122002

State Medical Board of Ohio

30 E. Broad St., 3rd Floor • Columbus, OH 43215-6127 • (614) 466-3934 • Website: http://.med.ohio.gov/

Ohio Addendum to Application

Ohio Training Program

Are you or will you be in an accredited training program in Ohio? ☐ Yes ☒ No
If yes, identify name of training program and location:

Name of Hospital/Training Program _____ City _____ Start Date: ____/____ month/year

Specialty Boards

Name of Specialty Board (If none, enter "N/A")	Year Certified	Country
American Board of Family Medicine	2010	USA

MEDICAL BOARD
APR 29 2013

TOEFL IBT

(International Medical School Graduates only)

THE TOEFL, TWE, ECFMG'S ENGLISH EXAM (PRIOR TO 7/1/98), ETC., ARE NOT EQUIVALENT AND CANNOT BE SUBSTITUTED FOR THE TOEFL IBT

Graduates of medical schools located outside the United States and Canada must achieve a score of at least 26 in Speaking and 26 in Listening with a total score of 90 on the TOEFL IBT, regardless of citizenship or country of birth. Prior to July 2006 the Test of Spoken English was required with a minimum score of 40 (between 7/95-7/06) or 230 (prior to 7/95). The following are the only exceptions permitted under Ohio law:

	YES	NO
Have you completed two years of undergraduate college work in the United States?	☐	☐
During the five years immediately preceding the date of your application, have you: (Please note you must be able to answer "YES" to both parts of this question) Held a current medical license (i.e., unrestricted, training certificate, educational permit) in the United States? **AND** Have you been actively practicing medicine (graduate medical education is included) in the United States?	☐	☐
Have you completed a Fifth Pathway program?	☐	☐
Have you passed the Clinical Skills Assessment examination given by ECFMG on or after July 1, 1998?	☐	☐

If you answered **NO** to all of the above questions, you **must** take the TOEFL IBT. Refer to the application instructions for contacting the Educational Testing Service. The Board cannot waive this requirement.

OK KR 5/16/13

Ohio Addendum to Application

Preliminary Education Form

TO BE COMPLETED BY ALL APPLICANTS

Full Name	Last (Surname)	First	Middle	Suffix (Jr., II)
	Romanos	Catherine	Eileen	

High School or Equivalent

School Name: Northwestern Regional High School #7

City: Winstead | State: CT | Country: USA

Dates Attended — From: MO/YR 8/93 To: MO/YR 6/97

Undergraduate College or Equivalent

School Name: New York University

City: New York | State: New York | Country: USA

Dates Attended — From: MO/YR 8/97 To: MO/YR 5/01 | Degree Received: BA

School Name:

City: | State: | Country:

MEDICAL BOARD
APR 29 2013

Dates Attended — From: MO/YR / To: MO/YR / | Degree Received:

Medical or Osteopathic School of Graduation

School Name: University of Connecticut School of Medicine

City: Farmington | State: CT | Country: USA

Dates Attended — From: MO/YR 8/03 To: MO/YR 5/07 | Degree Received: MD

FOR BOARD USE ONLY

CERTIFICATE OF PRELIMINARY EDUCATION

NO: 126238 DATE ISSUED: 5/23/13

This is to certify that this applicant has met the preliminary education requirements for study in conformity with the Statutes of Ohio and the regulations of the State Medical Board of Ohio

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Applicant Name: Catherine Romanos, MD Date: 4/19/13

Ohio Addendum to Application
Additional Information
Medicine or Osteopathic Medicine

If you answer "YES" to any of the following questions, you are required to furnish complete details, including date, place, reason and disposition of the matter. All affirmative answers must be thoroughly explained on a separate sheet of paper. You must submit copies of all relevant documentation, such as court pleadings, court or agency orders, and institutional correspondence and orders. Please note that some questions require very specific and detailed information. Make sure all responses are complete.

(Please place a ☑ in the yes or no box)

		YES	NO
1.	Have you ever been denied staff membership at any hospital, nursing home, clinic, health maintenance organization, or similar institution?	☐	☑
2.	Have you ever been warned, censured, disciplined, had admissions monitored, had privileges limited, had privileges suspended or terminated, been put on probation, or been requested to withdraw from or resign privileges at any hospital, nursing home, clinic, health maintenance organization, or other similar institution in which you have trained, been a staff member, or held privileges, for reasons other than failure to maintain records on a timely basis, or failure to attend staff or section meetings?	☐	☑
3.	Have you ever resigned from, withdrawn from, or terminated, or have you ever been requested to resign from, withdraw from, or otherwise been terminated from, a position with a medical partnership, professional association, corporation, health maintenance organization, or other medical practice organization, either private or public?	☐	☑
4.	Have you ever resigned from, withdrawn from, or have you ever been warned by, censured by, disciplined by, been put on probation by, been requested to withdraw from, dismissed from, been refused renewal of a contract by, or expelled from, a medical school, clinical clerkship, externship, preceptorship, residency, or graduate medical education program?	☐	☑
5.	Have you ever transferred from one graduate medical education program to another?	☐	☑
6.	Have you ever, for any reason, lost specialty board certification in the U.S. or elsewhere, or been denied such certification, or denied examination for such certification?	☐	☑
7.	Has any board, bureau, department, agency or other body, including those in Ohio, in any way limited, restricted, suspended, or revoked any professional license, certificate or registration granted to you; placed you on probation; or imposed a fine, censure or reprimand against you?	☐	☑
8.	Have you ever voluntarily surrendered, resigned, or otherwise forfeited any professional license, certificate or registration issued to you by any board, bureau, department, agency, or other body; or have you ever withdrawn any application for licensure, relicensure, or examination, in any state (including Ohio), territory, province, or country?	☐	☑
9.	Have you ever, for any reason, been denied licensure or relicensure, application for licensure or relicensure, or the privilege of taking an examination, in any state (including Ohio), territory, province, or country?	☐	☑

		YES	NO
10.	Have you ever been requested to appear before any board, bureau, department, agency, or other body, including those in Ohio, concerning allegations against you?	☐	☑
11.	Have you ever entered into an agreement of any kind, whether oral or written, with respect to a professional license, in lieu of or in order to avoid formal disciplinary action, with any board, bureau, department, agency, or other body, including those in Ohio?	☐	☑
12.	Have you ever been notified of any investigation concerning you by any board, bureau, department, agency, or other body, including those in Ohio, with respect to a professional license?	☐	☑
13.	Have you ever been notified of any charges, allegations, or complaints filed against you with any board, bureau, department, agency, or other body, including those in Ohio, with respect to a professional license?	☐	☑
14.	Have you ever been denied or have you ever surrendered a state or federal controlled substance or drug registration; had it revoked, terminated, or restricted in any way; or been warned, reprimanded, or fined by, or been requested to appear before, the responsible agency?	☐	☑
15.	Have you ever pled guilty to, been found guilty of a violation of any law, or been granted intervention or treatment in lieu of conviction regardless of the legal jurisdiction in which the act was committed, other than a minor traffic violation? If yes, submit copies of all relevant documentation, such as police reports, ***certified*** court records and any institutional correspondence and orders. Photocopies will not be accepted.	☐	☑
16	Have you ever been arrested, forfeited collateral, bail, or bond for breach or violation of any law, police regulation, or ordinance other than for a minor traffic violation; been summoned into court as a defendant or had any lawsuit filed against you (other than a malpractice suit)? If yes, submit copies of all relevant documentation, such as police reports, ***certified*** court records and any institutional correspondence and orders. Photocopies will not be accepted.	☐	☑
17.	Have you been a defendant in a legal action involving professional liability (malpractice), or had a professional liability claim paid on your behalf, or paid such a claim yourself? In addition, ask your malpractice insurance carrier(s) to provide a complete claims history report for the last 10 years to the State Medical Board of Ohio. If your current carrier has provided coverage for less than 10 years, ask your previous carrier to submit a claims history report to the Board.	☐	☑
18.	Have you ever been denied professional liability insurance or coverage, or had such insurance or coverage canceled, limited, or restricted in any way?	☐	☑
19.	Have you ever been denied or relinquished participation in any third party reimbursement program, whether governmental or private, including Medicaid and Medicare; or had such participation limited, restricted, suspended, or revoked; or been warned, reprimanded, requested to appear before, or fined by the responsible body?	☐	☑
20.	Have you ever been denied privileges, or had privileges revoked, suspended, restricted, reduced, or terminated by the Department of Defense, the Veteran's Administration, or any of their respective components?	☐	☑

		YES	NO
21.	Have you ever been diagnosed as having, or have you been treated for, pedophilia, exhibitionism, or voyeurism?	☐	☑
22. a)	Within the last ten years, have you been diagnosed with or have you been treated for, bipolar disorder, schizophrenia, paranoia, or any other psychotic disorder?	☐	☑
b)	Have you, since attaining the age of eighteen or within the last ten years, whichever period is shorter, been admitted to a hospital or other facility for the treatment of bipolar disorder, schizophrenia, paranoia, or any other psychotic disorder?	☐	☑

If you answered "YES" to any part of this question, please provide details on a separate sheet, including date(s) of diagnosis or treatment, and a description of your present condition. Include the name, current mailing address, and telephone number of each person who treated you, as well as each facility where you received treatment, and the reason for treatment. Have each treating physician submit a letter detailing the dates of treatment, diagnosis and prognosis.

For purposes of questions 23 and 24 the following phrases or words have the following meaning:

"Ability to practice medicine" is to be construed to include all of the following:

1. The cognitive capacity to make appropriate clinical diagnoses and exercise reasoned medical judgments and to learn and keep abreast of medical developments; and
2. The ability to communicate those judgments and medical information to patients and other health care providers, with or without the use of aids or devices, such as voice amplifiers; and
3. The physical capability to perform medical tasks such as physical examination and surgical procedures, with or without the use of aids or devices, such as corrective lenses or hearing aids.

"Medical condition" includes physiological, mental, or psychological conditions or disorders, such as but not limited to orthopedic, visual, speech, and hearing impairments, cerebral palsy, epilepsy, muscular dystrophy, multiple sclerosis, cancer, heart disease, diabetes, mental retardation, emotional or mental illness, specific learning disabilities, HIV disease, tuberculosis, drug addiction, and alcoholism.

		YES	NO
23.	Do you have, or have you been diagnosed as having, a medical condition which in any way impairs or limits your ability to practice medicine with reasonable skill and safety? **You may answer "NO" to this question if** you hold a current training certificate to pursue training in Ohio and the only such medical condition is chemical dependency or substance abuse, and you have successfully completed or are currently receiving treatment at a program approved by this board and have adhered to all statutory requirements as contained in Sections 4731.224 and 4731.25, O.R.C., and related provisions. Any questions concerning approval can be directed to the board offices.	☐	☑
a)	Are the limitations or impairment caused by your medical condition reduced or ameliorated because you receive ongoing treatment or received treatment in the past (with or without medication) or participate in a monitoring program?	☐	☐

If you receive such ongoing treatment or participate in such monitoring program the board will make an individualized assessment of the nature, severity, and duration of the risk associated with an ongoing medical condition so as to determine whether an unrestricted license should be issued, whether conditions should be imposed, or whether you are not eligible for licensure. Have each treating physician submit a letter detailing the dates of treatment, diagnosis and prognosis.

b)	Are the limitation or impairments caused by your medical condition reduced or ameliorated because of the field of practice, the setting, or the manner in which you have chosen to practice?	☐	☐

"Chemical substances" is to be construed to include alcohol, drugs, or medications including those taken pursuant to a valid prescription for legitimate medical purposes and in accordance with the prescribers direction, as well as those used illegally.

		YES	NO
24.	Do you use chemical substance(s) which in any way impair or limit your ability to practice medicine with reasonable skill and safety?	☐	☑
	a) Are the limitations or impairment caused by your use of chemical substances reduced or ameliorated because you receive ongoing treatment (with or without medication) or participate in a monitoring program?	☐	☐

If you receive such ongoing treatment or participate in such monitoring program the board will make an individualized assessment of the nature, severity, and duration of the risk associated with an ongoing medical condition so as to determine whether an unrestricted license should be issued, whether conditions should be imposed, or whether you are not eligible for licensure. Have each treating physician submit a letter detailing the dates of treatment, diagnosis and prognosis.

	b) Are the limitation or impairments caused by your use of chemical substances reduced or ameliorated because of the field of practice, the setting, or the manner in which you have chosen to practice?	☐	☐

For purposes of question 25 the following phrases or words have the following meaning:

"Currently" does not mean on the day of, or even in the weeks or months preceding the completion of this application. Rather it means recently enough so that the use of drugs may have an ongoing impact on one's functioning as a licensee, or within the past two years.

"Illegal use of controlled substances" means the use of controlled substances obtained illegally (e.g. heroin or cocaine) as well as the use of controlled substances which are not obtained pursuant to a valid prescription or not taken in accordance with the direction of a licensed healthcare practitioner.

		YES	NO
25.	Are you currently engaged in the illegal use of controlled substances?	☐	☑
	a) If "YES," are you currently participating in a supervised rehabilitation program or professional assistance program which monitors you in order to assure that you are not using illegal controlled substances.	☐	☐

State Medical Board of Ohio

30 E. Broad Street, 3rd Floor, Columbus, OH 43215-6127 614-466-9257

MEDICAL BOARD

MAY 02 2013

Ohio Addendum to Application
Certificate of Recommendation
Medicine or Osteopathic Medicine

I, Mia D. Sorunelli Smith, currently hold an active license to practice as a physician in the state of
(Recommending physician, print name legibly)
Massachusetts, attest that all information I am providing is in conformance with the "Instructions for Completion of Recommendation Form," and provide this recommendation form related to the request for professional licensure by Catherine Romanos, MD.
(Applicant, print name legibly)
Further, the photograph affixed hereto is a genuine likeness of the applicant, who has been personally known to me for 6 years/months.

1. How do you know this applicant? trained in residency for 3 years, served as co-chief residents during this time, shared office space for 2.5 years after
2. How would you describe the applicant's medical knowledge? excellent
3. How would you describe the applicant's clinical technique? excellent - very thorough, caring,
4. How would you characterize the applicant's relationship with patients? strong - her patients trust her and care about her.
5. How would you describe the applicant's ability to work with peers and clinical staff? excellent - very helpful.
6. Does the applicant possess good moral character? (If no, explain) ☒ Yes ☐ No
7. Do you recommend this applicant for the professional license being sought? (If no, explain) ☒ Yes ☐ No
8. Are you aware of any other information (favorable or unfavorable) that could potentially impact this applicant's suitability for professional licensure or the Board's consideration of his/her application? (If yes, explain) ☐ Yes ☒ No
9. Have you attached additional correspondence or information to this form? ☐ Yes ☒ No

Signature of Recommending Physician (Name stamps not accepted)

150 Park St Lawrence, MA 01841
Address (include house number and street, city, state and zip code)
State of Licensure and License Number 242682 MA

Subscribed and sworn to before me this 26 day of April, 2013.

Notary Public Signature

NOTARY SEAL

WANDA L. MOYA
Notary Public
Commonwealth of Massachusetts
My Commission Expires
May 23, 2014

Date Commission Expires May 23 2014

Signature of Applicant

Date Photo Taken: 04 / 13
Month Year

Eff 4/12

State Medical Board of Ohio

30 E. Broad Street, 3rd Floor, Columbus, OH 43215-6127 614-466-9257

Ohio Addendum to Application
Certificate of Recommendation
Medicine or Osteopathic Medicine

I, Suhani Bosa, MD (Recommending physician, print name legibly), currently hold an active license to practice as a physician in the state of Massachusetts, attest that all information I am providing is in conformance with the "Instructions for Completion of Recommendation Form," and provide this recommendation form related to the request for professional licensure by Catherine Romanos, MD (Applicant, print name legibly).

Further, the photograph affixed hereto is a genuine likeness of the applicant, who has been personally known to me for 2 years 6 months years/months.

1. How do you know this applicant? We are colleagues - we worked in the same clinic for 2 years and 4 months.
2. How would you describe the applicant's medical knowledge? excellent, evidence-based
3. How would you describe the applicant's clinical technique? excellent, she is efficient + thoughtful in her medical decision making
4. How would you characterize the applicant's relationship with patients? compassionate, dedicated, thorough
5. How would you describe the applicant's ability to work with peers and clinical staff? cheerful + pleasant demeanor, is always respectful of clinic staff and has a good relationship with her peers
6. Does the applicant possess good moral character? (If no, explain) ☒ Yes ☐ No
7. Do you recommend this applicant for the professional license being sought? (If no, explain) ☒ Yes ☐ No
8. Are you aware of any other information (favorable or unfavorable) that could potentially impact this applicant's suitability for professional licensure or the Board's consideration of his/her application? (If yes, explain) ☐ Yes ☒ No
9. Have you attached additional correspondence or information to this form? ☐ Yes ☒ No

Signature of Applicant
Date Photo Taken: 04 / 13
Month Year

Signature of Recommending Physician (Name stamps not accepted)

20 Grove St. #54 Somerville, MA 02144
Address (Include house number and street, city, state and zip code)
State of Licensure and License Number MA 249528

MEDICAL BOARD
MAY 06 2013

Subscribed and sworn to before me this 30 day of April, 2013.

Notary Public Signature

NOTARY SEAL

WANDA I. MOTA
Notary Public
Commonwealth of Massachusetts
My Commission Expires
May 23, 2014

Date Commission Expires May 23, 2014

Eff 4/12

4/29

UA UNIFORM APPLICATION FOR PHYSICIAN STATE LICENSURE

Affidavit and Authorization for Release of Information

This form should be sent to the state board you are applying to.

