Frederick L. Cohn, M.D., F.A.C.O.G.
Anne S. McNulty, M.D., F.A.C.O.G.
Sharon S. [illegible], R.N., C.N.M.

Waterbury Medical Center
1389 West Main Street, Suite 320
Waterbury, Connecticut 06708
203 754-5129

Greater Waterbury Obstetrics, Gynecology and Fertility Associates, P.C.

RECEIVED
BOARD OF REGISTRATION IN MEDICINE

4/29/95

Dear Sirs:

This letter is to advise you that I am presently not practicing medicine in Massachusetts. Therefore, I have not renewed my license this year.

My license number is 75815.

Thank you for your help.

Sincerely,
Jonathan T. Foster
[signature]

REDACTED COPY

PS

I am registered in
Connecticut and my
home address is

Commonwealth of Massachusetts Board of Registration in Medicine
Ten West Street, 3rd Floor, Boston, Massachusetts 02111
1993-1995 Physician Registration Renewal Application

Registration No.	Status	Fee	Renewal Date	Late Fee
75815	ACTIVE	$250.00	03/08/93	$25.00

Mailing Address:
JONATHAN TODD FOSTER, M.D.

Correction of Mailing Address:
Address (Mailing): ______
City/Town: ______
State: ______
Country Code (See Table 1): ______

Directions: Staple check to bottom of form. Add late fee if necessary.
- *Questions 1-8 include information from Board files. Please correct as necessary in the boxes provided on the right hand side of the page.*
- Before proceeding, please read the instruction booklet. Some questions are optional.
- **Make a copy of this form and all attachments for your own records** - you will need copies for credentialing and other purposes. The Board will charge a fee for each copy it provides.
- Enclose the $250.00 renewal fee by means of a certified check, money order or personal check made payable to the Commonwealth of Massachusetts.

For Office Use Only
M.R. MAR 05 1993
P. FP MAR 05 1993
Bk.D.E. 3/5/93 O.H.

Pre-Printed Information

1. Other name(s), if any, under which you were licensed:

2. a) Address (Home):

   b) Address (Business):

3. Date of Birth: Sex: M
   Lic. Issue Date: 05/13/92 SS#:
   Telephone Number:
   Home Business
   (914)630-9236

4. Name of Medical School:
   Yale University School of Medicine

   Year Graduated: 90 Degree: MD

5. a) *Other states where you are now licensed to practice (Abbr):*
   b) *States where you previously were licensed to practice (Abbr):*

6. Specialty Code(s) (See Table 2):
   Code Hours per Week in Mass.
   0
   0

7. a) If you are currently American Specialty Board Certified, enter Codes: (See Table 3)
   Code: Code:

   b) If you previously were American Specialty Board certified, but are no longer, please enter codes of prior certification: (See Table 3)
   Code: Code:

8. Drug License Number(s), if any: a) Federal (DEA)
   b) State (MA)

Corrections of Pre-Printed Information

Name: ______
Address (Home): ______
City/Town: ______
State: ______ Zip: ______
Country Code: ______ If 999 print Country: ______
Address (Business): ______
City/Town: ______
Country Code: ______ If 999 print Country: ______

Date of Birth (M/D/Y): __/__/__ Sex (M/F): ______
Lic. Issue Date (M/D/Y): __/__/__ SS#: ______
Telephone Number:
Home: ( ) ______ Business: ( ) ______

Full Name of Medical School: ______

Year Graduated: ______ Degree (MD/DO): ______

Code ______ Hours per Week in Mass. ______

If OS, print specialty: ______

Code: ______ Code: ______

Code: ______ Code: ______

Federal (DEA):
State (MA):

9. I have completed my CME requirements in the two years preceding my renewal date: Yes X No, waiver requested ______
You must fill out a separate Waiver Form. The waiver must be granted by the Board before your license will be renewed. See instructions for CME requirements. Do not submit documentation of your CMEs with your renewal application.

Staple Check Here

PRINT NAME AND NUMBER: Physician Last Name: Foster Registration Number: 75815

10. **Activity Status:** I am applying to be registered with the following status: Active X Inactive ___

- **I hereby certify that if requesting Inactive status, I will not practice medicine, including writing prescriptions, in Massachusetts.**

11. My medical malpractice insurance is covered by (a) INSURANCE CARRIER X or (b) LETTER OF CREDIT___ If applicable, check one.

List Insurer: Crico, JUA

Alternatively, indicate as follows: I am registering with ACTIVE status, but I am not covered by medical malpractice insurance because I am (Check One): (i) NOT INVOLVED IN DIRECT/INDIRECT PATIENT CARE IN MASS: ___ (ii) OTHERWISE EXEMPT: ___

(State how otherwise exempt): ___

12. Current Health Care Facility Affiliations. Supply the codes from Table 4 and place a check mark next to those facilities where you have admitting privileges (AP).

Facility Code: 4 2 1 / ___ (AP) Facility Code: 9 9 9 / ___ (AP) Facility Code: ___ ___ ___ / ___ (AP)

Facility Code: 1 6 8 / ___ (AP) Facility Code: ___ ___ ___ / ___ (AP) Facility Code: ___ ___ ___ / ___ (AP)

If 999, print name(s): Preterm

Additional hospitals at which you previously held privileges and other health care facilities with which you were associated in the past 2 years. (See Table 4.)

