Profile - 1.042373

This profile contains information that may be used as a starting point in evaluating a health care provider. This profile should not, however, be the sole basis for selecting a health care provider. Please direct questions and comments about this profile to: Connecticut Department of Public Health, Physician Profiles, 410 Capitol Ave., M.S. 12 APP, P.O. Box 340308, Hartford, CT 06134-0308, oplc.dph@ct.gov.

Name	CAROL L WATSON MD
Credential	1.042373

Current Practice Locations

Are you currently practicing your licensed profession in Connecticut?

Yes

Are you actively involved in patient care?

No

Enter your practice locations

Practice Name	Address 1	Address 2	Address 3	City	State	Zip Code	Primary Practice	Languages Spoken at this Location
Farmington Obstetrics & Gynecology Group	20 West Avon Road			Avon	Connecticut	06001	Yes	Spanish Spanish
Farmington Obstetrics & Gynecology Group	1 Mill Lane			Farmington	Connecticut	06032	Yes	Spanish Spanish
Farmington Obstetrics & Gynecology Group	100 Retreat Avenue	Suite 506		Hartford	Connecticut	06106	Yes	Spanish Spanish

Connecticut Staff Privileges

Indicate the Connecticut hospitals or nursing homes for which you have staff privileges

Facility Name	City	State
HARTFORD HOSPITAL		
JOHN DEMPSEY HOSPITAL OF THE UNIVERSITY OF CONNECTICUT HEALTH CENTER		

Medical School

Medical School

Albany Medical College

Year of Graduation

2000

Post Graduate Training

List your postgraduate training:

Site Name	City	State	Country	Start Date	End Date	Level	Type
University of Connecticut - OB/GYN	Farmington	Connecticut	UNITED STATES	07/01/2000	06/30/2004	Resident	OB/GYN

Specialty Area/American Board Certification

Please indicate practice specialties, subspecialties and the date you were certified by ABMS or ABOMS.

Specialty	Subspecialty	Certifying Board	Certification Date

Medical Education Responsibilities

Are you a member of the faculty of a Connecticut medical school?

No

Select the state medical schools at which you are a member of the faculty.

Do you have current responsibility for graduate medical education?
Yes

Publications, Professional Services, Activities, and Awards

In this section, you may add any publications, professional services, activities, and awards that you would think useful to viewers of your profile.

Publisher/Issuer	Title/Award Name	Date
Board Eligible in Obstetrics & Gynecology		
Society of Laparoendoscopic Surgeons. 2004	Outstanding Laparoendoscopic Resident Surgeon	
Dr. Spero neckles Award. 2004	Outstanding Resident Research Paper	

Medical Malpractice Information

Indicate your malpractice insurance carrier:

Indicate the medical malpractice payments that have been made by you or on your behalf within the past ten years.

Some studies have shown that there is no significant correlation between malpractice history and a physician's competence. At the same time, consumers should have access to malpractice information. This profile contains information about the malpractice payment history of the physician. Payment amounts have been placed into three statistical categories: below average, average and above average. To make the best health care decisions, you should view this information in perspective. You could miss an opportunity for high quality care by selecting a doctor based solely on malpractice history.

When considering malpractice data, please keep in mind:

- *Malpractice histories tend to vary by specialty. Some specialties are more likely than others to be the subject of litigation. This report compares physicians only to the members of their specialty, not all physicians, in order to make an individual physician's history more meaningful.*
- *This malpractice information reflects data for the last 10 years of the physician's practice. For physicians practicing less than 10 years, the data covers their total years of practice. You should take into account how long the doctor has been in practice when considering malpractice averages.*
- *The incident causing the malpractice claim may have happened years before payment is finally made. Sometimes it takes a long time for a malpractice lawsuit to move through the legal system.*
- *Some physicians work primarily with high-risk patients. These physicians may have malpractice histories that are higher than average because they specialize in cases or patients who are at very high risk of problems.*
- *Settlement of a claim may occur for a variety of reasons that do not necessarily reflect negatively on the professional competence or conduct of the physician. A payment in settlement of a medical malpractice action or claim should not be construed as creating a presumption that medical malpractice has occurred. For example, an insurer may choose to settle a case even if the physician opposes such settlement.*

You may wish to discuss the information provided in this report, and malpractice generally, with your physician.

Payments made by or on behalf of this healthcare provider:

Resolved Date	Payment Category	Specialty

Connecticut Hospital Discipline

This section contains categories disciplinary actions taken by hospitals during the past ten years which are specifically required by law to be released in the physician's profile.

Please enter any disciplinary actions taken against you by any hospital within the previous 10 years.

