleasant and enthusiastic student who got along well with the health care team.

Ms. Carr's tutor for the second year of the Basic Clerkship observed:

Shannon showed excellent progress. Her interactions with patients are professional. Her physical examination skills are good, and her written work is very strong.

CLINICAL SCIENCE CORE

The following are comments taken from evaluations submitted by attending and resident physicians who supervised Ms. Carr during the Clinical Science Core. The evaluations are presented in the order in which the rotations were completed.

Family Practice: Shannon was very eager to learn. She is an exceptional student. **PASS**

Internal Medicine: Shannon was reliable and thorough. She is already developing that sixth sense about differentiating between who is sick and who is not that any good physician needs. She adjusted quickly to clinical demands and became actively involved with the patients. She established good rapport and easily integrated herself into the team. She demonstrated independent learning through literature searches and use of a computer database. She functioned well above her training level. She is extremely hard working, highly compassionate, and mature. She is very much a team player. She has an amazing fund of knowledge. She is an eager and energetic student who has good rapport with her patients. She often made useful suggestions. Shannon is very conscientious and provided optimal care for her patients. Her enthusiastic spirit and positive attitude were refreshing. In the outpatient setting she was very motivated and did a good job. **HONORS**

Psychiatry: Shannon turned in a very good performance. She was particularly impressive in regard to her motivation. She was very available and worked very long hours. She asked many excellent questions. She was very sensitive and empathic with patients. She was well informed about her patients. She worked very well independently. Shannon is bright, thorough, and conscientious. She has an excellent grasp of medical concepts and expresses herself orally and in writing with impressive skill. She is both caring and curious. **PASS**

Surgery: Shannon Carr did four weeks of general surgery, two weeks of trauma surgery, and two weeks of pediatric surgery. She worked independently and showed initiative in researching topics. She was eager to learn and easy to work with. She was very industrious and asked pertinent questions. She was very reliable. She established good relationships with her patients. She was enthusiastic, interested, and inquisitive. She has good problem solving skills. She is a very caring person who worked well with all the health care personnel. **PASS**

Pediatrics: Shannon is a very hard working student who combined an inquisitive mind with a great attitude. Her strengths include her enthusiasm to learn and her thorough commitment to her patients. Her written work was excellent. She was eager, competent, well organized, and bright. She would merit a grade of "high pass" if this were an option. **PASS**

Obstetrics and Gynecology: Shannon has an appropriate and professional demeanor with patients. She is reliable, eager, and energetic. She has excellent rapport with patients and is very kind. Her outgoing personality and well-developed intuition allowed her to develop strong, trusting relationships with staff and patients. She is a hard worker. She was very enthusiastic about obstetrics and gynecology. She asked great questions and showed great attention to detail. She has a witty sense of humor. She is curious and motivated. She read extensively and applied her new knowledge to her patients' problems. She was capable of translating classroom knowledge into the clinical setting skillfully. Her histories and physical examination were always clear, thorough, organized, well thought out, and of high quality. She was obviously doing considerable external reading. Her knowledge base surpasses that of most of her peers. She showed exceptional interest, poise, and surgical expertise. She will be an excellent house officer. She was a truly wonderful student to work with. **HONORS**

Only forty-one students in this class earned honors grades in two or more rotations in the Clinical Science Core. This was a strong performance by Ms. Carr.

PATHOLOGY FELLOWSHIP

Following completion of the Clinical Science Core Ms. Carr elected to delay her advanced clinical studies in order to pursue a Pathology Fellowship with our Department of Pathology. She completed this fellowship from January through December 1997. Her work during the fellowship is described as follows:

Shannon's overall performance as a student fellow was excellent. She rotated through the autopsy service, surgical pathology, microbiology, cytopathology, chemistry, and immunopathology. She spent one month in Boston working in gynecological pathology at Brigham and Women's Hospital. Her evaluations were excellent. Shannon worked diligently and showed excellent medical knowledge. She was invariably upbeat and enthusiastic.

Shannon became actively engaged in our teaching program for first and second year medical students. She was very effective in this role, and her work was unusually well received by the students.