Applicant:

Securely tape or glue a recent (less than 6 month old) front-view 2" x 2" passport-type color photo of yourself in the square below.

Sign this form with attached photo in the presence of a notary public.

Send the notarized form to the board you are applying to for licensure.

I, the undersigned, being duly sworn, hereby certify under oath that I am the person named in this application, that all statements I have made or shall make with respect thereto are true, that I am the original and lawful possessor of 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.

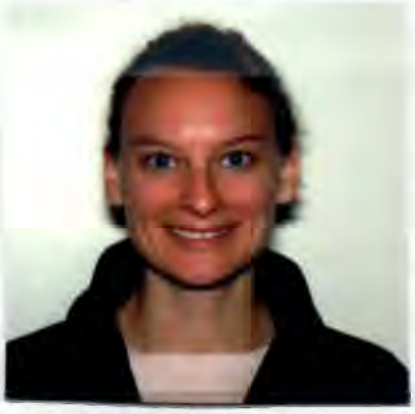
I acknowledge that I have read and understand the Uniform Application for Physician State Licensure and have answered all questions contained in the application truthfully and completely. I further acknowledge that failure on my part to answer questions truthfully and completely may lead to my being 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 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 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 Board, its agents or representatives, and any 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 of any and all liability of every nature and kind arising out of investigation made by the Board.

I will immediately notify the Board in writing of any changes to the answers to any of the questions contained in this application if such a change occurs at any time prior to a license to practice medicine being granted to me by the Board.

I understand my failure to answer questions contained in this application truthfully and completely may lead to denial, revocation, or other disciplinary sanction of my license or permit to practice medicine.



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

MEDICAL BOARD
APR 29 2013

Romanos

Applicant's printed last name

Catherine E.

Applicant's printed first name, middle initial, and suffix (e.g., Jr.)

4/17/13

Date of signature (must correspond to date of notarization)

Notary

State of MA, County of Essex

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 17th day of April, 2013

Notary Public Signature: Jennifer L. McManus

My Notary Commission Expires: 6/4/2015

NOTARY PUBLIC SEAL
Notary Public
COMMONWEALTH OF MASSACHUSETTS
My Commission Expires
June 4, 2015

DEVAL L. PATRICK
GOVERNOR

TIMOTHY P. MURRAY
LIEUTENANT GOVERNOR

Commonwealth of Massachusetts
Board of Registration in Medicine

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

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

4/29/2013

To Whom It May Concern:

This certifies that Catherine E Romanos, M.D., a 2007 graduate of University of Connecticut School of Medicine, has been duly registered by this board as provided by the laws of the Commonwealth.

Certificate Number 242461 was issued to Dr. Romanos on 12/16/2009. The license status is: Active. The expiration date is 1/28/2015.

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

Closed Complaint Information

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

Final Board Disciplinary Action

Our files contain 0 disciplinary action(s) taken against this physician by the Board.

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

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

www.mass.gov/massmedboard

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

Francee L Mulero

SEAL

Staff Member, Board of Registration in Medicine

Francee Mulero

MEDICAL BOARD

MAY 0 2 2013

UA UNIFORM APPLICATION FOR PHYSICIAN STATE LICENSURE

Licensure Verification (UA Form #1)

This form should be sent to each board with which you have ever held a license.

Applicants:

Complete Section 1. In the Authorization area, list the board that needs to verify your license as well as your license number. Type or print legibly.

Send this form and any required fee for this verification to the authorizing board.

Copy this form for multiple licenses.

Section 1: Applicant Information

Last name: Romanos Suffix: _____

First name: Catherine

Middle name: Eileen

Date of birth: 01-28-79 Social Security number*: Redacted

**The social security number is to be used for purposes of identification only and may not be used for any other reason.*

In listing the Board information below, please reference http://www.fsmb.org/directory_smb.html.

Name of Board applying to: State Medical Board of Ohio

Board address: 30 E. Broad St. 3rd Floor

Board city/state/zip code: Columbus OH 43215-6127

Authorization: I am applying for a license to practice medicine. The Board I am applying to requires that this form be completed by each state or Canadian province in which I hold or have held licenses, whether now current or not. I authorize the licensing agency of the state/province of Massachusetts to provide any and all information pertaining to license number 342461 to the Board listed above.

Applicant signature: _____ **Date:** 4/15/13

State Licensing Board or Canadian Province:

Please complete Section 2. Send this form to the board at the address listed in Section 1.

Section 2: Licensure Verification

Name of Licensee: _____
Last First Middle Suffix

License type: _____ License number: _____

Issue date: _____ Expiration date: _____

Is this license current? ☐ Yes ☐ No If not current, please explain: _____

1. Have formal disciplinary proceedings been initiated against applicant's license by a disciplinary authority in your state? ☐ Yes ☐ No ☐ Cannot answer under state law

If yes, please explain: _____

2. Has the applicant ever been warned, censured, placed on probation, formal consent, reprimand, or in any other manner disciplined, or has the applicant's license ever been revoked, suspended, or, in any other manner, limited by a licensing or disciplinary authority in your state?
☐ Yes ☐ No ☐ Cannot answer under state law

If yes, please explain: _____

I CERTIFY THAT to the best of my knowledge and belief, the foregoing is a true, accurate, and complete statement of the record of the individual named on this form.

AFFIX BOARD SEAL HERE

(If no seal is available, this form must be notarized.)

Signature: _____

Print name: _____

Title: _____

Date: _____

Email: _____

THE UNIVERSITY OF THE STATE OF NEW YORK
THE STATE EDUCATION DEPARTMENT
DIVISION OF PROFESSIONAL LICENSING SERVICES
89 WASHINGTON AVENUE
ALBANY, NEW YORK 12234

This is to certify that according to the records of the Division of Professional Licensing Services, New York State Education Department Albany, New York, ROMANOS CATHERINE EILEEN
was issued license/certificate number 257511 for the practice of MEDICINE on 06/24/10.

MEDICAL BOARD
MAY 16 2013

Our records also indicate the following information:
Date of birth: 01/28/79
School attended: UNIV OF CONN SCH OF MED
Date of graduation: 05/13/07
Degree earned: MD

Program was acceptable in accordance with the NYS Regulations of the Commissioner of Education. Requirements met at the time of licensure.

Basis of licensure:

DATE	FLEX1	NBME1	USML1	NBME2	FLEX2	USML2	NBME3	USML3	OTHER
07/09								00099	OOSMA
06/06						00090			
06/05			00081						

EXMS TAKEN=03

A license is valid during the life of the holder unless revoked, annulled or suspended by the Board of Regents. A licensee must register periodically with this Department to practice in this state.

Currently Registered: YES Reg period ends: 12/31/13
Address: 150 PARK ST LAWRENCE MA 01841-0000

Disciplinary information: No charges have been preferred against this licensee
Comments:

I, Cathy Hanczaryk, Principal Clerk, Division of Professional Licensing Services of the New York State Education Department, do hereby state that as Principal Clerk of said Division, I have legal custody of the official records of the Division of Professional Licensing Services and to the best of my knowledge, the aforesaid information is true and correct.

SEAL

Cathy Hanczaryk 05/10/13
Principal Clerk

4/29

UA UNIFORM APPLICATION FOR PHYSICIAN STATE LICENSURE

Licensure Verification (UA Form #1)

This form should be sent to each board with which you have ever held a license.

MEDICAL BOARD
MAY 16 2013

Applicants:

Complete Section 1. In the Authorization area, list the board that needs to verify your license as well as your license number. Type or print legibly.

Send this form and any required fee for this verification to the authorizing board.

Copy this form for multiple licenses.

Section 1: Applicant Information

Last name: Romanos Suffix: _____

First name: Catherine

Middle name: Eileen

Date of birth: 01-29-79 Social Security number*: Redacted

**The social security number is to be used for purposes of identification only and may not be used for any other reason.*

In listing the Board information below, please reference http://www.fsmb.org/directory_smb.html.

Name of Board applying to: State Medical Board of Ohio

Board address: 30 E. Broad St 3rd Floor

Board city/state/zip code: Columbus, OH 43215-6127

Authorization: I am applying for a license to practice medicine. The Board I am applying to requires that this form be completed by each state or Canadian province in which I hold or have held licenses, whether now current or not. I authorize the licensing agency of the state/province of New York to provide any and all information pertaining to license number 257511-1 to the Board listed above.

Applicant signature: _____ **Date**: 4/15/13

State Licensing Board or Canadian Province:

Please complete Section 2. Send this form to the board at the address listed in Section 1.

Section 2: Licensure Verification

Name of Licensee: _____
Last First Middle Suffix

License type: _____ License number: _____

Issue date: _____ Expiration date: _____

Is this license current? ☐ Yes ☐ No If not current, please explain: _____

1. Have formal disciplinary proceedings been initiated against applicant's license by a disciplinary authority in your state? ☐ Yes ☐ No ☐ Cannot answer under state law

If yes, please explain: _____

2. Has the applicant ever been warned, censured, placed on probation, formal consent, reprimand, or in any other manner disciplined, or has the applicant's license ever been revoked, suspended, or, in any other manner, limited by a licensing or disciplinary authority in your state?
☐ Yes ☐ No ☐ Cannot answer under state law

If yes, please explain: _____

I CERTIFY THAT to the best of my knowledge and belief, the foregoing is a true, accurate, and complete statement of the record of the individual named on this form.

AFFIX BOARD SEAL HERE

(If no seal is available, this form must be notarized.)

Signature: _____

Print name: _____

Title: _____

Date: _____

Email: _____

Employer Recommendation Form

URGENT LICENSURE PENDING

State Medical Board of Ohio

30 E. Broad St., 3rd Floor • Columbus, OH 43215-6127 • (614) 466-3934 • Website: http://med.ohio.gov/

Dr. Catherine Romanos, MD
(PLEASE PROVIDE THE FIRST AND LAST NAME OF THE APPLICANT)

is applying for licensure in the State of Ohio. We would appreciate your assistance in filling out the following evaluation so that we can process his/her application for licensure. To ensure processing of the physicians application, please complete and return this form to the State Medical Board of Ohio at the above within two (2) weeks. The form may also be faxed to the Board at (614) 644-1464. Your immediate attention to this matter will be greatly appreciated by the applicant as well as by us. Thank you for your time and assistance.

Position(s) held: STAFF PHYSICIAN

Dates of employment: 1/24/13 ⇒ PRESENT

(1) How long have you known him/her? 1 YEAR

(2) What is/was your supervisory capacity? MEDICAL DIRECTOR

(3) At what hospital? PLANNED PARENTHOOD MOHAWK HUDSON

(4) How would you rate his/her medical knowledge and techniques? EXCELLENT

(5) In your opinion is he/she a person of good moral and ethical character? YES

(6) Does he/she work well with peers and medical staff? VERY WELL INDEED

(7) Does he/she relate well to patients? YES - VERY COMPASSIONATE

(8) How is his/her command of the English language if applicable)? EXCELLENT (FIRST LANGUAGE) / ALSO FLUENT IN SPANISH

(9) Would you recommend him/her for licensure? YES

Additional comments, please: (if needed, an extra sheet of paper may be used)
WE WILL MISS HER + WE WOULD RE-HIRE IMMEDIATELY

Sincerely,
Nicole Weaver
Chief, Licensure

Signature of Physician

MARC HELLER MD
Name of Physician (please type or print clearly)

MEDICAL DIRECTOR
Position

518-374-5353
Telephone number (include area code)

518-382-5753
FAX number (include area code)

MEDICAL BOARD
APR 29 2013

Employer Recommendation Form

URGENT LICENSURE PENDING

State Medical Board of Ohio

30 E. Broad St., 3rd Floor • Columbus, OH 43215-6127 • (614) 466-3934 • Website: http://med.ohio.gov/

Dr. Catherine Romanos, MD
(PLEASE PROVIDE FIRST AND LAST NAME)

is applying for licensure in the State of Ohio. We would appreciate your assistance in filling out the following evaluation so that we can process his/her application for licensure. To ensure processing of the physicians application, please complete and return this form to the State Medical Board of Ohio at the above within two (2) weeks. **The form may also be faxed to the Board at (614) 644-1464**. Your immediate attention to this matter will be greatly appreciated by the applicant as well as by us. Thank you for your time and assistance.

Position(s) held: Family Physician

Dates of employment: 4/8/13 - present

(1) How long have you known him/her? July 2007 - present

(2) What is/was your supervisory capacity? I was The Residency Program Director for D. Romanos from 7/2007 to 6/2009 and her supervisor in practice from 7/2013 to the present

(3) At what hospital? Lynn Community Health Center

(4) How would you rate his/her medical knowledge and techniques? Excellent

(5) In your opinion is he/she a person of good moral and ethical character? yes

(6) Does he/she work well with peers and medical staff? yes

(7) Does he/she relate well to patients? yes

(8) How is his/her command of the English language if applicable)? yes

(9) Would you recommend him/her for licensure? yes

Additional comments, please: (f needed, an extra sheet of paper may be used)

Sincerely,

The Licensure Staff

Signature of Physician

Scott Earle MD
Name of Physician (please type or print clearly)

Chief Medical Officer
Position

781-596-6618
Telephone number (include area code)

FAX number (include area code)

Lynn COMMUNITY health CENTER

FACSIMILE TRANSMITTAL SHEET

269 UNION STREET
LYNN, MA 01902

TO:

FROM: Peggy Ventullo

COMPANY: State Medical Board Ohio

EMAIL: Pventullo@lchcnet.org

FAX NUMBER: 614-644-4464

PHONE NUMBER: 781-586-6630

FAX NUMBER: 781-598-1050

TOTAL NO. OF PAGES, INCLUDING COVER: 2

*If you do not receive all pages, please contact me.

DATE: June 12, 2013

SUBJECT: Catherine Romano, MD

☐ URGENT ☐ FOR REVIEW ☐ PLEASE COMMENT ☐ PLEASE REPLY ☐ PLEASE RECYCLE

MESSAGE:

Evaluation Signed by Dr. Scott Early on behalf of Catherine Romano, MD.

Employer Recommendation Form

URGENT LICENSURE PENDING

State Medical Board of Ohio

30 E. Broad St., 3rd Floor • Columbus, OH 43215-6127 • (614) 466-3934 • Website: http://med.ohio.gov/

Dr. Catherine Romanos MD
(PLEASE PROVIDE FIRST AND LAST NAME)

Catherine Romanos MD

is applying for licensure in the State of Ohio. We would appreciate your assistance in filling out the following evaluation so that we can process his/her application for licensure. To ensure processing of the physicians application, please complete and return this form to the State Medical Board of Ohio at the above within two (2) weeks. **The form may also be faxed to the Board at (614) 644-1464**. Your immediate attention to this matter will be greatly appreciated by the applicant as well as by us. Thank you for your time and assistance.

Position(s) held: Primary Care Clinician / Family Physician.

Dates of employment: Sept 1, 2010 - March 31, 2013

(1) How long have you known him/her? Six years (3 yrs as a Resident, 3 yrs Attending)

(2) What is/was your supervisory capacity? Residency Supervisor Attending / Med Site director

(3) At what hospital? Lawrence General Hospital. Lawrence, Ma.

(4) How would you rate his/her medical knowledge and techniques? Excellent

(5) In your opinion is he/she a person of good moral and ethical character? Yes.

(6) Does he/she work well with peers and medical staff? Yes.

(7) Does he/she relate well to patients? Yes

(8) How is his/her command of the English language if applicable)? Excellent

(9) Would you recommend him/her for licensure? Yes.

Additional comments, please: (f needed, an extra sheet of paper may be used)

Sincerely,

The Licensure Staff

Jacobson MD. for Catherine Romanos MD

Signature of Physician

Carin Jacobson MD

Name of Physician (please type or print clearly)

Medical Site Director

Position

978 685-1770

Telephone number (include area code)

FAX number (include area code)

Uniform Application for Physician Licensure

UA Username cromanos **Date Submitted** 4/15/2013
FCVS Status Applicant has an FCVS Packet

1. Name: Indicate your full legal name. If your name has changed at any time during your life and you are not using FCVS, you must submit a copy of the legal document (marriage certificate, divorce decree, etc.) supporting your name change.

1. Full Name (use no initials)

Last Name Romanos
First Name Catherine
Middle Name Eileen
Suffix
Maiden Name
M.D. [X] **D.O.** [ ]

All other names used

First	Middle	Last	Suffix

2. Address/Phone: Please complete all sections and indicate which address you wish to be used for public access and which is to be used for mailings from the medical board. Each state's law determines whether each address or phone number is a public record in the state in which you are applying. You may wish to contact the licensing authority for that state for further information. Many boards publish the "Public Access" address on their website, therefore you should consider what your preferred address is for these purposes.

2. Address/Phone

Business
[X] **Public Access** **Street** 269 Union St
[ ] **Mailing**
City Lynn **State/Province** MA **Zip Code** 01901
Country USA
Telephone 7815813900
Fax
Email catherine.romanosmd@gmail.com
Alternate Phone

Home
[ ] **Public Access** **Street** 104 HIGH ST # 3
[X] **Mailing**
City CHARLESTOWN **State/Province** MA **Zip Code** 02129-3019
Country USA
Telephone 860-490-0897
Fax
Email catherine.romanosmd@gmail.com
Alternate Phone

3. Identification: If you are not using FCVS, you must submit either a notarized copy of your birth certificate or a notarized copy of your current, valid passport.