Hospital Name	City	State	Country	Discipline Date	Disciplinary Action

Other State License

Indicate states outside of CT where licenses are held, current or expired

State	Disciplinary Action

Connecticut Licensure Disciplinary Actions

The following lists any past disciplinary actions taken against this licensee. If there is no data present, there has been no disciplinary action taken.

Date of Action	Action	License Status

Felony Convictions

Please enter any felony convictions within the previous ten years.

Conviction Date	Conviction

Profile Attestation

I hereby certify that to the best of my knowledge, the information contained in this profile is true and accurate and understand that providing false information may be grounds for sanction, which may include suspension revocation of my license to practice my profession in Connecticut.

Attestation Date

Review

2017 License Renewal

Renewal - 1.042373

Name	CAROL L WATSON MD
Credential	1.042373

Fee Details

Renewal Application Fee	$575.00
	$575.00

Workforce Survey Introduction

Dear Licensee:

Thank you for renewing your license online.

As part of this renewal application, you will be asked to enter your National Provider Identification (NPI) number. Please make sure you have that information available before proceeding. If you do not have your NPI number with you, you can find it online at https://npiregistry.cms.hhs.gov/. You will also be asked to enter information regarding your practice location, specialty and patients served.

The purpose of the questions is to allow the Department of Public Health to collect valuable workforce and patient care data that is critical in identifying and addressing healthcare workforce shortage and patient care issues.

Thank you for assisting the Department in this important initiative.

Demographic Information-Renewal

1. Please provide your Date of Birth
   10/16/1972

2. Gender
   Female

3. Ethnicity: Please choose one
   Not Hispanic or Latino

4. Race:
   Black or African American

Email Address Verification

Please be advised that the Department no longer mails hardcopy licenses and renewal notices. Rather, licenses and renewal notices will be sent via email. You will receive an electronic copy of your license via email within a few days of completing this transaction. Renewal notices will be sent via email approximately 60 days prior to your license expiration date.

Residence Address

Please enter the information below regarding the address of your residence. Please note that entering your address here will not change your mailing address in our system. If you have a change of address, please email it to oplc.dph@ct.gov. For your protection, please include your profession, license number and the last 4 digits of your SSN in your request.

5. Street Address
   10 Weatherstone Ridge Road

6. Unit/Apartment Number

7. City
   Plainville

8. State (two letter abbreviation)

CT

9. Zip Code
06062

Medical Education

10. Medical School
Albany Medical College

11. Year of Graduation
2000

Specialty/Board Certification

12. Please indicate practice specialties, subspecialties and the date you were certified by ABMS or ABOMS, if applicable. Board certification is not a requirement for licensure.

Specialty	Subspecialty		Certifying Board	Certification Date
Obstetrics and Gynecology	**Subspecialty**	**Certification Date**	American Board of Obstetrics and Gynecology	01/19/2009

Current Workforce Status in Medicine

13. What is your current work status in medicine?
Full Time - (40 hours or more per week)

14. In the next 12 months, do you plan to (please mark all that apply):
None

15. If 100% of your primary professional position is not direct patient care, please indicate which of the following apply:

16. If your response to the previous question was other, please enter additional comments here.

National Provider Identifier

The National Provider Identifier (NPI) is a 10-digit identifier required on all HIPAA standard electronic transactions. NPIs have replaced all separately issued identifiers, including Medicaid PINs and Medicare UPINs, on HIPAA standard electronic transactions. In the past, health plans assigned an identifying number to each provider with whom they conducted electronic business. Since providers typically work with several health plans, they were likely to have a different identification number for each plan. The NPI has been put in place so that each provider has one unique, United States federal government-issued identifier to be used in transactions with all health plans with which the provider conducts business.

17. Please enter your NPI number here (if you do not know your NPI number, you may retrieve it at https://npiregistry.cms.hhs.gov.) If you do not have an NPI number, please enter ten (10) zeros):
1578654976

Physician Renewal Practice Location

18. Please indicate the name and address of your primary practice location as well as languages spoken at that location. Please note that you can add additional practice locations but you may only select one (1) primary practice location.

Practice Name	Address 1	Address 2	Address 3	City	State	Zip Code	Primary Practice	Languages Spoken at this Location
Starling Physicians	300 Kensington Avenue			New Britain	Connecticut	06051	No	
Starling Physicians	40 Dale Road	Suite 105		Avon	Connecticut	06001	Yes	

19. Approximately how many physicians are associated with your practice (If you are in residency training, please enter zero (0) here)?