Facility Code: ___ ___ ___ Facility Code: ___ ___ ___ Facility Code: ___ ___ ___ Facility Code: ___ ___ ___ Facility Code: ___ ___ ___

If 999, write name(s): ___

13. Are you currently in a post-graduate training program in MA as a resident or clinical fellow? Yes X No___ (Check one)

14. a) What is your principal work setting? (See Table 5) 1 0

b) Care of patients in Massachusetts (MA) (See instruction booklet.)

i) How many hours per typical week are you currently involved in *outpatient* care in MA? 40 hrs/wk in MA

ii) How many hours per typical week are you currently involved in *inpatient* care in MA? 60 hrs/wk in MA

Questions 15 through 23 refer <u>to the past two years only.</u> Check either YES or NO (NOT N/A) to each question. Provide details on Form 15A for all YES answers. Refer to the instruction booklet for additional information.

IN THE PAST TWO YEARS:

	YES	NO
15. Has any medical malpractice claim been made against you, whether or not a lawsuit was filed in relation to the claim?		
16. Have you been charged with any criminal offense, other than a minor traffic violation?		
17. Have you formally been charged with or disciplined for any violation of the rules, by-laws or standards of practice of any governmental authority, health care facility, group practice or professional society or association?		
18. Has your privilege to possess, dispense or prescribe controlled substances been surrendered to or suspended, revoked, denied or restricted by any state or federal agency?		
19. Have you withdrawn an application for a medical license o[r bee]n denied a medical license for any reason?		
20. Have you had any mental illness which has impaired your ability to practice medicine or to function as a student of medicine?		
21. Have you had an organic illness which has impaired your ability to practice medicine or to function as a student of medicine?		
22. Are you now, or have you been in the past two years, dependent upon alcohol or drugs?		
23. Has any professional liability insurance provider restricted, limited, terminated or imposed a surcharge on your coverage?		

- **Pursuant to G.L. c. 112, sec. 2, I will not charge to or collect from a Medicare beneficiary more than the Medicare reasonable charges.**

- **Pursuant to G.L. c. 62C, sec. 49A, I hereby certify under the penalties of perjury that, to the best of my knowledge and belief, I have filed all Massachusetts state tax returns and paid all Massachusetts state taxes that are required under law. NOTE: This applies even if you reside out-of-state or out of the country.**

- **I hereby certify that I will fulfill my obligation to report abuse or neglect of children pursuant to G.L. c. 119, sec. 51A.**

- **I hereby certify under the penalties of perjury that all information on this form and Form 15A is true.**

Signature: [signature] Date: 2-28-93

NAME Foster, Jonathan T.

DATE PROCESSED 03/27/92
BD. STAFF F.P.

YES ✓
NO X
NOT APPLICABLE N/A

DATE REVIEWED 5/6/92
REVIEWER RKB

BRD READY DATE ____
REVIEWER ____

APPL/FEE/PG ✓ ✓ ✓

Pls list on 5/13/92 Bd
KKB

SIGNATURE

NAME CHANGE

SUPPLEMENT
YES ANS.

MORAL & PROF.
CHAR. STATEMENT

PRE. MED.

MED. ED.

EXAM SCORES

LIC. VERIF.

TAX MED.

EVALUATIONS
POOR/FAIR

ECFMG CERT.

IMG E/F+TRANSSCRIPTS

PG/G-H-I-

DIPLOMA

PROBLEMS: ____

BRING TO LIC. ATT. __/__/__

BRING TO LIC. COMM. __/__/__

AMA X

FED ✓

DEROG ✓

update Mailed 4/24/92 FP

Commonwealth of Massachusetts
Board of Registration in Medicine

Ten West Street
Boston, Massachusetts 02111

(617) 727-3086

DINESH PATEL, M.D.
CHAIRMAN
ALEXANDER F. FLEMING
EXECUTIVE DIRECTOR

An Agency within the Executive Office of Consumer Affairs and Business Regulation

June 12, 1992

Dear Physician:

Please acknowledge receipt of this wall certificate by signing the statement below.

Sincerely yours,

Kate H. Graca
Director, Licensing Unit

I hereby acknowledge the receipt of an original wall certificate bearing my name, medical school, certificate number, and date of issue.

Jonathan Foster
NAME (Please Print)

SIGNATURE

75815
License #

June 13, 1992
DATE

RECEIVED
JUN 22 1992
BOARD OF REG. IN MEDICINE
COMMONWEALTH OF MASSACHUSETTS

THE COMMONWEALTH OF MASSACHUSETTS
BOARD OF REGISTRATION IN MEDICINE

Fee — $300 to be submitted

MAR 20 1992

For Office Use	
Form of Fee:	Application #:
Certificate #: 75815	Date of Issue: 5/13/92

Please Print

SWORN STATEMENT

Date: March 4, 1992

Name: Jonathan Todd Foster (First / Middle)

Address*:

Date of Birth:

Place of Birth: New Haven, CT

Address valid from: (Dates) 6/90 - present

Name on Birth Certificate: same

Phone #: DAY: 9146309236 HOME:

Pre-Medical Education	Medical Education
School: Pace University	School: Yale University
Years Attended: 1982 - 1985	Years Attended: 1986 - 1990

C7001

Postgraduate Education & Hospital Appointments from graduation from Medical School to the present time.

Place	Position	Dates
Brigham and Women's Boston Mass 02115	Resident Ob6yn	6/90 - Present

Is this your first license? NO If applicable, please list all other states where you are or have been licensed:

Other names under which you have been licensed: N/A

List Specialty Boards by which you are certified: N/A

REASON APPLYING FOR A MASS. LICENSE: Seeking extra curricular employment now and eventual private practice in Massachusetts

*NOTE: Change of address must be submitted to the Board of Registration in Medicine in writing. Please include effective dates of new address.