3. Identification

01/28/1979	Torrington	Connecticut	USA
Date of Birth (mm/dd/yyyy)	Birth City	Birth State/Province	Birth Country

F	Redacted	1659574192	Are you a U.S. Citizen?	[X] Yes [ ] No
Gender	Social Security Number	NPI		

Your social security number is required to facilitate reporting to the federal Healthcare Integrity & Protection Data Bank (42 U.S.C. Sections 1320a-7e(b), 5 U.S.C. Section 552a, and 45 C.F.R. pt. 61) and for accurate identification under the federal and state child support enforcement law (42 U.S.C. Section 666 and applicable state law). It may also be used for reporting to the National Practitioner Data Bank (42 U.S.C. Section 11101 and 45 C.F.R. pt. 60) and for other investigative/enforcement purposes in compliance with state laws governing physician discipline or as otherwise required by state or federal law.

The National Provider Identifier (NPI) is a Health Insurance Portability and Accountability Act (HIPAA) Administrative Simplification Standard. For more information on the NPI, please go to http://www.cms.hhs.gov/NationalProvidentStand/.

4. Medical School: List all medical schools you have attended, even those from which you did not graduate, in chronological order. Attach an additional sheet if necessary. If you are not using FCVS, you must complete the attached "Medical Education Verification" form and send it to all medical schools you have attended. You must include a copy of your diploma to which the medical school must attach their seal prior to forwarding it to this Board. Additionally, the medical school must provide this Board with an official copy of your transcripts. The medical school must forward all documentation directly to this Board.

4. Medical School

1

School Name University of Connecticut School of Medicine
Address 263 Farmington Avenue
City Farmington
State/Province CT
ZIP Code 06030
Country USA
Attendance Dates **From (mm/yyyy)** 08/2003 **To (mm/yyyy)** 05/2007
Graduation Date 5/13/2007
Degree MD

5. Fifth Pathway: If you attended a Fifth Pathway program and are not using FCVS, you must complete the attached "Fifth Pathway Verification" form and send it to your medical school and to the institution where you completed your rotations. You must include a copy of your diploma. The medical school and institution must forward all documentation directly to this Board.

5. Fifth Pathway (if applicable)

Medical School Name			
Address			
City			
State/Province			
ZIP Code			
Country			
Attendance Dates	**From (mm/yyyy)**	**To (mm/yyyy)**	**In Progress**
Graduation Date			
Degree			
Institution name where rotations performed			
Address			
City			
State/Province			
ZIP Code			
Country			
Rotation Dates	**From (mm/yyyy)**	**To (mm/yyyy)**	**In Progress**
Certification Date			

6. Postgraduate Training: List **all** postgraduate programs you have attended, even those you did not complete. Attach an additional sheet if necessary. If you are not using FCVS, you must complete the attached "Postgraduate Training Verification" form and send it to **all** postgraduate training programs you have attended. You must submit a copy of your certificate of program completion to this Board. The postgraduate program must forward all documentation directly to this Board.

6. Postgraduate Training

1

Hospital Name Greater Lawrence Family Health Center
Hospital Address 34 Haverhill Street

City Lawrence
State/Province Massachusetts
ZIP Code 01841-2884
Country USA

PGY: (e.g., 1, 2, 3, etc.) ☐ **Internship** ☒ **Residency** ☐ **Fellowship** ☐ **Research** ☐ **Other**

Department/Specialty Family Medicine

From: 06 /2007 **To:** 06 /2010 **Successfully Completed?** ☒ **Yes** ☐ **No** **In Progress** ☐

Month Year Month Year

7. Examination History: If you are not using FCVS, you are responsible for contacting the appropriate examination entity and having a certified transcript of your scores sent directly to this Board.

7. Examination History

List each licensure examination, U.S. or international, you have taken (USMLE, NBME, NBOME, LMCC, Etc.).If additional space is necessary, please enclose a separate sheet with your application and include all the information below

Examination	State	Most Recent Date taken(Month/Year)	Passed (P) or Failed (F)		Number of attempts
USMLE Step 1		06/2005	[X] P	[ ] F	1
USMLE Step 2		06/2006	[X] P	[ ] F	1
USMLE Step2 CS		07/2006	[X] P	[ ] F	1
USMLE Step 3		07/2009	[X] P	[ ] F	1

8. ECFMG: If ECFMG is applicable and you are not using FCVS, you are responsible for contacting ECFMG and having a certified “Status Report” forwarded directly to this Board. There is a separate fee for this report. Reports can be obtained through the ECFMG web site at www.ecfmg.org.

8. ECFMG (if applicable)

Certificate Number	Issue Date	Valid Through Date

9. State or Professional Licensure: List all state and Canadian provinces where you currently hold or have ever held any type of medical/osteopathic license. You must also complete the attached “Licensure Verification” form (Form #1) and forward it to all states in which you have held any health care license or certification. The verifying entity must forward all documentation directly to this Board. Some state boards charge a fee for this information. Contact the state board where you hold or held a license to determine their requirements.

9. State Licensure

1	**State/Province**	MA	**Practitioner Type (MD, DO, etc.)**	MD	**Type of License (Full, Temporary, etc.)**		
	License Number	242461	**Status**	Active	**Issue Date**	11/1/2010	
2	**State/Province**	NY	**Practitioner Type (MD, DO, etc.)**	MD	**Type of License (Full, Temporary, etc.)**		
	License Number	257511-1	**Status**	Active	**Issue Date**	6/1/2010	

10. Chronology of Activities: List ALL activities (medical, non-medical, and postgraduate training) in chronological order beginning with medical school graduation to the PRESENT date, using **MONTH** and **YEAR**. *For any non-working time, you MUST state on the form exactly what your activities were, such as "vacation" or "seeking employment," as well as your permanent address.* If you worked for a physician-staffing group or did locum tenens, you must list all facilities where you worked and include complete dates and addresses. **DO NOT SUBSTITUTE ANY OTHER RESUME FOR THIS FORM**. Be sure to indicate the percentage of working time spent in clinical administrative duties.

10. Chronology of Activities

Dates: From/To	Practice/Employment
1 From: Month: 09 Year: 2010 To: Month: 04 Year: 2013 In Progress ☐	**Practice/Employment Name** Greater Lawrence Family Health Center (or list non-working time as indicated above) **Practice/Employment Address** 34 Haverhill St **City** Lawrence **State/Province** Massachusetts **ZIP Code** 02129 **Country** USA **Position and Department** Family Physician-Family Medicine/Residency **Percent Clinical:** 100% **Percent Administrative:** 0% **Employment** ☒ **Staff Privileges** ☒ **Affiliation** ☐ **Other**
2 From: Month: 01 Year: 2013 To: Month: Year: In Progress ☒	**Practice/Employment Name** Planned Parenthood Mohawk Hudson (or list non-working time as indicated above) **Practice/Employment Address** 1040 State St **City** Schenectady **State/Province** New York **ZIP Code** 12307 **Country** USA **Position and Department** Physician-Medical **Percent Clinical:** 100% **Percent Administrative:** 0% **Employment** ☒ **Staff Privileges** ☒ **Affiliation** ☐ **Other**
3 From: Month: 04 Year: 2013 To: Month: Year: In Progress ☒	**Practice/Employment Name** Lynn Community Health Center (or list non-working time as indicated above) **Practice/Employment Address** 269 Union St **City** Lynn **State/Province** Massachusetts **ZIP Code** 01901 **Country** USA **Position and Department** Family Physician-Family Medicine **Percent Clinical:** 100% **Percent Administrative:** 0% **Employment** ☒ **Staff Privileges** ☒ **Affiliation** ☐ **Other**

11. Malpractice: List of all claims or suits for medical malpractice made against you. A claim is any formal or informal demand for payment to any person or organization. If you do not have any such claims or suits, this section will be blank. Please have your information available before reviewing this section and contact the state board or FCVS to make changes.

11. Malpractice Liability Claims Information

Name of patient involved:

In which state did the action take place? **Case number (if applicable)**

Which court?
(If private compromise or settled before initiation of civil action, state here)

Current status of claim:

☐ Open (pending) ☐ Closed (settled or judgment) ☐ Dismissed (no money paid out) ☐ Other

Amount of judgement or settlement $ **Amount paid on your behalf $**

Month and year of event precipitating claim:

Month and year of lawsuit:

Insurance carrier at time:

What is/or was your status? ☐ **Primary defendant** ☐ **Co-defendant** ☐ **Other**

Please provide specifics in reference to the adverse event including the allegations and your role in the event:

Uniform Application for Physician Licensure

UA Username cromanos **Date Submitted** 6/11/2013
FCVS Status Applicant has an FCVS Packet

1. Name: Indicate your full legal name. If your name has changed at any time during your life and you are not using FCVS, you must submit a copy of the legal document (marriage certificate, divorce decree, etc.) supporting your name change.

1. Full Name (use no initials)

Last Name Romanos
First Name Catherine
Middle Name Eileen
Suffix
Maiden Name
M.D. [X] **D.O.** [ ]

All other names used

First	Middle	Last	Suffix
Catherine		Romanos	
Catherine	E	Romanos	

2. Address/Phone: Please complete all sections and indicate which address you wish to be used for public access and which is to be used for mailings from the medical board. Each state's law determines whether each address or phone number is a public record in the state in which you are applying. You may wish to contact the licensing authority for that state for further information. Many boards publish the "Public Access" address on their website, therefore you should consider what your preferred address is for these purposes.

2. Address/Phone

Business
[X] **Public Access** **Street** 269 Union St
[ ] **Mailing**
City Lynn **State/Province** MA **Zip Code** 01901
Country USA
Telephone 7815813900
Fax
Email catherine.romanosmd@gmail.com
Alternate Phone

Home
[ ] **Public Access** **Street** 104 HIGH ST # 3
[X] **Mailing**
City CHARLESTOWN **State/Province** MA **Zip Code** 02129-3019
Country USA
Telephone 860-490-0897
Fax
Email catherine.romanosmd@gmail.com
Alternate Phone

3. Identification: If you are not using FCVS, you must submit either a notarized copy of your birth certificate or a notarized copy of your current, valid passport.

3. Identification

01/28/1979	Torrington	Connecticut	USA
Date of Birth (mm/dd/yyyy)	Birth City	Birth State/Province	Birth Country

F	Redacted	1659574192	Are you a U.S. Citizen?	[X] Yes [ ] No
Gender	Social Security Number	NPI		

Your social security number is required to facilitate reporting to the federal Healthcare Integrity & Protection Data Bank (42 U.S.C. Sections 1320a-7e(b), 5 U.S.C. Section 552a, and 45 C.F.R. pt. 61) and for accurate identification under the federal and state child support enforcement law (42 U.S.C. Section 666 and applicable state law). It may also be used for reporting to the National Practitioner Data Bank (42 U.S.C. Section 11101 and 45 C.F.R. pt. 60) and for other investigative/enforcement purposes in compliance with state laws governing physician discipline or as otherwise required by state or federal law.

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State/Province CT
ZIP Code 06030
Country USA
Attendance Dates **From (mm/yyyy)** 08/2003 **To (mm/yyyy)** 05/2007
Graduation Date 5/13/2007
Degree MD

5. Fifth Pathway: If you attended a Fifth Pathway program and are not using FCVS, you must complete the attached "Fifth Pathway Verification" form and send it to your medical school and to the institution where you completed your rotations. You must include a copy of your diploma. The medical school and institution must forward all documentation directly to this Board.

5. Fifth Pathway (if applicable)

Medical School Name			
Address			
City			
State/Province			
ZIP Code			
Country			
Attendance Dates	**From (mm/yyyy)**	**To (mm/yyyy)**	**In Progress**
Graduation Date			
Degree			
Institution name where rotations performed			
Address			
City			
State/Province			
ZIP Code			
Country			
Rotation Dates	**From (mm/yyyy)**	**To (mm/yyyy)**	**In Progress**
Certification Date			

6. Postgraduate Training: List **all** postgraduate programs you have attended, even those you did not complete. Attach an additional sheet if necessary. If you are not using FCVS, you must complete the attached "Postgraduate Training Verification" form and send it to **all** postgraduate training programs you have attended. You must submit a copy of your certificate of program completion to this Board. The postgraduate program must forward all documentation directly to this Board.

6. Postgraduate Training

1

Hospital Name Greater Lawrence Family Health Center
Hospital Address 34 Haverhill Street

City Lawrence
State/Province Massachusetts
ZIP Code 01841-2884
Country USA

PGY: (e.g., 1, 2, 3, etc.) ☐ **Internship** ☒ **Residency** ☐ **Fellowship** ☐ **Research** ☐ **Other**

Department/Specialty Family Medicine

From: 06 /2007 **To:** 06 /2010 **Successfully Completed?** ☒ **Yes** ☐ **No** **In Progress** ☐

Month Year Month Year

7. Examination History: If you are not using FCVS, you are responsible for contacting the appropriate examination entity and having a certified transcript of your scores sent directly to this Board.

7. Examination History

List each licensure examination, U.S. or international, you have taken (USMLE, NBME, NBOME, LMCC, Etc.).If additional space is necessary, please enclose a separate sheet with your application and include all the information below

Examination	State	Most Recent Date taken(Month/Year)	Passed (P) or Failed (F)		Number of attempts
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USMLE Step2 CS		07/2006	[X] P	[ ] F	1
USMLE Step 3		07/2009	[X] P	[ ] F	1

8. ECFMG: If ECFMG is applicable and you are not using FCVS, you are responsible for contacting ECFMG and having a certified “Status Report” forwarded directly to this Board. There is a separate fee for this report. Reports can be obtained through the ECFMG web site at www.ecfmg.org.

8. ECFMG (if applicable)

Certificate Number	Issue Date	Valid Through Date

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1	**State/Province**	MA	**Practitioner Type (MD, DO, etc.)**	MD	**Type of License (Full, Temporary, etc.)**		
	License Number	242461	**Status**	Active	**Issue Date**	11/1/2010	
2	**State/Province**	NY	**Practitioner Type (MD, DO, etc.)**	MD	**Type of License (Full, Temporary, etc.)**		
	License Number	257511-1	**Status**	Active	**Issue Date**	6/1/2010	

10. Chronology of Activities: List ALL activities (medical, non-medical, and postgraduate training) in chronological order beginning with medical school graduation to the PRESENT date, using **MONTH** and **YEAR**. *For any non-working time, you MUST state on the form exactly what your activities were, such as "vacation" or "seeking employment," as well as your permanent address.* If you worked for a physician-staffing group or did locum tenens, you must list all facilities where you worked and include complete dates and addresses. **DO NOT SUBSTITUTE ANY OTHER RESUME FOR THIS FORM.** Be sure to indicate the percentage of working time spent in clinical administrative duties.

10. Chronology of Activities

Dates: From/To	Practice/Employment
1 From: Month: 06 Year: 2010 To: Month: 09 Year: 2010 In Progress ☐	**Practice/Employment Name** Post residency vacation (or list non-working time as indicated above) **Practice/Employment Address** 115 Museum St Apt 2L **City** Somerville **State/Province** Massachusetts **ZIP Code** 02143 **Country** USA **Position and Department** vacation **Percent Clinical:** 0% **Percent Administrative:** 0% **Employment** ☐ **Staff Privileges** ☐ **Affiliation** ☐ **Other**
2 From: Month: 09 Year: 2010 To: Month: 04 Year: 2013 In Progress ☐	**Practice/Employment Name** Greater Lawrence Family Health Center (or list non-working time as indicated above) **Practice/Employment Address** 34 Haverhill St **City** Lawrence **State/Province** Massachusetts **ZIP Code** 02129 **Country** USA **Position and Department** Family Physician-Family Medicine/Residency **Percent Clinical:** 100% **Percent Administrative:** 0% **Employment** ☒ **Staff Privileges** ☒ **Affiliation** ☐ **Other**
3 From: Month: 01 Year: 2013 To: Month: Year: In Progress ☒	**Practice/Employment Name** Planned Parenthood Mohawk Hudson (or list non-working time as indicated above) **Practice/Employment Address** 1040 State St **City** Schenectady **State/Province** New York **ZIP Code** 12307 **Country** USA **Position and Department** Physician-Medical **Percent Clinical:** 100% **Percent Administrative:** 0% **Employment** ☒ **Staff Privileges** ☒ **Affiliation** ☐ **Other**

Dates: From/To	Practice/Employment
4 From: Month: 04 Year: 2013 To: Month: Year: In Progress [X]	**Practice/Employment Name** Lynn Community Health Center (or list non-working time as indicated above) **Practice/Employment Address** 269 Union St **City** Lynn **State/Province** Massachusetts **ZIP Code** 01901 **Country** USA **Position and Department** Family Physician-Family Medicine **Percent Clinical:** 100% **Percent Administrative:** 0% **Employment** [X] **Staff Privileges** [X] **Affiliation** [ ] **Other**

11. Malpractice: List of all claims or suits for medical malpractice made against you. A claim is any formal or informal demand for payment to any person or organization. If you do not have any such claims or suits, this section will be blank. Please have your information available before reviewing this section and contact the state board or FCVS to make changes.