10

20. Is the primary site where you spend most time providing direct patient care a JCAHO/NCQA recognized patient care centered medical home?
No

21. Please select the best choice for the type of ownership of your practice.
Private practice

Practice Ownership - Organization

22. Please enter the name of the organization/person that owns the practice where you work.
Starling Physicians

23. City
Rocky Hill

24. State (two letter abbreviation)
CT

New Patients

25. Please select the best response that describes your patient care practice status:
I can accept some new patients; my practice is far from full

26. Are you accepting new patients covered by:
Both

Primary Source of Payment

Please answer the questions to the best of your ability. If you do not know the exact amount, please select the answer that you think is correct. This information is used by the Department to analyze current trends in the practice of medicine in Connecticut and is not used in any way to determine your eligibility for license renewal.

What percent of your patients have the following source of payment?

27. Medicare
less than 10%

28. Medicaid
11 - 25%

29. Self-Pay
less than 10%

30. Private Insurance
51 - 75%

31. Other
None

32. Does your practice offer sliding fee scale based on ability to pay?
Yes

33. Approximately what percentage of your patients use sliding fee schedules?
Less than 10%

Populations Served

Please answer the questions to the best of your ability. If you do not know the exact amount, please select the answer that you think is correct. This information is used by the Department to analyze current trends in the practice of medicine in Connecticut

and is not used in any way to determine your eligibility for license renewal.

Please approximate the percentage of patients at your primary practice location that are:

34. Homeless
Less than 10%

35. Migrant/Seasonal Farm Workers
Less than 10%

36. Native Americans
Less than 10%

Connecticut Prescription Monitoring and Reporting System

All prescribing practitioners possessing a Connecticut controlled substance registration (CSP) issued by the Connecticut Department of Consumer Protection (DCP) must register with the Connecticut Prescription Monitoring and Reporting System (CPMRS) online at www.ctpmp.com.

After you have completed this renewal transaction, please visit the DCP's website at www.ct.gov/dcp and select 'Programs & Services' then 'Prescription Monitoring Program' for information regarding registration.

37. I acknowledge that I have read the information regarding registration in the Connecticut Prescription Monitoring and Reporting System.
10/31/2017

Physician Attestation

38. Within the last year, have you been convicted of a felony?
No

39. If yes, please provide details here

40. Within the last year, have you had any disciplinary action taken against you or any such actions pending by another State's licensing/certification authority?
No

41. If yes, please provide details here

42. I attest that I am in compliance with the mandatory continuing education requirements and that I am in compliance with the mandatory professional liability insurance coverage requirements.
Yes

43. I attest that on this date I completed this renewal application online and that all of the statements made by me on this renewal are accurate.
10/31/2017

American Medical Association's Opinions

The Connecticut Medical Examining Board and the Connecticut Department of Public Health encourage you to read the following opinions of the American Medical Association’s Code of Medical Ethics related to common reasons for discipline on Connecticut physicians’ licenses.

AMA Code of Ethics

Opinion 1.2.1 Treating Self or Family

Treating oneself or a member of one’s own family poses several challenges for physicians, including concerns about professional objectivity, patient autonomy, and informed consent.

When the patient is an immediate family member, the physician’s personal feelings may unduly influence his or her professional medical judgment. Or the physician may fail to probe sensitive areas when taking the medical history or to perform intimate parts

of the physical examination. Physicians may feel obligated to provide care for family members despite feeling uncomfortable doing so. They may also be inclined to treat problems that are beyond their expertise or training.

Similarly, patients may feel uncomfortable receiving care from a family member. A patient may be reluctant to disclose sensitive information or undergo an intimate examination when the physician is an immediate family member. This discomfort may particularly be the case when the patient is a minor child, who may not feel free to refuse care from a parent.

In general, physicians should not treat themselves or members of their own families. However, it may be acceptable to do so in limited circumstances:

(a) In emergency settings or isolated settings where there is no other qualified physician available. In such situations, physicians should not hesitate to treat themselves or family members until another physician becomes available.

(b) For short-term, minor problems.

When treating self or family members, physicians have a further responsibility to:

(c) Document treatment or care provided and convey relevant information to the patient's primary care physician.

(d) Recognize that if tensions develop in the professional relationship with a family member, perhaps as a result of a negative medical outcome, such difficulties may be carried over into the family member's personal relationship with the physician.

(e) Avoid providing sensitive or intimate care especially for a minor patient who is uncomfortable being treated by a family member.

(f) Recognize that family members may be reluctant to state their preference for another physician or decline a recommendation for fear of offending the physician.

AMA Principles of Medical Ethics

Opinion 9.1.1 Romantic or Sexual Relationships wth Patients

Romantic or sexual interactions between physicians and patients that occur concurrently with the patient physician relationship are unethical. Such interactions detract from the goals of the patient-physician relationship and may exploit the vulnerability of the patient, compromise the physician's ability to make objective judgments about the patient's health care, and ultimately be detrimental to the patient's well-being.