AFFADAVIT OF APPLICANT:

I, the undersigned applicant, hereby certify that all information included in this application for licensure constitutes a true statement made under penalty of perjury.

(SIGNATURE OF APPLICANT) Jonathan Foster

Date: 3/4/92

Batch # 3352

FED. OK

Date 03/30/92 By FP

(Yes)

(1)

00 801.

COMMONWEALTH OF MASSACHUSETTS BOARD OF REGISTRATION IN MEDICINE SUPPLEMENT TO APPLICATION FOR ______ LICENSE

TO BE COMPLETED BY APPLICANT. PLEASE TYPE OR PRINT.

NAME: Jonathan Foster Day time phone #: 732 5445

MAILING ADDRESS: ______ Business Address:

Address valid until: 1/1/93

YOU ARE REQUIRED TO COMPLETE THE QUESTIONS BELOW.

IMPORTANT NOTE: The Board's regulations, 243 CMR 3.02, define "disciplinary action" as referred to in the questions on this application. Please consult this definition, which follows this portion of the application.

YES NO

1. Has any medical malpractice claim been made against you in the last ten years (whether or not a lawsuit was filed in relation to the claim)? (You must complete Form 1B, attached, for each claim)
2. Have you ever been denied the right to participate or enroll in any system whereby a third party pays all or part of a patient's bill?
3. Have you ever applied for licensure or to sit for an examination or taken an examination under a different name? If so, previous name: ______
4. Have you ever been denied the privilege of taking or finishing an examination or been accused of cheating and/or improper conduct during an examination or otherwise been subject to any disciplinary action (see definition) at an academic institution since your matriculation in college?
5. Have you ever failed any of the following examinations: the FLEX examination, any state Board examination, failed Part III of the National Boards or failed to gain certification from the National Board of Medical Examiners?
6. Have you ever failed a foreign licensing or certification examination?
7. Have you ever been denied a medical license, whether full, limited or temporary, for any reason?
8. Have you ever had staff privileges, employment or appointment in a hospital or other health care institution denied, suspended or revoked, or resigned from a medical staff in lieu of disciplinary action (see definition)?
9. Are any formal disciplinary charges pending or has any disciplinary action (see definition) been taken against you in the last ten years by any governmental authority, by any hospital or health care facility, or by any professional medical association (international, national, state or local)?
10. Have you ever voluntarily surrendered a license to practice medicine or any healing art?
11. Have you ever withdrawn an application for medical licensure, hospital privileges or appointment, for any reason?
12. Have you ever, for any reason, lost American Specialty Board Certification?
13. Have you been denied required recertification by one or more specialty boards? If yes, which one(s)? ______
14. Have you, at any time, been a defendant in any criminal proceeding other than minor traffic offenses?
15. Has your privilege to possess, dispense or prescribe controlled substances ever been suspended, revoked, denied, restricted or surrendered, or have you been called before or warned by this state or any other jurisdiction including a federal agency at any time?
16. Have you ever had any emotional disturbance or mental illness which has impaired your ability to practice medicine or to function as a student of medicine?
17. Have you ever had an organic illness which has impaired your ability to practice medicine or to function as a student of medicine?
18. Are you now, or have you been in the past, dependent upon alcohol or drugs?
19. Have you ever held a license in Massachusetts or any other state or country? If yes, list other jurisdictions. Massachusetts ______, ______
20. Have you ever been enrolled in a residency training program(s) that you did not complete?

IMPORTANT: SEE FOLLOWING PAGES FOR FURTHER INFORMATION REQUIRED FOR "YES" ANSWERS.

NOTE ON QUESTIONS 16-18: *The harm that befalls physicians and patients alike when impairment goes undetected and untreated by the medical profession is devastating. The Board wants impaired physicians treated in the early stages of impairment before irreparable harm to the physician or patient occurs.*

IF RESPONSES TO QUESTIONS CHANGE DURING THE TIME THE APPLICATION IS PENDING, THE APPLICANT MUST MAKE THE BOARD AWARE OF THE NEW INFORMATION.

I will read the Board's regulations. 243 CMR 1.00 through 3.00. To the best of my knowledge I meet the qualifications for full licensure in Massachusetts.
I certify that I will fulfill my obligation to report abuse or neglect of children pursuant to M.G.L.c.119 sec 51A.
I hereby certify under the penalty of perjury that all information on this application, (front, back, and all attachments) is true.

SIGNATURE: [signature] DATE: 3/4/92

CERTIFICATE OF MORAL AND PROFESSIONAL CHARACTER

ATTENTION APPLICANT: This certificate must be signed by a physician legally authorized to practice medicine in the United States. This statement should be executed by someone other than a relative who knows you well and for a substantial period of time. The Board especially seeks statements from physicians licensed to practice in Massachusetts.

PHOTOGRAPH	CERTIFICATE OF MORAL & PROFESSIONAL CHARACTER
:ent fou e a om	DATE: 3/12/92 This certifies that I have been personally acquainted with Jonathan T. Boster (NAME) (ADDRESS) for 2 years; that I believe him to be of good moral & professional character, and in every respect worthy of confidence. I recommend him to the Massachusetts Board of Registration in Medicine.
Jonathan Bo... Signature of Applicant	Michael ... M.D. Signature of certifying physician
I certify that the photograph above is a genuine likeness of the maker of the signature above.	MICHAEL R. STELLUTO, MD NAME TYPED OR PRINTED 75 FRANCIS ST - BOSTON, MA 01930 ADDRESS of certifying physician
Martha Williams Signature of Notary 6/18/93 (Expiration Date of Commission)	License # 27206 State MA.