11. Malpractice Liability Claims Information

Name of patient involved:

In which state did the action take place? **Case number (if applicable)**

Which court?
(If private compromise or settled before initiation of civil action, state here)

Current status of claim:

☐ Open (pending) ☐ Closed (settled or judgment) ☐ Dismissed (no money paid out) ☐ Other

Amount of judgement or settlement $ **Amount paid on your behalf $**

Month and year of event precipitating claim:

Month and year of lawsuit:

Insurance carrier at time:

What is/or was your status? ☐ **Primary defendant** ☐ **Co-defendant** ☐ **Other**

Please provide specifics in reference to the adverse event including the allegations and your role in the event:

Uniform Application for Physician Licensure

UA Username cromanos **Date Submitted** 6/11/2013
FCVS Status Applicant has an FCVS Packet

1. Name: Indicate your full legal name. If your name has changed at any time during your life and you are not using FCVS, you must submit a copy of the legal document (marriage certificate, divorce decree, etc.) supporting your name change.

1. Full Name (use no initials)

Last Name Romanos
First Name Catherine
Middle Name Eileen
Suffix
Maiden Name
M.D. [X] **D.O.** [ ]

All other names used

First	Middle	Last	Suffix
Catherine		Romanos	
Catherine	E	Romanos	

2. Address/Phone: Please complete all sections and indicate which address you wish to be used for public access and which is to be used for mailings from the medical board. Each state's law determines whether each address or phone number is a public record in the state in which you are applying. You may wish to contact the licensing authority for that state for further information. Many boards publish the "Public Access" address on their website, therefore you should consider what your preferred address is for these purposes.

2. Address/Phone

Business
[X] **Public Access** **Street** 269 Union St
[ ] **Mailing**
City Lynn **State/Province** MA **Zip Code** 01901
Country USA
Telephone 7815813900
Fax
Email catherine.romanosmd@gmail.com
Alternate Phone

Home
[ ] **Public Access** **Street** 104 HIGH ST # 3
[X] **Mailing**
City CHARLESTOWN **State/Province** MA **Zip Code** 02129-3019
Country USA
Telephone 860-490-0897
Fax
Email catherine.romanosmd@gmail.com
Alternate Phone

3. Identification: If you are not using FCVS, you must submit either a notarized copy of your birth certificate or a notarized copy of your current, valid passport.

3. Identification

01/28/1979	Torrington	Connecticut	USA
Date of Birth (mm/dd/yyyy)	Birth City	Birth State/Province	Birth Country

F	Redacted	1659574192	Are you a U.S. Citizen?	[X] Yes [ ] No
Gender	Social Security Number	NPI		

Your social security number is required to facilitate reporting to the federal Healthcare Integrity & Protection Data Bank (42 U.S.C. Sections 1320a-7e(b), 5 U.S.C. Section 552a, and 45 C.F.R. pt. 61) and for accurate identification under the federal and state child support enforcement law (42 U.S.C. Section 666 and applicable state law). It may also be used for reporting to the National Practitioner Data Bank (42 U.S.C. Section 11101 and 45 C.F.R. pt. 60) and for other investigative/enforcement purposes in compliance with state laws governing physician discipline or as otherwise required by state or federal law.

The National Provider Identifier (NPI) is a Health Insurance Portability and Accountability Act (HIPAA) Administrative Simplification Standard. For more information on the NPI, please go to http://www.cms.hhs.gov/NationalProvidentStand/.

4. Medical School: List all medical schools you have attended, even those from which you did not graduate, in chronological order. Attach an additional sheet if necessary. If you are not using FCVS, you must complete the attached "Medical Education Verification" form and send it to all medical schools you have attended. You must include a copy of your diploma to which the medical school must attach their seal prior to forwarding it to this Board. Additionally, the medical school must provide this Board with an official copy of your transcripts. The medical school must forward all documentation directly to this Board.

4. Medical School

1

School Name University of Connecticut School of Medicine
Address 263 Farmington Avenue
City Farmington
State/Province CT
ZIP Code 06030
Country USA
Attendance Dates **From (mm/yyyy)** 08/2003 **To (mm/yyyy)** 05/2007
Graduation Date 5/13/2007
Degree MD

5. Fifth Pathway: If you attended a Fifth Pathway program and are not using FCVS, you must complete the attached "Fifth Pathway Verification" form and send it to your medical school and to the institution where you completed your rotations. You must include a copy of your diploma. The medical school and institution must forward all documentation directly to this Board.

5. Fifth Pathway (if applicable)

Medical School Name			
Address			
City			
State/Province			
ZIP Code			
Country			
Attendance Dates	**From (mm/yyyy)**	**To (mm/yyyy)**	**In Progress**
Graduation Date			
Degree			
Institution name where rotations performed			
Address			
City			
State/Province			
ZIP Code			
Country			
Rotation Dates	**From (mm/yyyy)**	**To (mm/yyyy)**	**In Progress**
Certification Date			

6. Postgraduate Training: List **all** postgraduate programs you have attended, even those you did not complete. Attach an additional sheet if necessary. If you are not using FCVS, you must complete the attached "Postgraduate Training Verification" form and send it to **all** postgraduate training programs you have attended. You must submit a copy of your certificate of program completion to this Board. The postgraduate program must forward all documentation directly to this Board.

6. Postgraduate Training

1

Hospital Name Greater Lawrence Family Health Center
Hospital Address 34 Haverhill Street

City Lawrence
State/Province Massachusetts
ZIP Code 01841-2884
Country USA

PGY: (e.g., 1, 2, 3, etc.) ☐ **Internship** ☒ **Residency** ☐ **Fellowship** ☐ **Research** ☐ **Other**

Department/Specialty Family Medicine

From: 06 /2007 **To:** 06 /2010 **Successfully Completed?** ☒ **Yes** ☐ **No** **In Progress** ☐

Month Year Month Year

7. Examination History: If you are not using FCVS, you are responsible for contacting the appropriate examination entity and having a certified transcript of your scores sent directly to this Board.

7. Examination History

List each licensure examination, U.S. or international, you have taken (USMLE, NBME, NBOME, LMCC, Etc.).If additional space is necessary, please enclose a separate sheet with your application and include all the information below

Examination	State	Most Recent Date taken(Month/Year)	Passed (P) or Failed (F)		Number of attempts
USMLE Step 1		06/2005	[X] P	[ ] F	1
USMLE Step 2		06/2006	[X] P	[ ] F	1
USMLE Step2 CS		07/2006	[X] P	[ ] F	1
USMLE Step 3		07/2009	[X] P	[ ] F	1

8. ECFMG: If ECFMG is applicable and you are not using FCVS, you are responsible for contacting ECFMG and having a certified “Status Report” forwarded directly to this Board. There is a separate fee for this report. Reports can be obtained through the ECFMG web site at www.ecfmg.org.

8. ECFMG (if applicable)

Certificate Number	Issue Date	Valid Through Date

9. State or Professional Licensure: List all state and Canadian provinces where you currently hold or have ever held any type of medical/osteopathic license. You must also complete the attached “Licensure Verification” form (Form #1) and forward it to all states in which you have held any health care license or certification. The verifying entity must forward all documentation directly to this Board. Some state boards charge a fee for this information. Contact the state board where you hold or held a license to determine their requirements.

9. State Licensure

1	**State/Province**	MA	**Practitioner Type (MD, DO, etc.)**	MD	**Type of License (Full, Temporary, etc.)**		
	License Number	242461	**Status**	Active	**Issue Date**	11/1/2010	
2	**State/Province**	NY	**Practitioner Type (MD, DO, etc.)**	MD	**Type of License (Full, Temporary, etc.)**		
	License Number	257511-1	**Status**	Active	**Issue Date**	6/1/2010	

10. Chronology of Activities: List ALL activities (medical, non-medical, and postgraduate training) in chronological order beginning with medical school graduation to the PRESENT date, using **MONTH** and **YEAR**. *For any non-working time, you MUST state on the form exactly what your activities were, such as "vacation" or "seeking employment," as well as your permanent address.* If you worked for a physician-staffing group or did locum tenens, you must list all facilities where you worked and include complete dates and addresses. **DO NOT SUBSTITUTE ANY OTHER RESUME FOR THIS FORM.** Be sure to indicate the percentage of working time spent in clinical administrative duties.

10. Chronology of Activities

Dates: From/To	Practice/Employment
1 From: Month: 06 Year: 2010 To: Month: 09 Year: 2010 In Progress ☐	**Practice/Employment Name** Post residency vacation (or list non-working time as indicated above) **Practice/Employment Address** 115 Museum St Apt 2L **City** Somerville **State/Province** Massachusetts **ZIP Code** 02143 **Country** USA **Position and Department** vacation **Percent Clinical:** 0% **Percent Administrative:** 0% **Employment** ☐ **Staff Privileges** ☐ **Affiliation** ☐ **Other**
2 From: Month: 09 Year: 2010 To: Month: 04 Year: 2013 In Progress ☐	**Practice/Employment Name** Greater Lawrence Family Health Center (or list non-working time as indicated above) **Practice/Employment Address** 34 Haverhill St **City** Lawrence **State/Province** Massachusetts **ZIP Code** 02129 **Country** USA **Position and Department** Family Physician-Family Medicine/Residency **Percent Clinical:** 100% **Percent Administrative:** 0% **Employment** ☒ **Staff Privileges** ☒ **Affiliation** ☐ **Other**
3 From: Month: 01 Year: 2013 To: Month: Year: In Progress ☒	**Practice/Employment Name** Planned Parenthood Mohawk Hudson (or list non-working time as indicated above) **Practice/Employment Address** 1040 State St **City** Schenectady **State/Province** New York **ZIP Code** 12307 **Country** USA **Position and Department** Physician-Medical **Percent Clinical:** 100% **Percent Administrative:** 0% **Employment** ☒ **Staff Privileges** ☒ **Affiliation** ☐ **Other**

Dates: From/To	Practice/Employment
4 From: Month: 04 Year: 2013 To: Month: Year: In Progress [X]	**Practice/Employment Name** Lynn Community Health Center (or list non-working time as indicated above) **Practice/Employment Address** 269 Union St **City** Lynn **State/Province** Massachusetts **ZIP Code** 01901 **Country** USA **Position and Department** Family Physician-Family Medicine **Percent Clinical:** 100% **Percent Administrative:** 0% **Employment** [X] **Staff Privileges** [X] **Affiliation** [ ] **Other**

11. Malpractice: List of all claims or suits for medical malpractice made against you. A claim is any formal or informal demand for payment to any person or organization. If you do not have any such claims or suits, this section will be blank. Please have your information available before reviewing this section and contact the state board or FCVS to make changes.

11. Malpractice Liability Claims Information

Name of patient involved:

In which state did the action take place? **Case number (if applicable)**

Which court?
(If private compromise or settled before initiation of civil action, state here)

Current status of claim:

☐ Open (pending) ☐ Closed (settled or judgment) ☐ Dismissed (no money paid out) ☐ Other

Amount of judgement or settlement $ **Amount paid on your behalf $**

Month and year of event precipitating claim:

Month and year of lawsuit:

Insurance carrier at time:

What is/or was your status? ☐ **Primary defendant** ☐ **Co-defendant** ☐ **Other**

Please provide specifics in reference to the adverse event including the allegations and your role in the event:

FCVS FEDERATION CREDENTIALS VERIFICATION SERVICE

Medical Professional Information Profile

This report provides credentialing information for

Name: **Catherine Eileen Romanos**

Social Security Number: Redacted

Date of Birth: **January 28, 1979**

FID#: **215020876**

Recipient: **OH - State Medical Board of Ohio**

ABOUT THIS PROFILE

The Federation Credentials Verification Service (FCVS) was retained by the above referenced medical professional 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 medical professional 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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FCVS FEDERATION CREDENTIALS VERIFICATION SERVICE

Credentials Analysis Summary Report

Federation of STATE MEDICAL BOARDS

Note: *Your board may wish to review the unresolved items below marked by an "X"*
Please review the Credentials Analysis report for further details on the unresolved items

Medical Professional Name: **Catherine Eileen Romanos**
Date of Birth: **January 28, 1979**
Social Security Number: Redacted
FID: **215020876**

I. FCVS Reports

II. FSMB and Other Reports

III. Identity

A. Valid Original Passport

IV. Medical Education

A. Pre-medical Schools

B. Medical Schools

University of Connecticut School of Medicine
1. Medical Education Form
2. Medical Education Dean's Letter
3. Medical Education Transcript
4. Medical Education Diploma

C. Fifth Pathway Program

D. ECFMG Certification

V. Graduate Medical Education

Greater Lawrence Family Health Center
1. GME Form
2. GME Completion Certificate

VI. Licensure Examination History

A. FSMB Exams

End of report for: Catherine Eileen Romanos

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FCVS FEDERATION CREDENTIALS VERIFICATION SERVICE

Medical Professional Information Profile

Federation of STATE MEDICAL BOARDS

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Section I

FCVS Reports

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FCVS FEDERATION CREDENTIALS VERIFICATION SERVICE

Medical Professional Information Report

Federation of STATE MEDICAL BOARDS

Identity

Medical Professional Name:	**Catherine Eileen Romanos**
	Documentation: Valid Original Passport
Gender:	Female
Date of Birth:	January 28, 1979
Place of Birth:	CT, UNITED STATES
Social Security Number:	Redacted
FID:	215020876
Physical Description:	Height: 5 ft. 2 in.
	Weight: 115 lbs.
	Eye Color: Green
	Hair Color: Blond

Contact Information

Mailing Address:	104 HIGH ST # 3 CHARLESTOWN, MA 02129-3019 UNITED STATES
Permanent Address:	104 HIGH ST # 3 CHARLESTOWN, MA 02129-3019 UNITED STATES
Telephone Numbers:	Primary: (860) 490-0897
	Secondary: N/A
	Fax: N/A
	Other: N/A

Premedical Education

(Provided by Applicant. Not verified with the primary source.)

Institution: **New York University/Faculty of Arts and Science**
Address: New York, NY 10003
UNITED STATES
Dates of Attendance: 09/--/1997 To 05/--/2001
Degree Conferred/Issued: Bachelor of Arts

ECFMG

There are none identified or not applicable.

Medical Education

Medical School: **University of Connecticut School of Medicine**
Address: 263 Farmington Avenue
Farmington, CT 06030-1912
UNITED STATES

Dates of Attendance: 08/18/2003 to 05/13/2007
Date Certificate Issued: 05/13/2007
Degree Conferred/Issued: Doctor of Medicine

Unusual Circumstances
Leave of Absence/Extension: **No**
Probation: **No**
Disciplined: **No**
Negative Reports: **No**
Limitations: **No**

Fifth Pathway

There are none identified or not applicable.

Graduate Medical Education

Institution: **Greater Lawrence Family Health Center**
Address: 34 Haverhill Street
Lawrence, MA 01841-2884
UNITED STATES

Training Level: 1
Program Type: Residency
Specialty: Family Medicine
Dates of Attendance: 06/16/2007 To 06/27/2008
Completed Successfully: Yes
Accreditation: ACGME

Training Level: 2
Program Type: Residency
Specialty: Family Medicine
Dates of Attendance: 06/28/2008 To 06/28/2009
Completed Successfully: Yes
Accreditation: ACGME

Training Level: 3
Program Type: Internship
Specialty: Family Medicine
Dates of Attendance: 06/28/2009 To 06/28/2010
Completed Successfully: Yes
Accreditation: ACGME

Unusual Circumstances
Leave of Absence/Extension: **No**
Probation: **No**
Disciplined: **No**
Negative Reports: **No**
Limitations: **No**

Licensure Examinations

FSMB Transcript USMLE Step 1	Date: 06/2005	Passed the Exam
FSMB Transcript USMLE Step 2 CK	Date: 06/2006	Passed the Exam
FSMB Transcript USMLE Step 2 CS	Date: 07/2006	Passed the Exam
FSMB Transcript USMLE Step 3	Date: 07/2009	Passed the Exam

ABMS Verification

A report of the result from a search of the data provided by the American Board of Medical Specialties is enclosed.

Board Action

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

End of report for Catherine Eileen Romanos FID: 215020876

FCVS FEDERATION CREDENTIALS VERIFICATION SERVICE

Credentials Analysis Report

Federation of STATE MEDICAL BOARDS

The Credentials Analysis Report is a comparative report of a medical professional's credentials as reported to FCVS by the 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.

Medical Professional Identification

Medical Professional Name:	**Catherine Eileen Romanos**
Date of Birth:	**January 28, 1979**
Social Security Number:	Redacted
FID:	**215020876**

Omissions

There are no omissions identified.

Discrepancies

There are no discrepancies identified.

Miscellaneous Information

There is no miscellaneous information identified.

End of report for: Catherine Eileen Romanos

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FCVS FEDERATION CREDENTIALS VERIFICATION SERVICE

Chronology of Activities

Federation of STATE MEDICAL BOARDS

The Chronology of Activities is a comprehensive report of a medical professional's activities as reported to FCVS by the medical-professional applicant.

Medical Professional Name: **Catherine Eileen Romanos**
Date of Birth: **January 28, 1979**
Social Security Number: Redacted
FID#: **215020876**

Start Date	End Date	Activity	Location	Overlap Explanation	Program Length Explanation
8/2003	05/2007	Medical Education Record	University of Connecticut School of Medicine,263 Farmington Avenue Farmington, CT 06030-1912 UNITED STATES		
6/2007	06/2010	GME Record	Greater Lawrence Family Health Center,34 Haverhill Street Lawrence, MA 01841-2884 UNITED STATES		

End of report for Catherine Eileen Romanos

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Section II

FSMB and Other Reports

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FPDC | FEDERATION PHYSICIAN DATA CENTER

Board Action Clearance Report

June 14, 2013

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

Re: Board Action Query Dated: June 14, 2013
FSMB Batch Number: BQ2276881

The following is a report of the search results from the Board Action Data Bank as of June 14, 2013 for practitioners submitted as part of the above-referenced batch for which NO board actions were identified.