A physician must terminate the patient-physician relationship before initiating a dating, romantic, or sexual relationship with a patient.

Likewise, sexual or romantic relationships between a physician and a former patient may be unduly influenced by the previous physician-patient relationship. Sexual or romantic relationships with former patients are unethical if the physician uses or exploits trust, knowledge, emotions, or influence derived from the previous professional relationship, or if a romantic relationship would otherwise foreseeably harm the individual.

In keeping with a physician's ethical obligations to avoid inappropriate behavior, a physician who has reason to believe that nonsexual, nonclinical contact with a patient may be perceived as or may lead to romantic or sexual contact should avoid such contact.

Important Note

To continue processing your transaction, please click "Add to Invoice" on the NEXT screen (read the rest of this information first).

On the top right of the invoice screen, select **"Pay Invoice".**

PLEASE NOTE THAT WHEN ENTERING YOUR CREDIT CARD NUMBER, DO NOT ENTER SPACES OR DASHES AS IT WILL RESULT IN A FAILED TRANSACTION.

Thank you for processing your application online.

Review

2016 License Renewal

Renewal - 1.042373

Name	CAROL L WATSON MD
Credential	1.042373

Fee Details

Renewal Application Fee	$575.00
	$575.00

Workforce Survey Introduction

Dear Licensee:

Thank you for renewing your license online.

As part of this renewal application, you will be asked to enter your National Provider Identification (NPI) number. Please make sure you have that information available before proceeding. If you do not have your NPI number with you, you can find it online at https://npiregistry.cms.hhs.gov/. You will also be asked to enter information regarding your practice location, specialty and patients served.

The purpose of the questions is to allow the Department of Public Health to collect valuable workforce and patient care data that is critical in identifying and addressing healthcare workforce shortage and patient care issues.

Thank you for assisting the Department in this important initiative.

Demographic Information-Renewal

1. Please provide your Date of Birth
   10/16/1972

2. Gender
   Female

3. Ethnicity: Please choose one
   Not Hispanic or Latino

4. Race:
   Black or African American

Email Address Verification

Please be advised that the Department will no longer be mailing hardcopy licenses and renewal notices. Rather, licenses and renewal notices will be sent via email. You will receive an electronic copy of your license via email within a few days of completing this transaction. Renewal notices will be sent via email approximately 60 days prior to your license expiration date. After you complete this transaction, please select the 'My Account' link at the top right of the homepage and make sure that your email address on file is correct. If it is not correct, please update it. Thank you.

5. By entering a date in this field, I confirm that I will verify that the Department has my correct email address on file.
   10/28/2016

Medical Education

6. Medical School
   Albany Medical College

7. Year of Graduation
   2000

Specialty/Board Certification

8. Please indicate practice specialties, subspecialties and the date you were certified by ABMS or ABOMS.

Specialty	Subspecialty		Certifying Board	Certification Date
Obstetrics and Gynecology	Subspecialty	Certification Date	American Board of Obstetrics and Gynecology	01/19/2009

Current Workforce Status in Medicine

9. What is your current work status in medicine?
Full Time - (40 hours or more per week)

10. In the next 12 months, do you plan to (please mark all that apply):
None

11. If 100% of your primary professional position is not direct patient care, please indicate which of the following apply:

12. If your response to the previous question was other, please enter additional comments here.

National Provider Identifier

The National Provider Identifier (NPI) is a 10-digit identifier required on all HIPAA standard electronic transactions. NPIs have replaced all separately issued identifiers, including Medicaid PINs and Medicare UPINs, on HIPAA standard electronic transactions. In the past, health plans assigned an identifying number to each provider with whom they conducted electronic business. Since providers typically work with several health plans, they were likely to have a different identification number for each plan. The NPI has been put in place so that each provider has one unique, United States federal government-issued identifier to be used in transactions with all health plans with which the provider conducts business.

13. Please enter your NPI number here (if you do not know your NPI number, you may retrieve it at https://npiregistry.cms.hhs.gov. If you do not have an NPI number, please enter ten (10) zeros):
1578654976

Physician Renewal Practice Location

14. Please indicate the name and address of your primary practice location as well as languages spoken at that location. Please note that you can add additional practice locations but you may only select one (1) primary practice location.