CERTIFYING PHYSICIAN: PLEASE RETURN DIRECTLY TO: THE BOARD OF REGISTRATION IN MEDICINE, 10 WEST ST., BOSTON, MA 02111

Commonwealth of Massachusetts
Board of Registration in Medicine

Ten West Street
Boston, Massachusetts 02111

(617) 727-3086

DINESH PATEL, M.D.
CHAIRMAN

ALEXANDER F. FLEMING
EXECUTIVE DIRECTOR

An Agency within the Executive Office of Consumer Affairs and Business Regulation

TO ALL APPLICANTS

Massachusetts General Laws Chapter 62C, section 49A, requires that you complete this statement to obtain licensure to practice a profession.

I, Jonathan Todd Foster,
Name

certify, under the pains and penalties of perjury, that I, to my best knowledge and belief, have filed all state tax returns and paid all state taxes required by state law.

Date: March 4 1992. [signature]
Signature

Social Security Number, Optional

Massachusetts General Laws Chapter 12, section 5, and 243 CMR 2.04(2)(k) require that you complete the following statement:

I will not charge to or collect from a Medicare beneficiary more than the Medicare "reasonable charge" for services, in compliance with Chapter 475 of the Acts of 1985.

Date: March 4 1992 [signature]
Signature

Commonwealth of Massachusetts
Board of Registration in Medicine

FORM E

Ten West Street
Boston, Massachusetts 02111

(617) 727-3086

DINESH PATEL, M.D.
CHAIRMAN
ALEXANDER F. FLEMING
EXECUTIVE DIRECTOR

An Agency within the Executive Office of Consumer Affairs and Business Regulation

VERIFICATION OF PREMEDICAL AND MEDICAL INSTRUCTION AND GRADUATION

INSTRUCTIONS TO THE DEAN OR DESIGNATED OFFICIAL OF MEDICAL SCHOOL

Please complete this form in full and return it **DIRECTLY TO THE ADDRESS ABOVE.** This Verification cannot be accepted nor can a license be issued to the applicant unless you send this form directly to the Board of Registration in Medicine. Thank you for your cooperation.

I CERTIFY THAT Jonathan Todd Foster CREDITABLY
NAME OF APPLICANT

COMPLETED AT LEAST TWO YEARS OF A PREMEDICAL COURSE INCLUDING PHYSICS, BIOLOGY, INORGANIC AND ORGANIC CHEMISTRY AT:

Pace University
NAME AND LOCATION OF UNDERGRADUATE EDUCATIONAL INSTITUTION

NAME AND LOCATION OF SECOND UNDERGRADUATE INSTITUTION (IF APPLICABLE)

for admission to: Yale University School of Medicine
NAME OF MEDICAL SCHOOL

New Haven, CT USA
LOCATION OF MEDICAL SCHOOL (CITY, STATE, COUNTRY)

I FURTHER CERTIFY THAT Jonathan Todd Foster
NAME OF APPLICANT

HAS COMPLETED AND ATTENDED FOR 4 ACADEMIC YEARS OF INSTRUCTION,
NUMBER

OF NOT LESS THAN THIRTY TWO WEEKS IN EACH ACADEMIC YEAR

AT: Yale University School of Medicine
NAME OF MEDICAL SCHOOL

FORM E CONTINUED ON NEXT PAGE

Commonwealth of Massachusetts
Board of Registration in Medicine

Ten West Street
Boston, Massachusetts 02111

(617) 727-3086

DINESH PATEL, M.D.
CHAIRMAN

ALEXANDER F. FLEMING
EXECUTIVE DIRECTOR

An Agency within the Executive Office of Consumer Affairs and Business Regulation

NAME OF APPLICANT: Jonathan Todd Foster

TO MEDICAL SCHOOL: (Give exact dates of instruction, including month, day of month and year for each year to show the number of weeks, excluding vacations, in each year.)

	MONTH	DAY	YEAR		MONTH	DAY	YEAR
FROM:	09	08	86	TO:	05	22	87
FROM:	09	14	87	TO:	05	06	88
FROM:	07	05	88	TO:	06	18	89
FROM:	07	05	89	TO:	05	25	90
FROM:				TO:			
FROM:				TO:			

AND HAS RECEIVED/WILL RECEIVE A DEGREE OF MD

ON May 28, 19 90.

Judy Mayo
SIGNATURE OF DEAN OR DESIGNATED OFFICIAL

Judy Mayo, Registrar
NAME AND TITLE (Please type or print)

SCHOOL SEAL

DATE: 03/13/92

RECEIVED
MAY 6 1992
BD OF REG. IN MEDICINE
COMMONWEALTH OF MASSACHUSETTS

6

Certification of Post-Graduate Training FORM G

Instructions: This form must be completed and signed by the Director of your internship or residency training program. If you had postgraduate training in more than one program, this form may be duplicated. Upon proper completion, this form must be returned directly by the hospital to the Board's address below.