Provider cleared with No Actions as of June 14, 2013

Name	DOB	School	Yr/Grad	Provider ID
Catherine Eileen Romanos	01/28/1979	007010	2007	281333

License History

Licensing Entity
MASSACHUSETTS
NEW YORK
VERMONT

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.

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As of:	**06/14/2013**
Medical Professional Name:	**Catherine Eileen Romanos**
Date of Birth:	**1/28/1979**
Year of Graduation:	**2007 (Doctor of Medicine)**
ABMSUID#:	**947618**

Certification

Certification:

Board:	Family Practice
Specialty:	Family Practice
Status:	ACT
Initial Certification:	07/14/2010

End of report for Catherine Eileen Romanos

All certification 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 III

Identity

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FCVS FEDERATION CREDENTIALS VERIFICATION SERVICE

Affidavit and Release

Federation of STATE MEDICAL BOARDS

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 me 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.

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.

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.

While the FSMB will only use collected personal information for the purposes described on our website and in the FCVS application materials, the FSMB has no control over the entities to which an applicant authorizes the release of FCVS materials. Such entities may include state medical boards, state osteopathic boards, and other entities that may be subject to state and federal public information or open records laws, which might require the release of certain FCVS packet information to the public upon request.

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

Romanos,
Catherine Eileen

Applicant's Printed Last Name

4/2/13

Date of Signature (must correspond to date of notarization)

State of Massachusetts, County of Suffolk,
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 2nd day of April, 2013.

Notary Public Signature: Vera Burdick

VERA BURDICK
Notary Public
COMMONWEALTH OF MASSACHUSETTS
My Commission Expires
February 18, 2016

My Notary Commission Expires: 2/18/16

281333 281333 215020876

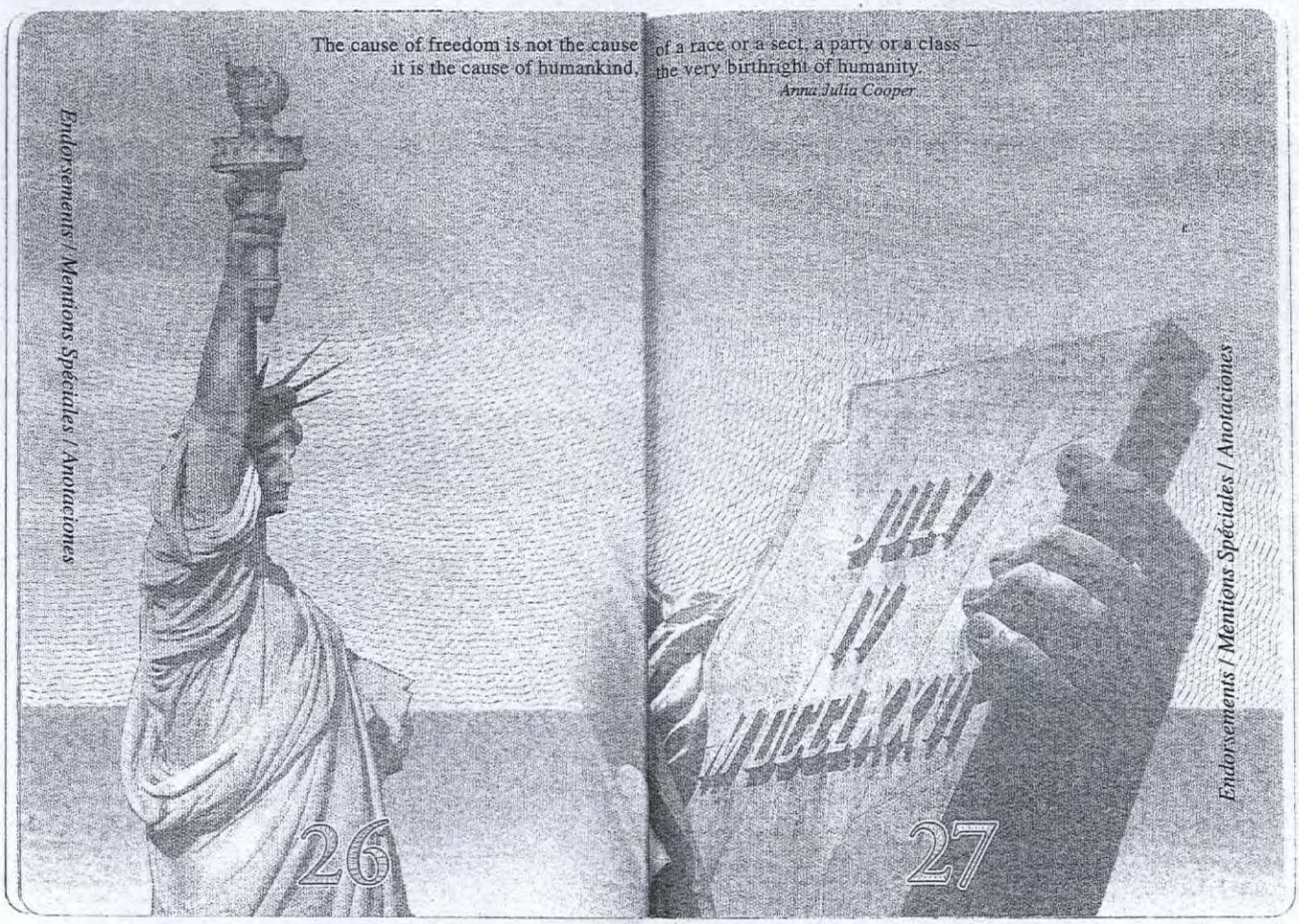
THE FEDERATION OF STATE MEDICAL BOARDS OF THE UNITED STATES MCMXII

The Federation Credentials Verification Service certifies that this page was copied directly from the original document.

Kevin Caldwell
Federation Credentials Verification Service

Date: **May 6, 2013**

2/1333



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Kevin Caldwell
Federation Credentials Verification Service

Date: **May 6, 2013**

281333

Section IV

Medical Education

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FCVS FEDERATION CREDENTIALS VERIFICATION SERVICE

Verification of Medical Education

Federation of STATE MEDICAL BOARDS

Instruction to the Dean

Please complete both pages of this form, sign date and seal on the front page then return to:

Federation Credentials Verification Service
400 Fuller Wiser Rd
Suite 300
Euless, TX 76039

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 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).

Institution Name: University of Connecticut School of Medicine

Address Line 1:
263 Farmington Avenue

Address Line 2:
Room Number: LM039

City: Farmington **State/Province:** CT **Zip Code (Postal Code):** 06030
Country: US

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: 4
Credential/degree presented by the applicant for admission to your medical school: N/A

Enrollment and Participation: Our records indicate that Romano Catherine E.
(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: **From:** 8/18/2003 (Month Day Year) **To:** 5/13/2007 (Month Day Year)

This individual
Was awarded the degree of Doctor of Medicine on 5/13/2007 (Month Day Year)
Was NOT awarded a degree because: (please explain - additional page if necessary)

Attestation

Affix Institutional Seal Here

If no seal is available, this form must be notarized.

Watermark
For FCVS internal use only.

SEAL VERIFIED

Name: Robin Frank
Signature:
Title: Dir. Stud. Services
Date of Signature: 5/7/13 **Phone:** 860 679-8745
Fax: 860 679-1902 **Email:** frank@uchc.edu

281333 2250 215020876

281333 2250

FCVS FEDERATION CREDENTIALS VERIFICATION SERVICE

Verification of Medical Education

Federation of STATE MEDICAL BOARDS

Unusual Circumstances

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

If Yes, please specify the reason(s) for, indicate the date of the interruptions(s) or extension(s) and check whether the Interruption/extension was approved or unapproved:

Personal/Family	From (Mo/Yr)___/___	To (Mo/Yr)___/___	___ Approved	___ Unapproved
Academic remediation	From (Mo/Yr)___/___	To (Mo/Yr)___/___	___ Approved	___ Unapproved
Health	From (Mo/Yr)___/___	To (Mo/Yr)___/___	___ Approved	___ Unapproved
Financial	From (Mo/Yr)___/___	To (Mo/Yr)___/___	___ Approved	___ Unapproved
Participation in joint degree Program (e.g., MD/PhD)	From (Mo/Yr)___/___	To (Mo/Yr)___/___	___ Approved	___ Unapproved
Participation in non-research special study (e.g., fellowship, international experience)	From (Mo/Yr)___/___	To (Mo/Yr)___/___	___ Approved	___ Unapproved
Participation in non-degree research	From (Mo/Yr)___/___	To (Mo/Yr)___/___	___ Approved	___ Unapproved
Other	From (Mo/Yr)___/___	To (Mo/Yr)___/___	___ Approved	___ Unapproved

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? ___ YES ✓ NO

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

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

Please specify a 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? ___ YES ✓ NO

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 for behavioral reasons or an investigation by the medical school or parent university? ___ YES ✓ NO

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

___ YES ✓ NO

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?**

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

400 FULLER WISER ROAD | SUITE 300 | EULESS, TX 76039 TEL(817)868-5000 FAX(817)868-5099

281333

Applicant Reported Unusual Circumstances

Medical School

Medical Professional Name: Catherine Eileen Romanos

University of Connecticut School of Medicine

Unusual Circumstances

Did you have any interruption(s) or extension(s) in 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 by instructors?	Yes	**No**
Were any limitations or special requirements imposed on you because of academic performance, incompetence, disciplinary problems or for any other reason?	Yes	**No**

End of report for Catherine Eileen Romanos

PROVIDED BY APPLICANT

Medical Student Performance Evaluation

Catherine Romanos

November 1, 2006

Identifying Information:

Catherine Romanos is a fourth-year student at the University of Connecticut School of Medicine in Farmington, Connecticut.

Unique Characteristics

A. Premedical

Catherine Romanos was born and grew up in Litchfield County, Connecticut. A graduate of Northwestern Regional High School, she selected New York University for her undergraduate studies. A review of her records reveals a concentration in Spanish Literature highlighted with a semester abroad in Madrid and significant immersion in service work in Spain and Italy. Her emphasis on humanities and social sciences was complemented by a strong preparation in the sciences. While at New York University, she received extensive clinical exposure in emergency medical service at Bellevue Hospital. Her sophomore summer was spent as a research assistant at Cornell Medical College. Back in Connecticut, Catherine contributed to college expenses working as an assistant pension plan administrator, and was active in the Rainbow Summer Theater. While spending her junior year of college abroad in Spain, she volunteered at El Hospital de la Princesa. While in Florence, she took an intensive course in Italian language and culture. While in Chivasso, Italy, she worked with a group of international volunteers to bring care and recreation to those in need. Upon graduation, Catherine took a position as a project coordinator with the Albert Einstein Cancer Center bringing cancer prevention, education, and support to the people of the Bronx. Her college advisor summarized. "Catherine is one of our best students applying this year! Following all of her passions has allowed her to get a good, realistic look at the world. She is ready to contribute generously." A senior faculty interviewer at UConn commented, "Just a great dynamic candidate! Catherine is a mature, caring individual with a wealth of interesting experiences. Personable, funny, thoughtful, articulate, inquisitive, and tenacious." We quickly admitted Catherine under the School's Early Decision admission plan.

B. Extracurricular Activities in Medical School

Catherine is involved in an extraordinary array of leadership activities. She is currently the Co-Director of the South Park Inn Homeless Shelter Clinic, a student-run clinic held twice a week for the last 15 years. Catherine coordinates hundreds of medical students and physicians who volunteer at the clinic. Catherine also initiated a Women's Health Services Clinic at the same location, creating and implementing a monthly acute care clinic for women. Catherine has also been an active volunteer in all of the other student-run clinics. In her first year Catherine taught in the Hartford Health Education Program, presenting weekly health related topics to a bilingual group of third and fourth graders. Catherine has been selected to serve on the third year Curriculum Planning Committee and on the Community Curriculum Planning Committee. These

two very important groups are charged with overseeing significant portions of the medical school curriculum. Catherine has been a member of the Family Medicine Interest Group since 2003.

Academic History:

Date of expected graduation from medical school: -----May, 2007
***Date of initial Matriculation*: -----** August, 2003

Extensions, leaves, gaps or breaks: None
Repeated or remediated coursework: None
Adverse actions: None

ACADEMIC PROGRESS:

Preclinical/basic science curriculum:

We are a pass/fail school with no grade point average or class rank. Catherine successfully completed all components of the Basic Science curriculum. Narrative comments include those from her Principles of Clinical Medicine preceptors, "Catherine had consistently demonstrated an eagerness to learn from each new experience. She easily develops rapport with patients. Catherine was an outstanding student, certainly at the top of her class. She enthusiastically participated in discussions and proved to be a very self-directed learner. Catherine's superb interpersonal skills and positive attitude were evident in her patient interviewing and physical examination." Catherine participated in an Emergency Medicine Elective. Her preceptor wrote, "Catherine did a superb job, she was a very active participant in the seminar sessions. I was impressed by her ability to apply her classroom learning to the clinical discussion." In the summer between her first and second year, Catherine participated a Family Medicine Elective in Puerto Rico, working in a small practice in a rural area. Her preceptor wrote, "Catherine accepts responsibility and demonstrates motivation and initiative. She shows maturity and demonstrates concern about health care. She consistently communicated effectively with patients, demonstrating courtesy. She was empathic with patients".

Core Clinical Clerkships and Elective Rotations:

Please note that our Core Clerkships—with the exception of Family Medicine and Ob/Gyn—consist of both an inpatient and an outpatient phase often separated by several months; therefore, it is not possible to present them in strict chronological order.

Family Medicine

HONORS - Catherine was assigned to the Asylum Hill Family Medicine Residency Clinic. She had a superior performance overall, with every rating in the 7-9/9 range for the 15 clinical domains. Catherine was awarded outstanding ratings for her self-directed learning, interactions with staff members and patients, reliability, participation and initiative. The director of medical education wrote, "Catherine is very adept at eliciting sensitive information from patients. Catherine's presentations were thorough and detailed yet concise and she was able to adjust them appropriately given the specific clinical setting. Catherine consistently interacts with patients

with genuine warmth and empathy. She is very adept at integrating psychosocial issues into clinical care. Her level of knowledge was well above average and she worked diligently during the rotation to expand it. One attending stated that Catherine's history taking skills were in the top quartile of the students he had ever worked with. Her chart notes were very well-organized, detailed yet concise. Her management plans improved substantially during the course of the rotation. She responded well to feedback regarding improvement in a level of sophistication in her management plans. She had well developed physical exam skills far above average for a third year student. Catherine received feedback at the midpoint evaluation and substantially improved her differential diagnosis generation. Catherine rapidly developed facility with the use of EMR in the office. She used it effectively in the direct delivery of care and also as a tool for asynchronous communication. She was very enthusiastic and a highly motivated learner. Catherine actively sought feedback during the rotation and incorporated it readily into patient care. Catherine is gregarious and generous of spirit. She interacts wonderfully with office staff, and residents, as well as preceptors. She is extremely reliable. Catherine was a fixture at morning report and frequently went on rounds with the residents to see interesting inpatients prior to beginning the clinic. Catherine actively sought out obstetric experience during the rotation. In summary, she is very bright and came to the rotation with a knowledge base that was well above average for a third year student. One attending noted she optimized learning from every patient care encounter. She genuinely seems to enjoy patient care and brings great enthusiasm to learning opportunities. All at the same time she is very sensitive to the patients needs. Catherine demonstrated a clear understanding of the role of culture and psychosocial issues in illness and delivery of effective medical care. Overall her performance during the rotation was truly exceptional, the effort she devoted to learning. The level of her history and physical skill demonstrated a non-judgmental empathy she brings to patient encounters."

Internal Medicine

Catherine rotated at Hartford Hospital for inpatient Internal Medicine. She received excellent ratings in the following domains: interviewing skills, interactions with patients and staff, clinical reasoning, self-directed learning, reliability, patient advocacy, participation and initiative. Her preceptor wrote, "Catherine was very engaged with the rotation from the word go. She understood her role, clarified things she was unfamiliar with and participated in the rotation with enthusiasm, eager for feedback, which she meaningfully applied to further her learning, and understanding of medicine. Her documentation was comprehensive, and well synthesized. She presented cases very well at the bedside; eager to look up new information. Her notes are very legible and well scribed. Very detailed in content and synthesis. Progress notes were equally good and gave a clear sense of the progression of the case. Very professional, respectful to patients, colleagues and all co-workers. Communicates effectively. Overall, Catherine performed very well this rotation and her performance is rated as very good."

Catherine had an outstanding rotation at the Burgdorf Clinic in Hartford for ambulatory Internal Medicine, receiving ratings of 7-9/9 in all domains. Her attending wrote, "With an infectious enthusiasm, love of learning and care for patients, Catherine contributed to us all. Her fund of knowledge is strong. She is professionally mature, and faced with a clinical dilemma or simply an unfamiliar situation, she readily seeks advice and guidance - then follows it up with her own studies after immediate patient issues are resolved. Catherine is adept in communication skills with patients of varied backgrounds and cultures, with staff of various experience and across professional disciplines."