Practice Name	Address 1	Address 2	Address 3	City	State	Zip Code	Primary Practice	Languages Spoken at this Location
Starling Physicians	40 Dale Road	Suite 105		Avon	Connecticut	06001	Yes	
Starling Physicians	300 Kensington Avenue			New Britain	Connecticut	06051	No	

15. Approximately how many physicians are associated with your practice?
10

16. Is the primary site where you spend most time providing direct patient care a JCAHO/NCQA recognized patient care centered medical home?
No

17. Please select the best choice for the type of ownership of your practice.
Private practice

Practice Ownership - Organization

18. Please enter the name of the organization/person that owns the practice where you work.
Starling Physicians

19. City
Rocky Hill

20. State (two letter abbreviation)
CT

New Patients

21. Please select the best response that describes your patient care practice status:
I can accept some new patients; my practice is far from full

22. Are you accepting new patients covered by:
Both

Primary Source of Payment

What percent of your patients have the following source of payment?

23. Medicare
less than 10%

24. Medicaid
11 - 25%

25. Self-Pay
less than 10%

26. Private Insurance
51 - 75%

27. Other
None

28. Does your practice offer sliding fee scale based on ability to pay?
No

29. Approximately what percentage of your patients use sliding fee schedules?
None

Populations Served

Please approximate the percentage of patients at your primary practice location that are:

30. Homeless
None

31. Migrant/Seasonal Farm Workers
Less than 10%

32. Native Americans
Less than 10%

Connecticut Prescription Monitoring and Reporting System

All prescribing practitioners possessing a Connecticut controlled substance registration (CSP) issued by the Connecticut Department of Consumer Protection (DCP) must register with the Connecticut Prescription Monitoring and Reporting System (CPMRS) online at www.ctpmp.com.

After you have completed this renewal transaction, please visit the DCP's website at www.ct.gov/dcp and select 'Programs & Services' then 'Prescription Monitoring Program' for information regarding registration.

33. I acknowledge that I have read the information regarding registration in the Connecticut Prescription Monitoring and Reporting System.
10/28/2016

Physician Attestation

34. Within the last year, have you been convicted of a felony?
No

35. If yes, please provide details here

36. Within the last year, have you had any disciplinary action taken against you or any such actions pending by another State's licensing/certification authority?
No

37. If yes, please provide details here

38. I attest that I am in compliance with the mandatory continuing education requirements and that I am in compliance with the mandatory professional liability insurance coverage requirements.
Yes

39. I attest that on this date I completed this renewal application online and that all of the statements made by me on this renewal are accurate.
10/28/2016

Important Note

To continue processing your renewal, please click "Add to Invoice" on the NEXT screen (read the rest of this information first).

On the top right of the invoice screen, select **"Pay Invoice".**

PLEASE NOTE THAT WHEN ENTERING YOUR CREDIT CARD NUMBER, DO NOT ENTER SPACES OR DASHES AS IT WILL RESULT IN A FAILED TRANSACTION.

Thank you for processing your renewal online.

Review

2015 License Renewal

Renewal - 1.042373

Name	CAROL L WATSON MD
Credential	1.042373

Fee Details

Renewal Application Fee	$575.00
	$575.00

Demographic Information-Renewal

2. First Name
CAROL

3. Middle Initial
L

4. Last Name
WATSON

5. Maiden Name

1. Please provide your Date of Birth.
10/16/1972

6. Gender
Female

7. Ethnicity: Please choose one:
Not Hispanic or Latino

8. Race:
Black or African American

Workforce Survey Introduction

Dear Licensee:

Thank you for renewing your license online.

The purpose of the next several questions is to allow the Department of Public Health to collect valuable workforce data that is currently unavailable but critical in identifying and addressing healthcare workforce shortage issues.

Thank you for assisting the Department in this important initiative.

Current Workforce Status in Medicine

9. What is your current work status in Medicine?
Full Time - (30 hours or more per week)

Workforce Survey

10. In the next 12 months, do you plan to (please mark all that apply):

11. If you are **NOT** working in your licensed profession, please indicate your plans for returning to work in your licensed field.

12. Please provide the number of hours per week that you provide DIRECT PATIENT CARE in your primary professional position.

If you do not provide hours in this category, please indicate 0.
60

13. Please provide the number of hours per week that you work as an ADMINISTRATOR/MANAGER in your primary professional position.

If you do not provide hours in this category, please indicate 0.
4

14. Please provide the number of hours per week that you work as an EDUCATOR/FACULTY in your primary professional position. If you do not provide hours in this category, please indicate 0.
4

15. Please provide the number of hours per week that you work as a RESEARCHER in your primary professional position. If you do not provide hours in this category, please indicate 0.
0

16. If your primary profesional position is in a category other than those above, please provide that category in the box below and indicate the number of hours per week.

If you do not provide hours in this category, please indicate 0.

17. Please indicate the setting of your primary professional employment.

Enter comments if "Other" is selected.

Practice Location

If you are providing direct patient care, please identify the location of the primary site where you spend the most time providing direct patient care.