I, Kenneth J. Ryan, M.D. (Name), Chairman, Dept. of Ob/Gyn (Title)

hereby certify that Jonathan T. Foster, M.D. has served 1+5/6 year(s)

of post-graduate training as a Resident (Position) in Obstetrics & Gynecology (Specialty)

at Brigham & Women's Hospital (Hospital), Boston (City), MA (State).

This program is x is not ____ approved by the ACGME or the RRC.

Dr. Foster participated in this program from

July (Month), 1990 (Year) to date (Month), ____ (Year) and was issued ____ was not

issued x a certificate as proof of completion of said training. (If not issued a certificate, please explain.)

Dr. Foster is still in his residency. He is expected to complete his training 6/30/94.

I further certify that at the time of completion of the above training, this physician was, to the best of my knowledge, competent to practice medicine and there was no disciplinary action outstanding or pending involving him or her.

[signature]
Signature of Director

May 1, 1992
Date

Hospital Seal
Marylou Williams
Notary Public
6/18/93

RETURN THIS FORM DIRECTLY TO: COMMONWEALTH OF MASSACHUSETTS
BOARD OF REGISTRATION IN MEDICINE
TEN WEST STREET, 3RD FLOOR,
BOSTON, MASSACHUSETTS 02111

Commonwealth of Massachusetts
Board of Registration in Medicine

Ten West Street
Boston, Massachusetts 02111

(617) 727-3086

ANDREW G. BODNAR, M.D., J.D
CHAIRMAN

BARBARA NEUMAN
EXECUTIVE DIRECTOR

An Agency within the Executive Office of Consumer Affairs and Business Regulation

DATE 4/20/90

Physician Profile
American Medical Association
535 North Dearborn Street
Chicago, Il. 60610

ECFMG
3654 Market Street
Philadelphia, Pa. 19104

THE MASSACHUSETTS BOARD OF REGISTRATION IN MEDICINE REQUESTS A PHYSICIAN PROFILE OR ECFMG CERTIFICATION CONCERNING THE FOLLOWING INDIVIDUAL:

NAME: FOSTER, JONATHAN T

ADDRESS: c/o 75 FRANCIS ST BOSTON MA

MEDICAL SCHOOL: YALE UNIVERSITY

DATE OF GRADUATION: ___/___/1990

DATE OF BIRTH:

ECFMG NUMBER:

PLEASE MAIL THE RESPONSE TO THE FOLLOWING ADDRESS:
MASSACHUSETTS BOARD OF REGISTRATION IN MEDICINE
TEN WEST STREET, THIRD FLOOR
BOSTON, MASSACHUSETTS 02111
ATTN: LICENSING UNIT

This section is to be completed by the office of the Executive Director of the Educational Council for Foreign Medical Graduates to verify the ECFMG certification.

ECFMG Certificate Number_____ or Certificate Letter_____

ECFMG Expiration Date: ___/___/___

Signature: ____________ (Seal of ECFMG)

NAME: ____________ DATE: ___/___/___
(Typed or Printed)

Members of the Board

Commonwealth of Massachusetts
Board of Registration in Medicine

Ten West Street
Boston, Massachusetts 02111

(617) 727-3086

ANDREW G. BODNAR, M.D., J.D.
CHAIRMAN

BARBARA NEUMAN
EXECUTIVE DIRECTOR

An Agency within the Executive Office of Consumer Affairs and Business Regulation

DATE 4/20/90

Physician Profile
American Medical Association
535 North Dearborn Street
Chicago, Il. 60610

ECFMG
3654 Market Street
Philadelphia, Pa. 19104

FED. OK Date 4/25/90 Batch # 146 By F.L.

THE MASSACHUSETTS BOARD OF REGISTRATION IN MEDICINE REQUESTS A PHYSICIAN PROFILE OR ECFMG CERTIFICATION CONCERNING THE FOLLOWING INDIVIDUAL:

NAME: FOSTER, JONATHAN T

ADDRESS: c/o 75 FRANCIS ST BOSTON MA

MEDICAL SCHOOL: YALE UNIVERSITY 00801

DATE OF GRADUATION: __/__/1990

DATE OF BIRTH:

ECFMG NUMBER:

PLEASE MAIL THE RESPONSE TO THE FOLLOWING ADDRESS:
MASSACHUSETTS BOARD OF REGISTRATION IN MEDICINE
TEN WEST STREET, THIRD FLOOR
BOSTON, MASSACHUSETTS 02111
ATTN: LICENSING UNIT

This section is to be completed by the office of the Executive Director of the Educational Council for Foreign Medical Graduates to verify the ECFMG certification.

ECFMG Certificate Number__________ or Certificate Letter__________

ECFMG Expiration Date: __/__/__

Signature:______________________(Seal of ECFMG)

NAME: ______________________ DATE: __/__/__
(Typed or Printed)

Members of the Board

RETURN TO: BOARD OF REGISTRATION IN MEDICINE
TEN WEST STREET, THIRD FLOOR
BOSTON, MASSACHUSETTS 02111

VERIFICATION OF LICENSURE

NA

In applying for a license to practice medicine in the Commonwealth of Massachusetts, the Board of Registration in Medicine requires that this form be completed by each state where I hold or have ever held licensure. This is your authority to release any information in your files, favorable or otherwise. Please send this form directly to the Board at the above address. Your early response is greatly appreciated.