Obstetrics and Gynecology

HONORS - Catherine rotated at Hartford Hospital, and was awarded outstanding ratings in every domain by the site director. Catherine gave outstanding verbal presentations that were concise and organized. She skillfully used warmth and rapport with patients for therapeutic gains. She had an outstanding knowledge base for her level of training, understanding medical principles at a much greater depth than was expected. She had outstanding clinical diagnostic skills, and developed outstanding logical and thorough differential diagnoses. Catherine was outstanding at soliciting and receiving constructive criticism with interest and grace. She was extremely sensitive to the work and needs of others, exceptionally conscientious and dependable, and made an effort to take care of patients in a coordinated fashion. She assumed a might higher level of responsibility than expected. Her preceptor concluded, "Catherine had an outstanding rotation. She was a team player, self-starter, very enthusiastic and possessed excellent history, physical assessment and management skills. She will make an excellent resident".

Pediatrics

Catherine was assigned to the Connecticut Children's Medical Center Clinic for ambulatory Pediatrics. She received ratings of 7-9/9 in all domains. Her preceptor wrote, "This was Ms. Romanos' first clinical rotation and she performed well above the expected level. Catherine is best described by this observation - She was presenting at the bedside of a six month old baby who was vying for her attention, without missing a beat, she presented the history and physical directly to the cooing baby giving a comprehensive, accurate and succinct presentation despite the distraction and challenge this presented. Her directly observed history taking skills showed well-developed ability to balance open-ended questions with targeted questions. Her skill level was in the par of a new intern. Her directly observed exams were appropriate and complete. She was at all times professional and personable. She is an efficient worker, readily establishes rapport in obtaining thorough and logical histories. Her Spanish language skill was an asset in this busy urban clinic. She interacted exceptionally well with challenging families and demonstrated a strong desire to maintain continuity with patients over time. Ms. Romanos is skillful at eliciting sensitive information and taking a non-judgmental approach with families. She demonstrated particular skill in connecting with and gaining the trust of one young mother with significant mental illness. Because of her confident manner and strong organizational abilities, some staff members assumed she was an intern."

Catherine had an excellent performance overall during inpatient Pediatrics at the Connecticut Children's Medical Center, earning excellent ratings for her interviewing skills, interactions with patients, history-taking, and physical examination. Her preceptor wrote, "Catherine was very relaxed during her observed H&P. She asked excellent and thorough questions during the interview. She gathered information in a logical sequence and included all necessary details related to the case. Catherine was well-organized on morning rounds and she demonstrated good decision-making skills. Catherine has excellent interactions with her patients and families. During her observed H&P, she sat with the mother, made excellent eye contact and had appropriate body language during the interview. Despite multiple distractions during her observed H&P, Catherine was relaxed and flexible with her interview and physical examination. Catherine made excellent progress with her written history and physical exam reports. She integrated quickly into the team and worked well with all health care members. In summary, Catherine did a great job in her inpatient Pediatric rotation."

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Psychiatry

HONORS - Catherine had an unusual experience for her ambulatory Psychiatry experience, being assigned to the Niantic Women's Prison Clinic. She had regular contact with several patients with severe and chronic psychiatric illness. Catherine was awarded ratings of 8-9/9 in all domains and received many laudatory comments. Her preceptor concluded, "Excellent presentation skills, able to concisely provide a full description of complicated cases far above the usual level of a medical student. Catherine is able to provide an empathic attitude to patients from diverse backgrounds in a seemingly effortless fashion. She was able to follow patient initiated leads without sticking to a scripted set of questions. Her charts were clear, concise, and legible. She was able to provide several differential diagnoses and to correctly pick out the most likely ones using clear logic based on solid psychiatric knowledge. She actively sought feedback at different times through the rotation. She was fantastic at integrating in the treatment team. It was a true pleasure to have Catherine in our service. She easily became an important member of the treatment team and was well liked by patients and staff and her performance was of the highest caliber. She has a keen ability to be supportive, empathic, and professional that was well beyond that usually seen in medical students at this stage of training. She did a fantastic job."

Catherine rotated at John Dempsey Hospital for inpatient Psychiatry and received an excellent overall rating for her performance. Her strengths were noted to include excellent verbal presentations, medical knowledge, interviewing skills and comprehensive medical charting. Catherine was very empathic and respectful in the clinical encounter and very knowledgeable concerning cultural issues. She understood psychiatric principles to a much greater depth than was expected. She was able to effectively adapt her interviewing style to the patients affect. She was a strong self-directed learner. She was exceptionally conscientious and dependable and assumed a much higher level of responsibility than was expected. She was an exemplary team member. Her preceptor concluded, "I was impressed with her and found no areas of weakness."

Surgery

Catherine worked in a private surgical practice for Ambulatory Surgery. Her preceptor rated her excellent-to-outstanding in all categories, with exemplary professionalism ratings (reliability, participation and initiative). Catherine developed, negotiated and implemented superior cost effective management plans. She was an outstanding patient advocate, effectively incorporating the VNA, social services and family members to improve patient care. [No comments included]

Catherine was assigned to New Britain General Hospital for her inpatient Surgery experience. Her attending physician gave her outstanding ratings across the board and wrote extensive comments, "Excellent interviewing skills, very attentive, asked the right questions, maintains a comfortable style, puts patients at ease. She is very comfortable with oral presentations, confident and composed, warm, compassionate, attentive; all the traits required to gain trust in the doctor-patient relationship. She seems to have a very strong knowledge base, read and was prepared for cases in which she was involved. She writes very complete and accurate notes, organized, legible and easy to follow. She has excellent clinical reasoning skills, able to arrive at a good differential diagnosis focusing on the most likely problem using the information she obtained from the H&P and other diagnostic data. She understands the reasoning behind management plans. Definitely a self-motivated student, Catherine actively sought opportunities to learn and did not require much direction from her residents. She knew where she

should be and wanted to gain the most out of the rotation; Very professional demeanor, serious in her approach, comfortable with staff all levels, a team player; Punctual, reliable, completed tasks and sought to help the team in whatever way she could. She participated actively in all aspects of the rotation and sought opportunities to see and learn as much as she could; definitely a strong student, motivated, attentive, smart, really seemed to get a lot out of this rotation and enjoy it."

BTE (Integrated Inpatient Experience)

BTE is a unique two-week inpatient experience at the University of Connecticut where students are assigned to patients from the ED through discharge. The intent of the experience is to have students work intensively with a preceptor on clinical skills and to understand inpatient medicine from a patient's perspective. Students meet daily with the preceptor to present cases and work on physical diagnostic skills. Catherine was assigned to Saint Francis Hospital and worked under the direction of a Family Medicine attending. He awarded her outstanding ratings for her clinical diagnostic skills and for her reliability, participation, initiative and patient advocacy. Her preceptor wrote, "Catherine was instrumental in helping bridge some of the provider-to-provider communication gaps; she provided continuity as patients were transferred from one service to another. There was a significant language barrier in one case - the patient was Spanish speaking and Catherine was the only person on any of the teams involved in his care who spoke Spanish. I think Catherine worked very diligently during BTE and was able to perceive some of the significant shortcomings of our system of our care. At the end of the rotation she had first hand experience of how cultural and institutional factors can adversely affect patient outcomes."

Student Continuity Practice

The Student Continuity Practice is a required course at the University of Connecticut. Students are assigned to a primary care office for one half-day per week over the first three years of medical school, where they actively practice clinical skills with patients. Catherine worked for three years in a private suburban Family Medicine practice. The patient population was approximately 80% Spanish speaking, allowing Catherine to use her fluent Spanish effectively. At the completion of her third year she was awarded an "Outstanding Pass' overall (the highest available). She was commended for her ability to establish excellent rapport with patients. The staff looked forward to her weekly visits to the clinic. She was able to consistently initiate patient education and behavioral counseling. She integrated factors of community health and population medicine effectively in her care of patients. Her preceptor concluded, "Hard worker, caring, good follow through, great interpersonal skills."

Medical Intensive Care Unit - Saint Francis Hospital – August 2006

Catherine had a superior experience overall on the Medical Intensive Care Unit, garnering ratings of excellent or outstanding in every category. Her knowledge of pathophysiology was above expected level. She understood pathophysiological principles and was able to apply them consistently in the clinical setting. She effectively integrated her knowledge base with clinical data in identifying, prioritizing and approaching problems. She had mature clinical judgments. Catherine was exceptionally efficient and accurate in her histories and physical examination. Her oral presentations were clear and concise delineations of patient's illness and chronology; they were very well organized, flowed smoothly and far above expected level for training. Catherine

received outstanding ratings for all of her professionalism domains. She was hardworking, conscientious and exceptionally mature. She also had exceptional insight into her own personality and the psycho-dynamic issues in patients and family interactions. Catherine showed evidence of extensive outside reading for conferences and patient care, and asked thoughtful, pertinent questions. She was adept at assessing her own performance and sought resources to remediate self-identified deficiencies. She had highly developed internal standards. Her preceptor concluded, "Catherine was an exceptional subintern in a busy N/SICU. A pleasure to work with and teach."

Family Medicine Subinternship - Middlesex Hospital – October, 2006

Catherine had a truly outstanding performance during her Family Medicine subinternship, garnering 'Above Expected Level' ratings for 14/14 subcomponents of the 6 core competencies (patient care, medical knowledge, practice-based learning, interpersonal & communication skills, professionalism, and systems-based practice). Her preceptor, Dr. Alan Douglass, wrote, "Catherine has an outstanding ability to efficiently gather all relevant information and distill it into a cogent differential and treatment plan. Catherine carried an intern's patient load and responsibilities with apparent ease. Attendings were impressed with Catherine's knowledge base. Catherine was a motivated, inquisitive learner who went out of her way to learn more about her patients' illnesses. Outstanding oral presentations were delivered in a clear and confident manner. She communicated in a compassionate manner to patients and families. Catherine is trustworthy and responsible; a supportive team player and a hard-worker. She communicated well with attendings, consultants, an nursing staff. Catherine delivered an outstanding performance. We think she will make a wonderful Family Physician; we would be thrilled I she chose our residency program for her post-graduate training."

SUMMARY:

Catherine Romanos is that rare individual who combines strong intellect with phenomenal interpersonal skills. Her Departmental Honors in 3 clinical disciplines places her firmly in the top echelon of her class. This was further supported by Catherine's superior subinternship in Family Medicine in October of her fourth year. She is an effective self-motivated learner who has taken responsibility for augmenting her medical knowledge, as evidenced by her strong performance on the USMLE step II exam. She excels at establishing relationships with patients, peers, and mentors. She incorporates seamlessly into health care teams. Catherine brings a genuine enthusiasm and upbeat manner in interacting with patients. She is intrigued by the wide variety of patients she will see in Family Medicine. She is eagerly anticipating becoming emotionally and intellectually involved with their care over time. She is a young woman who is judicious with her words, which makes her an effective listener and communicator with patients. She is able to overcome cultural and language barriers with ease.

Catherine has had a long standing interest in service and international health. This took root before medial school, and was reinforced with her elective in Puerto Rico after her first year. She has a planned elective in Honduras this winter to further use her fluent Spanish and expand her cultural experience.

We are delighted to recommend Catherine Romanos to you as an **Outstanding** candidate for postgraduate training.

Soc Sec: Redacted

281333

November 1, 2006

Signature Anthony J Ardolino

Anthony J. Ardolino, MD,
Professor of Medicine
Associate Dean for Medical Student Affairs
ardolino@nso1.uchc.edu
860-679-2113

Soc Sec: Redacted

Student: **Catherine Romanos**

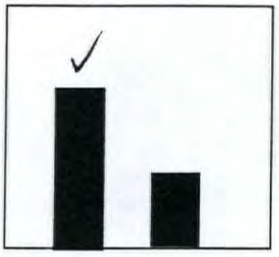
APPENDIX A: Comparative performance in the pre clinical years:
Unavailable— Years 1 & 2 are strict pass- fail, with no class rank

APPENDIX B: Comparative performance in Core Disciplines (Class of 2007 data):

Family Medicine

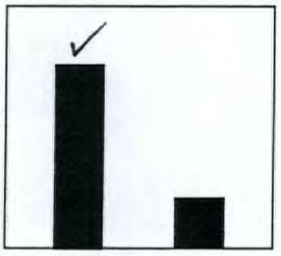
Pass Honors (21%)

Medicine



Pass Honors (31%)

Pediatrics

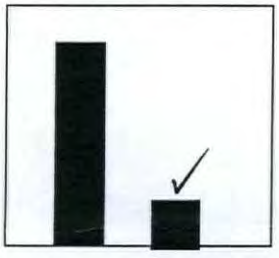


Pass Honors (15%)

OB/Gyn

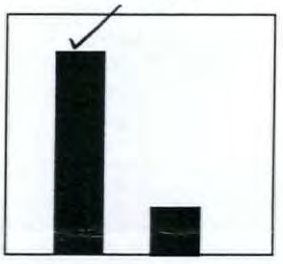
Pass Honors (28%)

Psychiatry



Pass Honors (14%)

Surgery



Pass Honors (15%)

Appendix C: Professional Attributes:

-Students are required to submit professional journals in their Student Continuity Practice (SCP), which are reviewed by PCM faculty. There is formal coursework in law, ethics and professionalism throughout all four years. Our Clinical Skills Assessment Program evaluates a broad array of professional skills. There are several 'professionalism' domains formally evaluated in SCP, Principles of Clinical Medicine, and in the third and fourth year clerkships. There is a required third year seminar series devoted to personal & professional development.

Appendix D: Overall Performance:

Exceptional = 4% of the class

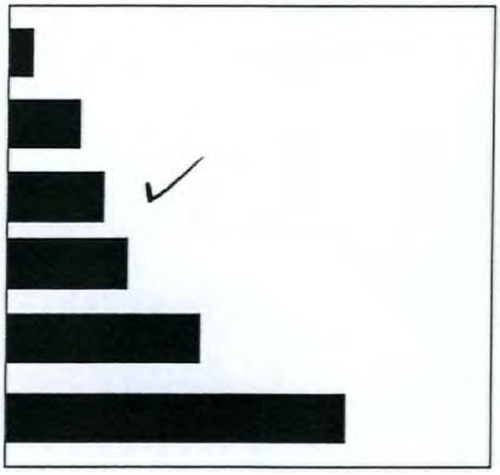
Exceptional/Outstanding = 9%

Outstanding = 12%

Excellent/Outstanding = 15%

Excellent = 22%

Qualified, Well Qualified = 38%



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University of Connecticut
School of Medicine
Office of the Registrar
263 Farmington Avenue
Farmington, Connecticut 06030-1827

Date Generated
05/07/13

Romanos, Catherine Eileen

ID Number: 106327

Date Matriculated: 08/18/2003
Primary Program: Medicine
Sub Program:

Degree: Doctor of Medicine
Conferred: 05/13/2007
Completed: 05/13/2007

Number	Title	Grade	Hrs
	... 2003-2004 ...		
M100-000	HUMAN SYSTEMS	S	
	Human Biology		
	Organ Systems I		
	Organ Systems 2		
	Organ Systems 3		
M100-100	CORRELATED MEDICAL PROBLEM SLV	S	
M100-200	CLINICAL MEDICINE COURSE	S	
	Principles of Clinical Medicine		
	Student Continuity Practice		
M100-300	MEDICAL SCIENCE ELECTIVE - 1	P	8.0
	Emergency Medicine		
	... 2004-2005 ...		
M200-000	MECHANISMS OF DISEASE	S	
	General Pathology, Immunolo-pathology, Pharmacology		
	Infectious Disease		
	Diseases Affecting Homeostasis		
	Oncology		
	Diseases of the Nervous System		
	Diseases of Reproductive System		
	Immune and Non-Immune Mediated Dis. of Skin, Conn. Tiss., Bone		
	Diseases Affecting Metabolism		
M200-100	CORRELATED MEDICAL PROBLEM SLVNG	S	
M200-200	CLINICAL MEDICINE COURSE	S	
	Principles of Clinical Medicine		
	Student Continuity Practice		
M200-300	MEDICAL SCIENCE ELECTIVE - 2	P	8.0
	Family Medicine		
M200-400	HUMAN DEVELOPMENT/HEALTH	S	
	... 2005-2006 ...		
M300-000	MULTIDISCIPLINARY AMBULATORY EXP	S	
	Home Week-MAX 1		
	Home Week-MAX 1		
	Home Week-MAX 2		
	General Internal Medicine		
	Ob/Gyn		
	Ambulatory Pediatrics		
	Ambulatory Psychiatry		
	Orthopedics		
	General Surgery		
	ENT		
	Family Medicine		
M300-100	INPATIENT EXPERIENCE	S	
	Medicine		
	Surgery		
	Pediatrics		
	Psychiatry		
	Beginning-to-End		
M300-200	STUDENT CONTINUITY PRACTICE	S	
	---------- ACADEMIC HONORS EARNED THIS TERM ----------		
	Family Medicine		
	Ob/Gyn		
	Psychiatry		

Number	Title	Grade	Hrs
	... 2006-2007 ...		
M400-000	ADVANCED CLINICAL EXPERIENCE	S	
	AIE Family Medicine		
	Middlesex Memorial Hospital		
	Emergency Medicine Experience		
	New Britain General Hospital		
	Critical Care Experience		
	St. Francis Hospital		
M400-300	SELECTIVES	S	
	A pre-travel curriculum for students traveling to La Paz, La Paz, Honduras		
M408-261	PEDIATRIC INFECTIOUS DISEASE	S	
	CT Children's Hospital		
M412-012	NEUROLOGY	S	
	UConn Health Center		
M420-000	SPECIAL ELECTIVE	S	
	Healthcare in Honduras		
M420-000	SPECIAL ELECTIVE	S	
	Peds, Gtr. Lawrence Fam. H.Ctr.		
M800-000	COMMUNITY SERVICE REQUIREMENT	S	
M900-000	CLINICAL SKILLS ASSESSMENT	S	

SEAL
VERIFIED

The Family Educational Rights and Privacy Act of 1974 prohibits the release of this information without the student's written consent.