Shannon's fellowship experience has provided her with an exceptionally strong background in gynecologic pathology. She was an excellent student fellow.

ADVANCED BASIC SCIENCE CORE

Ms. Carr completed the Advanced Basic Science Core in January of 1998. She earned a grade of "pass" in all her courses. The Advanced Basic Science Core is graded on a pass/fail basis only. No honors grades are awarded.

SENIOR SELECTIVE PROGRAM

During the final Senior Selective phase of the curriculum, currently in progress, Ms. Carr has received the following evaluations. The evaluations are presented in the order in which the rotations were completed.

Nurse Midwifery Service, Fletcher Allen Health Care, Burlington, Vermont: Shannon is a quiet, concerned care provider. She has excellent patient rapport and is sensitive to psychosocial concerns. **PASS**

Acting Internship in General Obstetrics: Shannon assisted in seventeen vaginal deliveries and several cesarean sections. She did numerous evaluations of patients for possible labor or ruptured membranes. She was certified in the skills of cervical examinations, sterile speculum examinations, spontaneous vaginal deliveries, and newborn care. She is an excellent team player who was very willing to help in all functions. She has excellent technical skills and very good patient interaction skills. She is eager to learn, diligent, and resourceful. She has good interpersonal skills. She was able to be flexible with her approach to her patients. She has a great sense of humor. She is hard working, and she takes criticism well. She was always eager to learn. **HONORS**

Anesthesiology, Fletcher Allen Health Care, Burlington, Vermont: Shannon is a very strong student. She displayed solid clinical skills and a willingness to learn and improve. She clearly met the objectives of the rotation. **PASS**

Infectious Diseases, Fletcher Allen Health Care, Burlington, Vermont: Shannon did an outstanding job. Her notes were organized, well written, and legible. She was serious and enthusiastic about her work. **HONORS**

Acting Internship in Critical Care Medicine, Fletcher Allen Health Care, Burlington, Vermont: Shannon did an excellent job caring for several very sick patients in our intensive care unit. She was reliable and timely with her notes. She always followed up on loose ends. She worked well with many consultants. Her verbal presentation of complex information improved a lot during the month. **PASS**

Urogynecology, Fletcher Allen Health Care, Williston, Vermont: Shannon was outstanding with respect to diligence and reliability. She had very good technical skills and related well to patients and staff. **HONORS**

Internal Medicine, Houlton, Maine: Ms. Carr has a good clinical fund of knowledge. Her physical examination is through and systematic. Her history taking skills were excellent. She is an independent thinker. Her patient presentations were organized and logical. She was extremely conscientious and had excellent relationships with patients and staff. **NO GRADE ASSIGNED**

Dermatology, Fletcher Allen Health Care, Burlington, Vermont: Shannon was exceptionally helpful in clinic. She has a good clinical knowledge base, diligence, good rapport with patients, and excellent technical skills. **HONORS**

Gross Anatomy, University of Vermont College of Medicine, Burlington, Vermont: Shannon was a teaching assistant while we were teaching abdomen, pelvis, and perineum. She was very conscientious and worked hard. Students really appreciated her knowledge and the extra time she spent with them outside the lab. She was very helpful and knowledgeable. She has a fabulous teaching style. She was patient, enthusiastic, and helpful. She had a deep grasp of the material and was very excited about it. She provided useful clinical correlations and explained herself clearly. **PASS**

Clinical Infertility, University of Arizona College of Medicine, Tucson, Arizona: Shannon Carr has an excellent fund of general medical knowledge. She is well read in obstetrics and gynecology. She was knowledgeable regarding her patients. She showed excellent problem solving and judgement. She was able to prioritize patients' problems with multiple and complex conflicting variables. She is a true self-starter. She took responsibility for her educational experience. She was always present for weekend patients and procedures. She took extra overnight call to gain experience in labor and delivery. Shannon has excellent rapport with patients, staff, and colleagues. She has good skills in history taking and physical examination and has solid basic obstetrical and gynecological examination skills. She developed competence with specialized procedures including transvaginal ultrasound. **HONORS (unofficial)**