SIGNATURE OF PHYSICIAN*: ______

NAME OF PHYSICIAN: ______ LICENSE NUMBER: ______

The State Board fills out the following information:

State of: ______ Full Name of Licensee: ______

Graduate of: ______

License Number: ______ Issue Date: ______

By Endorsement/Reciprocity with: ______ By Your State Board's Written Examination? ___Yes ___No

Is License current? ___Yes ___No

If No, why not? ______

Has this License been suspended or revoked? ___Yes ___No

If yes, why? ______

Has licensee ever been on probation? ___Yes ___No

If yes, why? ______

Has licensee ever been requested to appear before your Board? ___Yes ___No

If yes, why? ______

Derogatory information, if any? ______

Comments, if any? ______

Signed ______

Title: ______

BOARD SEAL

State Board: ______ Date: ______

*NOTE TO APPLICANT: Most states charge a fee for this service. We suggest that you call the different states in which you are licensed before you mail this form.

ICANT'S NAME: Jonathan T. Foster

FORM E

...ACHUSETTS INSTITUTION WHERE TRAINING WILL BE DONE: Brigham + Women's Hospital 75 Francis St. Boston

BOARD OF REGISTRATION IN MEDICINE
TEN WEST STREET, THIRD FLOOR
BOSTON, MASSACHUSETTS 02111

VERIFICATION OF MEDICAL INSTRUCTION AND GRADUATION

Instructions:

To the Applicant: This Form E must be sent to your medical school for completion by the Dean or designated official and returned **DIRECTLY by the medical school to the Board's office address above.** If you attended more than one medical school, you must duplicate this form and forward a copy to each medical school at which your received academic credit.

To the Medical School: Please complete the enclosed form in full and return **it DIRECTLY to the address above.** This verification cannot be accepted nor can a license be issued to the applicant unless you send this form directly to the Board of Registration in Medicine at the above address. Thank you for your cooperation.

I HEREBY CERTIFY THAT Jonathan T. Foster (name of applicant) HAS COMPLETED AND ATTENDED

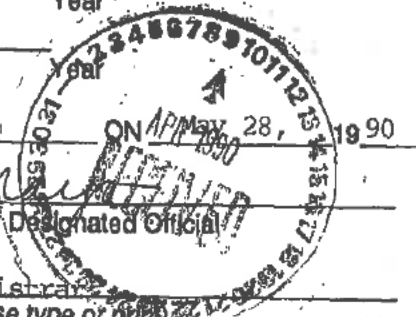
FOR 4 (number) ACADEMIC YEARS OF INSTRUCTION, OF NOT LESS THAN THIRTY TWO WEEKS IN

EACH ACADEMIC YEAR AT Yale University School of Medicine (name and location of medical school)

(Give *exact* dates of instruction, including month, day of month and year for each year to show the number of weeks, excluding vacations, in each year):

FROM: (Month Day Year)	TO: (Month Day Year)
9/8/86	5/22/87
9/14/87	5/6/88
7/5/88	6/18/89
7/5/89	5/25/90

AND HAS RECEIVED/WILL RECEIVE A DEGREE OF: Doctor of Medicine ON May 28, 1990



Signature of Dean or Designated Official

School Seal

Judy Mayo, Registrar
Name and title (please type or print)

DATE: April 5, 1990

approval date 5/2/90

Commonwealth of Massachusetts Board of Registration in Medicine
Ten West Street, 3rd Floor, Boston, Massachusetts 02111
Initial Limited License Application, Page 1 of 2

$ 50.00 Fee Payable to The Commonwealth of Massachusetts

4-19-90
#1486
CJ.

90-3943-94

Important:
. *Read the accompanying instructions in their entirety before completing this form.*
. *Print legibly or type your answers.*
. Answer all non-optional questions (front and back of form) completely.-Even though the Board may have the information, it is not adequate to state that the Board already has the information.
. *Sign the application at the bottom of page two.*
. ***Make a copy of this form and all attachments for your own records--you must give hospitals and other health care facilities copies for credentialing purposes.***

Applicants please check one: I am a 1) Graduate of a Medical School in the U.S., Canada or Puerto Rico X 2) Graduate of Foreign Medical School ___ 3) Graduate of Foreign Medical School applying under the Special Refugee Physician Program___.

PLEASE NOTE: GRADUATES OF FOREIGN MEDICAL SCHOOLS MUST COMPLETE ADDITIONAL FORMS AS PART OF THE APPLICATION PROCESS.

SECTION A: Sworn Statement to be Completed by Applicant. (Complete Reverse Side Also)

1. a) Name (LAST:) Foster, (FIRST:) Jonathan, (M.I.:) T

1. b) Other Name(s): Have you ever been known under a different name or combination of names? Have you ever been licensed under a different name? If yes, please specify (and attach documentation): no

1. c) Have you ever applied for licensure or to sit for an examination or taken an examination under a different name? If yes, please specify: no

2. a) Name & address of Massachusetts Training Hospital: Brigham + Women's Hospital, 75 Francis St, Boston MA

2. b) Local residence address & telephone: not yet known - will advise Tel.#

3. Place of Birth: New Haven, CT, USA

4. Date of Birth (MO/DA/YR): 5. Sex: MALE X FEMALE ___ 6. Social Security No. (*Optional*):

7. a). Name of Premedical school(s): Pace University 7 b)Location: (City, State, Country) Pleasantville, NY, USA

8. a) Medical School Name: (See #3 under instructions) Yale University CT001 8 b) Location: (City,State,Country) New Haven, CT USA

8. c) Year Graduated: 1990 8. d) Degree: M.D. X D.O.___ Other (Specify)

9. a) Previous post-graduate training: ___yes X no

b) Name of Institution:

Address:

c) Name of Program: Dates of training:

Continue answer on additional page if necessary

10. If you have had any one of the following, please circle which one and attach an explanation to this form: **a) Leave of absence from medical school b) USMG more than four years of medical school education. c) FMG more than six years of medical education. Question 10 applies to me ___Yes X No.** I have attached an explanation, Yes___ No___.