18. Address 1
40 Dale Road

19. Address 2
Suite 105

20. City
Avon

21. State
CT

22. Zip Code
06001

Primary Source of Payment

What percent of your patients have the following source of Payment?

23. Medicare
less than 10%

24. Medicaid
11 - 25%

25. Self-Pay
less than 10%

26. Private Insurance
76 - 100%

27. Other
None

Connecticut Prescription Monitoring and Reporting System

All prescribing practitioners possessing a Connecticut controlled substance registration (CSP) issued by the Connecticut Department of Consumer Protection (DCP) must register with the Connecticut Prescription Monitoring and Reporting System (CPMRS) online at www.ctpmp.com.

After you have completed this renewal transaction, please visit the DCP's website at www.ct.gov/dcp and select 'Programs & Services' then 'Prescription Monitoring Program' for information regarding registration.

28. I acknowledge that I have read the information regarding registration in the Connecticut Prescription Monitoring and Reporting System.
10/15/2015

Attestation

29. Within the last year, have you been convicted of a felony?
No

33. If yes, please provide details here

30. Within the last year, have you had any disciplinary action taken against you or any such actions pending by another State's licensing/certification authority?
No

34. If yes, please provide details here

31. **By completing this renewal online, I verify that all the information I have provided is accurate and that I satisfy the renewal requirements that apply to my license.**
10/15/2015

32. I attest that on this date I completed this renewal application online and that all of the statements made by me on this renewal are accurate.
10/15/2015

Important Note

To continue processing your renewal, please click "Next" below (read the rest of this information first).

On the review screen, click **"Add to Invoice."**

On the top right of the invoice screen, select **"Pay Invoice".**

PLEASE NOTE THAT WHEN ENTERING YOUR CREDIT CARD NUMBER, DO NOT ENTER SPACES OR DASHES AS IT WILL RESULT IN A FAILED TRANSACTION.

Please note that you will receive your new licensing documents (2 wallet-sized cards and 1 suitable for posting) during the third week of next month.

Thank you for processing your renewal online.

Fee

Pursuant to Public Act 15-5, the Connecticut General Assembly passed legislation that increased license renewal fees by $5.00. The additional $5.00 fee is allocated for services provided by the Health Assistance InterVention Education Network (HAVEN), a confidential program designed to assist qualifying health care practitioners who suffer from chemical dependency, emotional or behavioral disorders, or physical or mental illness to maintain their license while receiving the support necessary to practice safely

and effectively. To learn more about HAVEN, please visit their website at http://www.haven-ct.org/.

Review

STATE OF CONNECTICUT
DEPARTMENT OF PUBLIC HEALTH

475

PHYSICIAN APPLICATION FOR:

X Initial licensure ($450)

____Reinstatement (Fee $450) CT License No.: _____ Date Granted: _____

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

	National Board of Medical Examiners (NBME)		Federation Licensing Examination (FLEX)
	State Board Licensing Exam _____(State) Year Taken: _____		Licentiate of the Medical Council of Canada (LMCC)
X	United States Medical Licensing Examination (USMLE) Was Step 3 taken in CT? If yes, what date? 12/18/01		Combination of Segments (please specify)
	National Board of Osteopathic Examiners (NBOME)		

Last Name: WATSON First Name: CAROL MI: L Maiden Name: n/a

Date of Birth: 10 / 16 / 72 Social Security No.: [redacted] Gender: female

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

Name on License: Carol L. Watson

Address: 50 Ebert Drive #65

City, State, Zip: Bristol, CT 06010

Daytime Phone Number: (860) 583-9890 E-mail: cwatson35@hotmail.com

MEDICAL EDUCATION:

List name and location of medical school(s) attended — Dates of Attendance

Albany Medical College 8/96 - 5/00

M.D. DEGREE AWARDED BY: Albany Medical College (Name of school) **DATE AWARDED:** 5/2000

MEDICAL LICENSURE:

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

STATE	LIC. NUMBER	DATE ISSUED	LICENSED BY: EXAM	LICENSED BY: ENDORSEMENT
NONE				

SPECIALTY:

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

AMERICAN BOARD OF: _____ **DATE CERTIFIED:** _____

MEDICAL PRACTICE:

List all medical practice you have engaged in since graduation from medical school (identify internship and residency):

Hospitals Associated With	Location	Dates
New Britain General Hospital	New Britain, CT	7/00 - present
Hartford Hospital	Hartford, CT	7/00 - present
UCONN- John Dempsey Medical Ctr	Farmington, CT	7/00 - present

Answer only if applying for endorsement of the Medical Council of Canada license. Have you requested a "certificate of good standing" with scores from the Medical Council of Canada? _____ **(Yes or No)**

If you are a foreign medical graduate, do you hold current Educational Commission for Foreign Medical Graduates (ECFMG) certification or have you completed a Fifth Pathway Program? _____ **(Yes or No)**

STATEMENT OF PROFESSIONAL HISTORY

Please answer the following questions referring to the instructions, if applicable.