Acupuncture, Burlington, Vermont: Ms. Carr is astute, focused, and eager to learn. Her diligence to the patients' needs and her reliability to the office's needs were outstanding. Her presence puts patients at ease. She read extensively on her own and posed relevant questions. She was very attentive. She was open minded and willing to learn outside her usual paradigm. **HONORS (unofficial)**

Independent Study on Ethical Issues in Obstetrics and Gynecology around the Globe: Shannon's work in this independent study was outstanding. She worked to achieve a solid understanding of foundational ethical principles and concepts through her careful reading of both core bioethics texts and classic articles in obstetrics and gynecology ethics. Through increasingly self-directed readings on ethics and global population policy, she focused on readings that tied in with her plans to work in clinics in Nepal in the upcoming year. Most impressive was her decision to culminate her independent study with a project that would not merely advance her own knowledge and skills, but also those of her peers and professors as well. She organized an expert panel discussion on "Global Population Policy as it Affects Reproductive Choice: An Ethical Dilemma." She structured the panel in advance and served as a skillful facilitator of the session, responding effectively and creatively to moderate the presentation, and structure an informative and provocative teaching session. **HONORS**

(Extramural rotations at non-affiliated sites are officially graded as pass or fail only. Official honors grades may only be awarded by faculty of the

University of Vermont College of Medicine. The College of Medicine does not use a "high pass" grade.)

INTERNATIONAL ELECTIVE

Ms. Carr traveled to Nepal in April 1999; she plans to remain there through November 1999. She is working in the field of women's health and perinatal health at the Tribhuvan University Teaching Hospital in Kathmandu. She elected to delay her graduation for a year in order to experience this elective opportunity.

RESEARCH

Ms. Carr received a research fellowship for a project which she completed during the summer following her first year. Under the direction of Paula Tracy, Ph.D., a faculty member in the Department of Biochemistry, she studied the potential role of platelets in the hypercoagulable state associated with diabetes mellitus.

EXTRACURRICULAR ACTIVITIES

During her time in medical school Ms. Carr assisted the Committee on Admissions as a discussion leader and tour guide for medical school applicants. With other members of the local chapter of the American Medical Student Association (AMSA) she participated in a blood pressure screening clinic at a local farmer's market. She is a member of the American Medical Women's Association (AMWA). She was student participant in the reaccredidation process when the University of Vermont was reviewed by the Liaison Committee on Medical Education in 1997.

UNITED STATES MEDICAL LICENSING EXAMINATION

Ms. Carr passed Step 1 of the United States Medical Licensing Examination (USMLE) in October 1997 with a score of 225. She passed Step 2 in March 1999 with a score of 223.

SUMMARY

The small size of the University of Vermont College of Medicine allows me to develop a personal relationship with each student. I meet individually with students at least four times during the course of their enrollment.

Shannon Carr is an eager, hard working, reliable, and enthusiastic student who is recognized for her excellent relationships with patients, her strong fund of knowledge, and her initiative in learning independently. She is distinguished by her year of

additional training in pathology and by her interest and experience in international health.

Ms. Carr has chosen to pursue further training in the field of obstetrics and gynecology. Her conscientious, thorough, and compassionate approach to patient care will make her a welcome and effective contributor to the residency program that is fortunate to match with her.

The University of Vermont College of Medicine does not calculate or otherwise identify a class rank. Using the rating scale below I am pleased to endorse Ms. Carr as an excellent house officer candidate. This endorsement is based on my assessment of her overall performance in our curriculum.

Sincerely yours,

Marga Susan Sproul

Marga Susan Sproul, M.D.
Associate Dean for Student Affairs

Scale:
SUPERIOR
EXCELLENT
VERY GOOD
GOOD
SATISFACTORY

November 1, 1999

The University of Vermont

COLLEGE OF MEDICINE, OFFICE OF STUDENT AFFAIRS
E215 GIVEN BUILDING, 89 BEAUMONT AVENUE
BURLINGTON, VERMONT 05405
TEL. (802) 656-2150
FAX (802) 656-9377

OFFICIAL TRANSCRIPT OF GRADES

RECORD OF CARR, Shannon Louise CLASS ~~1998~~ ~~1999~~ 2000

PERMANENT ADDRESS [redacted]