SECTION B: TO BE COMPLETED AND SIGNED BY THE DESIGNATED OFFICIAL OF THE INSTITUTION AT WHICH THE APPLICANT HAS RECEIVED AN APPOINTMENT.

This certifies that Jonathan T. Foster, M.D. *has been appointed to the position of intern* X, *Resident*___, Fellow___ in Program Obstetrics/Gynecology (Program) at Brigham & Women's Hospital (Institution) beginning 6/20/90

Anticipated completion Date of training 6/30/94 OBG

This program is accredited by the ACGME: Yes x No___ 921

If no, we have an ACGME approved training program in the applicant's specialty: Yes___ No___.

Designated Official's Signature: Sheridan Kassirer

Type or Print Name and Title: Sheridan L. Kassirer, Vice President

(Applicant See reverse side - You must complete Section C)

FORM 11/89

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SECTION C: Sworn Statement to be Completed by Applicant (Complete Reverse Side Also)

11. Other States where you are now fully licensed to practice:
(Abbreviate): N/A

12. States where you previously were licensed to practice (This includes Residency Training Licenses)
(Abbreviate): MA

13. If more than one year will have passed between the date of your graduation from medical school and the anticipated start date of your limited licensure in Massachusetts, please list your professional activities up to the present time, in chronological order. Please include employment experiences and training programs. Question 13 applies to me: Yes___ No X I have attached an explanation: Yes___ No___

14. Have you ever been enrolled in a residency training program(s) that you did not complete? Yes___ No X If yes, please attach an explanation detailing your reasons for not completing the program(s). In addition, you must provide a letter from the Program Director at the training program that you did not complete, certifying the circumstances under which you left the program. This letter must be sent directly to the Board by the Program Director. I have attached an explanation: Yes___ No___ Program Director's Certification has been requested: Yes___ No___

Questions 15 through 24. Check either YES or NO (not N/A) to each question. Provide details on Form 15B, attached. .... Yes No

15. Has any medical malpractice claim been made against you (whether or not a lawsuit was filed in relation to the claim)?

16. Have you been a defendant in any criminal proceeding other than a minor traffic offense?:

17. Are any formal disciplinary charges pending or has disciplinary action (as defined by Board regulations; See Attached From 15B) been taken against you by any governmental authority, hospital or other health care facility, or professional medical association (international, national, state or local)?

18. Has your privilege to possess, dispense or prescribe controlled substances been suspended, revoked, denied, restricted, surrendered, or have you been called before or been warned by this state or any other jurisdiction including a federal agency?

19. Have you withdrawn an application for a medical license or been denied a medical license for any reason? Have you ever voluntarily surrendered a license to practice medicine or any healing art in lieu of disciplinary action (as defined by Board regulations; see attached Form 15B)?

20. Have you had any mental illness which has impaired your ability to practice medicine or to function as a student of medicine?

21. Have you had any organic illness which has impaired your ability to practice medicine or to function as a student of medicine?

22. Are you now, or have you been in the past, dependent upon alcohol or drugs?

23. Have you ever been denied the privilege of taking or finishing an examination or been accused of cheating and/or improper conduct during an examination or otherwise been subject to any disciplinary action (as defined by Board regulations; See Attached Form 15B) at an academic institution, since your matriculation in college?

24. Have you ever had staff privileges, employment or appointment in a hospital or other health care institution denied, suspended or revoked, or have you resigned from a medical staff in lieu of disciplinary action (as defined by Board regulations; See Attached Form 15B)?

IF RESPONSES TO QUESTIONS 15-24 CHANGE DURING THE TIME THE APPLICATION IS PENDING, THE APPLICANT MUST MAKE THE BOARD AWARE OF THE NEW INFORMATION.

Pursuant to M.G.L. c.62C sec.49A, I certify under the penalties of perjury that, to my best knowledge and belief, I have filed any Massachusetts state tax returns and paid any Massachusetts state taxes that are required under law. Note: This applies even if you reside out-of-state or out of the country.

I will read the Board's regulations, 243 CMR 1.00 through 3.00. To the best of my knowledge, I meet the qualifications for limited licensure in Massachusetts.

I hereby certify under the penalties of perjury that all information on this form--front and back and ALL__attached pages--is true to the best of my knowledge.