5/7/13

Office of the Registrar **Date**

281737 2250

University of Connecticut School of Medicine:

Accreditation:
Liaison Committee on Medical Education of the American Medical Association and the Association of American Medical Colleges

Curriculum Description:
Phase 1 (years 1 and 2)
Human Systems: The Human Systems course runs for 38 weeks. The content is sequenced to begin with the basic biochemistry and molecular biology of the cell, and progresses to a presentation of the gross anatomy, histology, biochemistry, and physiology of tissues and organs.
Correlated Medical Problem Solving (CMPS): The CMPS course runs for 38 weeks in year 1 and 38 weeks in year 2. The sole instructional format is problem-based learning. Cases used in this course serve to expand upon and integrate basic science concepts introduced in the Human Systems, Human Development and Health, and Mechanisms of Disease courses.
Clinical Medicine Course (CMC): CMC is a comprehensive course extending throughout phases 1 and 2, which is devoted to student mastery of the fundamental skills, attitudes, and knowledge needed to practice clinical medicine. The course has the following two components:

Student Continuity Practice (SCP): SCP is a longitudinal experience which begins in the fall of the first year and continues through year 3 (optional as elective in year 4). Students spend one half-day per week in an ambulatory clinical site, under the supervision of a physician preceptor.

Principles of Clinical Medicine (PCM): PCM is devoted to medical history-taking skills, physical examination, and professional development. The course is run in a seminar format one half-day per week throughout phase 1.

Human Development and Health: The Human Development and Health course begins the second academic year, and runs for 8 weeks. It comprises a multidisciplinary survey of psychological and social development from conception to death; and investigation of the behavioral and social determinants of health and illness; an introduction to principles of medical law and ethics; an overview of health care services across the life span; and an introduction to clinical epidemiology as it applies to medical practice.
Mechanisms of Disease: The Mechanisms of Disease course runs for 30 weeks in year 2. It focuses on the pathophysiology and pathology of the organ systems, the epidemiology of specific diseases, and relevant therapy.
Elective-I: Electives run throughout phase 1, and are designed to expand upon the core curriculum. Students must complete 12 hours of elective credit during phase 1.

Phase 2 (year 3)
During phase 2 (year 3), there are two courses - Multidisciplinary Ambulatory Experience (MAX) and Inpatient. MAX is divided into two 16-week components - MAX-1 and MAX-2. These three 16-week components can be taken in any order. Students may earn "honors" in major clinical disciplines during phase 2.
MAX-1: There are two six-week experiences: Internal Medicine and Pediatrics; and one-week experiences in Orthopedics and ENT. During these experiences the students have a half-day/week ambulatory Psychiatry clinic.
MAX-2: There are two six-week experiences: Family Medicine and OB/GYN; and a three-week experience in ambulatory General Surgery.
Inpatient Experience: The inpatient block is 16 weeks in duration, and consists of rotations in Medicine (4 weeks), Surgery (4 weeks), Psychiatry (4 weeks), Pediatrics (2 weeks), and an experience called Beginning-to-End (2 weeks). In the Beginning-to-End experience, students follow patients from admission in the Emergency Department through discharge, regardless to which service the patient is admitted.
Home Week: During MAX-1 and MAX-2 the students have three Home Week sessions, where all students return to the medical school. Evaluations are an essential activity during Home Week. In addition, each Home Week is oriented around a cross-disciplinary theme.

Phase 3 (year 4)
Advanced Clinical Experiences (ACE): This course is 3 months in duration, and provides students with an intensive inpatient experience, and exposure to issues related to critical and emergency/urgent care. It is divided into three sections (each 1 month in duration), which can be scheduled at any time during phase 3.

Advanced Inpatient Experience: Students can choose between Medicine, Pediatrics, Surgery, or Family Medicine.

Emergency/Urgent Care Experience: Students rotate through an urgent/emergency setting.

Critical Care Experience: Students can choose between Medical Intensive Care Unit, Surgical Intensive Care Unit, Coronary Care Unit, or Pediatric/Neonatal Intensive Care Unit.

Students may earn "honors" in each section of this course.
Selectives: The Selectives course is 2 months in duration (block or longitudinal) and can be scheduled at any time during phase 3. Students develop and carry out an independent project in one of the following areas; research, community health, or education.
Electives-II: Students have 5 months of elective time in phase 3, with each elective being 1 month in duration (students may use 1 month for vacation/residency interviews). Electives can be scheduled at anytime during phase 3.
Community Service Requirement: Students must complete a minimum of 15 hours of community service prior to the spring of year 4; students participate in a range of established community service programs and/or design their own independent service activity.
Clinical Skills Assessment: Students must pass a clinical skills assessment in year four using standardized patients representing each of the major clinical disciplines.

Grading Policy:
Phase 1 (Years 1 and 2): Courses, with the exception of phase 1 electives, are graded on a Satisfactory/Unsatisfactory basis. Phase 1 electives are graded on a pass/fail basis and only those electives passed by the student are reflected on the transcript. Credits are assigned only to Phase 1 electives.
Phase 2 (Year 3): Courses are graded on a Satisfactory/Unsatisfactory basis. To receive a satisfactory grade, students must pass each individual experience. Students may receive Honors recognition from departments during phase 2. Honors is designated by a notation at the end of the Spring semester of the third year. Honors may be received in the following disciplines: Family Medicine, Medicine, Obstetrics/Gynecology, Pediatrics, Psychiatry or Surgery.
Phase 3 (Year 4): Courses are graded on a Satisfactory/Unsatisfactory basis. To receive a grade of S in Advanced Clinical Experience (ACE), students must pass each individual component. The selected area for a student's Advanced Inpatient Experience (AIE) is noted beneath the course listing for ACE. Components of the course not yet taken by the student at the time of transcript preparation are so noted. Honors may be received in each component of ACE, and honors earned at the time of transcript preparation are noted. Honors designations are not awarded for the other courses in year 4.

Grading Key:

I	Incomplete
IP	Course in progress, may span full year - grade to be posted at year end
NR	No grade reported
P	Pass
S	Satisfactory
U	Unsatisfactory
W	Withdrawn
WD	Withdrawn

Neither grade point average or class rank are used in this grading system.

Combined Degree Programs:
MD/Ph.D.: For students jointly pursuing the Doctor of Philosophy degree, phase 1 elective requirement and phase 3 selective requirements are waived. Students are required to do at least 3 months of electives during phase 3.
MD/MPH: For students jointly pursuing the Master of Public Health degree, phase 1 elective requirement and phase 3 selective requirements are waived.
MD/MBA: For student jointly pursuing the Master of Business Administration degree, the phase 1 elective requirement and phase 3 selective requirement are waived.
MD/OMFS: Students in the Oral and Maxillofacial Surgery Program are admitted with advanced standing and special status into the first year of Medical School. This insures their eligibility to sit for the USMLE Step 1 exam. Phase 1 of the School of Medicine curriculum is primarily satisfied through curriculum previously completed in dental school. During phase 1 students take only Principles of Clinical Medicine in year 2. Students begin full-time study in the School of Medicine during phase 2. The phase 3 selective requirement and community service requirement are waived. Students take a minimum of 4 months of Oral & Maxillofacial Surgery, 2 months of Anesthesiology, and 1 month of Head and Neck Anatomy Research. Rev11/2007

University of Connecticut

Be it known that

Catherine Romanos

having satisfied the requirements for the Degree of

Doctor of Medicine

in

The School of Medicine

has been admitted to that degree with all the related honors, privileges, and obligations. In recognition we present the seal of the University and the signatures as authorized by the Board of Trustees.

Given at Farmington, in the State of Connecticut, on the Thirteenth day of May, Two Thousand and Seven.

Peter J. Dekkers MD
Dean, School of Medicine

UNIVERSITY OF CONNECTICUT 1881

President of the University

President of the Board of Trustees

5/7/13

SEAL VERIFIED

281333 2250

Section V

Graduate Medical Education

400 FULLER WISER ROAD | SUITE 300 | EULESS, TX 76039 | TEL(817)868-5000 | FAX(817)868-5099

Federation of STATE MEDICAL BOARDS

Federation Credentials Verification Service (FCVS)
400 Fuller Wiser Road, Suite 300, Euless, TX 76039
Tel: (817) 868-5000 Fax: (817) 868-5099

Verification of Graduate Medical Education

Institution: Greater Lawrence Family Health Center
Attention: **Program Director**
Specialty: Family Medicine
Affiliated University: _____
Address: Lawrence, MA

Verification For:
Name: Romanos, Catherine Eileen
DOB: 01/28/1979
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: PGY1 (e.g., 1, 2, 3, etc.)
☐ Internship ☒ Residency ☐ Chief Residency ☐ Fellowship ☐ Research
Specialty/Subspecialty: FAM MED
From: 6/16/07 **To:** 6/27/08
Successfully Completed?: ☒ Yes ☐ No ☐ In Progress
Accredited by: ☒ ACGME ☐ AOA ☐ LCGME ☐ RSC ☐ CFPC ☐ RCPSC ☐ APPAP ☐ None of these

Training Level: PGY2 (e.g., 1, 2, 3, etc.)
☐ Internship ☒ Residency ☐ Chief Residency ☐ Fellowship ☐ Research
Specialty/Subspecialty: FAM MED
From: 6/28/08 **To:** 6/28/09
Successfully Completed?: ☒ Yes ☐ No ☐ In Progress
Accredited by: ☒ ACGME ☐ AOA ☐ LCGME ☐ RSC ☐ CFPC ☐ RCPSC ☐ APPAP ☐ None of these

Training Level: PGY3 (e.g., 1, 2, 3, etc.)
☒ Internship ☐ Residency ☐ Chief Residency ☐ Fellowship ☐ Research
Specialty/Subspecialty: FAM MED
From: 6/28/09 **To:** 6/28/10
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 in this space. If no seal is available, you must have this [illegible] clarified

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)**.

Name: Joseph Gravel, MD
Signature: Joseph Gravel, MD
Title of Signatory: Program Director
Date of Signature: 5/3/13
Tel: 978-725-7410 Fax: 978-687-2106 E-Mail: jgravel@glfhc.org

ELECTRONIC SEAL VERIFIED

Applicant Reported Unusual Circumstances

Graduate Medical Education

Medical Professional Name: Catherine Eileen Romanos
Greater Lawrence Family Health Center
Family Medicine

Unusual Circumstances

Did you have any interruption(s) or extension(s) in 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 by instructors?	Yes	**No**
Were any limitations or special requirements imposed on you because of academic performance, incompetence, disciplinary problems or for any other reason?	Yes	**No**

End of report for Catherine Eileen Romanos

PROVIDED BY APPLICANT

GREATER LAWRENCE FAMILY HEALTH CENTER AND THE LAWRENCE GENERAL HOSPITAL

hereby certify that

Catherine Romanos, MD

Has successfully completed the studies and requirements of a Residency in Family Medicine and is accorded all rights, honors, privileges and responsibilities pertaining thereto.
Given this Twenty-fifth day of June in the year Two Thousand and Ten.

Greater Lawrence Family Health Center
Chief Executive Office

Lawrence General Hospital
Chief Executive Officer

Lawrence Family Medicine Residency
Program Director

Section VI

Licensure Examination History

(State Licensing Authorities Only)

400 FULLER WISER ROAD | SUITE 300 | EULESS, TX 76039 | TEL(817)868-5000 | FAX(817)868-5099

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) 868-4000

Date : **04/30/2013**

Recipient:

Federation Credentials Verification Service
ATTN: FCVS

Packet ID: 281333

Examinee: Romanos, Catherine Eileen
Alt Name(s):

Examinee ID#: 5-152-240-7
Date of Birth: 01/28/1979

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, the recommended minimum passing score ("MP") is shown in parentheses. Pass/fail outcomes are based upon the minimum passing level in place at the time of test administration and are not altered by subsequent revisions to the minimum passing level. Effective April 1, 2013, test results are reported on a three-digit scale only; two-digit scores reported for prior administrations will no longer be reported. Test results reported as passing represent an exam score of 75 or higher on a two-digit scoring scale.

USMLE STEP 1

	Test Date	Pass/Fail	Total	MP	Comments
	06/21/2005	Pass	199	(182)	

USMLE STEP 2

Clinical Knowledge (CK)

	Test Date	Pass/Fail	Total	MP	Comments
	06/27/2006	Pass	223	(182)	

Clinical Skills (CS)*

	Test Date	Pass/Fail	Total	MP	Comments
	07/05/2006	Pass			

USMLE STEP 3

	Test Date	Pass/Fail	Total	MP	Comments
MASSACHUSETTS	07/09/2009	Pass	232	(187)	

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

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) 868-4000

Examinee: Romanos, Catherine Eileen

Examinee ID#: 5-152-240-7
Date of Birth: 01/28/1979

INTERPRETATION OF RESULTS

USMLE transcripts include a complete examination history. On those Step examinations for which numeric scores are reported, a three-digit scale is used. Most scores fall between 140 and 260 on this scale. The recommended minimum passing score is shown on the front of the transcript next to the examinee's score for each administration along with a pass/fail outcome. Test results reported as passing represent an exam score of 75 or higher on a two-digit scoring scale. The level of proficiency required to meet the recommended minimum passing level for each USMLE Step is reviewed periodically and is subject to change. Such changes do not alter pass/fail outcomes from prior test administrations.

For examinations with reported scores, the Standard Error of Measurement (SEM) provides an index of the variation that would be expected to occur if an examinee were tested repeatedly using different sets of items covering similar content. The SEM is usually in the range of 4 to 8 points.

STEP 2 CLINICAL SKILLS (CS)

Step 2 CS results are reported as pass or fail, with no numeric score. Had the two-digit reporting scale been used, examinees would have had to achieve a score of 75 or higher in order to pass.

ANNOTATIONS APPEARING UNDER "COMMENTS"

Circumstances in connection with an administration shown on this transcript may result in one or more annotations listed next to the score. A description of each Comment is provided below:

Indeterminate - Results are at or above the passing level but cannot be certified as representing a valid measure of the examinee's knowledge or competence as sampled by the examination. **No score is reported.** Information regarding the nature of the indeterminate score is available. If such information is not enclosed with this transcript, it may be obtained by contacting the organization from which you received the transcript or the USMLE Secretariat, 3750 Market Street, Philadelphia, PA 19104, telephone (215) 590-9700.

Incomplete - The examinee sat for some, but not all, of the scheduled examination. **No score is reported.**

Irregular Behavior - The Committee for Individualized Review determined that the examinee engaged in irregular behavior. Examples of irregular behavior are described in the current edition of the *USMLE Bulletin of Information*. Information regarding the nature of the irregular behavior and the determination of the Committee is available. If such information is not enclosed with this transcript, it may be obtained by contacting the organization from which you received the transcript or the USMLE Secretariat, 3750 Market Street, Philadelphia, PA 19104, telephone (215) 590-9700.

Score Not Available - The score is not available. Further review and/or analysis may be pending, or it may have been determined that the score cannot be reported.

Test Accommodations - Following review and approval of a request from the examinee, test accommodations were provided in the administration of the examination.

ANNOTATIONS APPEARING AS "NOTE"

Circumstances not in connection with an administration shown on this transcript may result in one or more annotations and an explanation or instructions to contact the appropriate individual or organization. The Note will appear at the end of the document.

BOARD ACTION DATA BANK INFORMATION APPEARING AS "NOTE"

The Board Action Data Bank of the Federation of State Medical Boards (FSMB) contains actions reported to the FSMB by U.S. licensing and disciplinary boards, Canadian licensing authorities, the U.S. Armed Forces, the U.S. Department of Health and Human Services, and other credentialing entities. To be included in the Data Bank, an action must be a matter of public record or be legally releasable to state medical boards or other entities with recognized authority to review physician credentials. Certain actions reported to and released by the Board Action Data Bank are not disciplinary or otherwise prejudicial in nature. Such actions are reported to ensure that records are complete and to assist in preventing misrepresentation or the use of lost or stolen credentials by unauthorized persons. Once reported to the FSMB, an action becomes part of the permanent record of the individual physician, and the existence of such an action may be indicated on the USMLE transcript by a Note.

4/2013

State Medical Board of Ohio

30 E. Broad St., 3rd Floor • Columbus, OH 43215-6127 • (614) 466-3934 • Website: http://med.ohio.gov/

8/9/2013

Catherine Eileen Romanos, MD
104 High St., #3
Charlestown MA 02129-3019

This is to notify you that you are now licensed to practice medicine or osteopathic medicine and surgery in the State of Ohio. The Board approved your request and your license number **121940** was issued on **08/09/2013** and will expire on **04/01/2014**.

Enclosed is your wallet card and wall certificate. The wall certificate, by law, must be displayed in your office or the place where a major portion of your practice is conducted.

Please be advised that verification of your Ohio license must be obtained directly from the Board's website at http://med.ohio.gov in the "Licensee Profile and Status section. The website is updated immediately to reflect newly issued licenses.