BIRTH DATE [redacted]/66 SOCIAL SECURITY NO. [redacted]

COLLEGES ATTENDED U Maine Farmington, Biology BA 5/94
Magna Cum Laude

University of Vermont
COLLEGE OF MEDICINE
Burlington, Vermont

BASIC SCIENCE CORE

8/16/94-6/16/95
8/21/95-12/7/95

Anatomy, Gross	PASS
Anatomy, Microscopic	PASS
Basic Clerkship	PASS
Biochemistry	PASS
Medical Microbiology	HONORS
Intro. to Psychopathology	PASS
Neurosciences	PASS
Physician in Society	PASS
Pathology, General	HONORS
Pathology, Systemic	PASS
Pharmacology	PASS
Physiology	PASS
Optional Clinical Elective	

CLINICAL SCIENCE CORE

1/2/96-12/20/96

Medicine	HONORS
Obstetrics and Gynecology	HONORS
Pediatrics	PASS
Psychiatry	PASS
Surgery	PASS
Family Practice	PASS

ADVANCED BASIC SCIENCE CORE

1/5/98-1/30/98

Epidemiology	PASS
Medical Genetics	PASS
AdvCardiacLifeSupp	PASS
ClinicalPharmacology	PASS
HumEmbryology/MedApp	PASS

SENIOR SELECTIVE PROGRAM

2/1/98-3/31/99; 12/1/99-4/30/00

Nurse Midwifery Service	PASS
General Obstetrics AI	HONORS
Anesthesiology	PASS
Infectious Diseases	HONORS
CCU AI/MMC	PASS
Urogynecology	HONORS
Internal Medicine/Houlton, ME	PASS
Dermatology	HONORS
Gross Anatomy TA	PASS
Clinical Infertility/UArizona	PASS
Acupuncture/Burlington, VT	PASS
Independent Study OB/GYN	HONORS
OB/GYN Internship/Nepal	PASS
EM/MMC	PASS
OutptGyn/PlannedPrnthoodVT	PASS

International elective 4/99 - 11/99 Pathology Fellowship 1/97-12/97

M.D. DEGREE GRANTED 5/21/2000

APR 15 2000

For an explanation of this transcript, see reverse side.

AUTHORIZED SIGNATURE

An Equal Opportunity/Affirmative Action Employer

SEAL VERIFIED

KEY TO TRANSCRIPT

Prior to September 1967, the work of students was evaluated on the basis of 100 percent. The lowest passing grade was 75 percent except in the case of minor subjects. In the first and second years, the passing grade for each minor subject was 75 percent. In the third year, a grade of 60 percent was accepted for individual minor subjects, but the average for a group of minor subjects must have been 75 percent.

September 1967-August 1969, the work of students was evaluated on the basis of A, B, C, and F. The lowest passing trade was C.

In September of 1969, the College adopted a pass/fail method of student evaluation:

P or Pass = satisfactory completion of all course work
F or Fail = less than satisfactory performance
Fail/Pass = less than satisfactory performance in initial endeavor, course repeated and makeup work evaluated as satisfactory.

Beginning with the class entering in September 1981 (Class of 1985 and those following), student performance has been graded in courses and clinical rotations taught or supervised by the faculty of the University of Vermont College of Medicine on the basis of honors, pass, or fail. However, the following courses are/were graded on a pass/fail basis without any honors grade option:

Basic Clerkship
Case Studies in Health and Illness
Clinical Electives during the Basic Science Core
Doctoring Skills
Doctoring in Vermont
Human Behavior
Medical Sexuality
Physician and Society
Physician in Society

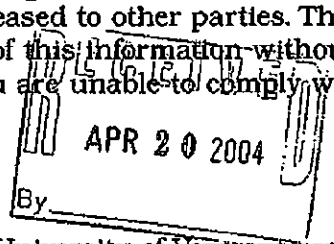
Courses in the Advanced Basic Science Core have been graded on a pass/fail basis beginning with the Class of 1994.

Courses and clinical rotations not supervised by the University of Vermont College of Medicine faculty are recorded as pass or fail on our transcript, though the faculty evaluator at another institution may have awarded a different grade based on the grading system in effect at the other institution.