Applicant's Signature: [signature] Date: 3/31/90

FORM 11/89

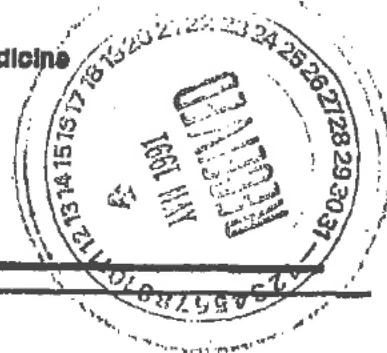
Commonwealth of Massachusetts, Board of Registration in Medicine

Ten West Street, 3rd Floor, Boston, Massachusetts 02111

Limited License Application, Page 1 of 2

___Renewal

Fifty Dollar Fee Payable to The Commonwealth of Massachusetts



Board Use Only:

Registration No.	Status	Fee $50	Date
			MAY 21 1991

M.R.	______	__/__/__
Pr.	______	__/__/__
Bk.	______	__/__/__
Ch.	______	__/__/__
D.E.	______	__/__/__
Fl.	______	__/__/__

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. *Print legibly or type your answers.*
. *Answer all non-optional questions (front and back of form) completely*--**Even though the Board may have the information, it is not adequate to state that the Board already has the information.**
Sign the application at the bottom of page two.
. **Make a copy of this form and all attachments for your own records--you must give hospitals and other health care facilities copies for credentialing purposes.**

SECTION A: Sworn Statement to be Completed by Applicant. (Complete Reverse Side Also)

1. Name (LAST:) Foster (FIRST:) Jonathan (M.I.:) T.
2. Mailing Address:
3. Name & Address of Training Hospital: Brigham + Women's Hospital, 75 Francis St., Boston MA 02115
4. Medical School Name: Yale Univ. School of Medicine
5. Current Limited License Number: 90-3943-94
6. **To be completed by Program Director:**

I hereby certify that the above-named physician is in good standing in the Residency/Fellowship indicated. Has the physician been subject to past or pending disciplinary action in this program? ______Yes __x__No

Type or Print Name and Title Kenneth J. Ryan, M.D., Program Director

Signature of Program Director [signature]

SECTION B: TO BE COMPLETED AND SIGNED BY THE DESIGNATED OFFICIAL OF THE INSTITUTION AT WHICH THE APPLICANT HAS RECEIVED AN APPOINTMENT.

This certifies that Jonathan Foster, M.D. has been appointed to the position of Intern______, Resident PGY-2,

Fellow____ in Program Obstetrics & Gynecology (Program) at Brigham and Women's Hospital (Institution) beginning July 1 and

Anticipated completion date of training 6/30/94.

This program is accredited by the ACGME: Yes x No
If no, we have an ACGME approved training program in the applicant's specialty: Yes___ No___.

Designated Official's Signature: [signature]

Type or Print Name and Title: Hiroshi Tokubo, Assistant VP Clinical Services Date 4/23/91

(Applicant See reverse side - You must complete Section C)

FORM 1/91

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SECTION C: Sworn Statement to be Completed by Applicant (Complete Reverse Side Also)

7. Other States where you are now fully licensed to practice:
(Abbreviate): NA

Questions 8 through 14 not applicable.

Questions 15 through 24. Check either YES or NO (not N/A) to each question. Provide details on Form 15B, attached.

Yes No

15. Has any medical malpractice claim been made against you (whether or not a lawsuit was filed in relation to the claim)?

16. Have you been a defendant in any criminal proceeding other than a minor traffic offense?

17. Are any formal disciplinary charges pending or has disciplinary action (as defined by Board regulations; See Attached From 15B) been taken against you by any governmental authority, hospital or other health care facility, or professional medical association (international, national, state or local)?

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Pursuant to M.G.L. c.62C sec.49A, I certify under the penalties of perjury that, to my best knowledge and belief, I have filed any Massachusetts state tax returns and paid any Massachusetts state taxes that are required under law. Note: This applies even if you reside out-of-state or out of the country.

I certify that I will fulfill my obligation to report abuse or neglect of children pursuant to M.G.L.c.119 sec. 51A

I will read the Board's regulations, 243 CMR 1.00 through 3.00. To the best of my knowledge, I meet the qualifications for limited licensure in Massachusetts.

I hereby certify under the penalties of perjury that all information on this form--front and back and ALL attached pages--is true to the best of my knowledge.

Applicant's Signature: [signature] **Date:** 3/1/91

HARVARD MEDICAL SCHOOL

KENNETH J. RYAN, M.D.
Kate Macy Ladd Professor of Obstetrics and Gynecology
Chairman of the Department

RECEIVED MAR 19 1992
BOARD OF REG. IN MED.
COMMONWEALTH OF MASSACHUSETTS

BRIGHAM AND WOMEN'S HOSPITAL

CHAIRMAN, DEPARTMENT OF OBSTETRICS AND GYNECOLOGY

Brigham and Women's Hospital
75 Francis Street
Boston, Massachusetts 02115
Tel: Area Code (617) 732-5444

March 17, 1992

Alexander F. Fleming
Executive Director
Massachusetts Board of Registration in Medicine
10 West Street
Boston,MA 02111

Dear Mr. Fleming:

I am writing on behalf of Dr. Jonathan Foster concerning his application for licensure. Dr. Foster came to the Brigham & Women's Hospital from Yale Medical School in 1990 as a first year resident in Obstetrics & Gynecology. His medical school evaluation was excellent.

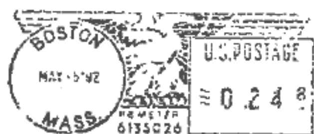
Dr. Foster successfully completed his first year of residency, which involves medicine and surgery as well as obstetrics and gynecology, as of July, 1991. He is now in his second year and is doing a fine job as a competent and caring physician.

Sincerely,

Kenneth J. Ryan, M.D.

Department of Obstetrics & Gynecology
Brigham & Women's Hospital
75 Francis Street, ASBI-3-073
Boston, Massachusetts 02115

PRESORTED
FIRST-CLASS



Commonwealth of Massachusetts
Board of Registration In Medicine
Ten West St., 3rd Floor
Boston, MA 02111

Address Correction Requested