The Ohio Medical Board operates a "staggered renewal" system based upon the first letter of your last name at the time of licensure. Enclosed is a chart and information outlining the staggered medical license renewal system and continuing medical education (CME) hours required. Renewal applications are mailed approximately six months prior to the date of expiration. CME information may also be obtained from the Board's website.

SECTION 4731.281, OHIO REVISED CODE REQUIRES WRITTEN NOTICE TO THE BOARD OF ANY CHANGE OF PRINCIPAL PRACTICE ADDRESS OR RESIDENCE ADDRESS WITHIN THIRTY DAYS OF THE CHANGE. *A CHANGE OF ADDRESS FORM IS AVAILABLE ON THE BOARD'S WEBSITE.*

This notice authorizes you to make application for a U.S. Drug Enforcement Administration certificate of registration (controlled substance permit). To make such application, contact:

Drug Enforcement Administration (DEA)
431 Howard St.
Detroit, Michigan 48226
(800) 230-6844
www.deadiversion.usdoj.gov/

Any questions regarding the DEA registration must be directed to the DEA office.

Sincerely,

Nicole Weaver
Nicole Weaver
Chief, Licensure

Date Posted: 10/21/2013 5:16:47 PM

Please review all information you have provided. Click on the "Review" button to change any information given or click on the "I Agree" button to verify that all information posted below is correct and to proceed to payment options.

Please note that knowingly providing false information may result in denial of registration.

License Information

License Number	35.121940
License Name	Catherine Romanos

Fees

Relicensure Fee	$305.00
	========
Total Fees	**$305.00**

Medical Board Correspondence Email

1. **Did you provide a Credential email address? Please note this information is a public record.**

. . . . . YES

Specialty Codes

1. Please select one specialty from the field below

. . . . . FAMILY MEDICINE

2. Please select one specialty from the field below, if applicable.

. . . . . *{not Answered}*

3. Please select one specialty from the field below, if applicable.

. . . . . *{not Answered}*

CME-Physicians

1. Have you met the above CME requirements for your license?

. . . . . YES

Discipline

1. Have you been found guilty of, or pled guilty or no contest to, or received treatment or intervention in lieu of conviction of, a misdemeanor or felony?

. . . . . NO

2. Have you surrendered, consented to limitation of, or to suspension, reprimand or probation concerning, a license to practice any healthcare profession or state or federal privileges to prescribe controlled substances in any jurisdiction other than Ohio?

. . . . . NO

3. Have any malpractice awards been paid by you or on your behalf for acts

occurring in any state other than Ohio?

. . . . . NO

4. Has any board, bureau, department, agency, or any other body, including those in Ohio **other than this board,** filed any charges, allegations or complaints against you?

. . . . . NO

5. Have you had any clinical privileges or other similar institutional authority suspended, restricted, revoked or placed on probation for reasons **other than failure to maintain records on a timely basis or to attend staff meetings?**

. . . . . NO

6. Have you been addicted to or dependent upon alcohol or any chemical substance; or been treated for, or been diagnosed as suffering from, drug or alcohol dependency or abuse?

. . . . . NO

Social Security Number

1.

. . . . . Redacted

Nurse Collaboration Info

1. Are you currently in a collaboration agreement with any Clinical Nurse Specialists, Certified Nurse-Midwives or Certified Nurse Practitioners?

. . . . . YES

2. List the name/names and type of licensure for each nurse with whom you are collaborating. **For example: Jane Doe, CNP; Mary Smith, CNS.**

. . . . . Jill Burns, CNP, Erin Cooke, CNP, Holly France-Kremin, CNP, Laura Hallock, CNP, Colleen Quinlan, CNP, Alicia Shanks, CNP, Lindsey Romney, CNP, Caroline Strzesynski, CNP, Julia Stuart, CNP, Ashley Taylor, CNP, Johanna Taylor, CNP, Louann Alexovich, CNM, Latina Brooks, CNP, Colleen Cahill, CNP, Debbie Darnell, CNP, Valerie Dudziak, CNP, Nicole Erinakes-Chauvette, CNM, Jean Friedman, CNP, Erica Gutshall, CNP, Sarah Halter, CNM, CNP, Pam Hetrick, CNM, Lauren Howman, CNP, Jeanne Knudtsen, CNM, Ginny Melver, CNP, Michelle Meredith, CNP, Diane Molnar, CNP, Brittney Moore, CNP, Sarah Noggle, CNP, Mary Nowicki, CNM, Jill Palajac, CNP, Jane Peterson, CNP, Lola Pustelnik, CNM, Connie Rackow, CNP, Ann Raffis, CNP, Shannon Riley, CNP, Jennifer Tabin, CNM, Tracey Thompson, CNP, Emily Wilford, CNP, Louise Yunck, CNM

Ohio Employment

1. Do you practice in Ohio?

. . . . . YES

Ohio Workforce Questions

1. "Clinical" - direct patient care

. 30-34

2. "Research" - study of a treatment, procedure or medication done in a medical setting or for a medical purpose

. 0

3. "Administration" - activities related generally to patient care other than direct contact with a patient (e.g. recordkeeping, clerical tasks, chart review, prior authorizations with insurers, claims, billing issues, etc.)

. 10-14

4. "Education" - preceptor, mentor, etc.

. 1-4

5. "Volunteering" - providing medical and medical-related services at no cost

. 0

6. "Other" - medical professional activities not included in above categories

. 1-4

Clinical - Practice setting

1. Enter the number of hours per week spent in "Office/Clinic/Ambulatory care" (out-patient care).

. 40-44

2. Enter the number of hours per week spent in "Hospital (in-patient care)".

. 0

3. Enter the number of hours per week spent in "Emergency Room".

. 0

4. Enter the number of hours per week spent in "Urgent Care".

. 0

5. Enter the number of hours per week spent in "Other".

. 0

Workforce Counties

1. Enter the first zip code:

. 43213

2. Enter the first county:

. . . . . Franklin

3. Enter the second zip code:

. 44146

4. Enter the second county:

. . . . . Cuyahoga

5. Enter the third zip code:

. 43222

6. Enter the third county:

. . . . . Franklin

7. Do you have more than one practice location?

. . . . . YES

Workforce Practice Address

1. Please list all practice locations. Include street address, city, state and zip. Example "123 E Main St, Suite 2, Anywhere, OH 55555;" Separate multiply addresses with a semicolon.

. . . . . 3255 E Main St, Columbus, OH 43209; 1511 W Broad St, Columbus, OH 43222; 25350 Rockside Rd, Bedford Heights, OH 44146

Practice Arrangement (size)

1. Solo practitioner

. . . . . NO

2. Single-specialty Group

. . . . . N/A

3. Multi-specialty Group

. 2-5

4. Employee of a clinical facility or hospital? (Clinical facility is an urgent care, industrial clinic or similar entity)

. . . . . NO

Workforce Language Question

1. Do practitioners or staff in your practice communicate in sign language or in a language other than spoken English?

. . . . . YES

Languages

1. Select a language from the drop down list.

. . . . . Spanish

2. Select a language from the drop down list.

. . . . . *{not Answered}*

3. Select a language from the drop down list.

. . . . . *{not Answered}*

ABMS Certified

1. Are you certified by an ABMS Board?

. . . . . NO

NPI number

1. Please enter your current NPI number

. 1659574192

DEA number

1. Please enter your DEA number

. . . . . FR4108228

I understand that submitting a false, fraudulent, or forged statement or document or omitting a material fact in obtaining licensure may be grounds for disciplinary action against my license.

Under penalty of law, I hereby swear or affirm that the information I have provided in the application is complete and correct, and that I have complied with all criteria for applying on line.

Date Posted: 10/21/2015 12:22:55 PM

Please review all information you have provided. Click on the "Review" button to change any information given or click on the "I Agree" button to verify that all information posted below is correct and to proceed to payment options.

Please note that knowingly providing false information may result in denial of registration.

License Information

License Number	35.121940
License Name	Catherine Romanos

Fees

Relicensure Fee	$305.00
	========
Total Fees	**$305.00**

Medical Board Correspondence Email

1. **Did you provide a Credential email address? Please note this information is a public record.**

. . . . . YES

Specialty Codes

1. Please select one specialty from the field below

. . . . . FAMILY MEDICINE

2. Please select one specialty from the field below, if applicable.

. . . . . *{not Answered}*

3. Please select one specialty from the field below, if applicable.

. . . . . *{not Answered}*

CME-Physicians

1. Have you met the above CME requirements for your license?

. . . . . YES

Discipline

1. **At any time since signing your last application for renewal of your certificate** have you been found guilty of, or pled guilty or no contest to, or received treatment or intervention in lieu of conviction of, a misdemeanor or felony?

. . . . . NO

2. **At any time since signing your last application for renewal of your certificate** have you surrendered, consented to limitation of, or to suspension, reprimand or probation concerning, a license to practice any healthcare profession or state or federal privileges to prescribe controlled substances in any jurisdiction other than Ohio?

. . . . . NO

3. **At any time since signing your last application for renewal of your certificate** have any malpractice awards been paid by you or on your behalf for acts occurring in any state other than Ohio?

. . . . . NO

4. **At any time since signing your last application for renewal of your certificate** has any board, bureau, department, agency, or any other body, including those in Ohio **other than this board,** filed any charges, allegations or complaints against you?

. . . . . NO

5. **At any time since signing your last application for renewal of your certificate** have you had any clinical privileges or other similar institutional authority suspended, restricted, revoked or placed on probation for reasons **other than failure to maintain records on a timely basis or to attend staff meetings?**

. . . . . NO

6. **At any time since signing your last application for renewal of your certificate** haveyou been addicted to or dependent upon alcohol or any chemical substance; relapsed, been treated for, or been diagnosed as suffering from, drug or alcohol dependency or abuse?

. . . . . NO

Social Security Number

1.

. . . . . Redacted

Nurse Collaboration Info

1. Are you currently in a collaboration agreement with any Clinical Nurse Specialists, Certified Nurse-Midwives or Certified Nurse Practitioners?

. . . . . YES

2. List the name/names and type of licensure for each nurse with whom you are collaborating. **For example: Jane Doe, CNP; Mary Smith, CNS.**

. . . . . BRATSCH, STACEY A, CNP BURNS, JILL M, CNP CAHILL, COLLEEN A, CNP DARNELL, DEBORAH K, CNP DEESER, BRENDA S, CNP GROGG, CORRIE E, CNP GUTSHALL, ERICA D, CNP HOWMAN, LAUREN S, CNP KALOCZI, LISA D, CNP KING, VIRGINIA L, CNP KNUDTSEN, JEANNE A, CNM LEATHERS, LASHERRI A, CNP LESLIE, EMILY H, CNM LUCAS, DENISE R, CNP MEREDITH, MICHELLE R, CNP MOORE, BRITTNEY N, CNP MORGENSTERN, JENNIFER L, CNM NOGGLE, SARAH M CNP PALAJAC, JILL L, CNP QUINLAN, COLLEEN M, CNP RACKOW, CONNIE S, CNP RAFFIS, ANN M, CNP ROMNEY, LINDSEY M, CNP SHANKS, ALICIA, CNP STUART, JULIA A, CNP TABIN, JENIFER F, CNM TAYLOR, ASHLEY N, CNP WALKER, EBONEE L, CNP WYATT, COURTNEY M, CNP YODER, DEBORAH K, CNP YUNCK, LOUISE A, CNM

Ohio Employment

1. Do you practice in Ohio?

. . . . . YES

Ohio Workforce Questions

1. "Clinical" - direct patient care

. 35-39

2. "Research" - study of a treatment, procedure or medication done in a medical setting or for a medical purpose

. 0

3. "Administration" - activities related generally to patient care other than direct contact with a patient (e.g. recordkeeping, clerical tasks, chart review, prior authorizations with insurers, claims, billing issues, etc.)

. 1-4

4. "Education" - preceptor, mentor, etc.

. 1-4

5. "Volunteering" - providing medical and medical-related services at no cost

. 1-4

6. "Other" - medical professional activities not included in above categories

. 1-4

Clinical - Practice setting

1. Enter the number of hours per week spent in "Office/Clinic/Ambulatory care" (out-patient care).

. 35-39

2. Enter the number of hours per week spent in "Hospital (in-patient care)".

. 0

3. Enter the number of hours per week spent in "Emergency Room".

. 0

4. Enter the number of hours per week spent in "Urgent Care".

. 0

5. Enter the number of hours per week spent in "Other".

. 1-4

Workforce Counties

1. Enter the first zip code:

. 43213

2. Enter the first county:

. . . . . Franklin

3. Enter the second zip code:

. 43215

4. Enter the second county:

. . . . . Franklin

5. Enter the third zip code:

. . . . . *{not Answered}*

6. Enter the third county:

. . . . . *{not Answered}*

7. Do you have more than one practice location?

. . . . . YES

Workforce Practice Address

1. Please list all practice locations. Include street address, city, state and zip. Example "123 E Main St, Suite 2, Anywhere, OH 55555;" Separate multiply addresses with a semicolon.

. . . . . 3255 E Main St, Columbus, OH 43213: 206 E State St, Columbus, OH 43215

Practice Arrangement (size)

1. Solo practitioner

. . . . . NO

2. Single-specialty Group

. . . . . N/A

3. Multi-specialty Group

. . . . . N/A

4. Employee of a clinical facility or hospital? (Clinical facility is an urgent care, industrial clinic or similar entity)

. . . . . YES

Workforce Language Question

1. Do practitioners or staff in your practice communicate in sign language or in a language other than spoken English?

. . . . . YES

Languages

1. Select a language from the drop down list.

. . . . . Spanish

2. Select a language from the drop down list.

. . . . . *{not Answered}*

3. Select a language from the drop down list.

. . . . . *{not Answered}*

ABMS Certified

1. Are you certified by an ABMS Board?

. . . . . NO

NPI number

1. Please enter your current NPI number

. 1659574192

DEA number

1. Please enter your DEA number. Only enter one, or the primary DEA number.

. . . . . FR4108228

OARRS Registration

1. Since signing your last renewal have you prescribed or personally furnished opioid analgesics or benzondiazepines while practicing in Ohio?

. . . . . YES

2. Are you registered with the Ohio Automated Rx Reporting System (OARRS)?

. . . . . YES

I understand that submitting a false, fraudulent, or forged statement or document or omitting a material fact in obtaining licensure may be grounds for disciplinary action against my license.

Under penalty of law, I hereby swear or affirm that the information I have provided in the application is complete and correct, and that I have complied with all criteria for applying on line.

Contact Audit Trail for ROMANOS CATHERINE

Date	User	Table	Field	New	Old
8/15/2013 4:05:08 PM	Bates, J	CONTACTADDRESS	CELLPHONE	(860) 490-0897	
8/15/2013 4:05:08 PM	Bates, J	CONTACTADDRESS	CELLPHONE	(860) 490-0897	
8/15/2013 4:05:08 PM	Bates, J	CONTACTADDRESS	ZIPCODE	43209	43215
8/15/2013 4:05:08 PM	Bates, J	CONTACTADDRESS	ZIPCODE	43209	43215
8/15/2013 4:05:08 PM	Bates, J	CONTACTADDRESS	PHONE		(860) 490-0897
8/15/2013 4:05:08 PM	Bates, J	CONTACTADDRESS	PHONE		(860) 490-0897
8/15/2013 4:05:08 PM	Bates, J	CONTACTADDRESS	ADDRESS2	174	
8/15/2013 4:05:08 PM	Bates, J	CONTACTADDRESS	ADDRESS2	174	
8/15/2013 4:05:08 PM	Bates, J	CONTACTADDRESS	ADDRESS1	3000B E Main St	672 Kerr St
8/15/2013 4:05:08 PM	Bates, J	CONTACTADDRESS	ADDRESS1	3000B E Main St	672 Kerr St
8/12/2013 7:15:38 AM	Hawk, L	CONTACTADDRESS	COUNTYID	Franklin	Out of State
8/12/2013 7:15:38 AM	Hawk, L	CONTACTADDRESS	COUNTYID	Franklin	Out of State
8/12/2013 7:15:38 AM	Hawk, L	CONTACTADDRESS	STATECODE	OH	MA
8/12/2013 7:15:38 AM	Hawk, L	CONTACTADDRESS	STATECODE	OH	MA
8/12/2013 7:15:38 AM	Hawk, L	CONTACTADDRESS	ZIPCODE	43215	02129-3019
8/12/2013 7:15:38 AM	Hawk, L	CONTACTADDRESS	ZIPCODE	43215	02129-3019
8/12/2013 7:15:38 AM	Hawk, L	CONTACTADDRESS	CITY	Columbus	Charlestown
8/12/2013 7:15:38 AM	Hawk, L	CONTACTADDRESS	CITY	Columbus	Charlestown
8/12/2013 7:15:37 AM	Hawk, L	CONTACTADDRESS	ADDRESS1	672 Kerr St	104 High St., #3
8/12/2013 7:15:37 AM	Hawk, L	CONTACTADDRESS	ADDRESS1	672 Kerr St	104 High St., #3
4/23/2013 11:50:06	Moore, A	CONTACT	DATEOFBIRTH	19790128	

AM					
4/23/2013 11:50:06 AM	Moore, A	CONTACT	BIRTHCITY	Torrington	
4/23/2013 11:50:06 AM	Moore, A	CONTACT	BIRTHSTATE	CT	
4/23/2013 11:50:06 AM	Moore, A	CONTACT	GENDER	F	
4/23/2013 11:49:53 AM	Moore, A	CONTACT	OLRPASSWORD	*******	*******