Course work is completed only when grades appear. All courses without grades have not yet been completed.

RELEASE OF INFORMATION

The information provided on the reverse side of this document is being forwarded to you at the request of the student with the understanding that it will not be released to other parties. The Family Educational Rights and Privacy Act of 1974 prohibits release of this information without the student's written consent. Please return this material to us if you are unable to comply with this condition of release.



AUTHENTICATION OF THE RECORD

This transcript is not official without the original impression of the University of Vermont seal and signature of authorized person in the Office of Student Affairs, College of Medicine.

The College of Medicine
of

The University of Vermont

To all to whom these presents may come, sendeth greetings
Whereas the Faculty of the College and the University Senate
have recommended

Shannon Louise Carr, B.A.

as having completed the Studies assigned and passed the Examinations required, We, the Trustees of the University by virtue of the authority vested in us do hereby confer upon her the Degree of

Doctor of Medicine

and admit her to all the rights, privileges and honors appertaining thereto
In Witness Whereof, the seal of the University and the signature of the President the Dean and the Secretary are hereunto affixed.

Given at Burlington, Vermont on the twenty-first day of May in the year of our Lord,
Two Thousand and of the University the Two Hundred and Ninth.

Martha P. Heath
Secretary of the Board of Trustees

John N. Evans
Dean

Judith A. Ramaley
President of the University

SEAL
VERIFIED

Certified as a true and exact copy of the original document.
Margaret Susan Sproul, M.D.
Associate Dean for Student Affairs
4/15/04

Section IV

Graduate Medical Education Training

Federation of STATE MEDICAL BOARDS

Federation Credentials Verification Service (FCVS)

Federation Place / 400 Fuller Wiser Road Suite 300 / Euless, TX 76039
Tel: (817) 868-5000 Fax: (817) 868-5099

Verification of Graduate Medical Education

Institution: Maine Medical Center
Address: 22 Bramhall Street
Portland ME 04102

Attention: **Program Director**
Affiliated University: ____

Verification For:

Name: **Shannon Carr M.D.**

DOB: [redacted]1966
Individual's Name on Record (If different from above): ____

Program Participation:

Important:
Report Incomplete Training Levels (years) separate from those that were successfully completed.

If the training level (year) is currently in progress report the expected completion date in the "To" field.

Report Internships, Residencies and Fellowships separately.

Use one section per Department/Specialty. If the Department/Specialty is rotating or transitional, please provide a schedule of rotations.

Training Level: 1 (e.g., 1, 2, 3, etc.)
☒Internship ☐Residency ☐Chief Residency ☐Fellowship ☐Research
Specialty/Subspecialty: obgyn
From: 07/01/2000 **To:** 06/30/2001
Successfully Completed?: ☒Yes ☐No ☐In Progress
Accredited by: ☒ACGME ☐AOA ☐LCGME ☐RSC ☐CFPC ☐RCPSC ☐APPAP ☐None of these

Training Level: 2,3 (e.g., 1, 2, 3, etc.)
☐Internship ☒Residency ☐Chief Residency ☐Fellowship ☐Research
Specialty/Subspecialty: obgyn
From: 07/01/2001 **To:** 06/30/2003
Successfully Completed?: ☒Yes ☐No ☐In Progress
Accredited by: ☒ACGME ☐AOA ☐LCGME ☐RSC ☐CFPC ☐RCPSC ☐APPAP ☐None of these

Training Level: 4 (e.g., 1, 2, 3, etc.)
☐Internship ☐Residency ☒Chief Residency ☐Fellowship ☐Research
Specialty/Subspecialty: obgyn
From: 07/01/2003 **To:** 06/30/2004
Successfully Completed?: ☒Yes ☐No ☐In Progress
Accredited by: ☒ACGME ☐AOA ☐LCGME ☐RSC ☐CFPC ☐RCPSC ☐APPAP ☐None of these

Unusual Circumstances:

Check the correct response. Omitted responses require written explanation.

If necessary, you may continue your explanation on a separate sheet of paper.