1. Have you ever been censured, disciplined, dismissed or expelled from, had admissions monitored or restricted, had privileges limited, suspended or terminated, been put on probation, or been requested to resign or withdraw from any of the following:

-Any hospital, nursing home, clinic, or similar institution;
-Any health maintenance organization, professional partnership, corporation, or similar health practice organization, either private or public;
-Any professional school, clinical clerkship, internship, externship, preceptorship or postgraduate training program;-Any third party reimbursement program, whether governmental or private?

Yes ☐ No ☒

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

2. Have you ever had your membership in or certification by any professional society or association suspended or revoked for reasons related to professional practice?

Yes ☐ No ☒

If your answer is "yes", give names of professional society or association, date and reasons your membership or certification was suspended or revoked on a separate notarized statement.

3. Has any professional licensing or disciplinary body in any state, the District of Columbia, a United States possession or territory, or a foreign jurisdiction, limited, restricted, suspended or revoked any professional license, certificate, or registration granted to you, or imposed a fine or reprimand, or taken any other disciplinary action against you?

Yes ☐ No ☒

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

4. Have you ever, in anticipation or during the pendency of an investigation or other disciplinary proceeding, voluntarily surrendered any professional license, certificate or registration issued to you by any state, the District of Columbia, a United States possession or territory, or a foreign jurisdiction?

Yes ☐ No ☒

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

5. Have you ever been subject to, or do you currently have pending, any complaint, investigation, charge, or disciplinary action by any professional licensing or disciplinary body in any state, the District of Columbia, a United States possession or territory, or a foreign jurisdiction or any disciplinary board/committee of any branch of the armed services? You need not report any complaints dismissed as without merit.

Yes ☐ No ☒

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

6. Have you ever entered into, or do you currently have pending, a consent agreement of any kind, whether oral or written, with any professional licensing or disciplinary body in any state, the District of Columbia, a United States possession or territory, any branch of the armed services or a foreign jurisdiction?

Yes ☐ No ☒

If your answer is "yes" give full details on a separate notarized statement and submit notarized copy of agreement.

STATEMENT OF PROFESSIONAL HISTORY (continued)

7. Have you ever been found guilty or convicted as a result of an act which constitutes a felony under the laws of this state , federal law or the laws of another jurisdiction and which, if committed within this state, would have a felony under the laws of this state? Yes ☐ No ☒

If your answer is "yes" give full details on a separate notarized statement and furnish a Certified Court Copy (with court seal affixed) of the original complaint, the answer, the judgment, the settlement, and/or the disposition of the case.

8. Have you ever been denied or surrendered a state or federal controlled substance registration, had it revoked or restricted in any way, or been warned, reprimanded or fined by the responsible agency? Yes ☐ No ☒

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

On this 25th day of February 2004 (month/ year) Carol Watson **(applicant's name)** personally appeared before me, who being duly sworn says that she/he is the person referred to in the foregoing application and that the photograph attached hereto is a true picture of self and that the statements made herein are true in every respect.

[redacted]

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

Carol Watson

SIGNATURE OF APPLICANT

Sworn to me this 25th day of February (month/year) 2004

Notary Public Signature Kathleen M. Daly My Commission Expires 7-31-2006

PLEASE RETURN THIS APPLICATION AND THE FEE FOR $450 (CERTIFIED CHECK OR MONEY ORDER) MADE PAYABLE TO, **"TREASURER, STATE OF CONNECTICUT"** TO:

DEPARTMENT OF PUBLIC HEALTH
PHYSICIAN LICENSURE
410 CAPITOL AVE., MS# 12MQA
P.O. BOX 340308
HARTFORD, CT 06134-0308

Carol Louise Watson, M.D.
50 Ebert Drive, #65
Bristol, CT 06010
(860) 655-7401
(860) 583-9890
cwatson35@hotmail.com

Resident Education

University of Connecticut Health Center, Farmington, CT
Residency program in Obstetrics and Gynecology
07/00-present

Medical Education

Albany Medical College, Albany, NY
08/96-05/00
Medical Doctor

Undergraduate Education

Yale University, New Haven, CT
08/90-05/95
Bachelor of Science, Biology

Trinity College, Hartford, CT
01/92-05/92

Honors/Awards

The Dr. George C. Carter Award- awarded to the fourth year medical student for outstanding efforts toward the growth and development of the Minority Affairs Program