1. Did this individual ever take a leave of absence or break from his/her training? ☐Yes ☒No
2. Was this individual ever placed on probation? ☐Yes ☒No
3. Was this individual ever disciplined or placed under investigation? ☐Yes ☒No
4. Were any negative reports for behavioral reasons ever filed by instructors? ☐Yes ☒No
5. Were any limitations or special requirements placed upon this individual because of questions of academic incompetence, disciplinary problems or any other reason? ☐Yes ☒No

Please explain any "Yes" response from above:

____

____

Certification:

Affix your institutional seal here

ELECTRONIC SEAL VERIFIED

Completion of the following is certification that the information above is an accurate account of this individual's records and is true and correct. **The signature line must contain the original signature, or the electronic typed signature, of the program director (M.D./D.O. ONLY – PLEASE REPORT WHICH).**

Name: Kalli Varaklis M.D.
Signature: *Kalli Varaklis, MD*
Title of Signatory (e.g., Program Director): Director OB/Gyn Residency
Date of Signature: 12/22/11
[redacted] 207-662-2749 Fax: 207-662-6252 E-Mail: varakk@mmc.org

Federation of STATE MEDICAL BOARDS

PROVIDED BY APPLICANT

Full Name: Shannon Louise Carr

Packet ID: 39936

20. Graduate Medical Education

List all of the graduate medical education programs you attended in chronological order. **Use one page per institution.**

IMPORTANT:

Report incomplete training levels (years) separate from those that were successfully completed.

If your training level (year) is currently in progress, indicate the EXPECTED completion date in the "To" field.

Report internships, residencies, fellowships and research programs separately.

Use one section per department.

If a break of six (6) months or more occurred between any of your graduate medical education activities, please provide a written explanation outlining your activities during this period on the "Explanation of Other Activities" form.

Maine Medical Center
Complete name of hospital where training was conducted (Do not abbreviate).
University of Vermont College of Medicine
Complete name of affiliated university or college (Do not abbreviate).
22 Bramhall Street
Address line 1

Address line 2
Portland — City
Maine — State/Province
USA — Country
04102 - _____ — ZIP/Postal Code

Training Level (e.g; 1, 2, 3, etc.): 1
☐ Internship ☒ Residency ☐ Chief Residency ☐ Fellowship ☐ Research
Ob-Gyn — Specialty/Subspecialty
From: 06 /2000 To: 06 /2001
Successfully Completed? ☒ Yes ☐ No ☐ In Progress

Training Level (e.g; 1, 2, 3, etc.): 2
☐ Internship ☒ Residency ☐ Chief Residency ☐ Fellowship ☐ Research
Ob-Gyn — Specialty/Subspecialty
From: 07 /2001 To: 06 /2002
Successfully Completed? ☒ Yes ☐ No ☐ In Progress

Training Level (e.g; 1, 2, 3, etc.): 3
☐ Internship ☒ Residency ☐ Chief Residency ☐ Fellowship ☐ Research
Ob-Gyn — Specialty/Subspecialty
From: 07 /2002 To: 06 /2003
Successfully Completed? ☒ Yes ☐ No ☐ In Progress

Training Level (e.g; 1, 2, 3, etc.): 4
☐ Internship ☒ Residency ☐ Chief Residency ☐ Fellowship ☐ Research
Ob-Gyn — Specialty/Subspecialty
From: 07 /2003 To: 06 /2004
Successfully Completed? ☒ Yes ☐ No ☐ In Progress

Unusual Circumstances (check yes or no):

Did you ever take a leave(s) of absence or break(s) from your medical education?	☐ Yes ☒ No
Were you ever placed on probation?	☐ Yes ☒ No
Were you ever disciplined or placed under investigation?	☐ Yes ☒ No
Were any negative reports for behavioral reasons ever filed against you?	☐ Yes ☒ No
Were any limitations or special requirements imposed on you because of academic, incompetence, disciplinary problems or for any other reason?	☐ Yes ☒ No

Please explain any "YES" response from above:

_____

Signature: *Shannon Louise Carr, MD* Date: 12/16/2011

By typing my name above, I certify that I am the individual referenced in the FCVS application and that I agree to the terms and conditions set forth therein. Furthermore, I acknowledge that I have answered all questions and reported all information on this application page truthfully and completely.