Albany Medical College Merit Scholarship- full tuition scholarship for 4 years

Mellon Undergraduate Research Award, Yale University 1995

Licensure

USMLE Step 1 06/98 191
USMLE Step 2 03/00 209
USMLE Step 3 12/01 196

Lectures/Presentations

Carol Watson. Pelvic Inflammatory Disease, Proper Diagnosis and Management.
Quality Assurance Conference, Hartford Hospital, November 2003

Carol Watson. Triplets. Perinatal Conference, Hartford Hospital, April 2002

Carol Watson. Ovarian Vein Thrombosis. New Britain General Hospital Grand Rounds, September 2001

Research Experience

10/02-present
New Britain General Hospital, Departments of Pathology and Gynecologic Oncology.
Research under the direction of James Hoffman, MD and Lisa Laird, MD
Chief resident research paper entitled, *Grading of Epithelial Ovarian Cancer- Does It Really Matter?*

07/95-08/96
Yale University School Of Medicine, Pediatric Gastroenterology
Research assistant, lab of Frederick Suchy, MD
Conducted experiments on the bile acid transporter of rats and humans, examining its presence, expression, and function in the context of growth and development

09/94-05/95
Howard Hughes Medical Institute, Yale University
Student research, lab of Pietro DeCamilli, MD
Conducted experiments on the fusion and exocytosis of synaptic vesicles with the plasma membrane. Yale University senior essay entitled, *Synaptic Vesicle Exocytosis*

06/94-08/94
New York University School of Medicine
Student research, lab of David Sabatini, MD/PhD
Conducted experiments on the fusion and targeting of proteins in the Golgi apparatus

Employment

06/91-06/92
Cigna Insurance Company, Medical Claims Division
Central Distribution Center
Employee of the month

Professional Organizations

American College of Obstetrics and Gynecology. Junior Fellow, 2001-present

Student National Medical Association. Secretary, 08/96-07/97. Treasurer, 08/97-07/98. Mentor, 08/96-5/00.

STATE OF CONNECTICUT
DEPARTMENT OF PUBLIC HEALTH
VERIFICATION OF RESIDENCY TRAINING

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

Applicant's name: CAROL WATSON Date of Birth: 10/16/72

Dear Chief of Staff/Program Director:

Please provide the following verification of residency training for the above-named Connecticut physician licensure applicant.

Name of facility where residency training was completed: University of Connecticut

Dates of Residency: From 7/1/00 To 6/30/04
month/day/year (month/day/year)

In what specialty was the residency training completed: Ob-GYN

At what level(s) was this residency completed (PGY1, PGY2, etc.)? PGY1-PGY4

At the time of the applicant's training, was the residency training program in this specialty area accredited by the Accreditation Council for Graduate Medical Education? Yes (YES or NO)

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

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

I, John F. Greene Jr. MD, being duly sworn, do depose and certify that I am the Chief of Staff/Program Director at:

Name of Facility: University of Connecticut

Address: Farmington Ave. at
Farmington, CT. 06030

Telephone Number: (860) 679-2853

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

John F Greene
Signature of Chief of Staff/Program Director

Subscribed and sworn to me this 24th day of February (month/ year) 2004

Angeline Rivera
Notary Public's Signature

My Commission Expires ANGELINE RIVERA NOTARY PUBLIC MY COMMISSION EXPIRES MAY 31, 2008

Please return this form directly to:

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

Website: www.dph.state.ct.us

STATE OF CONNECTICUT

DEPARTMENT OF PUBLIC HEALTH

April 29, 2004

Carol L. Watson M.D.
50 Ebert Drive
65
Bristol, CT 06010

Dear Licensee:

I am pleased to inform you that you have met all requirements for licensure as **a Physician/Surgeon** in Connecticut. Your license number is **042373** and is effective as of the date of this letter. Your formal license will be mailed to you in the near future. Your name will appear on your license as shown above unless you notify us otherwise.

It is your responsibility to notify the Department of Public Health, Office of Practitioner Licensing and Certification, in writing, of any changes of name, residence address or business address, either within or outside Connecticut. Such notification to the Department of Public Health is required by law; failure to provide same may jeopardize the status of your license.

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

Should you have any questions or concerns regarding the renewal of your license, please contact the renewal staff at (860) 509-7603.

Respectfully,

Stephen B. Carragher

Stephen B. Carragher
Health Program Supervisor
Office of Practitioner Licensing and Certification

SBC:MM

Phone: (860) 509-7603
Telephone Device for the Deaf (860) 509-7191
410 Capitol Avenue - MS # 12MQA
P.O. Box 340308 Hartford, CT 06134
An Equal Opportunity Employer
Website for licensure verification http://www.ct-clic.com