Section V

Examination History/Score Transcripts

United States Medical Licensing Examination™ (USMLE™)
Certified Transcript of Scores

This document was prepared by the
Federation of State Medical Boards of the United States, Inc.
Federation Place, 400 Fuller Wiser Road, Suite 300, Euless, TX 76039-3856 – Telephone (817) 868-4041

Date: 11/16/2011

Recipient:
Federation Credentials Verification Service
ATTN: FCVS

Euless, TX 76039

Packet ID: 39936

Examinee: Carr, Shannon Louise
Alt Name(s): Carr, Shannon

Examinee ID#: 5-007-860-9
Date of Birth: [redacted]966

Results for Steps taken by this examinee (and for which results have been reported to date) are shown below. For Steps that span more than one day, the test date reflects the day on which the examination began. Where numeric scores are reported, there are two scales used and the recommended minimum passing score ("MP") on each scale is shown in parentheses.

USMLE STEP 1

			Three-Digit Score		Two-Digit Score		
	Test Date	Pass/Fail	Total	MP	Total	MP	Comments
	10/14/1997	Pass	225	176	89	75	

USMLE STEP 2

Clinical Knowledge (CK)

			Three-Digit Score		Two-Digit Score		
	Test Date	Pass/Fail	Total	MP	Total	MP	Comments
	03/02/1999	Pass	223	170	87	75	

USMLE STEP 3

			Three-Digit Score		Two-Digit Score		
	Test Date	Pass/Fail	Total	MP	Total	MP	Comments
MAINE	07/28/2003	Pass	196	182	80	75	

NOTE: A search of the Board Action Data Bank of the Federation of State Medical Boards (FSMB) reveals no reported information on this examinee.

Patent 5636874

TouchSafe®

SEE REVERSE SIDE FOR EXPLANATION OF INFORMATION REPORTED ABOVE.

NMMB 2015 CME AUDIT FORM

REQUIRED INFORMATION
PLEASE PRINT

*NAME: SHANNON L. CARR MD *LICENSE NUMBER: MD 2012-00.

Date	CME Course	Hours	Staff Use Only
11/30/2013	ASOG MAINTENANCE OF CERTIFICATION	35	
10/24/2014	ASOG MAINTENANCE OF CERTIFICATION	35	
6/2014	PAIN MANAGEMENT: REDUCING RISK PRESCRIBING PATIENTS	5	

American Board of Obstetrics and Gynecology
2915 Vine Street
Dallas, TX 75204
Phone: (214) 871-1619
Fax: (214) 871-1943

November 30, 2013

Shannon Louise Carr, M.D.
3424 Campus Blvd, NE
Albuquerque, NM 87106

Dear Doctor:

Congratulations! I am pleased to inform you that you have satisfactorily completed the 2013 Maintenance of Certification assignments. You have earned 35 AMA Category 1 CME credits. These will be awarded by the American College of Obstetricians and Gynecologists.

You should have received a 2013 MOC label insert from Jim Henry, Inc. within 60 days from the time of your MOC application.

Your certification in Obstetrics and Gynecology is valid through 12/31/2014. The ABOG MOC process is now a continuous certification process, and you must apply and participate each year.

Please use this letter to provide documentation of your certification for your hospital(s). Please remember that you must re-apply for MOC annually. The application for the 2014 program will be available through your ABOG Member Login page beginning in November, 2013.

Sincerely yours,

George D. Wendel, Jr. M.D.
Director of Maintenance of Certification

GDW

ABOG ID: 9008732

American Board of Obstetrics and Gynecology
2915 Vine Street
Dallas, TX 75204
Phone: (214) 871-1619
Fax: (214) 871-1943

October 24, 2014

Shannon Louise Carr, M.D.
3424 Campus Blvd, NE
Albuquerque, NM 87106

Dear Doctor:

Congratulations! I am pleased to inform you that you have satisfactorily completed the 2014 Maintenance of Certification assignments.

As of this date, you have earned 35 AMA Category 1 CME credits for completion of the 2014 Part II MOC requirements. These will be awarded by the American College of Obstetricians and Gynecologists.

You should have received a 2014 MOC label insert from Jim Henry, Inc. within 60 days from the time of your MOC application.

Your certification in Obstetrics and Gynecology is valid through 12/31/2015. The ABOG MOC program is a continuous certification process, and you must participate each year. The application for the 2015 program will be available through your ABOG Member Login page beginning in December, 2014.

Please use this letter to provide documentation of your certification for your hospital(s).

Sincerely yours,

George D. Wendel, Jr. M.D.
Director of Maintenance of Certification

GDW

ABOG ID: 9008732

Certificate of CME

HealthInsight New Mexico certifies that

Shannon Carr, MD

Has participated in the **enduring material** event titled

Pain Management: Reducing Risk Protecting Patients

And is awarded **5.0** *AMA Physician's Recognition Category 1 Credit(s)™*

6/2014

John Seibel, MD
HealthInsight New Mexico Medical Director

HealthInsight
New Mexico

HealthInsight New Mexico is accredited by the New Mexico Medical Society (NMMS) to provide Continuing Medical Education (CME) for physicians.

Physician should claim only the credit commensurate with the extent of their participation in the activity.

Approved by the New Mexico Medical Board to meet the requirements for rule no. 16.10.14

9/15/2015

Carr, Shannon **Medical Doctor** **MD2012-0010**

1. Since your last renewal has your professional liability coverage been terminated by action of the insurance company except as a result of the company ceasing to offer insurance to physicians?	N	04/22/2015
2. Since your last renewal have you been denied professional liability insurance coverage?	N	04/22/2015
3. Since your last renewal has your professional liability carrier excluded any specific procedures from your coverage?	N	04/22/2015
4. Since your last renewal have you been denied membership or renewal thereof, or been subject to disciplinary action in any professional organization?	N	04/22/2015
5. Since your last renewal have you been excluded from or sanctioned by Medicare and/or Medicaid?	N	04/22/2015
6. Since your last renewal, have you been arrested? If so explain the circumstance, regardless of the outcome (i.e. expunged, dismissed, sealed, vacated).	N	04/22/2015
7. Since your last renewal, have you been named as a defendant in any criminal proceedings?	N	04/22/2015
8. Since your last renewal, have you 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?	N	04/22/2015
9. Since your last renewal have you 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)	N	04/22/2015
10. a. Since your last renewal have your privileges at any healthcare entity been voluntarily or involuntarily suspended, restricted, diminished, revoked, surrendered, or not renewed, except for medical records delinquency?	N	04/22/2015
10. b. Since your last renewal have you agreed not to exercise your clinical privileges while under investigation?	N	04/22/2015
11. Since your last renewal have you resigned from a healthcare entity to avoid modification, suspension, or termination of privileges, or while under investigation?	N	04/22/2015
12. a. Since your last renewal has your application for licensure or license to practice in any jurisdiction been investigated, voluntarily or involuntarily limited, suspended, revoked, surrendered or denied?	N	04/22/2015
12. b. Are any currently held licenses pending investigation or being challenged?	N	04/22/2015
13. Since your last renewal have you been notified to appear before any licensing agency for a hearing or complaint of any nature?	N	04/22/2015
14. Since your last renewal has your federal or state narcotics registration certificate in any jurisdiction been voluntarily or involuntarily limited (stipulations), suspended, revoked, restricted, or are there currently challenges to any of these items?	N	04/22/2015
15. Since your last renewal have you 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 for each claim or suit. Please type on a separate sheet	N	04/22/2015
16. Since your last renewal have you been reported to the National Practitioner Data Bank?	N	04/22/2015
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?	N	04/22/2015
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	N	04/22/2015
19. I certify that I have completed a minimum of 75 AMA Category I hours of Continuing Medical Education as required by 16.10.4 NMAC?	Y	04/22/2015
19a. I certify that 5 hours of the required 75 hours of CME are in Pain Management, as required by 16.10.14. 11 NMAC OR I certify that I do NOT hold a NM Controlled Substance Registration.	Y	04/22/2015
20. I attest that I will limit my practice to areas in which I am competent to practice.	Y	04/22/2015